FFT LLC, NYC ACS Questions, June 2019

Overview of model

How was the model developed? Commencing in the 1960s, Dr. James F. Alexander of FFT LLC, an Emeritus Professor of Psychology at the University of Utah and now considered a foundational figure in the field of family therapy, began a series of outcome studies to examine the effectiveness of a family-based method of interventions for at-risk and delinquent adolescents. Alexander's early studies developed and shaped a therapy protocol that is now known internationally as Functional Family Therapy.

In 1982 Dr. Alexander and Dr. Bruce Parson, the developers of the FFT model, published their first book on Functional Family Therapy. Through the 1980s and the 90s FFT was evaluated extensively, and by late 1990s FFT and Dr. Alexander had received national accolades from The US Surgeon General, the Department of Justice, Blueprints for Healthy Development and other national and international organizations.

Dr. Alexander has worked exclusively with FFT LLC since its inception. His and FFT LLC's focus with FFT since 2007 has been to and develop and establish an evidence base for FFT LLC's implementation/training systems and demonstrate, through science, FFT LLC can reliably, efficiently and cost effectively replicate the FFT model across diverse communities with the same outcomes found in FFT formal evaluations. To that end, ***since 2007 FFT LLC's proprietary training, fidelity, assessment, and quality assurance protocols have been shown effective in 20 independent, peer-reviewed evaluations conducted both in the US and abroad.***

What is the underlying philosophy? FFT draws from family systems theory and integrates behavioral approaches. It is based on the theory that 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, parenting skills, etc) and developing family member skills that are directly linked to risk factors (e.g., emotion regulation, decision making) and issues leading to the need for formal therapeutic intervention.

For more information about FFT contact hollyfft@comcast.net or call 206-369-5894

Core components

What are the core components of the model? FFT is a conjoint family therapy that is systemically focused, using an array of behavior change interventions (i.e. cognitive behavioral, etc) that match the risks of clients, with case management as necessary to assist families, navigate systems, and sustain family change. The California Evidence-Based Clearinghouse for Child Welfare notes FFT has "five distinct intervention phases":

1. Engagement: Introduction/Impression (Pre-Intervention). The goal is to maximize family initial expectation of positive change
2. Motivation: Induction/Therapy (Early sessions). The goal is to create a motivational context for long-term change.
3. Relational Assessment (by conclusion of early sessions): The goal is to assess and understand family relationships to provide foundation for changing behaviors in subsequent phases
4. Behavior Change (Middle sessions). The goal is to facilitate individual and interactive/ relational change. FFT LLC maintains a library of appropriate FFT interventions that therapists can draw on to help create change plans.
5. Generalization (Later sessions). The goal is to maintain individual and family change, and facilitate change in multiple systems

How frequently do contacts occur? Face to face contacts occur at least weekly or more based on risk/need. Contacts are necessary to keep families engaged, focused, and following through on treatment. ACS requirements are at least 4 face to face contacts per month. **Duration is** 12 to 14 sessions; the number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three to four-month period. The 4,000+ therapists that FFT LLC supports in the United States currently average 4.8 months of FFT.

Populations served: From the California Evidence Base Clearinghouse on Child Welfare

What is the target population for the model? 11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse. Younger siblings are often a part of therapy.
What are ages of children/youth served? 11-18.
What are the exclusionary criteria? FFT families take many different forms but share a sense of history and a future prospect of living together. There are no evaluations demonstrating effectiveness for FFT with youth living outside of the family, in residential facilities, group homes or foster care. There are no evaluations demonstrating effectiveness where a sexual

For more information about FFT contact hollyfft@comcast.net or call 206-369-5894

offense is the primary reason for referral. If a youth is suicidal or actively psychotic, another intervention besides FFT is appropriate.

Outcomes

What are the model's outcomes? For research on efficacy, effectiveness and dissemination implementation, see attached table of FFT LLC evaluations.
How have they been measured? Since 2010 alone there have been 20 published, independent, peer reviewed studies showing the feasibility, acceptability and positive outcomes for FFT LLC's implementation, practices and training protocols. These studies on FFT LLC's training practices include evaluations from 5 different countries and 7 U.S. States.

Staffing requirements

What are the staffing requirements? 3-8 Master's level therapists seeing cases on their own averaging 8 families each.
How are teams structured? Therapists see families on their own and work together as a team for training and consultation.
What are the caseload requirements? 8 for a full-time caseload. Treatment duration averages 4.8 months.
Are supervisors required to carry caseloads? Supervisors are selected from therapists and are required to carry a least a half time caseload of 3-5 families.

Average length of service

What is the average length of service? For FFT, 12-14 sessions over 3-5 months. Average time across recent data showed across 4,000 FFT LLC trained therapists duration averaged 4.8 months.

Training requirements

What are the training requirements for new frontline staff? FFT is trained in 3 core phase – first year focuses on therapists, 2nd year trains a supervisor to take over consultation of the group, the 3rd phase helps maintain quality assurance. See attached FFT LLC general information packet.
What training is available for supervisors? See above (Phase/year 2)
What is available for refresher training or when there is turnover? Therapist replacement training for therapists happen in NYC on at least a monthly basis.
Can executive/managerial staff be trained? Executives/managerial staff are encouraged to attend trainings and consultation and can access implementation assistance as necessary. There are on-going city-wide opportunities for cross agency learning and sharing.

Fidelity monitoring/quality assurance activities

What activities are required of providers to ensure fidelity? Adherence is assessed by consultants and FFT Supervisors through weekly consultations that are a part of FFT LLC training. Data that therapists and supervisors put in to the FFT LLC web-based system is important to assist in fidelity measurements. As well the FFT LLC system generates a Tri-Yearly report that helps target quality assurance activities for therapists who need assistance in applying the model with fidelity.
Is there a model-specific data system? What does it involve? The FFT LLC web-based system was revised in 2019 based on the last decade's 20 evaluations of FFT LLC's effectiveness. Therapists enter session and assessment data to understand their practice, family perspectives and goals achieved.
What technology is required for fidelity monitoring? Internet access and an up to date computer/tablet/cell phone.

Implementation support

What support is available? FFT LLC currently provides implementation support more than 350 FFT sites worldwide. Its 4,000 therapists serve 30,000 families per year across the globe. FFT LLC begins by helping sites respond to RFPs through on going contact and a variety of readiness tools. These services are free of charge.
For how long is support provided? Implementation support is available throughout the life of the project, and this support is a standard component of all phases of site development.
Will providers have access to networks or learning communities? The on-going FFT LLC NYC Provider Consortium will continue with citywide and annual conferences and support meetings both in the U.S. and abroad to assist both therapists, supervisors and providers to grow, share successes and learn from other's challenges.
What resources are available for evaluation? FFT has a research department and is involved in assisting agencies with numerous ongoing evaluations throughout the world. The revised 2019 FFT web-based system allows agencies broad dexterity in aggregating therapist, family and project wide outcomes.

