

# Evolution of Functional Family Therapy as an Evidence-Based Practice for Adolescents with Disruptive Behavior Problems

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*This article summarizes the evolution of functional family therapy (FFT) based upon four decades of clinical practice and scientific scrutiny through research evidence. FFT research has evolved from an initial focus upon clinical process research, which examined sequential exchanges between therapists and family members. A key element of this research has been an examination of the way in which clinicians acquire, consolidate, and maintain the skills needed to implement FFT effectively with youth and families. Many randomized efficacy and effectiveness studies have evaluated the impact of FFT across diverse clinical populations. Subsequent research investigated factors that influence the effectiveness of implementation across more than 300 clinical settings in which more than 2,500 trained clinicians have provided service to nearly 400,000 families. Another important set of investigations concerned the cost-effectiveness of the interventions.*

*Keywords:* Functional Family therapy; Adolescents; Delinquency; Substance Use; Research

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**F**unctional family therapy (FFT; Alexander & Parsons, 1982; Alexander, Waldron, Robbins, & Neeb, 2013) is an evidence-based treatment (EBT) for adolescents with disruptive behavior problems. The evolution of the FFT model into an EBT has occurred over the past 45 years through the systematic interplay between theory, research, and practice. Szapocznik and Kurtines (1993) coherently describe how clinical model development is neither static nor rigid, but rather unfolds continuously based on new information and experiences. The process of evolution is iterative with new data emerging from clinical experience or research evidence feeding into new questions or ideas about change; questions and ideas which are then subjected to scientific scrutiny and evaluation; and the results of such inquiries can lead to new articulations of the clinical model. Scientific scrutiny, thus, represents the penultimate link in the evolutionary process of an evidence-based approach.

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In this article, we summarize the results of the four decades of research that has fed into the articulation of FFT model and that has resulted in FFT being designated as an evidence-based model for children and adolescents with behavior problems. We first present a brief overview of the FFT model, and second, we summarize findings from five key areas of research, including basic research, efficacy research, effectiveness research, implementation/dissemination research, and change mechanisms (process/moderators and mediators) research.

## OVERVIEW OF FFT

Functional family therapy (Alexander & Parsons, 1982; Alexander et al., 2013) is an integrated approach that combines systemic and cognitive-behavioral theories to address the range of behavior problems that youths and their families present in therapy. FFT provides a coherent theory for understanding family relationship patterns and identifying the relational “payoff” or “function” of behaviors within the family. Interventions are subsequently designed to increase adaptive behaviors and decrease or eliminate maladaptive behaviors while accommodating to the family’s relational functions. That is, rather than attempting to change relational functions, FFT therapists seek to find ways for family members to achieve their relational functions via adaptive means. This focus permits therapists to design interventions that are appropriate, sensitive, cost-effective, and matched to the unique characteristics (e.g., strengths, culture, resources) of each family/family member.

Functional family therapy (Alexander & Parsons, 1982; Alexander et al., 2013) is a brief intervention that—on average—consists of 12–14 1-hour weekly family sessions. FFT is applied in five distinct phases: engagement, motivation, relational assessment, behavior change, and generalization. In the Engagement Phase, the focus is on maximizing family members’ initial expectations/perceptions about treatment to facilitate their attendance at the first treatment session. In the Motivation phase, the focus is on reducing family conflict, blame, and hopelessness and developing a relational focus and balanced alliances with family members to create a motivational context for change. In the relational assessment phase, the focus is on identifying the interactional and functional aspects of specific behaviors, attributions, and feelings of family members and extra-familial significant others (e.g., close relatives, peers). This assessment sets the stage for designing and implementing the behavior change phase, which involves training and applying maintenance technology (e.g., parent-child communication training, behavioral contracting, emotional expression and regulation). Skills training interventions such as problem-solving and other behavioral intervention strategies are included using a menu-driven process from the behavior therapy literature (e.g., listening skills, anger management, parent-directed behavioral consequences, improved parental supervision). A unique feature of FFT is the specific focus on skills in the context of assessed relational functions of behavior (e.g., separation, contact) within each dyad of the family system. The focus of change is on replacing maladaptive behaviors used to maintain relationship functions. In the generalization phase, the focus is on extending new skills and behaviors to the home and environment to maintain and extend the treatment gains independently from the therapist.

## RESEARCH ON FFT

The FFT model has been subjected to numerous trials and research evaluations. The initial studies were conducted by Alexander and colleagues at the University of Utah, but over time independent researchers and research groups, both nationally and internationally, have examined the impact of FFT. The FFT model has undergone a number of

outcome research studies, including both controlled efficacy trials and community-based effectiveness studies as well as a number of innovative studies designed to identify (a) malleable change targets and (b) relevant change mechanisms or processes. As shown in Figure 1, several types of research have profoundly shaped the articulation of the FFT model.

Basic research refers to nonclinical or anecdotal studies that help to provide valuable insights about the clinical population (e.g., delinquent youth) or potential clinical targets (e.g., negative attributions). Efficacy studies refers to well-controlled, randomized clinical trials where the focus was primarily on internal validity. Effectiveness studies include controlled, randomized studies in which the focus was primarily on external validity or the impact of FFT compared to alternative treatments in real world settings. Dissemination/implementation research refers to studies evaluating the impact of FFT in real world settings. These studies often adopt matched cohorts or quasi-experimental designs to examine the impact of FFT compared to alternative interventions. Cost and benefit analyses are an important component of these evaluations. Process research includes studies examining the clinical interior of treatment, including the examination of therapist and family member behavior and interactions in the clinical setting.

Because of the length of the tables, the material is presented as supporting information, which is available from the online version of this article. The supporting tables provide a summary of research on FFT, organized along the five areas of research noted above. Other summaries of FFT research (e.g., Waldron, Robbins, & Alexander, 2012) provide a detailed description of the majority of the studies summarized in Table S1. Our intent here is to provide a general overview of key findings that have either led directly into a clinical model development or revision (basic and process research) or that have provided support for the positive effects of FFT under well-controlled circumstances (efficacy research) or in real world settings (effectiveness and dissemination/implementation research). In doing so, we summarize several features of these studies that have not been highlighted in prior reviews, including (a) whether the study was conducted by the model developer or an independent researcher/group, (b) the clinical population and referral source/setting, (c) information about gender, ethnicity and age, (d) the type of study that was conducted, and (e) the key outcomes. With respect to the key outcomes, we include information about primary variables such as youth delinquency and substance use as well as information about relevant moderators, mediators, change processes, and cost-effectiveness.

