Implementing Functional Family Therapy (FFT) the “real world”:

Keys to Supporting Successful FFT Implementation

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Conflict of Interest

One of the presenter(s) of this information is required by Indiana University to reveal a potential conflict of interest. He is an owner of a training program that receives income from that activity, his primary writing and scholarly work is in this area, and he promotes this particular model of therapy.

The Challenge to Communities

These are all Family Problems

Range of Youth Behavior Problems

- problems are family based
- solutions are family based
- These require Family Based Solutions

Externalizing
Internalizing
At risk
The Problem with Problem Adolescents

- Often seen as “difficult to treat,” “difficult to engage”... for good reason
  - Kazdin (2003), not uncommon to find dropout rates up to 60%
  - Poor clinical outcomes
  - Recidivism rates of 50 to 75%
  - “Toughest” kids
- Outcome expectations are low
  - Willing to accept long treatment
  - Willing to accept low/moderate outcomes
  - Willing to see only long term outcomes
  - Continue to see Adolescents and families are not motivated

Helping Youth and Families

We have come along way.......

- We have very good treatments... treatments that work
- We also missed something....
  - How to successfully implement these programs in a way that promotes the “best outcomes possible”
  - Most often...up to 50% of the Effects are lost just by moving treatments into community settings.

Evolution of Evidence-based Treatment & Prevention

These “traditional approaches” cemented into mental health service delivery systems as typical “treatment”

Yet... little, if any evidence that these work...
The best treatments are “Evidence Based Practices”

What are they......

- Research (community based studies)
- Practice (what works in community practice)

Use in only 10-20% of the treatment provided to youth and their families

What does this mean....

- Treatments with the greatest likelihood of success
- EBP provide families with help they can rely on
- “maps” to guide therapists/social workers/family support staff
- A “yard stick” of what is best for community and resident staff

Major Challenges

- Creating motivation to change in local communities
- How to take structured treatment programs and “fit” them into community based agencies
- How to create partnerships between developers and communities to work together to get the most out of EBP
- How to monitor fidelity and outcomes in an active way

Great Benefits:

- Good treatment for youth and families
- Unique adaptations for special populations (FFT with adults)
- Community ownership over the intervention program

Our goals

- Identify what an EBP like Functional Family therapy can bring to a community
- Illustrate “real life” implementation examples illustrating the challenges and benefits in successful community based implementation
- Show a unique method of collaborative community based monitoring and assessment
  - Allows for administrative monitoring by community
  - Clinical monitoring by agency, staff, & supervisors
  - Training monitoring by developers
  - Research and Evaluation tool for use in demonstrating outcomes and compare these to others (using FFT)
What Functional Family Therapy offers to Communities, Families and Youth

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Functional Family Therapy

- Systematic, client centered, evidence based, family-based program
- Research-based prevention and intervention program for at-risk adolescents and their families
- Targets youth between 11-18...
  - Prevention intervention-status/diversion kids
  - Treatment intervention-moderate and serious delinquent youth
- Short-term
  - 8-12 session for most cases,
  - 26-30 for more serious cases spread over 3 to 8 months

Where does FFT fit?

- FFT can serve as:
  - As a set of “engagement” strategies
  - As a “reentry” program
  - As a diversion program
  - An “bridge” that integrates community and residential interventions
  - A common language for community, resident, youth and family members to use in working collaboratively
Functional Family Therapy

Areas of Clinical Applications

- Clinical problems falling under the label “Externalizing Adolescent Behavior Disorders”
  - Conduct disorder
  - Oppositional defiant disorder
  - Drug abuse
  - Other behavior problems…violence, school problems etc.
- Other mental health problems of adolescents
  - Anxiety/depression with behavior disorder symptoms secondary
- Parent-child/family conflict issues
- At-risk behaviors…precursors of more serious problems (Kazdin, 2003)
- Adult behavioral problems

The “Adult FFT Project”

