Foundations
What Works Centre for Children & Families

Last reviewed: February 2018

Intervention website: www.fftllc.com/

GUIDEBOOK INTERVENTION INFORMATION SHEET

Functional Family Therapy

Please note that in the 'Intervention Summary' table below 'child age', 'level of need', and 'race and ethnicities information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary	
Description	Functional Family Therapy (FFT) is an intensive intervention for families with a young person aged between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse. It is delivered by a family therapist or social worker to young people and their parents through 8 to 30 weekly, one-hour sessions, depending on the needs of the family.
Evidence rating	3+ mixed
Cost rating	3
Child outcomes	• Preventing crime, violence and antisocial behaviour - Reduced involvement in crime. • Preventing substance abuse - Reduced use of marijuana.
Child age (population characteristic)	10 to 18 years
Level of need (population characteristic)	Targeted Indicated

Intervention summary	
Race and ethnicities (population characteristic)	• African American • Hispanic/Latino • Mixed racial background • Native American • White.
Type (model characteristic)	Individual
Setting (model characteristic)	• Home • Outpatient setting.
Workforce (model characteristic)	A master's qualified social worker, family therapist, or clinical psychologist
UK available?	Yes
UK tested?	Yes

Model description

Functional Family Therapy (FFT) is for families with a young person aged between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse. The young person is typically referred into FFT through the youth justice system at the time of a conviction.

FFT is delivered to the young person and parents through 8 to 30 weekly sessions for as long as the family needs. Families with moderate needs typically require 8 to 14 sessions; families with more complex needs may require up to 26 to 30 sessions spread over a six-month period.

FFT is applied in five distinct phases: Engagement, Motivation, Relational Assessment, Behaviour Change, and Generalisation. Each phase has associated specific goals, techniques, and important therapist relationship and structuring skills.

The primary goal of the initial phases is to increase family members' motivation for change by helping all members interact more positively with each other. Therapists do this by 'reframing' parents and children's behaviour, so that family members gain a deeper insight into each other's actions and are less likely to attribute blame.

During the middle phases, the therapist will suggest new strategies for family interaction that are carefully matched to the needs and capabilities of each member. These strategies typically include

positive methods of communication, family problem-solving exercises, methods for managing moods and anger, methods for managing cravings and relaxation exercises. A primary aim of the middle phases is to improve interactions within the family context.

During the final phase, family members learn to 'generalise' these skills to contexts outside of the immediate family, including the young person's school, peers and the wider family system.

Families also learn how to identify situations that could create future risks and generate methods for preventing these risks. The therapist also helps family members identify sources of ongoing support that can be used once the therapy has concluded.

A unique feature of FFT is the specific focus on skills in the context of assessed relational functions of behaviour (e.g. separation, contact) within each relationship within the family system (for example, mother/father; father/child; mother/child). The focus of change is on replacing maladaptive behaviours used to maintain relationship functions.

Readiness for therapy is based on the family demonstrating the generalisation of new skills and behaviours to the home and environment outside the therapy session, the maintenance of treatment gains, and the ability to function independently from the therapist.

Target population

Age of child	10 to 18 years
Target population	Young people aged between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

Theory of change

Why		Who	How	What		
Science-based assumption	**Science-based assumption**	**Science-based assumption**	**Intervention**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
• Every family member's behaviour serves a function within the family system. • Poor family functioning may increase the risk of young people engaging in substance misuse or re-engaging with antisocial or criminal behaviour.	Understanding behaviours, their function in the family system, and their consequences provides an opportunity to change and improve them.	Young people aged between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse.	FFT therapists help family members identify positive and negative functions of family behaviours (including the young person's antisocial behaviour) and develop strategies for changing them within the family system.	Family members experience less conflict and improved communication.	Young people are better able to manage their emotions and behaviour.	• Young people are less likely to reoffend and misuse substances • Young people are more likely to remain with family and attend school.

