Office of Mental Health and Substance Abuse Services
Bureau of Policy and Program Development

HealthChoices Behavioral Health

Policy Clarification

Issue Clarification #:	*04-2012*	*Applicability:*	*All Zones*
Date of Receipt:	*7-11-2012*	*Source Documentation:*	

Submitted by: ***OMHSAS, Bureau of Children's Behavioral Health Services***

Topic Area: ***Updated Family Based Mental Health Services (FBMHS) Procedures***

Background:
The Office of Mental Health and Substance Abuse Services (OMHSAS) is updating procedural changes related to training and clinical supervision in FBMHS as allowed in the state plan. This Policy Clarification will supersede PC FB-09 specific to training hours.

The Bureau of Children's Behavioral Health Services in conjunction with Dr. Gordon Hodas, consulting psychiatrist and the directors of the three approved training centers have updated the procedures for FBMHS providers regarding training and supervision requirements. These concepts are developed in depth in the following two documents which provide the basis for the requirements listed below:

1). "Synopsis of the Family Based Mental Health Services (FBMHS) Treatment Model" by Gordon Hodas, MD
2). "Clinical Supervision in PA FBMHS: Recommendations for Best Practices A Proposal Jointly Prepared by Patricia Johnston, C. Wayne Jones and Marion Lindblad-Goldberg 7/27/11"

The attached documents describe the evolution of the FBMHS Model and the need to emphasize the role of the supervisor to assure that FBMHS staff are adhering to the Model. The documents clearly define the roles and responsibilities of FBMHS clinical supervisors by emphasizing supervisor responsibility for: 1) clinical development of therapists, 2) therapists adherence to the model and 3) positive outcomes of families served by the program.

Updated Procedures

Supervision:
The following procedural change provides specific clarification as to the number of hours and context of supervision provided by the clinical supervisor to each individual therapist, each FBMHS team and the program as a whole.

The following clinical supervision must occur:

a. 1 ½ hours of individual and FBMHS team per week and
b. 1 ½ hours of group supervision per week

The division of time spent in individual or team supervision is based on individual and team learning contracts. Two or more teams at one session is considered to be group supervision. Group supervision may be no larger than the number of FBMHS teams who together serve a maximum of 40 families.

In addition, supervisors will develop learning contracts with each staff and each FBMHS team as part of their continuing clinical development.

In like fashion, training centers will develop learning contracts with each supervisor as part of their continuing clinical development.

Training:

All staff, including therapists and the person(s) who serves as the clinical supervisor, are required to attend DPW approved FBMHS Eco-systemic Structural Family Therapy (ESFT) training from an approved training center.
The following requirements will supersede PC FB-09 in regards to the specified hours of the FBMHS training:

Currently: ESFT training is 102 hours each year (17 days) for 3 years for a total of 306 hours
Updated Procedure:

a. ESFT FBMHS Orientation for therapy staff: 18 hours within the first year of training or ESFT Orientation to Supervision for supervisors: 18 hours the first year
b. Core ESFT FBMHS training: 255 hours of specific ESFT FBMHS training provided at the rate of 85 hours annually over a 3 year time frame. Core ESFT training is comprised of didactic sessions as well as clinical application sessions (clinicals).

Currently, staff graduate upon completion of attending the three year training program.
Updated Procedure:

a. Staff are required to attend Core ESFT FBMHS training and pass competency criteria as defined by the FBMHS training centers and approved by OMHSAS in order to graduate. This criteria will be consistent across training centers.

Currently, staff who have graduated from the training are required to obtain an additional 17 days of training annually.
Updated Procedure:

a. FBMHS Master's and bachelor level therapy staff will attend 30 hours ESFT Booster training annually from approved FBMHS training centers following graduation from Core training.
b. Clinical supervisors will attend 30 hours ESFT Supervisor Core training annually. Additionally, clinical supervisors must attend Core ESFT FBMHS training when their staff are presenting a family therapy session for clinical discussion. Supervisors are strongly encouraged to attend all clinical training sessions with their staff as best practice.

