Looking for and replicating model programs for 'at risk' children and families

Frank Ainsworth

At the present time there is a need for a new generation of programs to address the needs of 'at risk' children and families. This is an issue that is exercising the minds of service planners in both government and non-government community service organisations. This need arises from the fact that many existing programs have yet to be rigorously evaluated and are of questionable effectiveness. This lack of evidence of effectiveness does not sit well in the current climate of accountability. It also runs contrary to the increasingly strident calls for evidence based practice.

Many new programs arrive in Australia from the US as this country is often the source of program innovation as illustrated by the importation in the 1980s and 1990s of family preservation and family reunification programs. In the US, promotion of 'model programs' has taken another step and a systematic effort at program replication is now in evidence. The question is, how might model programs from overseas be successfully replicated in Australia? And what is required, if anything, to replicate these models effectively taking account of our different cultural traditions?

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Identifying and then replicating model programs is at least a two step process. The first step is an examination of existing research and outcome data from the community services sector. Illustrations of this first step are documents such as the *Messages from Research* series from the UK Department of Health (1991) and *What Works in Child Welfare?* (Alexander, Curtis & Kluger, 2000). An Australian resource is the National Child Protection Clearing House which has a searchable program and activities database.

More advanced methods include systematic reviews from the umbrella groups for crime and justice and social welfare that are part of the Campbell Collaboration (Schuerman, Soydan, Macdonald, Forslund, de Moya & Boruch, 2002). Both the Campbell Collaboration and the Cochrane Collaboration (for health care) have electronic libraries that give access to reviews on topics as diverse as 'Cognitive-behavioural interventions for assisting foster carers in the management of difficult behaviours' (Kakavelakis & Macdonald, 2003) and "Scared Straight' and other juvenile awareness programs for preventing juvenile delinquency' (Petrosino, Turpin Petrosino & Buehler, 2003). A further example is the US evaluation of family support programs that uses meta-analysis (Layzer, Goodson, Bernstein & Price, 2001). Meta-analysis is a core methodology for Campbell type reviews which is used to show that these programs produce small but significant effects (Shadish, Cook & Campbell, 2002) across a range of outcomes for children and families.

Transferring research and evaluation findings into practice will not happen if child and family service practitioners fail to access these resources and do not restructure their practice to take account of new knowledge from these sources. It is known that in medicine, up to two decades may pass before research findings are translated into improvements in practice (Agency for Healthcare Research and Quality, 2001). In an effort to address this issue, clinical practice guidelines and pathways have emerged that aim to optimise the transfer process and improve the quality of practice (Holt, Ward & Wilson, 1996). Child and family service practitioners will need to make similar efforts if evidence based practice is to emerge successfully from the current morass of questionable service effectiveness.

The next step beyond dissemination is the implementation or replication of programs that have been subject to rigorous

evaluation by the scientific community and have been shown to be effective. These programs deserve their elevated status as 'model programs'.

It is these programs that may warrant replication in other places. In fact it can be argued that only these programs are worthy of replication since programs that have not been subject to rigorous effectiveness research can hardly claim to be ethical (Ainsworth & Hansen, 2002). Effectiveness is the cornerstone of ethical and evidence based practice.

ONE SMALL STEP

One small step, although primarily a dissemination activity, was the 'Showcase Presentations' at the recent Child and Family Welfare Association of Australia (CAFWAA) Practice Symposium held in Canberra in September 2003. At this recent event, selected agencies were asked to make a presentation about a particular program using a template provided by the symposium organisers. The idea was to get away from the self promotional aspects of conference presentations and to provide showcase participants with planning and evaluation data against which they could judge a program. The template provided to the presenters asked for the details as shown below in Figure 1.

Figure 1

Program design
- Program objectives
- Theoretical foundation and supportive research
- Program structure
- Program components
- Program processes
- Intervention techniques
- Agency nominated performance indicators
- Program modifications since start-up date, if any, and why

Program details
- Date of start-up
- Staff-client ratio
- Staff numbers, qualifications and experience
- Program capacity
- Cost per client served

Client details (aggregate data)
- Age and gender
- Eligibility criteria
- Number of clients served so far

Evaluation
- When, by whom, method used
- Source and rate of referral
- Number of ineligible referrals
- Completion rates
- Client outcome data (ie, client benefits and how these were measured)
- Client follow-up data (ie, how long were the benefits maintained and how these were measured)

Lessons learned
- What would you do differently next time and why?

It seems that while some of the showcase presenters followed this format, others were less diligent. Importantly, where the template was followed, symposium participants gained access to program data and were in a position to make a judgement about the program's effectiveness to a greater degree than was the case when presentations served primarily a promotional purpose. The rigorous use of these presentations to share hard program data offered new benefits to symposium participants.

