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In Search of Program Implementation: 792 Replications of the Teaching-Family Model

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Abstract

This article discusses a solution-oriented and incremental approach to solving major social problems. If we are to solve important social problems such as child abuse, delinquency, and illiteracy, researchers need to generate effective programs that can be replicated and social service providers need to implement those programs with fidelity. The Teaching-Family Model, based on over 30 years of research, evaluation, and program experience, has been replicated across North America. We present an analysis of 792 attempted replications over a period of 15 years. The analysis reveals certain aspects of the treatment program that were found to be sufficient conditions for treatment program implementation and survival. These "Site services" are described and the implications for effective practices in services for children are presented.
Keywords: Teaching family homes, replication, delinquency, organizational behavior management in social services

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INTRODUCTION

Children, families, and vulnerable adults face a multitude of problems in our society. The statistics are clear and the newspapers each day carry personal reminders of the tragedies that abound in families, schools, and neighborhoods across North America. For a number of these difficult problems, the popular conception is that "nothing works." Juvenile delinquency, teenage pregnancy, school drop outs, illiteracy, poverty, low birth weight babies, child abuse and neglect, domestic violence, and so on seem to occur at alarming rates in spite of our efforts as a society.

Part of the problem lies with the kinds of research that have been supported for the past several decades across North America. During his term as president of the American Psychological Association, Frank Farley (1994) identified this issue and suggested a change in the research agenda.

> "I want SOLUTIONS to the problems confronting us. We already KNOW THE STATISTICS. Psychology has the greatest potential of any creation of the human mind in the past several centuries to SOLVE some of these dreadful problems and we must focus on those SOLUTIONS. We need more solution-oriented research, more research directed at solving these massive human problems. Significant parts of our research establishment have for decades been enslaved in a publish or perish paradigm they can't seem to break out of, and it often encourages quick studies on easy and minor problems. According to citation analyses, the overwhelming majority of published studies have no demonstrable effect on anyone, anywhere, anytime, and the vast submerged corpus of unpublished research presumably has even less impact! These are often clever studies, bringing to bear monumental research methods and skills upon minor topics apparently to no end. No end, at least, where the critical problems confronting the human race are concerned." (p. 3, capitalization in the original)

Another part of the problem lies with the providers of human services. Many research and evaluation studies have pointed to effective intervention processes but these are often ignored or are "conceptually adopted" without significant change in actual services. Lipsey (1992) examined over 400

studies of treatment for delinquent behavior and found that, "When the researcher was more closely involved in the design, implementation, and monitoring of treatment, the effects were larger. While this could reflect some experimenter bias artifact, it is also plausible that it represents the effects of greater treatment integrity, i.e., consistent delivery of the treatment as intended to all clients" (p. 10). Shadish (1984) studied adoption rates of social science solutions and found that, "When an attempt is made to implement those solutions, powerful social networks are activated whose interests have been ignored and who are, therefore, often hostile to implementing the solution" (p. 727).

There is no doubt that applied research is difficult to do and that organizational changes to accommodate new intervention strategies and techniques are fraught with barriers and administrative headaches. These also is no doubt that our society needs to find ways to work toward solutions to these problems so that we can begin to see incremental improvements over time for all children in North America. The human suffering and the costs to society are too great to ignore.

IMPLEMENTATION

Other than most chemical interventions and some surgical interventions, any treatment endeavor in the human services is labor intensive. It is the skillful interaction of a Practitioner with a child, parent, or other adult that produces benefits. The more difficult the problem, the more skillful and complete the performance of the Practitioner must be in order to achieve a beneficial outcome. The Practitioner-child or Practitioner-adult interaction is where and how treatment is actualized in the human services.

What do Practitioners implement? Consider for a moment Table 1 concerning treatment procedures or whole treatment programs. Poor outcomes are relatively easy to achieve while good outcomes only occur under specific conditions. Thus, if we are to solve important social problems researchers need to generate effective programs that can be replicated and Practitioners need to implement those programs with fidelity. Under those conditions we can produce good outcomes. Anything else results in the status quo: poor outcomes for children and families and social problems that remain intractable from one generation to the next.

Table 1: The sources of good outcomes for children and families.

