Functional Family Therapy

Contingency Management (FFTCM)

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Treatment Population and Parameters

- Behavior problem or at risk youth/families
- Age range: 11-18
- Service Delivery Contexts
  - Mental health
  - Child welfare
  - Juvenile Justice
  - Schools
- Short term intervention
  - Average of 12-14 sessions
  - Average between 3-6 months

Outcomes

Treatment Process

- Engagement
- Retention
- Family functioning

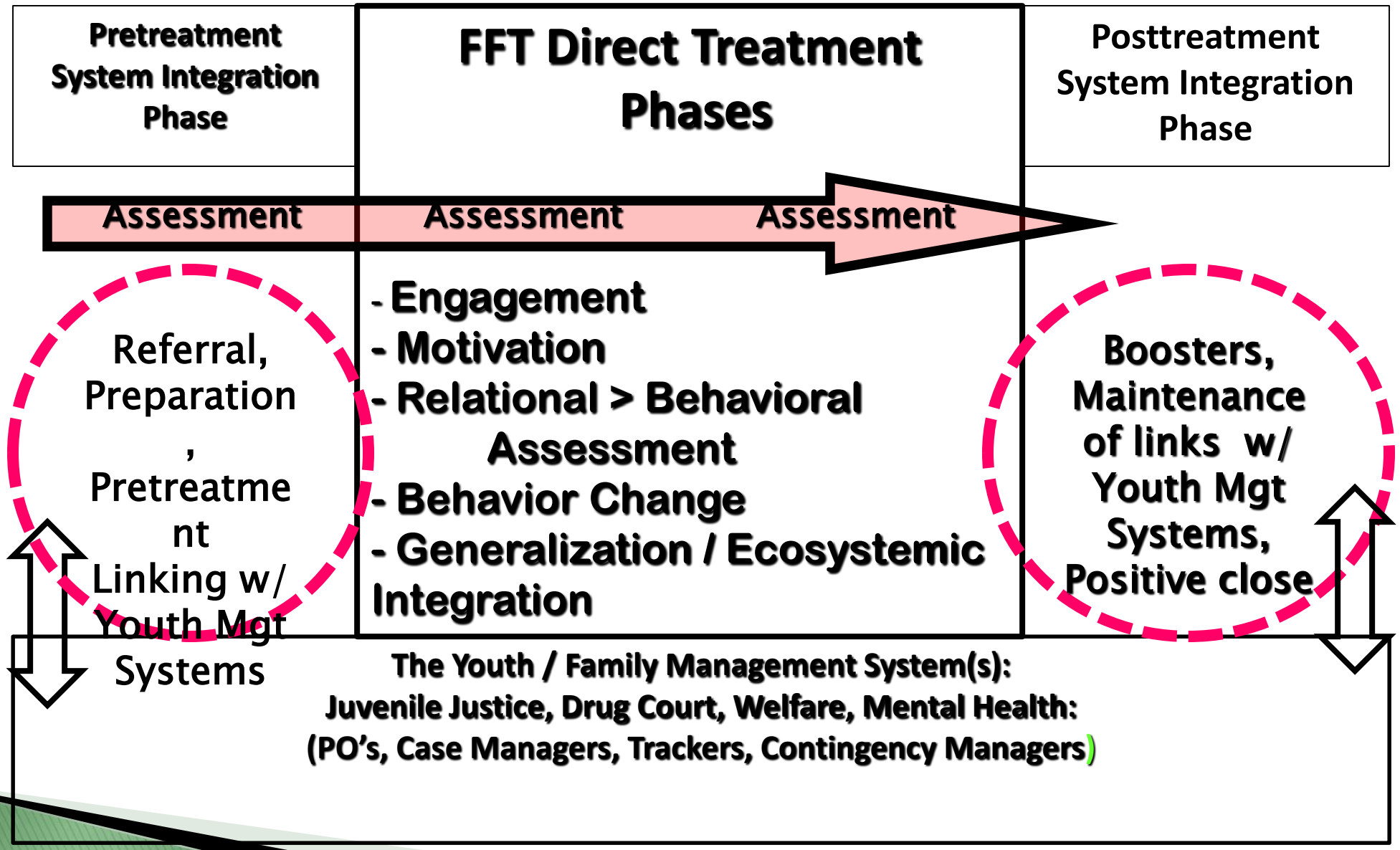
Individual

- Conduct/ Delinquency
- Drug use
- HIV Risk
- School
- Internalizing
- Parent distress /drug use

