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Functional Family Therapy: An Interview With Dr. James Alexander

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❖ Interview

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Dr. James Alexander is a professor at the University of Utah. In addition, he is progenitor (with B. V. Parsons) of functional family therapy (FFT), a nationally and internationally acclaimed and empirically demonstrated intervention model for juvenile delinquents, oppositional and conduct disordered youth, and substance abusing youth. He has been honored in several areas, including but not limited to the following: member of the Top U.S. Mental Health Experts noted in *Good Housekeeping*; Superior Teaching Award and Faculty Fellow Research Award from the University of Utah College of Social and Behavioral Sciences; and Scientist Exemplar Award (American Association for Marriage & Family Therapy). He has led more than 200 national and international clinical training workshops and authored more than 85 chapters and refereed journal articles. He also has been the senior consulting editor for *The Family Psychologist* and a past or present editorial board member for seven major family-related journals.

This article presents the functional family therapy of James Alexander, focusing on his work with high risk, youth who are high risk, delinquent, and who abuse substances. The interview addresses evidence-based interventions, individualizing treatment, and prevention of violence. Training efforts and recent developments in functional family therapy are discussed.

Keywords: *functional family therapy; family system; youth, behaviors; skills, motivation; community*

Onedera: Functional family therapy (FFT) is a family-based treatment for youth who are high risk. In some of the literature its design is referred to as a "blueprint program," "family-based empirically supported program," and I am wondering if we could start with that. How do these designations best describe functional family therapy?

Alexander: Well the "blueprint," that's an easy one because in the mid- to late-90s a number of major, we'll call them institutions, such as the Center for Disease Control, Office of Juvenile Justice and Delinquency Prevention, a lot of people got interested in more-effective treatments of delinquency, violence, that sort of thing. And the Center for the Study of Prevention of Violence, and this is Del Eliot, with Sharon Mihalic, got together a huge grant that included money from National Institute of Justice (NIJ), Centers for Disease Control, and some other crime commissions to look at what seemed to be evidenced-based approaches that met very rigorous criteria about being effective for dealing with these kinds of kids. They found very, very few (evidenced-based approaches). They started out a review with 500 programs, now they're up to almost 1,000. But out of the 500 they only found initially 10.

Onedera: My goodness.

Alexander: And the qualifications were that they had strong empirical records including randomized trials. They also had to have been independently replicated so it wasn't just all at one place, with one guru or one person running the show. They also required that the programs had manuals that could be replicated, had the evaluations for what could be accountable in terms of what therapists do, etc., etc. So that's what gave it the designation of "blueprint." It was just number one of these blueprints, and they were called Blueprints for Effective Violence Prevention. That's all that means. And there are a number of other labels such as a "level one model program," that's what the surgeon general's report called it. And then evidenced-based. All of these different titles say that it's one of that very small group that has satisfied these criteria.

Onedera: Okay and some of those criteria are that it's working with this population. Would that be correct?

Alexander: Yes, that it is working, and it's been proven to work with very rigorous testing, not just a lot of assertion, case reports where people are saying "X percent of our people are getting better." Because a lot of programs do a lot of advertising; but yet when they are subjected to randomized trials they don't have an impact that's notable. Classic examples are things like the D.A.R.E (Drug Abuse Resistance Education) program. You know D.A.R.E. was very popular. You hear all kinds of testimonials, and yet all of the national reviews are being very clear: D.A.R.E. does not impact drug involvement among youth.

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Onedera: Using the D.A.R.E example, what would be some of the differences between the D.A.R.E program and the functional family therapy program that make the functional family therapy program work?

Alexander: Well, probably the biggest difference is that D.A.R.E. is not individualized. D.A.R.E. goes in with a kind of curriculum-based notion. It's a somewhat demeaning way to put it, but it's actually one that really is very appropriate. So the D.A.R.E. program comes in and says, "These are the kinds of things, you know, don't use drugs for the following reasons . . . these are the kinds of ways that people think who use drugs." It's erroneous thinking. It's like a lot of programs that are group based, including, you know, a lot of the prevention programs and a lot of treatment programs. They have basically this notion that, "Here is what's wrong with people who use drugs or belong in families that have drug-involved kids, etc., etcetera . . . and here's what you need to do." So we have, for example (programs sending the following message), "The parents need to do more or less of this." A lot of the parenting programs are that way. And they are not individualized.

