# Accessing Functional Family Therapy (FFT)

## *A Guidance Document For local Virginia Children's Services Act (CSA) Offices*

*Created by AMIkids (AMI) and Evidence-Based Associates (EBA) through the VA Department of Juvenile Justice (DJJ) Regional Service Coordination (RSC) Project.*

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# Introduction

The purpose of this document is to provide guidance to local CSA programs including CSA Coordinators, CPMTs and FAPTs, and to orient the CSA Programs to a community-based, evidence-based program known as Functional Family Therapy (FFT). After review of these documents, CSAs will have the information needed to decide if their localities will adopt FFT and understand the process for making an appropriate referral to FFT.

The current FFT teams, which were developed by AMIkids (AMI) and Evidence-Based Associates (EBA) as part of the Virginia Department of Juvenile Justice's Regional Service Coordination project, align geographically with DJJ's administrative regions (see regional map). See Attachment B for a list of agencies providing FFT in Virginia and the corresponding catchment areas.

## *To learn more about FFT, refer to the following:*

- Functional Family Therapy, LLC, https://www.fftllc.com/
- VA Commission on Youth: *Collection of Evidence Based Treatment Models,* http://vcoy.virginia.gov/collection.asp
- Blueprints For Healthy Youth Development https://www.blueprintsprograms.org/
- Evidence-Based Prevention & Intervention Support Center (EPIS Center) Comparison between MST and FFT http://www.episcenter.psu.edu/sites/default/files/FFT%20and%20MST%20May%205%202018%20Final%20%281%29.pdf

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# I. What is FFT and Why All the Fuss About 'Fidelity'?

*FFT works with the family*, so the youth and his/her caregivers are present *at every session*. Consequently, sessions are often held after school and on evenings and weekends. FFT proceeds through *five phases of treatment (three primary phases)*, each designed to reduce specific risk factors and enhance protective factors. Early in treatment, the emphasis is on *engaging* the family *and motivating* them to participate in therapy. The therapist then conducts *a relational function assessment* of the family, which is used to guide interventions for *behavior change*. Interventions often include psychoeducation and communication skills training, with a focus on changing patterns of family interaction that are maintaining the problem behavior. Once change has occurred within the family with respect to the presenting problems, the therapist helps the family *generalize* their new skills to other problems within the family as well as to situations outside of the home, such as problems that may be occurring at school.

| FFT in Brief | |
|---|---|
| Target Population | Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for youth. A major goal of FFT is to improve family communication and supportiveness while decreasing the intense negativity so often characteristic of these families, working in three phases. |
| CSA Possible Funding Categories | Services may be provided to youth that fit the following categories: Children in Need of Services (CHINS), Foster care-prevention; Foster Care (for Reunification and trial home placements only), SPED Wrap-Around, Non- Mandated, Probation/ Parole and youth at risk of or returning from out of home placement. |
| CANS | Priority to include actionable needs (i.e. rated 2 or 3) in the following possible domains: school, child behavioral/emotional needs, and child risk behaviors; may include subcategories of substance use needs, violence needs, runaway and juvenile justice needs (JJN) modules. |
| YASI (DJJ) | Risk factors or the absence of protective factors in the following areas: Legal History, Family, School, Community/Peers, Alcohol/Drugs, Mental Health, Violence/Aggression, Cognitive Skills , Attitudes/Values/Beliefs and Employment/Use of Free Time |
| Ages | 11-18 |
| Duration | FFT is a time-limited family intervention, with range age of 3-5 months treatment period, with a target of 90 days of services. |
| Exclusionary Criteria | ☐ Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers;<br>☐ Youth who are actively suicidal, homicidal, or psychotic (youth who are appropriately assessed and treated to ameliorate active ideation may be later referred to FFT);<br>☐ Youth whose psychiatric problems are the primary reason leading to referral, or who have severe psychiatric problems;<br>☐ Youth where sexual offending occurs in the absence of other delinquent behavior, who have not had treatment for the offending behaviors.; and<br>☐ Youth with severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism (youth on the higher end of the autism spectrum may be served) |
| EBP Directory Endorsements | Blueprints: Model Plus, www.blueprintsprograms.org<br>California Evidence-Based Clearinghouse (CEBC): Well-Supported, www.cebc4cw.org/<br>Virginia Commission on Youth Collection of Evidence-Based Practices, http://vcoy.virginia.gov/collection.asp |
| Certification | FFT is implemented **only** in teams; individual clinicians may not practice the model outside of their team; however, each family is assigned a single clinician to work with the family unit. The Virginia teams consist of 3-7 master's level therapists (and a supervisor) with caseloads of 8-12 families. Teams must be certified by FFT LLC with ongoing training and weekly supervision by an FFT consultant. |

