

# EFFECTIVE FAMILY-BASED MENTAL HEALTH SERVICES FOR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE IN PENNSYLVANIA

The Ecosystemic Structural Family Therapy Model

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I'm getting so used to being put into placement. It's like life - a pain in the butt. I have a lot of anger inside. Placement's really screwing me up. I remember getting chucked into a van and getting sent to some home. I was only 11 years old and that scared the crap out of me. If you're going to put me in placement, throw me into a cell somewhere - treat me like an animal - like a throw-away kid.

Bill, age 14

I want to beat Sam's rear end so he thinks I'm the wicked stepmother. He may be 15 but he acts like an out-of-control 2-year-old. Ever since his older brother got sent away to some place, Sam's dad won't lift a finger. The kid's been evicted from three inpatient units. The special school in that other county just kicked him out, so where's he gonna go? The principal of the school down the street doesn't want him cause he's either truant or fighting. I'm at the end of my rope.

Sue, age 43

Before 1988, children or adolescents like Bill were inevitably placed in residential treatment programs because Pennsylvania had no intensive mental health home-based services in the state's continuum of care. Fortunately, the implementation of family-based mental health services (FBMHS) throughout Pennsylvania, beginning in 1988, changed the trajectory of Sam's emotional, family, and academic life, as well as the lives of many other young people like him.

### Overview

In 1985, funding from the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) initiative provided an opportunity for Pennsylvania to examine the needs of children and families from a mental health practice perspective. Mental health consumers and providers throughout the state were asked such questions as: Do services need to be modified or adapted to meet the special needs of children and their families? The resounding response was a need

for services for *both* families and children, designed to improve the functioning of children *and* help families better cope with their children's special needs.

Pennsylvania's CASSP philosophy was also developed and underscored the beliefs that a family's needs are best met through services that are: individually tailored, family-centered, community based, interagency supported, culturally competent, and least restrictive/least intrusive. The family-based mental health services (FBMHS) were designed as Pennsylvania's first statewide service initiative to implement the CASSP values. Working with parents as partners, FBMHS sought to improve child and family functioning through time-limited, team-delivered family therapy, creating collaborative linkages between appropriate community and family resources, and providing family support funds for concrete services such as transportation, emergencies, creative treatment planning, and interventions that provide respite. (See Table 1 below for FBMHS program elements.)

**Table 1**

**PA's Family-Based Mental Health Services**

- Targeted to children and youth with SED
- Team-delivered (MA and BA) in the home, school and community
- Eight months duration
- Maximum of 8 cases per team
- Three hours of weekly supervision
- On-call emergency service
- Family support services
- Therapeutic component: Ecosystemic Structural Family Therapy (ESFT)
- Case management and service coordination
- Three years (53 days) of mandated training
- Eight years of clinical effectiveness research (1988-1995)

FBMHS were developed to serve children at risk for out-of-home placement due to psychiatric diagnoses indicating severe emotional or behavioral disturbances (SED). They also target children and adolescents who need to be reunified with their biological or substitute care families following discharge from inpatient hospitals or psychiatric residential placements. Overall program goals include not only preventing out-of-home placement of children in residential treatment facilities but also reducing the number of crises-driven emergency room visits for mental health problems and increasing intentional planning for psychiatric hospitalizations that do occur. Since their inception in 1988, the continuing development of FBMHS

has been encouraged by public and private managed care as a clinically effective, preferred alternative to inpatient hospitalization or psychiatric residential placement.

**The Ecosystemic Structural Family Therapy Model (ESFT)**

An innovative feature of Pennsylvania's FBMHS is the adherence to a unifying Ecosystemic Structural Family Therapy (ESFT) Model as a theoretical and practical basis for developing the statewide FBMHS, training and evaluation initiatives. The ESFT Model is a modification of the well-researched Structural Family Therapy Model developed by Salvador Minuchin (1974). The theoretical and practical framework for the ESFT Model is described in *Creating Competence from Chaos: A Comprehensive Guide to Home-Based Services* (Lindblad-Goldberg, Dore, & Stern, 1998). This framework encompasses assessment methods, therapeutic goal setting, and treatment interventions with families and youth with SED served by FBMHS. The model has been highlighted in recent reviews of mental health, family therapy-oriented home-based services (Hansen, Litzelman, and Salter, 2002; Nichols & Schwartz, 2004).