What we mean by *individualized* is that a given disorder, such as violence, drug involvement, depression, suicidality, they have as many differences as similarities. And most of those programs focus on the similarities. (For example) "Everyone who commits suicide is depressed and impulsive." So therefore, they think that since it is impulsivity and it's depression, if we just deal with the depression and impulsivity (such as providing) ways to avoid it, this is how it should be treated for everyone. Then we are going to impact suicidality. And yet sometimes it doesn't work that way. Different people commit suicide for different reasons, and we must understand this on a case-by-case basis. This same principle goes for people in different cultures, value systems, and the like.

Onedera: Well one of things that struck me was that the functional family therapy really considers multicultural sensitivity and sound clinical judgment, and I would think that those two among many other factors really contribute to this idea of working with the client on an individual basis.

Alexander: And on their own terms, and it has to be, yes, in a respectful manner.

Onedera: Okay.

Alexander: You know a sharp contrast, and this is one that is very popular . . . Dr. Phil is a wonderful example of somebody who comes in, and he is very "opinionated" and very knowledgeable. He tells people things that supposedly they need to hear. But it sometimes is not "respectful" in the sense of that it accepts them (clients) on their own terms. You've seen, I've seen some of the advertisements for Dr. Phil. And he'll say things, "There are 14 signs of a serial killer and your son has 11 of them. And you have to get on the program here or you're going to be raising a serial killer." That is information that may be statistically true, but many people see that as extraordinary criticism and disrespectful, and certainly blaming.

Onedera: It also sounds like there is a positive approach to working with individuals, especially who are high risk.

Alexander: Absolutely. And a lot of the programs that are very popular for these kids are more punitive and negative such as scared straight, boot camps, all of those things that have been proven not to have a positive impact.

Onedera: Okay, well as long as we are talking about this, what are some of the target populations that you are working with?

Alexander: Target populations in terms of disorders tend to be, first of all, age; we are usually talking about 7 to 18. In terms of behavioral problems, you have a range of so-called externalizing behavior problems that include everything from truancy, violence, drug involvement, delinquency, curfew, all of those kinds of things. We also have populations that have a lot of comorbidity, or they have comorbid problems of depression, anxiety, and other so-called comorbid disorders. In one of our most recent statewide projects, we haven't published the data on this yet, but they were published by the Washington State for Public Policy.

In that project roughly 50% of the kids that we ended up seeing have had documented physical or sexual abuse. We have kids, we're used to dealing with kids that come in with lots of so-called comorbid or highly at-risk kind of problems. So these are not the selected kids that are motivated to change or don't have a lot of problems. In fact, they do have a lot of problems. The delinquency, oftentimes, is just one part of a much larger pattern of problems.

Onedera: You also mentioned in your article (*Functional Family Therapy*) this idea of preventing delinquency. How does that work?

Alexander: Any time that you do a family-based program that changes the nature of the family system, you are also, in a positive direction, preventing the appearance of those very same delinquent behaviors in younger siblings. Because when a kid comes from a family that is quote, "delinquent," violent, whatever it is, they are more at risk than the general population becoming that way themselves. So if you deal with it in the context of fixing one set of larger system problems you also prevent other problems in that system. Another way in which the prevention is used is to prevent a continuation or an escalation in terms of severity of disorders.

Onedera: So functional family therapy, as far as prevention is concerned, tries to prevent the continuation of a problem, as well as addressing some of the siblings of the adolescents that you might be working with.

Alexander: You don't necessarily address them (siblings) directly. What you do is you deal with the family system and the dysfunctional patterns within the family system that elicit and/or support the deviant behavior. When you do that you are changing the family system and many of those parameters that, in fact, put other kids at risk. So they are at less risk, but you are not necessarily going in and saying, "Now let's talk about your seven-year-old that isn't having problems yet. It isn't addressing them directly in that sense. It's more like addressing the whole system.

Onedera: And in doing that it seems like it's also done in what is called a "short-term intervention process."

Alexander: Very short term.

Onedera: What's the helpfulness of keeping it a short-term therapy, namely, short-term interventions with the family system, and the individual?

Alexander: The helpfulness is really kind of a side benefit. The helpfulness is that it's much less costly.

Onedera: I see.

Alexander: And the other reason, it actually improves long-term functioning but it costs less and takes less time. The bottom line is improving functioning and significantly decreasing negative behaviors (such as) drug involvement, etc. The reason that the short term brings additional factors on is that you do not undertake many of the quote, "as usual," approaches that are less effective but are more traditional.

