Table 1. Summary of FFT research: Basic, and Process, Efficacy, Effectiveness, Meta-Analysis, and Dissemination/Implementation

Citation	Bias*	Population / Referral	Demographics	Design	Outcomes
Basic Research					
Alexander (1973)	Dev	Delinquent	n = 20; 55% male; Mostly White	Non-clinical; Observational	Change Mechanisms -Delinquent families engaged in more *defensive communications* -non-Delinquent families engaged in more supportive communications -Delinquent families *reciprocated defensive behaviors* and did not reciprocate supportive behaviors -non-Delinquent families *reciprocated supportive behaviors* and did not reciprocate defensive behaviors
Alexander et al. (1989); Study 1	Dev	Delinquent	n = 32; 50% male; Primarily White	Non-clinical; Observational; Cooperative or Competitive set	Change Mechanisms -Parents of delinquent youth respond with more *defensive communications* than families of non-delinquent youth in competitive set -Parents of delinquent youth engage in significantly *less defensive communications* in cooperative vs. competitive set
Alexander et al. (1989); Study 2	Dev	Delinquent	n = 49; Primarily White	Non-clinical; Manipulation of attribution set	Change Mechanisms -Parents made as many positive dispositional attributions in the satisfied set as negative attributions in the dissatisfied set -Parents used more internal than external attributions for both the child's successful behaviors and problem behaviors
Alexander et al. (1989); Study 3	Dev	Delinquent	n = 61; Primarily White	Observational; Compared impact of relabeling vs. 3 interventions	Change Mechanisms -Neither positive information nor relabeling were able to reduce blaming attributions
Barton, Alexander, & Turner (1988)	Dev	Delinquent	n = 32; 56% males Primarily White Age: 14-17	Observational; Non-clinical Cooperative or Competitive set	Change Mechanisms -Delinquent families expressed significantly lower rates of negative communication in a cooperative set than in a competitive set -Delinquent families expressed significantly lower rates of adaptive communication than non-delinquent families in the cooperative set
Mas, Alexander, & Turner (1991)	Dev	Substance use or delinquent; Mental Health	n = 49; 61% male; Primarily White Age: 13-18	Observational; Interactions in two priming conditions	Change Mechanisms -Low-conflict family members made *fewer blaming attributions* about other family members dissatisfying vs. satisfying behaviors -High-conflict family members made *equivalent amounts of blaming attributions* for both satisfying and unsatisfying behaviors -High-conflict family members behaved *more defensively* than low-conflict family members

Morris, Alexander & Turner. (1991)	Dev	Non-clinical; Undergraduate students	n = 120; Primarily White	Anecdotal; Observational; Randomized	Change Mechanisms -Experimental *reattributions* (similar to relabel/reframe) significantly reduced the intensity of blaming attributions
Process Research					
Alexander, Barton, Schiavo, & Parsons (1976)	Dev	Delinquent	Youth/family n = 21; 48% male; Majority White Therapists: n = 21; 67% male	Clinical; Experimental; Observational	Change Mechanisms -Therapist *relational skills as opposed to structuring skills* were associated with good clinical outcomes -Family member *supportive to defensive behaviors at the end of treatment* (not earlier in treatment) were associated with clinical outcomes
Cunningham, Foster, Kawahara, Robbins, Bryan, Burleson, Day, Yu, & Smith (2018)	Dev	Delinquent; Community-based sample; Therapist and supervisor reviews of cases	Therapists (n=40); 16 African American; 5 Latin/Hispanic: 18 White non-Hispanic; 1 other; 77% female; M=36.5 years old Supervisors (n=20) 9 African American; 10 White non-Hispanic; 1 other; 80% female; M=39.1 years old	Clinical; Qualitative methods	Change Mechanisms -Identified five major themes for mid-treatment challenges: engaging families in treatment; difficulties implementing strategies; family relational and communication problems; complications external to therapy; and youth problem behavior. Analyses examined caregiver, therapist, and youth variables as predictors of these common mid-treatment problems and whether treatment outcomes varied depending on the type of problem, therapy model, and race/ethnic match of therapist and family. -MST and FFT therapists and supervisors identified many similar problems. There were, however, model-specific differences consistent with differing features of the models (e.g., FFT participants identified more family relational problems and fewer follow-through problems than their MST counterparts).
Cunningham, Foster, Kawahara, Robbins, & Bryan (2020)	Dev	Delinquent; Substance Use Community-based sample; Therapist and supervisor reviews of cases	Therapists (n=29) 37% Black; 9.4% Latino; 46.9% White non-Hispanic; 6.3 Other; 79% female [reported about 32 families] Youth age (M=15.5) Caregivers: 50% Black; 18.8%	Clinical; Qualitative methods	Change Mechanisms -Therapists reported that mid-treatment problems were often embedded in additional secondary difficulties and that they employed multiple relationship techniques and process-focused strategies to try to resolve these problems. -For the most part, therapists described difficulties and strategies for successful and unsuccessful families in similar ways, although they cited more generic relationship-building and advice-giving strategies and less focus on specific intervention strategies with unsuccessful families.