The ESFT Model is based on the fundamental assumption that individual functioning is inextricably linked to environment. Therefore assessment focuses on the needs and strengths of both the individual and the environment (i.e., family and community). Individual assessment focuses on developmental domains (cognitive, emotional, social, physical). Recurring relational patterns of interaction are explored both within the family (i.e., family structure) and between the family and the community. Adaptive family interactions can promote mastery of specific individual challenges, and nonadaptive family interactions can exacerbate an individual's difficulties. By strengthening parenting supports, capacities, and skills, including increased problem-solving, communication, understanding of children's individual differences, and management of parental emotional and developmental challenges, it is believed that parents can, in turn, be more responsive to the social-emotional needs of their children. In addition,

enhanced environmental responsiveness as evidenced in part by supportive school placements, appropriate recreational activities, and support for parents in need of respite is believed to be a key element in preventing further family breakdown and child placement.

The model's ecosystemic orientation is evident in the FBMHS intake process which involves consultation and collaboration with the major child-serving systems in each community. It is also evident in the program's therapeutic approach that

aims to expand a family's competence by changing patterns of transaction both within the family system and between the family and community systems so that a family can make better use of its internal resources as well as resources in its environment. (See Table 2 summarizing theoretical assumptions of the ESFT Model).

**Table 2**

**Theoretical Assumptions of the Ecosystemic Structural Family Therapy Model**

- All behavior is a form of communication within a defined cultural context.
- Symptoms occur within the context of social interactions.
- Causality is a circular, not linear, phenomenon.
- Families are evolving multibodied systems that continually regulate their internal structure, rules and roles in response to developmental and environmental changes.
- Adaptive functioning is determined by the fit of a family's structure to the functional demands made upon it from within and beyond the system.
- Family members relate to each other in patterned ways that are observable and predictable.
- Repetitive patterns created by family roles and rules evolve in an interlocking, complementary fashion.
- Family members develop a preferred degree of emotional and functional levels of proximity and distance in relating to one another.
- Families are hierarchically organized, with unwritten rules for interactions between and within the subsystems.
- Inadequate hierarchical structure and boundaries maintain symptomatic behavior.
- Family patterns are replicated in the surrounding ecosystems.
- Individuals are inherently competent, although rigid interactional patterns can inhibit the expression of that competence.
- Change in family structure contributes to change in the behavior of individual members.
- Promoting alternative transactional patterns broadens the flexibility and competence of individuals and subunits in the family and its ecosystems.
- Families are their own best resource for change.

From: Lindblad-Goldberg, M., Dore, M. M. and Stern, L. (1998). *Creating Competence from Chaos: A Comprehensive Guide to Home-Based Services*. New York: W. W. Norton and Co.

In the ESFT model, clinicians develop collaborative relationships with families and learn from them about the cultural uniqueness of each family. On a highly individualized basis, treatment goals and interventions are developed in

collaboration with the family, and family strengths are used to promote therapeutic change. Clinicians facilitate and support change, by coaching family members in individual, parent(s)-child, parental, marital, or family sessions to engage in growth-

producing interactions with each other and with community resources. Here many of the interventions associated with structural family therapy are used, such as boundary making, increasing intensity, enactments, unbalancing, reframing, punctuation, etc. (Minuchin & Fishman, 1981). When indicated, pharmacological interventions are used. Treating a child with symptoms within this model means working simultaneously with the child and family, the home setting, and the family's community network (neighborhood, school, job, recreation, church, agency resources, medical facilities, friends, relatives, neighbors, etc.)

The four overlapping treatment stages within the model are: (1) constructing the therapeutic system; (2) establishing a meaningful therapeutic focus; (3) creating key growth-promoting interpersonal experiences; and (4) solidifying changes and termination. Creating the foundation for treatment and targeting focal areas for change occur in Stages One and Two. Stage Three involves intensive collaborative efforts aimed at specific change experiences for family members. Stage Four is characterized initially by a family's deepened understanding of emotions and behaviors that inhibit or promote change. Subsequently, family members demonstrate their ability to engage in problem-solving methods and other interventions, so that they are able to maintain changes while dealing effectively with ongoing or future challenges. Once the family has internalized key elements of the therapy process, Stage Four also involves preparing the family for termination. Further information on the model's stages and interventions are elaborated in a recent review of contemporary Structural Family Therapy (Jones & Lindblad-Goldberg, 2002).

### **Translating the ESFT Model into Practice**

The following vignettes from a case study—"Sam and his Family"—are presented to highlight how the ESFT Model is translated into family-based mental health practice.