INTERVENTION PHASES

Onedera: Dr. Alexander, I would like to move into those approaches, specifically these interventions phases. I'm wondering if you could talk a little bit about these interventions processes or these intervention phases.

Alexander: The first and, in many ways, the most important phase, *the linchpin phase*, is engagement and motivation. Without engagement and motivation, all of the rest of the phases, even if they are done perfectly, are basically almost doomed to failure; an outcome that doesn't improve the situation over what any other approach would do. All of the behavior change phase (the second phase) and what we call *generalization* (the third phase, which ties the family into other multisystemic contexts, getting them involved back in more-positive peer relationships, etc.), will be ineffective if you haven't addressed the engagement and motivation in the youth and in the family system that is wrapped around the youth.

Onedera: And some of these examples of what goes on in the first phase, engagement and motivation, is this idea of developing a family focus, minimizing hopelessness, and reducing negativity.

Alexander: Yes. Those are the goals and the important thing to point out is that they are relational and belief goals; that is, they are not behavioral goals; it doesn't say, "Getting people to learn to communicate better," it doesn't say, "Helping people learn better study skills," it doesn't say, "Help people get refusal skills for drugs," it doesn't say, "Getting people the ability to increase their linking to underhelping agencies." It is all relational and attitudinal within the family. That is what the "hope" is. That's what the reducing negativity and blame is all about.

Onedera: How is that incorporated, let's say, into intervention techniques; this idea of relational goals and improving those?

Alexander: Well there are a number of techniques. I can tell you in the negative just as well as I can in the positive. For example, if you go in and ask everybody what they want from treatment, you are automatically going to elicit high rates of blaming and focus on person-individual problems. But if you avoid going into that sort of listing of the bad things need to be changed and, instead, go to a process that we summarize as reframing and creating positive relational themes, that switches the focus in terms of what the drug abuse, or the violence, or the truancy is all about. It helps people experience that the problems really come from a very, very different place. And it's a place that does not involve blame that is the biggest shift that you can go through. So people come in, they are blaming themselves, they're blaming each other, or they're blaming the outside system.

Onedera: So again, going back to this idea of hopefulness and belief in the individual and the family of the individual; one of the questions that I had about some of the techniques was regarding decreasing resistance. I am wondering how exactly does that happen, how exactly do therapists train in functional family therapy to help decrease the resistance let's say in the client-counselor relationship or within client motivation?

Alexander: You do it by being respectful rather than disrespectful, by focusing on relationships and reframing the motivation for behaviors rather than trying to stop the behaviors. I will give some clear examples. With many therapists and in many traditional and other kinds of programs, if someone shows up and they're drunk or high, they won't have therapy with them. And they will blame them, they will tend to say things like, "You know this drinking that you're doing has a lot to do with why your son uses drugs." And then the child of this parent hears this as blame, and he or she becomes defensive. The kid hears it as an excuse, "See it's not a problem, it's because my dad is a drunk or whatever." So it "dismotivates"; that is not a real word, but we use it a lot. It dismotivates an awful lot of people. Another thing that we do that is very different from traditional; if people come in and they are depressed, traditionally the first thing that people do is get their medication for their depression so that then they can start doing family therapy.

Onedera: Okay.

Alexander: We argue that if we can give people hope in one or two sessions, then a lot of times the drugs are not necessary. Because it is the lack of hope that feeds depression. And if you do need to give drugs to help clients deal with the depression you do it *after* people are engaged and motivated to change. Many of our traditional approaches, and I use the word again, *dismotivate* people to change. If the parent hears, "The problem your son is having is because he's ADHD," then they think that the solution is going to be the medicine that the doctor gives them. And it literally makes it less likely that they're going to do the hard work that's necessary to change the parenting process. Because after all, "It's not our fault, it isn't us." On the other hand, if people come in and say, "it *is* your fault. You need to improve your parenting." The parents hear that as blame and are relieved if traditional approaches either blame neurotransmitters, society, the kids, or the peers. In this context, is very difficult to go in and say, "We blame no one," and yet that is what FFT does. We acknowledge how bad the behaviors are, we do not go in assign blame for them.

Onedera: Sounds like in some ways you have the job of getting in there and breaking that cycle of blame that I am sure typically happens.

