

The Development and Implementation of Functional Family Therapy- Child Welfare (FFT-CW)

An FFT Adaptation

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FFT-CW: Development History

FFT Model Developed: early 1970s by Dr. Jim Alexander

FFT LLC Formalized as Training Organization: Late 1990's

FFT-CW Adaptation: Circa 2010-2011

Early Large-Scale Implementation: Mid 2010's: NYC all 5 boroughs

General Information: Traditional FFT

11-18 years old

Youth behavior problems, such as conduct disorder, violence, delinquency, and substance abuse

Average of 12-16 sessions

Average length of service between 3-5 months

Youth living with/or expected to live with “family”



FFT LLC Dissemination

Over two decades of training community-based therapists

Supported clinical work in more than 40 US states and 14 countries

Worked with more than 500,000 youth and family members

Over 25 publications in the last decade demonstrating the positive impact of our work

General Information: FFT Child Welfare

0-18 Years Old

Indicated and/or at-risk youth and families

Child welfare referral issue: Abuse, neglect

Average of 12-20 sessions

Average length of service between 5-7 months

Children/Youth living with/or expected to live with “family”

The Context for FFT-CW

Why Was FFT-CW Developed

- To “address abuse, neglect, and associated risk/protective factors” with a family-systems, CBT approach.
- This was an explicit shift from standard FFT’s delinquency focus to the realities of child-welfare cases.
- Similar to YJ, we knew that child welfare services lack a coordinated plan that takes into account individual AND family needs
- “Safety” needs typically over-ride “clinical” decision making
 - Results in long term out-placement
 - Poor long-term outcomes
 - “Revolving door”

Why Was FFT-CW Developed

- FFT's experience working with System – Involved Families
- We knew what it takes to motivate families for change
- We had been working with child-welfare involved families through FFT for decades.
- We believed that by adapting FFT to the unique developmental stages of children and families we could be successful.

Functional Family Therapy-Child Welfare

- **Family-based model** that addresses a range of at-risk families
- **Cost-sensitive model** that uses a **triage** process to “match” typical child welfare workers skill sets and families needs
- **“General practitioner”** model that addresses full developmental range of youth and problems experienced by family members

General Practitioner Model

- Addresses spectrum of referral behaviors
- Focuses on problems for all family members
- Targets risk and protective factors across the social ecology

