Program Summary:
Functional Family Therapy (FFT) is a short-term, behaviorally oriented family therapy program that targets youth ages 10-18 with severe behavior problems and chronic delinquency, as well as youth at risk for delinquency. Trained FFT therapists address a youth’s referral behavior by providing intensive family therapy to change patterns of family interaction that are contributing to the problem behavior and by helping family members develop specific skills (e.g., communication, problem solving, conflict resolution and effective parenting skills). After change has been achieved within the family, the FFT therapist helps the family generalize changes to other situations and settings, such as peers, school, and community, and identifies supports that can help to maintain the progress made. Treatment is structured around five phases of treatment, each with specific assessment and intervention components that are tailored to the unique characteristics of each family. Sessions occur at least once per week and more often if needed, typically for 3-4 months, and can be delivered in both community-based and office-based settings. Research shows that FFT reduces the likelihood of out-of-home placement, reduces youth substance use and criminal recidivism, and improves family functioning and youth behavior. FFT is an evidence-based treatment program and is recognized as a Blueprints for Healthy Youth Development Model Program.

Developer: James F. Alexander, Ph.D., FFT Inc.
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FREQUENTLY ASKED QUESTIONS

1. What population is FFT designed to target?
2. What risk and protective factors does FFT target?
3. What kind of outcomes can be expected from FFT?
4. How does FFT work?
5. How do FFT therapists spend their time?
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16. What evaluation tools should we use?
17. In what ways can we involve our local collaborative board and key stakeholders?
18. Are there other sites in PA implementing FFT?
1. **What population is FFT designed to target?**

   FFT was developed to address the treatment needs of adolescents presenting with or at risk for delinquency, including those with substance abuse issues. FFT has been used effectively with youth and families from a variety of racial, ethnic, and socioeconomic backgrounds, from rural to metropolitan areas. The model strives to be culturally responsive, with an emphasis on respect, non-judgment, and understanding each family on its own terms.

   The following eligibility criteria would be appropriate for an FFT program:
   a. Ages 10-18 years.
   b. Youth presenting with externalizing behaviors, ranging from oppositional, defiant, and disruptive behaviors (at risk for delinquency) to serious, chronic criminal offenses.
   c. Youth with a primary substance abuse diagnosis. (Note: In Pennsylvania, providers who treat substance abuse must be appropriately licensed to do so by the Department of Health.)
   d. Poor family relationships and/or negative parenting practices.
   e. Youth with a wide range of co-morbid diagnoses including serious mental illness are appropriate for FFT so long as the youth also presents with externalizing behavior and does not meet the exclusionary criteria listed in (f).
   f. The main concern is not sexual offending or sexual abuse, and the youth does not present with acute suicidal, homicidal, or psychotic symptoms.
   g. The youth lives in the community or is ready to live in the community.
   h. There is at least one caregiver willing to participate in treatment. Youth is not living independently or in serial placements.

   In Pennsylvania, when services are funded by Medical Assistance youth need to meet medical necessity guidelines and the eligibility criteria in the provider’s OMHSAS-approved service description. Furthermore, according to state policies, best practice dictates that referral decisions be based on evaluation of the youth by a licensed psychologist or physician and input from the child’s treatment team. This team includes the youth and family as key decision makers in the process.

2. **What risk and protective factors does FFT target?**

   **Protective Factors Targeted for an Increase**
   - Positive parenting
   - Family cohesion and bonding
   - Supportive communication within the family
   - Positive peer relationships
   - Positive school-family and community-family relationships
   - Therapeutic alliance; Therapist and program credibility (increases likelihood of treatment completion)

   **Risk Factors Targeted for a Decrease**
   - High family conflict
   - Negative and blaming communication patterns within the family
   - Poor parenting skills
   - Low social support
   - Family hopelessness

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3. **What kind of outcomes can be expected from FFT?**

The goal of FFT is to change the maladaptive behaviors of challenging youth and families using a short-term, cost-effective treatment model, in turn creating more positive outcomes for those youth, their families, and their communities. Research conducted by both the program’s developers and independent evaluators over the past 40 years shows that FFT is successful in achieving these goals.