# II. FFT Clinical Model Phases Across Time


| | Engagement/ Motivation | Behavior Change | Generalization |
|---|---|---|---|
| Phase Goal | ○ Develop alliance<br>○ Reduce negativity<br>○ Minimize hopelessness<br>○ Reduce dropout potential<br>○ Develop family focus<br>○ Increase motivation for change | ○ Develop and implement individualized change plans<br>○ Change presenting delinquency behavior<br>○ Build relational skills (communication, parenting) | ○ Maintain/generalize change<br>○ Relapse prevention<br>○ Community resources necessary to support change |
| Risk & Protective Factors Addressed | ○ Negativity & blaming (risk)<br>○ Hopelessness (risk)<br>○ Credibility (protective)<br>○ Alliance (protective)<br>○ Treatment availability (protective)<br>○ Lack of motivation (risk) | ○ Poor parenting (risk)<br>○ Negative/blaming communication (risk)<br>○ Positive parenting (protective)<br>○ Supportive communication (protective)<br>○ Interpersonal needs<br>○ Parental pathology<br>○ Developmental level | ○ Poor relationship-school/community (risk)<br>○ Low social support (risk)<br>○ Positive relationship-school/ community (protective) |
| Assessment Focus | ○ Behavioral (presenting problem, risk & protective factors)<br>○ Relational<br>○ Contextual (risk & protective)) | ○ Quality of relational skills (communication, parenting)<br>○ Compliance with behavior change plan<br>○ Relational problem sequence | ○ Community resources needed<br>○ Maintenance of change |
| Therapist Intervention/ Skill | ○ Interpersonal skills (validation, positive interpretation, reattribution, reframing, sequencing)<br>○ High availability | ○ Structuring (session focusing)<br>○ Implementing change plan<br>○ Modeling/focusing/<br>○ Directing/training | ○ Family case manager<br>○ Resource help<br>○ Relapse prevention implementation |
| Referring Agencies Expectations | ○ Weekly email on progress<br>○ Parent calling redirect to therapist<br>○ Youth behavior may not improve immediately | ○ Monthly report<br>○ Weekly email on progress<br>○ Attend court as needed<br>○ More adherence w/ behavior and parents taking more ownership | ○ Pre-discharge meeting<br>○ Monthly report<br>○ Weekly email on progress<br>○ Relapse prevention plan |

# III. Getting Started: How to Build Program Readiness for FFT

*CSA's interested in exploring the use of FFT for their region should contact their RSC to initiate a local stakeholder meeting. Those located in the North and Central part of the state should contact EBA, and those located in the South and Eastern part of the state should contact AMIkids. As the RSC's, AMI and EBA partner with the FFT Teams to deliver quality services and provide ongoing oversight in implementation and utilization management.*