			Latino; 31.3% White non-Hispanic		
Flicker, Waldron, Turner, Brody, & Hops (2008a)	Dev	Substance Use	n = 86; 64% male; 50% Hispanic; 50% White; Age: *M* = 15.7 (13-19)	Random assignment: a. FFT b. integrated FFT+CBT Assessment Period -4 months post-randomization	Clinical Outcomes -Significant pre-post *reductions in substance use* for all youth in FFT and FFT+CBT. Change Mechanisms -Hispanic youth with Hispanic therapists showed *greater decreases in substance* use compared to Hispanic youth with Anglo therapists. Ethnic match was not related to treatment outcomes for Anglo youth
Flicker, Turner, Waldron, Brody, & Ozechowski (2008b)	Dev	Substance Use	see Flicker 2008a	Clinical interaction; Observational	Change Mechanisms -Hispanic families who dropped out of treatment had *greater unbalanced alliances* than Hispanic families that completed treatment -No differences were observed between dropouts and completers among White families
Gan, Zhou, Hoo, Cheng, & Choo (2018)	Ind	Delinquent, Singapore	n=31 (demographics not reported)	Single Group -Comparison of treatment delivery to US-based and New Zealand-based samples (engagement, completion, number of sessions)	Clinical Outcomes -87% of youth/families engaged into treatment -6.3% dropout rate -Average of 10.6 sessions -All results are comparable to US and New Zealand samples; and are consistent with FFT LLC recommended implementation parameters
Jacob, Robbins, & Turner (2022)	Dev	Delinquent; Florida	n=3 Hispanic therapists; n=33 Hispanic youth and families	Clinical; Qualitative methods	Change Mechanisms Grounded theory analysis elicited nine codes related to therapist-reported behaviors: Absolute language, therapist sharing of personal experiences, cultural sensitivity, directive coaching, emotion regulation and processing, communication, relational improvement, perspective sharing and relational reframing, and use of vivid language.
Mas, Alexander, & Barton (1985)	Dev	Delinquent	n = 49; 61% male; 100% White; Age: 13-18	Clinical interaction; Observational	Change Mechanisms -Adolescents *spoke less with female therapists* than male therapists
McPherson, Kerr, Casey, & Marshall (2017)	Ind	Community-based sample;	Family Participants	Qualitative Interviews	Clinical Findings

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

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

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

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

				-19 months post-randomization	-FFT and IBFT were *more cost-effective* than IT or GT at post-treatment -GT was more cost-effective than the other treatment conditions at follow-up
Effectiveness Research					
Barnoski (2004) Outcome Evaluation WSIPP (Follow-up to Barnoski, 2002; Sexton & Turner, 2010)	Ind	Delinquent; Community-based sample	n =700 Age *M* = 15.35 (13-17)	Random assignment a. FFT b. Probation services as usual Assessment Period -18 months post-randomization	Clinical Outcomes -No overall differences between conditions in *adjudicated felony recidivism rates* Change Mechanisms -*Adjudicated recidivism felony recidivism rates* were lower for competent FFT therapists than usual probation services, and non-competent FFT therapists
Gan, Zhou, Abdul Wahib, Ruby, & Hoo (2021)	Ind	Delinquent; Community-based sample; Youth probation; Singapore	n=120; Age M=16.2 (13-18); 89.2% Male	Random Assignment a. FFT + Management as Usual b. Management as Usual Assessment Period -Pre-post -Follow-up	Clinical Outcomes -Improvements in adolescent *mental well-being* over time in the FFT group; these improvements were marginally significant compared to TAU. -For youth at or above the clinical range at the baseline assessment, families in FFT showed significantly more improvement (clinical recovery) in *family functioning* than TAU. -Youth in FFT were significantly more likely to *complete probation* than youth in TAU, Treatment Process -84% treatment completion rate in FFT -High fidelity observed for FFT therapists
Humayun, Herlitz, Chesnokov, Doolan, Landau, & Scott (2017)	Ind	Community-based sample; Youth offenders, antisocial youth; England	n=111 Age *M* = 15.0 (10-17)	Random Assignment a. FFT b. Treatment as Usual Assessment Period -18 months post-randomization	Clinical Outcomes -For both treatment conditions, large reductions were observed for all measures of offending and antisocial behavior, but no significant changes in parenting behavior or parent-child relationship. -Between intervention and control groups, there were no differences at 6 or 18 months on self-reported delinquency, police records of offending, symptoms or diagnoses of Conduct Disorder or Oppositional Defiant Disorder, parental monitoring and supervision, directly-observed child negative behavior, or parental positive or negative behavior. -In contrast to expectations, FFT+MAU showed lower levels of directly-observed child positive behavior at 18 months compared to MAU
Lantz (1982)	Ind	Delinquent	n = 46	Random assignment:	Clinical Outcomes -FFT had *lower rates of recidivism* than alternative treatment