For more information about FFT contact hollyfft@comcast.net or call 206-369-5894

FUNCTIONAL FAMILY THERAPY

Functional Family Therapy:

Principles of Clinical Intervention, Assessment,

and

Implementation

James F. Alexander, Ph. D.

FFT Founder

Functional Family Therapy

General Information

Functional Family Therapy (FFT) is an empirically grounded, well-documented and highly successful family intervention program for dysfunctional youth. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk preadolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. In most programs sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model.

The FFT clinical model is appealing because of its clear identification of specific phases which organize intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success. The phase-based goals of FFT are to:

1) **Engage** youth and family members into treatment by establishing your credibility by being responsive and availability**.**
2) **Motivate** youth and their families by decreasing the intense negativity (blaming, hopelessness) so often characteristic of these families. Rather than ignoring or being paralyzed by the intense negative experiences these families often bring (e.g., cultural isolation and racism, loss and deprivation, abandonment, abuse, depression), FFT acknowledges and incorporates these powerful emotional forces into successful engagement and motivation through respect, sensitivity, and positive reattribution techniques.
3) **Assess** interpersonal functions (i.e., payoffs) within the family to organize/match interventions.
4) **Behavior Change:** Reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions, including cognitive/attributional interventions, systematic skill-training in family communication, parenting, problem solving, and conflict management.
5) **Generalize** changes across problem situations by increasing the family's capacity to **utilize multisystemic community resources** adequately, and to engage in relapse prevention.

The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost–effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. FFT program implementation targets clinical teams of up to 8 clinicians who work together by regularly staffing cases, attending follow-up training, and participating in ongoing telephone supervision.

FFT LLC is the parent organization for Functional Family Therapy training, service, and core process research. FFT LLC also represents the primary contact for information regarding FFT clinical studies and training programs. You can find more about FFT LLC by contacting the following:

For general FFT Information:

Holly DeMaranville

Communications Director

1251 NW Elford Dr.

Seattle, WA 98177

holly@fftllc.com

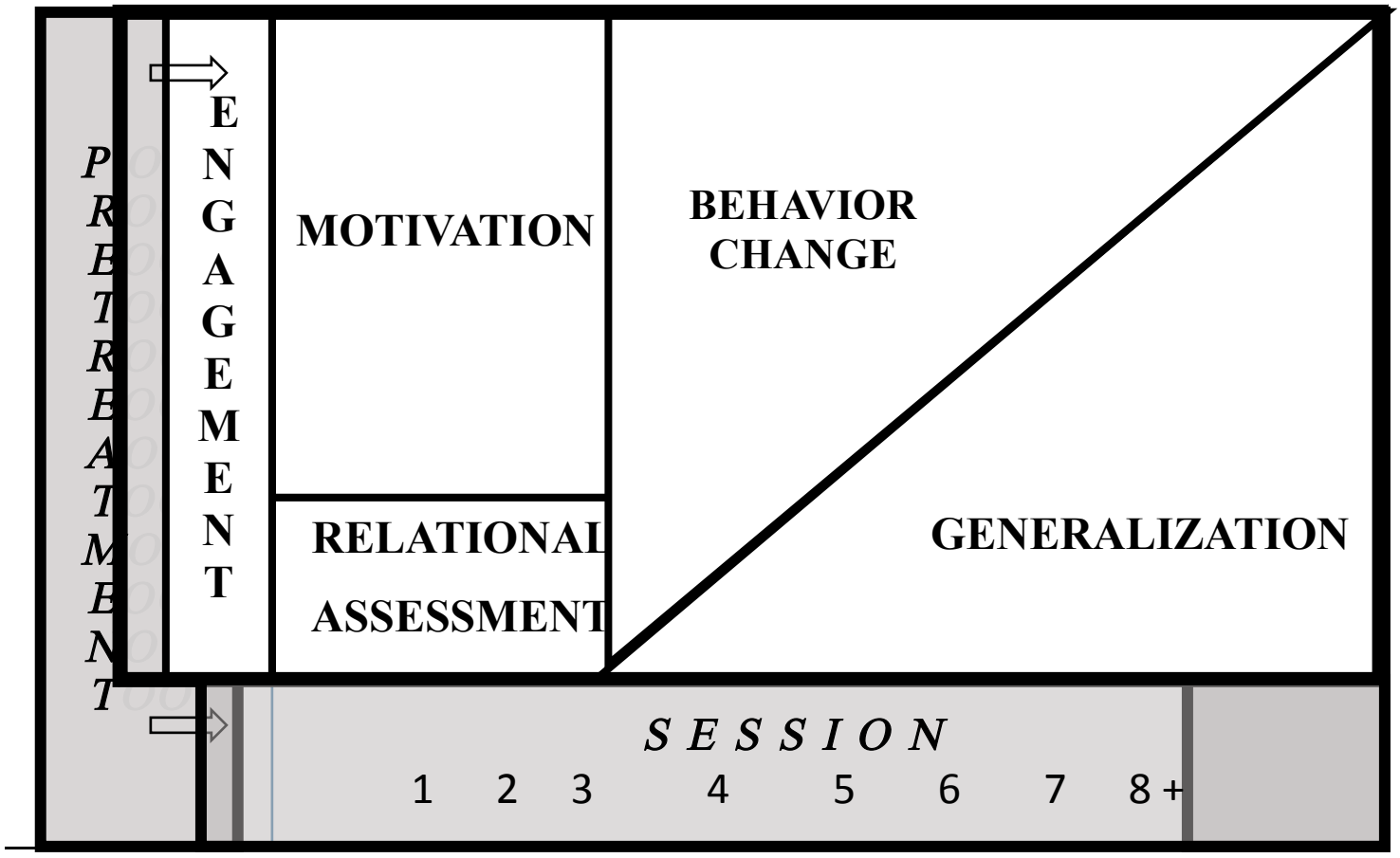
(206) 369-5894

(206) 453-3631-fax

Additional information about FFT can be found at **www.fftllc.com.**

Phases of

Functional Family Therapy



	Engagement	Motivation	Relational Assessment	Behavior Change	Generalization
Goal	Maximize family initial expectation of positive change	Create a motivational context for long-term change	Identify relational functions (connectedness and hierarchy) in the family	Facilitate individual and interactive/ relational change	Maintain individual and family change, and facilitate change in multiple systems
Risk and Protective Factors Addressed	• Negative perception about or experiences with treatment • Reputation of treatment agency • Transportation • Therapist availability • Intake staff skills and attitudes	• Family negativity and blame • Hopelessness • Level of motivation	• Individual skills or behaviors that are associated with problem behaviors • Intrafamilial and extrafamillial patterns of behavior	• Youth temperament • Parental pathology • Beliefs and values • Developmental level • Parenting skills • Conflict resolution / negotiation skills • Level of family support • Peer refusal skills	• Youth bonding to school • Parent attitudes about school, peers, drugs, etc. • Level of social support • Access and connection to prosocial youth and systems
Therapist Skills / Interven-tion Focus	• High availability • Manage intake processes to present agency, self, and treatment in a way that matches to inferred family characteristics • Enhance perception of credibility	• Interpersonal skills (validation, positive reattribution, reframing, relational) • Build balanced alliances • Reduce negativity and blame • Create hope • Enhance motivation to change	• Intelligence • Perceptiveness • Elicit descriptions of relational sequences	• Directive / teaching / structuring skills • Modeling • Setting up, leading, and reviewing in-session tasks • Assigning homework	• Interpersonal and structuring skills • Family case manager • Accessing appropriate formal and informal community resources • Anticipate and plan for future extra-familial stresses

Functional Family Therapy

Training – Site Certification

The primary goal of the FFT implementation and certification process is the successful replication of FFT program as well as its long-term viability at individual community sites.

Functional Family Therapy Site Certification is a 3-phase process.

Phase 1—*Clinical Training*: The initial goal of the first phase of FFT implementation is to impact the service delivery context so that the local FFT program builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training/consultation. By the end of Phase I, FFT's objective is for local clinicians to demonstrate strong adherence and high competence in the FFT model. Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System, through FFT weekly consultations and during phase one FFT training activities. It is expected that Phase One be completed in one year, and not last longer than 18 months. Periodically during Phase I, FFT personnel provide the site feedback to identify progress toward Phase I implementation goals. By the eighth month of implementation, FFT will begin discussions identify steps toward starting Phase 2 of the Site Certification process.

Phase II—*Supervision Training*: The goal of the second phase of FFT implementation is to assist the site in creating greater self-sufficiency in FFT, while also maintain and enhancing site adherence/competence in the FFT model. Primary in this phase is developing competent on-site FFT supervision. During Phase II, FFT trains a site's extern to become the on-site supervisor. This person attends two 2-day supervisor trainings, and then is supported by FFT through monthly phone consultation. FFT provides one 1-day on-site training or regional training during Phase II. In addition, FFT provides any on-going consultation as necessary and reviews the site's FFT CSS database to measure site/therapist adherence, service delivery trends, and outcomes. Phase II is a yearlong process.

Phase III and beyond—*Practice Research Network*: The goal of the third phase of FFT implementation is to move into a partnering relationship to assure on-going model fidelity, as well as impacting issues of staff development, interagency linking, and program expansion. FFT reviews the CSS database for site/therapist adherence, service delivery trends, and client outcomes and provides a one-day on-site training for continuing education in FFT.

Phase 1 of 3 "Clinical Training" Activities include:

STEP 1 One-Day On Site Implementation/Assessment and CSS Training

The implementation visit lasts one day, is on-site, and includes meetings with stakeholders, information sessions, reviewing referral systems, and providing overviews to FFT training for therapists. The goal is to confirm site readiness, identify any critical factors impacting FFT implementation, and build necessary community/stakeholder understanding of implementation challenges.

Training in the CSS is on site and requires one day. The FFT Family Assessment Protocol is a systematic approach to understanding families in a way that enhances treatment and uses the most current assessment tools. The Clinical Services System (CSS) represents software offered by FFT to support and guide therapists in organizing and adhering to the model.

STEP 2 – Two Day On Site Clinical Training

The two day on-site introduction covers the core constructs, phases, assessment and intervention techniques of FFT. Didactic materials include handouts and videotape examples.

STEP 3 – Begin cases (using FFT, the Assessment protocol, and the CSS)

STEP 4 – Ongoing Telephone Supervision

Each team receives telephone supervision as a group for one hour per week. Supervision focuses particularly on individual cases and model adherence.

STEP 5 – Externship

Each clinical team must include one team member who attends externship. This intensive, hands on, training experience with actual clients includes supervision from behind the mirrored window. The Externship consists of three separate training experiences over a three month period at an off site location.

STEP 6 –Two Day Follow-up Visits (3 per site during year 1)

The three on-site follow-up training sessions, each of two days in duration, represent more specific focus on implementation issues and processes.

STEP 7 – Two Day On Site Clinical Training

The second two day training occurs at month 8-9 during the training year at your team's location.

ONGOING: Implementation and Consultation

Implementation and consulting services are directed at helping sites implement FFT with respect to such issues as staff development, interagency linking, and program expansion.

For additional information about FFT implementation, training costs and requirements, contact Holly DeMaranville at 206-369-9854 or by email at holly@fftllc.com.

Functional Family Therapy

Clinical Services System

The FFT Clinical Services System (CSS) is designed to build therapist competence and skills in the application of Functional Family Therapy (FFT). Therapists access the CSS via the internet. The Clinical Services System is the implementation tool that allows therapists to track the modalities essential for successful implementation: Session process goals, comprehensive client assessments, and clinical outcomes. The goal of the CSS is to increase therapist competence and skill by keeping therapist focused on the relevant goals, skills, and interventions necessary for each of the phases of FFT. The computer-based format allows the therapist to have easy access to a wide variety of process and assessment information in order to make good clinical decisions and complete outcome information to evaluate case success.

Client Assessment

Multiple domains of the risk and protective factors operative in family functioning are the focus of client assessment. Assessment of *family functioning* helps highlight the intra family communication, problem solving, and emotional support patterns. *Individual* assessment identifies current symptom concerns, and *behavioral/contextual functioning* assessment helps determine potential intervention targets and estimate the risk potential of the adolescent.

Case Tracking

The CSS allows therapists to track, monitor, and evaluate the contacts he/she may have with a family. Using this system, therapists can summarize client contact, describe client characteristics, and determine attendance and no-show rates, and termination types in order to target important system level barriers to successful treatment.

Process Tracking

The CSS is designed to help therapist adhere to the FFT model in order to increase skill and competence in FFT implementation.