1. Upon being contacted by an interested CSA, the provider program manager or an EBA or AMIkids team member will meet with the CSA Coordinator (via meeting or phone call) to determine a clear understanding and expectations of the Model. As part of the conversation, the FFT Provider Supervisor will share informational material with the CSA Coordinator or CMPT (e.g. existing brochures, etc.).
2. Next, an EBA or AMIkids team member or the FFT Team Supervisor will schedule with the CSA Coordinator, CPMT, and/or FAPT a stakeholder meeting to be held on location to discuss the program specifics with stakeholders.
    a. The Site Visit/Stakeholder meeting is open to anyone interested in supporting FFT adoption but shall include a minimum of representatives from the FAPT and/or CPMT (depending on the locality these could occur simultaneously).
    b. The Site Visit shall be jointly hosted by the CSA Coordinator, the Provider, and RSC.
    c. The stakeholder meeting (i.e., a Site Visit) will typically include discussion of the following - specific topics/ agenda items:

**Overview of FFT Treatment Model**

- Data and research overview
- Overview of FFT Treatment Model
    - FFT Model and Attitude
- How FFT is specified and practiced
    - Phase Based approach
    - Family member Participation
- Outcomes, Quality Control, and Adherence Monitoring
- Referral Consideration
    - Inclusionary and Exclusionary Criteria

# IV. Referral Procedures

*The purpose of this section is to detail the referral process so that all FFT staff, key stakeholders and referral agents understand the process. Such understanding will assist FFT staff to better serve the referring agency. Referrals may be accepted if the youth/ family resides in the identified catchment area for the FFT Team.*

## Where To Send Referrals:

The FFT referral form is located on the EBA and AMIkids websites. The form can also be electronically sent to the CSA office, following a stakeholder meeting for distribution to case managers. A completed referral form and attachments are required to complete the packet.

- Referrals for EBA's regions may be sent to: RSCNorth@ebanetwork.com or RSccentral@ebanetwork.com
- Referrals for AMIkids regions should be sent to: VAServices-Referrals@amikids.org

## Inclusionary Criteria

- ☐ 11 to 18 years old
- ☐ In community or ready to return to the community within 30 days.
- ☐ Family available and willing to participate.
- ☐ Inclusionary referral behaviors include externalizing behaviors, internalizing symptoms, and/or substance abuse.
- ☐ Referral issues can be from one domain (externalizing alone) or in combination (co-morbidity of substance abuse and externalizing behaviors).

## Exclusionary Criteria

- ☐ Youth who have no psycho-social system that constitutes family (shared history, sense of future, some level of co-habitation)
- ☐ Youth is scheduled to be sent away from family (remanded, placement, foster care, etc.)
- ☐ Youth with current acute psychosis.
- ☐ Youth who needs sexual offender treatment as a primary need
- ☐ Youth that present with severe psychiatric illness.
- ☐ Youth, actively suicidal, homicidal, or actively psychotic
- ☐ Youth involved in other family therapy service

## Priority Criteria for Waiting Lists

*If the FFT Provider is at capacity and the referral must be placed on a waiting list, referrals will be prioritized based upon the considerations listed below and then triaged. Referrals are not prioritized based solely on date of referral or the convenience of a provider. The RSC and FFT Provider may also staff any high priority/ high risk cases with the FFT consultant to see if appropriate for services or to determine triage order.*

- Court status/ DJJ involvement (e.g. parole or probation);
- YASI risk assessment score (prioritizing high and moderate risk levels);
- Seriousness, duration, and frequency of offending (e.g., status vs. criminal, person vs. property);
- Multiple court / system involved youth in the home;
- Immediate placement risk or numerous failed services and/or history of out of home placements.
- Availability or access to services
- CANS score (e.g. priority to include actionable scores noted in the following possible categories: school, child behavioral/ emotional needs, and child risk behaviors; may also include subcategories of substance abuse needs (SUN), violence needs (VN), runaway and juvenile justice needs (JJN) modules)

# V. Program-Level Information

## Who Participates in the FFT Process?

1. Family member(s) seen as part of the "problem" according to referral source(s).
2. Family members we think (based on referral info and first calls to the family) are likely to "shut the process down" - and who probably can!
3. Family members we think are necessary to begin change
4. Important larger family system members (e.g., grandmother) or involved support systems (e.g., mother's best friend & neighbor) who will participate and are "appropriate" participants vis-à-vis retaining a highly influential role with the youth / family.
5. Important non-family members or involved support systems (e.g., mother's best friend & neighbor) who will participate and are "appropriate" participants maintain a highly influential role with the youth / family or closely involved with the youth's day to day activities (e.g. girlfriend/ boyfriend).

