

Functional Family Therapy

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Unwavering champions for children and families.

Referral Considerations

- 11 to 18 years old
- In community or ready to go into the community
- Family Available
 - Shared sense of history or shared sense of future
- Clinical problems of “Externalizing Adolescent Behavior Disorders”
 - Conduct Disorder
 - Oppositional Defiant Disorder
 - Drug use/abuse
 - Other behavior problems (violence, school problems, truancy)
- Other mental health problems in adolescents: anxiety/depression with behavior disorder symptom expressions
- Parent child conflict issues



Treatment Pacing

- Short-term, highly effective, family-based program
- Treatment generally lasts 3 to 5 months (12-14 sessions for moderate cases, 26-30 sessions for more serious cases)
- Sessions in the home or community
- 3 sessions within the first 10 days
- Weekly sessions ongoing, additional sessions as needed
- Flexible scheduling (evenings/weekends), no formal on-call
- Can be provided in conjunction with other services




Functional Family Therapy

Clinical Model Overview



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FFT “Attitude”



Core Values	<ul style="list-style-type: none">• Respectfulness• Non-judgmental• Strength-based
Family-Based	<ul style="list-style-type: none">• Relational vs. Individual• Balanced alliances• Matching to individuals, relationships, family, and environment
Accountable to families	<ul style="list-style-type: none">• Specific and individualized change• Fidelity to model



To Address This Negativity, FFT Relies on a Foundation of Respectfulness of Culture and Diversity

The goal of FFT is not to create “healthy” or “normal” families according to someone’s theory or ideal, but to achieve obtainable changes that will help this family function in more adaptive, acceptable, productive ways with their resources ...
and their value systems...
in their context...

