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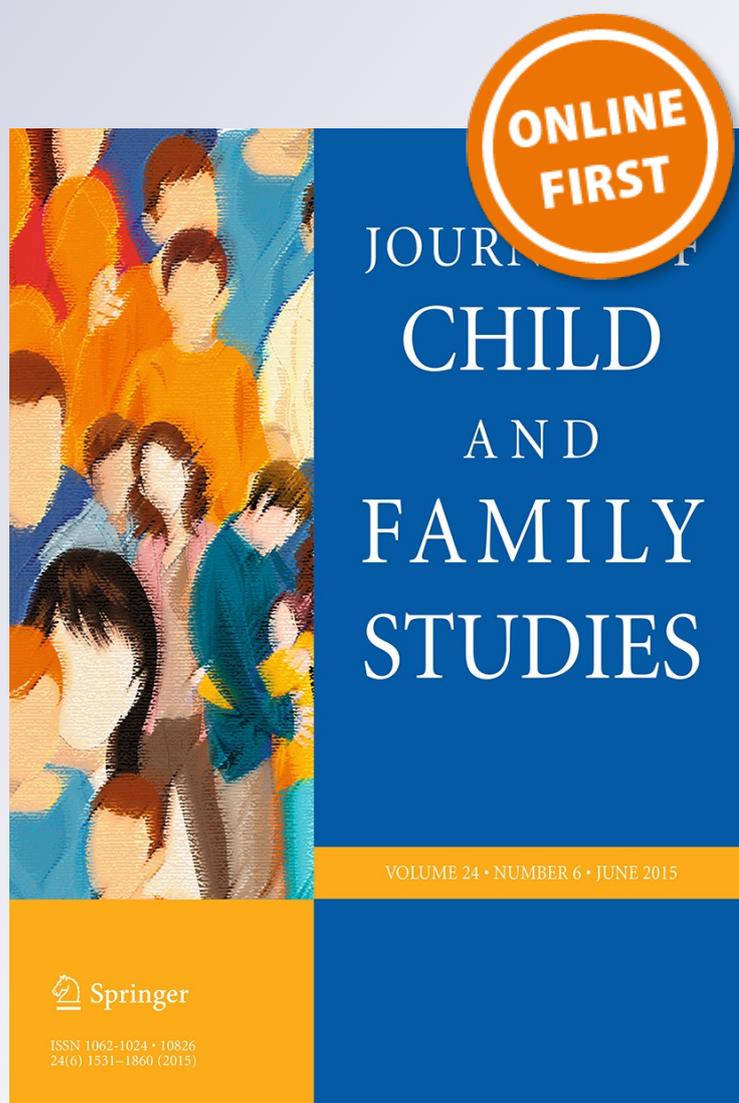
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An ARC-Informed Family Centered Care Intervention for Children's Community Based Mental Health Programs

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Abstract The experience of parents in helping their children access and use mental health services is linked to service outcomes. Parent peer support service, based on the principles of family-centered care, is one model to improve parent experience and engagement in services. Yet, little is known about how best to integrate this service into the existing array of mental health services. Integration is challenged by philosophical differences between family-centered services and traditional children's treatment services, and is influenced by the organizational social contexts in which these services are embedded. We describe an organizational and frontline team intervention that draws on research in behavior change, technology transfer, and organizational social context for youth with serious emotional disturbance. The two-pronged intervention, called FAMILY (FCC and ARC Model to Improve the Lives of Youth) is guided by the evidence-based Availability, Responsiveness, and Continuity (ARC) organizational intervention, targeted primarily at program and upper management leadership and includes a family-centered care (FCC) intervention, targeted at frontline providers. The approach employs multilevel

implementation strategies to promote the uptake, implementation and sustainability of new practices. We include examples of exercises and tools, and highlight implementation challenges and lessons learned in facilitating program and staff level changes in family-centered service delivery.

Keywords Organizational social context · ARC · Family-centered care · Community-based mental health services · Parent peer support

Introduction

National health care reform and efforts to control the crippling costs of care in the United States are creating pressures on healthcare systems, plans, and providers to re-engineer their services to improve accountability, broaden healthcare coverage, improve access, and reduce per capita costs (Berwick et al. 2008). Within these broad quality improvement goals, consumers and their families (hereafter referred to as service users) have a central role as the ultimate arbiters of what constitutes quality care. The focus on patient and family-centeredness, or in the case of children's mental health, an understanding of care not only from the child experience but also from the parent/caregiver (hereafter referred to as parent) experience, constitutes a core value by which healthcare systems are being redesigned (Barry and Edgman-Levitan 2012; Bernabeo and Holmboe 2013).

Growing evidence from both the health and mental health fields suggest that service users' experience of care, especially how they experience provider-service user communications and the care encounter, is related to outcomes (Manary et al. 2013). In particular, positive communication is associated with clinical adherence (Alegría et al. 2008, 2009; Druss et al. 2010; Jha et al. 2008),

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reduced readmissions (Boulding et al. 2011; Sledge et al. 2011), and reduced mortality (Glickman et al. 2010). Failure to pay attention to service users' experience of care has an equal and opposite reaction—that of disengagement or premature dropout, de-activation, and mistrust (Garcia and Weisz 2002; Kazdin et al. 1997; Koren et al. 1997; McCabe 2002), which can potentially result in harm or worsened health status that requires more intensive and costly interventions.

A Picker Institute study identified eight characteristics of care as important markers of quality and safety. These reinforce the importance of family-centered care and include: respect for the service user values, preferences, and expressed needs; coordinated and integrated care; clear, high-quality information and education for the service user; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family members and friends, as appropriate; continuity, including care transitions; and access to care (Gerteris et al. 1993; Institute of Medicine 2001; Wagner et al. 2001). Studies show that service users want to participate in decisions about their care, particularly in situations when treatment options are available, when different outcomes may be equally acceptable, or where different options have different and important lasting consequences (Bernabeo and Holmboe 2013). Within behavioral health services, the evidence, including risks and benefits for various treatment options is often equivocal. Potential benefits may be known, but iatrogenic effects or risks are rarely, if ever, discussed or even recognized by providers, let alone disclosed and discussed with service users. A key component of care experience that has been promoted as part of efforts to improve healthcare redesign involves shared decision making (Institute of Medicine 2006; Substance Abuse and Mental Health Services Administration “[SAMHSA]” 2006). Shared decision making is considered the pinnacle of consumer and/or family-centered care (Barry and Edgman-Levitan 2012; Lee and Emanuel 2013). Shared decision-making is an interactive and collaborative process between service users and their clinicians about decisions that are relevant to the individual's treatment and recovery. A shared decision-making process provides an opportunity for assessing a treatment's advantages and disadvantages from both a service provider and a service user perspective—and those views can be significantly different (Covinsky et al. 2000; Deegan and Drake 2006).