				a. FFT b. alternative treatment <u>Assessment Points</u> -<u>Post-treatment</u>	-*Lower rates of outplacements* were observed in FFT than alternative tx
Lewis, Piercy, Sprenkle, & Trepper (1990)	Ind	Substance Use	n = 84; 81% male; Age *M*=16 (12-22)	<u>Random assignment</u> a. Purdue Brief Family Therapy (based on FFT) b. Family Drug Education <u>Assessment Period</u> -Post-treatment	<u>Clinical Outcomes</u> -*Reductions in substance use* only for family therapy condition involving an adaptation of FFT but not the Family Drug Education condition
Regas & Sprenkle (1982)	Ind	ADHD (referrals to Child Welfare)	n = 55	-<u>Random assignment</u> a. FFT b. group therapy c. no tx control <u>Assessment Period</u> -Post-treatment	<u>Clinical Outcomes</u> -FFT and group therapy produced *significant improvements in ADHD* behaviors at home and at school <u>Change Mechanisms</u> -Only FFT also led to significantly *more positive perceptions of the family*
Robbins, Waldron, Turner, Brody, Hops, & Ozechowski (2018)	Dev	Community-based; Delinquent, mental health	n=164; 59% male; 62% Hispanic; 19% African American; 12% Non-Hispanic White	<u>Random Assignment (Sites)</u> -Compared FFT provided using "supervision as usual" to supervision guided by audio-recordings (BOOST) community agencies that provide FFT services <u>Assessment Period</u>	<u>Clinical Outcomes</u> -Improvements in *externalizing behaviors* and *felony offenses* were observed in both supervision conditions -BOOST was significantly more effective than Supervision as Usual in *reducing externalizing behaviors* for youth who scored in the clinical range on externalizing at baseline (no differences were observed for youth below threshold) -Statistically significant treatment differences were also shown for improvements in family functioning with youth who scored above the clinical threshold in externalizing improving more in BOOST than Supervision as Usual. -Exploratory analyses demonstrated significant *improvements in youth internalizing behaviors* based on parent and youth reports (small and moderate effect sizes, respectively); no significant differences were observed between supervision conditions

				-12 months post-treatment	
Sexton & Turner (2010)	Ind	Delinquent; Community-based sample	n =917; 79% (724) male; 78% White; 10% African American; 5% Asian American; 3% Native American; Age *M* = 15.35 (13-17)	<u>Random assignment</u> a. FFT b. probation services as usual <u>Assessment Period</u> -12 months post-randomization	<u>Clinical Outcomes</u> -Overall, no differences were found between FFT and services as usual in adjudicated recidivism <u>Change Mechanisms</u> -When therapists were adherent to the model, FFT showed significantly *greater reductions in felonies, and violent crimes*, with a marginally significant *reduction in misdemeanors*, compared to services as usual
Thornberry, Kearley, Gottfredson, Slothower, Devlin, & Fader (2018); Gottfredson, Kearley, Thornberry, Slothower, Devlin, & Fader (2018)	Ind	Delinquent, gang-involved, or at risk for gang-involvement ; Community-based sample	N=129; 100% male; 80% African American; 19% Hispanic (based on caregiver report)	<u>Random assignment</u> a. FFT b. Treatment as usual <u>Assessment Period</u> -18 months post-randomization	<u>Clinical Outcomes</u> -*Overall*, FFT was significantly more effective than TAU at the 18-month follow-up assessment on the percent of youth with drug charges, the percent of youth adjudicated, and the percent with property changes -FFT was effective in engaging and retaining both low- and high-risk youth in treatment -No significant between-group differences on outcomes were observed for youth at *low risk for gang membership* -At the 6-month assessment, FFT was significantly more effective than TAU for youth *at high risk for gang membership* in the levels of general delinquency, drug and alcohol use, time spent in residential placement, prevalence of felony charges, crimes against person charges, and property crime charges. -During the follow-up period (7 to 18 months post-randomization), FFT was significantly more effective than TAU for *youth at high risk for gang membership* in the prevalence and frequency of arrests, the number of felony charges, and the number of crimes against person charges -Over the entire follow-up period (baseline to 18 months), FFT was significantly more effective than TAU for *youth at high risk for gang membership* in the prevalence of arrest; number of arrests; felony charges, crimes against person charges, and property crime charges; and the rate of being adjudicated delinquent <u>Cost Analyses</u> -Youth who receive FFT are less likely to receive alternative, more costly, public services (such as residential