Alexander: It is one of the most predictive factors that is characteristic. People who are substance involved tend to be in denial and externalizing. People who have kids, especially older kids, that are having major behavior problems, they're not sometimes unmotivated to participate; they are often literally motivated to get the kid out. A lot of times, for example, the classic stepfather who marries into a family and the oldest is the one who is acting out, he is literally more motivated to get rid of that kid than he is to make this work. Because it won't cost him as much money, the turmoil will

go down, and the stepdad may well feel that the difficulty that this kid causes (because there is not a relational bond there) is going to decrease if the youth leaves the family. And so in a lot of situations with these blended families at least one of the parents is absolutely prepared to get rid of the kid; to get him into a boot camp, to get him in wilderness programs, to get rid of him or her.

That is one of the things that a lot of people in our field don't tend to acknowledge. They tend to act as if they believe that if we give parents a tool to be good parents, they are going to be happy and just start adopting those tools. And even when the kid changes, a lot of times the parent won't change, and the thing falls apart. A lot of treatment programs that are residential experience this; they pull kids out of the home environment and "fix them" and then put them back in the original environment. Then what they say is, "You all have to continue to do the right thing the way we did in residential treatment." But you know residential treatment has people that are paid and trained to do things well.

Parents, in contrast, a lot of times have mental health or other issues themselves. Sometimes they are depressed themselves, they are using drugs themselves, or they are very, very upset because one problem kid is going to create problems in the other kid. So they are negative and frightened and angry. And all of these things do not allow them to continue the positive changes that, in fact, were made in residential treatment, boot camp, or similar programs that remove the youth from their natural environment but then return them without changing the natural environment. In contrast, evidence programs such as FFT and multisystemic therapy deal directly with those natural environments.

Onedera: It sounds like all of these things are very important factors that come into play in this first phase of engagement and motivation. What happens then when the client and family of the client are motivated, and we move into Phase II, the behavior change phase?

Alexander: During the behavior change, you give people the tools. These include emotional tools, cognitive tools, and behavioral tools to initiate and maintain the short-term and then long-term behavior changes that are necessary for them to be more adaptive within the family and outside the family. This includes the standard things such as communication skills and careful listening, and also includes such strengths as study skills, job-interviewing skills, peer-relational skills, time-management skills, and drug-refusal skills. There are a whole bunch of skills that a lot of programs address. And you notice that we are not saying, "There is a different set of skills for FFT." The difference is, we're saying, "The first thing to do is engage and motivate," and you don't do it through negative consequences. Instead, you develop an alliance-based motivation. Then, based on that, the behavior change skill training is relatively easy.

Onedera: And in addition to that, it seems like there is also a focus on changing in cognition, emotions, and relationships that go along with what you just said.

Alexander: Cognitions, emotions, and behaviors. There are three major ways in which people exist in the world. Some people would argue that spiritual would be the fourth. To some degree, this is important if *spiritual* means that the people you are working with believe in some kind of god or higher power; whatever is the case, people have a certain belief in what human nature is, and we must respect that no matter what that belief is (including the belief that there is no God).

Onedera: Okay.

Alexander: We are going to kind of include that more in the cognitive. So people have belief systems, and they have ways of thinking. They also have behavior patterns. They also have emotional reactions. You need to address all of those, and you need to address them differently based on different people. Certain people are walled off from their emotions, and it is inappropriate to force them to get in touch with their emotions to have positive change because that then is disrespectful. Such an approach implies to people "you have to change on our terms." That is one of the reasons that we argue so many programs have higher dropout rates. In contrast, we have very high engagement and completion rates given this population. The only way to do that is for our families to experience that we accept them in terms of what mode *they* have for dealing with the world. And you need to work with what they bring you rather than having that "one-size-fits-all" kind of notion such as this is the way you have to think, this is the way you have to feel, this is the way you have to behave.

Onedera: In other words, FFT therapists really need to be very strong in their therapeutic skills that address, like you, all three of those dimensions.

Alexander: Yes, and to do flexibly.

Onedera: Okay. So when we move on then from Phase II to Phase III, Generalization Stage, talking about the establishment and strengthening of community links and institutional services, how exactly does that work?

Alexander: That involves helping them (e.g., at-risk youth) learn how to and practice how to engage those systems, sometimes on their own but also sometimes through our reaching out into those systems. A lot of times some of those systems won't respond to individual clients, especially if they had a bad tradition, a bad history, with them. A lot of school principals are not interested in dealing with a kid who is the third kid in the family who has been thrown out of the school if the parent calls up and says, "Let my kid back in." The school systems often are not open to doing that because it costs them time and money. So a lot of times we initially have to do that for the family. We have to help intercede with a variety of things they are not capable of getting their hands on; everything from getting their Medicaid reimbursements back on track. So we're helping them get a hold of resources. On the other hand, there are many things that are strengths in the community that they also can access but haven't felt okay to do it. These would be things like faith-based systems, 12-step programs, or other resources. And they haven't felt like that was available to them or they felt like they didn't belong, they didn't fit. And we help them go through whatever is necessary to help them connect with these systems you need those larger, multisystemic supports in place to maintain change.