Program Characteristics	**Poorly Implemented**	**Well Implemented**
Replicable Effectiveness	Poor Outcome (Implementation Issue)	Good Outcome
Non-Replicable or Ineffective	Poor Outcome	Poor Outcome (Effectiveness Issue)

The Teaching-Family Model

Any discussion of implementation begs the questions of implementation of what, by whom, when, under what conditions, how? If implementation is "a means to some end" (Webster's New World Dictionary, 1972), what are the "means" and what is the "end"? There must be a plan in order to have implementation. Usually, in human services we are referring to some procedure or set of procedures intended to provide benefits to people. That is "what" we are trying to implement. For many of us working with difficult children and families, the plan is the Teaching-Family Model.

The Teaching-Family Model was initiated in 1967 with the opening of Achievement Place, a group home for delinquent children. In the 1960s, 1970s, and 1980s the NIMH Center for the Study of Crime and Delinquency provided funding for research on treatment and for evaluation of the Teaching-

Family training and replication efforts across the United States. The product of this effort is a treatment model that has demonstrated generality as it has been adapted to community-based and campus-based treatment agencies; to treatment foster care, home-based treatment, and classroom service delivery settings; and to children and adults with a variety of problems such as severe mental health problems, mental handicaps, autism, abuse and neglect, educational delays, substance abuse, and so on (Phillips, 1968; Phillips, Phillips, Fixsen, and Wolf, 1974; Braukmann, Fixsen, Phillips, & Wolf, 1975; Black, Downs, Brown, & Bastien, 1984; Blase, Fixsen, & Phillips, 1984; McClannahan, Krantz, McGee, and MacDuff, 1984; Fixsen and Blase, 1993; Blase, 1994; Wolf et al., 1995).

Goals of the Teaching-Family Model

The goals of the Teaching-Family Model were specified in the Teaching-Family Handbook (Phillips, Phillips, Fixsen & Wolf, 1974) and have been adopted by the Teaching-Family Association (1994). The goals are to be:

Humane: Characterized by compassion, consideration, respect, acceptance, positive regard, cultural sensitivity and adherence to the Standards of Ethical Conduct of the Teaching-Family Association (1993).

Effective: Progress toward resolving referral issues and achieving treatment goals, with high expectations for improvement and low tolerance for deviance. Research and evaluation demonstrate the current helpfulness of practices and provide for the systematic evolution of the Teaching-Family Model.

Individualized: Each aspect of the program is tailored to the unique history, strengths, and needs of each child and family. The treatment goals are based on the special needs of the child and family as assessed by family members and referral agents, in conjunction with the observations and descriptions of behavior by the Practitioner.

Satisfactory to Stakeholders: The program applications are satisfactory to children, parents, allied professionals, referral sources, and funding agents with respect to the cooperation, communication, effectiveness, and concern of the Practitioner.

Cost Efficient: The program is affordable, practical, and do-able with respect to costs related to treatment and support systems.

Replicable: The program is teachable, practical, and do-able with respect to treatment implementation and support systems.

Integrated: The program seeks to simultaneously achieve all of the above goals. No one goal can be emphasized to the detriment of any other goal.

Teaching-Parents in Group Homes

To accomplish these goals, each Teaching-Family group home treatment program is directed by a married couple known as Teaching-Parents. They, along with one or two assistants, are the Practitioners who comprise the sole staff of a group home for up to 7 youths. The couple lives in the home 24 hours a day, 7 days a week. The availability of a live-in couple facilitates consistent treatment, localizes accountability, models family-style living, and facilitates cost-effective treatment. Teaching-Parents have wide-ranging responsibilities. They design and carry out treatment procedures to correct problem behaviors and to teach appropriate alternative behavior. They supervise the activities of the youths in school, in the community, in their natural homes, and in the group home. They establish and maintain

positive relationships with the parents of the youths, the juvenile court, the social service department, the schools, the mental health department, community civic groups, and so on. They are responsible for working with a Board of Directors or other administrative entity to develop budgets and policies to operate the home (Phillips, Phillips, Fixsen, & Wolf, 1974).

The Teaching-Family Model was established on the strength of research on the behavior of delinquent children residing in-group homes (see Braukmann & Fixsen, 1975; Fixsen & Blase, 1993; and Wolf, et al., 1995 for summaries of the research on treatment practices). Research is important, but it is only a first step. To be helpful, the research findings must be useful in context (e.g., group home, classroom, foster home, therapist's office). Interventions have to be feasible and effective in the actual environments where people live, learn, work, and play. Thus, the single-variable approach to research in the laboratory is replaced by a multi-component approach to research in human service settings (Reppucci & Saunders, 1974).