					placement), which results in an estimated reduction in the costs of services of $2,000 per youth served during the time they are receiving treatment
Meta-Analyses					
Stanton & Shadish (1997)	Ind	Substance Use	n=1,571 (adults; adolescents)	Meta-Analysis	Clinical Outcomes -Family therapy shown to be more effective than (a) individual counseling or therapy, (b) peer group therapy, and (c) family psychoeducation. -Family therapy is as effective for adults as for adolescents and appears to be a cost-effective adjunct to methadone maintenance. -Family therapy frequently had higher treatment retention rates than did nonfamily therapy modalities; as such, when retention was controlled, the results were even stronger for family therapy.
Waldron & Turner (2008)	Dev	Substance Use	n=2,307 (17 studies); 75% males; 45% White, 25% Hispanic, 25% African American; 5% other	Meta-Analysis	Clinical Outcomes -Three treatment approaches, multidimensional family therapy, functional family therapy, and group CBT emerged as well-established models for substance abuse treatment. -Several other models are probably efficacious -None of the treatment approaches appeared to be clearly superior to any others in terms of treatment effectiveness for adolescent substance abuse
Baldwin, Christian, Berkeljon, Shadish, & Bean (2012)	Ind	Delinquent; Substance Use	Adolescents from 24 studies	Meta-Analysis	Clinical Outcomes -The results suggested that as a group the four family therapies had statistically significant, but modest effect sizes compared to treatment-as-usual and alternative therapies -The effect size for family therapy compared to control was larger but was not statistically significant due to low power. -There was insufficient evidence to determine whether the various family models differed in their effectiveness relative to each other.
Von Sydow, Retzlaff, Beher, Haun, & Schweitzer (2013)	Ind	Behavioral Disorders	Adolescents from 47 studies	Meta-Analysis	Clinical Outcomes -42 of 47 studies showed systemic therapy to be efficacious for the treatment of attention deficit hyperactivity disorders, conduct disorders, and substance use disorders. -Results were stable across follow-up periods of up to 14 years. -There is a sound evidence base for the efficacy of systemic therapy for children and adolescents (and their families) diagnosed with externalizing disorder
Hartnett, Carr, Hamilton, & O'Reilly (2016)	Ind	Behavioral Disorders;	Adolescents from 18 studies (all included FFT)	Meta-Analysis	Clinical Outcomes -Effect sizes were as follows: random assignment FFT versus control ($k = 3$, $d = 0.48$, $p < .01$); random assignment FFT versus TAU ($k = 3$, $d =$

		Substance Use			.20, ns); random assignment FFT versus alternative treatment (k = 5, d = .35, p < .05); nonrandom assignment FFT versus control (k = 2, d = .90, ns); nonrandom assignment FFT versus TAU (k = 2, d = .08, ns); and nonrandom assignment FFT versus alternative treatment (k = 3, d = .75, p < .001). -These results provide support for the effectiveness of FFT compared with untreated controls and well-defined alternative treatments, such as cognitive behavior therapy, other models of family therapy, and individual and group therapy for adolescents.
Montgomery & Weisman (2018); Robbins & Turner (2018)	Ind; Dev	Delinquent	Adolescents from 31 studies (all included FFT)	Overview of Reviews (Rebuttal)	Clinical Outcomes -Main effects on core outcomes (recidivism and substance use) were modest -Secondary outcomes were modest and generally positive -Quality of reviews is low Critique of Review -Robbins & Turner provide a critique of this review -Overall, the quality of the review is poor and the conclusions drawn do not match their results
Dissemination/Implementation Research					
Baglivio, Jackowski, Greenwald, & Wolff (2014)	Ind	Delinquent; Florida	n = 2203; 72 % male; 53% White; 47% non-White; Age: *M*=15.57 (10 to 19)	-Matched (Propensity) Assignment a. FFT b. MST Assessment Period -12 months post-discharge	Clinical Outcomes -Female youth referred to MST had *higher offense rates* during service than females referred to FFT -Low-risk youth referred to MST have a *higher rate of new arrests and/or violations of probation while receiving the therapy* than FFT-referred low-risk youth -The *recidivism rate differences* pre-matching for moderate-high to high-risk to re-offend youth remained significant (p < .05), but not at the Bonferroni-corrected level (p < .025), with those who received MST having a higher recidivism rate than those receiving FFT -Post matching, a new significant difference emerged with the "all youth referred" sample (the full sample) FFT youth having significantly *lower number of offenses* during service (at the non-corrected p < .05 level). Change Mechanisms -FFT has a significantly *higher completion rate* than MST -FFT had a significantly *lower length of service* than MST
Barton, Alexander, Waldron, Turner,	Dev	Delinquent; Utah	n = 27; Primarily White	Non-random assignment a. FFT	Clinical Outcomes -FFT had *lower recidivism rates* than the population base rate

