FUNCTIONAL FAMILY THERAPY (FFT) AND FUNCTIONAL THERAPY – CHILD WELFARE (FFT-CW)

The provider agency must have a current certification issued by the Institute for Functional Family Therapy (FFT), Inc. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with FFT, Inc. for training, supervision and monitoring of services. This occurs primarily through a FFT national consultant. The provider will also have a contractual relationship with FFT, Inc., allowing the provider to deliver the licensed FFT model.

FFT services are targeted for youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (attention deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

1. Youth, ages 10-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate;

2. At least one adult caregiver is available to provide support and is willing to be involved in treatment;

3. A DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance use disorders may be secondary;

4. Functional impairment not solely a result of an autism spectrum disorder or intellectual disability;

5. Youth displays externalizing behavior, which adversely affects family functioning. Youth's behaviors may also affect functioning in other systems; and

6. Documented medical necessity for an intensive in-home service.

Functional Family Therapy – Child Welfare (FFT-CW) services are targeted for youth and families with suspected or indicated child abuse or neglect. Problems include youth truancy, educational neglect, parental neglect or abuse, a history of domestic violence, adult caregiver substance use, and adult caregiver anxiety, depression and other mental health issues. Youth may also meet criteria for a disruptive behavior disorder (ADHD, ODD, and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and BH issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance use issues may be included if they meet the criteria below, and FFT-CW is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

1. Families of youth, ages 0-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate;

2. At least one adult caregiver is available to provide support and is willing to be involved in treatment;

3. DSM-5 diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder or internalizing psychiatric conditions and substance use. Diagnosis can be for youth or caregiver;

4. Functional impairment not solely a result of an autism spectrum disorder or intellectual disability; and

5. Documented medical necessity for an intensive in-home service.

FFT and FFT-CW are deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 (0 to 18 for FFT-CW) and are exhibiting significant

externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the member's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT/FFT-CW is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/ negative behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

The FFT/FFT-CW model of intervention/prevention is based on three core principles for understanding the following three components of the treatment: the members who are served, the problems the youth and families are faced with and the process of providing the therapeutic service. More specifically, the three core principles are defined as follows:

1. **Core Principle One: Understanding members:**
   This is a process whereby the therapist comes to understand the youth and family in terms of their strengths on the individual, family system and multi-systemic level;

2. **Core Principle Two: Understanding the member systemically:**
   This is a process whereby the therapist conceptualizes the youth's behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the youth's relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors; and

3. **Core Principle Three: Understanding therapy and the role of the therapist as a fundamentally relational process:**
   This is a process where the therapist achieves a collaborative alliance with the youth and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

Specific Design of the Service

On average, a youth receives FFT/FFT-CW for approximately 3 to 5 months. Over the course of this period, the therapist works with the family in twelve to fifteen one- to two-hour sessions for less severe cases and up to 30 -one- to two-hour sessions for youth with more complex needs. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the office, family's home and/or community at times that are convenient for the family. In addition to being available to families as needed (intensity is based on family risk and protective factors), FFT/FFT-CW therapists provide regular telephonic follow-up and support to families between sessions. FFT/FFT-CW is carried out in the context of five distinct phases. Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

The intervention program itself consists of five major components, in addition to pretreatment activities: (1) Engagement; (2) Motivation to change; (3) Relational/Interpersonal assessment and planning for behavior change; (4) Behavior change; and (5) Generalization across behavioral domains and multiple systems:

1. **Pretreatment phase**
   The goals of this phase involve responsive and timely referrals, a positive "mindset" of referring sources and immediacy. Activities include establishing collaborative relationships with referring sources, ensuring availability, appraising multidimensional (e.g., medical, educational, justice) systems already in place and reviewing referral and other formal assessment data;

2. **Engagement phase**
   The goals of this phase involve enhancing perception of responsiveness and credibility, demonstrating a desire to listen, help, respect and "match" and addressing cultural competence. The main skills required are demonstrating qualities consistent with positive perceptions of members, persistence, cultural/population sensitivity and matching. Therapist focus is on immediate responsiveness and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress,

proximal services or adequate transportation, contact with as many family members as possible, "matching" and respectful attitude;

3. **Motivation phase**
The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase;

4. **Relational assessment phase**
The goals of relational assessment include eliciting and analyzing information pertaining to relational processes, as well as developing plans for behavior change and generalization. The skills of perceptiveness and understanding relational processes and interpersonal functions are required. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, and resources and limitations). Therapist activities involve observation, questioning; inferences regarding the functions of negative behaviors and switching from an individual problem focus to a relational perspective;

5. **Behavior change phase**
   Behavior change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills, such as structuring, teaching, organizing and understanding behavioral assessment, are required. Therapists focus on communication training, using technical aids, assigning tasks and training in conflict resolution. Phase activities are focused on modeling and prompting positive behavior, providing directives and information and developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs; and

6. **Generalization phase**
   The primary goals in the generalization phase are extending positive family functioning, planning for relapse prevention and incorporating community systems. Skills include a multi-systemic/systems understanding and the ability to establish links, maintain energy and provide outreach. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans and helping the family develop independence.

