

THE EVIDENCE BASES FOR THE TEACHING-FAMILY MODEL



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Teaching-Family Model

In 1999, the Surgeon General's Report on Mental Health emphasized the need to develop effective methods for moving evidence-based programs into service settings where they can provide benefits to large numbers of children and families (Mental Health: A report of the Surgeon General, 1999). As stated by the National Institute for Mental Health (NIMH), "For many years, mental health researchers have assumed that an intervention deemed efficacious within clinical trials will be easily transmitted to the field; unfortunately, this has not been the case. Recent literature has instead underscored the importance of understanding the many factors that affect whether the practice community will use a given intervention." (NIMH, July 19, 2002, page 1). The National Institute of Mental Health also published a Blueprint for Change that called for the development of a "dissemination and implementation science" to help move science to service successfully and efficiently (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001).

The Teaching-Family Model provides an example of research that has been "transmitted to the field" to benefit large numbers of children and families. The Teaching-Family Model also has developed and tested a strategy for dissemination-implementation to help move "science to service successfully." The research on the development of the Teaching-Family Model was supported by NIMH for over 20 years. Saleem Shah and Tom Lalley of the NIMH Center for the Studies of Crime and Delinquency were instrumental in helping us define a "treatment model" and in conceptualizing how model development and replication interact over time as an outcome of mission-oriented research (Shah & Lalley, 1973; Lalley, 1976). They also encouraged us to look beyond our discipline to sociology (Eitzen, 1974), business (Faggin, 1985), and community action (Alinsky, 1971) for help and advice on program development and replication. In this conception, "model development" takes on NASA-like mission-oriented qualities where research bases are accessed or created and interdisciplinary research is done in order to sharply focus on solving problems and accomplishing mission goals (Fixsen, Phillips, & Wolf, 1978). Program development follows where the data lead.

The opening of the Achievement Place group home in 1967 marks the beginning of the development of the Teaching-Family prototype treatment program. For the next 4 years, the Achievement Place Research Project at the University of Kansas conducted intensive research in the group home environment to test possible treatment procedures and to organize those procedures into a practical set of daily routines suitable for the group home service setting (Phillips, 1968; Phillips, Phillips, Fixsen, & Wolf, 1974; see Wolf, Kirigin, Fixsen, Blase, & Braukmann, 1995 for a description of the beginnings of the Teaching-Family Model). Program development and research in context were challenging but enhanced the "robustness" of the intervention processes and helped ensure that contextual service delivery variables (e.g., referral processes, staff salary issues, neighborhood entry, working with schools and families) were addressed as the program was developed.

The opening of 3 other group homes in 1971 marks the beginning of the attempts to replicate the Achievement Place treatment program using various strategies funded by NIMH. Although the first two attempts met with failure, a great deal was learned and the Achievement Place treatment program was successfully replicated when Gary and Barbara Timbers (Teaching-Parents at Achievement Place for Girls) met the certification (fidelity) criteria. Based on the lessons learned from these early replication experiences, the treatment program was redefined and the "implementation drivers" (i.e., systems to select, train, consult, and evaluate Teaching-Parents for group homes) were established (Fixsen & Blase, 1993; Fixsen, Blase, Timbers, & Wolf, 2001). The successes and failures of the treatment program replications in the group home settings were evaluated by Fixsen & Blase (1993) who looked at survival rates of group home replications under two conditions:

- 1) a replication strategy with the group home as the unit of replication, or
- 2) a replication strategy with a site (an intermediary organization supporting a network of group homes) as the unit of replication.

The group home replication strategy involved working with individual boards of directors and agencies and directly providing the training and support for the practitioners (Teaching-Parents) from a research base in Kansas. Using this group home replication strategy, “over half of the first 25 attempts ended when the Teaching-Parent couple we originally trained left the group home, and only 24% lasted 6 years or more” (Fixsen & Blase, 1993, p 605).