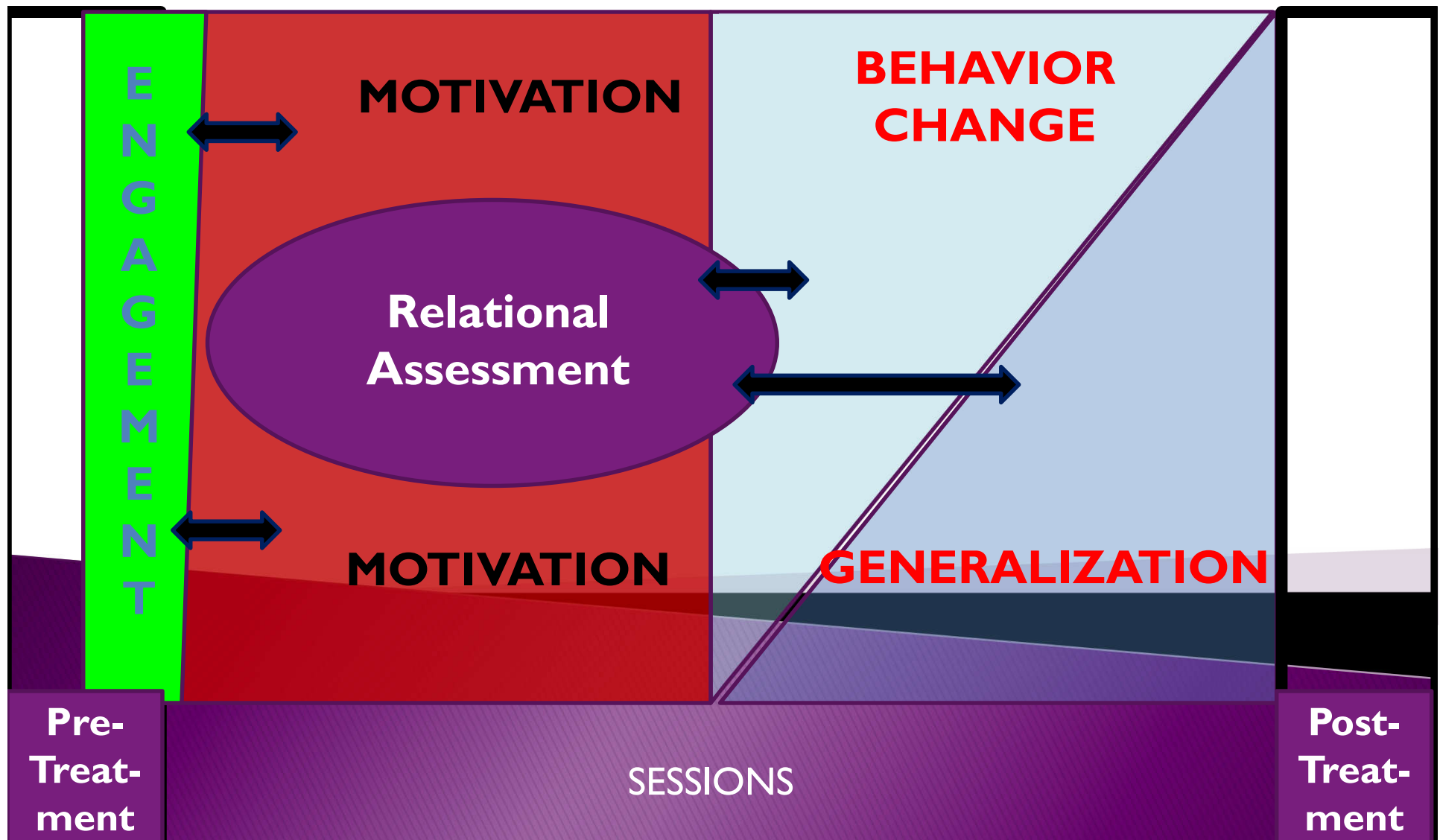


Who Are The “Major Players”?

1. Family members seen as part of the “**problem**” according to referral sources
2. Family members we think 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 retaining an influential role with the youth / family.



A phase-based approach....



Engagement Motivation Phase



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Family-Level Goals of the Motivation Phase

Decrease Conflict

- Less negative interactions
- Less blame
- More positive attributions
- More positive body language

Instill Hope

- Hopeful attitude
- View they have something to gain
- See potential benefit of therapy or therapist

Facilitate Relational Focus

- Increase family bonding
- Increased sense of familyness



Therapist-Family Level Goal of the Motivation Phase

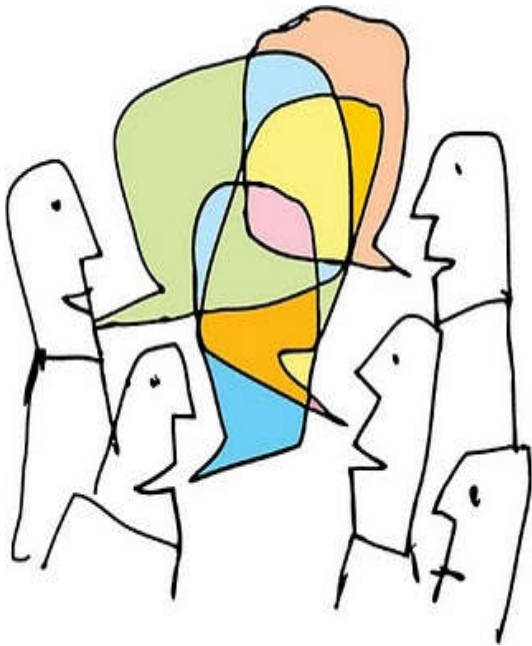
Balanced Alliance

- Sense of being heard and understood
- Sense of being respected
- Viewed with dignity or nobility



Interrupt/Divert

*Intervening to do something to
interrupt escalation*



Point Process

*Describing specific steps in an interaction
that you observe in the session*

Sequencing

*Describing interactions or facilitating
information about interactions that occurred
outside of session*