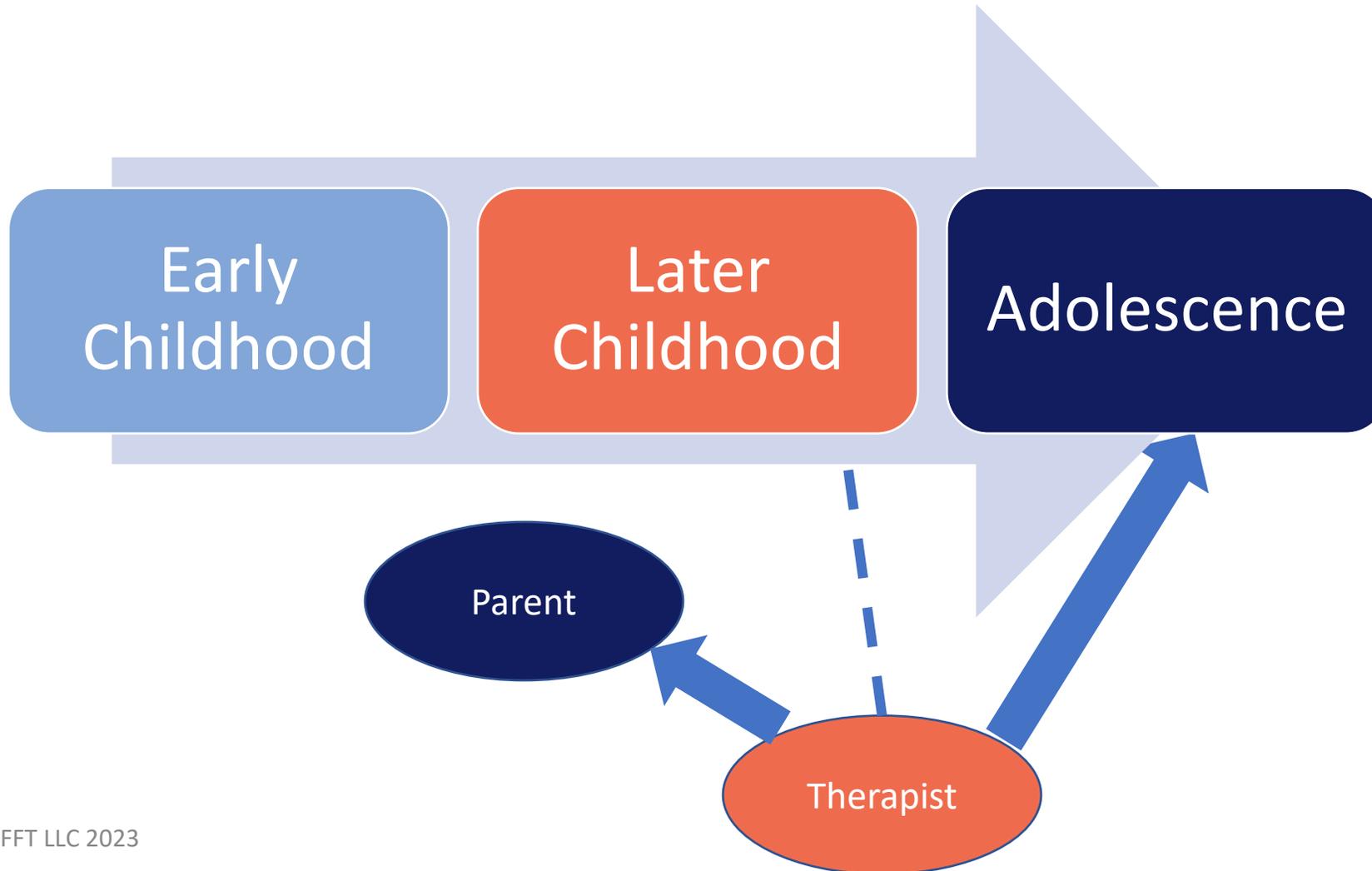


Functional Family Therapy-Child Welfare

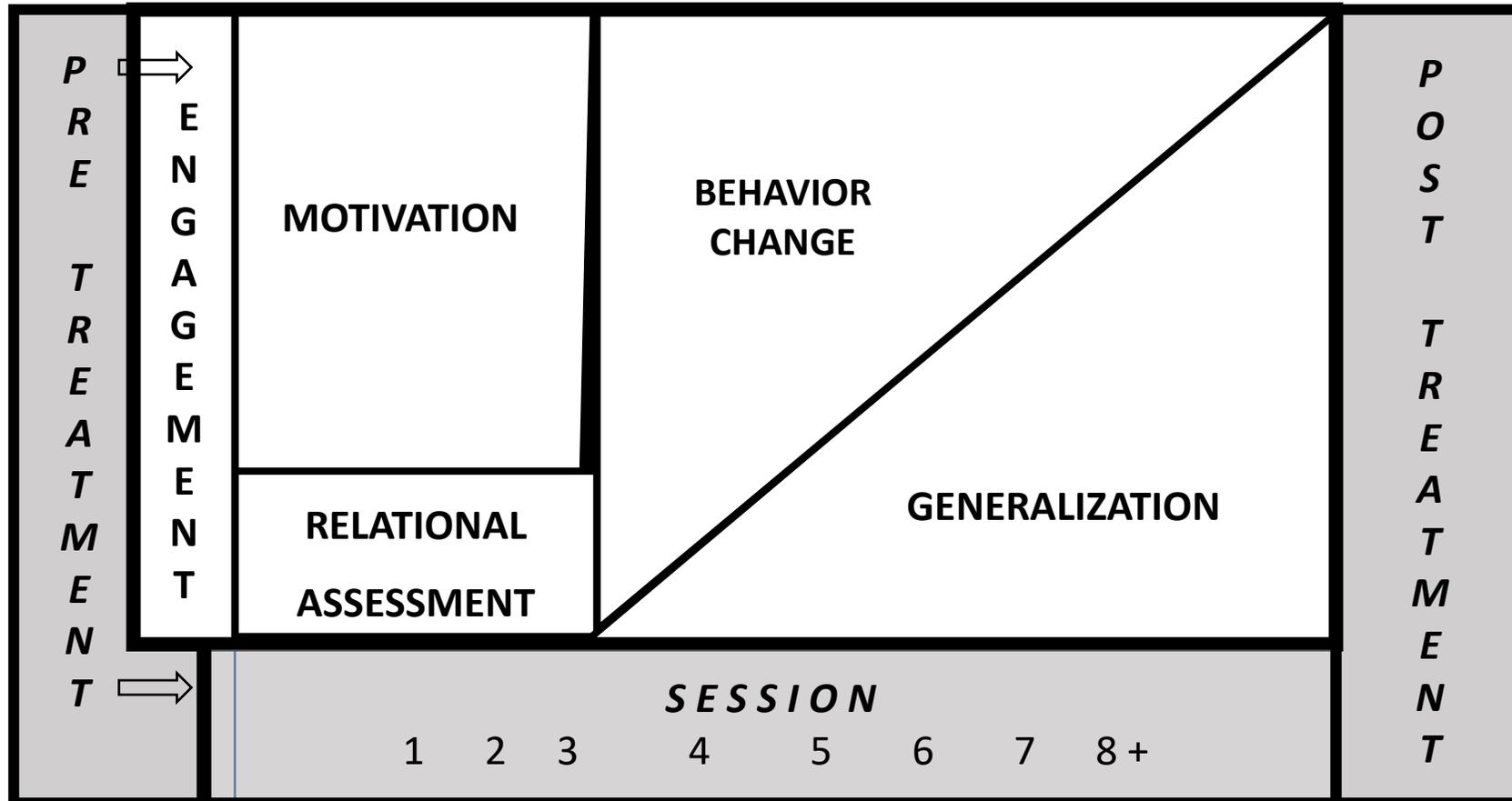
Risk Factors:

- Mental Health Issues: parents and/or youth
- Parental Substance Abuse
- Family Conflict, Harsh Discipline, Violence
- Environmental Stressors: Basic unmet needs, poverty, lack of safe housing, under-resourced communities
- Externalizing Behaviors in Youth (particularly older youth)

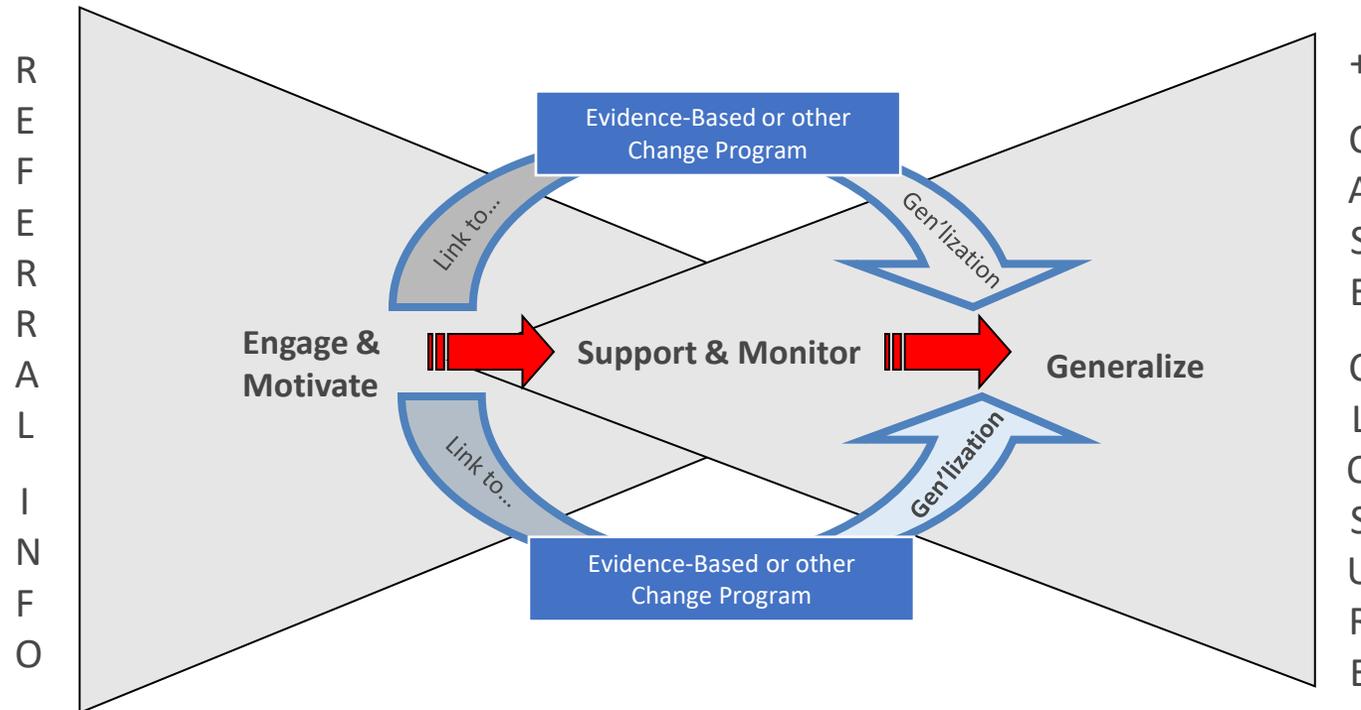
Implications on the Focus of Treatment



FFT-CW: High Risk Track



FFT-CW: LR or Case Management Track



Evaluating Impact: What Studies Show

NYC quasi-experimental evaluation (Turner, Robbins, Rowlands, Weaver, 2017)

