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Brief Strategic Family Therapy: Implementing evidence-based models in community settings

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Abstract

Reflecting a nearly 40-year collaborative partnership between clinical researchers and clinicians, the present article reviews the authors' experience in developing, investigating, and implementing the Brief Strategic Family Therapy (BSFT) model. The first section of the article focuses on the theory, practice, and studies related to this evidence-based family therapy intervention targeting adolescent drug abuse and delinquency. The second section focuses on the implementation model created for the BSFT intervention– a model that parallels many of the recommendations furthered within the implementation science literature. Specific challenges encountered during the BSFT implementation process are reviewed, along with ways of conceptualizing and addressing these challenges from a systemic perspective. The implementation approach that we employ uses the same systemic principles and intervention techniques as those that underlie the BSFT model itself. Recommendations for advancing the field of implementation science, based on our on-the-ground experiences, are proposed.

Keywords

Implementation; family therapy; intervention research

An increasing number of preventive and treatment interventions have been found to be efficacious in tightly controlled trials, and many of these have been found to be effective in randomized controlled trials in real world settings (Faggiano, Vigna-Taglianti, et al., 2010; Watkins, Hunter, Hepner, Paddock, de la Cruz, Zhou, & Gilmore, 2011). However, current community practice in medicine and behavioral health does not fully incorporate evidence-based interventions (Institute of Medicine, 2007). The present article grew out of our experience with one behavioral intervention, Brief Strategic Family Therapy® (BSFT®), which has undergone nearly 40 years of clinical development and research, and the challenges we encountered in bringing this evidence-based intervention to practice settings.

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The current article is organized into two major sections: (a) Brief Strategic Family Therapy: Theory, Research and Practice; and (b) Transporting and Implementing the BSFT Model in Community Based Settings: Challenge and Solutions. Put together, these two sections trace the evolution of the BSFT approach from initial model development through efficacy, effectiveness, process research, and the recent development of the BSFT Implementation Model.

Brief Strategic Family Therapy®: Theory, Research and Practice

The Brief Strategic Family Therapy® (BSFT®) approach is a short-term family treatment model developed for youth with behavior problems. Developed by a team of clinicians and clinician-scientists over nearly 40 years of research at the University of Miami's Center for Family Studies, the BSFT approach is based on the premise that families are the strongest and most enduring force in the development of children and adolescents (Gorman-Smith, Tolan, & Henry, 2000; Steinberg, 2001; Szapocznik & Coatsworth, 1999). Families of youth with behavior problems such as drug and alcohol use, delinquency, affiliation with antisocial peers, and unsafe sexual activity tend to interact in ways that permit or promote these problems (Vérroneau & Dishion, 2010). The goal of the BSFT approach, therefore, is to change the patterns of family interactions that allow or encourage problematic adolescent behavior. By working with families, the BSFT intervention not only decreases youth problems, but also creates better functioning families (Santisteban et al., 2003). Because therapists bring about changes in family patterns of interactions, these changes in family functioning are more likely to last after treatment has ended because multiple family members have changed the way they behave with each other.

The BSFT approach is based on an integration of structural (Minuchin & Fishman, 1981) and strategic (Haley, 1976; Madanes, 1981) approaches to family therapy. We proposed such an integration of structural and strategic principles given our early clinical experiences, where (a) adolescent behavior problems were clearly linked to structural problems (i.e., maladaptive patterns of interactions) within the family and (b) a time-limited, strategic approach, targeting only those family processes that are directly associated with the adolescent's symptoms, appeared to be the most efficacious way to engage and retain families in treatment. Indeed, our own clinical experiences have continued to guide the refinement of the BSFT model. We have used a collaborative, bidirectional approach between clinicians and clinician-scientists in developing the BSFT model and its various modules (e.g., BSFT Engagement).

Based on our early experience with Cuban families, within the BSFT approach, the family is conceptualized as a system that is "greater than the sum of its parts" (Bowen, 1978) – that is, a system in which the behavior and development of each family member is interdependent with the behavior and development of other family members. Changing the adolescent's behavior, then, requires changing the family system as a whole. Specifically, the BSFT approach aims to modify the repetitive patterns of family interactions that support the adolescent's drug use and associated negative behavior, and to strengthen adaptive family interactional patterns that promote healthy development.

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Specific Techniques Used in the BSFT Model

The BSFT intervention employs four specific theoretically and empirically supported techniques delivered in phases to achieve specific goals at different times during treatment. These techniques were built from the work of master clinicians such as Minuchin, Haley, and Madanes, and from the clinical experience of our clinicians and clinician-scientists in working with our minority families. As will be noted, this work is intended to make the family fully participatory – a full partner – in the change process. Early sessions are characterized by *joining* interventions that aim to establish a therapeutic alliance with each family member as well as with the family as a whole. The therapist here demonstrates acceptance of and respect toward each individual family member as well as the way in which the family operates as a whole. Early sessions within treatment also include *tracking and diagnostic enactment* interventions designed to systematically identify family strengths and weaknesses and develop an overall treatment plan. A core feature of tracking and diagnostic enactment interventions includes strategies that encourage the family to behave as they would usually behave if the counselor were not present. Family members are encouraged to speak with each other about the concerns that bring them to therapy, rather than have them direct comments to the therapist. From these observations, the therapist is able to diagnose both family strengths and problematic relations. *Reframing* techniques are then used to reduce family conflict and create a motivational context (i.e., hope) for change.