Outcome Assessment

Outcome assessment is accomplished through measuring changes in family functioning as a result of intervention. In addition, outcomes are measured with two short, non-intrusive measures of family members' perspective and the clinicians' monitoring of broad and general outcomes.

FUNCTIONAL FAMILY THERAPY

FFT LLC Research Table

Summary of research outcomes by study type:
Efficacy, Effectiveness, Dissemination/Implementation, Basic, and Process
2019

Since 2010, FFT LLC proprietary training and implementation has been evaluated in 20 published, peer-reviewed studies that show feasibility, acceptability, and positive outcomes. These studies were completed with samples from 5 different countries (Denmark, England, New Zealand, Singapore, and Scotland) and 7 US States (California, Florida, Louisiana, New Jersey, Pennsylvania, Ohio, and Washington).

For more information about FFT contact holly@comcast.net or call 206-3695894

Citation	Bias*	Population / Referral	Demographics	Design	Outcomes
Basic Research					
Alexander (1973)	Dev	Delinquent	n = 20; 55% (11) male; Mostly White	Non-clinical; Observational	Change Mechanisms -Delinquent families engaged in more *defensive communications* -non-Delinquent families engaged in more supportive communications -Delinquent families *reciprocated defensive behaviors* and did not reciprocate supportive behaviors -non-Delinquent families *reciprocated supportive behaviors* and did not reciprocate defensive behaviors
Alexander et al. (1989); Study 1	Dev	Delinquent	n = 32; 50% (16) male; Primarily White	Non-clinical; Observational; Cooperative or Competitive set	Change Mechanisms -Parents of delinquent youth respond with more *defensive communications* than families of non-delinquent youth in competitive set -Parents of delinquent youth engage in significantly *less defensive communications* in cooperative vs. competitive set
Alexander et al. (1989); Study 2	Dev	Delinquent	n = 49; Primarily White	Non-clinical; Manipulation of attribution set	Change Mechanisms -Parents made as many positive dispositional attributions in the satisfied set as negative attributions in the dissatisfied set -Parents used more internal than external attributions for both the child's successful behaviors and problem behaviors
Alexander et al. (1989); Study 3	Dev	Delinquent	n = 61; Primarily White	Observational; Compared impact of relabeling vs. 3 interventions	Change Mechanisms -Neither positive information or relabeling were able to reduce blaming attributions
Barton, Alexander, & Turner (1988)	Dev	Delinquent	n = 32; 56% (18) males Primarily White Age: 14-17	Observational; Non-clinical	Change Mechanisms -Delinquent families expressed significantly lower rates of negative communication in a cooperative set than in a competitive set -Delinquent families expressed significantly lower rates of adaptive communication than non-delinquent families in the cooperative set
Mas, Alexander, & Turner (1991)	Dev	Substance use or delinquent; Mental Health	n = 49; 61% (30) male; Primarily White Age: 13-18	Observational; Interactions in two priming conditions	Change Mechanisms -Low conflict family members made *fewer blaming attributions* about other family members dissatisfying vs. satisfying behaviors -High conflict family members made *equivalent amounts of blaming attributions* for both satisfying and unsatisfying behaviors -High conflict family members behaved *more defensively* than low conflict family members

Morris, Alexander & Turner. (1991)	Dev	Non-clinical; Undergraduate students	n = 120; Primarily White	Anecdotal; Observational; Randomized	Change Mechanisms -Experimental *reattributions* (similar to relabel/reframe) significantly reduced the intensity of blaming attributions
Process Research					
Alexander, Barton, Schiavo, & Parsons (1976)	Dev	Delinquent	Youth/family n = 21; 48% (10) male; Majority White Therapists: n = 21; 67% (14) male	Clinical; Experimental; Observational	Change Mechanisms -Therapist *relational skills as opposed to structuring skills* were associated with good clinical outcomes -Family member *supportive to defensive behaviors at the end of treatment* (not earlier in treatment) were associated with clinical outcomes
Flicker, Waldron, & Turner, Brody, & Hops (2008a)	Dev	Substance Use	n = 86; 64% (72) male; 50% Hispanic; 50% White; Age: *M* = 15.7 (13-19)	Random assignment: a. FFT b. integrated FFT+CBT Assessment Period -4 months post-randomization	Clinical Outcomes -Significant pre-post *reductions in substance use* for all youth in FFT and FFT+CBT. Change Mechanisms -Hispanic youth with Hispanic therapists showed *greater decreases in substance* use compared to Hispanic youth with Anglo therapists. Ethnic match was not related to treatment outcome for Anglo youth
Flicker, Turner, Waldron, Brody, & Ozechowski (2008b)	Dev	Substance Use	see Flicker 2008a	Clinical interaction; Observational	Change Mechanisms -Hispanic families who dropped out of treatment had *greater unbalanced alliances* than Hispanic families that completed treatment -No differences were observed between dropouts and completers among White families
Gan, Zhou, Hoo, Cheng, & Choo (2018)	Ind	Delinquent, Singapore	n=31 (demographics not reported)	Single Group -Comparison of treatment delivery to US-based and New Zealand-based samples (engagement, completion, number of sessions)	Clinical Outcomes -87% of youth/families engaged into treatment -6.3% dropout rate -Average of 10.6 sessions -All results are comparable to US and New Zealand samples; and are consistent with FFT LLC recommended implementation parameters
Mas, Alexander, & Barton (1985)	Dev	Delinquent	n = 49; 61% (30) male; 100% White; Age: 13-18	Clinical interaction; Observational	Change Mechanisms -Adolescents *spoke less with female therapists* than male therapists