Research studies* have shown that when compared to youth who received alternative services such as individual therapy, group therapy, and probation, youth who received FFT:

- Had higher rates of treatment completion.
- Were less likely to be placed out of home.
- Had improved family functioning, as evidenced by improved communication, increased family cohesion, and less verbal aggression and family conflict.
- Had decreases in delinquent behavior and general behavior problems.
- Had improved mental health, as evidenced by decreases in both internalizing and externalizing symptoms at discharge and fewer diagnoses up to 15 months after treatment.
- Had lower rates of drug and alcohol use more than a year after treatment.
- Had 20-60% lower rates of court referral, arrest, and criminal convictions up to 5 years after referral to FFT.

In addition, when compared to other family treatments, FFT resulted in a 65% decrease in the likelihood a youth’s sibling would come in contact with the court over the next two to three years.

For additional information about research outcomes:

- The FFT Inc web-site provides a list of research articles demonstrating the impact of FFT - [http://www.fftinc.com/about_effect.html](http://www.fftinc.com/about_effect.html)
- Outcomes specific to Pennsylvania as well as a logic model highlighting key research findings are available at the EPISCenter web-site - [www.episcenter.psu.edu/ebp/familytherapy](http://www.episcenter.psu.edu/ebp/familytherapy) and [www.episcenter.psu.edu/EBIReports](http://www.episcenter.psu.edu/EBIReports)

*The studies reviewed included five randomized trials, two studies with matched control groups, and two quasi-experimental studies.

4. **How does FFT work?**

FFT is based on the theory that youth’s problem behaviors serve a function within the family. Family members develop ways of interacting that help them to get their relational needs for closeness or distance met, but these patterns of interacting may also create or maintain behavior problems. When changes are made in how the family interacts (e.g., improving communication, problem-solving, and parenting skills), youth behavior problems will be resolved. Interventions are individualized to each family’s unique characteristics and emphasize enhancing protective factors while reducing risk factors.

A trained FFT therapist meets with the family at least once a week and more often if needed, generally for 3 to 4 months. FFT works with the entire family, so the youth and at least one caregiver must be present at
each session; consequently, sessions are often held afterschool and on evenings and weekends. Sessions may occur in the home or office. (Note: In Pennsylvania, MA-funded FFT must be delivered in the home.)

FFT is organized around five phases of treatment, each with specific assessment and intervention components that are tailored to the unique characteristics of each family. Early in treatment, the emphasis is on engaging family members and motivating them to participate in therapy. The therapist then conducts an assessment of the family, which is used to guide interventions for behavior change. Interventions focus on changing patterns of family interaction that are maintaining the problem behavior and often include psychoeducation, parent training, and skills training (e.g., communication, problem solving, conflict resolution skills). 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 and to situations outside of the home, such as problems that may be occurring at school. The therapist also helps the family develop supports and resources to promote lasting change.

The FFT model does not allow FFT therapists to be on-call around-the-clock, although the agency providing FFT may also provide crisis services. In order to reduce the need for after-hours crisis intervention, the FFT therapist provides crisis prevention by using interventions in the early phases of treatment that reduce crisis behaviors and by meeting with the family more often when risk for crisis is high. The intent of this approach is to empower the family and reduce reliance on formal systems.

5. How do FFT therapists spend their time?
FFT therapists spend their time engaged in a number of clinical activities:
- Carrying a caseload of 10-12 clients (for home-based FFT), all of whom are generally seen in the late afternoon and evening hours or on weekends
- Completing paperwork and documentation related to planning for cases, complying with state regulations, and meeting the requirements of funding sources
- Traveling to and from client homes
- Phone contacts and other communication with referral sources and the systems involved with each youth
- Maintaining client information in FFT’s web-based Client Services System (CSS)
- Attending mandatory weekly supervision (1 – 2 hours/week)

