

FAMILY FUNCTIONAL THERAPY (FFT)

Family Functional Therapy (FFT) – Youth

Definition

Family Functional Therapy (FFT) is a family-focused, community-based treatment for youth who are either “at risk” for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in juvenile court, in community-based clinic or outpatient settings and at times of transition from institutional placement.

FFT therapists recognize that solutions to behavioral health problems require an integration of high quality science, tested theoretical principles and extensive clinical experience to accomplish the achievement of specific functional goals for the youth, the family and society as a whole. These functional goals include the following.

- Engage and motivate the youth and family to change by decreasing the intense negativity often characteristic of these families. Work to motivate families and youth who (at the outset) may not be motivated or may not believe that they can change.
- Reduce the personal, societal and economic devastation that results from the continuation or exacerbation of the various disruptive behavioral challenges of the youth.
- Reduce and eliminate problem behaviors and family relational patterns that put the family and youth at risk. Develop individualized behavior change plans that focus on improving parenting skills, family communication, conflict resolution and problem solving skills.
- Generalize positive changes across problem situations by increasing the family’s capacity to adequately utilize community resources.

FFT incorporates specific intervention phases which include engagement, motivation, assessment, behavior change and generalization. Each phase includes a description of goals, requisite therapist characteristics and techniques. The intervention phases enable clinicians to maintain focus in the context of considerable family and individual disruption. The range of treatment is 3 to 30 sessions over a three month period with an average of 8 to 12 sessions.

Criteria	
Admission Criteria	<p><i>The youth must meet 1, 2 and 3 and at least ONE from 4 through 8.</i></p> <ol style="list-style-type: none"> 1. The youth is between the ages of 11 and 18. (Special consideration will be given to youth who are between the ages of 10 and 11.) 2. The DCBHS Assessment and other relevant information indicate that the youth needs FFT treatment. 3. The youth manifests behavioral symptoms consistent with a DSM IV-TR (Axis I through V) diagnosis that requires FFT intervention (e.g., Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, Substance Abuse Disorders, etc.); <p style="text-align: center;">OR</p> <p>The youth is “at risk” for developing antisocial behaviors consistent with a diagnosis such as Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS or Substance Abuse Disorders.</p> <p><i>The youth meets any ONE of the following:</i></p> <ol style="list-style-type: none"> 4. The youth manifests delinquent or antisocial behaviors which may include any of the following: <ol style="list-style-type: none"> a. The youth is physically aggressive at home, at school or in the community. b. The youth manifests verbal aggression which may include verbal threats of harm to others. 5. The youth is at imminent risk of out-of-home placement due to his/her behavioral problems. 6. The youth is adjudicated. 7. The youth is a chronic or violent juvenile offender 8. The youth manifests substance abuse issues in the context of the behavioral problems. 9. The youth is transitioning from an institutional placement and his/her behavioral challenges threaten the success of the transition.
Psychosocial, Occupational, Cultural and Linguistic Factors	<p><i>These factors may change the risk assessment and should be considered when making level of care decisions.</i></p>

<p>Exclusion Criteria</p>	<p><i>Any of the following is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The DCBHS Assessment and other relevant information indicate that the youth needs a more (or less) intensive level of care. 2. The youth is at imminent risk of causing serious harm to self or others. 3. The youth is actively psychotic or in need of crisis psychiatric hospitalization or stabilization. 4. The youth has been diagnosed with schizophrenia. 5. The youth is experiencing problems that are primarily psychiatric rather than behavioral. 6. The youth has been diagnosed with Autism or a Pervasive Developmental Delay. 7. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors. 8. The youth is living independently, or in serial foster care or in a long term residential treatment setting. 9. There is no identifiable primary caregiver to participate in treatment despite efforts to locate all extended family, adult friends and other potential surrogate caregivers. 10. The youth can be safely maintained and effectively treated in a less intensive level of care. 11. The youth and/or the parent/custodian/guardian do not voluntarily consent to treatment and there is no court order requiring such treatment. 12. The youth has a sole presenting diagnosis of Substance Abuse. 13. The youth's level of cognitive ability does not allow him/her to benefit from the MST therapeutic interventions.

<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The DCBHS Assessment and other relevant information indicate that the youth continues to need the FFT level of care. 2. The severity of the behavioral disturbance continues to meet the criteria for this level of care. 3. The youth’s treatment does not require a more intensive level of care and no less intensive level of care would be appropriate. 4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth’s clinical condition, his/her response to treatment and the strengths of the family. 5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice. 6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress. 7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment. 8. When clinically necessary, appropriate psychopharmacological treatment has been initiated. 9. There is documented evidence of active, individualized discharge planning.

<p>Discharge Criteria</p>	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The youth and family have met and sustained a majority of the overarching treatment goals. 2. The DCBHS Assessment and other relevant information indicate that the youth no longer needs the FFT level of care. 3. The youth has few significant behavioral problems and the family is able to effectively manage any recurring problems. 4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with prosocial peers and is not involved with (or is minimally involved with) problem peers. The therapists and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems. 5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care. 6. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment. 7. The youth meets criteria for a more (or less) intensive level of care.
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