Currently, staff when recommended by the clinical supervisor and training director, may voluntarily take an exam enabling the bachelor level staff to become a Certified Mental Health Worker.
Updated Procedure:

a. Both master's and bachelor level staff, are required to pass the FBMHS exam.
    1. A passing score enables the mental health worker to become a Certified FBMHS Mental Health Worker.
    2. A passing score enables the mental health professional to become a Certified FBMHS Mental Health Professional.

b. Supervisors may voluntarily take the FBMHS exam. However, they must meet competency criteria requirements of the approved training center director to become a Certified FBMHS Supervisor.

c. Previous Bachelor level staff who have graduated will continue to be required to pass the FBMHS exam in order to become a Certified FBMHS Worker.

d. Those master's level staff who have previously graduated from the Core training and have not passed the FBMHS exam must submit competency criteria in order to become a Certified FBMHS Professional.

e. Supervisors, in collaboration with the training center, will develop a learning contract with those individuals who do not pass the exam. The learning contract may require continued attendance at the Core training in order to attain competency necessary to pass the exam and become a Certified FBMHS Worker or Professional.

Cheryl L. Snyder

Director, Bureau of Policy and Program Development

Date: 7-11-2012

Gordon R. Hodas MD

SYNOPSIS OF THE FAMILY BASED MENTAL HEALTH SERVICES (FBMHS) TREATMENT MODEL

The Family Based Mental Health Services (FBMHS) treatment model in Pennsylvania is based on structural family therapy (SFT), as developed initially in the 1970's by Salvador Minuchin. FBMHS is a specific adaptation of ecosystemic structural family therapy (ESFT) done by Marion Lindblad-Goldberg in the late 1980's for the children's mental health system in Pennsylvania.

FBMHS is a home-based treatment service, which involves the use of two co-therapists who are expected to function as a professional team. The third member of the professional team is the FB supervisor, who oversees the work of the co-therapists, enhances their cohesion as co-therapists, promotes their professional development over time, and ensures that the needs of child and family are met. The FB co-therapists are assigned an intentionally small caseload in order to allow for individualized and at times intensive interventions, as needed by each client family.

FBMHS is intended to address the needs of a child (up to age 21 years) and his or her family, when the child has serious emotional disturbance (SED) and is at risk of Inpatient psychiatric hospitalization or out of home placement. Out of home placements include but are not limited to a residential treatment facility (RTF), a host home community residential rehabilitation (CRR) service, and a juvenile court placement. The risk of out-of-home placement may be imminent, or may be based on the emerging behaviors and functional limitations of the child with SED, in conjunction with multiple system involvement, significant challenges for the parents or legal guardians in parenting, and other risk factors for the arrest and/or out-of-home placement of the child. FBMHS can also be used for children and their families when a child is returning home from Inpatient, RTF, and other institutional and out-of-home settings.

An additional indication for FBMHS, when the above needs exist, is when there are multi-generational conflicts within a family interfering with the psychosocial functioning and emotional development of a child with SED, and when families, in recognition of the systemic and family focus of FBMHS, specifically request it. FBMHS may also be helpful in limiting the number of involved service providers when more than one child in the family has significant behavioral health issues and the family is in need of a cohesive, team-based process.

The goals of FBMHS involve addressing the presenting concerns related to the referred child, and also promoting the functioning and wellbeing of the family. Desired outcomes include the child being able to remain in the community with his or her family whenever possible, and the parents or guardians being able to support the positive development of the referred child, other family members, and the family as a whole.

While FBMHS assesses the needs of all family members including siblings of the referred child, the primary therapeutic focus involves the referred child, the child's parents or legal guardians, and the family system as a whole. It is expected that all relevant family members be included in some manner in the therapy, and that their needs be recognized and addressed. In this way, the positive impact of FBMHS can extend beyond just the referred child and his or her caregivers, to include siblings and other family members. However, when the individual needs of a caregiver and family members other than the referred child exceed the capacity of FBMHS to satisfactorily address, the FB team discusses appropriate services and resources that can be accessed through referral.