Throughout the entirety of treatment, therapists are expected to maintain an effective working relationship with family members (joining), facilitate within-family interactions (tracking and diagnostic enactment), and directly address negative affect/beliefs and family interactions. The focus of treatment, however, shifts to implementing *restructuring* strategies to transform family relations from problematic to mutually supportive and effective. These interventions include (a) directing, redirecting, or blocking communication; (b) shifting family alliances; (c) helping families develop conflict resolution skills; (d) developing effective behavior management skills; and (e) fostering parenting and parental leadership skills.

BSFT Engagement—Often, the same interactional problems that are linked with the adolescent's symptoms are also associated with the family's inability to coming to treatment. Within the BSFT model, specialized engagement techniques have been developed in collaboration with our senior therapists and evaluated by a team of clinical researchers (Coatsworth et al., 2001; Santisteban et al., 1996; Szapocznik et al., 1988). In this context, engagement refers to a set of strategies designed to bring all the relevant family members into treatment. The same intervention domains used in BSFT treatment – joining, tracking and diagnostic enactment, and reframing – are also used to engage families into therapy. The therapist begins to explore the family interactions in a first call by giving the caller a task such as bringing all the members of the family into the first session. Through the caller's response (e.g. "my husband won't come to treatment") the BSFT therapist can begin diagnosing family interactions. In these cases, and with the caller's approval, the therapist will insert herself into the family's process by reaching out directly to the family member who either does not want to come to treatment or whom the caller is not eager to bring to

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treatment, as a way of getting around the interactional patterns that interfere with bringing all family members into treatment.

BSFT Research

BSFT research has occurred in four primary domains: (a) studies evaluating BSFT efficacy in reducing adolescent behavior problems and drug use and in improving family functioning; (b) studies evaluating the efficacy of BSFT Engagement procedures in bringing and retaining families in treatment; (c) studies evaluating the effectiveness of the BSFT intervention in community settings; and (d) studies examining the effects of BSFT therapist prescribed behaviors on adolescent and family outcomes. These studies have led the U.S. Department of Health and Human Services to label the BSFT approach as one of its "model programs" and to be included in the National Registry of Evidence-based Programs and Practices (NREPP; http://nrepp.samhsa.gov/ViewIntervention.aspx?id=151). We discuss research in each of these four areas in this section.

Led by a team of clinical researchers, the majority of the earlier studies on the BSFT intervention were conducted with Hispanic families in Miami (Coatsworth et al., 2001; Santisteban et al., 1996, 2003; Szapocznik et al., 1988, 1989). The model was originally developed to address acculturation discrepancies between Cuban adolescents and their parents (Szapocznik, Scopetta, & King, 1978a, 1978b). At the time when the BSFT model was developed, Szapocznik et al. (1978) observed that the vast majority of the drug abusing and delinquent adolescents referred for treatment evidenced cultural, as well as normative developmental, conflicts with their parents. The researchers drew upon their own clinical experience, as well as on the experiences and observations of the therapists working with these adolescents and their families, in developing a model that would decrease the culturally related conflicts within client families. However, in addition to the efficacy research on the BSFT model with Hispanics, effectiveness research has suggested that the model is equally applicable to African American and White American families as well (Robbins et al., 2011b). The model is currently being used broadly with a variety of populations in the United States and Europe.

BSFT Efficacy—The efficacy of the BSFT model in reducing behavior problems and drug abuse has been tested in two randomized, controlled clinical trials. In the first trial, Szapocznik and colleagues (1989), including several very experienced clinicians, randomized behavior-problem and emotional-problem 6–11 year old Cuban boys to BSFT, individual psychodynamic child therapy, or a recreational placebo control condition. The two treatment conditions, implemented by highly experienced therapists, were found to be equally efficacious, and more efficacious than recreational control, in reducing children's behavioral and emotional problems and in maintaining these reductions at 1-year post-termination. However, at 1-year follow-up, the BSFT condition was associated with a significant improvement in independently rated family functioning, whereas individual psychodynamic child therapy was associated with a significant deterioration in family functioning. To reflect the participation of the therapists in the design and conduct of the study, all four therapists were authors on the major outcome paper (Szapocznik et al., 1989).

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In a second study, Santisteban and colleagues (2003) randomly assigned Hispanic (half Cuban and half from other Hispanic countries) behavior-problem and drug abusing adolescents to receive either the BSFT intervention or adolescent group counseling modeled after a widely used program in the community. Three therapists delivered the BSFT condition. One was a highly experienced clinician who was proficient as a BSFT therapist. Reflecting his broad and thoughtful contribution to the intervention delivery as well as to other aspects of the study, he was an author on the outcome article. The other two, more junior therapists were supervised by the experienced BSFT therapist. Within the control condition, group counseling, a very experienced school counselor conducted the sessions in line with the way group counseling was being conducted in the community, without receiving any guidance or interference from the study team.

The BSFT condition was significantly more efficacious than group counseling in reducing conduct problems, associations with antisocial peers, and marijuana use, and in improving independent ratings of family functioning (Szapocznik et al., 1991). Interestingly, baseline family functioning emerged as a moderator of treatment effects. For families entering the study with comparatively good family functioning, family functioning remained high in the BSFT condition, whereas it deteriorated in the families of adolescents in group therapy. For families entering the study with comparatively poor family functioning, the BSFT condition significantly improved family functioning, whereas family functioning did not improve in families assigned to adolescent group therapy.