McPherson, Kerr, Casey, & Marshall (2017)	Ind	Community-based sample; Child Welfare, Mental Health; Scotland	Family Participants -13 families; 12 adolescents (50% female); 14 caregivers Therapist participants (n=6)	Qualitative Interviews	Clinical Findings -FFT was viewed as an acceptable, appropriate and feasible intervention with the potential to improve adolescent wellbeing in 'real-world' settings
Newberry, Alexander, & Turner (1991)	Dev	Delinquent	N = 34; Majority White	Clinical interaction; Observational	Change Mechanisms -Mothers and fathers responded *more supportively to female therapists' supportive statements* than to male therapists' supportive statements -Fathers responded more *supportively to structuring statements* than mothers, irrespective of therapist gender -Female therapists were more likely than male therapists to *respond to family members' supportive statements with structuring statements*
Robbins, Alexander, Newell, & Turner (1996)	Dev	Delinquent	n = 35; 57% (20) male; Primarily White	Clinical interaction; Observational	Change Mechanisms -Therapist *reframing* more likely than alternative intervention strategies to increase family member positive statements
Robbins, Alexander, & Turner (2000)	Dev	Delinquent	n = 37; 70% (26) male; Primarily White Age: *M*=15 (12-17)	Clinical interaction; Observational	Change Mechanisms -Following defensive family member communications, therapist *reframing interventions* were more effective than alternative interventions in reducing subsequent defensive behaviors -*Family member non-defensive reactions* to a defensive communication were associated with lower levels of subsequent defensive behaviors than therapist reflection and elicit/structure interventions (but not reframing)
Robbins, Turner, Alexander, & Perez (2003)	Dev	Delinquent	n = 34; 59% (20) male; Primarily White Age = 12-18	Clinical interaction; Observational	Change Mechanisms -Dropouts had significantly *greater unbalanced alliances* (parent minus adolescent) with therapists than completers -Overall level of alliance did not predict outcome -Analysis of role showed significantly *higher unbalanced alliances in father-adolescent dyads* in dropout vs. completer cases. No differences were observed for mother-adolescent dyads.
Sholevar, Baron, Aussetts, & Spiga (2010)	Ind	Delinquent	n = 187; 66% (125) male; 76% African Am; Age *M*=14.3 (11-17)	Quasi-experimental; -Within group analyses of youth who were re-arrested following FFT	Change Mechanisms -Youth who completed 6 or fewer sessions had a *shorter time to arrest* than youth who complete 7 or more sessions (406 vs. 510 days, respectively) -*Substance use, association with deviant peers, and poor session attendance* (high numbers of cancellations/no shows) were associated with a lower number of days to first arrest

Efficacy Research					
Alexander, 1971	Dev	Delinquent	n = 40; Primarily White	Random assignment a. FFT only, b. individual therapy only (IT), c. FFT+IT d. minimal probation supervision Assessment Period -Post-treatment	Change Mechanisms -Family therapy plus individual therapy produced significantly greater *improvements in communication style* than other conditions
Alexander & Parsons (1973)	Dev	Delinquent; Juvenile Courts	n = 86 44% (38) male; Primarily White Age: 13-16	Random assignment (a-d): a. FFT b. client-centered family groups, c. psychodynamic family therapy, d. no treatment control, e. post hoc selected controls, n=46 f. county wide(n =2800) recidivism rates 1971 = 51% Assessment Period -18 month post-randomization	Clinical Outcomes -FFT *recidivism* was 26%, compared to 50% for no treatment control, 47% for client-centered family groups, and 73% for psychodynamic family therapy Change Mechanisms -FFT produced significant *improvements in family interactions* compared to all other comparison conditions
Friedman (1989); Stanton & Shadish (1997)	Ind	Substance Use	n = 135; 90 % (121) male; 89% White; Age *M*=17.2 (14-21);	Random assignment a. FFT b. parenting group intervention Assessment Period -15+ months post-randomization	Clinical Outcomes -Significant pre-post reductions in *substance use* at all follow-up points, with greater reductions in FFT, compared to parenting intervention Change Mechanisms -FFT *produced greater involvement of parents, lower family dropout rate, improved psychiatric and family functioning* in both conditions

Hansson, Cederblad, & Hook (2000)	Ind	Delinquent(Lund, Sweden)	n = 89; 87% (77) male; Primarily White; Age *M*=15 (10-18)	-Random assignment a. FFT b. treatment as usual (TAU) Assessment Period -24 month post-randomization	Clinical Outcomes -FFT more effective and TAU in *reducing recidivism* -FFT associated with greater reductions in youth and parent reports of *youth externalizing and internalizing symptoms*
Hops, Ozechowski, Waldron, Davis, Turner, Brody, & Barrera (2011)	Dev	Substance Use; HIV Risk	n = 225; 83% 187 male; 51% Hispanic; 49 % White; Age: 13-19	Random assignment: a. individual CBT (IT) b. integrated FFT+CBT Assessment Period -19 months post-randomization	Clinical Outcomes -Significant pre- to post-treatment reductions in *HIV-risk behaviors* for high-risk youth in both treatment conditions, with greater reductions in IT than FFT+CBT and greater reductions for high risk Whites, compared to Hispanics
Klein, Alexander, & Parsons (1977)	Dev	Younger siblings of delinquent youth (see Alexander & Parsons, 1973)	n = 99 referred 86 families followed; 44% (38) male; Primarily White Age: 13-16	Random assignment: a. FFT b. client-centered family groups, c. psychodynamic family therapy, d. no treatment Assessment Period -30-40 months post-treatment	Clinical Outcomes -Siblings of youth receiving FFT showed *lower arrest rates* than siblings from alternative treatment conditions 2 ½ to 3 ½ years post-treatment
Parsons & Alexander (1973); Alexander & Barton, (1976, 1980)	Dev	Delinquent	n = 40; 45% (18) male; Primarily White; Age *M*=15.1	Random assignment: a. FFT b. client centered family therapy, c. no treatment Assessment Period -Post-treatment	Change Mechanisms -FFT families displayed significant improvements in *family interactions* -No improvements in controls

Rohde, Waldron, Turner, Brody, & Jorgensen (2014)	Dev	Substance use; Depression	n = 170; 78% (133) male; 22% Hispanic; 61% White; 17% Other Age *M*=16.4 (13-18)	Random Assignment; Sequenced Interventions: a. FFT followed by Coping with Depression (FFT/CWD) b.CWD followed by FFT (CWD/FFT) c. coordinated FFT and CWD (CT) Assessment Period -18 months post-randomization	Clinical Outcomes: -FFT/CWD yielded better *substance use* outcomes than CT -For participants with baseline Major Depression, CWD/FFT had lower *substance use outcomes* than FFT/CWD and CT -*Depressive symptoms* decreased significantly for youth in all three treatment conditions, with no differences between treatments
Slesnick & Prestopnik (2009)	Ind	Alcohol abusing, runaway youth	n = 119; 45% (54) male; 29% White; 44% Hispanic; 11% Native Am; 5% African Am; 11% Other; Age: *M*=15.1 (12-17)	Random assignment: a. home-based ecological family therapy b. office-based FFT c. services as usual Assessment Period -15 months post-randomization	Clinical Outcomes -Significant pre- to post-treatment *reductions in alcohol and drug use* for all three conditions
Waldron, Slesnick, Brody, Turner, & Peterson (2001); Waldron, Ozechowski, Turner, & Brody, 2011; French, Zavala, McCollister, Waldron, Turner, & Ozechowski, (2008)	Dev	Substance Use	n = 120; 80% (96) male; 38% White; 47% Hispanic; 8% Native Am; 7% other; Age *M*=15.6 (13-17)	Random assignment: a. FFT b. individual CBT (ICBT) c. group therapy (GT) d. integrated FFT+CBT (IBFT) Assessment Period -19 months post-randomization	Clinical Outcomes -FFT, GT, and IBFT all showed significant r*eductions in substance use* -FFT and IBFT superior to ICBT Change Mechanisms -*Improvements in family functioning* associated with substance use reductions in the FFT conditions, but not GT, supporting family improvement as a mechanism of change in FFT Cost analyses -FFT and IBFT were *more cost effective* than IT or GT at post-treatment -GT was more cost effective than the other treatment conditions at follow-up