Additional Points to Cover

Outreach and linkages made with community supports are an essential part of the model, particularly during pre-treatment, engagement, and generalization phases; this includes non-face-to-face and telephonic contact with these sources, with or without the member present.

Description of Individualization for Youth and Family

The FFT/FFT-CW therapist must work with any treatment planning team, including the wraparound facilitator (WF) through the Coordinated System of Care (CSoC), to develop an individualized treatment plan.

There are four domains of assessment used to monitor progress towards goals including the following:

1. Member assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):

    a. Helps understand individual, family and behavior in a context functioning; and

    b. Adds to clinical judgment, helps target behavior change targets, tool in treatment.

2. Adherence assessment (through the use of the Family Self Report and Therapist Self Report, and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):

    a. Identifies adherence to FFT/FFTCW to enhance learning and supervision; and

    b. Judges clinical progress, monitor clinical decisions.

3. Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):

    a. Helps understand the outcome of your work – accountability; and

    b. Identifies changes in member functioning (pre-post).

    NOTE: The term "counseling" throughout the FFT section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by LMHPs under their respective scope of practice license.

4. Case monitoring and tracking (member service system reports):
    a. Every member contact/planned contact, outcome of that contact (helps monitor practice).

Cultural and Ethical Concerns

FFT/FFT-CW treatment is attuned to the importance of ethnicity and culture for all members referred for services. Cultural values and concerns are addressed in the context of the family system and the multi-systems which influence the intervention. Cultural sensitivity is an integral part of understanding the child and family from a systems perspective. FFT/FFT-CW can be carried out by therapists from diverse backgrounds. Thus, intervention involves the use of fostering resilience and identifying resources within the family systems and multi-systems. Inevitably, this will include understanding the family and multi-systems within the context of their cultural backgrounds.

Child Integration to Community

The treatment objectives demonstrate that FFT/FFT-CW focuses on fostering resilience for youth and family and capitalizing on resources within the family system and multi-systems (to include the community). Thus, in order to achieve generalization, the youth and family need to demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

The FFT/FFT-CW model is consistent with the Child and Adolescent Services System Program principles, which are critical treatment standards important to all families in Louisiana. For example, by maintaining the youth within the community, the least restrictive environment, FFT/FFT-CW treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. FFT/FFT-CW is delivered as an in-home community-based service. FFT/FFT-CW clinicians cannot directly bill for travel time.

Provider Qualifications and Responsibilities

FFT/FFT-CW agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and certified by the Institute for FFT, LLC. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must

maintain documentation and verification of licensure, certification through the Institute for FFT, LLC, staff criminal background checks, TB testing, drug testing and required training for staff employed or contracted with the agency. FFT/FFT-CW-only agencies are not required to be accredited due to the extensive nature of consultation by the Institute for FFT. These agencies must maintain good standing with the Institute for FFT, ensure fidelity to the FFT/FFT-CW model and maintain licensure through the Louisiana Department of Health (LDH).

NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to FFT/FFT-CW must be accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or The Joint Commission (TJC).

FFT/FFT-CW agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

Exceptions include the following:

1. Behavioral Health Service Providers (BHSPs) **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide medication management. Such BHSPs shall develop policies and procedures to ensure:

    a. Screening of clients for medication management needs;

    b. Referral to appropriate community providers for medication management including assistance to the client/family to secure services; and
    c. Collaboration with the client's medication management provider as needed for coordination of the client's care.

