FUNCTIONAL FAMILY THERAPY
FACT SHEET

GOAL: Reduce and eliminate problem behaviors of pre-delinquent and delinquent youth

SERVICE: A family-based prevention and intervention program for adolescent behavior problems.

DESCRIPTION: FFT utilizes a systematic yet individualized, family-focused approach that is organized into three phases. The program lasts on average from 8–12 one-hour sessions up to 30 sessions of direct service in more difficult situations. Sessions are spread over a three-month period.

ELIGIBILITY:
• Youth must be 10 –17 years of age
• Youth and family must be Baltimore County residents
• Youth and family must be available for regular weekly sessions with a therapist. This requires that the housing situation at the time of the referral is stable (not on verge of eviction, not on verge of turn-off notice for heat and/or electricity, for example), there is a way to contact the family directly (must at least have access to a phone) and no family member integral to the therapy process (youth, parent(s), guardian, etc) is chronically unavailable (in/out of hospitalizations, runaways lasting longer than a week at a time, for example).

Exclusionary criteria are as follows:
• Youth has an IQ of 70 or below
• Youth is a sex offender or he/she is demonstrating inappropriate sexual behaviors
• Youth has a Pervasive Developmental Disorder such as Aspergers
• Youth is in immediate need of crisis hospitalization due to active suicidal or homicidal thoughts or residential placement due to active, threatening and aggressive behavior toward family members
• Youth with lengthy histories (1+ years) of school problems that include suspensions, expulsions and alternative educational placements
• Youth with a history of out-of-home placements and/or multiple psychiatric hospitalizations preceding the referral

FFT has not been proven to be effective in reducing sexual acting out behaviors. Due to its heavy reliance on understanding relational interactions and active communication between a youth and his/her family, the program does
not accept youth diagnosed with MR or any form of PDD. In Baltimore County, FFT has been designated as an early intervention program for youth. This means that the youth has begun to show behaviors/symptoms recently; therefore, a youth with years of problems that have resulted in placements, hospitalizations and/or numerous school expulsions are not the population meant to be served by this particular program.

**HOURS:** Flexible. Sessions will be conducted at the convenience of the family. This includes evenings and Saturdays.

**LOCATION:** Home-based. Should a home situation be unsuitable to conduct sessions, a community-based site will be utilized to meet with the youth and family.

**FEES:** None

**CONTACT PERSON:** Brenda Richesson, Program Supervisor, at 410-887-3828
DATE OF REFERRAL: ______________________

NAME: ________________________________ M/F: _________

DATE OF BIRTH: ___________________________ AGE: _________ RACE: _________

ADDRESS: ________________________________ ZIPCODE: ________________

HOME PHONE: (____) __________________

CURRENT GRADE LEVEL: _____________________ REGULAR/SPECIAL ED: ________________

PRESENT SCHOOL PLACEMENT: ________________________________

WHOM IS CHILD LIVING WITH? ___________________________ RELATIONSHIP: ________________

PARENT(S) / LEGAL GUARDIAN(S):

OTHER OCCUPANTS LIVING WITH CHILD? (Names & Ages):

ADDRESS OF PARENT/LEGAL GUARDIAN (if different from above):

HOME PHONE: ______________________ WORK PHONE: __________________ CELL: __________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: __________________

EMERGENCY PHONE #: (____) __________________

REASON FOR REFERRAL/PRESENTING PROBLEM: __________________

________________________________________________________

________________________________________________________

________________________________________________________

Any suicidal history? ☐ Yes ☐ No If yes, ☐ < 6 months ☐ < 1 year ☐ + 5 years

Any psychotic behaviors? ☐ Yes ☐ No If yes, ☐ < 6 months ☐ < 1 year ☐ + 5 years

Any homicidal history? ☐ Yes ☐ No If yes, ☐ < 6 months ☐ < 1 year ☐ + 5 years

Any inappropriate sexual behaviors? ☐ Yes ☐ No

Is youth autistic? ☐ Yes ☐ No

Any current medications? ☐ Yes ☐ No If so, what? __________________________
Have you discussed a referral to FFT with the youth and family? □ Yes □ No  Comments

What is the family's level of motivation to participate in therapy? □ Minimal □ Moderate □ Strong
What is the youth's willingness to participate in therapy? □ Minimal □ Moderate □ Strong

REFERRING WORKER: __________________________  AGENCY: __________________________
PHONE #: (_____) AGENCY FAX #: (_____) __________________________

ADDITIONAL COMMENTS: ____________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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For BSA Use Only
Date Referral Received: ____________ Date Referral Accepted/Denied: ________________
Date Assigned to Therapist: __________________________