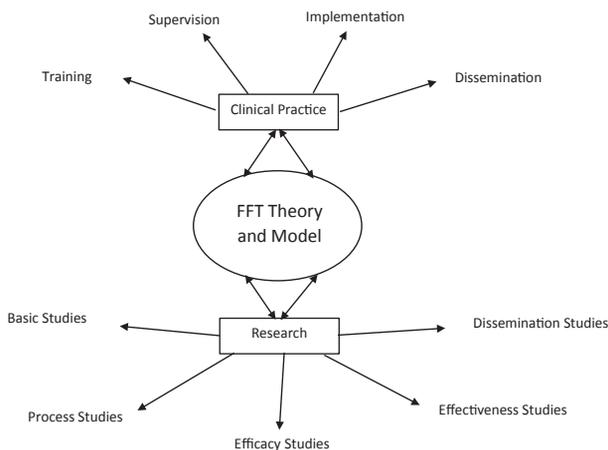


FIGURE 1. Interplay between theory, research, and practice.

## BASIC RESEARCH

The seven studies reviewed in this section provide a vivid portrayal of (a) how research has helped to identify characteristics of families with troubled youth, (b) how these characteristics differentiated these families from families with nondelinquent youth, and (c) potentially malleable risk factors associated with these characteristics. Importantly, unlike most studies, which have relied heavily on self-reports from therapists and family members, basic research studies utilized independent and reliable observation. The methods used in these studies permitted researchers to directly observe how family members interacted with one another in structured, nontherapy tasks (e.g., problem-solving, family activity planning to identify clinically meaningful and relevant family processes rather than relying solely on what they *said* about their family). Beyond the benefits of the objectivity associated with independent observations of family functioning, this strategy provided a vivid portrayal of interactions in families with a delinquent youth.

All of these basic studies were conducted by the developer/developer research group (Alexander et al., n.d.). Six studies included delinquent youth and their families, including one sample that also presented with co-occurring substance use problems, and one study included a nonclinical sample of undergraduate students. A total of 243 adolescents participated in these studies, with the majority being White and male. The 120 undergraduate students in the anecdotal study were also primarily White and male.

The results of these studies demonstrate the high rates of negativity and reciprocation of negativity in delinquent families and how delinquent families differ from nondelinquent families (e.g., Alexander, 1973; Alexander, Waldron, Barton, & Mas, 1989; Barton, Alexander, & Turner, 1988). Delinquent families, compared to their nondelinquent counterparts, show higher rates of negativity and blame, and lower rates of nurturance, warmth, empathy, and respect. The negativity observed in delinquent families appeared to be contingent on the type of interaction context in which the family was exposed (e.g., competitive or cooperative; Alexander et al., 1989 [study 1]; Barton et al., 1988). Also, low and high conflict delinquent families showed different patterns of blaming attributions. Moreover, this research showed how interaction set as well as specific strategies (such as relabel/reframing; Morris, Alexander, & Turner, 1991) could decrease observed negativity in delinquent families as well as reduce blaming attributions among undergraduate students. These findings point to the potential malleability of negativity interactions and blaming interactions in delinquent families, and that led to the development of specific interventions for engaging and motivating youth and families in treatment. Recent process research on FFT has established statistical procedures for linking clinical interaction patterns to outcomes when sample sizes are quite small (Ozechowski, 2014).

Taken together, the data provide support for reattribution techniques which are explicitly focused on expanding the families' frame to include a more positive, or workable, frame wherein family members are willing to try out new behaviors. These observational studies have been critical in influencing the development or articulation of specific intervention strategies, for creating a motivational context conducive to adaptive and supportive family behaviors.

## EFFICACY RESEARCH

Ten studies from efficacy trials have been published on the FFT model. Seven of these trials have been completed by the model developer (Alexander et al., n.d.), including the program of research Holly Waldron has led with substance using youth and their families. Three independent efficacy studies have also been conducted (Friedman, 1989; Hansson, Cederblad, & Hook, 2000; Slesnick & Prestopnik, 2009). These trials have included

delinquent (five studies) and substance-using (five studies) youth and their families. A total of 799 youth and their families have participated in these studies. The majority of the youth in these trials were male. These studies included a large proportion of White youth, followed by Hispanic, African American, and Native American. The studies primarily included 12–18-year-old youths. All of these studies included random assignment to treatment, comparisons to active treatment comparison groups, and at least 1 year or more follow-up assessment points.

Results of these studies provide strong support for the efficacy of FFT with delinquent and substance-using youth, including serious habitual offenders. The results also showed that FFT was efficacious in preventing delinquency in the younger siblings of delinquent youth (Klein, Alexander, & Parsons, 1977) and in reducing HIV-risk behaviors in youth being treated for substance use (Hops et al., 2011). The results appear to be robust across White and Hispanic youth as well as internationally (Hansson et al., 2000). With respect to internalizing disorders, the results suggest that FFT might be an efficacious treatment for modifying depressive symptoms for substance-using youth; however, for substance-using youth diagnosed with co-occurring major depressive disorder, there is evidence to suggest that sequencing treatment to start with coping with depression may be the most effective way to address depressive symptoms.

### **EFFECTIVENESS RESEARCH**

All of the five published studies in the effectiveness section (six trials) included random assignment. (Note that these four studies were included in this section because they represented planned studies focused on the generalizability of FFT in real world settings as opposed to the post-hoc evaluations that are included in the section on dissemination/implementation.) All of these studies were conducted by independent researchers/groups. Three studies were focused on delinquency, one on substance use, and one on youth referred for ADHD in a child welfare setting. The studies included 1,102 youth and their families, including approximately 80% males. The participants were primarily White. The sample in Barnoski (2004) and Sexton and Turner (2010) included participants that matched the diversity of the population in the state of Washington with approximately 80% White, followed by 10% African American, 5% and 3% Asian and Native American, respectively. The age of the youth in these samples ranged from 12 to 22 years, with a mean age between 15 and 16 years.