Out of Home Placement

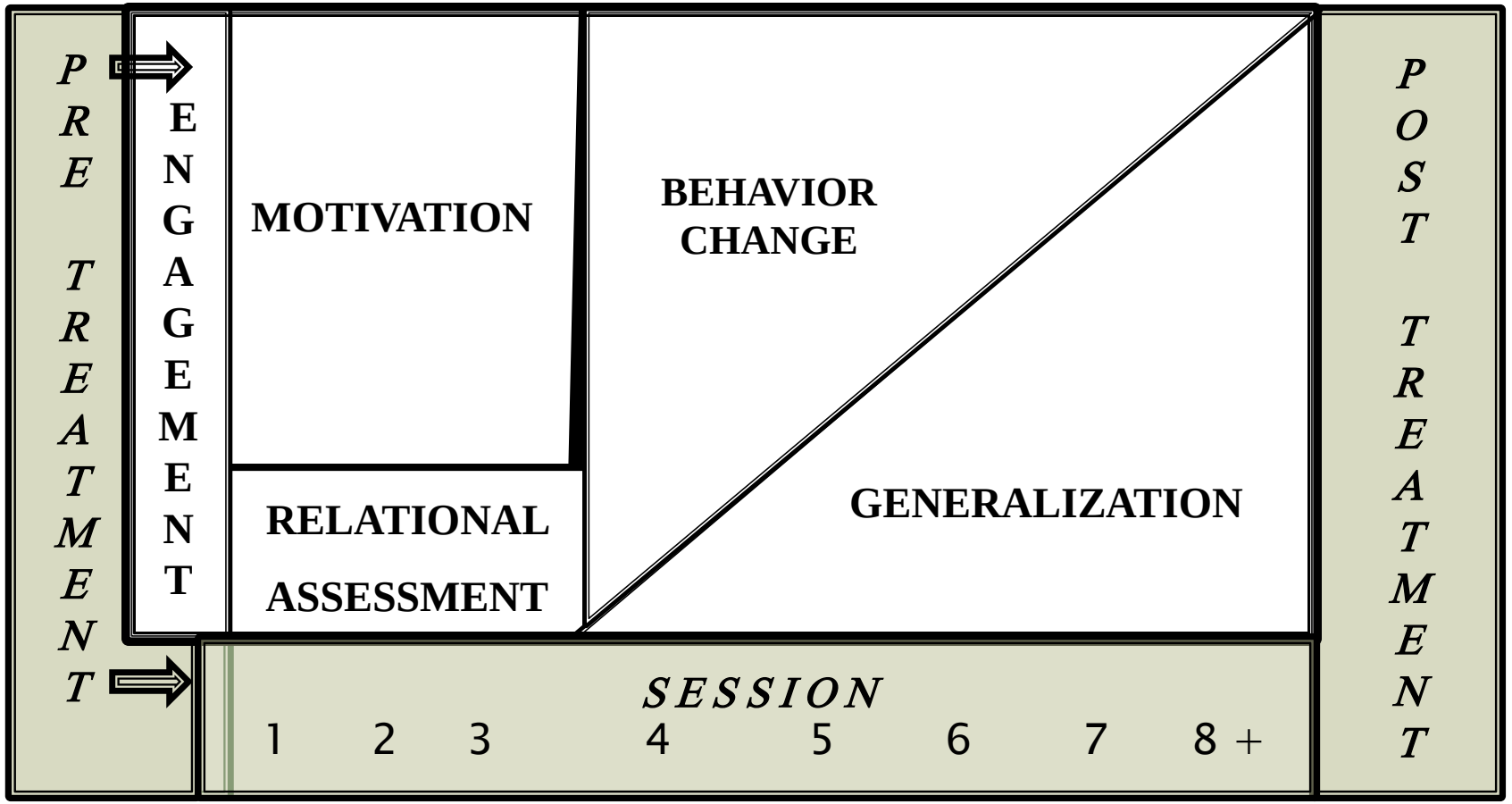
- Incarceration
- Residential
- Foster placement

The Big Picture: Integrating FFT with Other Systems*



* Based on Alexander et al, 1983; Barton et al, 1985; Waldron et al, 2001

Phases in FFT



Enhancing EBTs with Contingency Management (CM)

- *CM is a behavioral approach that involves providing low-cost tangible items (e.g., gift cards, vouchers) to patients who demonstrate a targeted behavior change while enrolled in substance abuse treatment (Stitzer & Petry, 2006).*
  - The probability of drug use decreases when alternative reinforcers are made available in the environment (Carroll et al., 1989; Higgins et al., 1999).
  - The positive effects of motivational incentive programs using low-cost reinforcers and urine screening have been noted across a variety of substances and behaviors, including abstinence, therapy attendance, HIV-risk behavior and recidivism (Carroll et al., 2001; Ghitza et al., 2008; Petry el al., 2005; Rhodes et al., 2003; Stitzer & Petry, 2006).