In desperation, Sue, age 43, a stepmother for three years, called the local child welfare agency for help. Her 15-year-old stepson, Sam, was threatening to beat up his 17-year-old sister, Jen. Additionally, he had been truant from his current high school for the past three months and hung out with a "bad crowd" with whom he occasionally smoked pot and drank alcohol. Sam refused to accept any authority and was verbally abusive to school personnel. For the past three years, he had been attending an out-of-county alternative school. While enrolled, he became suicidal and was sent to three different out-of-county psychiatric inpatient units. After the third hospitalization, the alternative school would not allow him to return, whereupon he returned to the academic public high school in his neighborhood.

While the child welfare agency indicated their willingness to consider a residential placement, they first referred Sue to the local community mental health center where Sam was evaluated. The psychiatrist's diagnostic results included concerns about Sam's major recurrent depression, attention deficit hyperactivity disorder, learning disability, and undersocialized, aggressive conduct disorder. The child welfare worker encouraged Sam, his father and his stepmother to attend the interagency CASSP meetings. At this meeting, FBMHS were recommended as a possible alternative to residential placement. The FBMHS program director, Mark, also attended the CASSP meeting, and family members agreed to explore the intensive in-home service.

### **Stage 1: Constructing the Therapeutic System**

The FBMHS program director, Mark, called the stepmother, Sue and her husband, Will (Sam's biological father), and arranged the first home visit. Before designating a treatment team, Mark wanted to conduct his own personal assessment of Sam and the family since he would be supervising the in-home team.

This was a very private family with no extended family, community, or neighborhood involvement. Will was reluctant to have an outsider come to his working class neighborhood and enter the sanctity of his home. While married to his first wife, Jane,

child protection workers had come to the home and his oldest son, Will Jr., had subsequently been residentially placed for three months. Shortly after this experience, Will and Jane had divorced. Jane moved to another state, remarried, and discontinued contact with her daughter, Jen (then 11 years) and Sam (then 9 years). A few months later, Will Jr. left home at 17 years and ceased contact with his father, sister Jen, and brother Sam.

The stepmother, Sue, was also fearful. In the first year of her marriage to Will, she had brought her two teenagers into the home. A neighbor had called child welfare about the lack of home supervision. When neglect charges were filed, Sue's ex-husband took custody of her two children. For both parents, outside interference meant the threat of loss.

Mark knew that this initial in-home visit was a crucial first step in beginning a collaborative therapeutic relationship that would be empathic to the reality of both Sue's and Will's mistrust, pain, and current crisis with Sam. His goal for the session was to explain FBMHS clearly, defining how he and his staff would work together with the family so that *they* could decide how *they* wanted to handle the situation with Sam. He clarified that FBMHS had no power to place children. He also informed the family that the FBMHS program worked closely with the agency's staff psychiatrist who could evaluate Sam and provide the psychotropic medications requested by Sam and his parents. During the session, as Sue and Will slowly began to respond to Mark's sincerity and respectful style, the other attending family members, Sam, Jen, and her boyfriend Ted, began to voice their hopes for positive, future experiences.

The assigned team continued the process of collaborative relationship-building with each family member and partnered with them around gathering assessment information and developing treatment goals.

### **Stage 2: Establishing a Meaningful Therapeutic Focus**

Within the first weeks of FBMHS, Sue and Will were enlisted as partners in understanding Sam's current emotional challenges and obstacles to school attendance. Information was collected on Sam's strengths, vulnerabilities and symptoms from multiple perspectives through interviews with the parents, Sam, his sister and her boyfriend, the current high school principal, and findings from the psychiatric evaluation, previous alternative school and three inpatient hospitalizations. Understanding the family's stressful journey was contextualized by eliciting family history and previous treatment efforts; punctuating external stressors, recent transitions, and normative demands for change; and simultaneously empathizing with each individual's emotional experiences and validating coping efforts. The intervention of enactment was used that highlighted symptoms or topics of concern to test hypotheses about current family structure, strength of attachments, and preferred approaches to emotion regulation. Family interconnectedness was explored that emphasized both growth-promoting and constraining interactional sequences. The team dialogued with the family about patterns observed and the meaning members made of their experience.

Following this comprehensive assessment, information was integrated to clearly define the central emotional challenges for both Sam and the family. The increase and decrease in Sam's symptomatology relative to critical life events suggested a recurrent cycle. Sam's symptoms of depression, anxiety, rage, out-of-control behavior in school or truancy, and drug and alcohol usage were correlated with his feelings of loss and abandonment. These feelings came from such events as deaths in the family; the threat, and subsequent loss, of his original family (parental conflict, marital separation, divorce, mother's remarriage and relocation to another state with no continued contact, brother's departure from the family); and distance in his relationship with his father due to a number of factors (father's remarriage, addition of stepsiblings in the home, and sister's boyfriend developing a close relationship with Sam's father). Together the team

and family defined how to successfully master emotional challenges and barriers to school attendance, thereby setting the goals of treatment.