NEW DEVELOPMENTS

In the US awareness of the importance of disseminating information about model programs that have been evaluated and that have been shown to be effective has led to the creation of a number of useful websites. The Centre for the Study and Prevention of Violence hosts an Information House that provides details of 11 model programs that the Centre calls 'Blueprints' (www.colorado.edu/cspv/blueprints/models/overview/html). These programs were selected from 600 violence prevention programs. The criteria used to select Blueprint programs establishes a very high standard – one that proved difficult to meet. Against each selected program the Centre then provides a brief word summary, a video segment describing the program and content information. The content information includes evaluation outcome details and costing data for each program. The programs selected are shown in Figure 2. This website also contains a list of 21 promising programs. These are programs that have yet to meet the evaluation criteria for recognition as a model blueprint program but which are striving to achieve this standard.

Another website hosted by the US Department of Health Promotion and Education (www.strengtheningfamilies.org/html/programs) lists 14 exemplary programs, 21 model programs and 5 promising programs. Each program is described by type and age group and rated against a set of criteria. The exemplary programs are shown in Figure 3.

Figure 2

- Midwestern Prevention Project (MPP)
- Big Brothers, Big Sisters of America (BBBS)
- Functional Family Therapy (FFT)
- Life Skills Training (LST)
- Multi-systemic Therapy (MST)
- Nurse-Family Partnership (NFP)
- Multi-dimensional Treatment Foster Care (MTFC)
- Bullying Prevention Program (BPP)
- Promoting Alternative Thinking Strategies (PATHS)
- The Incredible Years: Parent, Teacher and Child Training Series (IYS)
- Towards No Drug Abuse Project (TND)

Both of these websites are prime examples of information and dissemination and are a further step in the process of moving towards evidence based services. But this is just the beginning.

REPLICATING MODEL PROGRAMS

The real challenge is how to take a proven model and replicate it successfully in another place. An examination of attempts to replicate the Homebuilders model of family preservation (Kinney, Haapala, Booth & Leavitt, 1990) is informative in this regard. In fact , the study by Schuerman, Rzepnicki and Littell (1994) of the 'Families First' program in Illinois based on the Homebuilders model is essentially a study of the failure to replicate this program on a state-wide basis. It provides testimony to the fact that when replication of a model program is attempted, if the implementation process is not tightly managed, there will be deviations from the original tested model and the effectiveness of the program will be compromised. Likewise, some agencies in Australia can provide examples of where they have adopted the name and some parts of a program but have failed to replicate it completely.

This replication challenge is addressed by Chamberlain (2003) in terms of the difficulty of transferring an intervention model (Multidimensional Treatment Foster Care – MTFC), *which is a Blueprint program*, from a research-based environment to settings within community agencies. To this end the Oregon Social Learning Centre, the research organisation that developed the MTFC program model, created in 2001 a separate organisation, TFC Consultants Inc., whose sole responsibility is planning, implementing and monitoring the replication of MTFC in other agencies.

Figure 3

Functional Family Therapy
Helping the Noncompliant Child
The Incredible Years: Parents and Children Training Series
Multi-systemic Therapy
Preparing for Drug Free Years
Strengthening Families Program
Treatment Foster Care
Adolescent Transitions Program
Brief Strategic Therapy
Multi-dimensional Family Therapy
Parenting Wisely
Raising a Thinking Child: I Can Problem Solve Program for Families
Strengthening Families Program: for Parents and Youth 10-14

For TFC Consultants Inc. the implementation of MFTC in other agencies involves a series of steps. Firstly, they conduct an 'Organisational Readiness' interview in order 'to assess such areas as organisational structure, history of service, current resources and staffing patterns, relationship with key community stakeholders (e.g. juvenile justice, mental health) and potential barriers to implementation' (Chamberlain, 2003, p. 143).

This interview provides information about the agency strengths and suitability to host a MTFC program. If the outcome of this process is positive, a core team of staff, that minimally includes an administrator, program supervisor, family and individual therapists and a foster parent trainer/recruiter, is trained by TFC Consultants Inc. Once this is completed and the new agency has recruited foster parents, TFC Consultants Inc. provide foster parent training and prepare them to use the tools (including software) developed for use in the MTFC program. An Oregon based program consultant is also identified who holds weekly telephone consultations with the program supervisor and therapists and who reviews daily data for all cases in the new agency. In addition, the consultants make on-site visits usually every quarter. These activities ensure accountability and that the treatment integrity of the MTFC program is maintained (Shadish, Cook & Campbell, 2002).