For example, "Our original idea for improving school behavior was to teach the school teachers how to use the token economy in school. We quickly discovered, however, that the teachers were not very enthusiastic about having our youths in their classrooms let alone the extra work involved in learning and implementing a token economy for them" (Wolf, et al., 1995, p. 16). This led to the creation of a "daily report card" that was simple for the teachers to use and still led to large improvements in the youths' social and academic behaviors in the classroom (Bailey, Wolf, & Phillips, 1970). Experiences like this led us down the road toward mission-oriented research and program development (Fixsen, Phillips, & Wolf, 1978).

Thus, the treatment setting must be seen as a "natural laboratory" where research is conducted to find practical solutions to everyday problems. In these natural laboratories, research and practice exert a mutual influence and each stimulates progress in the other. In this way, more studies can be done that have applications and not just implications for clinical practice (Azrin, 1977).

The research and evaluation data on the effectiveness of the procedures and processes that define the Teaching-Family Model can be accessed in the literature (see the references at the end of this chapter) and are not the subject of this chapter. In this chapter we will focus our attention on the empirical bases for the processes we have found to be useful and practical over the past 30 years for assessing and assuring implementation at several levels of treatment and program operations.

15 YEARS OF IMPLEMENTATION DATA

Achievement Place, the prototype group home for the Teaching-Family Model, opened in 1967. The data presented below cover the period from 1967 through December 31, 1982, a 15-year period. During the 15-year period covered by the data, the Teaching-Family Model was conceived, developed, and replicated in group homes across the United States. As shown in Figure 1, during this time a total of 792 couples (the Teaching-Parents who operate Teaching-Family group homes) participated in training and started work in 303 Teaching-Family group homes. The data represent a total of 1,077 "Teaching-Parent years" of experience in providing treatment to delinquent, abused, neglected, emotionally handicapped, mentally handicapped, and autistic children nationally.

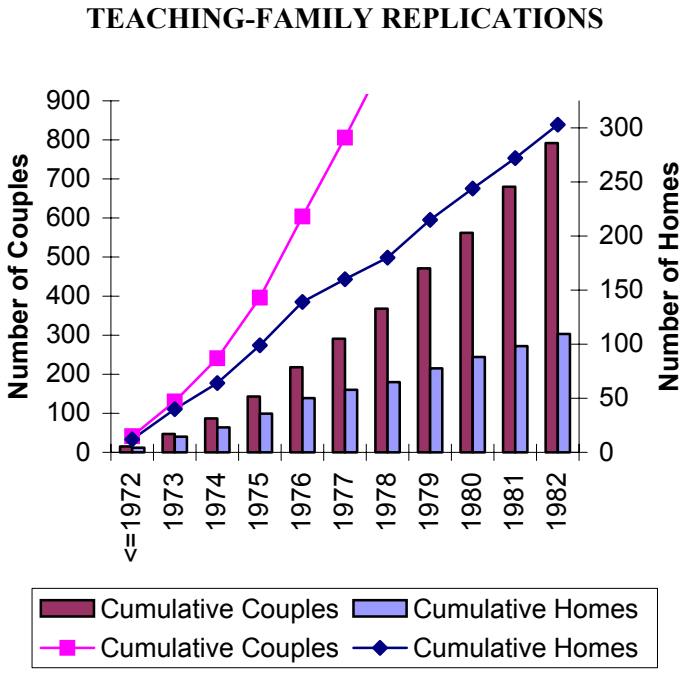

Figure 1. The cumulative number of Teaching-Parent couples (bar graph) and the cumulative number of Teaching-Family group homes operating (line graph) for the years 1967 through 1982.

Figure 1 shows that the growth of Teaching-Family Model group homes was fairly linear from 1972 through 1982 with about 30 new homes added each year. The number of Teaching-Parents increased in a more geometric fashion as more couples were being recruited and trained for existing group homes (replacement couples) as well as new ones (new home couples). The 303 Teaching-Family group homes were located in 32 different states and in one Canadian province.

As noted above, human services are labor intensive. Thus, each Practitioner is a replication of a treatment program and these data represent 792 attempted replications of the Teaching-Family Model. This huge range of data provides an excellent opportunity to look at program implementation empirically to see what makes a difference.

Initial Replication Attempts

First, however, we should note that the development, replication, and implementation of the Teaching-Family Model did not occur in the nice linear fashion implied by Figure 1. It almost ended in 1971 when we attempted our first replication of the Achievement Place group home program (see Blase, Fixsen & Phillips, 1984 and Wolf, et al., 1995 for a more complete description of the early replication experiences).