An underlying assumption of ESFT is that each child lives in a family and a community, and that the child's functioning needs to be understood within the context of relationships within the family and relationships with individuals and systems external to the family, not just in terms of the characteristics of the child individually. Since the family is a system, a child is affected by both their relationships with family members and by other family members' relationships with each other. The child is also affected by extra-familiar factors that impact the family as a whole, not just those that impact the child directly.

ESFT also recognizes the relevance of historical factors on a family's functioning. In particular, many families referred for FBMHS have experienced extensive trauma and loss. Often, this has occurred over multiple generations, impacting individual family members and the family as a whole. Trauma and loss can disrupt family development and diminish the capacity for resilience within the family and among individual members. Interrupting this cycle is challenging but essential.

Within an ESFT framework, positive adaptation and functioning by a child typically reflects the cumulative impact of the structure of family organization and relationships, the structure of the family's relationships with the community and external world, and the individual coping of the child. Family organization and structure are determined by characteristics of the family as a whole and also by the contribution of individual family members. In like manner, symptomatic and maladaptive behavior by a child typically reflects some combination of challenges specific to family organization and structure, challenges in the family's relationship to the external world, and challenges specific to the child.

ESFT identifies itself as a collaborative therapy, where the co-therapists work in a strengths-based manner in partnership with the parents/guardians, child, and other family members. With its attention to structure, ESFT is interested in family relationships within the nuclear family and also in relationships involving the extended family, particularly with those members of the extended family having frequent contact and closeness with the child and nuclear family. ESFT is committed to collaborate with all professionals involved with the child and family, including involved professionals from other child-serving systems. Finally, ESFT strives to help the family identify and expand

its natural supports, and the co-therapists, in conjunction with the family, collaborate with these extra-familial resource persons as well.

ESFT is committed to empowering parents/guardians to assume leadership in guiding the family and raising their children. ESFT interventions are also based on an understanding of the developmental tasks and challenges that involve the child and the family as a whole. There is emphasis on promoting and transferring a range of skills, so that the family can eventually function effectively following the departure of the co-therapists and can continue promoting the child's and family's positive development. Skill development is typically relevant for the family as a whole, the parents/guardians as a parental unit, the adults individually, the child, and the child's siblings.

Assessment and intervention in ESFT focus on both content and process within the therapy. *Content* pertains to the explicit topics under discussion, while *process* involves the patterns and sequences of interaction within the family.

> Content is important because the topics chosen by the family reflect its beliefs, values, preferences, and areas of concern. In addition, explanations and information offered by therapists to the family constitute family education, which can benefit the family.
>
> Process refers to the nonverbal responses of family members to one another and the sequence of verbal interactions within the family. Such responses and interactional sequences typically reflect family expectations, rules, and prohibitions, which constitute overt and more often covert messages within the family.

The FB co-therapy team, guided by their supervisor, provides psychotherapy for the child and family, working with the family as a whole and with various "subsystems" that include specific combinations of family members as indicated and the child individually. By design, FBMHS also includes case management by the co-therapy team as part of the core service. Other unique features of the model include the availability of respite services for child and family, if needed, and a limited amount of discretionary family support funds, to help the family address a tangible need that is linked to the treatment plan.

While a theory of change is not articulated as such, it appears that the theory of change within ESFT implicitly involves the following:

> The therapists need to engage child and family and build rapport and trust. As this is occurring, the therapists obtain information about the child and family, including information about strengths, needs, culture, and desired family outcomes. Information comes from direct observation of family interactions, which represent relationships in action, as well as from factual information conveyed by family members, referral sources, written records, and other collateral sources.

Building on information obtained and a developing therapeutic alliance, the team – which includes child and family, in addition to the professional therapists supported by the supervisor – develops a treatment plan based on identified goals and desired outcomes. Ongoing treatment then involves collaborative efforts to implement the treatment plan, followed by consolidation of gains and preparation for discharge and then, during the last phase, actual termination of services with careful attention to aftercare planning and implementation.