This approach to program model replication is also adopted by the originators of Multi-systemic Therapy (MST), a model of treatment of high risk antisocial youth and their families *that is also a Blueprint program.* MST was developed at the Medical University of South Carolina (MUSC) by Henggeler, Schoenwald, Borduin, Rowland and Cunningham (1998). To be licensed to deliver MST, it is necessary to undertake initial intensive training and consultation and then pay a substantial annual site fee. MST Services Inc. of Charleston, South Carolina, then provide a detailed training manual containing nine treatment principles and an intensive training regime that involves close supervision and stringent monitoring of the model when it is used in new agencies. Training begins with a one week orientation followed by on-going consultations on each case and quarterly booster sessions held in Charleston. MST Services Inc. are also explicit about the minimal actions required at an organisational level to successfully implement an MST program. They list required program characteristics and these are contained in Figure 4.

Even then, and with the support of MST Services Inc., the replication of the MST program is fraught with difficulty as the Ontario Ministry of Community and Social Services 5 year randomised study of MST makes clear (Cunningham, 2002). This study also bears some similarity to the Schuerman, Rzepnicki and Littell (1994) study of the failure to replicate the Homebuilders model in Illinois.

Figure 4

- MST therapists must be full-time employees of MST program solely.
- MST therapists (Master's level) must be accessible at times that are convenient to the clients and in times of crisis, very quickly. Issues to be addressed in the area include the dedicated nature of MST therapist role, the use of flexi-time/comp-time, policies regarding use of personal vehicles, and the use of pagers and cellular phones.
- MST therapists must operate in teams of no fewer that 2 people and no more than 4 therapists (plus the Clinical Supervisor) and use the family preservation model of service delivery.
- MST Clinical supervisors (often doctoral level mental health professionals) must be assigned to the MST program a minimum of 25% time per MST team to conduct weekly team clinical supervision, facilitate weekly MST telephone consultation, and be available for individual clinical supervision for crisis cases.
- MST caseloads must not exceed 6 families per therapist with a normal range of 4 to 6 families per therapist. The expected duration of treatment is 3 to 5 months.
- In order to achieve outcomes consistent adherence to the MST model MST therapists must track progress and outcomes on each case weekly by completing case paperwork, and participating in team clinical supervision and MST consultation.
- The MST program must have a 24/7 on call system to provide coverage when MST therapists are on vacation or taking personal time. This system must be staffed by professionals who know the details of each MST case and understand MST.
- With the buy-in of other organisations and agencies, MST therapists must be able to 'take the lead' for clinical decision making on cases. The organisation sponsoring the MST program has responsibility for initiating collaborative relationships with these agencies and organisations. Each MST therapists sustains these relationships through ongoing case-specific collaboration.
- Inappropriate referrals to the MST program include youth referred primarily for psychiatric behaviours (ie, actively suicidal, homicidal, actively psychotic), and youth referred for sex offences.
- MST program discharge criteria must be outcome-based and ameliorate the referral problem/behaviour.

The MST requirements are remarkably similar to those recommended by the originators of the Homebuilders model when they advised agencies about the replication of this model and the development of family preservation services in general (Kinney, Haapala. Booth & Leavitt, 1990, pp. 41-53). These requirements represent the conditions under which the effectiveness of MST has been tested and has been shown to work. As a result a cautionary note has to be struck. What we know is that, in most instances, local community service agencies who earlier considered developing a Homebuilders program baulked at the resource cost of this model. Agencies looking at MST or MTFC as new models may well react in the same way. What it is imperative to realise is that any implementation of an MST or MTFC program that does not adhere to the conditions prescribed by the model developers is, in effect, to build a program for which there is no evidence of effectiveness. By changing the program even slightly, the treatment integrity of the intervention will have been destroyed (Shadish, Cook & Campbell, 2002).

The MTFC and MST type of approach to program replication is a far cry from what has all too often happened in Australia in the past – that is, where someone saw, heard or read about a program (often while on an overseas study tour), thought it sounded great, and proceeded to try to replicate the program on their return home, usually with minimum technical assistance. Technical assistance is essential if evidence or science based program models are to be implemented away from their agency of origin. It must be emphasised that if a model program is implemented in a way that fails to maintain the treatment integrity of the program, then the evidence taken from the original program that indicated its effectiveness will no longer have any legitimacy. To do this is to waste time and money as the process of evaluating the program to establish its effectiveness has to start all over again. In fact, we are back at the beginning!