The BSFT model has also been tested with African American as well as Hispanic adolescents with behavior problems. In fact, Santisteban and colleagues (1997) found that BSFT treatment significantly reduced associations with antisocial peers and improved family functioning for both Hispanics and African Americans. However, BSFT treatment was significantly more efficacious in reducing association with antisocial peers among African Americans than among Hispanics, whereas it was significantly more efficacious in improving family functioning among Hispanics than among African Americans.

BSFT Engagement—The efficacy of BSFT Engagement was tested in three separate studies with Hispanic adolescents with behavior problems and their families. Clinicians played key roles on the research teams for all three of these studies. In the first study (Szapocznik et al, 1988), Hispanic (mostly Cuban) families with drug abusing adolescents were randomly assigned to BSFT + Engagement as Usual or to BSFT + BSFT Engagement. Results indicated that 93% of the families in the BSFT Engagement condition, compared with only 42% of the families in the Engagement as Usual condition, engaged into treatment. Further, 75% of families in the BSFT Engagement condition completed treatment, compared with 25% of families in the Engagement as Usual group. Two clinicians were authors on the major outcome paper (Szapocznik et al, 1988).

A second study (Santisteban et al., 1996), which included the senior clinician in the study as an author, found similar results, with 81% of families randomly assigned to BSFT Engagement successfully engaging in treatment compared to 60% of the families in an Engagement Control condition. A third study (Coatsworth et al., 2001) tested the ability of BSFT + BSFT Engagement to engage and retain adolescents and their families in

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comparison to a *community* control condition implemented by a community treatment agency. Findings in this study indicated that BSFT Engagement successfully engaged 81% of families into treatment – significantly higher than the 61% rate in the community control condition. Likewise, among families who were successfully engaged, 71% of BSFT cases, compared to 42% in the community control condition, were retained to treatment completion.

BSFT Effectiveness—A BSFT effectiveness study was conducted within NIDA's National Drug Abuse Treatment Clinical Trials Network (Tai et al., 2010). The Network is comprised of 13 nodes, each led by a university research team (the lead author is PI of one of these nodes) in collaboration with community providers, community-based substance abuse treatment centers, and medical programs. The Network was established to increase the rate at which evidence-based practices were being translated into the frontlines of practice. Providers had argued that many research studies had not been designed with provider settings in mind, making it challenging to translate evidence-based practices tested under laboratory conditions into clinical practice. To achieve increased translation, it was essential to involve both researchers and practitioners in designing the effectiveness studies that would be implemented in the Network's community settings (Tai, Sparenborg, Liu, & Straus, 2011). The concept was to conduct rigorous randomized clinical trials of evidence-based practices in real world, community-based settings. To help ensure that studies were designed to maximize adoption by providers, interventions would be delivered by real-world providers. To achieve this kind of synergy between researchers and practitioners, teams of providers and researchers selected the studies to be conducted and were intimately involved in their design. In this spirit, the BSFT study design, implementation, and manuscript writing team included clinician-scientists and provider-investigators, the latter from participating study sites. For example, denoting this kind of collaboration, the major outcome paper (Robbins et al., 2011b) was authored by seven clinicians in leadership roles in community-based adolescent drug abuse treatment programs, six university-based clinician-scientists, and one biostatistician. In the BSFT effectiveness trial, we recruited 480 families of adolescents (213 Hispanic, 148 White, and 110 Black; 377 male, 103 female) who had been referred to drug abuse treatment at 8 community treatment agencies located around the United States. Adolescents and their families were randomized to either BSFT or Treatment as Usual (TAU, which was allowed to vary based on whatever treatment the agency typically provided for drug using adolescents). Participating therapists were employees of the participating community agencies. They had a broad range of educational backgrounds (ranging from bachelor's to doctoral degrees) and prior experience (from minimal to extensive; from having worked with teens and families to never having done so).

Both families and therapists were randomized within each agency to either the BSFT or TAU modalities. Regarding engagement and retention, families in TAU were 2.33 times (11.4% BSFT; 26.8% TAU) more likely to fail to engage and 1.41 times (40.0% BSFT; 56.6% TAU) more likely to fail to retain compared to families in the BSFT condition. These significant differences were consistent across racial/ethnic groups.

Median drug use at the 12 months, the final follow-up, was significantly lower in the BSFT condition (Mdn = 2 days) than TAU (Mdn =3.5 days), although the actual number of drug

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use days remained low from baseline through follow-up in both conditions. These low levels of drug use may have been, at least in part, a function of the majority of adolescents having come from residential treatment or having been referred (and monitored) by the juvenile justice system.

Family functioning in this study differed between adolescent and parent reports, with the BSFT condition producing significantly greater improvements in parent-reported family functioning compared to the treatment as usual condition. Adolescents in both conditions, however, reported significant improvements in family functioning, with no statistically significant differences by treatment condition. Post-hoc analyses also demonstrated that the BSFT intervention was more effective than Treatment as Usual in improving parental functioning, and that this effect was mediated by parental reports of family functioning.

BSFT Therapist Behaviors, Therapy Process, and their Relationship to Outcomes

Research has demonstrated that negativity in family interactions in the first session leads to failure to retain families in treatment past the first session (Fernandez & Eyberg, 2009); that families are more likely to engage into treatment if negativity is reduced (Robbins, Alexander, & Turner, 2000); that reframing is an effective method of reducing negativity (Moran, Diamond, & Diamond, 2005); and that reframing is the technique that is least likely to damage therapists' rapport (alliance, bond) with family members (Robbins, Liddle, Turner, Dakof, Alexander, & Kogan, 2006). Research on BSFT engagement has indicated that if, in the first session, the therapist does not develop a balanced set of bonds with the parent and the youth, this imbalance leads to early dropout from treatment (Robbins et al., 2000). The empirical evidence derived from the work of these clinicians have brought about findings that have been incorporated into BSFT treatment as conducted today.