Change can be seen as resulting from a combination of the following: the development of the therapeutic alliance; changes in relationships within and external to the family, which alter the family's experience of one another and its connection to the outside world; identification and amelioration of internal and external barriers to more adaptive functioning; skill acquisition by the child and family as a whole; and the attainment of a problem-solving capacity that can be applied to diverse situations over time. Collectively, all of the above processes enable the family to promote the emotional development and wellbeing of the identified child, other family members, and the family as a whole.

CLINICAL SUPERVISION IN PA FBMHS: RECOMMENDATIONS for BEST PRACTICES

A Proposal Jointly Prepared by Pat Johnston, C. Wayne Jones & Marion Lindblad-Goldberg

7/27/11

Conceptual Synopsis

Given the complexity and clinical needs of the children and families served by FBMHS, clinical supervisors play a pivotal role in maintaining high quality clinical programs. However, there can be wide variation among supervisors on how they define their function and where they place their primary focus. This effects who benefits from supervision and in what manner. It also has a significant impact on the services that children and families receive, and most importantly, the outcomes they achieve. To date, neither the regulatory bodies nor the training centers have clearly formalized the roles and responsibilities of FBMHS clinical supervisors.

Historically, training programs have viewed their primary role as clarifying and teaching the clinical model (Lindblad-Goldberg et. al., 1998). Although the training programs have always supported supervisors in their supervisory efforts, there has been less **formal** focus on training of supervisors in supervisory skills and in the management of treatment fidelity. This has resulted in wide variation across programs with respect to how much accountability is placed on supervisors for their supervisees' competency, ensuring fidelity to the FBMHS clinical model, and family outcomes.

In order to expand and integrate the supervision of FBMHS, we believe the way we conceptualize and approach clinical supervision requires a more pronounced paradigm shift. This shift would have major implications for current FBMHS supervisors, their agencies, and the training centers, as well as for the relationships among them. Increased attention must be given to the actual services delivered to consumer-families and on the development of therapists. A best practice in FBMHS supervision expands the role of supervisors by emphasizing responsibility for: 1) clinical development of therapists, 2) therapists adherence to the model; and 3) positive outcomes of families served by the program. To create comprehensiveness and balance, these three important areas join with a focus on the person of the therapist and the development of general clinical skills.

Model of Supervision

The model of supervision proposed in this paper is based on the following principles:

- The established clinical model must be sufficiently specified such that standardized measures of treatment fidelity and client outcome are utilized across supervisors and agencies.

- The core responsibilities of clinical supervisors must be uniform across all FBMHS supervisors and agencies.

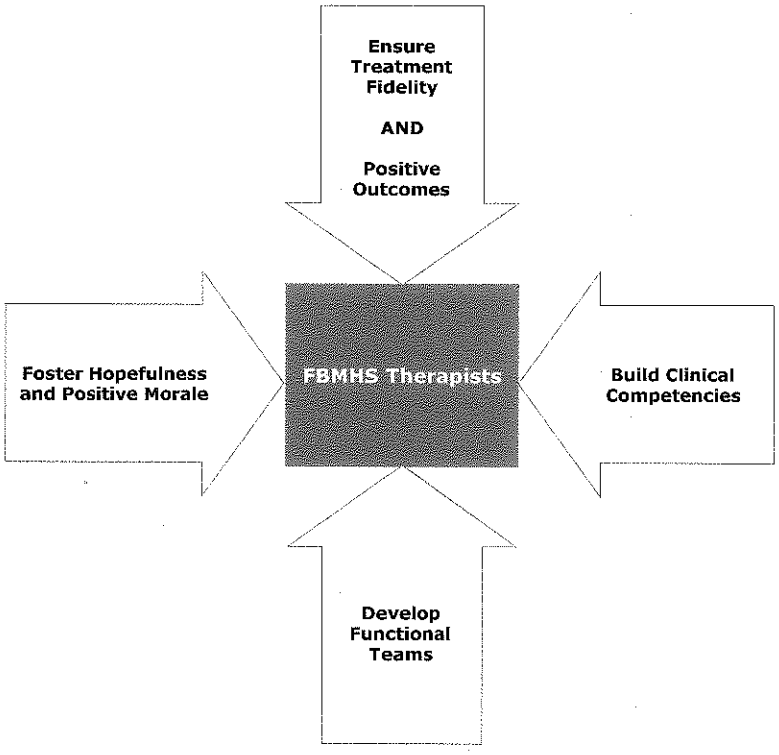
- Clinical supervisors must be fully committed to the practice and supervision of the established clinical model.

