Functional Family Therapy (FFT)

A Guidance Document For Referral Sources

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through the VA Department of Juvenile Justice (DJJ)
Regional Service Coordination (RSC) Project,
In collaboration with National Counseling Group (NCG)

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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). This document provides CSAs information needed to decide if their localities will adopt FFT and understand the process for making an appropriate referral to FFT; this is meant to enhance and summarize information and is not meant to replace presentations and workshops provided by the FFT team or EBA.

I. 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.

1. All referral packets shall be sent to carecenter@ncgcommunity.com.

    a. The FFT team supervisor is available to staff cases with a referral prior to FAPT or a formal referral. A full referral packet, including funding approval, is needed for acceptance by the FFT team.
2. The FFT referral form is located on the EBA website. The form may also be electronically sent to the CSA office, following a stakeholder meeting for distribution to case managers.

3. A Complete referral packet is required to initiate the process. The referral packet is completed by the CSA/ Lead Agency Case Manager; A complete packet shall include:

    - FFT Referral Form
    - Consent/ Release of Information, as applicable
    - Face Sheet (with youth demographics and family contact information)
    - Funding Approval
    - FAPT approved IFSP and meeting notes, (no needed for RSC funded cases)
    - Court paperwork, as appropriate including the CHINS Approval
    - Recent CANS Assessment/ or current YASI
    - 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.*

4. After making a referral, NCG FFT Supervisor 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.

    a. **Referral Acceptance:** NCG Supervisor will immediately *assign appropriate referrals to a Clinician; the clinician will initiate contact with the family within 48 hours.*

    b. If additional information is needed, the FFT Supervisor may request clarification from the case manager or review the case with the FFT Consultant.

    c. **Disposition of Inappropriate Referrals:** If it is necessary to deny a referral, the Supervisor 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.

    d. In the event the case is acceptable, but there is no immediate availability, the referring case manager will be notified of the wait list process and contacted with an anticipated start date. (see Priority Criteria for Waiting list)

II. Priority Criteria for Waiting Lists

If the FFT Team is at capacity and referrals must be placed on a waiting list, referrals will be prioritized and triaged based upon the considerations outlined below. Referrals are not prioritized based solely on date of referral.

Definitions:

Waitlist: When the FFT team is not be able to start services with referred youth/ family within 14 days from receipt of an accepted referral, due to capacity.

Pending: If the wait is less than 2 weeks, the youth is in PENDING status. The youth and family will be contacted promptly to schedule first session and intake. Also, after a referral is assigned to a clinician, the youth will remain in pending status, until the intake and first session occur.

Process

1. NCG will maintain a current capacity spreadsheet at least weekly.
    a. The available spaces will be made available to community stakeholders through the EBA Communique.
    b. Supervisor will notify the EBA RSC when they approach full capacity.
2. Regardless of start date, NCG should ALWAYS ensure referring case manager is contacted within 48 hours to make initial contact and discuss tentative start date timeline to confirm tentative timeline works for needs of family and court.
    a. NCG will provide ongoing communication is made with the referring agency to ensure they and the family are aware of the anticipated wait time.
3. NCG will review each appropriate complete referral to determine and log the triage score. The date of referral and triage score will be logged (spreadsheet to be provided by EBA). The triage score is meant to guide the process for the FFT Supervisor and RSC, allowing for individual risk factors to be taken into account as needed.

Triage scores will be developed on the following considerations:

- ☐ Youth on active parole or probation;
- ☐ Youth returning to community from out of home placement (i.e., direct care, detention, group home, residential) or at imminent risk of out of home placement;
- ☐ Youth who can NOT access other services (either due to insurance barriers, provider limitations in their area or transportation barriers);
- ☐ Current or prior services were unsuccessful in creating lasting change;
- ☐ Youth is involved in numerous systems (i.e. prevention, CPS, School SPED, CSU);
- ☐ Youth has siblings (or other household members) that display inclusionary behaviors, regardless of system involvement.

One (1) point will be given for each of the above factors, with a total of 6 points.

4. Note: If two youth score the same triage score, other factors will be taken into account, including:
    - Seriousness, duration, and frequency of offending (e.g., status vs. criminal, person vs. property);
    - YASI risk assessment score (prioritizing high and moderate risk levels especially in Family, Alcohol/Drugs, Attitudes/Values/Beliefs domains)

- 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)

5. Referral start dates will be prioritized based upon *how many* of the following considerations areas are met, which would equate to the youths assigned triage #. NCG is encouraged to staff any high priority/ high risk cases with EBA RSC and the FFT consultant to determine a service start date or contingency plan.
6. Once NCG Supervisor assigns the referral to a Clinician; the clinician will initiate contact with the family within 48 hours. *The youth will remain in pending status until the first session and intake.*

Practice Prioritizing:

Your agency has three cases come in and your team is at capacity with the following three on a wait list. What order will you prioritize starting with these?

1. Youth whom will be released from Bon Air JCC in 2 weeks on Parole, unsuccessfully completed IIH in past, high overall risk YASI score, High protective family score, has access to other services.
2. Youth on probation-moderate, Moderate overall YASI score, history of running away, high conflict in home with multiple siblings and several school complaints, lives in rural area with limited access to resources. Has had Outpatient therapy in past but not complaint due to transportation barriers, is facing Post-D program or residential.
3. Youth involved with CSA through foster care prevention, no probation or court involvement, case manager concerned about school attendance.

Answer key:

Wait List Priority Order-

First: Youth # 1- total triage score of 3. Returning home from direct care, will be on parole, unsuccessful with other services.

Second: Youth #2- total triage score of 5. At risk for out of home placement, unsuccessful with other services and lack of services in area. YASI indicates high risk in family domain.

Third: Youth #3- total triage score of 1. Youth involved in numerous systems (DSS and Schools). While FFT is a great fit for this youth, he/she will not take priority on a waitlist.

III. How Does FFT Work with Youth?

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	
Goal	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.
Possible Funding Categories	Services may be provided to youth through DJJ RSC Model and Adoption Subsidy and CSA. FFT fits the following CSA funding categories: Children in Need of Services (CHINS), Foster care-prevention; Foster Care (for Reunification, placement with relative, and trial home placements only), SPED Wrap-Around, Non- Mandated, 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.
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; ☐ 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); ☐ Youth whose psychiatric problems are the primary reason leading to referral, or who have severe psychiatric problems; ☐ Youth where sexual offending occurs in the absence of other delinquent behavior, who have not had treatment for the offending behaviors.; and ☐ 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 California Evidence-Based Clearinghouse (CEBC): Well-Supported, www.cebc4cw.org/ The Prevention Services Clearinghouse/ Approved Family First Prevention Services Act (FFPSA) https://preventionservices.abtsites.com/
Certification	NCG has a current and active contract with FFT LLC certified to provide the service 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.

IV. FFT Clinical Model Phases Across Time

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