Despite its promise in the general health field, professional, public, legal and political forces have countered the movement towards shared decision-making in the mental health field for several reasons (Adams and Drake 2006; Deegan and Drake 2006). These include concerns about the capacity of persons with mental illnesses to make informed decisions, discomfort among some providers with the shift

in roles required by shared decision-making, unease among some consumers regarding their ability to take on the responsibilities offered through shared decision-making, and lingering public fear and prejudice about persons with mental illnesses (Adams and Drake 2006; SAMHSA 2010). Such concerns are amplified within children's mental health, where many professionals have historically viewed parents as obstacles to treatment, irrelevant to the treatment process, or causes of or contributors to the problems, particularly when child protective services are involved (Peer Technical Assistance Network 2000). Despite studies documenting that matching treatment services to family preferences can reduce treatment dropout and improve outcomes (Bannon and McKay 2005; Crane et al. 1986), these longstanding, pervasive, and deeply held beliefs about parents are obstacles that keep some providers from adopting a child and family-centered framework.

To date, in spite of national, federal and state efforts to promote family partnership in services, challenges in family-provider communications are common in mental health (Cooper et al. 2008; Donner 2003; Peer Technical Assistance Network 2000; Stroul 1996). Service engagement and retention in the children's public mental health system continues to be poor—even as States expend significant resources to improve quality of care through the promotion of evidence-based treatments for children (Bruns et al. 2008; Ganju 2003). To address these challenges around family-centered care, an expanding service delivery model includes the use of parent peer specialists to take on professional roles in engaging and supporting parents of youth with mental health issues. Parent peer specialists are presumed to have special expertise that can be added to the care management teams. In particular, these specialists can diversify the held beliefs of care teams, promote family-centered care, improve engagement and retention in services, activate involvement in services, and improve the parent experience of care and hence health outcomes for youth (Hoagwood et al. 2010).

Parent Peer Support Services: A Model to Improve the “Family-Centeredness” of Care

Nationally, parent peer specialists are joining the workforce in increasing numbers; this workforce is seen as a potentially cost effective model for improving parent experience in care while simultaneously addressing workforce shortages in the field (The Annapolis Coalition on the Behavioral Health Workforce 2007). Many states have created networks of parent peer specialists to address issues of family preferences and service access (SAMHSA 2013). Certification for this emerging profession is available in several states (e.g., NY, TN, IL) and nationally through the Federation of Families for Children's Mental Health. These

parent peer specialists, typically parents of children with special needs themselves, serve in a peer-to-peer capacity, to share, consult, strategize, model, coach and support parents in their own journey to understand, cope with, advocate and negotiate across various service systems (Olin et al. 2010). Increasingly, youth advocates, usually young adults who have been recipients of services, are also being integrated into this network. A recent evaluation found that families and youth with access to peer services reported higher overall satisfaction, including satisfaction with service access, appropriateness of services, service participation, and parental perceptions of child functioning and social connectedness (Radigan et al. 2014).

Despite the rapid expansion of parent peer specialists nationally, the evidence for effectiveness of such services lag behind their rapid growth in mental health (Hoagwood et al. 2010; Olin et al. 2014a, b). In the current health care context, the viability of peer services depends on the ability to link quality components to outcomes (Obrochta et al. 2011). Until recently, there has been limited attention paid to specific competencies needed by providers and the healthcare system to optimize family engagement in services (Hoagwood and Burns 2014a; Olin et al. 2014). Efforts by this research team over the past decade yielded important lessons about factors that must be considered in improving parent peer services and integrating quality family-centered care concepts into care (Hoagwood and Burns 2014b; Rodriguez et al. 2011). While competency training has been well-received and parent peer specialists reported benefits in skills, self-efficacy and empowerment in their role, key challenges to implementation of family-centered care concepts were identified (Rodriguez et al. 2011). Parent peer specialists represent a highly varied workforce with a range of backgrounds and work experiences that influence their effectiveness and comfort in working on teams. Additionally, the frontline provider teams in which they are embedded are heavily influenced by work contexts that guide their perceptions of what should be expected from parent peer specialists, the role that they should play, and their status as equal partners, non-essential laypersons, or uninvited (even hindering) guests. Thus, specific interventions are needed to support the role, function and meaningful integration of parent peers into provider teams.

Organizational Social Context (OSC)

The importance of OSC is well documented and recognized (Aarons et al. 2011, 2012; Glisson et al. 2013; McHugh and Barlow 2010; Novins et al. 2013). OSC, including both dimensions of culture and climate, is a salient predictor of client, staff and organizational outcomes. Among the organizational outcomes is the success of

implementing and sustaining new treatments and innovations within organizational settings, e.g., evidence based practices (Glisson et al. 2006, 2010, 2012).

Commonly used to assess culture and climate in human services, the OSC measurement system can identify social context profiles that have been found to predict success and failure in implementation efforts. Highly effective social contexts are characterized by cultures of high proficiency, low rigidity, and low resistance. That is, high expectations for maintaining up-to-date, high quality skills and a focus on client wellbeing are accompanied by increased discretion and control of frontline staff over decisions affecting the care of clients. Rather than being impeded by rigid and bureaucratic rules that can impede client care, frontline providers are embedded in a normative context that invites innovation, does not fear change, and actively promotes exploration and improvement. Highly effective climate profiles are characterized by high engagement with clients, strong staff perceptions regarding the functionality of their organization, and low levels of emotional burnout, exhaustion, and overload (stress). Host agencies and frontline provider teams within highly effective organizational social contexts are guided via beliefs, norms, attitudes, as well as parallel organizational processes and systems, to actively engage new partners, innovations, and challenges to existing beliefs and practices.

Within ineffectual organizational social contexts, frontline providers are more likely to resist changes in procedures and practices, team routines, and power structures. Moreover, if new practices such as family-centered care challenge currently held shared values and beliefs that underlie clinical practice, resistance can be doubly difficult to overcome. Recent studies document these challenges, which include variability in the roles and responsibilities of parent peer specialists vis a vis families and other providers on the team (Kutash et al. 2014; Rodriguez et al. 2011; Salzer et al. 2010; Wisdom et al. 2014), variability of service quality across programs (Olin et al. 2014a, b), and the impact of social organization context in inhibiting or facilitating high quality parent peer services (Olin et al. 2014a, b). Clearly, training of parent peer specialists alone is insufficient. Strategies for effectively integrating parent peer specialists by embedding the concepts and practice of family-centered care into programs are critical. Likewise, addressing team and agency cultural patterns and perceptions of staff (climate) that influence receptivity to change as well as receptivity to family-centered care beliefs and practices, is essential.