Enhancing EBTs with Contingency Management (CM)

- *CM is a robust method that is often provided in conjunction with other treatments.*
  - Combining established EBTs for adults with CM appears more effective than those approaches offered without CM (Bickel at al., 1997; Higgins et al., 2003; Higgins & Silverman, 1999; Petry et al., 2000; Silverman et al., 1996).
  - Although the use of CM with adolescents has lagged behind the adult literature, recent studies demonstrate that CM can be used effectively with adolescents (Corby et al., 2000; Kamon et al., 2005).
  - Corby et al. (2000) found that smoking behavior among adolescents decreased only when contingencies were applied.

History of FFT-CM

- As part of the **Blue Sky Project**, all models agreed to develop and implement tailored substance abuse protocols**
  - What is unique to the protocol developed was that urine analyses (as part of the CM module) were conducted by FFT therapists during home-based sessions.
  - To accomplish this, the CM module had to maintain the FFT model principles (strength-based, alliance driven, relationally focused) while conducting individually-driven activities (UA completion).
  - As the protocol was being developed, it was not planned to only target youth drug use but also potentially target any family member's (parents, siblings) drug use. This maintained the balanced alliance principle.

**Based [illegible]dron (ORI) and Alexander (FFT progenitor)

Protecting FFT Fidelity

- To have any chance of this to be successful, it had to maintain the FFT core principles of:
  - FAMILY is our client
  - Maintain a relational (not problem) focus
  - Balanced alliance
  - Match to relational functions
- In the end, instead of thinking of CM as a completely different approach to FFT's Behavior Change Phase, CM was thought of as a very organized and referral behavior specific protocol of BC resulting in elimination of substance use (youth or parents)

FFT-CM E&M Phases—The Same

- Engagement and Motivation—no changes
  - No incentives used
  - No UA's conducted
  - Not focused on the behavioral elements of substance use.
- Changing meaning of substance use
- Repairing family bonds (emotional damages)
- Creating motivation to change and specifically to change substance use

FFT-CM Motivation

- Examples of how to view substance use relationally, strength-based?
  - Youth who drinks excessively to stop himself from hitting his brothers and from hurting his grandmother.
  - Mother who drinks excessively (to point of passing out) to prevent herself from beating her children.
  - Youth who smokes 3 blunts daily when feels rejected by family due to sexuality and to cope with boyfriend being murdered.

FFT-CM Behavior Change Phase

- Family must be demonstrating evidence of motivation to alter SA behaviors
  - Examples of evidence?
- Therapist must have clearly and specifically developed BC Phase Plan that considers:
  - What core family skills that once built, will alter the family interactions/patterns that sustain SA & other problem behaviors
  - How the substance use CM functional analysis (ABC) will build off core skills and what additional strategies may be needed to address triggers for using
  - Must have clear understanding of how relational functions have reinforced substance using behaviors in family patterns
  - If appropriate, how to teach family members to provide relational function-based incentives to motivate behaviors to replace SA
- Will target core generalizable family skills and behavioral strategies specifically targeting the SA symptoms

Behavior Change Attitude

- Equally important as therapist “Attitude” is in Engagement and Motivation Phases is therapist “Attitude” about the change process of Behavior Change
- The most essential therapist attitude is about respect of family structure (via relational functions) as the organizing element of all activities in Behavior Change.