On average, FFT therapists spend 2.5 – 4 hours/week on each case including at least one hour of face-to-face time with the youth and family. However, this varies considerably depending on factors such as the clinical need of each case, therapist experience with the model, travel times for the community being served, and documentation requirements for funding sources. For example, Medical Assistance funding in Pennsylvania requires the completion of MA-compliant session notes and treatment plans, which increases the documentation time per case. If a site does not have dedicated administrative support to coordinate meetings, facilitate access to funding, and so forth, these responsibilities may fall to the clinician.
6. **What is the implementation process for FFT in Pennsylvania?**

Before the decision is made to implement FFT, an interested provider or community should:

- Contact FFT Inc. for information about the model.
- Complete a community needs assessment. The community should consider the target population for FFT, risk/protective factors addressed by the model, and the outcomes they hope to affect by implementing FFT. An FFT program will typically need at least *90 opened cases each year* to support a team.
- Evaluate program feasibility. In addition to determining there is a need in the community:
  - Engage in dialogue with key stakeholders, including the county juvenile justice, child welfare, and mental health offices, Health Choices, and the Behavioral Health-Managed Care Organization. It is essential that the program has the support of these stakeholders *prior* to decision to implement and that they are invested in being active partners in the implementation process. For example, are county leaders willing to participate in regular meetings with the provider to ensure that implementation is successful? Are they willing to collaborate on processes to facilitate referrals and make funding accessible?
  - Identify if and when funding will be available. FFT programs in Pennsylvania are generally funded by a combination of Medical Assistance dollars and county funds. If the county plans to request a Special Grant through the Needs Based Plan and Budget process, funds must be requested almost a year in advance. For example, funds for Fiscal Year 2014/2015 must be requested in August 2013. Similarly, Health Choices programs often plan far in advance when bringing in new services for funding.

If the decision is made to pursue FFT, the readiness and planning process commences. The length of time needed to complete this process depends on a number of factors, but the process can be expected to take a *minimum* of 2 months. The provider will need to:

- Complete an application for site certification and submit it to FFT Inc. The application is reviewed by FFT Inc. and revised by the provider as needed.
- Contact the OMHSAS Children’s Bureau for a sample service description. The Children’s Bureau is also available to provide technical assistance to providers as they develop their service descriptions. The service description must then be submitted to OMHSAS Children’s Bureau for review and approval.
- Follow the BH-MCO process for becoming an enrolled FFT provider and negotiate a rate.
- Finalize a contract with the county. The clarification letter issued in January 2011 regarding the use of Special Grant funds may be useful in this process and can be found at [www.episcenter.psu.edu/resources/DPW](http://www.episcenter.psu.edu/resources/DPW)
- Hire staff.
- Engage in activities to educate referral sources and build interest in the program (e.g, presentations, mailings, open houses). A number of resources are available on the EPISCenter FFT page: [http://www.episcenter.psu.edu/ebp/familytherapy](http://www.episcenter.psu.edu/ebp/familytherapy)
- Participate in a one-day implementation / CSS (Client Services System) meeting conducted on-site.
- FFT Therapists attend a 2-day clinical training held on-site.
- Immediately following training, therapists begin seeing cases. Each therapist should have 5-6 cases to begin with.

The provider and community leadership should continue to work closely throughout this process, communicating regularly and planning collaboratively, to ensure a plan for long-term sustainability of the program. **Readiness and Planning Tools**, designed to help communities assess whether FFT fits with local needs and plan for sustainable implementation, are available at [http://www.episcenter.psu.edu/counties-EBIs](http://www.episcenter.psu.edu/counties-EBIs)
The EPISCenter is available to assist communities and providers with this process, from the point of a needs assessment through implementation.

FFT sites move through three phases of implementation, which are designed to train therapists who understand the FFT model, build an infrastructure to support the program, and gradually move the program toward greater self-sufficiency. Initially, FFT Inc. is closely involved with a site, even providing the weekly clinical supervision. As a site moves through the three phases and trains its own FFT site supervisor, FFT Inc. becomes less involved but continues to provide monitoring of the program, hold monthly phone calls with the site supervisor, and train new hires. Phase I typically lasts 12-18 months; Phase II lasts 12 months; Phase III lasts indefinitely.

