FFT and MST:
Frequently Asked Questions

Stakeholders often ask, "what is FFT? what is MST?" and how can communities benefit by providing evidence-based treatment models to at-risk youth and their families?

This document is designed to help the reader understand each of these evidence-based treatment models and to support community stakeholders as they strive to address the needs of at-risk youth by keeping them safely at home, in school, and out of trouble with the law.

FFT is a Blueprints Model program (http://www.blueprintsprograms.com/).with special endorsements from the Office of Juvenile Justice and Delinquency Prevention, the Center for Disease Control and Prevention, the American Youth Policy Forum, and the US Department of Justice.

MST is a Blueprints Model PLUS program, receiving this honor in 2016 as one of only two programs, and the only youth intervention in the world, that meet this highest standard of evidence-based models, including independent replication of research findings. http://www.blueprintsprograms.com/. MST is also endorsed by United Nations on Drugs and Crime, Center for Medicare and Medicaid Services, U.S. Department of Justice Office of Justice Program, the National Institute of Health, National Institute of Drug Abuse, and Substance Abuse and Mental Health Administration.

FREQUENTLY ASKED QUESTIONS

What are the target populations of FFT and MST?

FFT has been studied with youth ages 10 to 18 years old. FFT research supports the utilization of the intervention across all levels of risk, low, moderate, and severe, for adolescent behavior problems and substance use/abuse. FFT includes youth with multiple serious offenses including felonies and youth returning home following incarceration. FFT serves youth from multiple referral sources including, juvenile justice, child welfare, mental Health, and schools. Research on these youths has demonstrated reductions

in recidivism, earlier cessation of drug and alcohol use, as well as reductions in future criminogenic behaviors. Youth may demonstrate co-occurring internalizing symptoms, such as anxiety and depression; however, acting out behaviors, must be present to the degree that functioning is impaired. At least one adult caregiver must be available to provide support and willing to be involved in treatment.

Research has shown MST to be effective for youth with chronic or severe antisocial behavior, including youth with histories of violence or felonious behavior and youth with histories of incarceration.

For standard MST, inclusionary criteria include youth between the ages of 12-17 who are living with a caregiver, at risk of placement due to anti-social or delinquent behaviors, which may include problematic use of substances, youth involved in the child protective services, juvenile justice, and/or mental health systems, and youth who have committed sexual offenses in conjunction with other anti-social behavior.

Exclusionary criteria include youth living independently, sex offending behavior in the absence of other anti-social behavior, youth with moderate to severe autism (difficulties with social communication, social interaction, and repetitive behaviors) and youth whose psychiatric problems are primary reasons leading to referral or have severe and serious psychiatric problems.

An adaptation of Multisystemic Therapy for youth with Problem Sexual Behaviors (MST-PSB) is also available in some counties. MST-PSB is a clinical adaptation of MST that has been specifically designed and developed to treat youth (and their families) for problematic sexual behavior. Building upon the research and dissemination foundation of standard MST, the MST-PSB model represents a state-of-the-art, evidence-based practice uniquely developed to address the multiple determinants underlying problematic juvenile sexual behavior. MST-PSB is a Blueprints Model program.

What are the outcomes of FFT? What are the outcomes of MST?

Outcome assessment in FFT and in MST focuses on the "ultimate outcomes" of keeping youth at home, in school, and out of trouble with the law, and "instrumental outcomes" such as improved family relationships, improved parenting skills, involvement with prosocial peers, and increases in the family's social support network. Research suggests that these instrumental outcomes contribute to the ultimate outcomes.

FFT has been developed and tested for almost 50 years, with 44 published studies documenting the development, implementation, and outcomes supporting the FFT model. FFT has been shown to be highly effective across all levels of risk, including 12 evaluations in the past 10 years with more than 14,000 youth and their families.

MST has been studied for over 40 years with 67 published outcomes, implementation, and benchmarking studies. MST is the only intervention for high risk youth where results have been repeatedly replicated by independent research. To date the research on MST has involved over 55,000 families.

Research shows that both treatment models achieve the following short-term (immediate) outcomes: greater likelihood the youth remains at home, improved family functioning, reduced substance use, and fewer youth mental health symptoms and/or behavior problems.