- Retains the core principles of FFT (systemic view of the problem, systematic goals, therapeutic processes)
- Focuses on the family system adult offenders go to for assistance
  - Traditional, extended or elected families (offenders’ closest emotional connections)
  - with the goal of changing maladaptive interactions that weaken the individual social tie to the family and therefore are a risk factor for recidivism
  - Change the balance between risk and protective factors, that is, reduce risk factors and increase/strengthen protective factors within the family system
  - Attend to the multiple needs of the individual in the context of the local community, and address risks specific to the individual

... 3 components of effective treatment (National Institute on Drug Abuse, 2006)

More importantly FFT is family focused

Family is the primary lens:
  - Understanding behavior of youth
  - Problems
  - What to assess
  - What to change/how to change
  - A "unique case plan" for each family
  - Constant adaptation and adjustment (within principles)
  - Ongoing monitoring of progress (from clients perspective)
  - Built on an attitude of understanding & respect
  - A collaborative and alliance based process of “two experts”
FFT Randomized Trials
(Recidivism 6 – 12 months, 30 – 42 months, 24 months respectively)

FFT vs. No Treatment
Juvenile Treatment Program
Alternative Treatment
0.00% 10.00% 20.00% 30.00% 40.00% 50.00% 60.00% 70.00% 80.00%

FFT as compared to alternative treatments
(Sexton, in press)

FFT as compared to alternative treatments
(12 Month Recidivism)

Ireland RCT Study Outcomes (2014)
(SDQ Total Scores - Youth)

Mean total scores of treatment and control group on the adolescent version of the Strengths and Difficulties Questionnaire (SDQ) at intake (Time 1), discharge (Time 2), and 3 month follow-up (Time 3; treatment group only).
Ireland RCT Study Outcomes (2014)
(SDQ Total Scores - Parent)

Mean scores total of treatment and control group on the parental version of the Strengths and Difficulties Questionnaire (SDQ) at intake (Time 1), discharge (Time 2), and 3-month follow-up (Time 3; treatment group only).

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FFT with Adults
(Datachi & Sexton, 2012)

- Family changes:
  - Significant improvements in Family Cohesion and Family Conflict
- Individual symptom changes:
  - Levels of distress had decreased significantly (t(27) = -2.399, p = .029)
  - Psychopathology (t(27) = -2.164, p = .039)
- Interpersonal changes:
  - Statistically significant improvement in interpersonal relationships (t(27) = -3.191, p = .004)
- LSI-R changes:
  - Statistically significant difference between the adults who participated in FFT and those who received supervised probation only (F(1,78) = 5.569, p = .021)
  - The treatment group yielded lower scores on the LSI-R, suggesting that Functional Family Therapy, when added to traditional supervision, significantly reduces the risk factors associated with the probability of reoffending.

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FFT is unique in the EBP World

- Purposefully Creative
- Flexibly Structured
- Model focused and Client Centered
- Change that is guided by the model...driven by the Family...with respect for how the family “functions”
- Requires a collaboration between model, team, and community
The “LENS” of FFT

- Theoretical foundation
  - "a systemic approach"
- Pragmatic focus
  - focus how the family "functions"
  - Focus on change
- An "inside out" approach
- Obtainable & sustainable goals
- Match the context and the client
- Evidence-based implementation

The “MAP” Functional Family Therapy
Clinical Model

Goals
- Increase behavioral competency of all family
  - Consistent performance of competency in "real" problem situation

Clinical Model

Goals
- Maintain new skill - working together with new problems
- Support changes by using relevant outside resources
Engagement and Motivation Phase

Goals:
1. Lower within-family blame and negativity
2. Increase within-family alliance
3. Family focus to the presenting problem

Outcomes:
- Alliance
- Family/relationally based problem focus
- Reduced negativity/blame
- Shared responsibility and ownership

Behavior Change Phase

Phase-based Treatment Goals:
1. Build behavioral competencies that fit the family
2. Target the most relevant, obtainable, and maintainable competencies
3. Match competencies to relational functions

Outcomes:
- Increase behavioral competency of all family
- Consistent performance of competency in "not" problem situations

Discussion focused on:
- Homework, going out with peers, curfew specific spot in the sequence.
- Work on problems...our focus is on their process of doing so