Of course what sometimes gets replicated are simply ideas or philosophies. Recent examples, all from the US, are permanency planning, family preservation and family reunification philosophies. These philosophies have now been embedded in legislation in many places as a way of reshaping child and family services. The NSW Children and Young Persons (Care and Protection) Act (1998) is a prime example of this approach.

However, the legislative changes have not led to the development of specific, well evaluated Australian models of family preservation or family reunification (Maluccio, Ainsworth & Thoburn, 2000). Nor has the impact of the legislation been evaluated, with the result that we do not know if this legislation has improved the effectiveness in NSW of services for 'at risk' children and their families.

SERVICE SYSTEMS AND CULTURE

Clearly, the child and family service systems in the US and Australia are different. Both countries are a federation of states (and, in Australia, territories), although the level of central government intervention and innovation in the US is more apparent. This is illustrated by a raft of legislation enacted in the US over the last 25 years or more, examples of which are the Child Abuse Prevention and Treatment Act (1974), the Indian Child Welfare Act (1978) as well as the Family Preservation and Support Services Act (1993) and the Adoption and Safer Families Act (1997). This differs widely from Australia where, with the exception of the Supported Assistance and Accommodation Act (1994) for youth homelessness, there is little that might be described as national child welfare legislation. We may be on the cusp of a change in this regard given the Commonwealth Government's recent consultation about a National Plan for Foster Children and Carers (Community and Disability Services Ministers Council, 2003), their $1m funding of the Australians Against Child Abuse 'Every Child is Important' campaign (Anthony, press release, 2003a), and the support of the Mirabel Foundation work with grandparents as kinship carers (Anthony, press release, 2003b).

The issue of replicating programs from the US also received some attention in the early 1990s with the advent of family preservation services from the US (Scott, 1993; Ainsworth, 1993). At that time Ainsworth (1993) stated:

> Professional practice in the US, even within state child welfare services, is more clinically focused and there is a greater emphasis on psychologically based therapeutic or clinical interventions. Less consideration is given to the way societal arrangements, employment possibilities, housing options or income levels influence individual or family functioning and child rearing practices. (Ainsworth, 1993, p.10)

This continues to be true and it is largely the reason for the focus of MTFC and MST programs. But as 'treatment' is simply about 'dealing with or behaving towards a person' (Concise Oxford Dictionary of English, 1974) in a particular way which in this instance is through well designed and proven interventions, this language need not diminish our recognition of the professional value of these programs.

Another aspect of this issue was also nicely noted by Scott (1993) when she drew attention to 'the main cultural difference *between Australia and the US* (italics added) is the degree to which therapy is normative in the two societies'. She also rightly said, 'clinical practice needs to be congruent with its cultural context and ... culturally sensitive practice is important when we are crossing ethnic or racial boundaries' (Scott, 1993). And there are no barriers to MTFC or MST programs being culturally sensitive.

LESSONS FOR THE FUTURE

State departments responsible for services for 'at risk' children and their families are likely to seek expressions of interest from community service organisations for treatment foster care and other similar programs in order to broaden the range of services. There is also likely to be a requirement for any programs put forward to be evidence based in terms of their demonstrated effectiveness. What we also know is that these departments will be seeking value for money and, if past experience is a guide, that the money allocated to these developments will not take account of the cost of technical support, assistance and consultation that both TFC Consultants Inc. and MST Services Inc. regard as essential. Without high level technical assistance in implementing model programs, the danger is that what will be created is another generation of programs that are not evidence based and that are likely to be no more effective than those we already have. This would be a very sad outcome and this is not what 'at risk' children and their families need. For agencies and individuals there is an ethical dilemma – do we engage in partnership with the government sector and accept funding that we know is unlikely to be sufficient to support evidence based practice and the proper replication of proven model programs, or do we stand aside until such times as resources to develop effective services are available? Maybe the critical question is, do ineffective services help anyone? ■

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ELECTRONIC RESOURCES

Australian Institute for Family Studies, National Child Protection Clearing House, Melbourne (www.aifs.org.au/na2.html)

Campbell Collaboration (www.campbell.gse.upenn.edu)

Centre for Children and Families in the Justice System, London, ON. (www.lfcc.on.ca)

Cochrane Collaboration (www.cochrane.com)

Multi-systemic Services Inc. (www.mstservices.com)

Oregon Social Learning Centre, Eugene, OR. (www.oslc.org)

The Mirabel Foundation, Melbourne (www.mirabelfoundation)

University of Colorado, Centre for the Study and Prevention of Violence (www.colorado.edu/cspv/blueprints/model/overview.html)

US Department of Health and Human Services, Administration for Children, Youth and Families (www.acf.dhhs.gov)

US Department of Health promotion and Education (www.strengtheningfamilies.org/html/programs)