## Length of Treatment

FFT is a short-term-intervention designed to meet treatment goals quickly. The model is over the course of three to five months.

In FFT, the frequency of sessions is matched to the imminent risk of the family, as such families may receive as many as 3 sessions in 10 days. Frequency decreases as families gain skills as needed. Most families should expect to meet with their FFT therapist one-hour weekly, after the first 10 days. Once in the final phase of FFT, the therapists may reduce sessions to every other week to prepare the family for transition.

## Ongoing Reporting Requirements (with referring case manager)

Once the case is opened, all communication and billing will be coordinated directly between the FFT agency and local CSA office (e.g. referring case manager, CSA Coordinator). The provider may send a weekly e-mail or phone call to the referring staff providing a brief outline of the interaction with the youth and family, progression through the phases of FFT. The individual monthly report will provide an overview of the youth's progress on short-term objectives, successes, challenges, and dates of sessions. Monthly reports will be sent to the referring agency per the terms of the local CSA contract.

For DJJ referred youth, through the Service Coordination model, all monthly reports and invoices are sent by the RSC to the CSU on the 10th of each month.

# Appendix A: Making Referrals

## *Referral Packet*

The referral packet is completed by the CSA/ Lead Agency Case Manager; AA complete packet shall include:

- ☐ FFT Referral Form (located on EBA / AMIkids website)
- ☐ EBA / AMIkids Consent/ Release of Information (located on the EBA / AMIkids website)
- ☐ CSA Face Sheet (with youth demographics and family contact information)
- ☐ Funding Approval (may be sent to the Provider directly)
- ☐ FAPT approved IFSP and meeting notes
- ☐ CHINS Approval (as needed)
- ☐ Recent CANS Assessment
- ☐ Recent assessments or evaluations that provide details of recent behaviors, if applicable

*Failure to submit a complete referral packet, may cause a delay in service provision.*

## *Where to Send Referrals:*

All referral packets shall be sent via e-mail to the following e-mail addresses:

EBA based upon region: North: RSCNorth@ebanetwork.com

Central: RSCcentral@ebanetwork.com

AMI: VAServices-referrals@amikids.org

Referrals sent directly to the FFT Provider may cause a delay in services.

- *For the Northern VA region, basic information may be provided directly to the NCG Call Center. This information is received by the FFT Provider and EBA for an initial screening of the referral for appropriateness.*

## *What to Expect After Making A Referral:*

EBA or AMIkids will promptly (i.e., within 48 hours) reply acknowledging receipt of the referral and review the packet for completeness and ensure adequate information is available to determine appropriateness.

If additional information is needed, EBA or AMIkids will send the referral packet to the Provider's FFT Supervisor and cc the Case Manager on the request for additional information.

- *If the Provider FFT team receives the referral packet directly from the CSA – they will forward to the RSC and FFT Supervisor for review and cc the referring staff. All referrals will be screened and staffed for appropriateness prior to being assigned to an FFT Clinician.*

***Once the RSC has submitted the referral to the FFT provider and the referral has been received and reviewed by the providers FFT Supervisor, it is expected that the case will be assigned to a therapist and the therapist will initiate contact with the family within 48 hours.***