Targets of FFT Behavior Change

- Parenting: monitoring and supervising
  - Direct and concrete communication
- Conflict Management
- Problem Solving
Generalization Phase

Phase Based Treatment Goals:
1. Maintain Change - relapse prevention
2. Generalize change to other areas
3. Build systems support

Outcomes
- Increase behavioral competency of all family
- Consistent performance of competency in "real" problem situation

Ecosystemic System
- The Multisystemic Focus of Functional Family Therapy
- Clinical Symptoms/Behaviors
- Family Relational System

Identify the external systems and risk factors that are important for maintaining & supporting change
- School
- Peer Group
- Court System
- Peer Group Pressure Involvement

Sexton, 2010
Who is Cuyahoga County Juvenile Court?

- Division of the Court of Common Pleas
- Hear all juvenile delinquency and status offenses; juvenile traffic cases; abuse, neglect, dependency cases; parent/child relationship cases; private custody & child support cases
- Operate a Juvenile Detention Center
- Mission: To administer justice, rehabilitate juveniles, support & strengthen families & promote public safety.
What does Cuyahoga County Juvenile Court do?

• Main campus is the Juvenile Justice Center plus 6 satellite offices.
• Overall budget of approximately $56 million.
• Annually hear over 23,000 cases, including over 8,000 delinquency & unruly cases, involving over 12,000 charges and over 5,000 individual youth.
• Delinquency/unruly offenders involve 67% males; and overall include about 69% African American & 25% Caucasian.

Probation Services at Cuyahoga County Juvenile Court

• 11 different probation units; 6 supervisory probation; 2 investigative probation; 1 low-risk; 1 placement; 1 BHJJ unit.
• About 75 PO’s on staff – about 2/3 are union.
• Cuyahoga County Juvenile Court is a Title IV E court, completion of case plans and candidacy eligibility is required for about 98% of youth.
• Estimate about 75% of youth are Medicaid eligible.

Pre-FFT Court Programmatic Needs

• Court offered an array of community-based services, including substance abuse assessment/treatment; sex offender assessment/treatment; anger management; MST; in-home therapy; day treatment etc.
• In-home services were:
  o NOT evidenced-based;
  o Inconsistent across vendors;
  o Not monitored & no quality assurance applications.
Implementation Steps - Preliminary

- Identify funding – both for training & services.
- Request for Proposal process.
- Contract process *(2 vendors selected)*
  - Agree to train together;
  - Meet all FFT requirements, including equipment;
  - Appropriate staff complement;
  - “Fast pass” provision for Court referrals.

Implementation Steps - Court

- Education to Jurists, Probation Officers/Probation Managers, including:
  - What is FFT?
  - Who is an appropriate referral?
  - What will FFT do/not do?
  - Difference between FFT & MST
  - How to “sell” FFT to families.

Implementation - Challenges/Struggles

- Medicaid identification and related issues:
  - Differentiating between Medicaid eligible services & non-eligible services.
  - Vendors trying to meet reporting requirements for Medicaid eligibility services.
  - Vendors trying to meet productivity levels of staff.
  - FFT requirements for data input into CFS system.
  - Change is Ohio’s family therapy allowance in Medicaid.
Implementation - Challenges/Struggles

• Training methodology of FFT
  ○ FFT training involves lots of homework.
  ○ Preparation before training sessions, including FFT “book”, articles on-line, webinars.
  ○ FFT training is a “learn-as-you-go”, i.e., provide services as you learn the methodology.
  ○ FFT workers need to “trust in the process” – work through the 1st phase of the process without knowing the 2nd phase.

• Computer issues:
  ○ Computer literacy and abilities of FFT staff.
  ○ Change of the CFS platform in the middle of the 1st year of training.
  ○ Vendor’s FFT staff had a lack of understanding of what needed to be input into CFS.
  ○ Double inputting of case info (especially with Medicaid standards).

• Issues related to working with contracted vendors vs in-house staff.

• Individual agencies have their own:
  ○ Management structure;
  ○ Case flow structure;
  ○ Agency mission, vision, values.

