FFT and MST: What’s the Difference?

Communities and stakeholders often ask, “What is the difference between FFT and MST? Do we need both? Why or why not?” FFT (Functional Family Therapy) and MST (Multisystemic Therapy) are similar in a number of ways. Both are recognized as Blueprints Model Programs by the Center for the Study and Prevention of Violence and are among only a handful of programs that have met the highest standards for evidence-based programs. They serve similar, but not identical, populations and the research shows they achieve similar outcomes. However, FFT and MST achieve those outcomes by different means.

FREQUENTLY ASKED QUESTIONS

Are there differences in the target populations of FFT and MST?
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Which program is better for my community? Do we need both?

Are there differences in the target populations of FFT and MST?

FFT and MST have been shown effective for overlapping populations. FFT has been studied with youth ages 13 to 21 years old, although FFT programs will accept youth as young as 10 years old. FFT research has focused primarily on youth with behavioral offenses (e.g., running away, chronic truancy, shoplifting, “ungovernable”) and substance abuse, but has also included youth with multiple serious offenses including felonies and youth returning home following incarceration. Research has shown MST to be effective for youth ages 12 to 17 years old with chronic or severe antisocial behavior, including youth with histories of violence or felonious behavior and youth with histories of incarceration.

Both services require that there is a caregiver involved with the youth’s treatment. Neither program accepts youth whose primary referral concern is sexual offending or who are acutely suicidal, homicidal, or psychotic (i.e., need a higher level of care). Neither program has been studied with youth with autism spectrum disorders.

Based on the clinical models used by each program, the reasons behind a youth’s acting out behaviors and the youth’s most immediate treatment needs may be helpful in deciding which program to refer a youth. FFT may be a good fit when the youth’s behavior is driven by family issues (e.g., high conflict, histories of abuse or neglect) or psychiatric concerns, or when the caregiver is initially reluctant to participate. MST may be a good fit when the youth’s behavior constitutes “willful defiance” and is driven primarily by peer, school, or community factors, or when there needs to be immediate intervention.
outside of the family. While neither model has been evaluated for youth with intellectual disabilities, youth with lower IQs (e.g., 65-80) may be better served by MST. It is important to note that these suggestions are based solely on clinical reasoning; at this time, there is no research on how to best assign youth to the two programs. Furthermore, according to state policies in Pennsylvania, best practice dictates that referral decisions be based on evaluation of the youth by a qualified professional and input from the child's treatment team. This team includes the youth and family as key decision makers in the process.

In Pennsylvania, when services are funded by Medical Assistance, youth need to meet the eligibility criteria in the provider's OMHSAS-approved service description.

Are there differences in the outcomes of FFT and MST?
The outcomes emphasized in each model are very similar. Outcome assessment in FFT focuses on change within the family, such as improved parenting skills, improved communication, and reduced conflict, as well as whether the youth has refrained from substance use and criminal activity, stayed in school, and improved his/her behavior. Outcome assessment in MST focuses on the “universal 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, and involvement with prosocial peers, which research suggests contribute to the universal outcomes.

FFT has more than 40 years of research behind it, and MST has been studied since the 1980s. 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. Research on MST has also found to improve peer relations, improve school performance, and increase the likelihood that the youth will attend school. Clinical research trials for FFT have not yet examined these outcomes.

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 14 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.

Outcomes specific to Pennsylvania as well as logic models highlighting key research findings are available at the EPISCenter web-site: www.episcenter.psu.edu

Is there a difference in the theoretical rationale behind FFT and MST?
Both models draw from family systems theory and integrate behavioral approaches, but FFT and MST differ in where they focus.

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. When changes are made in how the family interacts (e.g., improving communication, problem-solving, and
parenting skills), behavior problems will be resolved. Interventions must take into account the needs of each family member and be tailored to the family’s unique risk and protective factors.