Implementation requirements

Who is eligible?	Young people aged between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse.
How is it delivered?	• Functional Family Therapy (FFT) is delivered in 8 to 16 sessions (with an average of 12 to 14 sessions for most cases). Challenging cases may receive 26 to 30 sessions. • Each session is 45 to 60 minutes' duration. • These sessions are delivered over 3 to 6 months. • FFT is delivered by one therapist (QCF-7/8), to families.
What happens during the intervention?	FFT is applied in five distinct phases: Engagement, Motivation, Relational Assessment, Behaviour Change, and Generalisation. Each phase has associated specific goals, techniques, and important therapist relationship and structuring skills. In the first phase, the focus is on enhancing therapist credibility and expectations. In the second phase, the focus is on building motivation for change by reducing negativity and blame, creating hope and a relational focus, and developing balanced alliances with family members. Relational assessment involves identifying the interactional and functional aspects of specific behaviours, attributions, and feelings of family members and extrafamilial significant others (e.g. close relatives, peers). This assessment sets the stage for designing and implementing the behaviour change phase. Motivation to participate in the change process is enhanced by effecting changes in the attitudes and feelings of family members about each other and problematic behaviours. The behaviour change phase involves training and applying maintenance technology (e.g. parent–child communication training, behavioural contracting). Skills training interventions such as problem-solving and other behavioural intervention strategies are included using a menu-driven process from the behaviour therapy literature (e.g. listening skills, anger management, parent-directed behavioural consequences, improved parental supervision).
Who can deliver it?	The practitioner who delivers this intervention is a master's qualified (or higher) psychologist, social worker, or family therapist.

Implementation requirements (Cont.)

What are the training requirements?	The therapist undergoes 24 hours of face-to-face training prior to the first meeting with the client. An additional 48 hours of face-to-face training is required during the course of the first year. Booster training of practitioners is recommended.
How are practitioners supervised?	Practitioner supervision is provided through the following processes: • FFT LLC trained consultants provide the clinical supervision to the FFT therapists on a team in phase 1 (year 1). During this time (phase 1), the on-site person who will become the clinical supervisor in phase 2 (year 2) goes through an off-site externship process (seeing clients behind a mirror with clinical oversight) and then they also attend off-site supervisor training. • Once they have done all of this, they take over the clinical supervision of the FFT therapists at their agency. The FFT consultant then provides supervision only to the on-site clinical supervisor. • This supervision of the supervisor continues throughout the time a site is providing FFT services.
What are the systems for maintaining fidelity?	Intervention fidelity is maintained through the following processes: • Training manual • Other printed material • Face-to-face training • Fidelity monitoring.
Is there a licensing requirement?	No
***Contact details**	Contact person: Holly DeMaranville Organisation: Functional Family Therapy Email address: holly@fftllc.com Website: www.fftllc.com *Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.

Evidence summary

Functional Family Therapy (FFT) has an evidence rating of 3+ 'mixed' based on findings from four evaluations conducted in the US and UK.

The first study was an RCT conducted in the United States with evidence consistent with Foundations' Level 3 evidence strength criteria. This study observed statistically significant

reductions in FFT young people's reports of marijuana use in comparison to young people not receiving the intervention.

The second study was an RCT conducted in the United States with evidence consistent with Foundations' Level 2+ evidence strength criteria. This study observed statistically significant reductions in the rates of criminal recidivism among FFT youths compared to young people not receiving the intervention.

The third study was a matched comparison groups study conducted in the United States with evidence consistent with Foundations' Level 2+ evidence. This study observed statistically significant improvements in FFT young people's out-of-home placement immediately after intervention completion compared to young people not receiving the intervention. However, these benefits faded in the months following treatment – resulting in no differences between the FFT and comparison group nine months post-intervention.

The fourth study was an RCT conducted in the UK with evidence consistent with Foundations' Level 3 evidence strength criteria. This study observed no benefits for FFT young people or their families in comparison to those not receiving the intervention.

FFT can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

Child outcomes			
Outcome	**Improvement index**	**Interpretation**	**Study**
Reduced recidivism			2
Reduced days using marijuana	+34	30.78-percentage point reduction in the number of days smoking marijuana (measured using the Timeline Followback Interview) (Immediately after the intervention)	1

Search and review

	Number of studies
Identified in search	29
Studies reviewed	4

	Number of studies
Meeting the L2+ threshold	1
Meeting the L3 threshold	1
Meeting the L3 threshold but showing no effects	2
Ineligible	25

Individual study summary: Study 1

Study 1	
Study design	RCT
Country	United States
Sample characteristics	120 young people between ages of 13 and 17 who were diagnosed with a primary substance abuse disorder
Race, ethnicities, and nationalities	• 46.67% Hispanic • 38.33% White • 7.5% Native American • 7.5% Mixed racial background /Other.
Population risk factors	Study participants on average started using drugs when they were 11 to 12. Most adolescents were mandated to treatment by court order, by probation officers in lieu of court order, or by schools in lieu of suspension or other consequence. Marijuana abuse was found to be most common across the sample. 89.8% were found to have a more-than-average delinquent behaviour. 29.7% were over the mean in terms of anxiety/depression, 27.3% in terms of attention difficulties, 47.7% in terms of externalising behaviour, and 45.4% internalising behaviour.
Timing	• Baseline • 4 months post-baseline

Study 1	
	• 7 months post-baseline.
Child outcomes	Reduced marijuana use (Youth self-report)
Other outcomes	None
Study Rating	3
Citation	Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W. & Peterson, T. R. (2001) Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. *Journal of Consulting and Clinical Psychology*. 69, 802–813.