Reframes

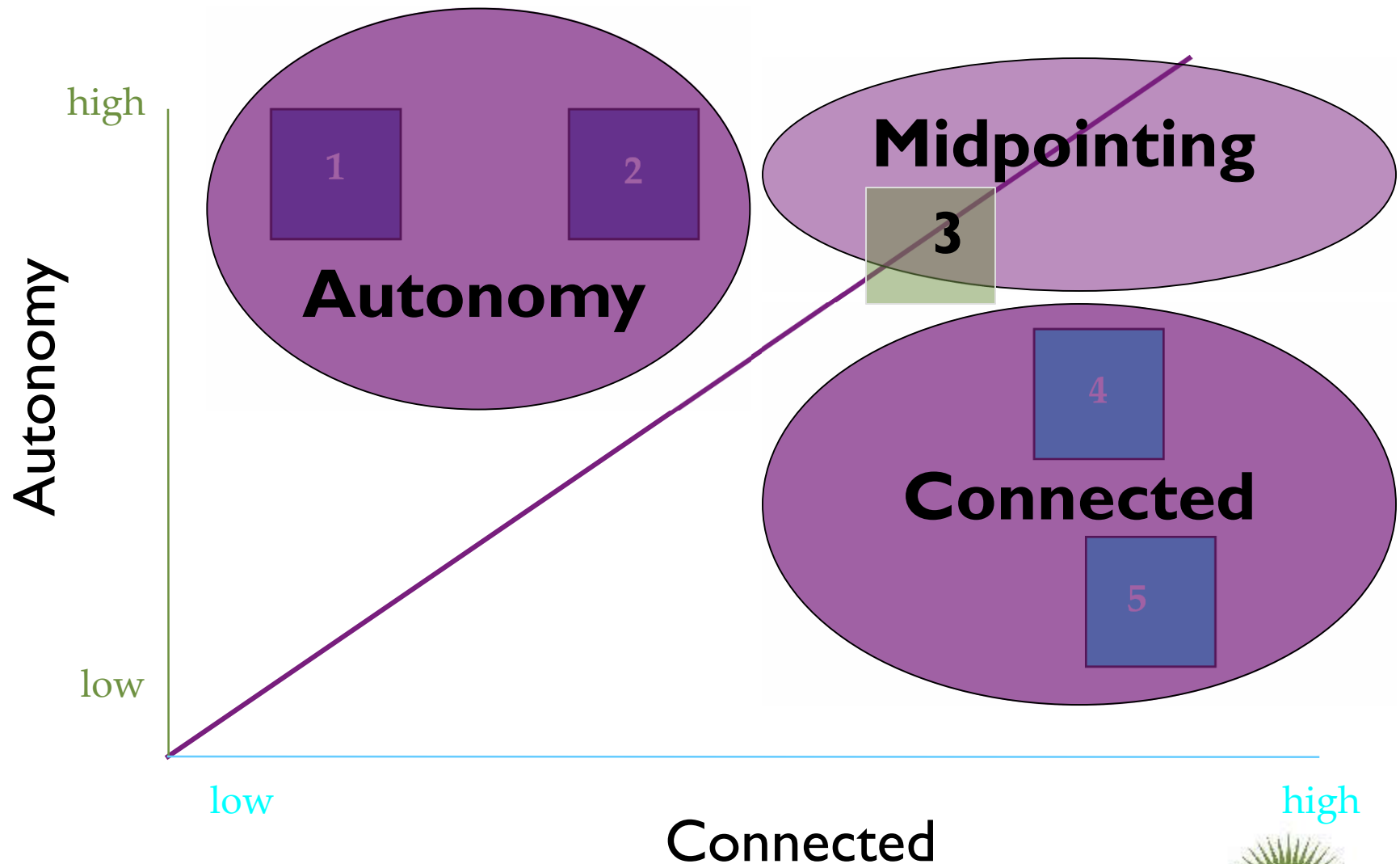
- Offer a possible benign or *noble but misguided intent* or meaning for the behavior;
- Based on the family members' reactions (affirming or disaffirming) you refine and elaborate the reframe ... or you apologize for “misunderstanding” and move on