A near-by community had called and asked us to help them establish a group home "like Achievement Place." It took us almost two years to obtain the funding, locate and renovate the house, secure the necessary zoning and licensing, find a couple brave enough to be the Teaching-Parents, and prepare the couple by having them participate in the best academic masters degree program that we could offer at the University of Kansas.

As soon as the new group home opened and youths started living with our new Teaching-Parents, it was clear that things were not going well. The youths were fighting among themselves, defiant,

running away, skipping school, and generally creating mayhem. Clearly, this was not a replication of the beautiful program that had been created at Achievement Place! We started driving back and forth between the two homes comparing the new couple and what they did with Lonnie and Elaine Phillips, the Teaching-Parents who were doing so well at Achievement Place. We spent hours each day observing and making video tapes and audio tapes trying to figure out what the differences were. As soon as we thought we had found something, we tried to get the new couple to implement it to see if things improved.

After a few months of this, the Board of Directors called us to a meeting and fired us! Fortunately, we had already started two more attempted replications by this time and these other two homes continued to provide us with a replication laboratory while we learned our lessons the hard way. Otherwise, the whole enterprise might have ended with that first dramatic failure to replicate.

Lessons From A Failure to Replicate

Out of this difficult and embarrassing experience, some hard lessons were learned. First, the hours of observation and videotapes helped us to discover the "teaching interaction" and reminded us of the importance of relationships. Lonnie and Elaine Phillips easily established warm and caring relationships with the youths and others and were natural teachers of a huge range of social behaviors at Achievement Place. They were so natural that we never saw how they did it until we had the second couple as a comparison. Since then, the teaching interaction has been refined and evaluated (Phillips, Phillips, Fixsen, & Wolf, 1974: Ford, 1974; Bedlington, Solnick, Schumaker, Braukmann, Kirigin, & Wolf, 1978; Ford, Evans, & Dworkin, 1982) and has become the cornerstone of the entire Teaching-Family Model.

Second, the master's degree training turned out to be ineffective and impractical with respect to teaching specific treatment skills. It was too much to ask trainees to translate theory and general statements of principles into actual effective practices, and 18 months of attending classes was not timely or practical for widespread dissemination in any case. Thus, a one-week preservice workshop was created (Braukmann, Fixsen, Kirigin, Phillips, Phillips, & Wolf, 1975) that provided introductory information and lots of behavior rehearsals specifically designed to teach the skills needed to work with delinquent children in a group home.

Third, after that first disaster, we wanted to get our feedback in smaller doses and in a more timely manner while we still had a chance to do something about it. To this end, we established an evaluation system (Phillips, Phillips, Fixsen, and Wolf, 1974) to regularly solicit the opinions of consumers such as parents, teachers, social service workers, court workers, and Board members via mail out questionnaires and telephone interviews. In addition, a youth interview was developed to get the opinions of the children who lived in the group home regarding the behavior of the Teaching-Parents and the care and treatment being provided. Finally, a professional in-home evaluation was included to directly observe and rate the skills being acquired by the youths, the skills of the Teaching-Parents in using the treatment components, and the development of other components of the Teaching-Family Model such as family–style living.

Fourth, criteria were established to certify Teaching-Parents and recognize their full implementation of the Teaching-Family Model (Phillips, Phillips, Fixsen, and Wolf, 1974; Braukmann, Fixsen, Kirigin, Phillips, Phillips, & Wolf, 1975). An initial evaluation was scheduled about 6 months after completion of the preservice workshop then an annual evaluation was scheduled at 12 months after the preservice workshop and annually thereafter. Any couple that met criterion on each evaluation component on an annual evaluation was certified as professional Teaching-Parents. This meant that the couple had to achieve a score of "satisfied" (6.0) or better on a 7-point scale that ranged from "completely

satisfied" (7.0) to "completely dissatisfied" (1.0) on the consumer evaluation, youth evaluation, and professional in-home evaluation components.

Putting Our Lessons to Good Use

We quickly put our newly discovered information to use in 1972 and by the end of that year the fourth set of Teaching-Parents, Gary and Barbara Timbers, became the first couple to successfully replicate the Achievement Place/Teaching-Family Model group home program. In addition, the first replication couple decided they still wanted to be Teaching-Parents and went through the revised training before becoming Teaching-Parents in another group home. They did very well as Teaching-Parents, were certified, and enjoyed a long tenure in that home. Clearly, the new training course was more functional.