One evidence-based organizational intervention, the availability, responsiveness, and continuity (ARC) model for organizational effectiveness, has been applied to improve the implementation and outcomes of new practices within children's mental health (Glisson 2008; Glisson

et al. 2010, 2012, 2013). However, such strategies have typically been tested alongside evidence-based practices as independent factors that influence service quality and client outcomes. This paper describes an initial effort to more closely coordinate and integrate an ARC-informed approach with the delivery of family-centered care within children's mental health service settings. This paper provides a description of FAMILY: family-centered care (FCC) and ARC model to improve the lives of youth, an organizational and frontline team-level intervention focused on developing the entire program and provider team to improve the delivery of family-centered care. Key implementation themes that facilitated the delivery of this team-based intervention will be illustrated through case examples.

Method

Study Context

The FAMILY intervention was developed within the context of a larger study that has systematically examined the role of parent peer support specialists, the organizational context within which they deliver parent support services, and the factors that support and/or inhibit the delivery of high quality services (Hoagwood and Burns 2014b). Specifically, this study took place in Home and Community Based Services (HCBS) Waiver Programs in New York State that have embedded parent peer specialists. HCBS Waiver programs are federally approved programs authorized under Title XIX of the Social Security Act; these programs provide states flexibility to design and offer a mix of service options in order to meet the needs of specific groups of individuals who would otherwise require institutional care. In New York State, HCBS Waiver Programs are an intensive, community-based program, serving children between 5 and 17 years of age with serious emotional disturbances who are at-risk for out of home placement. At the time of study recruitment, there were 33 HCBS Waiver programs located within New York State, each embedded within a larger human service agency. HCBS Waiver program staff generally include at least: (a) Agency Administrators, usually the CEO or designee of a large mental health agency that oversees several programs including the HCBS Waiver program; (b) Program Director, usually a master's level clinician who is responsible for the overall management of the program; (c) Individualized Care Coordinator, who conducts intake and screening, assessment of needs, service plan development, monitoring of goals, and consultation; (d) Parent Peer Specialists, who are peer providers of services with experience as a parent of a child with mental health needs and who provide advocacy and

support for parents of children with mental health issues; (e) Skill Builders, who assist the child in acquiring, developing, and addressing functional skills and support, both social and environmental; (f) Respite Workers, who provide a break for the family and the child to ease stress at home and improve family harmony; (g) Crisis Response Workers, who implement activities to stabilize occurrences of child/family crisis, and who provide intensive interventions in the home when a crisis response service is not enough (Olin et al. 2014a, b; Wisdom et al. 2014).

For the ongoing intervention trial, 12 of the original 21 HCBS Waiver programs who participated in the descriptive study (Hoagwood and Burns 2014b) volunteered to participate in the intervention study. These 12 programs were stratified and randomized to intervention or control groups based on program size (available slot numbers), number of parent peer specialists on staff, OSC profiles and region of the state. Intervention participants included all administrative and frontline providers from six HCBS Programs. The goal of the study is to test the impact of FAMILY on program level (e.g., organizational social context, program service quality), staff level (e.g., provider service quality, staff turnover, teaming) and family/youth level outcomes (e.g., parent activation, service utilization family and child outcome). This paper focuses on the development, refinement and implementation of FAMILY, the intervention being tested in the intervention trial.

Approach

The study team began by mapping key principles of ARC against family-centered care concepts to enhance the success of the FAMILY intervention. This process aided in identifying congruencies in underlying beliefs, principles, practices, strategies, and consultant approaches that could be consistently applied throughout the FCC and ARC-informed intervention (FAMILY). The study team employed key principles, elements, and strategies from the ARC model for organizational effectiveness targeted largely at supervisory and management staff who employed ARC processes with front-line staff; these ARC processes were augmented with direct family-centered training and consultation for frontline providers focused on parent experience and parent activation. Again, mapping of ARC and FCC in the initial stage allowed both the ARC and FCC specialists to more closely integrate concepts, training approaches, strategies, and targets for change across both the organizational and family-centered training work being conducted.

The development and refinement of the FAMILY intervention implementation employed an iterative process, where the study team served as key instruments, collecting "data themselves through examining documents, observing

behavior, and interviewing participants” (Creswell 2013). Adaptations to FAMILY involved both inductive and deductive analysis of multiple data sources (Creswell 2013). Data sources included: (a) structured progress notes completed after each training or consultation session by the intervention specialists; (b) weekly study team meetings to review implementation at each program and develop strategies to deliver an integrated approach to FCC by the ARC and FCC specialists, and (c) observations and reflections by the study team about the intervention specialists’ roles and program participants’ reactions and responses to the intervention. A dedicated note-taker was responsible for recording all team discussions about the FAMILY implementation. Data from these various sources were iteratively examined by the study team, using a “bottom up” inductive process to establish a broad and comprehensive set of themes relevant to implementing FAMILY. Deductive analysis was also involved as themes were identified by going back to the data to extract additional information that may provide support for each of the identified themes.

Below, we outline the primary components of this two-pronged, integrated intervention, including examples of exercises and tools used.

Results

FAMILY: Development and Implementation

The FAMILY Intervention is grounded in two complementary sets of principles and procedures for facilitating both organizational and service delivery change (Table 1). The core organizational principles and procedures of ARC aligned closely with the family-centered care concepts and allowed for the delivery of two sets of intervention strategies that were integrated and delivered in a coordinated way by the ARC (Hemmelgarn) and FCC (Madenwald) specialists. Both intervention specialists worked directly and indirectly with different levels of program staff. The intervention phases, activities and program staff involvement are detailed in Table 2. Both ARC and the FCC concepts draw upon behavior change theories related to attitudes and beliefs, norms, self-efficacy and expectancies, as exemplified below (Fishbein and Ajzen 1975; Jaccard et al. 1999, 2002; Olin et al. 2010). In particular, both ARC and FCC created expectancies around the benefits of delivering care that is consonant with family-centered care philosophy (e.g., paying attention to the parent care experience to improve child outcomes), laying the groundwork for change. Both ARC and FCC focused on developing shared norms and mental models that drive behaviors at the organizational and individual

provider levels respectively, with specific attention to family-centered care delivery. While ARC focused primarily on attitudes and beliefs of leadership and the development of leadership skills and competencies in creating an effective organizational social context, FCC focused primarily on the same change drivers at the frontline practice level. Through this two-pronged approach, barriers to family-centered care were considered at all levels of the organization, from state and organizational policies and regulations to program and individual provider level practices. FAMILY paid particular attention to addressing how barriers at these different levels interacted with one another to create obstacles to implementing FCC.