• Deciphering how individual agency ideals mesh with FFT case flow and philosophy.
Implementation - **Challenges/Struggles**

- **Staffing issues:**
  - Staff turnover.
  - Education/experience levels of vendor-selected staff.
    - Experience in justice-involved population.
  - Program “buy-in” of vendor selected staff -attitudes of supervisors flow top-down to front-line FFT workers.
  - Personality conflicts.

- **Engagement of families**
  - Difference between Court-ordered services & Court recommended services.
  - Vendor staff persistence in utilization of all resources to engage families.
    - Experience with the juvenile justice population vs. those that are seeking assistance.
  - Involvement of Probation Officer to engage the family.
  - Creativity in methodologies.

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**FFT program – Where are we?**

- FFT data to date – starting engaging families in February 2013 *(year 2 of training)*
- 2 vendors currently
FFT program – Where are we?

Total FFT Program Completions (N=192)

Successful
Unsuccessful
Neutral

FFT program – Resolutions/Strategies

- Regular meetings with vendors and FFT trainers (both conference calls and F2F).
- Current structure allows for Court to be the center to mediate/negotiate differences.
- Request changes in leadership/staffing of vendors.
- Keep lines of communication open for both vendors and FFT trainers.

FFT program – Present and Future

- 2 more years of training.
- Currently planning on continuing with both vendors.
- Continuing education of probation staff to bolster number of referrals.
Feel free to contact us if you have any questions.

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County Population: 141,888
Bloomington Population: 81,963
**Indiana University:** 42,133
Largest Age Demographic: 18–44 (53%)

History of “What Works” in Monroe County, Indiana

- **1998** - Indiana Department of Correction hosted “What Works” conference.

- **2001** - Dr. Tom Sexton relocated to Indiana University–Bloomington, and asked the Juvenile Probation Court, “Do you want to deal with the juvenile offender as an individual or as part of a family?”

- **2005** - The partnership between Monroe County and Indiana University for Functional Family Therapy was recognized by the National Institute for Mental Health and Juvenile Justice as one of seven national model programs. Approximately 200 programs were reviewed for the recognition.

- **2007** - The Functional Family Therapy model in Monroe County received national recognition from the National Center for Mental Health and Juvenile Justice as a Blueprint exemplary program for diverting youth in the juvenile justice system.

**Functional Family Therapy is only for juveniles?**

No
Old School Corrections Mentality

When family members show up with the offender, do you let them come back to the appointment?

No

They are “enablers”

Evidence Based Practices demand that the old dogs need to learn new tricks!

ADULT officers learn DYNAMIC factors can change

- Gain employment
- Gain GED /education
- Gain financial stability
- Gain better living conditions
- Gain pro-social support
- Attitudes, Values & Beliefs
“Do you want to deal with the ADULT offender as an individual or as part of a family?”

Monroe County decided to pilot FFT for the adult population five years ago. This was the first known use of FFT for adults nationally.

The pilot received Bureau of Justice Assistance (BJA) grant funding to research effectiveness of FFT with the adult population¹.

CITATION
The findings were promising for significantly reducing the risk factors associated with the probability of re-offending while under traditional supervision:

- Significant improvements in Family Cohesion and Family Conflict
- Levels of distress had decreased significantly ($t(27) = -2.309, p = .029$) & psychopathology ($t(27) = -2.164, p = .039$).
- Statistically significant improvement in interpersonal relationships ($t(27) = -3.191, p = .004$).
- Correctional Assessment changes: statistically significant difference between the adults who participated in FFT and those who received supervised probation/community corrections only ($F(1,78) = 5.569, p = .021$).

Reducing “triggers”

- Approximately 80% of offenders on community supervision in Monroe County have a substantial history of substance abuse.
- We have heard so often, “If you had my wife, husband, kids - you’d drink too.”
- Criminal justice involvement is seen as being passed from generation to generation.
- Family names are automatically associated with criminal activity.
- What can we do?
Our latest FFT endeavor is to train & collaborate with the community.

- Providing DOC grant support for Dr. Sexton to train therapists from four (4) local treatment providers with an open door to train more agencies.

- In exchange, each therapist trained will provide free FFT services to 3 families - either juvenile or adult cases.