7. What staff is needed for an FFT program?

Clinical Staff
FFT is delivered by individual therapists who are organized into sites (teams) comprised of 3-8 clinicians who meet regularly to staff cases and receive supervision/consultation together. Each site is assigned an FFT National Consultant employed by FFT Inc.

- FFT Therapists: For home-based services, a full-time FFT therapist carries a caseload of 10-12 families. FFT therapists should have a graduate degree in psychology, counseling, marriage and family therapy, social work or a related area. A solid background in family and systems theory and experience providing in-home services to high risk families are also beneficial. FFT strongly recommends that therapists be assigned to the program full-time. Providers considering using part-time therapists should discuss this with FFT Inc. When hiring FFT therapists programs should be cognizant of the fact that, while FFT does not provide 24/7 on-call to families, therapists primarily work late afternoons, evenings, and possibly weekends, in order to meet with entire families. A sample FFT Therapist Hiring Checklist can be found on the EPISCenter web-site: http://www.episcenter.psu.edu/ebp/familytherapy

- FFT Site Supervisor: As an FFT site moves toward Phase 2 of the three phases of implementation, an FFT site supervisor is identified (typically from the existing group of FFT therapists) and trained. The FFT site supervisor should be a masters-level clinician (see Therapist qualifications above). In addition to clinically supervising the FFT therapists, the site supervisor is expected to carry a caseload of at least five FFT cases.

Administrative & Support Staff
Additional information about administrative tasks and the importance of having designated staff responsible for these tasks, rather than assigning them to clinical staff, is available in Administrative Duties in EBIs, available at http://www.episcenter.psu.edu/counties-EBIs.

- FFT Administrator: The administrator is typically responsible for managing caseloads, collaborating with referral sources and stakeholders, overseeing compliance with agency policy and procedures, ensuring that the FFT program has adequate agency resources, and communicating and addressing clinical risks and other serious issues at the agency level. While some agencies place these responsibilities on the FFT site supervisor, such an arrangement often becomes burdensome for the supervisor, whose primarily role should be to manage the program clinically.

- Support Staff: Sites benefit from having staff available to provide case management and administrative support. Programs may spend a considerable amount of time helping youth become M.A. eligible, obtaining authorizations for care, scheduling evaluations and Interagency Service Planning Team (ISPT) meetings, tracking data required by funders, and so forth. It is not only more cost-effective to identify support staff to assist with these tasks rather than place the responsibility on clinical staff, but it also
allows clinical staff to focus their time and energy on providing care to clients and their families. It is strongly recommended that sites budget for support staff that can be responsible for these tasks.

When hiring, sites should be aware of staff qualifications required by their local or state licensing entities and funders, in addition to the guidelines of the FFT model.

8. What kind of training is needed for FFT?

FFT therapists and site supervisors must attend FFT trainings facilitated by FFT Inc. The frequency of training sessions is highest when a site is in Phase 1 of implementation and for newly hired staff. Supervision and consultation are also important parts of training.

- **Phase 1**
  - 1 day stakeholder meeting and team implementation/CSS training, plus a 2-day clinical training (on-site, prior to services starting)
  - 2-day clinical training (off-site, typically in Florida or Ohio, 6-8 months after services begin)
  - Three 2-day follow-up clinical trainings focused on model fidelity (on-site)
  - Team member identified to become site supervisor attends externship (3 trainings over 3 months, off-site, typically in Philadelphia or Florida)
  - Site receives at least 1 hour/week of phone consultation from an FFT National Consultant and 1 hour/week of peer supervision, both in group format

- **Phase 2**
  - Two 2-day site supervisor trainings (off-site, typically in Florida or Ohio)
  - 2-day team training (on-site)
  - FFT National Consultant provides phone consultation to the FFT site supervisor every other week and provides consultation to the site as needed
  - Group supervision led by FFT site supervisor (minimum 1 hr/week)

- **Phase 3**
  - 1 day per year of training and face-to-face consultation for therapists and site supervisor, provided by FFT National Consultant (on-site)
  - FFT National Consultant provides monthly phone consultation to the FFT site supervisor and provides consultation to the site as needed
  - Group supervision led by FFT site supervisor (minimum 1 hr/week)

It is recommended that therapists receive an additional hour/week of group or individual supervision

New hires (i.e., additions to the team or replacement staff) must attend a Replacement Training Series. There are two options for this series:

- **The Regional Replacement Training Series**: Beginning in September 2013, Pennsylvania sites have the option of sending new hires to a regional series which occurs 3 times per year. The location rotates between Pennsylvania, Maryland, and Washington DC.