FFT-CM BC Phase Protocol

- UA's or breathalyzers
- ABC for Substance Use (functional analysis)
- Identification of healthy/alternative behavior and activities to replace substance use
- Self-Monitoring Records
- Incentive Record
- Family Incentives (based on relational functions)
- Core skills
- Specific Behavioral Strategies

Behavior Change Process

- Behavior Change is about eliminating problem behaviors of all family members through…
  - Core skill development (parenting, communication, supervision and monitoring)
  - Specific behavioral strategies that target triggers for substance use (CBT strategies for mood and anxiety triggers, relationship skill strategies for relational triggers, etc
  - Specific strategies that target other problem behaviors linked to substance use (truancy, AWOL, etc)
  - Shifting Relational Functions to reinforce healthy behaviors
  - Considering developmental stages (and cognitive abilities) of family members…especially in child welfare

Behavioral Modification

****Goal is to attempt to reinforce desirable behaviors rather than punish undesirable behaviors*

- Impact is most powerful when immediately and consistently delivered
- Building up to weekly reinforcements is not as powerful as immediate reinforcements.
  - Even if reward is "small or minor", when delivered immediately contingent to the desired behavior the impact can be more powerful than "bigger and major" rewards.
    - May be best to do both (small/immediate along with big/build-up)
    - Get an iphone if go to school every day for 60 days versus get to go to girlfriend's house each afternoon youth goes to school (youth is autonomous with parent)
      - Have more opportunity to catch youth "doing good" and immediately reinforcing it on daily basis

Behavioral Modification via RF's

- Basic behavioral modification is about shifting focus to desirable behaviors and shifting interactions to increase desired behaviors thus decreasing undesired behaviors
- Relational Functions in Behavior Change = achieving a QUANTITY OF INTERACTION with another family member as a result of a behavior
- At the time of referral, youth and parents have been provided quantity of interaction *(contact, midpointing, autonomy)* in response to referral/problem behaviors rather than constructive behaviors…thus reinforcing (increasing) those undesirable behaviors

Behavioral Modification

- Positive—add something
- Negative—take away something
- Reinforcement—increase behavior
  - Positive reinforcement (add to increase)
  - Negative reinforcement (take away to increase)
- Punishment—decrease behavior
  - Positive punishment (add to decrease)
  - Negative punishment (take way to decrease)
- Focus on increasing DESIRED behaviors (reinforcement) by adding something (contact) or taking something away (autonomy)

Developing Collaborative Behavior Change CM Plan with Families

- Behavioral Modification via Relational Functions
  - There is a continuum for discussing "Relational Functions" with family members…must decide which process is best matched to families
  - Given that rewards in CM include relational payoffs and that families need to know what specific behaviors are expected of them, a discussion of these relational payoffs must be explicit and concrete in session
  - For some, complete demystification of relational payoffs is appropriate (full explanation of family members' relational functions with each other; explain how to shift when the payoffs are received from reacting to undesirable to proactively focusing on desirable behaviors; coaching them in session)…
  - For others, concrete coaching of how to respond differently without any explanation of functions is appropriate (coaching youth to hang out with Mom on evenings when Mom gets up and goes to work—Mom midpointing to youth)

Transitioning from BC to Generalization

- Transitioning to the Generalization phase occurs when there is evidence of:
  - eliminated substance abuse behavior (UAs, Breathalyzers)
  - that family is consistently and independently (from us) using their new skills.
  - anticipation of relapse.
  - of other targeted behavior elimination/reduction (school attendance, mental health symptoms, AWOL, etc).

FFT-CM Generalization

- Same Generalization goals:
  - Continued practice of skills (internal and external family circumstances)
  - Anticipation of relapse
    - Education about it
    - Identification of triggers via ABC and Relational Functions
    - Development and practice of strategies to prevent and reduce relapses
  - Additional support to help family continue to be successful…AND EMPOWERED

FFT-CM Generalization Protocol includes:

- In-session UA's continue
- Self-Monitoring Record continues
- Incentives (monetary and relational) continue
- Incentive Record continues

FFT CM—data from the field

- Elkhorn, WI
  - Trained in FFTCM in 2013
  - Collaborate with drug courts (44 referrals)
  - 73% success rate
- Dayton, OH
  - Trained in FFTCM in 2013
  - Collaborate with drug courts (250 referrals)
  - 75% success rate
- BlueSky NYC
  - Trained in 2012
  - Juvenile Justice/Probation (85 referrals)
  - 70% success rate

Considerations for CM Readiness

- Referrals (how many will be CM appropriate)
- For all therapists on team?
- Financial considerations
  - $100-150 total incentive money per family
  - Costs of testing equipment (UA during each BC and Gen'l session)
  - If testing multiple family members (parents, siblings, etc)…separate $100-150 per family member and testing equipment)
- Commitment of team to take full responsibility for eliminating substance use