So one difference between FFT and a lot of programs for these youth is that we don't use the youth alone to create change. We create the change internally in the family through engagement, motivation, and behavior change. And then we

reach out to multiple additional systems to maintain the changes. There are a lot of programs put them (clients) into medication, they get them into support groups, they get them into church to get change started. And we argue that in many ways that disempowers them internally. It doesn't get them a sense that this comes first from within. And that is what FFT is about.

TRAINING FFT COUNSELORS

Onedera: How do you feel that professional counselors today are being trained or not trained to conduct some of these systemic treatment links in treatment?

Alexander: Counseling psychology, clinical psychology, social work, and marriage and family therapy are four major groups that produce therapists in America. Many of them are not emphasizing evidenced-based practices. They are doing their major training in therapies that are traditions in the field, but many of them do not have any evidenced based in terms of being on these evidenced practice lists. And a lot of times that is because the instructors, teachers, the professors, the senior clinicians, the supervisors weren't trained in these models. They were trained in other models. And many times they do not move out of that comfort zone. So they continue training in kind of business as usual, the way it's pretty much been for a long time because those are seen as the standards in the field.

And for us a comparative example is in medicine. For many years, there were standards in terms of treatment for polio. That included iron lungs, with the field getting better and better with iron lungs. It included a lot of medical management. Then somebody comes along and says, "Guess what, if we can inoculate, if we can do this very differently then we used to do it we can have a huge impact. But it's very, very different." And teachers in the field of adolescent treatment are no different than any other kind of human beings, things that are very different can threaten their livelihood, and a result a lot of times is that the evidenced-based interventions are not adopted readily.

ASSESSMENT

Onedera: I'd like to talk a little bit more about your assessment procedure. I know that FFT is considered to be multilevel, multidimensional, and multimethod. What are some of the parts of FFT assessment as one is attending to each one of these criteria?

Alexander: You are going to be using everything from official records, from the juvenile court, arrest records, things like this. That is one source for the official records. You also are going to be using information from other official sources such as probation officers, schoolteachers, and all the rest. All of this requires very careful attention to privacy and issues of violation of privacy, making sure that all of this is done in the context of full awareness and protection of the people involved. So you've got official records, then you have official people in the environment. Then you have information that comes from the clients themselves, their own perceptions of their lives. This is developed at the level of individual youth, the parents providing information about the youth, the parents about themselves, and also the youth about the parents.

Onedera: Really getting all of the systems involved together.

Alexander: Well, not necessarily at the same time. It's not that we all sit down and have this big case conference. The FFT is an integrative element, but it's not like you get everybody at the table at the same time. Because then that leads to its own set of interesting kind of power and communication issues. Often we get information about the family from referral sources before we sit down with the family.

Onedera: The literature (about FFT) mentions the clinical service system or CSS, does that have anything to do with what we are talking about thus far, this idea of a multidimensional assessment?

Alexander: Yes, that's what I am describing and I hadn't finished. So you have official records, you have other external sources, then you have the family about each other and themselves. Then you have the therapist who is also making observations about the family. So think about it, with a given youth you have information coming in from numerous sources, and independent of that FFT therapists are involved in a weekly consultation process as part of our site certification process. This consultation comes from an independent consultant who's an expert in functional family therapy. And all of those represent input into a given youth and a given family.

Onedera: Okay, and that would summarize what the clinical service system (CSS) is.

Alexander: That's right, and it includes information, for example, from pediatricians who may have information about previous diagnoses. So you also have information from other medical systems; all of this is part of the decision-making process.

Onedera: Is it safe to say that the therapist is pretty much the director of all of this happening?

Alexander: Well, the therapist is the integrative resource for it. Whether or not the therapist is the director depends on a lot of systems. And whether or not those systems are invested in having, you know, a particular director. Some systems are going to require it to be a medical director, others require a probation officer, and so on. So we can't say the FFT therapist is the director, but the FFT is the person who in every single case has the resources and the vehicle to do this integration; but however that happens depends on all the systems involved. These vary tremendously in different communities, cultures, and countries.