Effectiveness Research					
Barnoski (2004) Outcome Evaluation WSIPP (Follow-up to Barnoski, 2002; Sexton & Turner, 2011)	Ind	Delinquent; Community-based sample	n =700 Age *M* = 15.35 (13-17)	Random assignment a. FFT b. Probation services as usual Assessment Period -18 months post-randomization	Clinical Outcomes -No overall differences between conditions in *adjudicated felony recidivism rates* Change Mechanisms -*Adjudicated recidivism felony recidivism rates* were lower for competent FFT therapists than usual probation services, and non-competent FFT therapists
Humayun, Herlitz, Chesnokov, Doolan, Landau, & Scott (2017)	Ind	Community-based sample; Youth offenders, antisocial youth	n=111 Age *M* = 15.0 (10-17)	Random Assignment a. FFT + Management as Usual b. Management as Usual Assessment Period -18 months post-randomization	Clinical Outcomes -For both treatment conditions, large reductions were observed for all measures of offending and antisocial behavior, but no significant changes in parenting behavior or parent-child relationship. -Between intervention and control groups, there were no differences at 6 or 18 months on self-reported delinquency, police records of offending, symptoms or diagnoses of Conduct Disorder or Oppositional Defiant Disorder, parental monitoring and supervision, directly-observed child negative behaviour, or parental positive or negative behaviour. -In contrast to expectations, FFT+MAU showed lower levels of directly-observed child positive behaviour at 18 months compared to MAU
Lantz (1982)	Ind	Delinquent	n = 46	Random assignment: a. FFT b. alternative treatment Assessment Points -Post-treatment	Clinical Outcomes -FFT had *lower rates of recidivism* than alternative treatment -*Lower rates of outplacements* were observed in FFT than alternative tx
Lewis, Piercy, Sprenkle, & Trepper (1990)	Ind	Substance Use	n = 84; 81% (68) male; Age *M*=16 (12-22)	Random assignment a. Purdue Brief Family Therapy (based on FFT) b. Family Drug Education	Clinical Outcomes -*Reductions in substance use* only for family therapy condition involving an adaptation of FFT but not the Family Drug Education condition

				Assessment Period -Post-treatment	
Regas & Sprenkle (1982)	Ind	ADHD (referrals to Child Welfare)	n = 55	-Random assignment a. FFT b. group therapy c. no tx control Assessment Period -Post-treatment	Clinical Outcomes -FFT and group therapy produced *significant improvements in ADHD* behaviors at home and at school Change Mechanisms -Only FFT also led to significantly *more positive perceptions of the family*
Robbins, Waldron, Turner, Brody, Hops, & Ozechowski (2018)	Dev	Community-based; Delinquent, mental health	n=164; 59% male; 62% Hispanic; 19% African American; 12% Non-Hispanic White	Random Assignment (Sites) -Compared FFT provided using "supervision as usual" to supervision guided by audio-recordings (BOOST) community agencies that provide FFT services Assessment Period -12 months post-treatment	Clinical Outcomes -Improvements in *externalizing behaviors* and *felony offenses* were observed in both supervision conditions; -BOOST was significantly more effective than Supervision as Usual in *reducing externalizing behaviors* for youth who scored in the clinical range on externalizing at baseline (no differences were observed for youth below threshold) -Statistically significant treatment differences were also shown for improvements in family functioning with youth who scored above the clinical threshold in externakizing improving more in BOOST than Supervision as Usual. -Exploratory analyses demonstrated significant *improvements in youth internalizing behaviors* based on parent and youth reports (small and moderate effect sizes, respectively); no significant differences were observed between supervision conditions
Sexton & Turner (2010)	Ind	Delinquent; Community-based sample	n =917; 79% (724) male; 78% White; 10% African Am; 5% Asian Am; 3% Native Am; Age *M* = 15.35 (13-17)	Random assignment a. FFT b. probation services as usual Assessment Period -12 months post-randomization	Clinical Outcomes -Overall, no differences were found between FFT and services as usual in adjudicated recidivism Change Mechanisms -When therapists were adherent to the model, FFT showed significantly *greater reductions in felonies, and violent crimes*, with a marginally significant *reduction in misdemeanors* , compared to services as usual
Thornberry, Kearley, Gottfredson, Slothower,	Ind	Delinquent, gang-involved or at risk for	N=129; 100% male; 80% African American; 19%	Random assignment a. FFT	Clinical Outcomes -*Overall*, FFT was significantly more effective than TAU at the 18-month follow-up assessment on the percent of youth with drug

Devlin, & Fader (2018); Gottfredson, Kearley, Thornberry, Slothower, Devlin, & Fader (2018)		gang-involvement; Community-based sample	Hispanic (based on caregiver report)	b. Treatment as usual <u>Assessment Period</u> -18 months post-randomization	charges, the percent of youth adjudicated, and the percent with property changes -FFT was effective in engaging and retaining both low- and high-risk youth in treatment -No significant between group differences on outcomes were observed for youth at *low risk for gang membership* -At the 6 month assessment, FFT was significantly more effective than TAU for youth *at high risk for gang membership* in the levels of general delinquency, drug and alcohol use, time spent in residential placement, prevalence of felony charges, crimes against person charges, and property crime charges. -During the follow-up period (7 to 18 months post-randomization), FFT was significantly more effective than TAU for *youth at high risk for gang membership* in the prevalence and frequency of arrests, the number of felony charges, and the number of crimes against person charges -Over the entire follow-up period (baseline to 18 months), FFT was significantly more effective than TAU for *youth at high risk for gang membership* in the prevalence of arrest; number of arrests; felony charges, crimes against person charges, and property crime charges; and the rate of being adjudicated delinquent <u>Cost Analyses</u> -Youth who receive FFT are less likely to receive alternative, more costly, public services (such as residential placement), which results in an estimated reduction in the costs of services of $2,000 per youth served during the time they are receiving treatment
Dissemination/Implementation Research					
Baglivio, Jackowski, Greenwald, & Wolff (2014)	Ind	Delinquent	n = 2203; 72 % (1599) male; 53% White; 47% non-White; Age: *M*=15.57 (10 to 19)	-<u>Matched (Propensity) Assignment</u> a. FFT b. MST <u>Assessment Period</u> -12 months post-discharge	<u>Clinical Outcomes</u> -Female youth referred to MST had *higher offense rates* during service than females referred to FFT -Low risk youth referred to MST having a *higher rate of new arrests and/or violations of probation while receiving the therapy* than FFT-referred low risk youth -The *recidivism rate differences* pre-matching for moderate-high to high risk to reoffend youth remained significant ($p < .05$), but not at the Bonferroni-corrected level ($p < .025$), with those who received MST having a higher recidivism rate than those receiving FFT