Brief summary

Population characteristics

This study was involved 120 youth who were diagnosed with a primary substance abuse disorder living in Albuquerque, New Mexico. Youths were eligible to take part if they met the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV) diagnostic criteria for a primary substance abuse disorder. Most adolescents were mandated to treatment by court order, by probation officers in lieu of court order, or by schools in lieu of suspension or other consequence. Marijuana abuse was found to be most common across the sample. Youths who required services other than outpatient treatment and those who primarily abused only alcohol and/or tobacco were excluded from participation.

There were 96 boys and 24 girls in the sample, who were between the ages of 13-17 (mean 15). 46.67% were Hispanic; 38.33% were White; 7.5% were Native American; and 7.5% were classified as Mixed racial background/Other.

Study design

The first study is a rigorously conducted RCT.

This study involved urn randomisation to balance groups on gender, age, level of substance use, ethnicity, psychiatric severity, and family constitution. Youth were assigned to one of four groups:

- Functional Family Therapy (FFT) (30 families), which included 12 hours of FFT intervention.
- Individual Cognitive Behavioural Therapy (CBT) (31 families), which included 12 hours of individual CBT therapy.

- Combined CBT and Family Therapy (29 families), which included one hour of FFT and one hour of CBT intervention per week, and 24 hours of therapy in total.
- Group intervention (30 families), which included eight 90-minute group sessions.

Analyses showed no statistically significant differences between treatment conditions on adolescent substance use, age, annual family income, primary caretaker education, ethnicity, gender, and family constitution.

Measurement

Assessment took place in baseline, and 4 and 7 months post-baseline.

- **Youth** report measures include the timeline follow-back interview (TLFB).

Other measures were used to assess the convergent validity of this measure – i.e. collateral reports from parents as well as urine drug screenings. These included:

- Child behaviour checklist (CBCL) – to assess child behaviour
- Problem Oriented Screening Instrument (POSIT) – to assess functional areas associated with adolescent substance misuse.

Study retention

88% (114) of participants completed post-intervention assessment at 4 and 7 months post-baseline.

Results

Data-analytic strategy

A 4 (treatment condition) X 3 (time) repeated measures ANOVA was used to compare the efficacy of four interventions in reducing the percentage of days marijuana was used. To examine the stability of change from pre-treatment to the 7-month follow-up, the study also conducted a second set of four planned comparisons using Bonferroni adjustment for a = 0.125.

In addition, to evaluate the clinical significance of the reductions in marijuana use, a dichotomous dependent variable was created to classify each adolescent as having minimal or heavy marijuana use. Minimal use indicated that the youth reported abstinence or near abstinence (i.e. reported use on fewer than 10% of the days) in the assessment period. The two-family conditions (FFT; Combined CBT and Family Therapy) were combined and contrasted with the CBT and group conditions at the 4- and 7-month measurement periods by use of Mann–Whitney tests. Missing data was estimated using the regression plus random residuals MVA module in SPSS.

Findings

There was a significant interaction between time and the four treatment conditions. FFT youth were found to have a significantly lower rate of marijuana use than did the CBT and group treatment youths from pre-treatment to 4-month post-baseline. At 7 months post-baseline, there was no longer a significant difference in the number of days marijuana was used compared to baseline, suggesting that the changes at 4 months were not maintained at 7 months.

Study 1: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Percentage of days marijuana was used	Timeline follow-back interview (TLFB) (Child self-report)	Not reported	Yes	114	4-month post-baseline

Individual study summary: Study 2

Study 2	
Study design	RCT
Country	United States
Sample characteristics	86 young people aged 13 to 16 who had been arrested or detained at the Juvenile Court for a behavioural offence
Race, ethnicities, and nationalities	Not reported
Population risk factors	Not reported
Timing	• Baseline • 6-month follow up • 18-month follow up.
Child outcomes	Reduced recidivism (Administrative measure)
Other outcomes	None measured
Study Rating	2+

Study 2	
Citation	Alexander, J. F. & Parsons, B. V. (1973) Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology*. 81, 219–225.