The results of the effectiveness studies support the finding that FFT can be implemented in community settings with high integrity and effectiveness. Specifically, these results showed that FFT was effective in reducing adolescent recidivism rates and substance use. Moreover, the results of these studies showed that FFT was as effective as group therapy in improving ADHD at home and school (Regas & Sprenkle, 1982). The effectiveness of FFT in preventing outplacements was noted by Lantz (1982).

### **DISSEMINATION/IMPLEMENTATION RESEARCH**

Of the twelve studies reported in the dissemination/implementation research section, nine were conducted by independent researchers/teams and three were completed by the developer/teams. The issues/referral sources for these studies included delinquency (eight studies), child welfare (four studies), and mental health. Over 11,000 youth and their families were included in these dissemination studies. Three of these studies included state-wide evaluations (Baglivio, Jackowski, Greenwald, & Wolff, 2014; Darnell & Schuler, 2015; Sexton & Turner, 2010). Taken together, the results of these studies include adequate representation of boys and girls as well as White, Hispanic, and African Americans.

Six studies included a matched design, including two propensity matched designed studies (Baglivio et al., 2014; Darnell & Schuler, 2015). Eight studies included follow-up rates of more than a year.

Results of these studies provide strong support for the implementation of FFT in community settings. FFT was associated with significant reductions in youth behavior problems, both with respect to comparisons to services as usual (Barton, Alexander, Waldron, Turner, & Warburton, 1985 [Study 1, 2]; Celinska, Furrer, & Cheng, 2013; Hansson, Johansson, Drott-Englén, & Benderix, 2004) and to an established evidenced-based treatment (Baglivio et al., 2014). Also, FFT was shown to be effective in engaging and retaining youth with callous-unemotional traits into treatment, and in weakening the link between callous-unemotional traits and behavior problems (White, Frick, Lawing, & Bauer, 2013). FFT was also effective in improving (a) youth internalizing symptoms (Celinska et al., 2013; Hansson et al., 2004), (b) parent internalizing symptoms/distress (Hansson et al., 2004), and (c) school attendance and achievement. In three studies, FFT was associated with significant reductions in outplacements in child welfare (Barton et al., 1985 [Study 2]; Stout & Holleran, 2013) and delinquent (Darnell & Schuler, 2015) samples. An adaptation of FFT, functional family probation services (FFP; Kopp & Medina, 2009) also showed promise in preventing outplacements, which is consistent with FFP's designation as an evidence-based practice in the State of Washington.

### **CHANGE MECHANISMS: RESEARCH ON CLINICAL PROCESS, MODERATORS, AND MEDIATORS**

This section summarizes information about potential mechanisms of action to account for the positive changes that are observed in research on FFT. The first section summarizes the findings from the majority of the process studies reported in Table S1. These studies provide insight into the aspects of the clinical interior of treatment; and, as such, the results are immediately relevant to practicing therapists. This section includes a review of the results of the two process studies that focused on the impact of therapist-family ethnic matching on key treatment outcomes. The section presents findings from studies examining treatment attendance and fidelity. The third section highlights outcomes about moderators and mediators that were observed in the outcome studies reported in Table S1.

#### **Process Research Findings**

Nine process research projects examined the “clinical interior” of treatment to address questions about how clients change, what therapists do to facilitate these changes, and the links between clinical processes and outcomes. Eight process studies were completed by the model developer/team and one was completed by an independent research team. All of these studies were focused on youth delinquency (seven) or substance use (two). The sample included 522 youth and their families. Youth were primarily male, ranged in age from 12 to 17 years, and White or African American. Seven studies used observational methods to examine within treatment processes, one was a secondary analysis of data from a randomized efficacy trial, and one examined process-outcome links in a community-based implementation of FFT.

The results of the observational studies provide valuable information about clinical processes and process-outcome links in FFT. Several process studies document that the high levels of conflict observed in the basic studies reported above are extended into family interactions in the clinical context. For example, Alexander, Barton, Schiavo, and Parsons (1976) note how early family negativity increases risk for treatment dropout, but those

improvements in the ratio of support to defensive communications by the end of treatment are associated with positive outcomes. In a later study, imbalances of alliances in early sessions (parent minus adolescent alliance with therapist) were also shown to be related to treatment dropout (Robbins, Turner, Alexander, & Perez, 2003). In a series of studies, the model developers showed how defensive and supportive communication processes in the session are influenced by family role (mother, father, adolescent) and therapist gender (Mas, Alexander, & Barton, 1985; Newberry, Alexander, & Turner, 1991). In two studies, the developers documented how therapist reframing can reduce expressions of negativity in early sessions (Robbins, Alexander, Newell, & Turner, 1996; Robbins, Alexander, & Turner, 2000). This research, and our early clinical experience, highlighted the critical importance of initial family engagement and the subsequent motivation process with troubled youth and their families. In many respects, this early research was the precursor for the rich "front loaded" interventions that FFT utilizes to negotiate the early phases of treatment. The pattern of results in these studies has been useful for shedding light on how static characteristics such as gender have a profound influence on clinical processes. This research has helped to engender in therapists the notion that all interactions are bidirectional and mutually influential and are not solely the result of what therapists do in the session. They also result from what the therapist represents to the family and its individual members.

Two process studies were conducted to examine the importance of therapist-client ethnic matching in FFT. The sample in these studies included White and Hispanic youth and their families who were treated by Hispanic or non-Hispanic therapists. In the first observational study, Flicker, Turner, Waldron, Brody, and Ozechowski (2008) demonstrated that imbalanced alliances were predictive of dropout in Hispanic families but not White families. Flicker, Waldron, Turner, Brody, and Hops (2008) reexamined these families, and showed that ethnic match was associated with greater reductions in substance use for Hispanic youth, and that ethnic match was not associated with outcomes for White youth. These results demonstrate the importance of providing cultural sensitivity training to therapists who serve culturally diverse clinical populations.

#### *Therapy quantity and quality: Attendance and fidelity*

Sholevar, Baron, Aussetts, and Spiga (2010) demonstrated a link between the number of sessions attended, density of services, and time to re-arrest in a sample of youth who were re-arrested in a large-scale implementation of FFT in Pennsylvania. In prior research, the cutoff of eight or more sessions was chosen as a minimum dose threshold for FFT (Robbins et al., 2003). The Sholevar et al. (2010) study, which included a slightly different cutoff (seven or more), provides support for the assertion that receiving at least a minimal dose of FFT is important for predicting clinical outcomes. It is important to note that the link between the number of sessions and outcomes were moderated by density of services. That is, getting to a minimal dose is important but better outcomes were observed for cases that moved more quickly through the process.