- The methodologies of supervision must be isomorphic with the established clinical model. This means small supervisor-to-team ratios and a focus on experience based learning.

- Clinical Supervisors/Program Directors must be accountable to other service systems.

The Goals and Responsibilities of Clinical Supervisors

PRIMARY FUNCTIONS OF CLINICAL SUPERVISORS IN FBMHS PROGRAMS



Goal 1: *Ensure that children and their families are receiving FBMHS in accordance with the established clinical model. This goal is achieved through the following supervisory actions:*

- Administer the treatment adherence scale for each family treated by a team on a bi-monthly basis

- Guide and coach teams to incorporate necessary model elements through a combination of videotaped supervision and review of treatment plans/progress notes.

Goal 2: *Create a supervisory context that fosters competence, hopefulness and positive morale. This goal is achieved through the following supervisory actions*:

- Maintain an ongoing, consistent availability to teams for support, guidance and technical assistance.

- Maintain a strengths-based perspective regarding children, families and supervisees.

Goal 3: *Foster development of functional family based teams. This goal is achieved through the following supervisory actions*:

- Following initial assessment, develop an individualized team plan in partnership with team members in order to enhance their ability to collaborate with one another and other involved community professionals and work in an intentional manner.

- Regularly assess team functioning and team process.

Goal 4: *Foster the development of each individual therapist's clinical and conceptual competencies. This goal is achieved through the following supervisory actions*:

- Assess each therapist's conceptual and technical skill levels and create a profile of strengths and weaknesses.

- Based on this profile of strengths and weaknesses, develop an individualized supervisory contract that builds clinical skills and increases adherence to the clinical model.

- In weekly supervision meetings reinforce the concepts and skills taught by trainers, using videotape supervision, group supervision, and when indicated, curriculum-related readings.

- Maintain a separate training file containing training documentations for each therapist.

- In preparation for a therapist's graduation from the three year training program, support, review, and approve the therapist's submission of documents meeting competency criteria. If remediation is required, work collaboratively with the training center to achieve the necessary remediation goals.

Goal 5: *Foster the integration of outcome measures into assessment and treatment protocols. This goal is achieved through the following supervisory actions:*

- Provide training in the implementation and interpretation of recommended outcome measures.

- Ensure that the findings of these measures are used to adjust treatment focus and methods.

Supervisory Methods

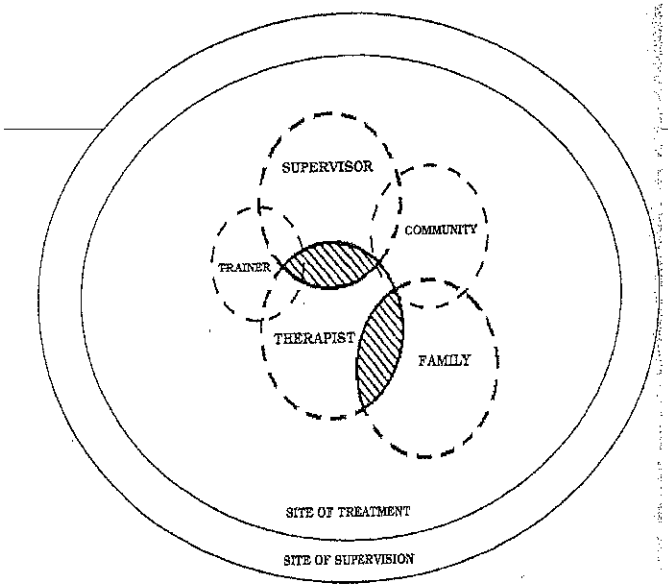
- Like the clinical model, supervision favors direct observation and experience over simply talking about families. Therefore, clinical supervisors are expected to require and regularly view videotaped treatment sessions and conduct home visits in their supervision of teams. The goals of these activities are to strengthen treatment adherence and clinical competencies. Direct observation of teams should occur at least *once a month for every family* seen in treatment.