Therapist collaboration in delivering evidence-based interventions is essential to achieve high adherence rates and, consequently, better outcomes. Using data from the effectiveness study, Robbins et al. (2011a) examined the extent to which BSFT therapists implemented the treatment protocol properly. Adherence (prescribed) items were rated in terms of the four theoretically and clinically relevant expected/prescribed therapist behaviors: joining, tracking and eliciting enactments, reframing, and restructuring. Therapist adherence to the BSFT model was associated with:

1. *Engagement*: Higher levels of restructuring and reframing (creating a motivational context for change) significantly increased the likelihood of families being engaged into treatment. Because joining, and tracking and diagnosis were high across most cases, what distinguished cases that came to a second session from those that did not were reframing and restructuring, the technique domains that therapists found most challenging.
2. *Retention*: The impact of adherence on retention was evaluated using adherence ratings for sessions 2–7, with retention defined as a family attending at least 8 sessions. Higher levels of all four technique domains – therapist joining, tracking and enactment, reframing, and restructuring – predicted significantly higher rates of retention. A one standard-deviation increase in reframing predicted a 19% increase

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in the likelihood of retention; a one standard-deviation increase in joining predicted a 22% increase in the likelihood of retention; a one standard-deviation increase in restructuring predicted a 59% increase in the likelihood of retention; and a one standard-deviation increase in tracking and eliciting enactment predicted a 62% increase in the likelihood of retention.

3. *Family functioning:* Overall joining levels predicted improvements in observer-reported family functioning.

4. *Adolescent drug use:* Therapists who were high in joining in early sessions and remained so throughout treatment were associated with “better” adolescent drug use outcomes. Therapists whose attempts to restructure maladaptive family interactions increased most during the course of treatment were also associated with “better” adolescent drug use outcomes. Thus, therapists who failed to implement sufficient numbers of restructuring interventions were less able to affect the youths’ drug use.

These results indicate that, within a sample of therapists from community agencies, therapists’ clinical interventions follow a pattern that is consistent with the theory behind the BSFT model. Indeed, the specific therapist behaviors prescribed by the BSFT approach are needed to engage families into treatment, retain them, improve family functioning, and reduce adolescent drug use. However, when therapists did not engage sufficiently in these behaviors, adolescent outcomes tended to suffer. On the basis of considerable input from the participating therapists as well as the authors’ own observations, the authors concluded that adherence ratings were affected by a number of systemic factors, including over-burdened therapists and therapists’ lack of embeddedness within dedicated BSFT units. That an effectiveness study, conducted with community providers as therapists, revealed such impactful effects of therapist adherence suggests strongly that implementing the model with fidelity in community agencies is necessary for adolescents and families to achieve the maximum benefits from the BSFT treatment model.

Transporting and Implementing the BSFT Model in Community Settings: Challenges and Solutions

What is involved in transporting an evidence-based intervention into community agencies? The literature suggests that the combination of a detailed treatment manual, well-developed training programs, and an organization (sometimes called a purveyor) that promotes the intervention provides therapists with training and ongoing monitoring, coaching and feedback are needed (Fixsen, Blase, Naoom, & Wallace, 2009). These resources were all available for the BSFT model a decade ago. However, implementation brings a number of challenges in terms of transforming agency practices to ensure that the model is implemented with fidelity (Fixsen, Blase, & Van Dyke, 2011) and sustained (Henggeler, 2011). Community agencies and clinicians may not be accustomed to the rigors of evidence-based treatments, and there are a number of important challenges that arise during the process of working with an agency that has expressed interest in delivering an evidence-based treatment.

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Our experiences in implementing the BSFT model within community agencies have been consistent with the challenges reported in the emerging literature on implementation (Fixsen et al., 2011). The solutions that we have utilized were not directly informed by the implementation literature – but our solutions have dovetailed with recommendations from leaders in the implementation science field (Addiction Technology Transfer Center Network Technology Transfer Workgroup, 2011). Similar to the implementation science literature (see Fixsen et al., 2009, 2011), we view successful implementation in terms of adoption, fidelity, and sustainability. *Adoption* refers to an agency's decision to deliver an evidence-based treatment model and to reconfigure itself so that the model can be delivered as intended; *fidelity* represents delivery of the model in accordance with the treatment manual; and *sustainability* represents a lasting commitment and ability to continue delivering the model on a long-term basis. Broadly, we have developed a systems approach to working with agencies, where some of the same principles that we use with families around the presenting system of "adolescent problem behaviors" are utilized with funders, agency leaders, supervisors, and therapists around the challenges of implementation. We describe these challenges and approaches in more detail in this section.