Therapist fidelity and youth behavior outcomes were compared by Sexton and Turner (2010). In this study, fidelity ratings were completed for a portion of participating families and sessions to measure the knowledge of core FFT principles therapists reflected during weekly supervision, their understanding of the family within the FFT framework, and their compliance with the manual-specified goals for each phase of the clinical intervention. Positive outcomes (i.e., reductions in recidivism) were found only for competently adherent therapists, and there was evidence that severity of youth and family problems influenced fidelity, with more severe cases being more likely to draw therapists off model.

Clearly, measuring adherence is a critical operation for ensuring FFT is implemented in community settings with integrity. The link between therapists' adherence and

outcome is well-known. One of the single most significant challenges associated with implementing EBTs in community practice is establishing therapists' competent adherence to a treatment model and sustaining fidelity (Forgatch, Patterson, & DeGarmo, 2005; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; Hogue, Dauber, et al., 2008; Hogue, Henderson, et al., 2008; Mihalic & Irwin, 2003; Rogers, 2003). To address the key issue of enhancing treatment competence, FFT LLC recently developed and implemented a sophisticated web-based application designed to monitor highly structured FFT therapists' progress notes, as well as supervisor and client ratings of therapist competence. The process helps to maximize sustainability for community programs by limiting costs. Hence, the supervision process involves feedback to therapists based on the progress notes and therapist-supervisor discussions of therapist performance. The current supervision and adherence monitoring system, changed as a result of the problems detected in Barnoski (2004; also reported by Sexton & Turner, 2010), was designed to enhance therapist fidelity and improve overall treatment effectiveness.

### *Impact on family functioning*

In the earliest studies, FFT was shown to be superior to alternative interventions in improving family communication and interaction (Alexander, 1971; Alexander & Barton, 1976; Alexander & Parsons, 1973; Parsons & Alexander, 1973). Improvements in family functioning (Barton et al., 1985 [Study 1]; Hansson et al., 2004), parent involvement (Friedman, 1989; Stanton & Shadish, 1997), positive perceptions of the family (Regas & Sprenkle, 1982), and living arrangements (Celinska et al., 2013). The inclusion of active comparison conditions with different formats (e.g., individual or group therapy) in these studies has permitted the evaluation of the extent to which change in family functioning is differentially affected in FFT. Alexander (1971) and Waldron, Slesnick, Brody, Turner, and Peterson (2001) showed that FFT was associated with improvements in family functioning, and that family interactions did not improve in individual therapy and group therapy alone.

### *Moderators: age, gender, and race/ethnicity*

Baglivio et al. (2014) provide support for the robust effects of FFT across both male and female adolescents. In fact, in this study, it appeared that female adolescents in FFT responded significantly better than their counterparts who received MST. This study is particularly important because the majority of clinical outcome research on EBTs is limited in reach due to the fact that girls are typically under-represented in research trials. The large sample of 2,203 youth in this study thus provided a unique opportunity to look at the impact of FFT with a large sample of male and females. Additional research is needed to determine, if FFT is particularly well-suited to the needs of girls with behavior problems. However, it is reasonable to assume that girls may be particularly tuned into the relational focus of FFT.

Functional family therapy research has included primarily White (urban and rural), Hispanic, and African American youth. With respect to these studies, there is generally very little evidence that the intervention's effectiveness varies by race or ethnicity. As noted above, therapist matching may be a relevant consideration in implementation with Hispanic youth but not White (non-Hispanic) youth. In one of the only studies to formally examine the moderating effects of youth ethnicity, Celinska et al. (2013) provided valuable information on how youth may differentially respond to FFT. Specifically, they noted that Hispanic youth responded better than other youth to measures of life domains and child risk behaviors, African American youth responded better to child emotional and behavioral needs, and White youth responded better to child strengths. In this study,

youth age was also associated with outcomes, with older youth responding better to treatment than younger youth.

### **COST-EFFECTIVENESS AND SAVINGS**

A number of investigators have provided information about the potential cost-benefits of savings resulting from FFT. Gordon, Arbuthnot, Gustafson, and McGreen (1988) conducted a cost-benefit analysis that indicated that the direct costs from out-of-home placements and cost of treatment was substantially higher for the probation only group (Gustafson, Gordon, & Arbuthnot, 1985). Stout and Holleran (2013) report that the cost-savings for outplacements avoided in New Jersey are approximately \$1.33 million annually, with FFT resulting in a savings of \$17.33 million to the state since 2005. This is consistent with the results of implementation of FFT in Renfrewshire, Scotland, where it is estimated that the implementation of FFT was associated with a savings of £1.5 million to Renfrew county in 2014 (Macleod, 2015).

Beyond the peer research reported above, investigators at the Justice Research Center (Winokur Early, Hand, Blankenship, & Chapman, 2012) have compared the cost-effectiveness of outcomes in Florida for youths assigned to community-based family interventions (including FFT, MST, BSFT) to those confined in residential facilities. This statewide implementation of the Florida Redirections community alternatives program had lower recidivism rates (30% vs. 37%) and lower recommitment rates (18% vs. 26%) than the residential programs. Since the community alternatives were less expensive (average = \$12,697 vs. \$35,332), the savings per juvenile was approximately \$22,635. By 2010, the state had saved approximately \$93 million by redirecting youths from residential to community-based interventions (Winokur Early et al., 2012).

The Urban Institute (Taxy, Liberman, Roman, & Downey, 2012) conducted a cost analysis for the implementation of FFT in Washington, D.C. The study determined that the FFT program reduced arrests by 22.6% for youths within the first year, and prevented at least one arrest for 76.7% of the youth. Each avoided arrest saved \$6,100 for federal and \$26,100 for local juvenile justice programs. In addition to public benefits, the program also reduced victimization costs of \$51,600 per episode. By combining the prevalence and cost of avoided offenses, the cost-benefit analysis estimated a net benefit of \$6,200 per participant in the program. A cost analysis was also performed by Washington State Institute for Public Policy (WSIPP) for the statewide implementation of FFT in the State of Washington (Barnoski, 2004; Lee, Aos, & Pennucci, 2015). This investigation, which was the precursor to the report of Sexton and Turner (2010), estimated that competent delivery of FFT could reduce court adjudicated felony recidivism rates when assessed at 6 (33%), 12 (42%), and 18 (37%) months after treatment. The WSIPP research provided estimated cost-savings of various EBTs including the Barnoski (2004) FFT program evaluation. Cost analyses for clients with competent FFT therapists indicated that the estimated financial benefits of the dissemination were \$8.94 for each dollar of the program cost (Aos et al., 2004; Lee et al., 2012).

