

FAMILY FUNCTIONAL THERAPY (FFT)

Family Functional Therapy (FFT) - Youth

Program Description

Family Functional Therapy (FFT) is a family-focused, community-based treatment for youth who are exhibiting severely impulsive and noncompliant behaviors, which appear to be consistent an Impulse Control Disorder or a Disruptive Behavioral Disorder. Co-occurring emotional symptoms involving anxiety or depression, or active substance use may also exist, as well as, problems with family functioning. 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 treatment.

FFT therapists recognize that solutions to behavioral health problems require an integration of high quality evidenced-based 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 that 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 9.</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 CSOC Assessment and other relevant information indicate that the
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	<p>youth needs FFT treatment.</p> <p>3. The youth manifests behavioral symptoms consistent with a DSM IV-TR (Axis I through V)/ DSM 5 diagnosis that requires FFT intervention (e.g., Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder Unspecified, Disruptive Mood Dysregulation Disorder, Substance Use Disorders, etc.);</p> <p>OR</p> <p>The youth is “at risk” for developing negative behaviors consistent with a diagnosis such as Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder Unspecified or Substance Use Disorders.</p> <p><i>The youth meets any ONE of the following:</i></p> <p>4. The youth manifests negative behaviors which may include any of the following:</p> <ul 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. <p>5. The youth is at imminent risk of out-of-home treatment due to his/her behavioral problems.</p> <p>6. The youth is adjudicated.</p> <p>7. The youth appears to be exhibiting severely impulsive and noncompliant behaviors, which appear to be consistent an Impulse Control Disorder or a Disruptive Behavioral Disorder. Co-occurring emotional symptoms involving anxiety or depression, or active substance use may also exist, as well as problems with family functioning.</p> <p>8. The youth manifests substance use issues in the context of the behavioral problems.</p> <p>9. The youth is transitioning from an institutional treatment and his/her behavioral challenges threaten the success of the transition.</p>
<p>Psychosocial, Occupational, Cultural and Linguistic Factors</p>	<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>Any of the following is sufficient for exclusion from this level of care:</p> <p>1. The youth and/or the parent/caregiver/guardian does not voluntary consent to treatment and/or there is no court order requiring such</p>

	<p>treatment.</p> <ol style="list-style-type: none"> 2. There is no identifiable primary caregiver to participate in treatment despite efforts to locate all extended family, adult friends and other potential surrogate caregivers. 3. The youth can be safely maintained and effectively treated in a less intensive level of care. 4. The CSOC Assessment and other relevant information indicate that the youth needs a more (or less) intensive level of care. 5. The youth is at imminent risk of causing serious harm to self or others, potentially indicating a need for psychiatric hospitalization and stabilization. 6. The youth is actively psychotic, has a psychotic disorder diagnosis, or in need of psychiatric hospitalization for acute stabilization. 7. The youth is experiencing behavioral and or emotional symptoms, which seem primarily psychiatric in etiology. 8. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder, Pervasive Developmental Disorder, or Intellectual Disability. 9. The youth’s level of cognitive ability does not allow him/her to benefit from the Family Functional Therapy therapeutic interventions. 10. The youth’s sole diagnosis is Substance Use Disorder, and the emotional or behavioral disturbances appear to be mainly correlated with substance use, intoxication or acute withdrawal effects of substances being used. 11. The youth is a juvenile sex offender or primarily exhibits problematic sexualized behaviors, and h/she does not manifest other delinquent or antisocial behaviors. 12. The youth is living independently, or in DCP&P placement or in a CSOC OOH treatment setting. 13. The youth is not a resident of New Jersey. For minors who are under 18 years of age, the legal residency of the parent, caregiver, or legal guardian shall determine the residence of the minor.
<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 CSOC 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

	<p>no less intensive level of care would be appropriate.</p> <ol style="list-style-type: none"> 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. Alternatively, 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>Transitional Criteria</p>	<p>If the FFT care management entity is requesting transition from FFT services via Needs Assessment, ALL of the additional following criteria must be met:</p> <p>The CSOC Assessment and other relevant information indicate that the youth requires a different clinical treatment focus within a different treatment setting. This documentation must include the following:</p> <ol style="list-style-type: none"> 1. Treatment needs that were addressed in current episode of care and any previous episodes of FFT treatment. 2. Treatment interventions that were successful and/or unsuccessful in current episode of care and any previous episodes of treatment 3. Behaviors/needs that warrant a different intensity of service 4. The youth’s perspective on proposed transition (applicable based on cognitive abilities) 5. Justification as to why another transition to another treatment service is in the youth’s and family’s best interest 6. Recommendations for the family in the event that there is a decompensation or escalation of behavioral, emotional difficulties in the future.
<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.

	<ol style="list-style-type: none">2. The CSOC 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 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 treatment7. The youth meets criteria for a more intensive or less intensive level of care.
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