Themes

- An *alternative meaning* of a painful past experiences
- This provides family members with a sense that they are **NOT** defined solely by their past bad behavior
- They are defined by a shared experience from misguided attempts at positive solutions, and the unfortunate realities of living with fewer resources than they need



Relational Connectedness



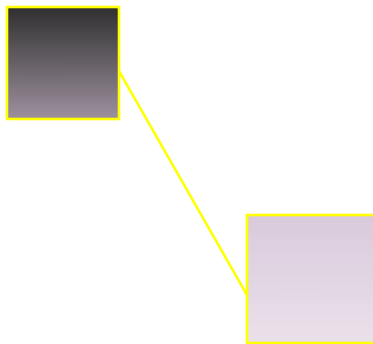
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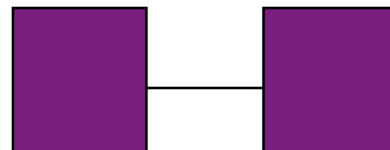
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Relational Hierarchy

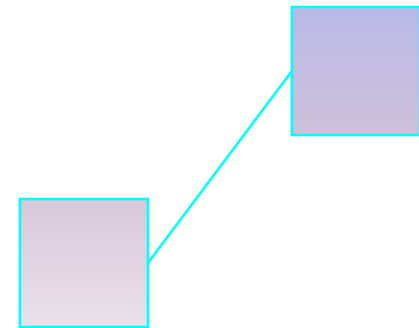
The pattern, over time, based on
power, position, and resources