In-session research studies of the FFT model have informed the development of specific evidence-

based strategies for addressing youth and family factors that have been shown to be associated with failure to engage or complete treatment. FFT has also been shown to weaken the link between callous-unemotional traits and negative outcomes.

Research on MST has also found improved peer relations, improved school performance, and increased likelihood that the youth will attend school.

In the long-term, both models have been shown to reduce criminal recidivism and arrest rates, decrease substance use, and decrease behavioral health problems.

The longest follow-up studies have been at 5 years for FFT and 25 years for MST.

Research has also shown that the younger siblings of youth who participate in FFT are less likely to have contact with the court 2 ½ - 3 ½ years later.

For MST, a 25-year follow up study demonstrated a 40-percent reduction in the nearest age sibling's overall arrest rates and a 55-percent reduction in felony arrest rates as compared to individual therapy siblings, who had a 3.36 times higher arrest rate for any crime.

What is the theoretical rationale behind FFT? behind MST?

Both models draw from family systems theory and integrate behavioral approaches.

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.
FFT achieves changes by improving family interactions (e.g., improving communication, problem-solving, and parenting skills) and developing family member skills that are directly linked to risk factors (e.g., emotion regulation, decision making) or the youth's behavior problems.

MST draws from social-ecological and family systems theories of behavior. MST views the youth as embedded within a number of interrelated systems (e.g., family, school, peer, community, and individual), each of which has an influence on the youth through both protective and risk factors. By identifying the here-and-now factors that "drive" a problem behavior and intervening to modify those factors, change will occur. MST therapists use interventions that have documented research support, such as cognitive-behavioral, behavioral, behavioral parent training, social-leaning theory, and strategic and structural family therapy approaches.

How are the FFT and MST treatment models similar?

There are some similarities between the two clinical models. Both models:

- Are strength-based.
- Strive to empower family members.
- Engage caregivers, who are viewed as essential participants in the youth's treatment. View improved family functioning as the path to resolving referral behaviors.

- Meet with families in their homes, at times convenient to the family. Adjust the frequency of sessions to meet the clinical needs of the family.
- Tailor treatment to the family's unique situation.
- Include the development of parenting skills and enhancement of family relationships when clinically indicated, and often include "homework assignments" between sessions.
- Help families build natural supports.
- Require that therapists receive group supervision on a weekly basis and spend a considerable amount of time between sessions planning interventions. Both models include some form of ongoing consultation from model experts to ensure ongoing model fidelity.
- In MST, this consultation occurs via weekly phone consultation from an MST model Expert.

How does FFT and MST work?

The chart below provides a quick at-a-glance view of each of the models.

	MST (Multisystemic Therapy)	**FFT (Functional Family Therapy)**
•Treatment Site	In the field: home, school, neighborhood and community.	Sessions in the field or the office, depending on family need.
•Provider	Single full-time therapist (as part of, and supported by generalist team)	Single therapist (as part of, and supported by generalist team)
•"Team" size	2 to 4 therapists plus a supervisor	3 to 8 therapists including the supervisor
•Treatment	Total behavioral health care (some exceptions for long-term care services such as psychiatric care, see more below under "Case Management Function") with an emphasis on addressing all systems in the youth and family's ecology that effect youth behaviors, and on empowering the family to manage challenges on their own.	Phase-based family therapy model that directly addresses youth behavior problems by systematically targeting risk and protective factors at multiple levels in the youth's ecology. Systemic and cognitive-behavioral interventions are included to change/replace maladaptive emotional, behavioral, and psychological processes within the individual, the family, and with relevant extra-family systems
•Case Management Function	Service provider rather than broker of services –success of referrals to long-term care providers, such as psychiatric care, are seen as responsibility of the MST therapist	After youth & family have adopted positive coping patterns will link with other resources to enhance skills and provide additional resources
•Approach to other co-occurring treatments	Family makes the decision regarding what co-occurring treatments are pursued, though MST therapists help the family minimize other services as much as possible	Exclude families currently engaged in family therapy