Given these results, in 1978 the replication focus shifted to a site replication strategy by working with organizations that supported networks of group homes in community-based or campus-based settings (Blase, Fixsen, & Phillips, 1984; Fixsen & Blase, 1993). This change was based on the success of the prototype Site that had been established in 1973 at the Bringing It All Back Home Study Center in Morganton, NC (Maloney, Timbers, & Blase, 1977). The implementation drivers (i.e., selection, training, consultation, evaluation, and administrative support systems) for practitioners that were needed to establish and maintain group-home-based treatment were built into intermediary organizations (i.e., sites). Under this second replication strategy, “Data from a more recent set of 25 attempted group home replications showed that only 4% ended after the original couple left, and 84% continued operating after 6 years” (p 605). Thus, the site replication strategy yielded substantially better results. This was very significant given the time and expense related to funding, Board development, community entry, licensing, staff training, etc. required to open a residential group home in a community setting. The first successful replication of a Teaching-Family Site was at Father Flanagan's Boys' Home, Boys Town, NE. The prototype Teaching-Family Site Development Program began in 1979 with funding from NIMH.

As we learned the hard lessons at each level we turned the program in on itself to produce more and better programs. This is much like the early scientists who developed an oscilloscope out of poor quality vacuum tubes then used that oscilloscope to develop better tubes which were used to build a more sensitive oscilloscope, and so on. It is also similar to the “bootstrapping” procedures used to develop complex computer software programs (such as Microsoft Windows) where programmers create a crude version of a program then use that version to create a better version. The refinements come about by having the programmers directly experience the limitations and problems in the current version being used by the programmers (in the behavioral sciences we call this “rule-generated and contingency-shaped” behavior). In these cases, a “positive technology spiral” is created that leads to exponential progress over time (Fixsen & Blase, 1993).

Starting in the mid-1970s, systematic replications of the Teaching-Family treatment program were conducted by organizations that were well-established operators of community-based Teaching-Family group homes for delinquent youths. The program was adapted to campus-based settings as well as community-based agencies; to service delivery settings such as treatment foster care, homebased treatment, supported independent-living, classrooms, and inner-city areas; and to children and adults with a variety of problems such as severe mental health problems, developmental disabilities, autism, abuse and neglect, educational delays, substance abuse, and so on. The task in these systematic replications has been to adapt the treatment technology to the new service delivery setting or population and develop the staff selection, staff training, staff consultation, staff evaluation, program evaluation, and administrative support systems needed to facilitate treatment in each of the systematic replication programs (Fixsen, et al., 2001).

The Teaching-Family Association was founded in 1975 and by 1978 had established standards for ethics and practice at the Teaching-Parent level and at the organizational level. Practitioners must be certified annually and organizations must be reviewed annually and certified every three years to be recognized as users of the Teaching-Family Model. Certification (a fidelity measure) at both levels is based on the completion of preservice and inservice training, direct observation of performance by 2 outside evaluators, and an evaluation by all consumers and stakeholders (Blase, et al., 1984). The Association functions as a “self-sustaining subculture or community of practice to perpetuate and modify program procedures and values” as described by Rosenheck (2001). On any given day in the United States and in Canada, over 10,000 children, families, and adults with special needs participate in group home treatment, treatment foster care, homebased treatment, supported independent living, or public or private education classroom interventions based on the Teaching-Family treatment program.

It is clear from these experiences that the replication of evidence-based programs is largely about changing the behavior of adult professionals. Helping clients (children, families, and adults) with problems is clearly the end goal and effectiveness at that level is the most important aspect of the entire enterprise. However, it is the behavior of adult professionals at many other interactive levels that significantly impacts implementation, adoption, fidelity, and sustainability. The following examples of research at the treatment practices level highlight the complexities of program development and replication and the importance of staff training in the replication process.

In a series of studies, the behavior of practitioner trainees was evaluated before and after a preservice workshop for training Teaching-Parents. Maloney, Davis, Davis, Harper, Harper, Ford, Ford, Phillips, Phillips, Timbers, Timbers, Fixsen, & Wolf (1974) studied the use of instructions, feedback, and modeling to train the direct-care staff (Teaching-Parents) of group homes for disturbed youths and found all three were better than any one alone. These factors were incorporated into preservice workshop training, and Kirigin, Ayala, Braukmann, Brown, Minkin, Fixsen, Phillips, & Wolf (1975) found that the preservice workshop training was effective in helping the Teaching-Parent trainees learn nearly all the components of the “teaching interaction” (a key therapeutic approach of the Teaching-Family Model). Bedlington, Solnick, Schumaker, Braukmann, Kirigin, & Wolf (1978) measured the use of teaching interactions as implemented in Teaching-Family group homes and found they were highly correlated with positive youth ratings of the Teaching-Parents and with lower levels of self-reported delinquency. Solnick, Braukmann, Bedlington, Kirigin, & Wolf (1981) systematically replicated the Bedlington, et al. study using court-recorded delinquency and again found that higher levels of teaching by the Teaching-Parents were associated with lower levels of delinquency.