### **Stage 3: Creating Key Growth-Promoting Interpersonal Experiences**

Specific goals and interventions were formulated for family members (Will, Sue, Sam, Dawn, and Ted) and outside helpers (director of the special education unit, current school principal, school psychologist, Sam's prosocial friends) that furthered overarching family goals. For example, a major emotional challenge for Sam was dealing with feelings that his mother and father had abandoned him. Sam stated that spending time with his father greatly decreased these feelings. Therefore, various enactments were encouraged to increase proximity between father and son. Father and son sessions were conducted that promoted dialogues wherein Sam could express his pain and his father could soothe him. The team suggested recreational experiences for father and son. Will and Sam went camping together and Sam helped his father at his bowling alley job. Father encouraged Sam to bring his prosocial friends to the bowling alley for fun and pizza. Sam's stepmother, Sue, had also felt abandoned by her biological children, and team interventions encouraged her to re-initiate contact with them. Many sessions were held with Will and Sue to help solidify a parental alliance and to encourage their mutual support as they each attempted to improve the relationships with their own biological children. It is a characteristic of the ESFT model that the treatment goals may at times extend beyond the immediate reasons for the child or adolescent referral. A major assumption is that strengthening all weakened family relationships will contribute to improvements in the referred child's emotions and behaviors.

The team organized meetings with Will, Sam, the current school principal, and the school psychologist who had tested Sam, to work together in securing the most appropriate school placement for Sam given his significant learning disability. In an individual session with Sam, he confided to the team that he was truant from school because he felt "dumb" for not being able to handle the academic

courses at the high school. He shared the secret that instead of going to school, he had been helping a contractor in a nearby neighborhood to rehabilitate an old house.

The team arranged a special, surprise get-together for his father, Sam, the contractor, and one of Sam's prosocial friends at the house where Sam had done the carpentry. The contractor praised Sam's excellent work on the house. It was the first time that father and son had the experience of being in a public setting where Sam's "performance" was verbally acknowledged to be "A+"! Will was so proud because he, too, excelled at carpentry. From this intervention - an enactment of competence - evolved the team and family's belief that the best school placement for Sam would be the county's excellent vocational school.

A major crisis developed at the end of the first month of treatment. The stepmother, Sue, called the emergency 24-hour on-call system, to report that Sam's behavior had suddenly deteriorated. In an individual session, Sam shared that unbeknownst to Will and Sue, Jane, the biological mother of Sam and his sister Jen, had begun telephoning Jen. During one of these calls Sam got on the phone and told his mother that his father didn't love him and that his stepmother was cruel to him. In a state of impulsive anger, his mother told him that she and her husband Larry would come and rescue him. They would kidnap him and take him back to their home in another state. The team and their supervisor, Mark, carefully reflected on how to use this crisis to create positive changes for Sam and the family.

The team then met with Will and Sue to develop a plan for how this unexpected visit from Sam's mother and stepfather could perhaps lead to a more active parenting effort on the part of biological mother in the future. Jane and her husband were contacted by the team and invited to an office session to discuss how the adults in Sam's life could work together on his behalf. During this crucial session, the team was able to develop trusting relationships with Jane and her husband and thereby secure an agreement that they would not kidnap Sam, but rather would promote the goal to have the biological parents cooperate to help Sam. A crucial

session was held with Will, Jane, and their son wherein Sam experienced his parents working together in his best interests for the first time in his life.

On the same day as this session, the stepmother, Sue, called the team on their beeper to report “a crisis within a crisis.” Sue’s oldest daughter was at her out-of-state home in a body cast due to a recent car accident. Unable to take care of herself, she wanted her mother to come live with her for the next month. Sue felt divided by the simultaneous pull of her commitment to support Will and her daughter’s needs. Both Will and the team supported Sue in the decision to respond to her daughter’s needs. Re-establishing the mother-daughter relationship would no doubt help Sue relax in her stepmother role with Sam, and providing concrete assistance in the form of payment of transportation costs for Sue and supportive telephone calls to Will during her month’s absence was viewed as furthering Sam’s treatment goals.