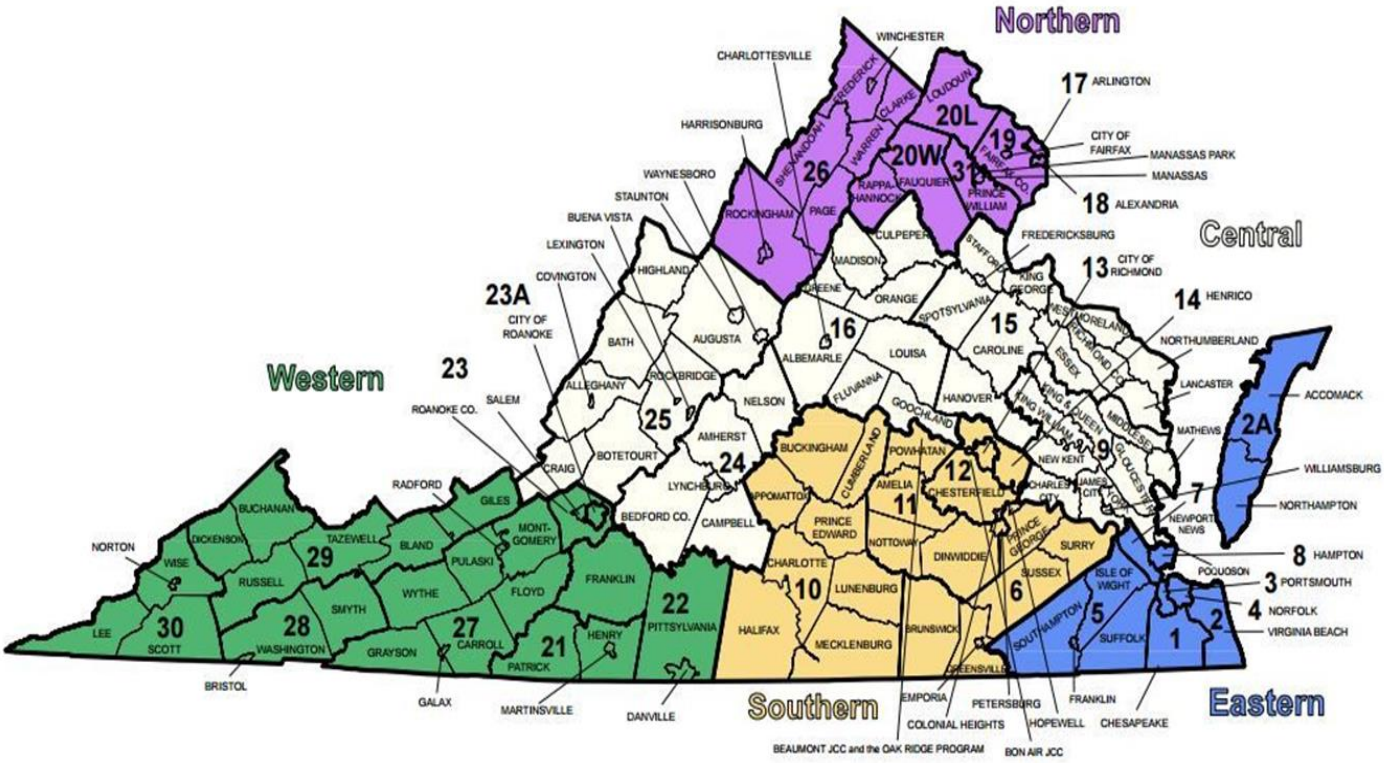
## *Disposition of Inappropriate Referrals*

- If it is necessary to deny a referral, the RSC will send an explanation to the referring agency and follow with a phone call to provide information to the referral source to improve future referrals.
- The RSC will include the FFT Supervisor (copied on the e-mail) in a denial of the referral to assist in educating CSA staff, and opening the door for support from the FFT provider in identifying other service options.

# Appendix B: Service Provision Area

## *Geographic service delivery area for contracted FFT Providers*

- *Northern Region:* National Counselling Group (NCG) is located in Manassas and serves a 90-minute travel radius.
- *Central Region:* United Methodist Family Services (UMFS) is based in Fredericksburg and serves a 90-minute drive-time radius. In addition, UMFS can serve the Charlottesville and Williamsburg communities.
- *Southern Region:* Family Focus Inc. is based in Henrico and can serve all 24 localities within the DJJ's Southern Region.

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