

## Frequently Asked Questions

### *Configuration of FFT*

#### **1. How many therapists can one supervisor support?**

One FFT site supervisor can support up to a team of eight. This site supervisor will be responsible for the supervision of the team using the FFT model of supervision he or she was trained in and the required paperwork that supports this supervision. There are situations where a single supervisor can support multiple teams, but typically this doesn't occur during the first year of supervisor training.

#### **2. Can (or should) the supervisors carry a therapy caseload? What are the constraints around the number of clients a supervisor can see (e.g., team size)?**

The site supervisor is required to carry a caseload. In the second year of FFT implementation, the site supervisor is expected to attend FFT supervisor trainings, assume supervision of the team, attend consultation with a FFT national consultant, complete FFT supervision paperwork and provide ongoing review of the client service system, while maintaining a caseload. Site supervisors may reduce their caseloads to meet the requirements of the position; however, this caseload must be a minimum of five active cases at all times.

#### **3. Is a supervisor required to regularly travel to visit clinicians who work at long distances away from the head office? If so, what is the purpose and parameters of this?**

FFT utilizes a team approach to consultation. Therefore, the team comes together weekly to receive consultation, either from a national consultant (during year one of training) or the site supervisor (during year two of training). The team approach allows for better adherence and model fidelity; the team creates a supportive network of FFT therapists to prepare and plan for cases. The FFT site supervisor is required to meet with the team weekly and be available as needed. Attendance by an agency supervisor, while beneficial, is not required.

#### **4. How accessible does the supervisor need to be afterhours?**

As a training organization, our role is both didactic and consultative. The FFT national consultant's goal is to supervise and monitor the team's ability to be adherent and gain competency in the model. For extenuating clinical issues, or those situations that impact agency policy and procedure, FFT would expect that the agency has a designated supervisor or other process to address after hours issues. Once the team has a local FFT site supervisor, he or she may be available as required by the agency's policy and procedures.

Regarding families in crisis, most agencies are required to provide afterhours crisis service. However, it is not a requirement of the model to offer 24/7 access to the FFT therapist. There are various skills and interventions used to reduce negativity and blame, which underlies crisis behavior. For example, based on referral information and assessment of family risk and protective factors, FFT may increase the frequency and length of sessions. This is how FFT addresses crisis, verses a traditional crisis management model. Note that the outcomes achieved in FFT clinical trials and outcome studies did not include a 24/7 contingency because it makes it more difficult for therapists to close cases and achieve outcomes.

#### **5. What administrative support is required for the web-based assessment and case-management system? For example, for a team of eight therapists, is there a need for a part-time administrative assistant?**

FFT has found that programs do well when there is some level of administrative oversight. This position typically focuses on caseload management, collaborating with referral sources and stakeholders and overseeing FFT as it relates to agency policy



and procedure. All the tasks that therapists perform are related to the model; meaning assessments are reviewed and entered by the therapist, and notes are completed by the therapist as they help him or her stay focused on the family in FFT terms. FFT progress notes are also used to plan for the next session. Therefore, the therapist must complete most of the documentation. However, additional support would be useful for any related agency requirements that could interfere with model fidelity.

**6. How often would FFT therapists talk (via conference phone) with an FFT consultant once we're up and running?**

The FFT national consultant will talk to the therapists weekly via phone. This call typically occurs at the same time each week. Consultation includes general topics, such as issues around documentation or caseloads, and moves into being more clinical, utilizing the FFT model of supervision and staffing of cases. The weekly call is considered a requirement for site certification, so attendance is mandatory.

**7. How is information about clinical risks communicated to our own clinical leaders?**

The role of the administrative lead is critical. This person may be a part of or separate from the team, however, he or she needs to be involved to the degree that risks and other serious issues can be communicated and addressed. This person should also provide relevant information regarding local practices and community related interests; be accessible for issues that come up around the project, while refraining from providing clinical feedback.