Our Early Implementation Experience

Our first attempts to disseminate the BSFT clinical intervention into the community involved simply training therapists from community agencies in the BSFT approach and supervising them to achieve a pre-specified level of fidelity in their delivery of the BSFT approach. These therapists would attend our training sessions, and would then apply the BSFT model receiving monitoring, coaching and feedback for fidelity. Many therapists would reach fidelity levels for "BSFT Therapist Certification". In most cases, however, these therapists encountered a number of obstacles to using the BSFT approach, and initial attempts to infuse the BSFT model into practical settings were largely unsuccessful in terms of attaining *enduring* fidelity and sustainability. We received considerable input from therapists that helped us to identify the challenges they were encountering. Agency supervisors, for instance, often place additional demands on therapists' time, such as additional caseloads using other therapy models that distracted therapists from their BSFT caseloads. For example, the BSFT approach mandates that families be seen wherever and whenever necessary – meaning that therapists must be available during evening and weekend hours. However, when therapists have large additional daytime caseloads, they may not be available when families are available – evenings and weekends. Indeed, we experienced these challenges in our effectiveness study when therapists who were assigned to deliver the BSFT model almost always had large caseloads using various treatment approaches. A dedicated BSFT team is necessary to deliver the model, given all of the requirements involved, and given the need for therapists to maintain conceptual focus on the model.

In our early implementation experience, although the agency had expressed interest in delivering the BSFT model, the agency leadership did not understand all that this entailed. When we followed up with therapists and agencies after training, we found that many therapists had not been able to continue to conduct the BSFT model without agency support, and had consequently reverted to previous less demanding treatment models. Moreover,

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without ongoing monitoring, coaching, and feedback, therapists were unable to maintain acceptable levels of adherence or fidelity.

As our experience attempting to solely train (with monitoring, coaching, and feedback throughout training) therapists using the BSFT model demonstrates, an evidence-based model cannot simply be "picked up" from the research setting and "put down" into a community agency. The members of the BSFT research team, most of whom are clinically trained, recognized that a second layer of intervention at the organizational level was needed to facilitate successful implementation. From a family systems theory perspective, we understand that it is difficult to change one family member's behavior without changing the family system. Similarly, we learned that the same principles applied to agencies and their therapists: it is difficult to implement an evidence-based intervention in a community agency without creating a participatory process with agency and therapist personnel that established the context that will support the adoption, fidelity, and sustainability of the model. Based on this experience, and on our unsuccessful attempts to train therapists without working directly with the agency leadership, we developed a BSFT implementation model, based on the systemic principles in which BSFT is grounded.

The feedback that we received from therapists and their local supervisors helped to shape the kind of implementation intervention that was needed. For example, it was clear that therapists were being pulled in many directions and did not have the time to dedicate to providing services to each family with the persistence required by the BSFT model. Therapists felt pulled in many directions not only by their heavy caseloads, but also because of the need to provide services using other approaches that are incompatible with the theoretical perspective underlying the BSFT approach. As a consequence, it became clear that a dedicated BSFT team with an agency advocate was needed to deliver the model, given all of the requirements involved, and given the need for the therapist to maintain conceptual focus on the model. This made sense because the efficacy of the BSFT model (and other family-based models) had always been tested with dedicated teams. Moreover, when we looked at other family-based models with successful sustainability, such as Functional Family Therapy (Breuk, Sexton, van Dam, Disse, Doreleijers, Slot, & Rowland, 2006) and Multisystemic Therapy (Henggeler, 2011), we observed that these models had dedicated implementation teams.

How the BSFT Model Informs "Adoption" in Our Implementation Model—The BSFT Implementation model now extends the concept of systems to apply to therapists, the agencies with which they work, and these agencies' social ecology. Similar to our work in BSFT intervention, our experience in BSFT Implementation has taught us that *a participatory approach* to organizational work – at all levels of the agency – is essential to establish the context for adoption, fidelity, and sustainability.

Just as families require support from their social ecologies – such as adequate financial resources and freedom from excessive stress on the parent figures, treatment agencies must become partners in the Implementation process to ensure that they, for example, seek and receive sufficient support from their funders, referral sources, and other stakeholders. Such support is essential to ensure that agencies have the flexibility to adopt (e.g., funding by case

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rather than by session), reach acceptable levels of fidelity (e.g., have time set aside for therapists and supervisors to train, be supervised, and review their own work) and achieve sustainability (e.g., long-term funding based on clinical outcomes rather than hours of services delivered; demonstrated cost savings to the funder and/or society; trained and certified BSFT on-site supervisor to ensure ongoing supervision to fidelity over time who can also function as an advocate for the model within the agency). Therefore, successful BSFT Implementation requires full collaboration between the BSFT Institute, the agency (e.g., BSFT therapists and supervisors, agency middle and upper management), and its context (e.g., funders and other stakeholders such as judges who are often a major referral source). Such collaborations help to create a broadly participatory process in which all of the levels of the organization and its context, from therapist to agency middle-management, agency leadership, and funders, are actively involved in the Implementation process.

To provide a BSFT Implementation intervention, we created the *BSFT Institute*, an example of an implementation "purveyor" whose goal is to facilitate adoption of, fidelity to, and sustainability of the evidence-based treatment model (Fixsen et al., 2009). The BSFT Institute is run by clinicians who are highly experienced and proficient in the BSFT therapy and/or Implementation models. The BSFT Implementation approach borrows from the BSFT clinical intervention by engaging all members of an organization to create a participatory process. For example, the BSFT consultant *joins* with each of the individuals inside and outside the agency who has, or will have, a critical impact in the functioning of the BSFT unit. This joining requires identifying the "key" members of the system – therapists, administrative supervisors, agency director, clinical director, community referral sources, funders, and other stakeholders. Joining also often includes identifying the goals of agency personnel at all levels and ensuring that the BSFT model can help to achieve these goals. For example, an agency director may cite pressure from funders to treat as many adolescents as possible, for the least possible cost, within a given period of time. We would then present evidence indicating that the BSFT approach is more effective in reducing adolescent drug use and behavior problems compared to other approaches commonly used by community agencies (Robbins et al., 2011a; Santisteban et al., 2003), and present evidence from Florida's Redirection program demonstrating reduced cost to the state (http://www.evidencebasedassociates.com/featured_projects/florida.html). Presenting such evidence helps promote buy-in on every level, making it more likely that the BSFT model will be adopted and supported by funders. Similarly, therapists are interested in outcomes in the sense that they want to help their client families. When therapists see their ability to engage and retain families increase, they quickly become supporters of the BSFT approach.