- Like treatment, supervision should be goal directed. Therefore, clinical supervisors are expected to develop an *individualized* supervision contract with each therapist and provide regular feedback about progress. Similarly, supervisors need to review progress with each individualized *team plan*.

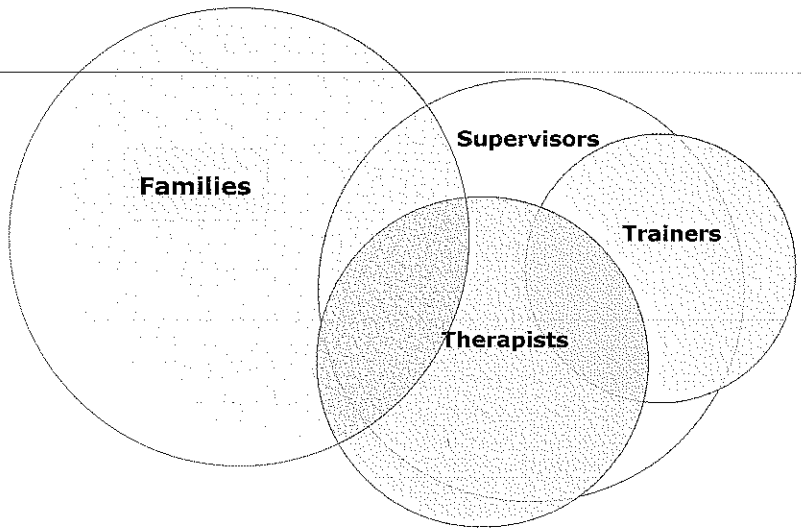
- Clinical supervisors are expected to incorporate and utilize standardized FBMHS tools, including but not limited to, the treatment plan and progress notes to review individual cases and plan interventions, as well as tools for measuring treatment fidelity and treatment outcomes.

The Supervisor-Therapist-Training Center Relationship

Previous Paradigm



New Paradigm



The figure on the left represents the supervisor-therapist-trainer relationship within an ecosystemic context as it was conceptualized twelve years ago (Lindblad-Goldberg, Dore, & Stern, 1998). Until recently, this paradigm has informed training and supervision. The training centers have historically seen teaching the clinical model as the primary focus of their relationships with therapists and supervisors. Although the figure highlights recognition of overlapping influences between the supervisor, therapist, community and the family, there are no clear reference to lines of responsibility and accountability.

The new paradigm is represented by the figure on the right. This figure highlights supervisors and therapists as a collaborative team in relation to the family. Among the interlocking circles in this figure, the family is the largest. This reflects an expanded emphasis within the supervisor-therapist-trainer relationship from skill development to the actual services families receive and their treatment outcomes. The implication of this expanded emphasis is a much larger role for supervisors. Graphically, this is reflected in the way the circle representing supervisors almost fully encompasses that of the therapists. In the new paradigm, we are emphasizing the supervisor's leadership role and accountability for therapists' completion of outcome measures and their competency in delivering clinical treatment that maintains the fidelity to the established clinical model. In turn, the therapists are responsible for delivering effective treatment to families in accordance with the clinical model.

In the new paradigm, the trainers focus more directly on the supervisors. The training centers are accountable for providing the training, support, technical tools and documentation necessary for supervisors to meet their responsibilities to the therapist teams. Specifically, this means that the training centers:

- Clarify, promote and teach the established clinical model
- Provide clinical assessment and skills along with administrative management tools for facilitating systematic delivery of the established clinical model
- Clarify, promote and teach the clinical use of treatment outcome measures
- Mentor supervisors in a model of supervision that is isomorphic to the clinical model and maintains a strengths based, ethical orientation
- Provide guidance, coaching and consultation to the clinical supervisors, in order to promote their competence and professional development, and those of the therapists they supervise.
- Assess each supervisor's conceptual and technical skills using an ESFT supervisor scale and create a profile of strengths and weaknesses. Based on this profile, develop an individualized contract with each supervisor that describes a development plan for increasing effective supervision of the model. Frequency of

contact with each supervisor will be determined by the need level reflected in these profiles.