**8. What would be the role of our clinical director(s) if FFT is introduced? The clinical director has numerous other responsibilities to other programs and may be involved only part time in the delivery of FFT.**

A clinical director often assists the program in those issues that are governed by agency policies and procedures. They may likewise work at larger system levels to assure smooth and appropriate referrals and assist with service and system integration. They may be the lead at an agency to assure that an FFT team has the agency resources and support for training and application of FFT with families.

**9. How close to the families (in geographic terms) must the FFT therapist be?**

Since the risk in the early stages of treatment with families is drop out, FFT therapists meet with families based on risk factors and family needs. Distance should not be a reason why a therapist doesn't meet with a family. Thus a site must consider whether the geography a therapist covers will allow them to still be responsive to families, particularly in early sessions. If not, drop out will increase and outcomes will diminish. FFT is used in very rural and remote areas of the world, as well as the center of large and diverse urban communities.

**10. Is a psychiatrist part of the team? Are they ever contracted in?**

FFT has trained psychologists, psychiatrists, nurses and teachers. Psychiatrists in some states are required to provide medical necessity for a client and will refer to FFT if appropriate. It is essential that the psychiatrist in this role understands the structure of the model. Some psychiatrists fulfill an administrative or clinical role while most of the time they are used for consultation with the family around issues such as medication management. Though the costs can be high, in some cases, psychiatrists have been integrated into FFT training and case consultation.

***Staff Characteristics***

**11. Are there any mandatory qualifications or experience required to become an FFT therapist or supervisor (apart from FFT training)? If qualifications are not mandatory, what are the recommended qualifications/experience?**

In the statewide replication of FFT in Washington State, a therapist's degree did not drive recidivism outcomes while fidelity to the model did. In a University-based trial, bachelor's level therapists had low recidivism outcomes when consultation was increased. When there was a drop in amount of consultation, outcomes dropped. FFT's recommendation is to use at least master's level clinicians unless extraordinary circumstances require the use of BA level therapists. It is the responsibility of the provider to meet or exceed local licensure and certification requirements.



Any person trained as an FFT supervisor must be a minimum of master's level, have completed all Phase I training, have seen two cycles of families, and have been successful in an FFT externship.

Traits to consider when hiring a potential FFT therapist include: willingness to work with these potentially highly disruptive families during non traditional hours in their homes; willingness to change clinical practice; openness to feedback and to accountability; and an ability to work with a team of therapists. Ability to approach families relationally correlates to better outcomes. Additional traits include: being non-judgmental, positive, strengths-focused, empathetic, relentless, ability to structure family conversations and being dynamic with families. It is important that the therapist is comfortable with looking at his or her own data and then using it to improve service to families.

#### **12. Is family therapy experience particularly useful?**

A good theoretical knowledge about families and systems theory can give the FFT therapist a good foundation, as does having experience working in homes doing family-based work with higher risk referrals in neighborhoods and communities similar to the area the site is serving.

#### **13. We understand that we can have part-time staff as long as they see five to seven clients per week. How are teams typically composed in terms of full- vs. part-timers?**

FFT recommends therapists be dedicated full time to FFT. It is the nexus between consultation, training and actual work with families where learning can occur. Working with more families provides more opportunities to be successful with families, and success breeds confidence that in turn can prompt therapists to be more engaged in the learning process. When using part-time staff the question is whether there is adequate capacity within the team and agency to support an intensive family therapist clinical practice. FFT will work directly with a potential provider to explore the appropriateness of using part time FFT therapists.

#### **14. What is the breakdown of therapist activities with families?**

With the understanding that the amount of FFT clinical activity is highly contingent based on risk and need of a family, in aggregate, a provider can expect:

- One to one and a half hours per week face-to-face with the family, 30 minute collateral phone calls or other contacts and 30 minute assessment and case planning,
- Travel time to families, as well as other agency expectations/documentation are highly variable team to team. More travel time or other activities decreases caseload.