Fidelity—Research on the BSFT clinical intervention (Robbins et al., 2011a) and other family-based models (e.g., multisystemic therapy; Schoenwald, Sheidow, & Letorneau, 2004) has demonstrated that fidelity is essential to achieve desired outcomes. Our research has demonstrated that independent rated adherence to prescribed BSFT behaviors predicts engaging and retaining families in treatment, improving family functioning, and reducing adolescent drug use. As a result, ensuring fidelity to the model is a core principle of moving intervention research into practice. As with other similar models (e.g., Functional Family Therapy, Multisystemic Family Therapy), BSFT implementation experience has indicated

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that, to attain and maintain fidelity over time, administrative units need to be established and dedicated to the BSFT model. These units have therapists devoted solely to delivering the evidence based intervention. In the BSFT model, typically four to five therapists are selected to form a BSFT team within the agency and weekly supervision occurs after initial training to ensure the therapists are adherent to the model. Additionally, an agency person outside of the BSFT therapy team is appointed by the agency as the BSFT program administrative coordinator to manage the BSFT program within the organization and the community, and to serve as a liaison between the BSFT Institute and the agency. The organizational component of the BSFT Implementation model is consistent with our BSFT intervention theory, in which agency-supported leaders are identified who can motivate and support therapists in such a way that the agency's desired outcomes of adoption, fidelity and sustainability can be achieved – that is, that will better adolescent outcomes and sustained funding for the program.

Interfacing with Therapists: In addition to addressing relevant organizational factors important for successful implementation, it is also essential to listen carefully to therapists' objections and feedback regarding their experiences with the BSFT model. In our experiences, along with those reported by others in the field of family therapy research (e.g., Henggeler, 2011), therapists, like professionals in other service fields, often understand the importance of fidelity to the evidence-based model, but they dislike the scrutiny that accompanies intensive supervision and regularly scheduled feedback sessions (Fixsen, Scott, Blase, Naoom, & Wagar, 2011). Some of the therapists in the agencies with whom we have worked have commented that the intensive supervision involved in delivering the BSFT approach "feels like graduate school all over again."

BSFT Implementation maintains an essential commitment to the clinicians who, at the front line of practice, make or break successful implementation. Although joining with agency clinicians and selecting and training the BSFT team of therapists enhances successful adoption and faithful utilization of the BSFT approach, obstacles nonetheless arise. Many therapists, for example, are often reluctant to adopt a manualized treatment (Henggeler, 2011), with the most experienced therapists often expressing the greatest doubts. Often therapists earlier in the careers are more willing to explore new clinical models, particularly when they feel that they are struggling with their current caseloads. Another challenge arises out of the BSFT supervision approach, which involves monitoring through videotaping *all* sessions. Therapists are often initially uncomfortable with the perceived scrutiny involved in this process. Given the systemic approach underlying the BSFT clinical and intervention models, the BSFT model manager views her/himself as maintaining a systemic relationship with each therapist, and as such, the model manager shares responsibility for therapists' behavior in therapy sessions. Thus, the BSFT model manager assumes a leadership role in helping therapists develop comfort with the manualized intervention and behaving with families in ways that are consistent with the model. BSFT clinical techniques such as reframing, which are useful in creating a motivational context for change with families, are also useful in creating a motivational context for change for therapists: "I can see that you struggle with videotaping. Yet your commitment to providing the best treatment for your

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clients is exemplary. Even when videotaping feels so awkward, you are willing to do it for the benefit of your clients."

Selecting Therapists: One way to maximize the likelihood that therapists will deliver the BSFT model properly is to select therapists who are best matched with the model's assumptions and requirements. The BSFT approach requires a strong commitment to systemic work, conceptual ability, the ability and willingness to take on challenging cases, and the willingness to work in rough neighborhoods. Moreover, bringing whole families to treatment is often quite difficult – and many therapists are wary of the work and potential frustration involved. Indeed, specialized BSFT Engagement strategies would not be necessary if drug abusing or delinquent adolescents' families were able to come to treatment together easily. When considering whether to accept therapists, the BSFT Institute uses these and other criteria, as assessed through interviews. In addition, a therapist's family therapy audition tape is used in the selection process. We do not expect therapists to know the BSFT model nor to have experience in family therapy. However, because we work with all family members, candidates must be able to support all family members and not to take sides for personal reasons. An example of an unsuitable therapist candidate would be someone who is unable to be supportive of male or female parents, who is likely to staunchly support one parent to the detriment of her/his relationship with another parent, or who takes generational sides (e.g., youth vs. parent). Although some of these abilities can be taught such as having balanced alliances, others such the ability to relate to all family members may be more difficult to teach. The therapist must be the leader who will help the parent and the child change their behaviors – which the therapist cannot achieve if s/he is unable to establish a strong bond with all of the people who need to change. Thus, therapists must be able to adopt a nonjudgmental stance toward family members who behave in ways that appear maladaptive. Therapists must also possess the maturity to "own" their negative reactions to family members, to set aside their own views of family members whom they dislike, and to avoid permitting their frustration concerning a family's lack of progress to derail the course of therapy. We all may have negative reactions to particular people, but when conducting therapy, we must be aware of these feelings so that we can manage them effectively. Accordingly, during the therapist selection phase, therapists are rated on a number of systems-based criteria, including the ability to communicate with all family members without judgment, the ability to recognize family strengths and to validate family members, and speaking to each family member in ways with which that family member can resonate.