Brief summary

Population characteristics

This study was conducted in the United States with a sample of young people who were arrested or detained at a juvenile court for a behavioural offence. Offences included running away; being declared ungovernable; being habitually truant; being arrested for shoplifting; being arrested for possession of alcohol, soft drugs, or tobacco. The young people ranged in age from 13 to 16; 38 were male and 48 were female.

Study design

This study was an RCT. This study involved random assignment of 99 young people to three conditions:

- FFT group (46 families)
- No-treatment control group (10 families)
- Alternative treatments: 19 families were allocated to a client-centred family groups programme, and 11 to a psychodynamic family programme.

No statistically significant differences were found between groups on demographic variables, prior recidivism rates, and pre-test scores on the study outcomes.

Measurement

Measurement took place at baseline, 6- and 18-month follow-up.

- **Administrative measure** included juvenile court records.

Study retention

100% (86) of participants completed assessments post-intervention.

Results

The study employed an intent-to-treat analysis and used Chi-Square tests to compare recidivism rates across the groups.

Findings

The results indicated that 46 families receiving the intervention demonstrated significantly reduced recidivism rates at follow-up when compared to the no-treatment control group and the group receiving alternative treatments.

Limitations

The conclusions that can be drawn from this study are limited by methodological issues pertaining to a lack of clarity as to whether the equivalence of groups was undermined by attrition, hence why a higher rating is not achieved.

Study 2: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Recidivism rates	Juvenile court records		Yes	86	18-month follow-up

Individual study summary: Study 3

Study 3	
Study design	QED
Country	United States
Sample characteristics	8,713 11- to 18-year-old African American and Latino youth who were recently released from court-ordered out of home placement and who could not remain in the home due to circumstances of the child's case and home life (e.g. family risk, maltreatment history, child behavioural health needs).
Race, ethnicities, and nationalities	• 61% Latino • 29% African American • 8% White • 2% Other.

Study 3	
Population risk factors	The child participants had around two prior arrests on average. Prior petitions included offences like assault with deadly weapon, battery, burglary, petty theft, robbery, and vandalism. On average, they were first arrested at age 14 to 15.
Timing	Over 36-month period post-release
Child outcomes	No
Other outcomes	None
Study Rating	NE
Citation	Darnell, A. J. & Schuler, M. S. (2015) Quasi-experimental study of Functional Family Therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. *Children and Youth Services Review*. 50, 75–82.

Brief summary

Population characteristics

This study was conducted in the United States, with a sample of 8,713 11- to 18-year-old African American and Latino youth who were recently released from court-ordered out of home placement between July 2007 and January 2012. They could not remain in the home due to circumstances of the child's case and home life (e.g. family risk, maltreatment history, child behavioural health needs). They were all under probation supervision and were returning home to live with their families. Most of them were male.

The child participants had around two prior arrests on average. Prior petitions included offences like assault with deadly weapon, battery, burglary, petty theft, robbery, and vandalism.

On average, they were first arrested/committed their first felony at age 14 to 15.

Study design

The third study is a rigorously conducted QED. Data were extracted from administrative data systems for juvenile justice and child welfare departments. The sample was divided into three groups.

- Functional Family Therapy (FFT) and standard probation (524 youths), with weekly FFT therapy sessions and monthly face-to-face contact with probation officers
- Functional Family Probation (FFP) only (216 youths), which was a probation supervision model that incorporates the principles of FFT
- Both FFT and FFP (539 youths).

The comparison sample consisted of 7,434 youths.

- 5,992 were released from placement during the intervention period but did not receive FFT or FFP.
- 1,442 were released from Placement during the 2006 federal fiscal year prior to implementation of the tested interventions.

Propensity score methods were used to balance the four groups. Propensity score weights were based on the following variables: gender, race/ethnicity (African American, Latino, White, Other), age at release from current Placement, age at first arrest, age at first felony, age at first OHP, count of prior arrests, count of prior OHPs, two variables representing geographic divisions of the service area, and counts of prior petitions of various types (i.e. battery, assault with deadly weapon, burglary, petty theft, robbery, and vandalism). Sufficient balance across the four groups was achieved.

Measurement

Measurement occurred over a 36-month period post-release.

- **Administrative measures** included juvenile justice and child welfare departments data.

Study retention

All data that fulfilled eligibility criteria were extracted and analysed.