Onedera: The system sounds also sounds like the community. Would that be correct?

Alexander: Well when you say the *community*, you don't have, for example, direct input from other people in the community. For example, we don't have community meetings where other people who live in the neighborhood are necessarily going to give you input about this kid and family.

Onedera: Okay.

Alexander: That is very dangerous in terms of issues of privacy and all the rest. So you got to realize that a lot of people when they want community input, they mean having literally patient advocates or people in the community, paraprofessionals, that kind of stuff. The problem with that is, that you then, like I said, have some real issues in terms of confidentiality

and privacy. And so we don't mean "community" in that way, we do mean input from the community of resources who are dealing with, or hopefully will be dealing with, these youth and families. Then we want other community members (neighbors, advocates) involved, but we have to be careful because medical records and psychiatric records and things like this are very, very private and privileged communication. So we don't have that from just anybody on a general basis.

Onedera: So part of this idea of community implementation is that members of the community are interested in the client or a population and are serving as service providers or advocates.

Alexander: I'm not sure if that is exactly what I said. Members of the community?

Onedera: Well, I am wondering about this idea of community implementation of functional family therapy and trying to get a better understanding of what that is.

Alexander: Okay. Community implementation, in the way we talked about it, means that we reach out to every potential positive resource that could be available in the community, and then link up with them either directly or through the family in ways that can maintain change.

Onedera: What would some of those examples be?

Alexander: 12-step programs. Those are a community resource. It could be one of a number of church programs. For us, Burger King, who hires kids, is also part of a community resource. If a kid does not have a job and getting a job is going to help kids not hang out and have to steal, then Burger King becomes a community resource. It's not one that we can pay, it's not one that pays us. They don't get any funding from anybody to do a community service for these kids. But if we can get the kid a job, then in fact that becomes part of the community that we reach out to in order to facilitate the process. But that does not mean that we call up and say, "Here is a delinquent" or "Here is a kid with a violence history, we want you to hire them." Many times we have to help the youth and families understand how you apply for a position at Burger King, how you dress, what skills you need, what we can work on with them so they can get a job. This is some of what our generalization phase involves, along with relapse prevention training and anticipating future stresses on the family.

RECENT FFT PROJECTS

Onedera: That's helpful. Thank you. We briefly summarized everything that's involved (in FFT), and I know there is so much more. I am wondering if you will talk about The Family Project, the partnership between the University of Nevada and the Clark County Department of Family and Youth Services (DFYS) or if there was another project that's going on.

Alexander: Well we have a number of them. I mentioned the Washington State Project. That was a statewide implementation across 14 different sites. In that project, they randomly assigned almost 500 youth to either functional family therapy or treatment services as usual. And they have already done 12- and 18-month follow-ups. In the process we've learned an awful lot about implementation; including the fact that therapist adherence to the model is critical for replicating the positive effects we've produced over the years. And Washington State has changed their whole juvenile justice system as part of this process. So that is one example. We are also doing it statewide in Pennsylvania. We're launching a new program through the Community Institute for Mental Health out of California, and we've also got a statewide, whole new initiative starting in New Mexico. In New York, we are working with the Office of Mental Health and the Office of Child and Family Services. So we have a number of those large systems. Tom Sexton just got back from Amsterdam where they have five teams that service a major part of the Netherlands. So there are a number of them that are out there we could talk about.

SUMMARY AND ADDITIONAL REFERENCES

Alexander: The best contacts for a lot of these larger project initiatives include Dr. Tom Sexton. He is referenced in a lot of the FFT information. Doug Kopp. They have a lot of additional summary materials that they can talk about, for example, the number of different languages in which FFT is now being delivered.

Onedera: Wonderful.

Alexander: In one community site in Oakland, California, I think they're doing FFT like in seven different Asian languages. And then, of course, we have huge populations that are Latino/Spanish speaking and then we have a number, you know we have bits and pieces here of such populations as Russian immigrants. It is very hard to provide services to these populations, and yet these are many times the very people that are the most at risk. So part of our "matching" philosophy is you need to provide services in a language and in a value and culture system that can maximally match the clients. That, of course, can be a huge challenge. That is the kind of thing that is very important to us in terms of community replications, in developing new funding streams and referral sources. Doug Kopp can provide some information on how many (youth) come from child welfare, how many come from juvenile justice, and so on.

Onedera: I want to be respectful of your time. And like I said, I think our conversation today provides a foundation for where people can get information.

Alexander: Thank you.

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