ARC-Informed Organizational Intervention

The ARC organizational strategy provides community-based mental health service programs with the structure, tools, and processes that enable administrators and frontline providers to collaborate in improving the social contexts of their work environments. Multiple randomized clinical trials have demonstrated ARC’s effectiveness for improving organizational social contexts, lowering staff turnover, improving client outcomes, and facilitating EBP implementation (Glisson et al. 2010, 2012). A thorough review of the ARC intervention can be seen in Glisson et al. (2006). The ARC organizational intervention is a structured process that introduces 12 organizational components to front-line teams, the cross-level organizational action team (OAT), and organizational leadership over four phases (problem identification, direction setting, implementation, and stabilization). Separate ARC manuals for team leaders, team members, OAT members, and upper leadership guide work on implementing ARC components with intensive onsite and off-site training by an ARC specialist. A carefully selected internal change agent, the ARC liaison, works closely and is trained by the ARC specialist to help facilitate organizational change. ARC team leaders, internal managers, are trained by the ARC specialist to guide structured meetings within front-line staff using ARC workbooks that introduce tools and processes associated with ARC’s organizational components [e.g., teamwork, feedback, conflict management, continuous quality improvement (CQI)]. The ARC components and their constituent tools and processes are introduced in “real time” as trained ARC team leaders work with their frontline teams (waiver teams) to identify and address barriers to service innovation and effectiveness. Unlike organizational interventions that introduce only technical aspects of organizational components, ARC uses a second strategy of embedding five core principles of effective service systems (see Table 1) to guide the implementation of ARC components and ARC organizational

Table 1 Family-centered care and ARC model to improve the lives of youth in New York State home and community based services waiver programs (FAMILY): outline of ARC principles and behavior change principles underlying family centered care (FCC) intervention

ARC principles	Key concepts underlying FCC intervention ^a
<i>Mission-driven versus rule driven</i> All staff and administrative actions and decisions must contribute to children's well-being	<i>Expectancies</i> Staff engagement in FCC practices depends on perceived benefits (e.g., family engagement in services) and whether such benefits outweigh perceived cost/barriers to FCC practice (e.g., time involvement, perceived risk)
<i>Results-oriented versus process oriented</i> Measure staff and program performance by improvements in children's well-being	<i>Attitudes/beliefs</i> Staff beliefs and attitudes towards (a) parents and their role in contributing to the child's difficulties and (b) whether their provider role as expert versus collaborator, influence openness to involving families in shared decision making
<i>Improvement-directed versus status quo oriented</i> Staff and administrators continually seek to try new things, be more effective, and improve	<i>Social norms</i> Staff motivations to adhere to FCC concepts are influenced by existing program/team culture
<i>Relationship-centered versus individual centered</i> Staff and administrators focus on consumer, stakeholder, and co-worker networks of relationships to be effective	<i>Self-efficacy</i> Provider confidence and competency in using FCC practices
<i>Participation-based versus authority based</i> Frontline-level staff have input and a key role in program decisions	

^a Adapted from unified theory of behavior change (Fishbein 1980; Jaccard et al. 1999, 2002; Olin et al. 2010)

change efforts. As can be seen in examples below, ARC also applies a third strategy of developing “mental models” and attitudes among front-line staff (administrators, managers, upper leadership, front-line staff) that support ARC components, ARC principles, and creating a social context characterized by service innovation, improvement, and change.

The FAMILY project applied a tailored intervention guided by the comprehensive ARC intervention to support more effective integration of FCC and parent peer support within Waiver programs. A succinct intervention of 12 months was created by focusing on selected ARC organizational components (CQI, team building, feedback, training systems, and conflict management) that directly aligned with implementation of FCC and parent peer support. Given the study's focus on only waiver teams, ARC also narrowed its focus with upper leadership and OAT members to primarily address system and organizational barriers and potential enhancements directly tied to a waiver team's ability to implement FCC and parent peer support. Preliminary and ongoing collaboration between the FCC specialist, ARC specialist, and researchers allowed ARC's second strategy of embedding ARC principles to also include FCC and parent peer support practices consonant with the ARC principles. Similarly, collaboration in the initial and ongoing design of FAMILY allowed the ARC and FCC specialists to employ ARC's third key strategy of fostering positive attitudes and “mental models” to be implemented in a consonant fashion across both ARC and FCC training. Examples of each of these strategies follow.

A critical element of FAMILY's design was to embed both core ARC principles and FCC practices within the social context of the waiver teams. The goal was to develop a social context within which waiver team members are

motivated to fully engage in learning, testing, and implementing new knowledge, skills, and practices (FCC and peer parent support). The ARC principles are defined in Table 1 and include being: mission driven versus rule driven, results-oriented versus process-oriented, improvement-directed versus status quo, relationship-centered versus individual-centered, and participation-based versus authoritarian based. For example, ARC's participatory-based principle encourages norms of discretion and input of front-line staff in identifying, processing, and helping to solve (improvement-directed) individual, program, and organizational barriers that interfere with successful client outcomes (mission-driven). Leadership and staff involved in FAMILY were continually challenged to observe, reflect upon, and create behaviorally specific plans to change decision making as well as behavioral and process patterns that were inconsistent with a participatory approach (e.g., top-down mandates). At a direct care level, teams were challenged to observe and reflect upon whether treatment planning and decision making is truly driven by families or if team member beliefs, protocols and organizational/system barriers existed that were inconsistent with a participatory approach. Throughout this work, parallels between ARC's participatory principle and FCC and parent peer training's practices on engaging parent participation were illuminated by both the ARC and FCC specialists. These parallels were subsequently used to identify potential changes in procedures, expectations, and processes at both the staff (organizational) and client (clinical) levels to enhance a participatory approach.

The introduction of selected ARC components for the FAMILY intervention and their constituent processes and tools (e.g., CQI tools) ensured that staff had at their disposal useable mechanisms for engaging in change, improvement, and implementation of new practices such as