Comparisons of benefit/cost statistics across models should be interpreted cautiously because various approaches may be serving different types of clients. However, a statewide evaluation of FFT and MST in Florida used propensity scoring methods to create matched samples (Baglivio et al., 2014) so that direct comparisons are more appropriate. These researchers noted that:

Finding no significant differences in the current study for the sample of all youth referred to MST or FFT, as well as no differences across race, leads to questions regarding the need for a more expensive service. If roughly twice as many youth may be served by the equally effective, cheaper

alternative, one would have trouble justifying not pursuing that path in the absence of empirical evidence to the contrary. Finding better outcomes for the less expensive alternative, such as lower arrests/violation rates during service for the “all youth referred” sample referred to FFT (5% lower rate), females referred to FFT (12% lower rate), and the low risk sample referred to FFT (11% lower rate), as well as lower recidivism for higher risk youth referred to FFT (9% lower recidivism rate), further highlights the importance of considering cost-effectiveness. (pp. 1051–1052)

Functional family therapy has also been shown to be a cost-effective approach for working with substance using youth and their families. French et al. (2008) found that the FFT conditions were significantly more cost-effective than alternative treatments in producing short-term reductions in substance use, although the long-term reductions were comparable. These adolescents entered treatment because of the potential harm associated with their use, and the FFT intervention removed the risk of harm more quickly in a cost-effective manner.

Taken together, FFT is a cost-effective approach for working with youth in juvenile justice, child welfare, and substance use settings. The cost-effectiveness of FFT is driven by the relatively low costs associated with its implementation, and a supervision and monitoring system to assure therapist fidelity in model implementation. The model achieves a favorable cost-benefit outcome, reducing the rates of observed youth re-arrest, conviction, and substance use, and the avoidance of incarcerations and outplacement into residential or foster care settings.

### **FUTURE RESEARCH: COMPLETED AND ONGOING STUDIES**

A number of controlled clinical trials have been completed and are at various stages in the publication process. Table S2 (see Supporting Information) summarizes the results of four efficacy and one effectiveness study. All four efficacy studies were completed by Waldron and colleagues at the Oregon Research Institute with substance abusing adolescents and their families. The results of these studies provide support for the efficacy of FFT in reducing alcohol use (Waldron, Brody, Turner, & Ozechowski, 2016; R01 AA12183), marijuana use (Waldron, Brody, Turner, & Ozechowski, 2016; Waldron, Brody, Turner, Ozechowski, & Hops, 2016; Waldron, Hops, et al., 2016; Waldron, Ozechowski, et al., 2016), and externalizing problems (Waldron, Brody, Turner, & Ozechowski, 2016; Waldron, Hops, et al., 2016; Waldron, Ozechowski, et al., 2016). The results of these studies also demonstrated the importance of sequencing interventions (Waldron, Brody, Turner, Ozechowski, & Hops, 2016; DA023568) and providing after-care phone or in-person sessions (Waldron, Ozechowski, et al., 2016; DA015762) to produce and sustain change.

Scott, Humayun, and Pearse (2015) examined the effectiveness of FFT for youth offenders in a community setting in the U.K. This study compared FFT plus Management as Usual to a Management as Usual condition. Both conditions produced significant improvements on a number of youth and family outcomes. However, no differences between treatment conditions were observed. Other implementation projects in the U.K. suggest that FFT is effective (and cost-effective) in preventing outplacements for youth in social welfare settings (Macleod, 2015; Pearse, 2015). Currently, a second trial is underway to evaluate the effectiveness of FFT in the U.K. Trials are also being conducted in Norway (recruitment phase of study underway), New Zealand (study recruitment and intervention completed), and Singapore (recruitment phase of study).

Several current NIH-funded studies are also being conducted in the U.S., including: (a) a collaborative effort involving Oregon Research Institute, FFT LLC, and the California Institute of Mental Health to examine the impact of two distinct supervision strategies on

therapists' competent adherence and clinical outcomes (Holly Waldron and Michael Robbins, Principal Investigators; DA029406); (b) a study examining if telemedicine delivery of FFT can produce positive effects for substance using youth in rural settings (Tim Ozechowski and Holly Waldron, Principal Investigators; R01DA032260); (c) a study examining if the addition of Contingency Management (Stanger, Budney, Kamon, & Thostensen, 2009) procedures are effective in enhancing the speed and durability of the effects of FFT and Group CBT (Michael Robbins, Principal Investigator; R01 DA032723); and two secondary data analyses examining the (d) effectiveness of FFT in a large sample of youth being redirected from incarceration (Charles Turner, Principal Investigator; DA036622), and (e) the effectiveness of an adapted version of FFT in a child welfare setting (Charles Turner, Principal Investigator; DA034742, in collaboration with the New York Foundling and FFT LLC).

### VARIATIONS IN FFT

Several variations to the FFT model have been developed and are at different stages of evaluation. The first, FFP (Kopp & Medina, 2009), is an intervention that was developed to train probation officers in a relational approach to help youth and families meet the terms of the youth's probation by enhancing motivation for change and linking the family to community resources. Community-based evaluations have documented the promise of FFPS in the US (Darnell & Schuler, 2015) and the Netherlands (Busschers, Boendermarker, & Dinkgreve, 2016). Functional family therapy-child welfare (FFT-CW) was developed to provide comprehensive behavioral and mental health services to youth and families in child welfare contexts. Youth (0–18) and families are triaged into two tracks of interventions that are modeled after FFPS or standard FFT, and interventions are planned to address the range of mental health, behavioral, and family problems that are common in child welfare settings. Early results showed the promise of FFT-CW in meeting the goals of treatment (Robbins & Rowlands, 2012) and a formal evaluation of the model is currently being conducted (Charles Turner, Principal Investigator; DA034742). FFT for gang-involved (FFT-G) or at risk youth was developed and implemented in a large urban setting in the US Northeast. A formal effectiveness trial is currently underway. Finally, a variation of FFT was developed by Tom Sexton (Sexton, 2010). This variation was shown to be effective in a preliminary comparison to a wait-list control group in Ireland (Hartnett, Carr, & Sexton, 2016). However, similar to the results of Sexton and Turner (2010), the positive effects were observed for the subset of therapists (five of nine) that demonstrated moderate adherence to the model. Further research is needed to establish the efficacy and effectiveness of this approach and the degree to which it can be replicated with fidelity across therapists and sites. To date, FFP is the only variation with positive results that have been replicated across sites. Controlled studies are needed to determine the efficacy and effectiveness of these variations.