& Warburton (1985); Study 1				b. district juvenile justice base rates <u>Assessment Period</u> -13 months post-treatment	<u>Change Mechanisms</u> -Significant *reductions in family defensiveness* in FFT
Barton et al. (1985) Study 2	Dev	Child Welfare; Utah	n = 325; Primarily White	<u>Non-random assignment</u>: a. FFT b. community-based social workers <u>Assessment Period</u> -Post-treatment	<u>Clinical Outcomes</u> -*Reduction in foster care placement referrals* FFT (11%) versus non-FFT (49%) <u>Change Mechanisms</u> -*Reduction in units of service per family* to less than half (14.7-6.2)
Barton et al. (1985) Study 3	Dev	Delinquent; Utah	n = 74; Primarily White	<u>Non-random assignment</u> a. FFT b. Alternative treatment <u>Assessment Period</u> -15 months post-treatment	<u>Clinical Outcomes</u> -*Lower recidivism rate* observed in FFT compared to alternative tx -Those in the FFT group who did re-offend did so at a lower rate/frequency than those in the regular services group
Celinska (2015)	Ind	Delinquent Mandated vs. non-Mandated; New Jersey	n=120; Gender and Race/ Ethnicity reported separately for mandated, non-mandated; 70% vs. 52% males 44% vs. 68% White; 41% vs 14% Black: 30% vs. 24% Latino	<u>Quasi-Experimental</u> (within FFT comparison) a. Mandated vs. non-Mandated to treatment <u>Assessment Period</u> -Post-treatment assessment	<u>Clinical Outcomes</u> -Youth improved significantly in life domain functioning, child strengths, acculturation, caregivers' strengths, caregivers' needs, child behavioral emotional needs, and child risk behaviors -No differences were observed between youth who were mandated to treatment vs. those who were not mandated

Celinska & Cheng (2017)	Ind	Delinquent; Behavioral/ Emotional; New Jersey	n=116; 62% males; 35% Black; 28% White; 25% Latino	Quasi-Experimental (within FFT comparison) a. Differences in treatment process and outcomes for boys vs. girls Assessment Period -Post-treatment assessment -Official records	Clinical Outcomes -Self-reports from pre-to-post-treatment showed: a) significant improvements for male and female adolescents on the Life Domain Scale and Child Behavior Emotional Needs Scale, the Child Strengths Scale, and Child Risk Behavior Scale b) Male adolescents improved more on the Child Risk Behavior Scale, c) Female adolescents improved more on the Child Strengths Scale. d) There was a statistically significant improvement on the Caregiver Strengths Scale for the caregivers of males -Examination of official records showed a) Significant reductions in convictions, but an increase in institutionalization b) No significant differences between both genders on changes before and after FFT in terms of number of delinquency cases, convictions, and institutionalizations; however, trend was for males to be at increased risk for institutionalization compared to females Referral Issues and Process Outcomes -No statistically significant differences between male and female adolescents based on race, ethnicity, duration in the program -Boys more likely to be mandated to treatment -Boys more likely to use drugs/alcohol
Celinska, Furrer, & Cheng (2013)	Ind	Delinquent / Child Welfare; New Jersey	n = 72; 69% males; 36% African American; 36% Hispanic; 19% White; 9% Other; Age: *M* =15.3 (11-17)	Matched Assignment a. FFT b. Matched control Assessment Period -Post-treatment assessment	Clinical Outcomes -Only FFT youth showed *improved functioning in life domains*, such as *living arrangements, school behavior/achievement/attendance, legal concerns, and vocational concerns* -Only FFT youth showed significant *reduction in emotional and behavioral needs as well as risk behavior* Change Mechanisms -*Older youth* responded better than younger youth -Hispanic youth responded better on l*ife domains and child risk behaviors* -White youth responded better on *child strengths* -African American youth responded better on *child emotional and behavioral needs*
Celinska, Sung, Kim, & Valdimarsdottir (2018)	Ind	Delinquent; New Jersey	n=155	Matched Assignment (check) a. FFT	Clinical Outcomes -FFT had significantly lower odds of recidivism as measured by reconvictions for drug offenses, property offenses, and technical violations