#### **15. Can staff work part-time in FFT and part time in another service/model as long as they are adherent to FFT in their capacity as an FFT therapist?**

Priority should be given to the FFT work the therapist is doing. Sites in this position must consider whether the other work will interfere with FFT activities and scheduling sessions with families when they are available. Many FFT therapists have found switching between two models or work tasks difficult, particularly when undergoing FFT training. FFT works with providers through application processes to determine with other non-activities are advisable in a project.

### ***Training Issues***

#### **16. What does training consist of?**

See 'Implementing FFT' page and section on Training and Certification.



### **17. Can we work with individuals in a family when doing FFT?**

FFT is different from some other family therapies in that FFT always meets with the whole family. Therapy is not organized around individuals, such as the parents. FFT is a model that draws on risk and protective literature in the last 10 years, which is significant in understanding family ecology within wider community ecology.

#### *Client/family Issues*

### **18. Can FFT work with clients/families that make occasional use of respite caregivers?**

We currently offer this to some of our clients. FFT works with the identified client and his or her family. As long as the family who attends therapy regularly is available, then FFT can occur. This is based on the family's schedule, FFT must occur at a time convenient for the family.

### **19. For those coming out of residential care, can an FFT therapist begin working with the family/client in the weeks immediately preceding residential discharge?**

FFT works in different ways with this population. FFT can begin when discharge is eminent and sessions can be held with the identified client and family in the facility, during the youth's home visit or FFT can occur as a recommended service at discharge. The FFT therapist can begin engaging the family and youth prior to discharge and start FFT immediately once the youth is home. Different potential re-entry models can be explored directly with FFT during the application process.

### **20. What pre-intake planning is required before a client formally 'enters' FFT? Is there a referral management system?**

FFT defers to agency referral procedures utilizing their process and forms. Most FFT programs require particular referral paperwork be gathered. The FFT therapist benefits by reviewing this information as it helps understand make up of the family, presenting issues and expectations from referral sources. However, for the model, this information is supplemental. FFT uses a specific battery of assessments to use for case planning and outcome information. FFT is concerned with assessment that unintentionally blames a family member; it can impede engagement and make an FFT therapist's job far more difficult.

### **21. Can families repeat FFT at a later date if they do not make progress the first time or their circumstances change and more input is requested?**

The length of service for FFT is typically three to four months. FFT looks at service delivery in terms of sessions and movement through the phases. This movement depends on particular goals that must be met at each phase before movement to the next phase can occur. Length is also predicated based on family risk factors and needs. In some cases, FFT may go longer if risk and need suggest an extension. FFT will offer booster sessions to families who are discharged, but later require additional intervention. If there is a re-referral at a later date, the question of whether FFT is appropriate given other options should be staffed by the team and the FFT consultant.

### **22. How effective is FFT with clients who have significant comorbid disorders such as autism, intellectual/learning disabilities, severe anxiety disorders and mood disorders?**

Comorbidity is often seen in youth involved in FFT. In FFT clinical trials and effectiveness studies, it was more often the case that referred youth had tri, quad or multi morbidities. In these studies, significantly developmentally delayed youth were typically routed to DD systems and not FFT. In the FFT studies, all youth referred were generally provided FFT.

### **23. Does FFT have impact with culturally diverse communities?**

FFT recognizes and respects the importance and influence of culture on families and the therapeutic process. The clinical models' concept of respect, non judgment, "match to," and understanding families on their own terms are culturally responsive and core to FFT. In the 50,000 families FFT works with each year, sites work with a vast variety of cultural and ethnic groups, as



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well as with families who are not English speakers. We disseminate FFT from Little Haiti in the Bronx to the Moroccan section of West Amsterdam.

In other studies, non-matched therapists did as well as matched therapists. African Americans and Latino populations had higher completion rates than Caucasian families in the U.S. in 2007.

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