Results

Data-analytic strategy

The study used logistic regression within a discrete-time survival model, including interaction terms with time, to compare the likelihood of out-of-home placement (OHP) between intervention and comparison groups over time.

Findings

This study found that there were no statistically significant improvements for intervention participants on the majority of measured timepoints for the outcome of interest, with the preponderance of the evidence demonstrating no direct benefits for the child in terms of in scope of outcomes. While there was an effect over the course of the intervention on out-of-home placements, this effect faded and at the post-intervention points there were no differences between the intervention and control groups.

Study 3: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Number of out of home placements	Juvenile justice and child welfare departments administrative data	Odds ratio: 0.32	Yes	8,713	1 month after release from court-ordered out of home placement
Number of out of home placements	Juvenile justice and child welfare departments administrative data	Odds ratio: 0.33	Yes	8,713	2 months after release from court-ordered out of home placement
Number of out of home placements	Juvenile justice and child welfare departments administrative data	Odds ratio: 1.35	No	8,713	6 months after release from court-ordered out of home placement
Number of out of home placements	Juvenile justice and child welfare departments administrative data	Odds ratio: 2.09	No	8,713	9 months after release from court-ordered out of home placement

Individual study summary: Study 4

Study 4	
Study design	RCT
Country	United Kingdom

Study 4	
Sample characteristics	111 young people between the ages of 10 and 17 who have been sentenced for offending or were receiving agency intervention following contact with the police for antisocial behaviour.
Race, ethnicities, and nationalities	90% White British
Population risk factors	• Most participants lived with single (55%), unemployed (57%) carers • 60% of young people's carers had no education beyond the age of 16.
Timing	• Baseline • 6-month post-baseline • 12-month post-baseline.
Child outcomes	No
Other outcomes	None
Study Rating	NE
Citation	Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S. & Scott, S. (2017) Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. *Journal of Child Psychology and Psychiatry*. 58 (9), 1023–1032.

Brief summary

Population characteristics

This study was conducted in the UK with a sample of 111 children. All youth had been sentenced for offending or were receiving agency intervention following contact with the police for anti-social behaviour. Young people were between 10 and 17 years of age (mean = 15). 70% of the sample was male, and 90% were White British. Around half of the study population offended in the previous six months. Around half had conduct disorder diagnosis, and around half had oppositional defiant disorder diagnosis. Youth were predominantly with below average IQ (M = 84). Most lived with single (55%), unemployed (57%) carers, 85% of whom were the youth's biological mother; 60% carers had no education beyond the age of 16.

Study design

This study is a rigorously conducted RCT. This study involved constrained adaptive random assignment of children to:

- Functional Family Therapy (FFT) (65 youths), alongside management as usual
- Management as Usual (MAU) (46 youths), with a support and counselling model.

Measurement

Measurement took place at baseline and 6- and 12-month post-baseline.

- **Youth report measures** included Self-report delinquency scale from Edinburgh Study of Youth Transitions and Crime.
- **Parent report measures** included Alabama Parenting Questionnaire, short version (APQ-15).
- **Observational measures** included Adolescent Parent Account of Child Symptoms and 'Hot Topics' measure.
- **Administrative measures** included UK Police National Computer database records.

Study retention

6-month post-baseline

81.08% (90) youths participated at 6-month post-baseline, representing 81.52% (53) of FFT youths and 80.43% (37) of youths in the control group.

12-month post-baseline

80.18% (89) youths participated at 12-month post-baseline, representing 80% (52) of FFT youths and 80.43% (37) of youths in the control group.

Results

Data-analytic strategy

All analyses were undertaken on an intention-to-treat basis using linear mixed modelling.

Findings

This study found no statistically significant improvements for intervention participants on all measured child outcomes. It identified one negative impact on a child outcome (on directly observed positive child behaviour when interacting with parent).

Study 4: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Youth delinquency	Self-report delinquency scale from Edinburgh Study of Youth Transitions and Crime (Youth report)	Standardised effect size B = 0.13	No	90	6-month post-baseline
Youth delinquency	Self-report delinquency scale from Edinburgh Study of Youth Transitions and Crime (Youth report)	Standardised effect size B = 0.12	No	89	12-month post-baseline
Youth offending behaviour	UK Police National Computer database records (Administrative data)	Odds ratio = 1.67	No	90	6-month post-baseline
Youth offending behaviour	UK Police National Computer database records (Administrative data)	Odds ratio = 0.88	No	89	12-month post baseline
Symptom counts of conduct disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Standardised effect size B = 0.22	No	90	6-month post-baseline