#### **Stage 4: Steps to Solidifying Changes and Termination**

In subsequent sessions, the incremental changes that each family member made were validated. Will’s tireless efforts to continually help Sam during Sue’s absence and Sam’s positive responsiveness were rewarded by the team. Will’s reward took the form of his going fishing for a weekend with a good friend. Sam’s reward was spending the weekend with a friend. Over time, it became clear that the relationship between family members had changed in a positive manner. Both Sam and his father had learned how to maintain a close relationship wherein each of their needs was met. Sam was now able to monitor his impulsive, negative outbursts when his father asked him to complete chores or inquired about his school behavior. His father had learned not to distance himself when Sam needed his help. Both father and son were able to voice their appreciation and enjoyment of each other. When Sue returned, she learned not to take over for Sam’s dad, but rather to support and encourage him in his dealings with Sam. She also continued to maintain positive ties to her own biological children. Sam’s biological mother continued contact with Sam by telephone

and was consistent in her support of Sam and also Will’s parenting. This new relationship pattern within the family was maintained despite daily pressures and struggles.

Over a period of eight weeks, one of the team members had made weekly impromptu visits to the county’s Director of Special Education in an attempt to build the relationship necessary to obtain a referral for Sam to attend the in-county vocational school. The Director viewed the parents as resistant “trouble-makers” and was reluctant to refer Sam to an in-county school. The Director was overscheduled and the team member’s relationship-building occurred as she walked with the Director to her various meetings. After eight weeks of this informal relationship-building, the Director finally agreed to refer Sam to the county’s vocational school. Meetings were held with the vocational school personnel, father, and Sam. The school allowed Sam to begin by attending half-days and counted as “school-time” the second half of the day that Sam spent rehabilitating houses with the contractor. Slowly over time, Sam eventually began to attend the vocational school full-time. All family members began to enjoy their relationship with the school system. They felt supported by the school personnel and were, in turn, supportive of the school’s efforts with Sam. [It should be noted that the relationship created with the Director of Special Education by the family-based therapist exemplifies the program’s mandate to incorporate interagency personnel in ongoing planning, as well as to advocate for needed services.]

After six months, the team and family collaboratively decided that the treatment goals had been accomplished and everyone began to prepare for termination. After discussions with the family, the team diminished their frequency of contact so that family members could have the experience of going it on their own. When sessions were held, family members described what each had done to maintain the positive changes in the family and with the school. A date was set for termination. Sessions now focused on reviewing the treatment progress of each family member, and each family member described what he/she had learned about his/her contribution to problems and solutions. Predictions

and plans for future crises and setbacks were discussed. The team shared what each family member had taught them about resilience and “making it.” In discussing aftercare services, family members expressed confidence in their own problem-solving abilities, but also indicated their willingness to seek outpatient services should the need arise. A termination party was held at the bowling alley with the team members, Sue, and Dawn competing with Will, Sam, and Ted. The journey was over. The family was now on their own road and would walk it their way.

### **Summary of Sessions and Follow-Up**

The treatment of this family covered a period of six months with session scheduling being the most intense during the first two months. Fifty-three scheduled meetings were held: 39 at the home, four in the office, three in the community, and seven at the public school, special education unit, or vocational school. During the entire treatment, there were only two cancellations by the team and none by the family. Given the complexity of this family’s situation, supervision and training consultation were critical in helping the team to maintain a clear focus in their clinical work. The two team members received help in case conceptualization, planning treatment interventions, dividing case management responsibilities, and clarifying the role each would take with various family and community members.

A telephone follow-up interview was conducted with Will and Sue three years after termination of FBMHS. Sam had graduated from vocational school and was working in the contractor’s construction company. All family members had attended Sam’s graduation: Will and Sue, Jane and her husband Larry, Sam’s older brother Will, Jr. and sister Jen. Sue’s children were maintaining contact with her by telephone and occasional visits.

As this case vignette illustrates, the ESFT Model of FBMHS is more than a means of managing a myriad of support services for a family in hopes that members will thereby change. These programs are not designed to ensure a quick “fix” of extremely complex family situations where lives have been seriously fragmented by every kind of trauma imaginable (Archaki-Stone, 1995). In this

effective, strengths-based approach, the family itself is seen as possessing the best resources for change. The home-based therapist views himself or herself as a change agent working in collaboration with the family and the community to generate alternatives. Working in proximity with the family, therapists exhibit an attitude of respectful curiosity, caring, and a firm belief in the family’s resilience and ability to change. The family members themselves make the decision when it is safe to change, then the family-based team actively facilitates and supports this change.