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In both options, FFT therapists from various sites come together and move through the training series in a group referred to as a “cohort.” Once a therapist begins training, he/she must complete training activities as scheduled with his/her training cohort. The Replacement Training Series includes:

- Month 1: 2 ½-day clinical training (off site)
- Month 2: 2-day follow-up training (off site)
- Month 3: 2-hour conference call

In addition to the FFT-specific trainings described above, staff should receive training in areas such as HIPAA, clinical documentation, client-therapist boundaries, CPR/First Aid, mandated reporting requirements, crisis management, psychotropic medications and side effects, and so forth, to meet state and agency training requirements.

9. How much does FFT training cost?
   The cost of site training is included in the annual fees paid to FFT Inc., with the exception of travel. The site is generally responsible for travel costs incurred by the National Consultant or National Trainer when he/she provides on-site trainings or visits (e.g., airfare/mileage, hotel, meals). There are also travel costs associated with trainings that occur off-site. Typical locations include West Palm Beach, FL; Lima, OH; and Philadelphia, PA. Estimated travel costs associated with each phase are included in FAQ #10.

Once the initial team has been trained, there are fees and travel costs associated with training new hires who must attend the Regional or National Replacement Training Series. The Regional Series is offered three times per year; sites pay a portion of the training fee and therapist travel costs. The National Series is held monthly; sites pay the full training fee and therapist travel costs. Again, specific costs can be found in FAQ #10.

10. What FFT costs should I budget for?
   The costs outlined below are intended to give a general idea of the expenses of implementing an FFT program:

   - **Site Certification Training Activities and Services**: Annual fees are paid to FFT Inc. for trainings, consultations, and the use of the web-based Client Services System (CSS). The specific activities included and the amount of the fee varies depending on the site’s Implementation Phase. Providers should also keep in mind that it is sometimes necessary for sites to return to a previous phase of implementation. For example, if a site in Phase 3 must train a new site supervisor, the site returns to Phase 2, which has higher fees. **Sites should plan ahead for this possibility.**
   - **Travel Costs**: The site is generally responsible for travel costs incurred by the National Consultant or National Trainer when he/she provides on-site trainings or visits. There are also travel costs associated with therapist and supervisor trainings that occur off-site. (See FAQ #8 and #9 for details.)

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<th>Annual Fees*</th>
<th>Estimated Travel Costs*</th>
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   | Phase 1 | $36,000 / year | $10,311 (for a team of 3)
   |         |              | $12,963 (for a team of 6)
   |         |              | $14,731 (for a team of 8) |
   | Phase 2 | $18,000 / year | $2,270                  |
   | Phase 3 | $10,000 / year | $652                    |

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• Training Fees & Travel for Replacement Training: Once the initial team has been trained, there are fees and travel costs associated with training new hires who must attend an off-site Replacement Training Series (see FAQ #8 and 9 for information). As noted above, sites may need to train new staff at times the in-state series is not available and should budget for the cost of sending staff to the National Replacement Training Series when necessary.

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<tr>
<th></th>
<th>Training Fee (amount paid by provider)*</th>
<th>Estimated Travel Costs*</th>
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<tbody>
<tr>
<td>Regional Training Series</td>
<td>$600 per person</td>
<td>$1,200</td>
</tr>
<tr>
<td>National Training Series</td>
<td>$1,600 per person</td>
<td>$1,900</td>
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*Fees and estimated travel costs are subject to change. Interested sites should contact FFT Inc. for a detailed breakdown of current fees and estimated travel costs.

• Staffing: Staff costs include salaries and benefits. (See FAQ #7 for information about staffing.)