Table 2 Intervention phases and activities

	ARC-informed intervention	FCC intervention
Pre-work		
Initial upper leadership development Jointly delivered by ARC and FCC specialists through 1 onsite meeting and phone calls with leadership		<p>Establish interpersonal relationships (e.g., trust, credibility) necessary for subsequent action and commitment of leadership</p> <p>Develop clear tension and rationale for change through examination of existing beliefs, practices, systems and strategic plans, in relationship to ARC principles and FCC concepts</p> <p>Use OSC (culture/climate assessment), program level and family support services level QI (FCC) data to inform impetus of change</p> <p>Clarify objectives, expectations and logistics of intervention</p> <p>Establish meaningful outcomes (at the client level) that the OAT will achieve and action plans to accomplish them</p> <p>Establish organizational action team (OAT), a cross-level and cross-functional team</p>
Months 1–4		
Orientation and training in ARC principles and FCC concepts for ARC liaisons and program/team leaders		Orientation training to develop/establish basic OAT team meeting and facilitation skills, including tools to foster effective team dynamics
One-day cross-programs orientation training on ARC principles and tools, and their relationship to FCC concepts		Establish psychological safety within team through developing norms for a safe, learning environment for all meetings and subsequent work
Monthly in person cross-program meetings with OAT (2–3 h), followed by individualized OAT consultation with both ARC and FCC specialists		Embed ARC principles and FCC concepts via initial exploration of their impact on staff outcomes and client care, and through exposure of incongruent existing norms, practices, and decisions with the ARC/FCC concepts; provide support for experimentation with alternative decisions, behaviors, and approaches consistent with ARC principles and FCC concepts
Weekly calls between ARC specialist and liaison between meetings (up to 1 h)		Careful examination and reframing of incidents, examples, and experiences of participants to reinforce learning and application of ARC principles and FCC concepts at ARC liaison, team leader and frontline team levels
		Highlight parallel process at the frontline team level and family level (i.e., importance of psychological safety, participation, relationships, and the knowledge that comes from “living the direct experience” that is essential in achieving sustainable change)
		Introduce CQI tools and barrier elimination process
		Model use of tools, processes, and norms and decisions consistent with ARC principles and FCC concepts throughout all meetings
	ARC-informed intervention	FCC intervention
Months 5–8		
Skill development and application of ARC principles and FCC concepts, separately with the OAT and frontline provider teams	Organizational model of effective training to develop context for training, particularly around use of FCC concepts and their relationship to ARC principles	Frontline teams identify barriers to FCC at the individual provider and frontline team levels. Such barriers may include individual provider attitudes and beliefs (conscious and unconscious) that interfere with effective integration of family preferences, values and beliefs in care management, team’s effectiveness in communication (e.g., splitting), and/or organizational demands for productivity, accountability and risk management protocols
Continued monthly onsite meetings with OAT team (2–3 h) and weekly calls with ARC specialist and liaison between meetings (up to 1 h)	OAT establish relationships across levels and redefine power differentials for frontline staff	
Kick off formal FCC frontline provider team training with a 1-day onsite training with all frontline providers and their supervisors from multiple agencies	OAT and team leaders encouraged to use participatory-based approaches to elicit frontline provider input into key program decisions and identification of barriers	
Monthly individualized onsite frontline provider team consultation and coaching (up to 4 h) on FCC	Team leaders and ARC liaisons refine skills in eliminating barriers	Monthly on-site team coaching/consultation on FCC concepts. Sessions are interactive, iterative and experiential, promoting reflection about experiences of service users, what builds trust, promotes activation and leads to sustainable outcomes. Consultation also focuses on staff personal beliefs about youth and families, role as service provider, awareness of results of various approaches to care, and heightened awareness of counter-productive practices
Continual correspondence between ARC specialist and FCC consultant to share events, experiences, and information on fidelity of participants to ARC and FCC principles and skills	Monthly team leader preparation meetings focus on problems occurring for OAT and weekly ARC frontline team meetings; group problem solving, action planning to address problems occurring in ARC/FCC meetings	
<i>Note overlap between OAT and FCC teams: same person functions as ARC team leader on OAT and FCC team leader; frontline provider from the FCC team is also typically part of the OAT</i>	OAT receive from frontline teams proposed barriers and potential solutions to which they provide implementation supports	
	Additional leadership skills and tools are taught (e.g., conflict management, outcome monitoring, feedback)	Barriers to FCC that arise during these coaching sessions are carried back to the frontline staff meetings for further problem solving using the ARC process
	Continual feedback and reflection on how staff supports ARC principles and FCC concepts. Brief phone consultations (using videos of team meetings) to further develop leaders	

Table 2 continued

	ARC-informed intervention	FCC intervention
Months 9–12: sustainability planning		
Facilitate OAT teams and team leader to take the reins in continuing to make improvements over time	<p>Intensive work with ARC liaison and OAT to identify and sustain key skills, processes and tools through ongoing training on ARC and FCC practices</p> <p>Intensive focus on ensuring existence of outcome monitoring and feedback that stimulates person development, organizational improvement and focus on FCC desired outcomes</p> <p>Collaboration with OAT, ARC liaison, Team leaders, and upper leaders to identify and action plan embedding learned practices, tools, concepts into broader organization</p>	<p>Facilitate frontline team adherence to FCC concepts, identify deviation from FCC concepts, and course correct using ARC processes to maintain fidelity to FCC concepts</p> <p>Development of team processes and tools that promote adherence to FCC</p> <p>Evaluation and modification of questions, approaches, documents, agendas that are counterproductive to FCC</p>
Up to 1 year post intervention		
Booster calls		
Phone consultations to facilitate ongoing skill application	<p>Up to 3 90-min phone meetings with the OAT team (at month 3, 6 and 12); up to 1 h-long monthly call with ARC liaisons for 6 months, tapering to one call quarterly at months 9 and 12 to ensure sustainability</p> <p>Ongoing consultations to troubleshoot, brainstorm, and assist the ARC liaison in their further dissemination of ARC and FCC principles, tools, strategies, and skills</p>	Up to four phone consultations (up to 2 h each) with frontline provider team leader and/or providers during 12 months post intervention

FCC. The ARC component of CQI is traditionally introduced to establish steps for identifying, analyzing, changing, and monitoring improvement. Thus, front-line waiver staff gained a technical CQI process that provided a pragmatic approach and specific skills to identify, examine, and eliminate barriers they experienced as they tried to implement new practices such as FCC and parent peer support. Second, the introduction of the ARC components provided the impetus for explicit work using ARC materials and training to examine existing norms, decision-making patterns, and organizational processes that were inconsistent with a participatory-based approach to CQI. Subsequently, the ARC specialist worked with organizational members at all levels to create specific plans for testing, changing, and ingraining new behavioral expectations and decision making patterns, thus altering power structures and processes to facilitate a participatory approach.

By design, ARC components are designed to embed ARC principles, such as ARC's CQI processes that require direct front-line involvement and action (participatory based). Additional ARC components were introduced in a similar fashion. This allowed staff at all levels to learn new organizational skills, tools, and techniques (team development, feedback systems, meeting tools, conflict management) that fostered efficacy and skill in managing change, improvement, and innovation; explicit work in fostering a social milieu (cultural norms and climate) to support the sustainment of these new tools occurred simultaneously. Again, both ARC and FCC specialists carefully identified

and capitalized on synchronous patterns of norms, behaviors, beliefs, and practices that promoted effective ARC organizational contexts and FCC and parent peer practices.