- Provide training and support in areas of weakness which addresses learning through videotape supervision, supervision literature, contact with supervisors between formal trainings and when indicated, enrollment in a course on supervision.

Implementation

In order to effectively support supervisors, a two pronged curriculum will be delivered by the training centers. One focuses on teaching therapists and supervisors the concepts and methods of the ESFT clinical model (which is the current developed curriculum that is operational). The second curriculum is focused on teaching supervisors the concepts and methods of effective clinical supervision in the ESFT approach to family based mental health services.

The training centers will standardize the core content of this supervisory training, but will be encouraged to individualize their implementation methods according to the needs of their contracted programs. The following topics will be included in this standardized curriculum: a) developing the supervisory-therapist alliance, b) addressing developmental themes in supervision including use of self, c) understanding theoretical constructs and skill application in supervision, d) addressing contextual and cross-cultural themes in supervision, e) using supervisor contracts, enactments, and feedback, f) using diverse supervisory modalities, g) teaching effective writing of treatment plans, progress notes, and discharge summaries, h) evaluating therapist competency, adherence, and client outcomes, and g) teaching ethical/liability issues.

In order to most effectively implement a dual curriculum, and enhance the competency of supervisors, the following four changes to the training are recommended.

Change One: Shift the Role of Supervisors Within Clinical Training

Clinical trainings provide an experiential context that focuses on clinical skill development. In the new training paradigm, supervisors will be encouraged to function more in line with their increased clinical responsibilities with staff. In collaboration with training faculty, supervisors will be provided with opportunities to be in a leadership position both prior to and during case presentations. Supervisors may:

- Select team and cases presented based on their assessment of therapists and team learning goals

- Review video clips and written material prior to presentation to ensure case has been formulated based on established clinical model.

- During case presentations, supervisors may introduce case presentations and video clips, facilitate group discussion of cases, and de-brief the team about what has been learned and how recommendations will be implemented.

Change Two: Increase Opportunities for Individualized Supervisor Support

There are three major types of support the training centers will provide each supervisor to enable them to function effectively and facilitate the delivery of high quality services. These include:

- Ongoing formal and concrete feedback to supervisors about how their therapists are performing. Feedback mechanisms include one or more of the following: oral or written summaries of therapists' performance after a clinical presentation, results of therapists' responses from pre-post testing following clinical or didactic trainings, and results from annual examinations of therapists' conceptual and technical skills. Training faculty will provide individualized guidance to supervisors for remediation of therapists' weaknesses.

- Ongoing formal and concrete feedback to supervisors about how they are functioning as supervisors. This feedback will be tied to supervisors' video presentations of their supervisory sessions during supervisor training, the accuracy of supervisor ratings on therapists' treatment adherence measures, and on level of preparation demonstrated by therapists' clinical case presentations. Feedback will be specific to supervisors' learning goals as outlined in their mutually developed supervisory learning contract.

- Opportunities between scheduled trainings for supervisors to consult individually with training faculty about implementing effective supervision. Methods may include telephone or web-based video conferencing, supervisory blogs, or small group face-to-face meetings. Web-based options will, of course, be based on program capabilities.

Change Three: Reallocation of Training Hours and Training Focus

In order to ensure that new FBMHS therapists have initial basic preparation for the clinical work with families, the training centers are standardizing a (webinar and classroom format) "start-up" curriculum that will be offered a minimum of twice per year. Topics to be included in this training include an introduction to: 1) the major concepts and principles of the ESFT treatment model, 2) building therapeutic relationships with all family members, 3) understanding team roles and effective team process, and 4) contextual assessment tools. Since some of this training will be made available through webinars or DVDs, therapists can access the material at any time and discuss it with their supervisors. Supervisors will orient new therapists to FBMHS regulations and basic paperwork requirements. They will also be responsible for helping them translate the start-up training to actual practice.

In order to augment effective clinical supervision and oversight of both new and experienced therapists, current training centers' resources need to be reallocated and expanded so that clinical supervisors receive more concentrated training.