• Assessment Measures: FFT utilizes specific assessment tools. Three of these tools – the Outcome Questionnaire, Youth Outcome Questionnaire, and the Youth Outcome Questionnaire-Self-Report – must be purchased by the site for use with clients.

• Operational Expenses: This includes but is not limited to office space, cell phone plans for clinical staff and supervisors, internet fees, mileage, and so forth. If any office-based services will be delivered, appropriate space must be available.

• Equipment & Furnishings: FFT programs need an office to serve as “home base” where staff can meet for supervision and meetings, documentation can be completed, files can be stored, and so on. An example of equipment and furnishings for one team may include a meeting table with chairs; a high-quality speaker phone; a desk and office chair for the site supervisor; work space for therapists (tables and chairs); a computer work station equipped with a PC, printer, and scanner; laptops with internet access for therapists; fax machine; office phone; copier; bookcase; storage cabinet; and large filing cabinet.

• Office Supplies: This includes items such as writing instruments, paper, file folders, staples, tape, staplers, a hole-punch, and so forth.

In Pennsylvania OMHSAS does not approve a new FFT provider for Medical Assistance funding until the site is FFT-certified, which typically occurs 6 weeks after service delivery begins. Therefore, clinical services provided during the first several weeks of implementation will not be M.A.-billable. Sites should anticipate and plan for this funding gap prior to implementation.

11. How many cases are needed to support an FFT site?
The number of cases needed annually varies depending on the size of the FFT site, whether therapists work part-time or full-time, and whether FFT is delivered in the office or in families’ homes. For community-based FFT, a small team of two full-time therapists and one site supervisor would need at least 90 cases per year. A large site with eight clinicians can serve over 300 clients per year under ideal circumstances.
12. What is the cost per youth?

The costs associated with an FFT program vary depending on a number of agency-specific and community factors. For example, program size, staff salaries, and the amount of travel associated with the region covered by the program all affect the budget and consequently the cost per case served. In the United States, the cost per youth generally ranges from $3,200 to $4,000. Costs can be expected to be higher when there are greater administrative demands due to the requirements of funders.

13. How is model fidelity monitored in FFT?

FFT’s web-based Client Services System (CSS) is the primary tool used to monitor program fidelity. Clinicians are required to document cases using the CSS, which is designed to ensure that the goals and interventions at each session are consistent with the family’s phase of treatment and the FFT model. Supervisors and consultants review documentation in the CSS as one way to monitor therapists’ adherence to the FFT model. Therapist alliance with family members, which is emphasized from the start of treatment and is critical to the model, is monitored by the Family Self Report (FSR) and Therapist Self Report (TSR), rating scales completed by the therapist and every family member after the first and second sessions. FSR and TSR scores help therapists identify when an alliance is not developing as it should.

In addition, specific adherence measures are collected in the CSS and monitored by the site supervisor and National Consultant. After supervision each week, the supervisor or consultant rates each therapist on a number of factors based on cases he/she discussed during supervision. At least three times per year these ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists’ adherence to and competence in the model. The Global Therapist Rating includes two scales:

- Dissemination Adherence, which is the degree to which the therapist adheres to FFT protocols such as timeliness of documentation, appropriate spacing of sessions, flexible scheduling, responsiveness to community partners, etc.
- Fidelity, which considers both therapist competence (e.g., sophistication of interventions, tailoring treatment to the family) and adherence (e.g., applying the model as intended and doing the “right thing at the right time”).

Cut-off scores indicate whether the therapist demonstrates satisfactory dissemination adherence and model fidelity, and each therapist has a Learning and Growth Plan to facilitate adherence and competence.

The FFT certification process described in FAQ #14 is also used to monitor model adherence.

14. What is the certification process for FFT?

The FFT certification process in Pennsylvania differs from the process used elsewhere and is driven in part by state standards for FFT. New sites receive their certification 6 weeks after completing the initial 2-day clinical training. Existing agencies who wish to add a new site/team are able to obtain a six-week pre-certification, if they are in good standing with FFT Inc. Sites are reviewed at least every 6 months and recertified annually. A Pennsylvania Site Certification Specialist (from FFT Inc.) collaborates with the site’s FFT National Consultant when conducting certification reviews. The areas of review vary depending on the site’s implementation phase, and improvement plans are developed when necessary.
15. What are some common challenges we might encounter when implementing FFT?