2. BHSPs exclusively providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a Medical Director. Such BHSPs shall have a Clinical Director in accordance with core staffing requirements detailed in

this manual chapter under *Provider Responsibilities* in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Allowed Provider Types and Specialties

1. PT 77 Mental Health Rehab PS 78 MHR; and

2. PT 74 Mental Health Clinic PS 70 Clinic / Group PSS 8E CSoC/ Behavioral Health.

Staff education level/qualifications and training topics

Education/qualifications

FFT/FFT-CW Therapists

The FFT/FFT-CW program at the provider level will consist of one site. This site will be comprised of (three to eight) therapists. Therapists are master's-level staff with graduate degrees in a clinical field. Other human service degrees may be accepted. Highly skilled bachelor's-level professionals may also be selected under certain hiring conditions. These conditions include: (1) the provider has actively recruited for master's-level therapists but has not found any acceptable candidates or the bachelor's-level applicant is clearly better qualified than the master's-level applicants and (2) the bachelor's degree must be in a human services field. A degree in a mental health field is preferred.

NOTE: The term "therapist" is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for licensed mental health professionals (LMHPs), who provide counseling and psychotherapy under their respective scope of practice license.

All FFT/FFT-CW therapists must have a background in family, youth and community service and a minimum of two years' experience working with children, adolescents and families. FFT/FFTCW therapists will meet the guidelines for training outlined below.

FFT Site Supervisor

At the cessation of Phase One, (approximately nine to twelve months after the initial training) the FFT/FFT-CW site supervisor is expected to emerge and be appointed. The site can appoint a site supervisor prior to the cessation of Phase Two; however, it is expected that, regardless, this person follow FFT/FFT-CW training guidelines which are outlined below.

Site supervisors are master's-level mental health professionals with graduate degrees in a clinical discipline. A background in family, youth and community service and a minimum of two years' experience working in these areas is required.

FFT National Consultant

The provider will work with a FFT national consultant, who will provide the monitoring, supervision, and training during the first two phases (typically the first two years) of site implementation. This person will have been involved in the delivery of FFT services for five years, has been a site supervisor, had training and is employed by FFT, LLC.

Note: FFT/FFT-CW provider agencies are required to employee or contract with an LMHP as a BHS organizational requirement of LDH. Utilization of the FFT/FFT-CW Supervisor does not exempt FFT/FFTCW agencies from this requirement.

All staff will have background checks, TB testing, screenings and required trainings on file before working with youth and families.

Training

FFT/FFT-CW services must maintain treatment integrity and meet fidelity criteria developed by FFT, Inc. FFT/FFT-CW fidelity is achieved through a specific training model and a sophisticated member assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. FFT therapists maintain fidelity by regularly staffing cases, attending follow-up trainings, and participating in individual and group supervision. FFT/FFT-CW clinical supervisors participate in regular consultation with a National FFT, Inc. consultant.

The following is the process the provider will use to become an approved site by FFT, LLC. This training regimen will be completed in order to ensure fidelity to the FFT/FFTCW model:

1. The provider will appoint individual therapists who have met the criteria for education and qualifications outlined above;

2. After the provider has identified appropriate staff, they will call FFT, LLC. to set-up the initial one-day orientation training. The provider has arranged for their team and all stakeholders to attend in order to learn the process of referring youth for FFT/FFT-CW in the providers' particular community. During this training, the site members will have learned successful implementation of FFT/FFT-CW to include use of assessment tools and protocols and the use of the CSS. At the cessation of this training, the provider will have agreed to have at least five referrals for FFT/FFT-CW for each team member to begin with after they have completed the next training session, which is the initial clinical training (CT1);

3. Approximately one to two weeks after the initial one-day orientation training, the provider will arrange to have all FFT/FFT-CW therapists attend the CT1 training. This will be conducted over a two-day period and be carried out on the site of the provider. An FFT developer or national consultant will conduct this training;

4. Six weeks post CT1, the site is eligible for site certification;

5. Immediately following the initial training, the therapists at the provider sites will begin to see their cases and engage in weekly supervision with the FFT national consultant. Each weekly supervision session will be conducted for approximately one hour. The National consultant will use a staffing procedure which reinforces the model, will review all CSS paperwork and provide feedback to the team or teams. In addition, the provider will ensure that the FFT/FFT-CW team/teams are meeting for an additional hour per week for peer supervision;

6. At six weeks, four to five months, and eight to ten months after the initial clinical training, the FFT national consultant will come to the provider's site and complete two-day follow-up trainings. All FFT/FFT-CW therapists employed by the provider

will attend the follow-up trainings. The purpose of these follow-up trainings will be to review phase goals and assessments, update therapists on current events or changes and to provide specialized training to the team in regard to their specific cases;

7. At six months following CT1, the provider's FFT/FFT-CW team/teams will attend the second clinical training (CT2). This will be conducted by the FFT developers or the national consultant. (Please note this is a new requirement by FFT, LLC.);