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Symptom counts of conduct disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Standardised effect size B = 0.07	No	89	12-month post-baseline
Symptom counts of oppositional defiant disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Standardised effect size B = 0.05	No	90	6-month post-baseline
Symptom counts of oppositional defiant disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Standardised effect size B = 0.15	No	89	12-month post-baseline
Diagnoses of conduct disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Odds ratio = 2.98	No	90	6-month post-baseline
Diagnoses of conduct disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Odds ratio = 2.93	No	89	12-month post-baseline
Diagnoses of oppositional defiant disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Odds ratio = 1	No	90	6-month post-baseline

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Diagnoses of oppositional defiant disorder	Adolescent Parent Account of Child Symptoms (Observational measure)	Odds ratio = 2.04	No	89	12-month post-baseline
Observed positive child behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.3	No	90	6-month post-baseline
Observed positive child behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.43	Yes (higher youth positivity in the control)	89	12-month post-baseline
Observed negative child behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.12	No	90	6-month post-baseline
Observed negative child behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.42	No	89	12-month post-baseline
Parent outcomes					
Poor parental supervision	Alabama Parenting Questionnaire, short version (APQ-15) (Parent report)	Standardised effect size B = 0.05	No	90	6-month post-baseline
Poor parental supervision	Alabama Parenting Questionnaire, short version (APQ-15) (Parent report)	Standardised effect size B = 0.18	No	89	12-month post-baseline

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Observed positive parent behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.36	No	90	6-month post-baseline
Observed positive parent behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.17	No	89	12-month post-baseline
Observed negative parent behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.18	No	90	6-month post-baseline
Observed negative parent behaviour	'Hot Topics' measure (Observational measure)	Standardised effect size B = 0.18	No	89	12-month post-baseline

Other studies

The following studies were identified for this intervention but did not count towards the intervention's overall evidence rating. An intervention receives the same rating as its most robust study or studies.

Baglivio, M. T., Jackowski, K., Greenwald, M. A. & Wolff, K. T. (2014) Comparison of multisystemic therapy and functional family therapy effectiveness: A multiyear statewide propensity score matching analysis of juvenile offenders. *Criminal Justice and Behavior*. 41 (9), 1033–1056.

Barnoski, R. (2002) *Washington State's implementation of Functional Family Therapy for juvenile offenders: Preliminary findings*. Washington State Institute for Public Policy

Barnoski, R. (2004) *Outcome evaluation of Washington State's research-based programs for juvenile offenders* (Document No. 04-01-1201). Washington State Institute for Public Policy.

Barton, C., Alexander, J. F., Waldron, H., Turner, C. W. & Warburton, J. (1985) Generalizing treatment effects of Functional Family Therapy: Three replications. *The American Journal of Family Therapy*. 13, 16–26.

Celinska, K., Furrer, S. & Cheng, C. C. (2013) An outcome-based evaluation of functional family therapy for youth with behavioral problems. *Journal of Juvenile Justice*. 2 (2), 23.

Friedman, A. (1989) Family therapy vs. parent groups: Effects on adolescent drug abusers. *The American Journal of Family Therapy*. 17 (4), 335–347.

Gordon, D. A. (1995) Functional family therapy for delinquents. In R. P. Ross, D. H. Antonowicz & G. K. Dhaliwal (Eds.), *Going straight: Effective delinquency prevention and offender rehabilitation* (pp. 163–178).

Gordon, D. A., Arbuthnot, J., Gustafson, K. E. & McGreen, P. (1988) Home-based behavioral-systems family therapy with disadvantaged juvenile delinquents. *American Journal of Family Therapy*. 16 (3), 243–255.

Gordon, D. A., Graves, K. & Arbuthnot, J. (1995) The effect of Functional Family Therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior*. 22 (1), 60–73.

Gustafson, K., Gordon, D. A. & Arbuthnot, J. (1985) *A cost-benefit analysis of in-home family therapy vs. probation for juvenile delinquents*. Paper presented at the annual Banff Conference on Behavioral Sciences, Banff, Alberta, Canada.

Hansson, K. (1998) *Functional family therapy replication in Sweden: Treatment outcome with juvenile delinquents*. Paper presented to the Eighth Conference on Treating Addictive Behaviours, Santa Fe, NM.

Hansson, K., Cederblad, M. & Hook, B. (2000) Functional Family Therapy: A method for treating juvenile delinquents. *Socialvetenskaplig tids*krift. 3, 231–243.

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Note on provider involvement: This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.