The third strategy of ARC employed by both the ARC and FCC specialists was the introduction of key concepts and training for developing attitudes and “mental models” that support a social milieu of openness, self (and organizational) examination, problem solving, and continuous improvement versus fault finding, defensive posturing, or hiding errors and problems. The shift from a milieu of fear-based reactions that precluded examination of organizational problems, barriers, limitations, or areas of potential growth, to a social context that promoted open examination of problems, led to more effective solutions and a more invested and engaged workforce. Intensive training and action planning for behavioral change based on concepts such as ARC's “psychological safety” involved all levels of organizational members in establishing expectations and behavioral norms (social context) that allowed staff to openly address challenges and problems. This work included examination and adaptation to organizational systems that interfered with psychological safety, such as punitive or blame based discipline and staff evaluation systems. Another example involved ARC work to address attitudes and mental models regarding data feedback held by leadership and front-line staff. To drive effective practice change, data and feedback must be desired or valued by staff, motivating, and effective in directing frontline staff improvement efforts. ARC guided close examination of current feedback systems, perceptions and norms

surrounding the usage of data, and beliefs that drive how data is used within organizations. Action planning and change efforts were then taken to establish social norms, expectations, and patterns of data usage that foster growth and improvement. Consonant with FCC concepts, attention and action to improve feedback was congruent across both ARC and FCC interventions of FAMILY. This approach assured that both the technical aspects of a feedback system and the appropriate social milieu (norms, expectations, and attitudes) were established to promote an effective data feedback mechanism for front-line staff.

Logistics of the ARC-informed organizational intervention involved monthly onsite training that employed structured manuals and consultation for program team leaders, ARC liaisons, and cross-level and cross-functional OATs within each agency. Front-line teams met approximately 3 out of 4 weeks a month (for 60 min) to work through the organizational processes and concepts that their team leaders have been trained to facilitate during onsite monthly training (2–3 h) with the ARC specialist. Subsequently, key elements of training were reinforced through monthly 90-min individualized onsite cross-level and cross-functional OAT meetings, guided by the in house ARC liaison and study ARC specialist. On average, the ARC specialist and liaison worked with six cross-functional staff per program on OAT teams; the FCC specialist worked with frontline provider teams, which included team leaders, direct care members, and additional service providers included at the discretion of the team leaders. The FCC specialist attended and participated in the ARC team leader trainings, onsite OAT meetings, and upper leadership meetings. Additionally, the ARC specialist met weekly by phone with each program's ARC liaison and maintained weekly calls with the FCC specialist to share information, troubleshoot, and plan for ongoing changes. Phone consultations were provided to upper leadership, team leaders, and other staff by both the ARC and FCC specialists on an as needed basis.

FCC Intervention with Frontline Provider Teams

With ARC principles and tools as a foundation to prepare social contexts that support teams for integrating new practices, FCC frontline team training, consultation, and coaching began in month 6. A clear focus was placed on the frontline providers' ability to identify, join with and harness families' strengths and to address family goals through collaboration and mutual responsibility for outcomes. FCC focused on services that are developed and delivered in consultation with families through informed and shared decision-making based on the best available empirical evidence and family values, beliefs and preferences.

All frontline providers and their team leaders received an initial day of onsite training and orientation to the concepts

and experience of family-centered care. Informed by behavior change theories (Fishbein 1980; Jaccard et al. 1999, 2002; Olin et al. 2010), which focuses on expectancies, social norms, attitudes, beliefs, and self-efficacy as key elements, the training was designed to create positive expectancies towards FCC practices and to explore existing program and provider social norms around FCC practices. This included in-depth exploration of current practices, program and staff attitudes and beliefs about families, and their roles as providers that may influence implementation of FCC practices. Additionally, frontline teams began to identify potential barriers within the organization that may be barriers to providing care consonant with FCC concepts such as program policies and regulations, available services; at the same time, barriers at the individual provider levels such as staff attitudes and self-efficacies around FCC were discussed. Introductory training was followed by individual monthly onsite consultation to each program team leader and their frontline staff (including parent peer specialist) to address barriers (organizational, attitudinal, knowledge and skill) to providing FCC within their program. The FCC frontline team coaching thus involved three key components:

First, FCC addressed mental models related to staff attitudes/beliefs about parents and their role in care (e.g., parent's role in causing or contributing to child difficulties; parent capacity to participate in care) and staff attitudes/beliefs about their own role in care (e.g., expert on the family vs. collaborator with the family). Immersive training exercises were used to shift staff attitudes and beliefs about the parent role and the provider role in care. Based on previously identified counterproductive practices within these same programs such as *using deficit-based language* or *being directive and making decisions for families* (Olin et al. 2014a, b), vignettes were developed that allowed teams to viscerally experience the impact of the counterproductive approaches. The exercises revealed biases and mismatches in provider stories and interpretations about parents and the range of normal, human explanations for parent behaviors and perspectives that become clearer when "walking in the shoes" of the parent. Exercises also raised awareness and sensitized participants to the seemingly inconsequential (but in fact quite consequential) missteps in provider-parent communications that impact family trust of the provider, treatment engagement, perceptions of treatment safety, and sense of empowerment or activation. For example, the same parent behavior of omitting information was viewed from a parent perspective as a protective parent withholding information for fear of having the child mislabeled or due to concern about how a provider will use the information; by contrast, providers were often quick to view the same action as parent subversion of treatment, parental neglect or non-compliance to the treatment plan. To raise awareness of interpretable

explanations for parental withholding of information, the FCC trainer would ask: "Have any of you ever withheld/ been dishonest about information from a health care provider?" Almost universally, participants will acknowledge that they have done so. The trainer then asks, "why?" Numerous explanations were then identified by trainees and an "aha" moment was experienced.

The consequences of varying interpretations were illuminated, for example, when provider actions shift away from family-centered services to assure compliance with prevailing program regulations (e.g., requirement to deliver specific services). When provider beliefs make it impossible to tell a better story about a parent (e.g., deeply held view that the parent is to blame for child's behavior), the tendency is to choose an approach that is coercive rather than collaborative (e.g., punishment for treatment non-adherence rather than curious inquiry about what would work better). Such limitations in provider/program knowledge, competency or scope of services can lead to precipitous referral to the emergency room or calling Child Protective Services rather than providing crisis resolution based on family strengths. As demonstrated in immersive exercises, initial mistrust of providers by parents can be further exacerbated by seemingly insensitive provider actions, leading to family disengagement and feelings of disempowerment. Thus, through the immersive training process, providers developed an increased awareness of the stories they were telling about families, what they were doing and why they were doing it. They also become more attuned to cues in how a family responded, to recognize, introspect and mitigate their own biases and to seek feedback from families and from colleagues. Staff were increasingly able to create a safe family climate for change, identify and respect family strengths, skills and knowledge, and align with parents "where they are" to facilitate change. At the core of these changes were deeply personal (and often emotionally powerful) alterations of the attitudes and beliefs that providers held regarding parents, their role in care, and the approaches that promote successful outcomes.