### CONCLUSIONS: CLINICAL AND POLICY IMPLICATIONS

Accountability to youth and families should be a core value in clinical practice. For FFT, the core value of accountability has translated into asking difficult questions about what works, and then designing studies to address and resolve critical questions and challenges that youth and their families, and the therapists that work with them, face in the real world. These studies have helped to shape the articulation of a potent clinical model, which provides a coherent theory as well as specific mechanisms involved in the change process. Basic and process research has led to very specific articulations on how to achieve change, providing clinicians with direct, tangible, and effective strategies for helping

youth and families. The principles and clinical practices of the FFT model allow successful outcomes for families regardless of their specific referral behavior needs and yet also are tailored to the unique nature of the specific needs of families and communities. That is, the FFT model has evolved through research to provide the theory and structure needed to help therapists navigate the challenges inherent in working with a traditionally recalcitrant treatment population; but, doing so in a manner that provides therapists with a flexible, dynamic platform for matching interventions to each youth and family.

Over the past 15 years, the FFT model has been successfully transported to community settings. Of course, facilitating and sustaining effective practices in real world settings is not a simple matter. Numerous evaluations have shown that fidelity to the FFT model must be achieved to produce positive outcomes (Barnoski, 2004; Sexton & Turner, 2010; Sholevar et al., 2010; Taxy et al., 2012; van der Put et al., 2013); and, it takes considerable effort to build and support competent practice. Competent practice, however, should be the gold standard in community-based implementation. FFT LLC, the training organization that was established to disseminate the blueprint-approved version of FFT (Elliott, 1998), directly oversees the implementation of FFT in over 350 community agencies, nationally and internationally. In this role, FFT LLC provides intensive, training, consultation, and ongoing quality assurance and improvement to facilitate the competent implementation of FFT. Over the past 15 years, FFT LLC has provided consultation to more than 3,000 practitioners and therapists that have worked with approximately 400,000 families. As shown above, these community-based dissemination efforts have yielded powerful effects for youth, families, and communities. The robustness of implementation challenges the notion that communities, states, governments, and policy makers should steer clear of “boutique” or “expensive” models evidence-based practices. Dissemination experience and research findings support that the FFT model is feasible, sustainable, and effective in real world settings. In fact, in numerous studies, FFT has been shown to be both more effective and less costly than community-based alternatives.

The next generation of research on FFT will likely continue the current trajectory of inquiry about the robust effects of FFT with new communities and clinical populations. This research will include identifying more effective methods for supporting therapists and agencies to implement the model with integrity. Also, research studies will likely be designed to identify strategies for coordinating and integrating other effective treatment methods into FFT to further enhance outcomes for troubled youth and families. For example, the work on CM and individual and group CBT represent sophisticated trials designed to enhance the speed and durability with FFT achieves changes for youth and families. At the same time, research will continue to look inward to identify effective methods for supporting therapists at the most critical point in implementation; the moment where all theory, research, and experience is manifested in the session with youth and families.

## REFERENCES

- Alexander, J. F. (1971). *Evaluation summary: Family groups treatment program* [Report to Juvenile Court, District 1]. Salt Lake City, UT: State of Utah.
- Alexander, J. F. (1973). Defensive and supportive communications in normal and deviant families. *Journal of Consulting and Clinical Psychology, 40*(2), 223–231. doi:10.1037/h0034514
- Alexander, J. F., & Barton, C. (1976). Behavioral systems therapy with families. In D. H. Olson (Ed.), *Treating relationships* (pp. 167–187). Lake Mills, IA: Graphic.
- Alexander, J. F., Barton, C., Schiavo, R. S., & Parsons, B. V. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656–664. doi:10.1037/0022-006X.44.4.656