Further, as noted by Phares, Lopez, Fields, Kamboukos, and Duhig (2005), fathers are seldom involved in family-based treatment, even if they are present in the home and/or in the child's life. In our experiences with BSFT therapist trainees, individuals in fathering roles – those who play responsible roles in their children's lives – are left out of treatment because therapists may not fully understand the critical role that every family member (especially father figures) plays in the family system. Fathers who have mental health, substance abuse, or criminal problems, and/or who appear not to be involved in their children's lives, are often left out of treatment because of the difficulties involved in engaging them into therapy. For example, a frequent family pattern of interaction has

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mothers and behavior-problem sons in a close relationship, whereas fathers are alienated from both mother and son. This pattern of interactions often gives rise to triangulations that can only be addressed when all members of the triangle are present. Hence, restructuring the father's (and the mother's) relationship with other family members – including the target adolescent – is vital to improving family functioning and to ameliorating the adolescent's symptoms. Fathers, like mothers, are essential members of the family and must be included in the treatment process. In our experience, when a critical family member is missing from the therapy session, it is impossible for the therapist to observe the family's repetitive patterns of interactions as they would occur at home (i.e., to diagnose the repetitive patterns of interactions that may be linked to the adolescent's problem behaviors) because a critical individual is missing who, when present, changes the family's patterns of interactions dramatically. What is essential in the selection process is to identify therapists who have the ability to relate to *all* family members, including fathers. Many people may be intimidated by father figures, more so than by mother figures.

Involving fathers may require conducting sessions at times when both parents are available; interfacing with substance-abuse, mental health, or criminal justice systems for fathers involved with these systems; or reaching out to a father who has remarried or lives with a new family. Therapists may initially be reluctant to take on the additional work that is required to include fathers in treatment. Just as joining with a family member requires convincing that person that she or he has something to gain from coming to therapy, overcoming a therapist's objection to working with whole families (including fathers) may require presenting research evidence demonstrating the importance of fathers (and all relevant family members) in adolescents' lives – and in their success in helping the target adolescent. The parental system must always participate in BSFT treatment, and fathers are very often part of the parental system.

A Broad Organizational Perspective: As we suggested earlier, consistent with the systemic approach on which the BSFT intervention is based, challenges in implementing the BSFT model and working with clinicians are also viewed from a broader, organizational perspective. Examples of such obstacles include cases where BSFT therapists are located in administrative units that are not dedicated to delivering the BSFT model. In such situations, therapists may be given caseload of 30–60 patients. Such caseloads can be managed through individual and group interventions, but are not possible to manage when whole families need to be engaged in treatment, when sessions often must be conducted in families' homes during evening and weekend hours, and when retaining family members requires frequent out-of-session contacts. The usual caseload for BSFT therapy is 10 families. For another example, if a community agency is not fully involved in the delivery of the BSFT model, therapists will often fail to submit videotapes required for supervision. Without these videotapes, we are unable to provide adequate monitoring, coaching, and feedback on BSFT adherence. Hence, supervisors cannot be successful unless the agency leadership is actively involved in ensuring that therapists have a caseload that allows them to deliver the BSFT intervention properly, are provided with adequate time to review their own videotapes, and are required to submit videotapes for supervision.

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Rather than faulting therapists or other agency members for implementation challenges, such as clinicians' reluctance to quickly adopt the BSFT model, BSFT Implementation focuses on exploring the interactional patterns that support and maintain these obstacles. Using this systemic thinking, the BSFT implementation team focuses on transforming interactional patterns that represent obstacles to change toward BSFT adoption and fidelity. BSFT Implementation applies BSFT intervention techniques such as joining, tracking and eliciting, diagnosing, reframing, and restructuring to transform organizational interactional patterns that are obstacles to Implementation. Because the BSFT intervention is a problem focused model, BSFT Implementation focuses only on those interactional patterns within the agency that must be reconfigured for the BSFT model to be delivered successfully. This principle is parallel to the focus of the BSFT clinical intervention – only those family interactions that are directly associated with the adolescent's symptoms are targeted in therapy. Other organizational issues are unlikely to be addressed if they are peripheral to BSFT implementation.

Sustainability—Much of the work already mentioned has found that engaging multiple levels of an agency are essential to sustainability. In addition, we collaborate with agency leadership to facilitate support from funders and referral agents, often giving presentations on the BSFT model to educate these stakeholders on evidence-based practices generally and the BSFT approach specifically. In terms of promoting sustainability, nothing is more important than an engaged funder. In addition, to ensure sustainable fidelity to the BSFT manual within the agency, as part of the training, monitoring, coaching, and feedback related to the BSFT approach, an "on-site" supervisor is selected in collaboration with agency leadership. The on-site supervisor is one of the therapists in training who distinguishes him/herself in their BSFT abilities, demonstrates leadership skills by helping his/her co-workers in providing guidance with their BSFT work, and has the support of his/her co-workers and the agency leadership. In addition to providing ongoing on-site supervision, this person becomes the BSFT advocate or champion within the agency, ensuring that agency functioning continues to support BSFT fidelity and sustainability.