The teaching interaction is an “active ingredient” in any Teaching-Family treatment program. These studies demonstrate that research can be done on the “active ingredients” of intervention as they are taught to practitioners during the training workshops, implemented in the treatment programs, and correlated with important outcomes for the youths and for the practitioners. Research has helped to develop the Teaching-Family Model and has helped to promote the effective adoption and sustainable implementation of the Model nationally.

Founders: Elaine A. Phillips-Stork, Elery L. (“Lonnie”) Phillips, Montrose M. Wolf, Dean L. Fixsen, Barbara J. Timbers, Gary D. Timbers, Karen A. Blase

Founding Organizations: University of Kansas, Appalachian State University, National Institute of Mental Health

Prototype Treatment Program: Achievement Place, Lawrence, Kansas (1967) initiated and funded by the JayCees and an anonymous donor in the community. Lonnie and Elaine Phillips created the Teaching-Parent role, were the first Teaching-Parents to be certified, and were co-directors of the research program along with Montrose Wolf and Dean Fixsen. Elaine Phillips developed the prototype Teaching-Parent evaluation system.

Replication of the Prototype Treatment Program: At Achievement Place for Girls, Barbara and Gary Timbers implemented the first successful replication of the Teaching-Family group home treatment program and met the certification criteria as Teaching-Parents.

Prototype Site: Bringing It All Back Home Study Center, Morganton, North Carolina (1973) funded by the Law Enforcement Assistance Administration. Gary Timbers was the director of the prototype site. At BIABH Karen Blase edited the first preservice workshop training manual for Teaching-Parents and developed the prototype consultation system for Teaching-Parents.

Replication of the Prototype Site: The first successful replication of a Teaching-Family site was at Father Flanagan's Boys' Home, Boys Town, Nebraska with Lonnie Phillips as the director.

Prototype Dissemination Center: Teaching-Family Dissemination Program (1979) funded by the National Institute of Mental Health. Karen Blase and Dean Fixsen were co-developers of the national program replication and implementation strategies.

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"In the long term, the development of a self-reinforcing, program-specific subculture is perhaps even more important than monitoring and enforcement of program standards. As experiences and challenges are shared, a community of practice develops... The key to developing such a community of practice is frequent interaction. Such interaction allows members to make sense of their common experience to codify their jointly accrued knowledge in catchphrases, symbols, and stories." (Rosenheck, 2001).

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Roberts, M. C. (1996). Model programs in child and family mental health. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

The American Psychological Association reviewed evidence-based programs internationally and selected the Teaching-Family Model as a "Model Program in Service Delivery in Child and Family Mental Health," one of 23 programs so identified after a two-year review of the literature and the field of psychology.

The Office of Juvenile Justice and Delinquency Prevention (1998).

Lipsey, M. W., & Wilson, D. B. (1998). Effective Intervention for serious juvenile offenders: Synthesis of research. In R. Loeber & D. Farrington (Eds.), Serious and violent juvenile offenders: Risk factors and successful interventions. NY: Sage Publications, Inc.

The authors conducted a meta-analysis of over 200 studies and looked for "specific program characteristics [that are] most closely connected with the reduction of reoffense rates of serious offenders." They reported those evidence-based practices that had an impact on serious juvenile offenders. Those interventions listed in the top classification, "positive effects, consistent evidence" included: Teaching-Family homes, interpersonal skills training, behavioral contracting, and individual counseling.

Mental Health: A Report of the Surgeon General (1999).

The Surgeon General of the United States reviewed the state of current knowledge in mental health and made recommendations to advance the field. In Chapter 3, the report listed two models of "therapeutic group homes" that are "conducive to learning social and psychological skills." The two named are the Teaching-Family Model and the Charley Model (developed at the Menninger Clinic).

Juvenile Forensic Evaluation Resource Center (2000).

M. Brunk conducted a review of evidence-based practices relating to conduct disorders in children. The two recommended "community systems based" programs are treatment foster care as described by P. Chamberlain at the University of Oregon and the Teaching-Family Model.

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