Programmatic Congruency

Institutional commitment needed for successful BSFT implementation requires both a theoretical and a practical understanding of the systemic contextual environment that will insure effectiveness and sustainability.

Do your homework! Know the BSFT® model! By understanding the model, you can create policies and practices aligned with the model. Adaptations can be made as needed, but only by the developers to insure core components are retained. BSFT adaptations, done by the co-developer Olga Hervis, have been implemented in more than 20 states in the USA and in a variety of clinical formats, including home and center-based programs.

Aligning the Fit Between BSFT® and the Target Population

Considerations include:

a. home or center-based program
b. any needed adaptations
c. need to fit the funding to the program

During the course of disseminating BSFT, we have taken a good, hard look at what constitutes successful implementation of an evidence-based practice in the field of service delivery, both from the "must do" and the "must avoid" perspectives. Academia is an antiseptic environment constructed to insure the integrity of the model during its development and trials. In the real world, agencies embarking on launching an EBP are charged with the complex task of bridging the science-to-service gap.

Efficacy research is helpful in choosing an evidence-based program (EBP), but the ***usability*** of an EBP has little to do with the *quality* or evidence regarding the program.

For successful implementation, agencies must align the "fit" between their chosen evidence based model and the target client population. This brings in the crucial consideration, and preparation, of adequate funding. Appropriate funding is required not only for the initial implementation but also for the maintenance of the infrastructure needed to sustain the EBP as it serves the community. Agencies, stakeholders and community resources must partner closely in this process.

There is no exaggerating the value of a properly funded organization that maintains skilled staff with effective managerial support. But like all matters in life, seasons pass and changes come.

The "when" and "how" will the treatment services be provided must be realistic for the population served and the agency's infrastructure. Create an Implementation Team that includes the Model developers actively working with agency administrators and staff as well as relevant community resources.

Organizational considerations must be addressed prior to embarking on the program. Organizational changes at various levels will be necessitated. Create changes in a system slowly, retaining old system practices while introducing new system approaches. Align structure with intended clinical outcomes.

Staffing

For the successful implementation and sustainability of BSFT, Masters-level clinicians, or Bachelor-level clinicians with 5+ years of experience, are suggested. The key component is that the clinicians' role be enhanced by a strong clinical team and significant administrative support.

While the clinicians need to have cultural competencies akin to the target population, much customization is considered by FTTIM when recommending caseloads, team size and roles. One mold does not fit all. Many variables affect recommendations: home-based or center-based training, high-risk or low-risk clients, nature of the caseloads, other therapeutic duties, etc.

Training

These EBPs require clinicians to develop clinical skills in family systems therapy via didactic, experiential, and supervised practicum formats. Please refer to our BSFT Training page on this website for details on becoming a BSFT-competent therapists and obtaining site licensing.

Fidelity and Adherence

Research has proven that lack of adherence and fidelity to an EBP produces negative results that mislabel the EBP as inadequate and ineffective.

FTTIM helps clinicians and their agencies create an environment that maintains programmatic fidelity in all aspects. In helping organizations successfully implement BSFT we have to see that the system be congruent theoretically and clinically with the model. If not, symptoms appear (poor outcomes, engagement and retention failures, loss of fidelity, staff turnover). The EBP then becomes, as we say in Family Therapy lingo, the Identified Patient of the agency system. As effectiveness decreases, funding is lost…. *the EBP dies.*

Adherence consists of demonstrated mastery in each of the four BSFT domains. Focusing adherence on the BSFT® treatment domains will identify fidelity issues early, provide clear direction for individual clinicians, and guide both the clinician and supervisor toward effective remediation. Olga Hervis, the BSFT model co-developer, periodically reviews each agency and clinician for fidelity, and will recommend any adaptations or other measures that will improve utilization and outcomes.

Referral and Intake Process

This is critical. Agencies must institute the mechanics of a referral process early on. Appropriate management of the referral and intake processes insure that BSFT® will result in treatment for a greater number of needy children, and that it will function as intended in perpetuity.

Insure that patient eligibility is accurately stated. Partner with relevant community systems to facilitate the services being provided by BSFT and that they reach the intended audience. Maintain the adequate funding streams necessary for successful implementation.

Sustainability Drivers

Once a site is moving fully operational, sustainability drivers must come into play for the successful survival of any evidence based model, such as BSFT. These drivers are:

a. data-driven monitoring and decision-making for program needs and client outcomes,
b. support system for therapists that provides job recognition, job satisfaction and opportunities for upgrading skill levels
c. contracting with therapists and providing a positive organizational climate
d. training in-house BSFT Competent Supervisors (BCS) and maintaining adherence monitoring as required for program success
e. targeting and assuring continuous funding streams

"Skilled practitioners, funding streams, and program requirements change, and champions move on to other causes. Through it all the implementation site leaders and staff, together with the community, must be aware of the shifting ecology of influence factors and adjust without losing the functional components of the evidence-based program or dying due to a lack of essential financial and political support. The goal during this stage is the long-term survival and continued effectiveness of the implementation site in the context of a changing world."

(Fixsen et al, 2005. Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network) (FMHI Publication #231).

Outcome Measures

Organizations implementing BSFT are encouraged to gather common outcome measures as well as any locally-relevant or required data. Four easy-to-use measures include:

- **McMaster Family Assessment Device (FAD)** Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy, 9, 171-180. https://www.ntnu.no/c/document_library/get_file?uuid=cd377890-a31d-4692-a9b8-47c563844862&groupId=10293

  This tool is designed to evaluate families according to the McMaster Model of Family Functioning. The FAD is made up of seven scales which measure Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control and General Functioning.

- **Youth Self Report (Achenbach)** http://www.aseba.org/forms/ysr.pdf

  This instrument is an adolescent self-repot instrument that assesses the severity of 119 problem behavior and degree of functioning on three dimensions of Social Competence. Problem behaviors can be scored along the dimensions of the super-ordinate domains of "internalizing" and "externalizing" behaviors or along smaller syndromes of behavior.

- **Parenting Practices Questionnaire.** Strayhorn, JM, and Weidman, CS: A parent practices scale, and its relation to parent and child mental health. Journal of the American Academy of Child and Adolescent Psychiatry, 27:613-618, 1988 http://www.jaacap.com/article/S0890-8567(09)65814-7/abstract?cc=y=

- **Structural Family Systems Rating - Hervis, O.E.**, Szapocznik, J., Mitrani, V., Rio, A. & Kurtines, W. (1998). Structural Family Systems Ratings Scale. In J. Touliatos (Ed.) Handbook of Family Measurement Techniques (2nd edition), New York: Microfiche Publications

  Our Institute can provide training in the usage of this tool. Please visit our **Other Training Programs** page. http://www.brief-strategic-family-therapy.com/other-training-programs/

There are several instruments which can be recommended, but they should be considered in light of an agency's interests and reporting requirements. Here are a few for consideration:

1. Revised Behavior Problem Checklist (Quay and Peterson). There are parent, child, and teacher forms. It also has a validated Spanish form.

2. DISC (Diagnostic Interview for Children) Predictive Scales. This measure is used at baseline to identify the presence or absence of 13 comorbid disorders. DISC has both youth and parent forms. This could be used Pre/Post.
3. Brief Symptoms Inventory. This measure is a self-report scale developed from its parent instrument the Symptom Checklist 90 to assess psychological problems.
4. National Youth Survey. This self-report delinquency scale assesses adolescent criminal behavior on 5 subscales.
5. Pittsburgh Youth Survey. This measure assesses parenting practices through both parent and adolescent report.
6. Family Environment Scale. This is used to measure the social-environmental characteristics of families.