Large citywide roll-out across all five NYC boroughs (FFT-CW n=1,625; usual care n=2,250; stepped-wedge design, 16-month follow-up). Key findings:

- ▶ **Faster completion** of services than usual care.
- ▶ **Higher likelihood of meeting all planned service goals.**
- ▶ **Fewer transfers** to other programs at case close.
- ▶ **Fewer recurring child abuse/neglect allegations** overall.
- ▶ **Out-of-home placement:** overall differences were not significant, **but** FFT-CW had **fewer placements among higher-risk families** (a subgroup effect).

Their Futures Matter Early Evaluation (UNSW/NDARC & Exhibit, 2020): NSW, AU

Outcome	Finding	Interpretation
OOHC Entry (All families)	Non-completers had up to 14.3× the odds of OOHC entry compared to FFT-CW High Track completers	Strong protective association for program completion
	Non-completers had 3.5× the odds vs Low Track completers	Directionally consistent, smaller magnitude
Sample sizes	High Track n = 120 • Low Track n = 23	Small but policy-relevant cohorts
Program completion	Families completing the program were less likely to experience OOHC entry within 12 months	Supports value of full engagement
Economic analysis	Interim benefit–cost ratio < 1	Early stage: costs exceeded monetised benefits (short horizon)

Evaluating Impact: On The Ground

Case Completion Data

- Completed, Non-Completed, Never Began

Family Risk and Protective Factors:

- Pre and Post Measures

Ultimate Outcomes

- Family Status at Time of Case Closure

Treatment Pacing

- Length of Service, Early Treatment Contacts and Sessions

FFT-CW Model Fidelity Structures



Adherence

- How much you utilize the model as your source of clinical intervention

Competence

- How well you perform the necessary skills and tasks outlined in each phase

Dissemination Adherence

- How well you are following the FFT implementation protocol

Training Structure

- **Phase 1:** Team Training (1 year)
- **Phase 2:** Supervisor Training (1 year)
- **Phase 3:** Ongoing support and partnership to ensure sustainability and model fidelity.

Funding Landscape

Medicaid

- Louisiana, Pennsylvania

Preventive Services

- New York City, New South Wales Australia

Private Funding

- California

Child Protection Department-Wide Implementation

- Wisconsin, Netherlands

Workforce Qualifications

FFT-CW High Risk

- Master's Level Clinician

FFT-CW LR Case Management

- Bachelor's Level Human Services

Promising FFT Adaptations:

FFT-Early Intervention

- 7-11 year-olds and their families

FFT-Emerging Adult

- Young Adults 18-23 and their families

What is FFT-CW?

Model Principles

FFT Principles

A Philosophy / Belief System about people which includes a core attitude of Respectfulness of individual difference, culture, ethnicity, family form

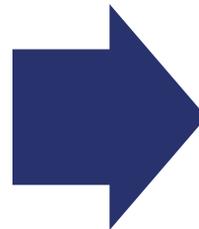
Family-focused intervention involving alliance and involvement with all family members (Balanced Alliances)

An overriding Relational (versus individual problem) focus

Therapists who are Non-judgmental and “avoid taking sides” or blaming family members

FFT Principles

“Strength Based” focus on risk and (especially) protective factors



Specific and individualized interventions for the unique challenges, diverse qualities, and strengths (cultural, personal, family forms) of all families and family members

A Strength-Based Relational Approach

Internal or ecological resources not in use by or available to the family (or community) at the time of the referral

A relentless focus on finding dignity, even (especially) about the referring behaviors and risk factors

Commitment to a focus on family

Matching

Interventions are specific and individualized to the unique challenges, diverse qualities (cultures, personal experiences), and strengths of all families and family members

Matching

The goal of FFT is not to create “healthy” or “normal” families according to someone’s theory or ideal, but ...

- to achieve changes that will help this family function in more adaptive, acceptable, productive ways
 - with their resources ...
 - and their value systems...
 - in their context

*This requires
relentless effort
to UNDERSTAND
and RESPECT
young persons
and families on
their terms*



Functional
Family Therapy

**For more information, visit
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