### **ESFT Training: Ensuring Treatment Fidelity**

Establishing statewide FBMHS services in Pennsylvania has also meant working with each of the 67 counties and their resources to support these family-focused programs. The ESFT Model was selected by the state because the values underlying ESFT are congruent with the CASSP philosophy. The importance of implementing the goals of coherence and consistency (i.e., *treatment fidelity*) in the implementation of the FBMHS program model throughout the state has been linked to quality control of staff development and ongoing evaluation of treatment outcome. This effort has been achieved through joint efforts in training and evaluation.

As new FBMHS programs were developed in each Pennsylvania county from 1988 through 1996, training in the ESFT Model targeted county and agency administrators (1988-1996), as well as the family-based clinicians and their supervisors. Since 1996, training has focused on FBMHS program directors, supervisors, and staff. Over 1,200 family-based directors, supervisors, and clinicians have been trained in the ESFT Model by Marion Lindblad-Goldberg, Ph.D., LMFT, and the faculty at the Philadelphia Child and Family Therapy Center, Inc. (formerly of the Philadelphia Child Guidance Center, a clinical, research, and training facility affiliated with the University of Pennsylvania Department of Psychiatry). Using Dr. Goldberg’s curriculum, over 554 family-based supervisors and clinicians have been similarly trained by Patricia Johnston, QCSW, BCD, and the faculty at the University of Pittsburgh Medical

Center Presbyterian, Western Psychiatric Institute and Clinic (Johnston, 2003).

Training offers a consistent theoretical map for the family-based programs and a strong emphasis on the quality of clinical skill development. The ESFT competency-based training curriculum demonstrates congruence between the family demographics and prevalence of clinical problems of the families served and the distinctive features of FBMHS. Training includes didactic presentations and clinical skill development. The basic theme underlying training is “how to” implement ESFT in the assessment and treatment of families. During a clinical skills day, ESFT theory is applied and practiced. Clinicians present written case presentations outlining aspects of ESFT and videotaped vignettes of consenting families currently in treatment. Role playing is frequently used to focus on such interventions as enactments, boundary making, unbalancing, etc. Consultation is provided on specific cases. Therapists are trained to assess and facilitate healthy child/family/community interactions based on cultural norms of the family being helped (Lindblad-Goldberg, Dore, & Stern, 1998).

Ongoing ESFT training sessions are also held for supervisors. As with family-based staff, bringing in supervision “raw data” is emphasized. Trainer consultation focuses on videotaped vignettes of the supervisor’s supervision of the family-based team’s clinical work as well as on specific cases. Supervisors are also encouraged to call their trainer at any time they need help on a case. Supervisors are invited to register for a four-day course on supervision offered yearly by the Philadelphia Child and Family Therapy Training Center. Currently, efforts are being made to develop a detailed training manual for practitioners and supervisors (Jones, Lindblad-Goldberg, & Graziano, in progress).

Each FBMHS supervisor and clinician receives two days of training per month for a total of 17 days per year over a three-year cycle at a geographically accessible regional training site. All new clinicians and supervisors also attend two days of start-up training. Thus a total of 53 days of training is

provided within the three-year period. Training graduates are eligible to take a certification exam in FBMHS proficiency administered by the Pennsylvania CASSP Training and Technical Assistance Institute; certification is granted to trainees who pass the exam by the Department of Public Welfare. As a result of this centralized, intensive training effort, evaluation of FBMHS can relate findings to the treatment model with a high level of confidence.

### **FBMHS Evaluation Study**

Outcome research usually involves either demonstration of a program’s efficacy or a program’s effectiveness. Efficacy studies are conducted under tightly controlled clinical or laboratory conditions to establish whether a particular intervention reduces symptoms or increases functioning. However, efficacy studies that screen patients carefully, randomly assign them to treatment groups, and carefully monitor and vary the treatments offered, are limited as to whether their findings generalize to treatment with children and families with complex needs outside the laboratory (Lonigan, Elbert, & Johnson, 1998). Effectiveness studies are generally carried out in the natural environments of practice where controls are limited. This factor weakens the ability to conclude that changes are due to the interventions alone. However, effectiveness studies reflect the complexities of “real world patients” provided in “real world practice settings” by the average practitioner. Our initial approach to evaluating the ESFT model falls under the general description of “effectiveness” data based upon **1,968** participating families and children.

Clarifying and specifying program goals and identifying valid and measurable outcomes in relation to the theoretical model of treatment is a critical first step in designing an outcome evaluation (Dore, 1991). Without clearly defined program goals, it is not possible to conduct a meaningful outcome evaluation. The draft FBMHS state regulations (Department of Public Welfare, 1993) define three outcome goals of these services: (a) to reduce the incidence of psychiatric hospitalizations and other out-of-home placements

of children and youth; (b) to enhance families' ability to cope with a child or adolescent with serious emotional disturbance; and (c) to enhance the psychosocial functioning of all family members, including the child with serious emotional disturbance.