				b. Comparison groups <u>Assessment Period</u> -Post-treatment assessment	-Also, youths in FFT self-reported more improvement, the differences between the groups were not statistically significant
Darnell & Schuler (2015)	Ind	Delinquent; Washington	*N*= 8713; (n=1279 FFT/FFP; 7434 SP) 78% male; 29% African American; 61% Hispanic; 8% White; Age *M* = 17 (11-18 yrs)	<u>Quasi-experimental Propensity Matched</u>; a. Standard Probation (SP) b. FFT plus SP c. Functional Family Probation Services (FFP) d. FFT plus FFP <u>Assessment Period</u> -36 months post-discharge	<u>Clinical Outcomes</u> -Youth receiving FFT (both FFT+SP and FFT+FFP) compared to SP alone had significantly *lower likelihood for outplacements in first two months following treatment*…but this advantage disappeared in later months. -Youth receiving FFP alone (as compared to SP alone) had *lower likelihood for outplacements in first two months (but not significant)* -Ultimately, at the end of the 36-month outcome observation period, there were *no significant differences in outplacements between any of the three intervention groups* -12 month survival analysis illustrated that youth in the FFT group remained *less likely to have an outplacement* than comparison youth
Gordon, Arbuthnot, Gustofson, & McGreen (1988); Gustofson, Gordon, & Arbuthnot (1985); Gordon, Graves, & Arbuthnot, 1995; Gordon (1995) - Study 1	Ind	Delinquent Rural; Low SES; Ohio	n = 54; 70% male; 100% White; Age: *M* 15.4	<u>Matched assignment</u> a. FFT b. probation services as usual <u>Assessment Period</u> -30-60 month post-treatment assessment of adult convictions	<u>Clinical Outcomes</u> -FFT group had *lower recidivism rates* compared to regular services group at 30- and 60-month follow-up <u>Cost analyses</u> -Cost-benefit analysis on these groups indicated that FFT had significantly *lower direct costs* than treatment as usual
Gordon & Arbuthnot (1990); Gordon, (1995) -Study 2	Ind	Delinquent; Ohio	n = 49 Age 17-18	<u>Non-random assignment</u> a. FFT b. statistical control (empirically derived risk of recidivating)	<u>Clinical Outcomes</u> -FFT had *lower new convictions after treatment and institutional commitments* than statistical control group

				Assessment Period -18 months post-baseline treatment	
Gordon (1995) - Study 3	Ind	Delinquent; Re-entry; Ohio	n = 52; Age 16-17	Matched assignment: a. FFT, n=27 b. probation services as usual Assessment Period -16 months post-baseline	Clinical Outcomes -FFT showed a significantly *lower recidivism rate*, compared to the services-as-usual group.
Hansson, Johansson, Drott-Englén, & Benderix (2004)	Ind	Community-based sample; Mental Health; Child Welfare; Lund, Sweden	n = 62; 90% male; Primarily White; Age: *M* =15 (13-18)	Matched Assignment a. FFT b. social work services as usual Assessment Period -18 months post-baseline	Clinical Outcomes -FFT had lower recidivism rates than services as usual -FFT group associated with *greater reductions in youth and parent reports of externalizing and internalizing symptoms* Change Mechanisms -*Improved family functioning, and reduced maternal depression, somatization, and anxiety* in FFT group
Heywood & Fergusson (2016)	Ind	Community-based sample; Child Welfare; New Zealand	n=59; 13.7 (age); 70% male; 45% Maori; 33% New Zealand European; 10% Cook Island Maori, 7% other European; 3% Tongan; 2% Niuean, 2% Fijian	Single Group -Evaluated improvements within FFT over time Assessment Period -18 months post-baseline	Clinical Outcomes -Parents reported significant improvement in Conduct Disorder, Oppositional Defiant Disorder, and delinquent behaviors -Youth reported significant improvements in delinquent behaviors -No significant differences were observed between Maori and non-Maori reports of youth problem behaviors -Parent satisfaction with FFT was “high” for non-Maori parents, and “very high” for Maori parents
Hukkelberg, Ogden, & Thogersen (2022)	Ind	Community-based sample; Child Welfare; Norway	n=453; 55% male; M=14.3	Single Group -Evaluated improvements within FFT over time from youth and parent perspectives Assessment Period	Clinical Outcomes -Improvements observed on a number of variables over time, with 4 of 8 variables demonstrating large effect sizes -Improvements were large from pre- to post-treatment, with some relapse noted at the 6- and 12-months -Boys showed higher levels of change than girls -Large improvements observed in Family/Parenting, Personality/Behavior, Education/Employment, and Leisure/Recreation