Organizational level barriers (e.g., regulations about required services) and how they interfered with staff flexibility in care delivery were also identified, and solutions proposed. Through these exercises, the importance of parent peer specialists on provider teams were highlighted, in particular, the unique lens through which they viewed both services and families and how they might diversify the perspectives of provider teams and families. By creating a common appreciation across all providers on FCC, other providers on the team better understood the role of parent peers and their functions on the team. Rather than co-opting parent peers to function as enforcers on teams whose responsibility was to get the parents to accept

treatment plans, providers began to understand the important role of parent peers in diversifying provider perspectives, clarifying family preferences and values in treatment planning, thus increasing the likelihood of better outcomes.

Second, FCC focused on staff competency development in specific areas of effective parent engagement and empowerment through shared decision-making. These included trainings on a range of evidence-based strategies derived from both theoretical and clinical frameworks, such as motivational interviewing techniques (Miller and Rollnick 2002), stages of change model (Prochaska and DiClemente 1986) to help identify where parents are in the change process, the parents as agents of change model (Olin et al. 2010) to meet parents where they are in the change process, and specific crisis resolution techniques. Parent peer specialists, in particular, honed skills for developing parent competencies around parent role on service teams, facilitating parent access to accurate information and tools to understand options, and supporting parent choices based on family values and preferences without fear of disapproval from providers.

Third, ongoing coaching and/or consultation with clinical leadership and program supervisors, including frontline provider teams as needed, were employed to facilitate application and sustainment of FCC concepts and strategies by frontline provider teams. These individualized consultations occurred monthly onsite and focused on embedding tools and concepts into supervisory and clinical structures, meetings and processes. Specifically, consultation focused on how mental models or deeply held beliefs (at the individual and/or program levels) may interfere with staff application of shared decision-making and partnership with families in care management.

Key Implementation Themes

Synergy Between Organizational and Frontline Team Training

The synergy between the ARC-informed organizational strategy and the FCC intervention was critical. First, the intervention focused on the development of shared mental models (norms, attitudes and beliefs) across ARC and FCC training, consultation, and ongoing implementation. This occurred across all levels of the organization throughout the intervention, directly addressing deeply held beliefs that influenced both organizational and clinical effectiveness. This synergy allowed the change efforts to go beyond a focus on behavior alone (i.e., practice change) to an accompanying focus on the deeply held beliefs and values that underscored the desired behaviors, and on the development of organizational procedures and practices that promote sustained behavioral change. This multidimensional approach created

impetus for sustained changes in service delivery that is challenging to achieve when an intervention focuses only at one level of an organization (e.g., leadership only or frontline staff only) or addresses only behavior and not beliefs.

Second, ARC tools, processes, and guided activities, introduced early on to embed normative patterns that support learning and change, enhanced staff motivation and engagement, and increased psychological safety in their social contexts, thus creating a milieu primed for ongoing improvement and learning. Subsequently, risks associated with the exploration and implementation of FCC beliefs, strategies, and skills could be openly discussed; new ideas and skills could be learned, practiced, and successfully implemented within and across teams.

Third, providing team members a focus and opportunities to enhance these skills around a clinical practice (in this case FCC) relevant to what program staffs do on a day-to-day basis was invaluable. Common among programs serving children and families with complex needs, the frontline providers in Waiver endorsed limited competencies and low self-efficacy around effective practices both clinically (e.g., crisis management) and organizationally (e.g., how to run a meeting and team building skills). Such endorsement is consistent with data on providers within these programs; while Waiver program directors typically have professional credentials, frontline providers were less formally educated and less likely to be credentialed (Wisdom et al. 2014). The FCC and ARC interventions thus provided targeted competencies that served to increase both team and individual provider self-efficacy, increasing the likelihood that providers have the tools necessary to effectively engage families in shared decision making during care delivery. Through this process, upper leaders gained increased understanding that the frontline providers are in the best position to recognize organizational and service barriers to good care. As frontline staffs were given increased discretion and tools to scan for barriers and to propose solutions, staff increased their skills as well as their sense of efficacy, investment and meaningful participation in the workplace. With this multi-level and multidimensional approach, FAMILY thus created a social context for supporting sustainable practice change.

To illustrate this synergy, we provide several case examples to highlight the importance of coordinating organizational level interventions with frontline practices. In one program, several historical events contributed to a program culture and climate characterized by authoritarian, controlling, and sometimes punitive approaches to attain results with staff and clients. The organization's cultural norms influenced frontline staff's ingrained beliefs in their role as "rescuers" of children from poor caretakers and a reliance on punitive approaches, e.g., threatening the risk of Child Protective Services as a means to gain

compliance. Norms in this setting supported intense scrutiny and concern regarding compliance and regulatory issues. Subsequently, staff feared being blamed for any lack of compliance to regulations and both leadership and staff experienced an atmosphere of distrust and anxiety. Similarly staff in this program spent significant effort on ensuring caretaker compliance to service plans; these efforts were further fueled by staff fears that families were being neglectful.

Through consultations with leadership and frontline staff, deeply held beliefs surfaced that helped staff understand the fears that drove their behaviors with staff and families. Addressing and understanding both the normative patterns of behavior and underlying beliefs driving these norms provided some impetus for change organizationally and clinically. ARC strategies helped leadership appreciate the unintended consequences of historical stressors on staff practices, and created an opportunity for discussion around staff discomfort and dissatisfaction with program policies and practices. Establishing psychological safety was critical in openly discussing these problems candidly with upper leadership. Furthermore, having organizational leadership support a reduced focus solely on regulatory and productivity demands and an increased focus on client well-being increased staff receptivity to FCC principles and practices. The FCC intervention helped frontline try different practices that could improve family engagement and adherence without compromising trust. Staff became more open to a technique of "walking in the shoes of parents" (as described above in the FCC intervention) and exploring alternative explanations for parental non-adherence (e.g., fear that medications were having negative effects can be an indicator of a protective parental instinct rather than neglect) and hence creating more empowered parents who felt safer about voicing their real concerns with imposed service plans. This does not imply that the change process is easy to complete for the organization.

In another program, the program leader used the ARC participatory principle and brainstorming techniques to solicit barriers to family-centered practice from staff. ARC and FCC was used to foster a context of safety when discussing limitations and deficits. Brainstorming techniques were then applied to broaden staff participation in developing practical and relevant solutions. Simultaneously, frontline providers began to recognize the value of a participatory approach in their work with families. As a result, frontline providers increased their comfort about seeking critical feedback. They developed an evaluation/feedback tool to solicit concrete feedback from families about the services they receive so that staff could improve services and better align with family needs and preferences based on direct family input. Just as frontline staff appreciated the value of being a part of programmatic solutions to barriers

in service delivery, staff in this program quickly recognized how this participatory approach increases family trust, comfort and engagement in services. They also recognized that input and increasing control by parents is not a risk, but a potential opportunity for their own professional growth and practice improvement.