Parent I - Up



Symmetrical



Parent I - Down

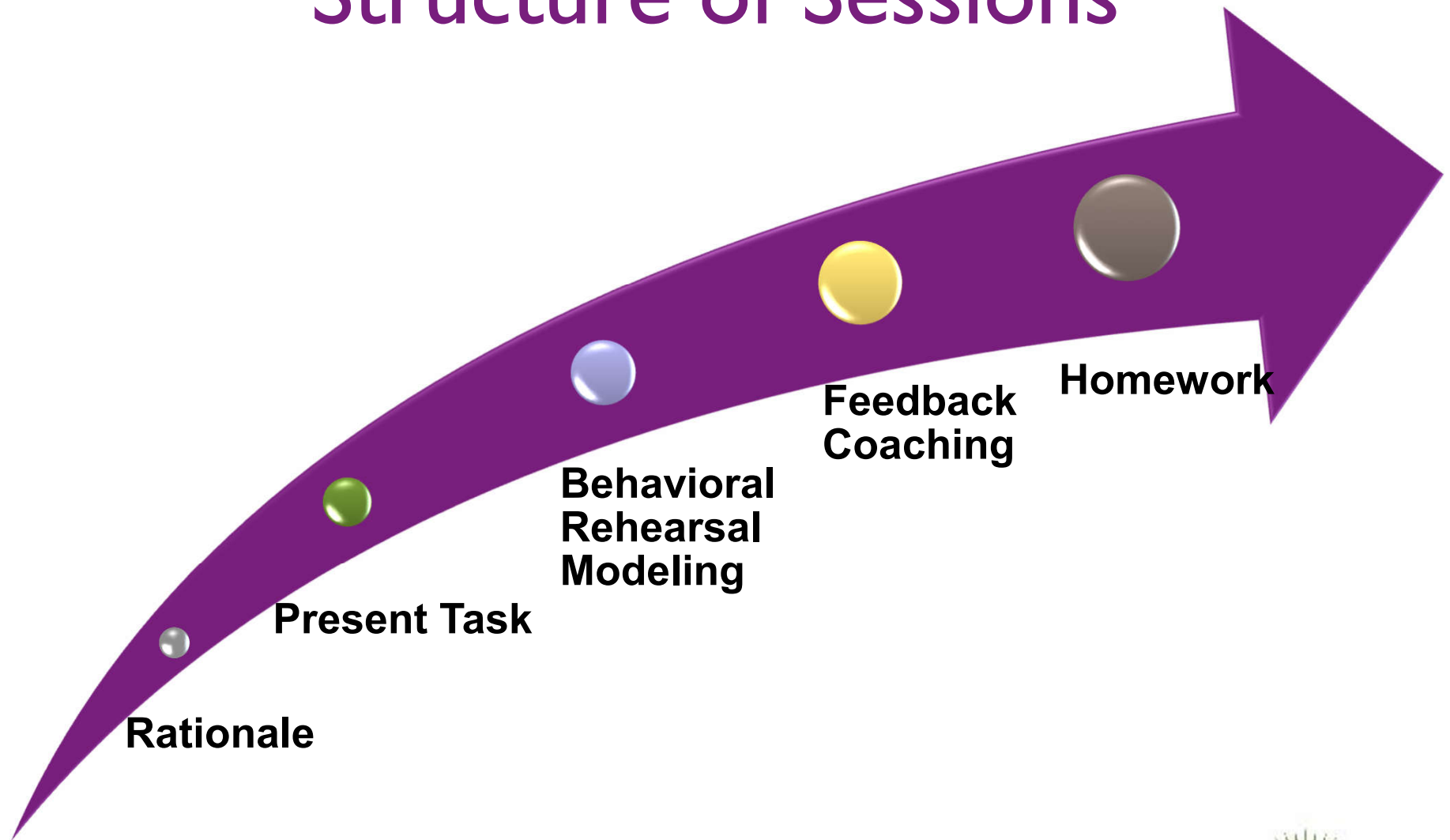


Behavior Change Phase

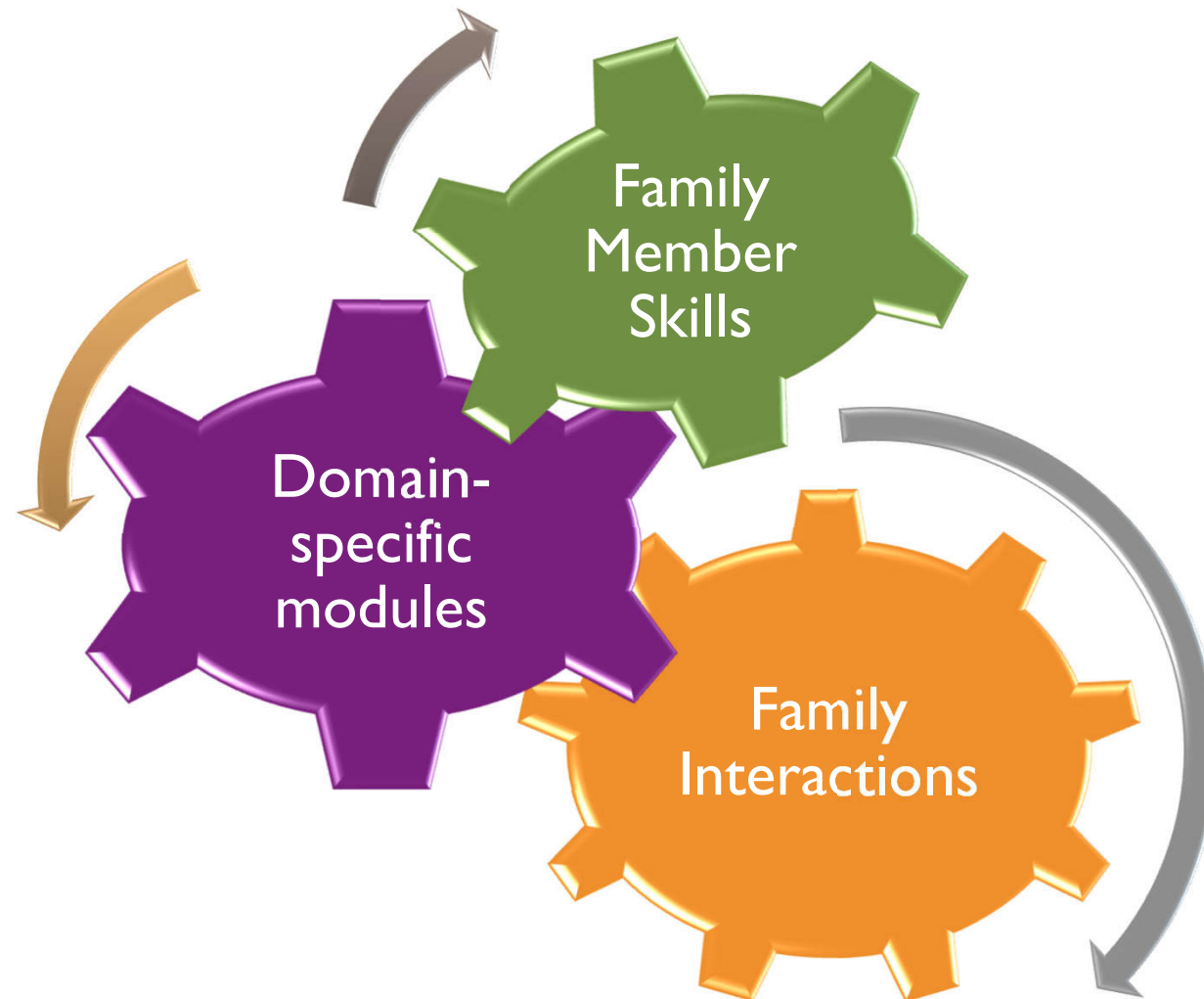


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Structure of Sessions



Behavior Change Targets



Family Interaction Targets

- Communication Training
- Problem Solving
- Negotiation
- Contracting
- Reinforcement
- Monitoring

Developmentally appropriate
Family specific
Accommodate to functions



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Family Member Skill Targets

- Anger management
- Assertiveness training
- Decision making
- Peer refusal skills
- Effective use of free time
- Emotional regulation