				-Pre-, post-, and 6- and 12-months	
Kretschmar, Tossone, Butcher, & Marsh (2018)	Ind	Community-based sample; Delinquent; Ohio	N=530; 60% female; 48% White; 35% Black	Single Group Design -Compared three groups based on completion of service (never began, began but did not complete, completed treatment)	Clinical Outcomes -Youth who successfully completed treatment had lower odds of offending as young adults and fewer young adult offenses than youth who completed unsuccessfully or who did not participate
Lange, Humayan, & Jefford (2022)	Ind	Community-based sample; Child welfare; Behavior problems; Telesessions during pandemic; England	Therapists (n=23) 78% female Youth/families (n=209) Youth were 46% female and M=14.0.	Mixed Methods -Qualitative evaluation -Single group evaluation of outcomes for youth in FFT	Study 1 (Qualitative Interviews with Therapists) -Therapists felt less in control of sessions and clinical work -Therapists reported increased challenges engaging families into sessions and maintaining their involvement over time and maintaining balanced alliances with family members -Therapists noted the need for increasing the number of questions they were asking family members due to lack of other cues and needing to be more structured and directive -Therapists reported need for being more prepared for and creative during sessions -Therapists noted that they needed to be were more risk-aware and risk-averse Study 2 (Implementation parameters with Families) -No differences in alliances between families that received mainly in-person sessions vs. mixed vs. mainly remote work -Less between-session contact for remote workgroup -The Mixed Group reported: 1) More sessions during the Motivation Phase, 2) a longer duration during the Motivation Phase, 3) More sessions overall and a longer length of service, 4) less dropout, and 5) better therapist-reported outcomes.
Marshall, Hamilton, & Cairns (2016)	Ind	Community-based sample, Child Welfare; Mental	n=164; Families that completed treatment and pre-post-treatment assessments (No demographics reported)	Single Group Design -Compared changes in FFT to population-based sample of high-risk youth	Clinical Outcomes -Parents reported significant improvements in overall stress, emotional distress, behavioral difficulties, hyperactivity/attention difficulties, peer problems, life impact, and prosocial behavior -Parents reported significant improvements in overall stress, emotional distress, behavioral difficulties, hyperactivity/attention difficulties, and life impact, and prosocial behavior

		Health, Scotland		Assessment Period -Post-treatment assessment	-Parents reported improvements in their own psychosocial distress -Improvements were shown to be greater than what would be expected if no treatment had been received and were comparable to the impact of other interventions
Robbins & Midouhas (2021)	Dev	Community-based sample; All FFT LLC sites	n=16,548; 56% male; 41% White; 28% Black; 15% Hispanic/Latin; 5% Bi-racial; 3% Native/First Nations/Indigenous; 2% Asian	Single Group Design -Descriptive comparison of implementation parameters and outcomes for youth served by FFT LLC supported sites in 2019 and 2020	Relevant outcomes -During 2020, FFT LLC supported therapists who served over 11,000 families and conducted over 35,000 tele-sessions with families. -Overall, results showed similar completion rates (79% vs. 75%), therapist fidelity (3.77 vs. 3.94), number of sessions (13.5 vs. 13.6), and therapist-reported outcomes in 2019 and 2020 (respectively), suggesting that delivering the FFT model can be implemented with fidelity using teletherapy formats. Training Considerations -Aspects of the webinar format have been beneficial, such as using multi-media during training, sharing multiple screens, scheduling training, and decreased travel-related costs. -Nonetheless, the feedback has been that the experiential, relationship-building aspects of in-person training are more challenging to replicate in a virtual webinar space. -Likewise, role plays and practicing skills do not have the same intensity and learning potential in a webinar format.
Scavenius, Granski, Lindberg, Vardanian & Chacko (2019)	Ind	Community-based sample; Child Welfare, Denmark	n = 428; 51% (females); Age: *M*=14.5 (SD=2.5); Referrals for school problems (61%), behavior problems (53%), family conflict (49%)	Single Group Design Results for FFT were compared to normative data on SDQ for Danish youth placed out of the home (youth report) and a population sample of the 20% highest scores (parent report) Assessment Period -Post-treatment	Clinical Outcomes -FFT showed a significant reduction in youth reports on both internalizing and externalizing for females, and on externalizing for males. -FFT showed a significant reduction in parent reports on both externalizing and internalizing for both females and males -FFT showed a significant reduction in parent and youth reports of family conflict Moderation Analyses -Parent reports showed that girls benefited more than boys in peer problems and family functioning, and boys benefited more in liking school -Age-by-gender interactions showed that for mental health and family outcomes, girls benefitted less than boys during early adolescence, but more than boys in late adolescence.