- **Sufficient referrals** – Even when community interest and buy-in is established up-front, programs often struggle to receive enough referrals to reach the desired program census. When FFT is new to a community, it may be competing with long-standing, more familiar programs. Furthermore, as an evidence-based program, FFT has specific eligibility criteria and referral sources may become discouraged when a youth cannot be accepted to the program. On-going outreach to potential referral sources to build relationships, educate them about the model, discuss possible referrals, and highlight positive outcomes is essential, as is follow-up with the referral source when a referral is not appropriate. Program-community partnership is also an important tool for addressing referral issues. Programs should work with stakeholders to create a smooth referral process and problem-solve with community leadership when referrals are low. Communities may need to make a concerted effort and have a process in place to ensure youth are referred to FFT, especially when the program is first establishing itself.

- **Creating and maintaining stakeholder buy-in** – While leadership of county agencies may be supportive of FFT, this does not always translate into interest and buy-in from the people who actually make referrals. It can be challenging to convince child welfare workers, probation officers, and judges to refer youth to a program that is unfamiliar. Repeated outreach may be needed to educate referral sources about the model and provide evidence of program effectiveness. Further, initial support and even excitement from community leadership may wane over time. Regular meetings between the FFT program and community leadership to assess the program’s progress and identify challenges to sustainability are critical to collaborative problem-solving, especially during the first years of implementation.

- **Ensuring services can start quickly** – The FFT model dictates that services begin quickly when a youth is referred. In fact, adherence data monitored in the FFT Client Services System includes the number of days from referral to first session. In Pennsylvania, where communities often look to Medical Assistance to fund FFT, this can pose a challenge. Youth may not have M.A. at the time of referral and, even if they do, many BH-MCOS require that youth have a psychological/psychiatric evaluation and interagency service planning team meeting before services are authorized. This generally takes a minimum of two weeks but often much longer. Medical Assistance cannot be depended on as the sole source of funding. It is imperative that FFT providers and county stakeholders work together on a plan to ensure services can begin quickly. The resource **Starting Services Quickly** may be a useful guide and is available at [http://www.episcenter.psu.edu/counties-EBIs](http://www.episcenter.psu.edu/counties-EBIs). It is also important that the protocol to access local funding be a simple one – complicated, unclear, or prolonged procedures generally discourage referral sources from making referrals to a program and can delay the prompt initiation of services.

- **Adequate revenue** – While FFT is one of the most cost effective EBPs in the state, sites need to make sure they generate enough revenue to cover staff and model costs. This will only occur if the site has adequate referrals (discussed above) but also a sufficient rate of reimbursement and a clear plan for braiding funding from various sources. When establishing a budget, sites should consider what is realistic in terms of the number of billable hours per week – first clarifying with funders what activities can actually be billed and then estimating billable hours/week accordingly. It is often necessary for the site to educate the funding source about the model parameters for caseload, therapist activities, and so forth, as well as present information about the impact of a unit rate vs. a weekly rate. The potential cost of moving back to an earlier phase of implementation should be planned for, as should the cost of training replacement staff and the salaries of administrative and support staff that are needed to ensure clinicians are not burdened with unnecessary administrative responsibilities. The **Collaborative Funding Plan** tool, available at [http://www.episcenter.psu.edu/counties-EBIs](http://www.episcenter.psu.edu/counties-EBIs), was designed to help providers and local stakeholders develop a clear and comprehensive plan for funding.

- **Complying with state regulations** – In Pennsylvania, virtually all FFT programs receive at least some funding from Medical Assistance and must comply with regulations for billing M.A. as well as regulations pertaining to the provision of mental health services. Programs must ensure that administrators and
staff are familiar with licensing and funding requirements before the program is implemented. The **FAQ Regarding M.A. Enrollment, Billing, and Program Monitoring** may be a helpful starting point for becoming familiar with OMHSAS expectations and is available at [http://www.episcenter.psu.edu/resources/DPW](http://www.episcenter.psu.edu/resources/DPW).