With this bit of encouragement we cautiously proceeded with more attempted replications of the Teaching-Family Model. We held "dissemination conferences" where we invited 30 – 40 decision-makers at a time (e.g., juvenile judges, welfare directors, researchers, political leaders) to Kansas where we described the Teaching-Family Model and had them visit Achievement Place or one of the replication homes near-by. We also sent out information on the model to anyone who asked. And, we continued to publish research, present at professional meetings, and participate in professional and public discussions of delinquency, mental health, and community-based programming issues.

As Figure 1 shows, there was no shortage of interested individuals and groups who wanted to replicate the Teaching-Family Model.

An Analysis of Proximity

By 1975 our organization in Kansas had attempted 60 replications of the Teaching-Family Model group home treatment program in Kansas and in 17 other states. As we did training and evaluations for new homes we also began losing group homes as couples left and were not replaced by Teaching-Parents or the Boards decided to close their homes.

The loss of homes was cause for considerable concern. Each group home represented a significant investment in terms of the start up resources to purchase and furnish a home, the effort required to clear all the zoning hurdles and obtain a license to operate, the time needed to establish referral and funding sources, the education of teachers, Board members, neighbors, and other consumers; the cost of recruiting and training and evaluating Teaching-Parent couples, and so on. Thus, the loss of a group home was a worrisome and costly problem.

Figure 2 shows an analysis of the first 60-replication group homes for the Kansas organization. As we analyzed the results for these homes, we found that 52% of the in-state homes continued to operate for 5 years or more while only 17% of the out-of-state homes operated that long.

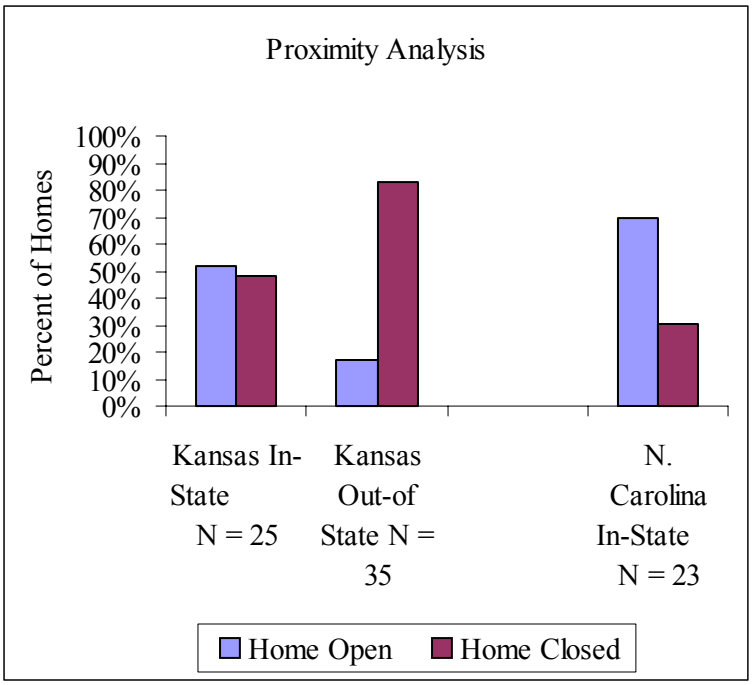

Figure 2. The impact of proximity of the group home and the support staff on the survival rates of Teaching-Family group homes sponsored by the Kansas staff and by the staff in North Carolina.

We began looking at our own behavior and found that we knew a lot more about the Kansas homes. We were there more often to give advice and support and help solve problems, the Teaching-Parents came to see us more often, we called them more often, and so on. Proximity seemed to be very important to these communication and support functions.

At about this same time we began to see the spectacular results coming from our colleagues in North Carolina as well. In 1973 three graduate students from the University of Kansas (Gary Timbers, Karen Blase, Dennis Maloney) had moved to Morganton to start a new organization of group homes to serve children in the western half of North Carolina. All three had participated in the Kansas training and research efforts in support of Teaching-Family homes.

When we analyzed the data from the Teaching-Family group homes in North Carolina we found an even more positive result. As shown in Figure 2, over 70% of their homes (all in-state) operated for 5 years or more.

Proximity allowed more frequent contact, more support, and more immediate assistance with program implementation problems, all of which seemed to be related in important ways to the survival rates of the Teaching-Family group homes.

The Teaching-Family Association

In 1975 we began a series of meetings involving the organizations that were training and supporting Teaching-Parents in the United States. Given the diversity in locations, populations served, operating requirements of different states, and so on we decided to try to define the essential elements of the Teaching-Family Model and develop an organization to set national standards for Teaching-Parent certification and standards governing the organizations providing training and support for Teaching-Parents. In 1978 the first meeting of the Teaching-Family Association was held with Teaching-Parents and support staff convening to share their procedures and their research.