- 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*(3), 219–225. doi:10.1037/h0034537
- Alexander, J., & Parsons, B. V. (1982). *The anatomy of family therapy functional family therapy*. Monterey, CA: Brooks/Cole Publishing Company.
- Alexander, J. F., Waldron, H. B., Barton, C., & Mas, C. H. (1989). The minimizing of blaming attributions and behaviors in delinquent families. *Journal of Consulting and Clinical Psychology, 57*(1), 19–24. doi:10.1037/0022-006X.57.1.19
- Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavior problems*. Washington, DC: American Psychological Association.
- 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. doi:10.1177/0093854814543272
- Barnoski, R. (2004). *Outcome evaluation of Washington State's research-based programs for juvenile offenders*. Retrieved January 12, 2016, from WSIPP: [http://www.wsipp.wa.gov/ReportFile/852/Wsipp\\_Outcome-Evaluation-of-Washington-States-Research-Based-Programs-for-Juvenile-Offenders\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/852/Wsipp_Outcome-Evaluation-of-Washington-States-Research-Based-Programs-for-Juvenile-Offenders_Full-Report.pdf)
- Barton, C., Alexander, J. F., & Turner, C. W. (1988). Defensive communications in normal and delinquent families: The impact of context and family role. *Journal of Family Psychology, 1*(4), 390–405. doi:10.1037/h0080468
- Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. *American Journal of Family Therapy, 13*(3), 16–26. doi:10.1080/01926188508251260
- Busschers, I., Boendermarker, L., & Dinkgreve, M. (2016). Validation and operationalization of intensive family case management: A Delphi Study. *Child and Adolescent Social Work Journal, 33*(1), 69–78. doi:10.1007/s10560-015-0403-7
- Celinska, K., Furrer, S., & Cheng, C. (2013). An outcome-based evaluation of Functional Family Therapy for youth with behavioral problems. *Journal of Juvenile Justice, 2*(2), Retrieved September 1, 2015, from <http://www.journalofjuvjustice.org/foj0202/article02.htm>
- 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. doi:10.1016/j.chilyouth.2015.01.013
- Elliott, D. S. (Series Ed.). (1998). *Blueprints for violence prevention*. Boulder, CO: Blueprints, University of Colorado, Center for the Study and Prevention of Violence.
- Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008). Ethnic background, therapeutic alliance, and treatment retention in Functional Family Therapy with adolescents who abuse substances. *Journal of Family Psychology, 22*(1), 167–170. doi:10.1037/0893-3200.22.1.167
- Flicker, S. M., Waldron, H. B., Turner, C. W., Brody, J. L., & Hops, H. (2008). Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. *Journal of Family Psychology, 22*(3), 439–447. doi:10.1037/0893-3200.22.3.439
- Forgatch, M. S., Patterson, G. R., & DeGarmo, D. S. (2005). Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon model of parent management training. *Behavior Therapy, 36*(1), 3–13. doi:10.1016/S0005-7894(05)80049-8
- French, M. T., Zavala, S. K., McCollister, K. E., Waldron, H. B., Turner, C. W., & Ozechowski, T. J. (2008). Cost-effectiveness analysis of four interventions for adolescents with a substance use disorder. *Journal of Substance Abuse Treatment, 34*(3), 272–281. doi:10.1016/j.jsat.2007.04.008
- Friedman, A. S. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335–347. doi:10.1080/01926188908250780
- 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. doi:10.1080/01926188808250729
- Gustafson, K., Gordon, D. A., & Arbuthnot, J. (1985, Spring). *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., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. *Socialvetenskaplig Tidskrift, 3*, 231–243.
- Hansson, K., Johansson, P., Drott-Englén, G., & Benderix, Y. (2004). Functional Family Therapy in child psychiatric practice. *Nordisk Psykologi, 56*(4), 304–320.
- Hartnett, D., Carr, A., & Sexton, T. (2016). The effectiveness of Functional Family Therapy in reducing adolescent mental health risk and family adjustment difficulties in an Irish context. *Family Process, 55*(2), 287–304. doi:10.1111/famp.12195
- Henggeler, S. W., Schoenwald, S. K., Liao, J. G., Letourneau, E. J., & Edwards, D. L. (2002). Transporting efficacious treatments to field settings: The link between supervisory practices and therapist fidelity in MST

- programs. *Journal of Clinical Child and Adolescent Psychology*, 31(2), 155–167. doi:10.1207/153744202753604449
- Hogue, A., Dauber, S., Chinchilla, P., Fried, A., Henderson, C., Inclan, J. et al. (2008). Assessing fidelity in individual and family therapy for adolescent substance abuse. *Journal of Substance Abuse Treatment*, 35(2), 137–147. doi:10.1016/j.jsat.2007.09.002
- Hogue, A., Henderson, C. E., Dauber, S., Barajas, P. C., Fried, A., & Liddle, H. A. (2008). Treatment adherence, competence, and outcome in individual and family therapy for adolescent behavior problems. *Journal of Consulting and Clinical Psychology*, 76, 544–555. doi:10.1037/0022-006X.76.4.544
- Hops, H., Ozechowski, T. J., Waldron, H. B., Davis, B., Turner, C. W., Brody, J. L. et al. (2011). Adolescent health-risk sexual behaviors: Effects of a drug abuse intervention. *AIDS and Behavior*, 15(8), 1664–1676. doi:10.1007/s10461-011-0019-7
- Klein, N. C., Alexander, J. F., & Parsons, B. V. (1977). Impact of family systems interventions on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology*, 45, 469–474. doi:10.1037/0022-006X.45.3.469
- Kopp, D., & Medina, J. (2009). *Functional family probation services* (Unpublished treatment manual). Seattle, WA.
- Lantz, B. L. (1982). *Preventing adolescent placement through Functional Family Therapy and tracking* (Grant No. CDP 1070 UT 83-0128020 87-6000-545-W). Kearns, UT: Utah Department of Social Services.
- Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012*. Retrieved January 12, 2016, from Olympia: [http://www.wsipp.wa.gov/ReportFile/1102/Wsipp\\_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf)
- Lee, S., Aos, S., & Pennucci, A. (2015). *What works and what does not? Benefit-cost findings from WSIPP*. Retrieved January 14, 2016, from Olympia: [http://www.wsipp.wa.gov/ReportFile/1602/Wsipp\\_What-Works-and-What-Does-Not-Benefit-Cost-Findings-from-WSIPP\\_Report.pdf](http://www.wsipp.wa.gov/ReportFile/1602/Wsipp_What-Works-and-What-Does-Not-Benefit-Cost-Findings-from-WSIPP_Report.pdf)
- Macleod, J. (April 2015). *Improving outcomes: Measuring value and evaluating success of evidence based programmes*. Presentation at the Evidence Based Programmes Conference (Hosted by Renfrewshire Council, Big Lottery Fund, and Action for Children). Renfrewshire, UK.
- Mas, C. H., Alexander, J. F., & Barton, C. (1985). Modes of expression in family therapy: A process study of roles and gender. *Journal of Marital and Family Therapy*, 11(4), 411–415. doi:10.1111/j.1752-0606.1985.tb00034.x
- Mihalic, S. F., & Irwin, K. (2003). Blueprints for violence prevention: From research to real-world settings-factors influencing the successful replication of model programs. *Youth Violence and Juvenile Justice*, 1(4), 307–329. doi:10.1177/1541204003255841
- Morris, S. B., Alexander, J. F., & Turner, C. W. (1991). Do reattributions of delinquent behavior reduce blame? *Journal of Family Psychology*, 5(2), 192–203. doi:10.1037/0893-3200.5.2.192
- Newberry, A. M., Alexander, J. F., & Turner, C. W. (1991). Gender as a process variable in family therapy. *Journal of Family Psychology*, 5(2), 158–175. doi:10.1037/0893-3200.5.2.158
- Ozechowski, T. J. (2014). Empirical Bayes MCMC estimation for modeling treatment processes, mechanisms of change, and clinical outcomes in small samples. *Journal of Consulting and Clinical Psychology*, 82(5), 854–867. doi:10.1037/a0035889
- Parsons, B. V., & Alexander, J. F. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology*, 41(2), 195–201. doi:10.1037/h0035181
- Pearse, J. (April 2015). *Functional Family Therapy for youth on the edge of care*. Presentation at the Evidence Based Programmes Conference (Hosted by Renfrewshire Council, Big Lottery Fund, and Action for Children). Renfrewshire, UK.
- Regas, S., & Sprenkle, D. (1982, October). *Functional Family Therapy with hyperactive adolescents*. Paper presented at the meeting of the American Association for Marital and Family Therapy, Dallas, TX.
- Robbins, M. S., Alexander, J. F., Newell, R. M., & Turner, C. W. (1996). The immediate effect of reframing on client attitude in family therapy. *Journal of Family Psychology*, 10(1), 28–34. doi:10.1037/0893-3200.10.1.28
- Robbins, M. S., Alexander, J. F., & Turner, C. W. (2000). Disrupting defensive interactions in family therapy with delinquent adolescents. *Journal of Family Psychology*, 14(4), 688–701. doi:10.1037/0893-3200.14.4.688
- Robbins, M.S., & Rowlands, S. (2012, April). *Using data to improve implementation outcomes and sustainability*. Paper presented at the Annual Blueprints for Violence Prevention Conference, San Antonio, TX.
- Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects. *Journal of Family Psychology*, 17(4), 534–544. doi:10.1037/0893-3200.17.4.534
- Rogers, E. M. (2003). *Diffusion of innovations* (5<sup>th</sup> ed.). New York: Free Press.
- Scott, S., Humayun, S., & Pearse, J. (2015) *Will it work in the U.K.? A randomized trial of Functional Family Therapy for young offenders in England*. Presentation at The Association for Child and Adolescent Mental Health national conference in Regent's Park, London, UK.