- **Non-Graduated Therapists**: The current requirement of 102 hours of training directed at therapists each year will be changed. In order to graduate from the center's training, it is suggested that therapists would need to meet a minimum of 255 hours of FBMHS training, in addition to meeting established competency criteria. Although this action represents a reduction in direct time spent in formal trainings offered by the training centers, it is offset by increased quality time spent with more highly skilled supervisors and other resources. It is also offset by the therapists who have additional time in the field serving children and families. The goal of the training remains the same for non-graduated therapists – learning to competently and effectively implement the established clinical model with children and families.

- **Graduated Therapists**: Graduated therapists would receive clinical training yearly by the training centers to maintain fidelity in the clinical model, or if recommended by the Program Director/Supervisor, to boost basic skills in delivering the model. The additional required hours annually of continuing education may be completed through continued participation in: 1) Agency in-service trainings, 2) MCO required trainings, 3) State, regional, or national conferences that offer **systemic family-focused** training in specialized topics of clinical practice such as; a) attachment disorders, b) trauma-informed care, c) co-occurring disorders, d) special need populations, etc. and 4) Courses or supervision required for Pennsylvania Licensure in marriage and family therapy, clinical social work and professional counseling.

- **Non-Graduated Supervisors**: Non-graduated supervisors would be required to attend the same annual hours of FBMHS training (dyadic and clinical) along with their supervisees, plus specialized supervisory training hours. All of this training would be provided by the training centers.

  Of the specialized hours: a) some hours involve ongoing supervisor training with graduated supervisors and b) Additional hours per year will be devoted to new, non-graduated supervisors and occurs in small groups or in 1:1 consultations. This would allow the training centers to have more frequent (monthly) contact during the training year with newer, non-graduated supervisors and provide a focused start-up supervisory curriculum.

- **Graduated Supervisors** would be required to attend annual hours of face-to-face training provided by the training centers; the focus is on teaching supervisory methods for strengthening clinical competency and teaching the measurement and management of treatment fidelity and treatment outcome. The additional required annual hours of continuing education may be completed outside the training centers through participation in: 1) Agency in-service trainings, 2) MCO required

trainings, 3) State, regional, or national conferences that offer **systemic family-focused** training in specialized topics of clinical practice, such as; a) attachment disorders, b) trauma-informed care, c) co-occurring disorders, d) special need populations, etc., and 4) Courses or supervision required for Pennsylvania Licensure in marriage and family therapy (MFT), clinical social work (MSW),and professional Counseling.

Change Four: Credentialing Of Supervisors

A fourth recommendation, also at the policy level, involves *credentialing of supervisors*. This process may have multiple components, such as:

- Documentation of completion of all required training hours (for the three year curriculum years for non graduated supervisors).
- Graduated supervisors will be grandfathered in terms of the training hour requirement.
- Both graduated and non-graduated Supervisors will be required to be certified.
- Supervisory competency will be assessed by the training faculty based on:
    - The quality of supervisors' documentation and video presentation of a supervisor's skill in furthering therapists' conceptual and experiential components of the clinical model.
    - Improvements in their teams' treatment fidelity data, use of outcome measures, and therapists' clinical competency measures.
    - Improvements in family outcome data.

Summary

First established in 1988, FBMHS has been a critical part of the array of services available to children and adolescents in Pennsylvania who experience severe emotional and behavioral problems. The program has proven extremely valuable to many families over the years. Like most services operating over time, reassessment and continuing improvement are necessary to ensure consumers receive the highest quality of service possible. This reassessment process is ongoing and has involved collaborative conversations between the Children's Bureau, representatives from the regional offices, MCOs, consumer families, FBMHS program directors/supervisors, and the training Centers.

The formulations and recommendations outlined in this paper are the result of a smaller workgroup between the Children's Bureau and the Training Center Directors. The goal of this workgroup was to enhance current approaches to supervision and

training in FBMHS. It is our hope that these changes will strengthen the treatment integrity of FBMHS across programs, improve treatment outcomes, and continue to move these needed services forward into the future.