- Continuous Quality Improvement - probation management can audit online FFT team meetings between Dr. Sexton & therapists.

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Important Role in Evidence Based Practices

- Evidence based practices are only as good as they are implemented
  - Implemented in ways that match models (fidelity)
  - Implemented in ways that match clients (individualize treatment)
- We know more is needed
  - Most programs lost 50% of ES when moved to community
- Functional Family Therapy Story (Sexton & Turner, 2012)
  - EBT with 8 RCT trials over 30 years
  - Multiple non-randomized trials
  - Demonstrated improvements in:
    - Family functioning
    - Youth behavior disorders
    - Youth offending

Practicing Functional Family Therapy in Evidence-based Ways:
The role of collaborative clinical feedback systems

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**FFT in Community Setting**

[Sexton & Turner, 2010]

- 38%* reduction in felony crime
- 50%* reduction in violent crime
- $14.67 return for each $1 invested
- $2400 per family cost to implement

* Statistically significant outcome as compared to the random control condition.

**Ireland Retrospective Study Outcomes (2013)**

- Dropouts
- Low Adherent
- High Adherent

**Functionality of FFT-CFS**

- Systematic Case Planning
  - Integrating client feedback with model specific case planning guides
- Systematic Clinical Supervision
- Training and Implementing Monitoring tool
- Local evaluation and research tool
- Clients, dosage, core clinical processes, & outcomes

Through...being part of daily clinician work flow needs

- Treatment plans/progess notes/service reports
- Scheduling, case material
- Clinical measures
- Reporting (to organization) for billing/hours/activity
Functional Family Therapy Clinical Feedback System

Web-based
Secure
Data entry from computer, iPhone, & iPad or tablet

Major sections of the FFT-CFS:

1. Directory
   • Your list of clients…access to their information
   • Add clients, cases
   • Case feedback

2. Sessions/Schedules
   • Opening/closing sessions
   • Rating sessions

Documents & Sessions

Assessment Title: Child Indicators

Child Indicators (if any):

Critical Issue (if any):

Referral:

How do you refer?:

Mark: # or check:

Referred or Not:

Secondary: Yes, No, or NA

What is the situation:

What is the situation:

Other:

How do you know:

What is the situation:

Other:

How do you know:

Other:

How do you know:

Other:

How do you know:

Other:

How do you know:

Other:

How do you know:

Other:

How do you know:

Other:
Main sections of the FFT CFS:

### Reports

**Average Session Status Members vs Caremodel**
A dashboard showing the status of all or your clients during the sessions for your clients.

- Appointment Status with Monitor
- Complete
- In Session
- Rescheduled
- DOM

### Alerts

- Status
- Fidelity
- Comparisons to other case & to FFT standards

Your list of clients…access to their information

Summary information (closed cases, time in treatment/positive)

### Feedback report

Trend

Where you set & close appointments

Directory

Add clients, cases

### Status

It helps therapists focus on the

It keeps therapists focused on the

It helps therapists focus on the

### Service delivery profiles

Focus on in treatment

Identify who to target and

### Member Page

Feedback report

Glance Clinical Feedback

### Planning of FFT supervision

Clinical Feedback through a series of

### Comparison to other case & to FFT standards

Differences between

Comparisons to other case & to FFT standards

### Trends over time

Differences between

Trends over time

### FFT calendar

Planning of FFT supervision

For the therapist FFT

For the therapist FFT

### Attrition

**Feedback** in the CFS

Areas so that client reported

Areas so that client reported

Areas so that client reported

### Interventions for each phase of FFT

Differences between

Comparisons to other case & to FFT standards

### Routine participation

Researchers use it to gather

### Agencies use it as an outcome

Agencies use it as an outcome

### Measurement and program evaluation

Researchers use it for participant-based research

Researchers use it to gather

Researchers use it for participant-based research

### Supervisor based reports in four

Supervisor based reports in four

### Data collection

Data collection

### Data collection

Data collection

### Data collection

Data collection

### Data collection

Data collection
Client perspective of progress (SFSS)

• Questions & Comments

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