					-Post matching, a new significant difference emerged with the "all youth referred" sample (the full sample) FFT youth having significantly *lower number of offenses* during service (at the non-corrected p < .05 level). Change Mechanisms -FFT has a significantly *higher completion rate* than MST -FFT had a significantly *lower length of service* than MST
Barton, Alexander, Waldron, Turner, & Warburton (1985); Study 1	Dev	Delinquent	n = 27; Primarily White	Non-random assignment a. FFT b. district juvenile justice base rates Assessment Period -13 months post-treatment	Clinical Outcomes -FFT had *lower recidivism rates* than the population base rate Change Mechanisms -Significant *reductions in family defensiveness* in FFT
Barton et al. (1985) Study 2	Dev	Child Welfare	n = 325; Primarily White	Non-random assignment: a. FFT b. community-based social workers Assessment Period -Post-treatment	Clinical Outcomes -*Reduction in foster care placement referrals* FFT (11%) versus non-FFT (49%) Change Mechanisms -*Reduction in units of service per family* to less than half (14.7-6.2)
Barton et al. (1985) Study 3	Dev	Delinquent	n = 74; Primarily White	Non-random assignment a.FFT b. Alternative treatment Assessment Period -15 months post-treatment	Clinical Outcomes -*Lower recidivism rate* observed in FFT compared to alternative tx -Those in the FFT group who did reoffend did so at a lower rate/frequency than those in the regular services group
Celinska (2015)	Ind	Delinquent Mandated vs. non-Mandated	n=120; Gender and Race/ Ethnicity reported separately for mandated, non-mandated; 70% vs. 52% males	Quasi-Experimental (within FFT comparison) a. Mandated vs. non-Mandated to treatment	Clinical Outcomes -Youth improved significantly in life domain functioning, child strengths, acculturation, caregivers' strengths, caregivers' needs, child behavioral emotional needs, and child risk behaviors -No differences were observed between youth who were mandated to treatment vs. those who were not mandated

			44% vs. 68% White; 41% vs 14% Black: 30% vs. 24% Latino	Assessment Period -Post treatment assessment	
Celinska & Cheng (2017)	Ind	Delinquent; Behavioral/ Emotional	n=116; 62% (72) males; 35% (41) Black; 28% (33) White; 25% (29) Latino	Quasi-Experimental (within FFT comparison) a. Differences in treatment process and outcomes for boys vs. girls Assessment Period -Post treatment assessment -Official records	Clinical Outcomes -Self-reports from pre-to-post treatment showed: a) significant improvements for male and female adolescents on the Life Domain Scale and Child Behavior Emotional Needs Scale, the Child Strengths Scale and Child Risk Behavior Scale b) Male adolescents improved more on the Child Risk Behavior Scale, c) Female adolescents improved more on the Child Strengths Scale. D) There was a statistically significant improvement on the Caregiver Strengths Scale for the caregivers of males -Examination of official records showed a) Significant reductions in convictions, but an increase in institutionalization b) No significant differences between both genders on changes before and after FFT in terms of number of delinquency cases, convictions, and institutionalizations; however, trend was for males to be at increased risk for institutionalization compared to females Referral Issues and Process Outcomes -No statistically significant differences between male and female adolescents based on race, ethnicity, duration in the program -Boys more likely to be mandated to treatment -Boys more likely to use drugs/alcohol
Celinska, Furrer, & Cheng (2013)	Ind	Delinquent / Child Welfare	n = 72; 69% (50) males; 36% African Am; 36% Hispanic; 19% White; 9% Other; Age: *M* =15.3 (11-17)	Matched Assignment a. FFT b. Matched control Assessment Period -Post-treatment assessment	Clinical Outcomes -Only FFT youth showed *improved functioning in life domains*, such as *living arrangements, school behavior/achievement/attendance, legal concerns and vocational concerns* -Only FFT youth showed significant *reduction in emotional and behaviors needs as well as risk behavior* Change Mechanisms -*Older youth* responded better than younger youth

					-Hispanic youth responded better on l*ife domains and child risk behaviors* -White youth responded better on *child strengths* -African American youth responded better on *child emotional and behavioral needs*
Celinska, Sung, Kim, & Valdimarsdottir (2018)	Ind	Delinquent	n=155 EMAIL Kashka for demographics	Matched Assignment (check) a. FFT b. Comparison groups Assessment Period -Post-treatment assessment	Clinical Outcomes -FFT had significantly lower odds of recidivism as measured by reconvictions for drug offences, property offences and technical violations -Also, youths in FFT self-reported more improvement, the differences between the groups was not statistically significant
Darnell & Schuler (2015)	Ind	Delinquent	*N*= 8713; (n=1279 FFT/FFP; 7434 SP) 78% male; 29% AA; 61% Hispanic; 8% White; Age *M* = 17 (11-18 yrs)	Quasi-experimental Propensity Matched; a. Standard Probation (SP) b. FFT plus SP c. Functional Family Probation Services (FFP) d. FFT plus FFP Assessment Period -36 months post discharge	Clinical Outcomes -Youth receiving FFT (both FFT+SP and FFT+FFP) compared to SP alone had significantly *lower likelihood for outplacements in first two months following treatment*…but this advantage disappeared in later months. -Youth receiving FFP alone (as compared to SP alone) had *lower likelihood for outplacements in first two months (but not significant)* -Ultimately, at the end of the 36-month outcome observation period, there were *no significant differences in outplacements between any of the three intervention groups* -12 month survival analysis illustrated that youth in the FFT group remained *less likely to have an outplacement* than comparison youth
Gordon, Arbuthnot, Gustofson, & McGreen (1988); Gustofson, Gordon, & Arbuthnot (1985); Gordon, Graves, & Arbuthnot, 1995; Gordon (1995) - Study 1	Ind	Delinquent Rural; Low SES	n = 54; 70% (38) male; 100% White; Age: *M* 15.4	Matched assignment a. FFT b. probation services as usual Assessment Period -30-60 month post-treatment assessment of adult convictions	Clinical Outcomes -FFT group had *lower recidivism rates* compared to regular services group at 30- and 60-month follow-up Cost analyses -Cost-benefit analysis on these groups indicated that FFT had significantly *lower direct costs* than treatment as usual