Domain-Specific Modules

- Drug Use
- Truancy
- Anxiety
- Depression
- Trauma

Drug Use

- Functional analysis of behavior
- Coping with urges and craving
- Urge Surfing
- Decision making

Anxiety/Depression

- CBT
- Challenging provocative thoughts
- Managing negative moods



Generalization Phase



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Generalization Phase Goals

- Improve family ability to manage relapse
- Improve family's ability to respond to new situations using recently acquired skills
- Aid family in linking them to community resources that support their positive family changes

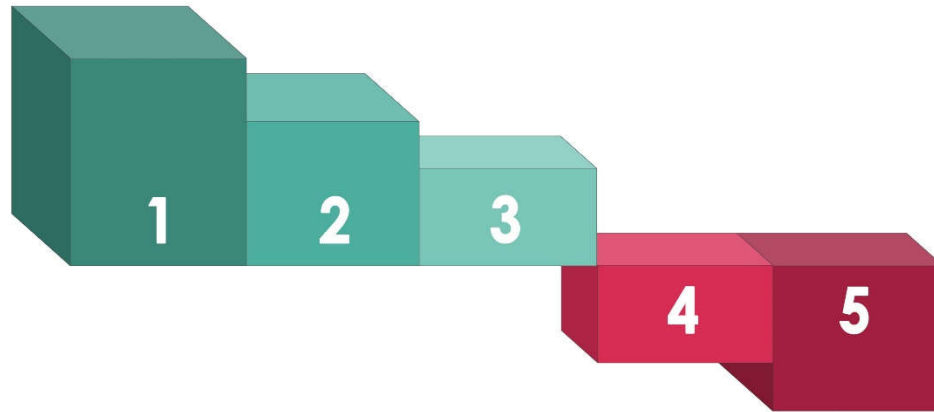


What makes it Evidenced Based?