In a third program, the importance of synergy between organizational practices and frontline practices was illustrated through the program's use of feedback and CQI processes. As part of organizational efforts, client outcome data were being considered for use by leadership as part of staff performance evaluation. Consequently, when frontline teams were asked to consider what they might track to inform efforts in FCC practice change as part of the ARC process, staff expressed significant discomfort as they feared that they would be held accountable for failures over which they had limited control (e.g., hospitalization rates, dropout). Through the ARC process, leadership became aware of these concerns and the risks of tying staff performance evaluation to program outcome data without an appropriately safe learning environment around data usage. Organizational work within the OAT and Waiver teams were conducted to alter both feedback processes as well as attitudes towards the use of data. Rather than viewing data as threatening, staff began to feel safer about the use of data (including, undesirable outcomes) to question existing practices, and altering care delivery. The ARC and FCC specialists jointly worked with leadership and frontline staff to build consensus around the utility and meaning of data. Ultimately, organizational leadership abandoned the use of client outcome data as a means to evaluate staff performance and instead, helped teams connect the relevance of data (especially health outcome data) to specific FCC practices. The focus became the collection and use of meaningful data to guide practice decisions at a team/family-level, and to guide work on organizational barriers.

Key Strategies to Promote Learning

Several learning techniques were instrumental in facilitating change and action among program teams and individual staff. Immersive learning, where providers are physically placed in context to "immerse" themselves in learning, was used to shift attitudes and beliefs. Immersive learning through innovative exercises (e.g., having providers walk in the shoes of the parents) are used to trigger powerful psychological associations that helped embed and deepen appreciation for FCC care; these techniques have been shown to facilitate transfer of skills to real world practice (Dede 2009). Based on written feedback from the training evaluation and spontaneous comments by training participants at the end of group training, this immersive aspect of the training was described as among the most powerful

experiences they had in learning. Specifically, participants described the realization that being strength based with kids did not necessarily translate into being strength based with parents. Many realized their approaches with parents were counterproductive and became more aware of their own biases and beliefs about parents (e.g., parents as contributors to the problem). This led to interest in learning about more productive approaches, including shared decision-making and directly soliciting input from parents about treatment plans in order to empower and activate parents as drivers of their children's healthcare.

The commitment that organizational members and Waiver teams made up front to set aside dedicated time for teaming, learning, discussion and practice of intervention principles, strategies and tools was another critical aspect of learning. Socratic approaches, facilitated by the trainers, were used during this dedicated time to develop safe environments that facilitated open exchanges of ideas that were then tested in practice. In all of this work, frontline staff, team leaders and upper leaders were challenged to operate outside of their comfort zone, to be introspective about what drives their current behaviors, and to take risks [e.g., trusting parent intuition (FCC) and in parallel, trusting frontline staff solutions (ARC) instead of imposing them from the top tiers of the organization].

In addition to internal cross-functional learning opportunities, cross-program learning through a mix of in-person training and networking opportunities as well as phone consultations, were critical aspects of learning. Mid-point through the intervention, staff from various programs began to make facilitated connections to learn from one another's experiences. Such opportunities for cross-program learning are a key component of the popular collaborative utilized throughout health care to promote uptake of new practices (Nadeem et al. 2014). Such interorganizational networks have also been identified as facilitators of implementation in other human services organizations (Henderson et al. 2010; Langley et al. 2010; Palinkas and Aarons 2009). Finally, regular feedback and support from the intervention specialists, involving a mix of cross-program groups and individualized program consultations and coaching were critical to reinforce real-time learning and transfer skills for application to local program context.

Discussion

The implementation challenges encountered and the strategies used to address them during the FAMILY intervention are consistent with extant literature around the multivariate factors associated with implementing evidence-based practices or innovations in real world context (e.g., Fixsen et al. 2013; Greenhalgh et al. 2004; McHugh

and Barlow 2010). The importance of multilevel contextual factors has been theorized but rarely systematically addressed in implementation of new practices. The FAMILY intervention explicitly focused on organizational social context at the program, team and individual level to motivate program and staff participation. This included observing and feeding back lessons learned about the influence of program culture (“how things are done”), individually held perceptions of the organization (i.e., climate), and the interactions of these factors with providers’ personal beliefs about their clients. These implementation lessons illustrate how to integrate broad organizational strategies with specific practices to promote implementation of innovations within children’s mental health service programs. The impact of the FAMILY intervention on program, staff and client outcomes is currently being examined in the larger research study.

Limitations

Given the developmental nature of this effort, the codification of FAMILY and its implementation was necessarily an iterative team-based process and subject to flexible adaptations to local context. While this iterative process may be viewed as a limitation, such processes are typical in implementation trials and important to capture as the field continues to struggle with bridging the research and practice gap. Our illustration of how FAMILY was used to address implementation challenges at organizational, program and individual level provider levels serve as an illustration of the complexities in transporting research-based strategies into real world service settings. Further, the generalizability of this study may be limited due to our small sample size and the voluntary nature of program participation. The intervention phase of the study coincided with significant changes in the public mental health system; many programs were under significant fiscal strains, and felt that they did not have the capacity to participate. The fact that <60 % of our original study sample chose to participate in this intensive intervention suggests caution about the acceptability of this intervention.

Conclusion

The Affordable Care Act has increased public attention to the use of practice innovations (especially evidence based care) as a means of improving quality of care. Effectively engaging consumers and families is at the core of many of these innovations. However, challenges to successfully implementing, scaling, and sustaining evidence based practices have been well-documented. Current implementation theories recognize the critical need to attend to

organizational context (e.g., Aarons et al. 2011; Feldstein and Glasgow 2008). The FAMILY intervention is, to our knowledge, the first intervention to integrate proven organizational strategies that support implementation with principles of family centered care to create more effective teams. It is the development of strong teams that we believe is a key component to addressing both clinical and organizational implementation barriers to evidence based care. Thus barriers such as state policies, program regulations, team functioning, staff attitudes and beliefs, and family responsiveness is strategically targeted. The current research study is examining the impact of this intervention on multi-level outcomes, including program and staff service quality and child and family outcomes. The descriptive data presented in this paper suggest that significant synergies occurred across ARC and FCC in beliefs, in learning, and in practice. The impact of integrative interventions, such as FAMILY, on the ultimate outcomes of child and family functioning and service effectiveness are an essential next step.

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