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., community, neighborhood, school, peers, family, 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 whenever possible, such as cognitive-behavioral, behavioral, behavioral parent training, and strategic and structural family therapy approaches.

How are the FFT and MST treatment models similar?
There are a number of similarities between the two clinical models. Both models:

- Are strengths-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. In FFT, interventions are based on an assessment of the family’s strengths and relational needs. In MST, treatment is tailored by identifying the “drivers” of a referral behavior and then developing interventions to address those drivers.
- 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.

What are the differences in how FFT and MST work?
There are many similarities in how MST and FFT approach treatment, but also some differences.

FFT works with the entire family, so the youth and his/her caregivers are present at every session. Consequently, sessions are often held afterschool 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 an 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.
MST can work with the caregivers, youth, or entire family. Sessions are often held with caregivers without the youth present. The therapist often intervenes in other systems, such as school or the peer domain, early in 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 often behavioral in nature, including strategies such as supervision and monitoring plans, reinforcement of desirable behavior, and sanctioning of undesirable behavior, but therapists may also provide family therapy to enhance relationships. MST strives to keep the need for formal services upon completion of MST to a minimum and build natural supports to help the family maintain their progress.

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

Which service is more intensive?
Both 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 both models, the frequency of sessions can be adjusted based on clinical need, allowing the service to be responsive to periods of crisis or high risk and to decrease the intensity for families with lower levels of need.

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 4 months and the average length of stay should be less than 6 months. The MST model is designed to be delivered in 3 to 5 months. According to data collected by the EPISCenter in 2010, the average length of treatment for Pennsylvania youth successfully completing FFT was 3.7 months; for MST, it was 3.6 months.

How do FFT and MST handle crisis situations?
MST teams are available to clients 24/7. When a crisis occurs, the family can call an MST therapist or supervisor, who will go out to the home if necessary.

FFT takes a different approach. When a family is at risk for crisis or is in a period of high need, the therapist increases his/her availability and meets with the family more often. Families are therefore provided crisis prevention to reduce the need for after-hours crisis intervention. FFT believes that this approach empowers the family while reducing reliance on formal systems. While the model does not allow FFT therapists to be on-call around-the-clock, many agencies that provide FFT also provide crisis services.

Can FFT and MST therapists keep the referral source informed?
Yes, this can occur in both programs. MST defines consultation to and collaboration with other systems as a key element of the model from the beginning of treatment. 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. However, FFT therapists can certainly keep referral sources informed about a youth’s progress 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. (Note: In Pennsylvania, programs funded by Medical Assistance must staff their teams in accordance with their OMHSAS-approved service description, which may include stricter, more specific hiring requirements.)

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. The supervisor may carry a small caseload under certain circumstances but it 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 at least 35 youth per year and a large team (4 therapists) can serve over 60 youth annually.

**Which program is more cost-effective?**

In 2004, the Washington State Institute for Public Policy derived economic benefits minus costs for a variety of prevention programs using a scientifically rigorous review and analysis of prevention programs. According to the WSIPP report, which is based on 2003 dollars, FFT outside Washington had a cost-benefit of $26,216 per youth, while FFT within Washington demonstrated a cost-benefit of $14,315 per youth. MST had a cost-benefit of $9,316 per youth. For more information on the Washington State Institute for Public Policy report, *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, access the full report at: [http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf](http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf)

Information regarding cost-savings in Pennsylvania is available in *The Economic Return on PCCD’s Investment in Research-Based Programs*, published in March 2008 by the Penn State Prevention Research Center: [http://prevention.psu.edu/pubs/docs/PCCD_Report2.pdf](http://prevention.psu.edu/pubs/docs/PCCD_Report2.pdf)
Which program is better for my community? Do we need both?

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 in Section 2 of the MST and FFT Implementation Manuals, located on the EPISCenter web-site: www.episcenter.psu.edu/ebp. The EPISCenter is also available to provide communities with assistance navigating this process.

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