- Weekly consultation with International FFT consultant
- Weekly Group Supervision/Individual Supervision
- Part time: minimum caseload of 5 cases (20 hrs/week)
- Full time: 10 to 12 cases
- Three-day initial clinical training and quarterly follow-up trainings with International FFT consultant on site
- Masters Level Clinician
- Web based CSS electronic record to assist with fidelity monitoring and quality improvement

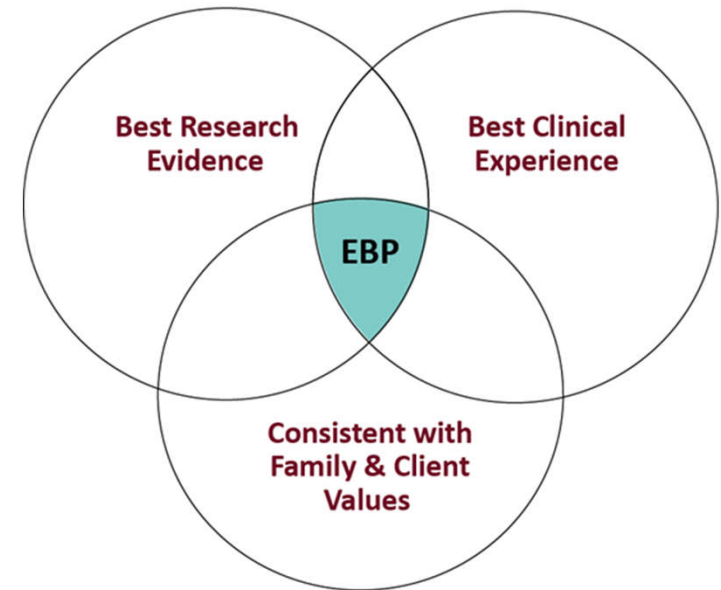


WELL-SUPPORTED ← → CONCERNING



1. Well-Supported by Research Evidence
 2. Supported by Research Evidence
 3. Promising Research Evidence
 4. Evidence Fails to Demonstrate Effect
 5. Concerning Practice
- NR. Not able to be Rated on the CEBC Scientific Rating Scale

CEBC's Definition of EBP for Child Welfare



[Based on Institute of Medicine, 2001]



<u>Topic Areas</u>	<u>Scientific Rating</u>	<u>Child Welfare Relevance</u>
<u>Alternatives to Long-Term Residential Care Programs</u>	2 — Supported by Research Evidence	Medium
<u>Behavioral Management Programs for Adolescents in Child Welfare</u>	2 — Supported by Research Evidence	Medium
<u>Disruptive Behavior Treatment (Child & Adolescent)</u>	2 — Supported by Research Evidence	Medium
<u>Substance Abuse Treatment (Adolescent)</u>	2 — Supported by Research Evidence	Medium

***Medium Child Welfare Relevance** means that the program was designed, or is commonly used, to serve children, youth, young adults, and/or families who are **similar to child welfare populations** and likely include current and former child welfare services recipients.



Cost Benefit of FFT

Evidenced-based programs have been shown to successfully treat delinquent youth in the community and decrease out of home placement costs between \$1,300 and \$5,000 per family, per year. Incarcerating just one youth will cost over \$50,000 per year with the likelihood for poorer outcomes for youth and families.”

State of Florida: Recidivism rates are 8% lower and Florida Redirections project has saved the taxpayers of Florida 193 million dollars.

State of Pennsylvania: For 2010, 1642 youth were served in FFT. This translates into an economic benefit of \$67 million dollars.



Referral Feedback

“In the past, prior to FFT, I had seen many of my clients understand the concepts of skill building, impulse control, goal setting, decision making, and exhibit motivation for change during our sessions. But then when they returned home and those concepts were not being understood or reinforced by the parents and the whole family unit, the client had a hard time sustaining their progress. “The model holds not just the client accountable to progress and change, it holds the family accountable as well.”

- William Fells Jr, Probation Officer



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For more information:

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Questions, Comments?
Thank you for your time!