Stout & Holleran (2013)	Ind	Child Welfare; New Jersey	Sample includes all outplacements in New Jersey from 2005 to 2011	Time Series Analysis -Comparison of FFT, MST, and other services -Dependent variable includes any outplacement for youth between 2005 and 2011	Clinical Outcomes -MST and FFT were estimated to yield an *approximate reduction of 31 outplacements a month or an annual reduction of 372 outplacements* Cost Savings Estimates -Projected a*nnual savings of $1.33 million for FFT and $2.16 million for MST* -Since 2005, estimated t*otal savings of $17.33 for FFT and $18.16 for MST*
Thogersen, Bjornebekk, Scavenius, & Elmose (2021)	Ind	Child Welfare; Callous-Un-emotional (CU); Denmark	n = 407; 49.1% female; 14.4 years	Non-randomized study. All youth received FFT. Assessments Period: Pre-post treatment	Clinical Outcomes -Although CU traits were related to increased problem severity at baseline, they predicted neither treatment dropout nor post-treatment externalizing behavior and family functioning. -CU traits were related to diminished improvement ratings, in particular with respect to parental supervision. -Reductions in CU traits were observed across the time of treatment, and these were most profound among adolescents with elevated levels of CU traits at baseline.
Turner, Robbins, Winokur Early, Blankenship, & Weaver (2018)	Dev	Community-based sample; Delinquent; Florida	Youth n=5,884; 41% Black; 36% White non-Hispanic; 18% Hispanic Therapists 79% female; 50% White non-Hispanic; 28% Hispanic; 20% Black	Non-randomized; Single group secondary data analysis	Clinical Outcomes -Analyses of clients' pretreatment recidivism risk and therapist's caseload of risky clients demonstrated that both individual and treatment site case mix of client criminal risk levels were associated with higher adjudicated felony recidivism. -Clinical process indicators suggest that therapists with larger rather than smaller caseloads of high-risk clients provided treatment with greater fidelity. -Results suggest that experience in working with challenging clients is critical for achieving fidelity with these cases
Vardanian, Scavenius, Granski, & Chacko (2019)	Ind	Child Welfare; Denmark	n=576; 51.2% female; M=14.5 years of age	Non-randomized; All youth received FFT Assessment Period Pre- and post-treatment	Clinical Outcomes -Significant improvements were found in youth behavior, family functioning, and school-related outcomes (e.g., like of school and truancy) -Parents and youth reported improvements in youth disruptive behaviors -Parents reported improvements in youth pro-social behaviors -Parent reports showed that youth with callous-unemotional traits showed improvements on all scales

White, Frick, Lawing, & Bauer (2013)	Ind	Delinquent; Callous-Un-emotional (CU); Community Mental Health; Louisiana	n = 134; 71.6% (96) male; 59% African Am; 35.1% White; 4.5% Hispanic; Age: *M* =15.34 (11-17)	Non-randomized study; All youth received FFT; Assessment Period -12 month post-treatment	Change Mechanisms -CU traits associated *with poorer adjustment (behavioral, emotional, social) prior to treatment* -CU traits correlated with *poorer levels of adjustment post-treatment*, *less perceived change over treatment by youth and parents, and increased likelihood of violent offending during treatment* -CU traits NOT associated with significantly lower rates of participation -CU traits NOT associated with higher rates of treatment dropout --CU traits associated with *greater improvements in adjustment over course of FFT* -*Association between CU traits and risk for violent charges decreased* over time

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

**Demographic data on total sample, gender, race/ethnicity, and age included when reported.

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[a]This technical report represents the first evaluation in the program of research on FFT.
[b]This report represents the first evaluation of implementation outcomes for FFT LLC in community-based settings.
[c]This presentation represents the first cost-benefit evaluation of FFT.
[d]This project represents the first evidence for the benefits of FFT in preventing outplacement.
[e]The outcomes in this presentation have been reported in numerous publications on FFT. The results represent the first extension of FFT to hyperactivity.
[f]This study examined outcomes for the FFT-CW[SM] model. The reference is included in this bibliography, but the results are summarized in a separate research table.