•Treatment Duration	3 to 5 months in most cases, an average of 4 months	Approximately 3 months, up to 5 months in serious cases
•Staff credentials	MA-level is preferred, exceptions can be made for highly skilled BA-level clinical staff	MA-level is preferred, exceptions can be made for highly skilled BA-level clinical staff
•Staff employment status	Full-time therapists with no other duties outside of MST. Supervisor commitment of 50% time per team as a minimum.	Preference is for full-time staff but part-time staff working with a minimum caseload of 5 families (approximately 10-12 hours per week) can be acceptable
•Client Families\Staff	4-6 cases per full-time therapist	10-12 cases for a full-time therapist
•Staff Availability	Expectation that staff will work flexible schedule based upon needs of the family. 24 hr.\7 day\wk. team available	Expectation that staff will work flexible schedule based upon needs of the family. No requirements for 24/7 on-call system.
•Treatment Outcomes	Responsibility of staff & agency	Responsibility of staff and agency
•Expectations of Outcomes	Immediate, maximum effort by family and staff to attain goals	Immediate, maximum effort by family and staff to attain goals
•Referral process guidelines	- Delinquent/anti-social youth - High risk youth - Youth needing access to 24-hour services due to youth and family needs, and to system concerns (i.e. community safety concerns, etc.)	- Delinquent/anti-social youth - Medium to high risk youth - Status offenders on the lower risk end - System expectations regarding planned linkage to post-care services

How FFT works?

FFT works with the family, so the youth and his/her caregivers are present at every session. Consequently, sessions are often held after school and on evenings and weekends. FFT proceeds through five phases of treatment, each designed to reduce specific risk factors and enhance protective factors. Early in treatment, the emphasis is on engaging the family and motivating them to participate in therapy. The therapist then conducts *a relational functions assessment* of the family, which is used to guide interventions for behavior change. Interventions often include psychoeducation/parent training and communication skills training, with a focus on changing patterns of family interaction that are maintaining the problem behavior. 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 as well as 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 support lasting change.

How does MST work?

MST can work with the caregivers, youth, or entire family. Sessions can be held with caregivers without the youth present. The therapist empowers the caregivers to intervene in other systems, such as school or the peer domain, throughout treatment. Assessment includes “fit circles” (identifying factors driving the referral behavior) and sequencing of problem situations. MST draws from a range of research-supported techniques. Interventions are designed to strengthen the family system, as well as relationships both within the family and between family members and others outside the family. Some interventions are behavioral, including strategies such as supervision and monitoring plans,

reinforcement of desirable behavior, and sanctioning of undesirable behavior. MST strives to keep the need for formal services upon completion of treatment to a minimum and builds natural supports to help the family maintain their progress.

MST provides a suite of services tailored to the individual youth's and family's needs. Alternative treatment models outsource these services, which create an incremental expense for communities.

Logic models for both programs are available at the EPISCenter website: www.episcenter.psu.edu

How intensive are the services?

FFT and MST provide intensive treatment to youth and can effectively serve youth with chronic, persistent delinquency who are at risk for out-of-home placement.

In FFT, the frequency of sessions is matched to the imminent risk of the family, as such families may receive as many as 3 sessions in 10 days. Frequency decreases as families gain skills as needed.

With a caseload averaging 5, MST Therapist can meet with families and key participants multiple times a week, as often as is clinically indicated, with a higher frequency early in treatment. The whole ecology is critical to MST treatment; therefore, therapists may spend time in the home, in the school, and in the community to ensure clinical intensity is sufficient to meet the family's needs. Frequency decreases as families gain skills as needed.

What is the average length of stay for each program?

Both FFT and MST are short-term interventions designed to meet treatment goals quickly.

The FFT model is designed to be delivered over a period of 3 to 6 months, with an average length of service of 4 months.

The MST model is designed to be delivered in 3 to 5 months, with the average length of stay at 4 months.

How do FFT and MST handle crisis situations?

For both models, when families are at risk for crisis or in a period of high need, the therapists increase their availability and meet with families more often. Both models are based in a belief that this approach empowers families and reduces their reliance on formal systems.

While the model does not require FFT therapists to be on-call around-the-clock, many agencies that provide FFT also provide crisis services. FFT matches interventions to the level of risk and imminent danger. As such early in treatment, therapist may conduct as many as 3 sessions in the first 10 days of treatment.