Between 1975 and 1978 the participants in these meetings defined the key aspects of **organizations** of Teaching-Family Model homes (we call them Teaching-Family Sites). The staff at Teaching-Family Sites provide staff selection, preservice and inservice training, on-going staff consultation, staff evaluations, program evaluation, and facilitative administration to group homes within reasonable proximity (usually 2 – 3 hours driving time) to the training and support staff.

The Keys to Implementation

The Teaching-Family Association (1980) published a directory listing all the Teaching-Family group homes that were affiliated with a Teaching-Family Site and, therefore, had been receiving the full complement of services (i.e., selection, training, consultation, evaluation, administration) mandated by the Teaching-Family Association through the end of 1979.

This permitted an interesting comparison. Using the Teaching-Family Association directory as the guide, we found that 653 couples had received the preservice training, in-home consultation, regular evaluation, and facilitative administrative supports mandated by the Teaching-Family Association. The remaining 139 couples had received preservice training and evaluation services, but not the full complement of Site services.

Figure 3 shows the results of this analysis. Those Teaching-Parent couples who received full Site services were Certified (annually) more often (79% vs. 53%) and received the Initial Evaluation (after 6 months) more often (89% vs. 75%). These data point to more complete implementation of the Teaching-Family Model by those couples who received full Site services that included consultation and administrative support in addition to preservice training and evaluation.

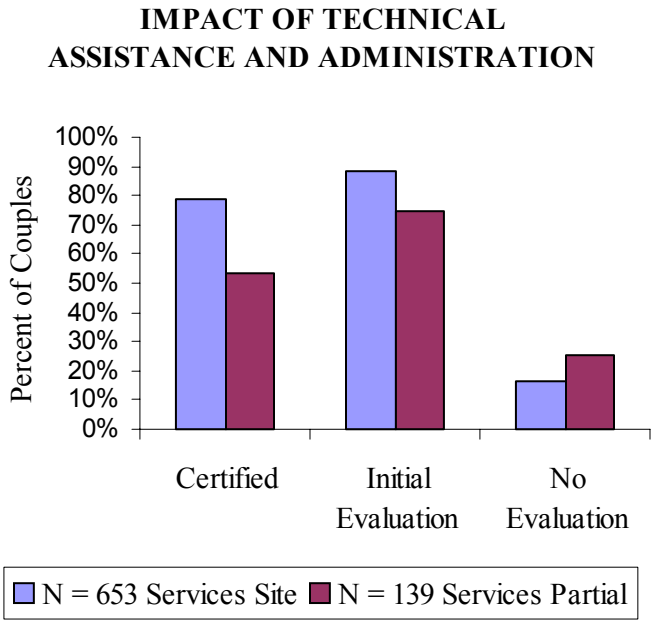

Figure 3. The impact of Site support services (i.e., selection, training, consultation, evaluation, administration) on implementation of the Teaching-Family Model.

The percentages in Figure 3 are based on eligibility for evaluation. That is, in the Site Services group there were 394 couples who had been in the home 365 days or longer and were eligible for the certification evaluation, 546 couples who had been in the home for 183 days or longer and were eligible

for the initial evaluation, and 107 couples who had been in the home for less than 183 days and were not eligible for an evaluation yet. Comparable numbers for the Partial Services group are 64, 104, and 35 couples.

We also looked at the survival rates of the group homes and found another dramatic difference. Figure 4 shows that only 17% of the 219 group homes that received Site Services closed within 5 years while 85% of the 84 group homes that received only partial services (training and evaluation) closed within 5 years.