- Sexton, T. (2010). *Functional Family Therapy in clinical practice: An evidence-based treatment model for working with troubled adolescents*. Abingdon, UK: Routledge.
- Sexton, T., & Turner, C. W. (2010). The effectiveness of Functional Family Therapy for youth with behavioral problems in a community practice setting. *Journal of Family Psychology, 24*(3), 339–348. doi:10.1037/a0019406
- Sholevar, E., Baron, D. A., Aussetts, M. A., & Spiga, R. (2010). Treatment adherence in family therapy with youth as a predictor of time to arrest. *American Journal of Family Therapy, 38*(1), 1–15. doi:10.1080/01926180902754695
- Slesnick, N., & Prestopnik, J. L. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy, 35*(3), 255–277. doi:10.1111/j.1752-0606.2009.00121.x
- Stanger, C., Budney, A. J., Kamon, J. L., & Thostensen, J. (2009). A randomized trial of contingency management for adolescent marijuana abuse and dependence. *Drug and Alcohol Dependence, 105*(3), 240–247. doi:10.1016/j.drugalcdep.2009.07.009
- Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122*, 170–191. doi:10.1037/0033-2909.122.2.170
- Stout, B. D., & Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. *Journal of Child and Family Studies, 22*(3), 311–321. doi:10.1007/s10826-012-9580-6
- Szapocznik, J., & Kurtines, W. M. (1993). Family psychology and cultural diversity: Opportunities for theory, research, and application. *American Psychologist, 48*(4), 400–407. doi:10.1037/0003-066X.48.4.400
- Taxy, S., Liberman, A., Roman, J. K., & Downey, P. M. (2012). *The costs and benefits of Functional Family Therapy for Washington, D.C.* Retrieved January 13, 2016, from The Urban Institute: <http://www.urban.org/research/publication/costs-and-benefits-functional-family-therapy-washington-dc>
- van der Put, C. E., Asscher, J. J., Stams, G. J., van der Laan, P. H., Breuk, R., Jongman, E. et al. (2013). Recidivism after treatment in a forensic youth-psychiatric setting: The effect of treatment characteristics. *International Journal of Offender Therapy and Comparative Criminology, 57*(9), 1120–1139. doi:10.1177/0306624x12452389
- Waldron, H. B., Brody, J. L., Turner, C. W., & Ozechowski, T.J. (2016). *Functional Family Therapy and cognitive behavioral treatments for adolescent alcohol misuse: A randomized clinical trial*. Unpublished manuscript.
- Waldron, H. B., Brody, J. L., Turner, C. W., Ozechowski, T.J., & Hops, H. (2016). *Adolescent substance abuse: Progressive treatment*. Unpublished data.
- Waldron, H.B., Hops, H., Brody, J.L., Turner, C.W., Davis, B., & Barrera, M. (2016). *Family-based and individual cognitive behavioral treatments for Hispanic and Anglo drug-abusing youth*. Unpublished manuscript.
- Waldron, H.B., Ozechowski, T.J., Brody, J.L., Turner, C.W., Hops, H., & Scherer, D. (2016). *Intensive in-home family systems intervention, clinical-based group therapy, and telephone-based counseling: A comparison of three transitional continuing care interventions following Functional Family Therapy for adolescent substance abuse*. Unpublished manuscript.
- Waldron, H.B., Robbins, M.S., & Alexander, J.F. (2012, September). *Functional family therapy: A summary of treatment outcome research from 1971 through 2011*. Retrieved August 15, 2015, from Oregon Research Institute Website: [http://www.ori.org/scientists/holly\\_waldron](http://www.ori.org/scientists/holly_waldron)
- 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*(5), 802–813. doi:10.1037/0022-006X.69.5.802
- White, S. F., Frick, P. J., Lawing, K., & Bauer, D. (2013). Callous-unemotional traits and response to Functional Family Therapy in adolescent offenders. *Behavior Sciences & the Law, 31*(2), 271–285. doi:10.1002/bsl.2041
- Winokur Early, K., Hand, G., Blankenship, J., & Chapman, S. (2012). *Redirection continues to save money and reduce recidivism*. Retrieved March 24, 2014, from [http://www.evidencebasedassociates.com/featured\\_projects/florida.html](http://www.evidencebasedassociates.com/featured_projects/florida.html)

## SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

**Table S1.** Summary of research outcomes by study type: efficacy, effectiveness, dissemination/implementation, basic, and process.

**Table S2.** Summary of completed (but unpublished) trials.