Making connections among program goals, treatment theory, and intervention strategies was critical in designing the evaluation and research initiative conducted from 1988 through 1995. Once program goals were translated into measurable outcomes, the instrumental goals that guide FBMHS practice, and the facilitating goals that implement them, were developed. Table 3 (see Appendix 1) depicts the Logic Model which guided evaluation of the FBMHS initiative in Pennsylvania (Lindblad-Goldberg, Dore & Stern, pp. 286-287).

The FBMHS evaluation examined and received empirical affirmation of the research questions found in Table 4 (Dore, 1996; see Appendix 2). From 1988-1995, data were collected on demographic characteristics of 1,968 participating families and children (See Table 5, Appendix 3), identifying patient placement history as well as treatment histories of other family members. Pre-post FBMHS comparisons examined the child's psycho-social functioning and family members' self-reports of six dimensions of family functioning (problem-solving, communication, role allocation, affective involvement, affective responsiveness, and behavior control). When FBMHS treatment ended, follow-up data were collected at three, six, and twelve months on outcome variables such as psychiatric hospitalization and emergency room use for mental health crises. Outcome data were also collected on the status of problems addressed during treatment, post-treatment placement experiences, and current family involvement with other community service systems.

These data indicate statistically significant positive pre-post FBMHS changes in the identified patient's psycho-social functioning and in all family members' self-reports on all dimensions of family functioning. The one exception was that the identified patient did not report positive changes in all areas of family functioning. Also, strong

problem resolution of families' reported problems was found for families who completed home-based services. At the one year follow-up post-treatment, families reported that 77% of the five main problems addressed during treatment were completely or partly resolved. Low percentages of out-of-home placements in various service systems were also found up to one year following FBMHS treatment. For example, although 80% of identified patients had experienced psychiatric hospitalization prior to FBMHS, only 28% of ANY family members (i.e. identified patient, mother, father, siblings) experienced a psychiatric hospitalization up to one year after termination of FBMHS. Evaluation of consumer satisfaction revealed families' extremely strong, positive reactions to FBMHS and also to the client's current school placement on one-year follow up data after treatment. Ninety-five percent of participants would recommend FBMHS to a friend with a similar problem. Eighty-two percent of participating FBMHS parents were satisfied with their child's school placement one year following FBMHS (Dore, 1996).

## **Conclusion**

Pennsylvania's statewide Ecosystemic Structural Family Therapy Model for family-based mental health services is a promising practice for children and adolescents with severe emotional and behavioral disturbance. Outcome results have empirically demonstrated treatment differences up to one year post-treatment.

Since their inception 16 years ago, these programs have not only blanketed the state, but training in the ESFT Model has created a qualified and sizeable workforce to provide treatment for families of children and adolescents with SED. Several programmatic features are crucial to the effectiveness of ESFT:

- The use of a home-based model of service delivery (i.e., team-delivered, low caseloads, time limited duration of treatment, on-call emergency service, family support services) removes barriers of access to care and provides

the high level of intensity and support needed to successfully treat youth with SED and their families with multiple needs.

- The philosophy of ESFT emphasizes that family-based service providers are accountable for engaging the family in treatment and, in partnership with families, for addressing barriers to successful outcomes.
- The overriding goal of supervision is to facilitate the clinicians' attempts to collaborate with families and other systems to attain favorable outcomes.
- ESFT family-based programs place great emphasis on maintaining treatment integrity, and as such, considerable resources are devoted to therapist and supervisor training, ongoing clinical consultation, and other types of quality assurance. The current efforts to develop a training manual by the Philadelphia Child and Family Therapy Center faculty will further our ability to maintain treatment fidelity as well as to provide a platform for additional research on the model. The future goals are to continually evolve and refine the model.

Marion Lindblad-Goldberg, Ph.D., LMFT, has been the Director of the Philadelphia Child and Family Therapy Training Center (formerly, the Family Therapy Training Center of the Philadelphia Child Guidance Center) since 1986. As a licensed psychologist and marriage and family therapist, she has been a clinician, teacher, supervisor, trainer, and researcher in the mental health field for 37 years. She has been an Associate Clinical Professor of Psychology in the Department of Psychiatry of the University of Pennsylvania School of Medicine since 1986. Dr. Goldberg developed Pennsylvania's ESFT competency-based training curriculum for the FBMHS initiative in 1988 and has been an FBMHS trainer since that time. She serves as Director of FBMHS training for Pennsylvania's Northwest, Northeast, Central, and Southeast regions. She is the author of numerous publications and has lectured extensively nationally and internationally.