- **Comfort with program performance monitoring** – FFT providers must participate in regular reviews of therapists’ dissemination adherence and fidelity and client outcomes, as well as be reviewed for certification processes. Not only must therapists be open to receiving feedback about their performance, but the program as a whole needs an attitude of openness to receive and use feedback to ensure a positive impact on the clients served. In Pennsylvania, state funders expect FFT sites to provide data related to specific Performance Measures, and many county stakeholders expect regular outcome reporting. Some providers, not accustomed to this level of accountability, may be uncomfortable with the process and perceived scrutiny. While the EPISCenter and FFT Inc. are both available to assist sites with the technical aspects of program measurement, it is important for sites to recognize the value of having outcome data available. A “results orientation” helps to maximize model fidelity and youth outcomes, demonstrates to stakeholders that the program is committed to having a significant impact on the community and ensuring community resources are well-spent, and is consistent with the spirit of evidence-based programming.

**16. What evaluation tools should we use?**

All FFT providers are required by FFT Inc. to use the web-based Client Services System (CSS), which collects information pertinent to monitoring sites’ fidelity and key outcomes. As part of the implementation process, FFT Inc. trains sites on how to use the CSS. FFT also utilizes specific assessment tools. Three of these tools – the Outcome Questionnaire, Youth Outcome Questionnaire, and the Youth Outcome Questionnaire-Self-Report – must be purchased by the site for use with clients, while other measures are available from FFT Inc. or within the CSS.

State-funded FFT sites in Pennsylvania are expected to utilize the web-based INSPIRE system to track additional data about each youth at enrollment, discharge, and follow-up. Using INSPIRE enables sites to easily generate outcome reports that address youth and parent satisfaction, successful vs. unsuccessful discharges, and the percent of youth who remain drug-free, avoid re-arrest, remain in the community, improve school attendance and performance, and improve family functioning. These outcomes must be reported on a quarterly basis to the EPISCenter, which is tasked by the state with monitoring the impact of evidence-based programs. INSPIRE-related resources, including **FAQ**, **Screen Guides**, and **Data collection Worksheets**, are available on-line at [http://www.episcenter.psu.edu/node/181](http://www.episcenter.psu.edu/node/181).

The EPISCenter is available to provide training in INSPIRE and help sites develop an evaluation strategy for FFT.

**17. In what ways can we involve our local collaborative board and key stakeholders?**

- Before deciding whether to implement FFT, meet with county leadership. This may take the form of a local collaborative board and at minimum should include representation from the county children and youth agency, juvenile probation, and mental health including Health Choices. Present the research on FFT, how FFT fits with local needs, and share your local goals for the program. Work together on a community needs assessment.
• Identify potential program champions or community gatekeepers that can advocate for the FFT program and help build relationships that may lead to program support from other key stakeholders. Sites can benefit from having multiple champions.
• Provide collaborative board members, county leaders, and potential referral sources with a fact sheet and the program’s logic model.
• Identify who is involved in securing sustainability funds, such as negotiating a managed care rate and requesting Special Grant funds in the Needs Based Plan and Budget.
• Establish a schedule for regular meetings with county leadership during the planning and start-up phases, as well as during the first years of implementation. These meetings can be a valuable tool for working collaboratively and problem-solving together as challenges arise, as well as sharing the successes of the program.
• Ask key stakeholders to help develop a clear, detailed plan to ensure youth are referred to the program.
• Identify stakeholders who can assist with providing follow-up data about recidivism and placement stability.
• Provide frequent verbal reports on the program’s impact and at least annually provide a written summary of program outcomes.

18. Are there other sites in Pennsylvania implementing FFT?
FFT has been active in Pennsylvania since 1998 and there are currently has a number of FFT sites across the Commonwealth. A list of sites is maintained on the FFT Inc. website at http://www.fftinc.com/sites_us.html#map.

Sources for this FAQ


FFT LLC. (2006). FFT site certification training services, estimated travel expenses, and other estimated implementation costs. Available upon request from FFT Inc.