Gordon & Arbuthnot (1990); Gordon, (1995) -Study 2	Ind	Delinquent	n = 49 Age 17-18	Non-random assignment a. FFT b. statistical control (empirically derived risk of recidivating) Assessment Period -18 months post-baseline treatment	Clinical Outcomes -FFT had *lower new convictions after treatment and institutional commitments* than statistical control group, and
Gordon (1995) - Study 3	Ind	Delinquent; Re-entry	n = 52; Age 16-17	Matched assignment: a. FFT, n=27 b. probation services as usual Assessment Period -16 months post-baseline	Clinical Outcomes -FFT showed a significantly *lower recidivism rate*, compared to the services as usual group.
Hansson, Johansson, Drott-Englén, & Benderix (2004)	Ind	Community-based sample; Mental Health; Child Welfare; Lund, Sweden	n = 62; 90% (54) male; Primarily White; Age: *M* =15 (13-18)	Matched Assignment a. FFT b. social work services as usual Assessment Period -18 months post-baseline	Clinical Outcomes -FFT had lower recidivism rates than services as usual -FFT group associated with *greater reductions in youth and parent reports of externalizing and internalizing symptoms* Change Mechanisms *-Improved family functioning, and reduced maternal depression, somatization, and anxiety* in FFT group
Heywood & Fergusson (2016)	Ind	Community-based sample; Child Welfare	n=59; 13.7 (age); 70% male; 45% Maori; 33% New Zealand European; 10% Cook Island Maori, 7% other European; 3% Tongan; 2% Niuean, 2% Fijian	Single Group -Evaluated improvements within FFT over time Assessment Period -18 months post-baseline	Clinical Outcomes -Parents reported significant improvement in Conduct Disorder, Oppositional Defiant Disorder, and delinquent behaviors -Youth reported significant improvements in delinquent behaviors -No significant differences were observed between Maori and non-Maori reports of youth problem behaviors -Parent satisfaction with FFT was “high” for non-Maori parents, and “very high” for Maori parents

Kretschmar, Tossone, Butcher, & Marsh (2018)	Ind	Community-based sample; Delinquent; Ohio	N=530; 60% female; 48% White; 35% Black	Single Group Design -Compared three groups based on completion of service (never began, began but did not complete, completed treatment)	Clinical Outcomes -Youth who successfully completed treatment had lower odds of offending as young adults and fewer young adult offenses than youth who completed unsuccessfully or who did not participate
Lindberg & Scavenius (2018)	Ind	Community-based sample; Child Welfare, Denmark	n = 428; 51% (females); Age: *M*=14.5 (SD=2.5); Referrals for school problems (61%), behavior problems (53%), family conflict (49%)	Single Group Design Results for FFT were compared to normative data on SDQ for Danish youth placed out of the home (youth report) and a population sample of the 20% highest scores (parent report) Assessment Period -Post-treatment	Clinical Outcomes -FFT showed a significant reduction in youth reports on both internalizing and externalizing for females, and on externalizing for males. -FFT showed a significant reduction in parent reports on both externalizing and internalizing for both females and males -FFT showed a significant reduction in parent and youth reports of family conflict
Marshall, Hamilton, & Cairns (2016)	Ind	Community-based sample, Child Welfare; Mental Health, Scotland	n=164; Families that completed treatment and pre-post-treatment assessments (No demographics reported)	Single Group Design -Compared changes in FFT to population-based sample of high risk youth Assessment Period -Post-treatment assessment	Clinical Outcomes -Parents reported significant improvements in overall stress, emotional distress, behavioral difficulties, hyperactivity/attention difficulties, peer problems, life impact, and prosocial behavior -Parents reported significant improvements in overall stress, emotional distress, behavioral difficulties, hyperactivity/attention difficulties, and life impact, and prosocial behavior -Parents reported improvements in their own psychosocial distress -Improvements were shown to be greater than what would be expected if no treatment had been received and were comparable to the impact of other interventions
Stout & Holleran (2013)	Ind	Child Welfare	Sample includes all outplacements in New Jersey	Time Series Analysis	Clinical Outcomes -MST and FFT were estimated to yield an *approximate reduction of 31 outplacements a month or an annual reduction of 372 outplacements*

			from 2005 to 2011	-Comparison of FFT, MST, and other services -Dependent variable includes any outplacement for youth between 2005 and 2011	Cost Savings Estimates -Projected a*nnual savings of $1.33 million for FFT and $2.16 million for MST* -Since 2005, estimated t*otal savings of $17.33 for FFT and $18.16 for MST*
White, Frick, Lawing, & Bauer (2013)	Ind	Delinquent; Callous-Un-emotional (CU); Community Mental Health	n = 134; 71.6% (96) male; 59% African Am; 35.1% White; 4.5% Hispanic; Age: *M* =15.34 (11-17)	Non-randomized study; All youth received FFT; Assessment Period -12 month post-treatment	Change Mechanisms -CU traits associated *with poorer adjustment (behavioral, emotional, social) prior to treatment* -CU traits correlated with *poorer levels of adjustment post-treatment*, *less perceived change over treatment by youth and parents and increased likelihood of violent offending during treatment* -CU traits NOT associated with significantly lower rates of participation -CU traits NOT associated with higher rates of treatment dropout --CU traits associated with *greater improvements in adjustment over course of FFT* *-Association between CU traits and risk for violent charges decreased* over time

*Refers to primary authors on the study. *Dev* (developer) denotes that the study was conducted by an investigator(s) that included the Developer of the model (Alexander) or by an investigator(s) that were trained by the Developer at the University of Utah. *Ind (i*ndependent) denotes that the study was conducted by an investigator(s) that did not include the Developer (Alexander) or other investigators that were trained by the Developer at the University of Utah. Most of the studies in the *independent* category can be considered replications of prior research or an extension of FFT into new clinical populations or settings.

**Demographic data on total sample, gender, race/ethnicity, and age included when reported. White is used to denote non-Hispanic White; Hispanic is used to denote Hispanic/Latino (very few youth/family members self-identified as Black Hispanic); African Am is used for African American; Native Am is used for Native American, American Indian, and First Nations.