C. Wayne Jones, Ph.D., a child and family psychologist, has been involved in the training component of Pennsylvania's FBMHS initiative since 1988 as a senior faculty member of the Philadelphia Child and Family Therapy Training Center. Dr. Jones is currently the Director of the Bala Child & Family Associates, an outpatient clinical practice, and is an Associate Clinical Professor of Psychology in the Department of Psychiatry of the University of Pennsylvania School of Medicine. In addition to his roles as clinician and teacher, Dr. Jones has been the principal investigator on several major federally sponsored research demonstration programs designed to provide family support services to high risk families with young children. He has published numerous articles and lectured extensively.

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**Appendix 1**

**Table 3  
Logic Model**

**FBMHS for Children and Adolescents with SED**

<b>Outcome goals</b>	<b>Instrumental goals</b>	<b>Facilitating goals</b>	<b>Outcome measure</b>	<b>Instrument/method</b>
1. Reduce incidence of out of home care for identified patient in participating families	1. Stabilize family goals in times of crisis	1a1. Establish 24-hour emergency response team 1a2. Establish a program of respite care	1. Number, percent, and length of planned and unplanned out-of-home placements before/after program	1. Intake and closing data plus telephone follow-up administered three, six and 12 months after closing
2. Enhance family's ability to cope with child with emotional disturbance	2a. Increase family level of functioning	2a1. Participate in family therapy 2a2. Enhance family communication skills	2. Family functioning before/after program participation	2a1. Administer McMaster Family Assessment Device at intake and closing, including problem-solving, communication, affective, behavior control, and general functioning scales  2a2. Parent assessment of progress on contracted treatment goals at three, six and 12-month follow-up
	2b. Increase acceptance and support of child	2b. Participate in parent support network		
	2c. Decrease environmental stress on family	2c1. Assist family in meeting unmet instrumental needs 2c2. Assist family in developing supportive service network		
3. Enhance coping and problem-solving skills of individual family members, including child	3a. Facilitate positive child behavior	3a1. Teach family members new coping strategies and problem-solving techniques 3a2. Facilitate linkages with education system 3a3. Help parents advocate for more appropriate school placements	3. Child's level of functioning before/after program participation	3. Global Assessment Rating Scale completed by clinician at intake and closing

## **Appendix 2**

### **Table 4**

#### **Statewide Clinical Effectiveness Evaluation Initiative Research Questions**

##### **Can Family-Based Mental Health Services:**

- Decrease the use of more restrictive forms of mental health care of children?
- Shorten the length of out-of-home placements of children with SED in psychiatric in-patient settings?
- Help to insure that such placements are planned?
- Prevent out-of-home placement of children in other child-serving systems, including child welfare, juvenile justice and substance abuse treatment?

##### **Is improvement in family functioning associated with:**

- Improvement in functioning of a child with SED?
- Better post-treatment outcomes for a child with SED?

##### **Is there a relationship between pre-treatment service system involvement of families and:**

- Changes in family functioning during treatment?
- Post-treatment outcomes for children with SED?

## Appendix 3

### Table 5

#### Family Demographics

N=1,968 Families from 39 FBMHS programs, 1988-1995

#### Racial Composition

88% - Caucasian  
5% - African-American  
3% - Hispanic  
1% - Asian  
<1% - Native American  
2% - Racially Mixed

#### Family Structure

20.5% two biological parents  
26% include one non-biological parent:  
    22%-remarried parents (17% stepfathers and 5% stepmothers)  
    4%-mothers with a live-in male partner  
50% single parent households (23% mother-only; 13% father-only)

#### Educational Levels

High School Diplomas (68% mothers; 69% fathers)

#### Reported Income Levels

Average Income: \$21,000

#### Family Functioning (measured by FAD):

Dysfunction in: problem solving, role allocation, behavior control, general functioning, communication, affective involvement, and affective responsiveness

#### Profile of Identified Patient

64% male; 46% female  
Average age: 12 years  
Most likely to be the oldest child in the family

#### Identified Patient DSM diagnoses

50% - Depressive Disorders and Bipolar Disorders, Anxiety Disorders, Psychotic Disorders, Pervasive Developmental Disorders, Eating Disorders, Aspergers, Tourette's, Communication and Learning Disorders;  
50% - ADD, especially ADHD, ODD, and Conduct Disorders

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