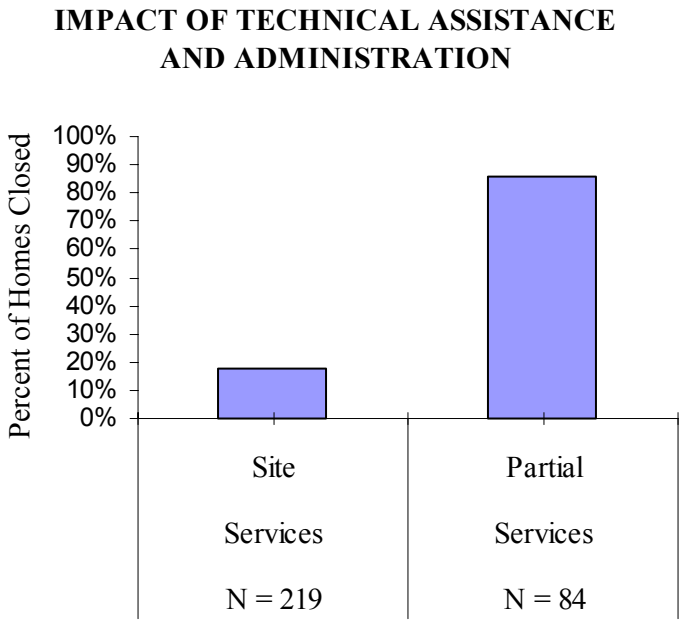

Figure 4. The impact of Site support services (i.e., selection, training, consultation, evaluation, administration) on survival rates for Teaching-Family group homes.

These results are very clear. Those Teaching-Parent couples who received the full complement of Site services (i.e., selection, training, consultation, evaluation, administration) achieved certification criteria 1.5 times more often and the group homes closed at a rate that was 1/5 of that for homes receiving partial services (i.e., staff training and evaluation). Thus, Site services were related to greater implementation of the Teaching-Family Model resulting in higher quality services and better survival rates.

CONCLUSION

The first 15 years of research and development of the Teaching-Family Model demonstrated that it is possible to generate effective programs that can be replicated and implemented carefully. Achievement Place provided a prototype for developing the treatment program and the attempted replications provided a natural laboratory for developing the support systems necessary to assure routine implementation by Practitioners. Research and practice have exerted a mutual, beneficial influence at each stage.

The data from the first 792 Teaching-Parent couples and the first 303 Teaching-Family group homes have several implications for practices in programs for delinquent children and for other human services as well.

1. Having well researched procedures working well in a prototype program is a good place to start but it is not sufficient to assure replicability and implementation. Replication of the prototype is a critical step in the development of the prototype program itself. As Sidman (1960) pointed out, replication is the key to science and the key to real knowledge. This was certainly true in the evolution of the Teaching-Family Model.

   Our early replication attempts provided the laboratory for us to learn what was really critical to the success we had seen at Achievement Place, the prototype group home. Comparing, contrasting, evaluating as best we could, implementing new knowledge as quickly as we could, and puzzling over what we were missing set the stage for further description and elaboration of the treatment model itself.

2. Program development and widespread implementation is mostly an inductive process where we start with a problem, look for a solution, and take data of some kind to serve as a guide as we oscillate our way toward our goal. This idea might be best illustrated by the cartoon that says, "Ready, fire, aim."

   As more replications of the treatment model were opened, we were presented with a variety of problems and barriers that had to be overcome to allow others to use the treatment model (e.g., government regulations, community concerns, funding, etc). Practical issues internal to the operations of the treatment unit regarding time management, costs, staff turnover, recruitment, personnel issues, etc. also began to surface and had to be dealt with in a programmatic way.

   We also discovered there are many aspects to operating a treatment environment with treatment planning and treatment procedures being just two of many (see Table 1 in Bernfeld, this volume). To be successful, a treatment approach must be able to comfortably fit within existing operating structures or must be able to specify new ones and be able to create them to fit the treatment program. As program developers, we had to look beyond our immediate interests in treatment and see the broader context in which we operated. Treatment can only exist and flourish in a supportive environment where the various parts are working in concert. In addition, the treatment model itself must compete for survival and for effectiveness on a scale that exposes the whole enterprise to the vagaries of larger systems of politics, finance, and community influences (also see Bernfeld, Blase & Fixsen, 1990, for a further discussion of these factors).

3. All the time and attention given to changing the behavior of children begins to pale compared to the time and effort required to initiate and sustain program settings and adult staff behavior across replications in order to assure implementation. For example, Teaching-Family Site services that were critical to the quality of care provided to children and families and to the longer-term survival of the services themselves included (also see Bernfeld, this volume, Appendix A):

   a. Staff selection
   b. Staff training
   c. Staff supervision and treatment consultation
   d. Staff evaluation
   e. Facilitative administration and program management

4. Human services are labor intensive. In a very real sense, the Practitioner <u>is</u> the treatment program. We have found that we can teach many of the important skills needed to be a good Practitioner of the Teaching-Family Model. Still, there are many skills and approaches to life that we need to select for during the hiring process. These include caring and commitment, common sense, intelligence, willingness to learn, philosophical fit, and background knowledge.