For the MST model, each program has an on-call system 24 hour a day/ 7 day a week to provide immediate support to families. This system is staffed by members of the MST team. The aim of the on-call system is to provide immediate support to the family as needed. Often families find the system helpful early in

treatment; as indigenous supports and skills are developed during treatment, families reduce and/or eliminate their use of the MST on-call system.

Can FFT and MST therapists keep the referral source informed?

Yes, this occurs in both programs.

MST defines consultation to and collaboration with other systems as a key element of the model from the beginning of treatment. At the start of treatment, the MST Therapist reaches out to all key participants to gather their desired outcomes. These desired outcomes are then used to develop treatment goals. Key Participants are then kept informed of treatment gains throughout the treatment process.

FFT therapists focus on the family system in the early phases of treatment and then collaborate with other systems as the family reaches the final phase of treatment. FFT includes pre-treatment systems work to connect with referral sources at the beginning of treatment and keeps these sources informed in a collaborative manner throughout treatment.

With both programs, referral sources should talk with the therapist about the type and frequency of progress reports they need. Regardless of which program a youth is involved in, state law generally prohibits mental health providers from sharing unnecessary information and sharing information about a client without appropriate consent.

Are there differences in staffing and caseloads for FFT and MST?

FFT and MST are both delivered by individual therapists who are organized into teams or "sites" for the purpose of supervision, consultation, and service area. FFT and MST therapists should be masters-level clinicians, although both models make exceptions in certain cases that allow for experienced and well-trained bachelor-level therapists.

FFT sites have 3 to 8 therapists, including the supervisor. Therapists are ideally full-time but may also be part-time. A caseload of 10-12 clients is recommended for a full-time therapist providing in-home FFT. FFT supervisors must carry a caseload of at least 5 clients.

MST teams have 2 to 4 full-time therapists plus a clinical supervisor. Each therapist carries 4 to 6 cases, with an expected case average of 5. The supervisor may carry a small caseload under certain circumstances but is not required to do so.

How many opened referrals are needed to sustain an FFT or MST program?

For community-based FFT, a small site (i.e., team of three) serves close to 90 youth per year, while a large site can serve over 300 clients per year under ideal circumstances.

A small MST team (2 therapists) serves approximately 30 youth per year and a large team (4 therapists) can serve over 60 youth annually. Provider agencies may have multiple MST teams to meet the needs of larger communities.

Are FFT and MST cost effective?

High quality, evidence-based programs like FFT and MST improve youth and family functioning, reduce future crime, and save tax payer dollars. To learn more about the cost savings of FFT and MST please follow the links provided below.

http://www.episcenter.psu.edu/sites/default/files/ebp/FFT-Three-Year-Report-ROI.pdf

http://www.episcenter.psu.edu/sites/default/files/ebp/MST-Three-Year-Report-ROI.pdf

How does a community decide to support FFT and MST?

Decisions about whether MST, FFT, or any other evidence-based program are a good fit for your community should be based on thorough assessment and prioritization of community needs and risk factors. This should be a collaborative process involving a diverse group of community stakeholders. Ensuring that the community has a sufficient number of appropriate referrals and will utilize the program is essential. More information about selecting an evidence-based program is available on the EPISCenter website: www.episcenter.psu.edu/ebp .

How does a youth gain access to FFT and MST in NC? Who pays for it?

MST is a Medicaid- , Health Choice-, and private health insurance-funded enhanced mental health service. Within NC, LME/MCOs offer a case rate for publicly-funded MST. To gain access, a youth must be referred to a licensed mental health clinician for a Comprehensive Clinical Assessment to establish that the service is medically necessary. The LME/MCO then reviews the recommendations from the CCA and must authorize the service before it can begin.

FFT is fully funded by the Juvenile Justice Section of the NC Department of Public Safety's Division of Adult Correction and Juvenile Justice in 89 counties within NC. A map detailing counties where the service is available can be found on the DPS website, here: https://www.ncdps.gov/juvenile-justice/community-programs/non-residential-contractual-services. A referral can be made via fax directly using a referral form that is found here: https://www.ncdps.gov/document/amikids-fft-referral-form.

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