Benefits for Clinicians

Despite their initial hesitations, clinicians often enjoy the parallel process in which they observe the BSFT Implementation consultant applying BSFT principles at an organizational level that are parallel to the BSFT principles clinicians are learning to apply at a family level. Often to a fault, clinicians are dedicated to their clients. BSFT clinicians develop a broader and more thorough skill set, which enhances their ability to work effectively with families and often improves their clients' outcomes. Consequently, when clinicians first realize that they are able to engage and retain families in treatment, they become excited by their new skill set, but more importantly by their newly acquired abilities to help their client families. Ultimately, clinicians realize that they no longer experience the frustration of so many family drop-outs, and that they can bring more families to treatment completion – which is highly rewarding both because families are being helped and because of the feeling of success that comes with helping families.

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The supervision that BSFT therapists receive promotes a consistently high-quality level of therapy and provides sustained support for their professional and often times their personal growth. Additionally, BSFT-trained therapists tend to be well regarded by others within the organization and are afforded the potential for enhanced career growth as they often become leaders within their respective organizations. After all, developing skills to manage complex systems, such as families, provides therapists with skills that can be used at the organizational level as well. BSFT therapists also find that they are more marketable, which increases their chances for career development; and as they learn to become leaders of the family-therapeutic system, they develop leadership skills that serve them well inside and outside of therapy.

Implementing the BSFT approach into a community setting also confers broader benefits on the organization and community. Like any evidence-based treatment, the BSFT model provides a structured framework for an organization, with demonstrated evidence for effectiveness and support for strong clinical outcomes. The BSFT Institute provides support throughout the process of adoption as well, providing guidance and recommendations that often improve the agency's functioning. For example, communication between segments of an agency may be improved as a result of the BSFT Implementation process – such as reducing the number of people required to approve administrative decisions related to the BSFT unit. Communities are likely to benefit as well when the prevalence and severity of adolescent drug abuse, delinquency, and other forms of risk taking are reduced. The BSFT model may serve as a secondary or tertiary prevention strategy. Secondary and tertiary prevention efforts may help to decrease costs involved with incarceration, hospitalization, and residential drug treatment (McCollister, French, & Fang, 2010).

Future Research

The field of implementation science is quite new, and much of what has been written is theoretical or anecdotal. The implementation science field within substance abuse prevention and treatment emerged out of a collective recognition within the research, practice and policy communities that evidence-based treatments cannot simply be "installed" into treatment agencies, and that systemic barriers within the agency (or said more systemically, "developers' naiveté about integrating new services into existing organizations") often interfered with the successful delivery of the intervention (Fixsen et al., 2009). We have much to learn about how to achieve successful implementation, including designing appropriate measures to index and quantify "buy-in" from various members of the treatment agency, to examine the efficacy of the training program, and to evaluate the systemic strategies used to transform the agency in the service of facilitating adoption, fidelity, and sustainability (Landsverk et al., 2007).

One of the first steps that should be taken in the implementation science field, and that we plan to take with the BSFT approach, is to conduct a randomized clinical trial – the gold standard for evaluating the efficacy of an intervention approach (where the systemic implementation strategy is an intervention) – to evaluate the BSFT Implementation program. As is typical in the implementation science field (Fixsen et al., 2009) and of BSFT Implementation (Szapocznik, Muir, & Schwartz, 2013), community providers would be full

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partners in all aspects of the design, conduct, and analysis of the study. Treatment agencies might be randomly assigned to "intervention" and "control" conditions. The intervention agencies would receive the full BSFT Implementation intervention, whereas the control agencies would receive only standard BSFT training, including therapist monitoring, coaching, and feedback on BSFT fidelity. An alternative trial would be to compare the full BSFT Implementation intervention to an implementation model derived from organizational theory, such as the models now being used to deliver other evidence-based interventions (Glisson & Schoenwald, 2005). Outcomes would be assessed at multiple levels, including (a) changes in family functioning and adolescent problem behavior for individual client families; (b) therapists' BSFT adherence and fidelity; (c) cost-effectiveness of the implementation intervention; (d) therapists' satisfaction with their work and with the outcomes of their cases; (e) agency, stakeholder and referral source support for the BSFT approach; and, (f) sustainability of the BSFT model over time.

Because the field of implementation science is so new, mixed-methods research – including qualitative as well as quantitative components – should be conducted (Palinkas & Soydan, 2012). Such research will provide first-person perspectives from therapists and agency leadership regarding the experience of participating in a structured implementation process versus an alternative condition. What specific challenges does BSFT Implementation address? Are therapists' initial concerns – such as concerns about manualized intervention strategies, discomfort with intensive supervision, and reluctance to engage whole families into treatment – diminished by the end of the implementation intervention? What aspects of the BSFT Implementation system are most beneficial for therapists, and are there interactions between the implementation approach and specific therapist and agency characteristics? And perhaps most importantly, do decreases in therapists' objections and concerns predict increased fidelity to the BSFT model and improved client outcomes? Answering these questions will help to advance not only BSFT Implementation, but also the field of implementation science as a whole.

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