8. At approximately nine months, a lead should emerge or have been appointed, who will serve as the FFT/FFT-CW supervisor. The provider will ensure that this staff member attends the FFT/FFT-CW externship. This externship will consist of three, three-day trainings occurring every month during the duration of the externship. This training will be conducted by FFT/FFT-CW externship trainers. At the cessation of this externship, it will be determined whether the selected FFT/FFT-CW supervisor will continue to serve in this role;

9. Once the site supervisor has completed the externship and is deemed qualified, the provider will be considered to be in Phase Two (approximately Year Two). At this time, the provider will ensure that the supervisor attends supervision trainings (two trainings), and he or she will begin taking over the supervision of the FFT/FFT-CW therapists. The site supervisor and therapists will also take part in one two-day training session conducted on site by the FFT national consultant; and

10. Should there be any staff turnover, the provider will ensure that new FFT/FFT-CW therapists attend the replacement trainings either in–state, if offered, or out-of-state, if need be.

Supervision

Intensive supervision and clinical consultation are an integral part of the FFT/FFT-CW model and are focused on promoting consistent application of the FFT/FFT-CW model to all cases. Supervision is built into the training protocol and certification process.

Supervision in FFT/FFT-CW includes the following:

1. The FFT national consultant will provide the monitoring, supervision and training during the first two years of the provider's implementation of FFT/FFT-CW:

    a. This supervision will include one, one-hour weekly phone consult with the site during Year One of implementation; and

    b. During Year Two, the FFT national consultant will provide two one-hour supervision sessions to the site supervisor in training.

3. During Year Two of implementation, the provider's site supervisor will provide oversight to the therapists and will complete all required trainings outlined by FFT, LLC. The site supervisor will hold one-hour weekly sessions with the therapists;

4. FFT/FFT-CW therapists at the provider will also engage in one one-hour weekly peer supervision sessions during Year One. During Year Two, this requirement is left up to the site. Typically, the site supervisor holds one- to two-hour weekly supervisions then. Please indicate your site's intention regarding these supervision times; and

5. Phase/Year Three is considered a maintenance phase. A national consultant is assigned to monitor the site monthly through a call with the site supervisor, and this national consultant will do one site visit per year.

Additional Supervision

Child psychiatrists and/or psychologists or medical psychologists provide consultation to the FFT/FFT-CW teams, as needed. Psychiatrists and/or psychologists are employees/subcontractors of the provider. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

Monitoring and assessment of service delivery

The provider will assess and monitor the delivery of the FFT/FFT-CW service via the use of the CSS. This is an online data base which has been originated by FFT, LLC. The type of data collected by the CSS includes the following:

1. Assessments of risk and protective factors (Risk and Protective Factors Assessment);

2. Relationship assessments (this is embedded in the progress note);

3. Individual functioning (pre- and post-intervention) (OQ-45.2);

4. Functioning within the context of the assessments (pre- and post-intervention) YOQ 2.01 and YOQ SR;

5. Assessments of family and therapist agreement (Family Self Report and Therapist Self Report);

6. Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond);

7. FFT/FFT-CW global therapist rating; and

8. Tri-yearly Performance Evaluation, which provides Completion rates, Time of drop-out, Reasons for drop-out, Caseload information, Case tracking information, Fidelity and Adherence information, Assessment Completion information.

Each FFT/FFT-CW therapist will receive a log on and password for the CSS for referencing their own members only. The provider will receive an administrator/evaluator log on and password. The FFT national consultant will also have access to the data from the CSS.

Please see the FFT website for additional information: www.fftinc.com.

Exclusions

FFT shall not be billed in conjunction with PRTF services.

As standard practice, FFT/FFT-CW may be billed with medication management and assessment. FFT **may** also be billed in conjunction with another behavioral health service (such as individual therapy, Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), or ILSB) if:

1. The youth has a high level of need such that a combination of both family-focused and individually-focused services is needed to meet the youth's required level of treatment intensity;

2. There is a clear treatment plan or Plan of Care indicating distinct goals or objectives being addressed by both the FFT/FFT-CW service and by the concurrent service; and

3. The services are delivered in coordination of each other to ensure no overlap or contradiction in treatment.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. FFT/FFT-CW may be billed under CPST, but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved, and the child/youth receiving treatment does not need to be present for all contacts;

2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

   NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education

programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly;

4. Medicaid may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ), who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the FFT/FFT-CW, except for the oversight of restorative measures, which is an OJJ function;

5. Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs), which are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions; and

6. Medicaid does not pay when the vocational supports provided via FFT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.