5. The work with children and families is too important to leave to Mom and Pop couples who have raised their own children or to whatever skills BA or MA level staff may have. Program-specific training must be provided to assure implementation of procedures and coordination of efforts. Thus, as soon as a Practitioner is employed in a Teaching-Family treatment setting, a one-year training program commences. First, we provide a six-day, skill-oriented preservice workshop to teach the basic skills involved in providing Teaching-Family treatment. Then we provide "shadow training" where a consultant (described below) shares responsibility for decision making and implementing treatment for a few weeks. The consultant and the Practitioner work on in vivo skill development and applications and work on clinical judgement and implementation of values and philosophy in the context of daily interactions with children, families, and staff. We need to make sure the child and family get the treatment they need at the same time that the new Practitioner is learning the basics.

6. A consultant/supervisor is needed to facilitate implementation by focusing on the professional development of the Practitioner (especially treatment planning, treatment implementation, and clinical judgement). The consultant provides coaching for skill development as well as personal and emotional support to each Practitioner. It is the nature of work with children and families that a Practitioner will come face-to-face with his or her own issues in one family or another. The consultant can help Practitioners over these personal hurdles while maintaining quality treatment for children and families.

   Consultants have a very important role in the Teaching-Family Model. Consultants integrate treatment, training, consultation, evaluation, and administrative systems and promote a systematic flow of information among all these program components. They help to conduct interviews to select Practitioners, they are trainers and evaluators, they are the supervisors of Practitioners within the organizational scheme of things, they tutor and support new Practitioners, they help deal with difficult child and family issues, and they contribute in many ways to the development of new treatment technology and operating systems. Almost without exception, consultants started out as Practitioners then obtained the extra training to become consultants.

7. Regular evaluations of staff performance is another key to implementation of replicable procedures. For example, to be Certified as a Practitioner in the Teaching-Family Model a Practitioner must participate in and successfully complete a series of events over the course of one year. This includes:

   a. complete the preservice workshop
   b. receive regular consultation and supervision
   c. complete the initial performance evaluation at 6 months
   d. continue to receive regular consultation and supervision
   e. complete the annual performance evaluation
   f. meet all criteria and ethical standards on the annual evaluation

   Certification must be renewed each year by completing the annual performance evaluation and meeting all criteria and ethical standards.

   A Practitioner performance evaluation at 6 months, 12 months, and annually thereafter has four main parts:

   a. Youth consumer evaluation: Children are interviewed by an evaluator and asked to provide ratings and comments about the Practitioner's cooperation, communication, effectiveness, fairness, concern, helpfulness, and availability.

b. Staff practices evaluation: Children are interviewed by an evaluator and asked about any potential abusive practices used by staff. This interview helps to prevent and detect practices that might infringe on the youths' rights and safety.
c. General consumer evaluation: A brief questionnaire is mailed out to parents; all mental health, court, and social service employees that have involvement with each child; all the youths' teachers and principals; and other stakeholder agencies asking them to provide ratings and comments about the Practitioner's cooperation, communication, effectiveness, and advocacy.
d. Professional in-home evaluation: Two qualified evaluators review the treatment plan and treatment efforts made to date, then directly observe the treatment being provided over a 2 to 4 hour visit. The evaluators systematically review motivation system records and youth files and directly observe and rate treatment planning, teaching skills, relationships with youths, use of the motivation systems, use of self-government systems, family-style living, intervention progress, clinical judgment, and record keeping.

8. Successful treatment programs require an organization that has clear goals, clear philosophy, and clear lines of communication, well-practiced feedback loops, and integrity at the point of implementation. With everything working in harmony, good treatment practices have a chance to be implemented with excellence.

We have found that the performance of Practitioners embodies the performance of the entire program model. The performance of Practitioners reflects how well the selection process worked, how good the preservice training was, how well the consultation process has functioned, and the degree to which administrative practices actually facilitate the treatment processes. No one evaluation will provide enough information on these broader issues, but looking across 5 or 10 or 20 evaluations starts to point out where consistent problems are occurring and where program efforts need to be focused. Thus, the performance evaluations for Practitioners are the prompts for administrators and other staff to make continuous, incremental improvements to the treatment model itself and to the overall operations of the agency.

This may seem like a lot of work and administrators always wonder where the funds will come from to recruit and support Practitioners in these ways. But, the data are clear. If we want well-implemented treatment programs that benefit children and families in a sustained manner, these are the supports we must offer. Otherwise, we will continue using public resources that only maintain the status quo: poor outcomes for children and families and social problems that remain intractable from one generation to the next.

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