

Functional Family Therapy

Review: February 2018

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

Functional Family Therapy (FFT) is for young people between 10 and 18 years involved in serious antisocial behaviour and/or substance misuse.

The young person is typically referred into FFT through the youth justice system at the time of a conviction. The young person and his or her parents then attend between eight to 30 weekly sessions (depending on need) to learn strategies for improving family functioning and addressing the young person's behaviour.

Evidence
rating: **3+ ***

Cost rating: **3**

EIF Programme Assessment

Functional Family Therapy has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence
rating: **3+ ***

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

What does the plus mean?

The plus rating indicates that this programme has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

What does the asterisk mean?

The asterisk indicates that this programme's evidence base includes mixed findings: that is, studies suggesting positive impact alongside studies that on balance indicate no effect or negative impact.

More detail on mixed findings for this programme

- **3+** reflects the strength of the international FFT evidence-base suggesting positive impact (including Waldron et al., 2001, Alexander & Parsons, 1973).
- **Mixed findings** reflects the fact that there are also robust studies with more equivocal findings. Particularly, we have reviewed two robust studies, one conducted in the USA (Darnell et al. 2015) and another conducted in the UK (Humayun et al. 2017), suggesting FFT had no impact relative to standard services.
- For more information on EIF's approach to mixed findings, see: [What happens when the evidence is mixed?](#)

Cost rating

A rating of **3** indicates that a programme has a **medium cost** to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of **£500–£999**.

Cost rating: **3**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Preventing crime, violence and antisocial behaviour

Reduced recidivism

Based on study 2

Preventing substance abuse

Reduced days using marijuana

Based on study 1

30.78-percentage point reduction in the number of days smoking marijuana (measured using the Timeline Followback Interview)

Improvement index: **+34**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 84% and worse outcomes than 16% of their peers, if they had received the intervention.

Immediately after the intervention

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Preadolescents
- Adolescents

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Children's centre or early-years setting

The programme may also be delivered in these settings:

- Home
 - Children's centre or early-years setting
 - Primary school
 - Community centre
 - Out-patient health setting
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How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated
-

Where has it been implemented?

Australia, Belgium, Canada, Chile, Denmark, New Zealand, Norway, Singapore, Sweden, United Kingdom, United States

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence includes evaluation conducted in the UK.

Spotlight sets

EIF does not currently include this programme within any Spotlight set.

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About the programme

What happens during delivery?

How is it delivered?

- Functional Family Therapy (FFT) is delivered in 8–16 sessions (with an average of 12–14 sessions for most cases). Challenging cases may receive 26–30 sessions.
- Each session is 45–60 minutes duration.
- These sessions are delivered over 3–6 months.
- FFT is delivered by 1 therapist (QCF-7/8), to families.

What happens during the intervention?

- FFT is applied in five distinct phases: Engagement, Motivation, Relational Assessment, Behaviour Change, and Generalisation. Each phase has associated specific goals, techniques, and important therapist relationship and structuring skills.
- In the first phase, the focus is on enhancing therapist credibility and expectations.
- In the second phase, the focus is on building motivation for change by reducing negativity and blame, creating hope and a relational focus, and developing balanced alliances with family members.
 - Relational assessment involves identifying the interactional and functional aspects of specific behaviors, attributions, and feelings of family members and extrafamilial significant others (e.g. close relatives, peers).
 - This assessment sets the stage for designing and implementing the behaviour change phase.
 - Motivation to participate in the change process is enhanced by effecting changes in the attitudes and feelings of family members about each other and problematic behaviors.
- The behaviour change phase involves training and applying maintenance technology (e.g. parent-child communication training, behavioural contracting). Skills training interventions such as problem-solving and other behavioural intervention strategies are included using a menu-driven process from the behaviour therapy literature (e.g. listening skills, anger management, parent-directed behavioral consequences, improved parental supervision).
- A unique feature of FFT is the specific focus on skills in the context of assessed relational functions of behaviour (e.g. separation, contact) within each dyad of the family system. The focus of change is on replacing maladaptive behaviours used to maintain relationship functions.
- Readiness for therapy is based on the family demonstrating the generalisation of new skills and behaviours to the home and environment outside the therapy session, the maintenance of treatment gains, and the ability to function independently from the therapist.

What are the implementation requirements?

Who can deliver it?

- The practitioner who delivers this programme is a therapist with QCF-7/8 level qualifications.

What are the training requirements?

- The therapist undergoes 24 hours of face-to-face training prior to the first meeting with the client. An additional 48 hours of face-to-face training is required during the course of the first year.
- Booster training of practitioners is recommended.

How are the practitioners supervised?

Practitioner supervision is provided through the following processes:

- FFT LLC trained consultants provide the clinical supervision to the FFT therapists on a team in phase 1 (year 1). During this time (phase 1), the on-site person who will become the clinical supervisor in phase 2 (year 2) goes through an off-site externship process (seeing clients behind a mirror with clinical oversight) and then they also attend off-site supervisor training.
- Once they have done all of this, they take over the clinical supervision of the FFT therapists at their agency. The FFT consultant then provides supervision only to the on-site clinical supervisor.
- This supervision of the supervisor continues throughout the time a site is providing FFT services.

What are the systems for maintaining fidelity?

Programme fidelity is maintained through the following processes:

- training manual
- other printed material
- face-to-face training
- fidelity monitoring.

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- FFT is based on the assumption that every family member's behaviour serves a function within the family system.
- Once family members understand the function of their behaviours, they are in a better position to improve and/or change them.
- FFT therapists help family members identify positive and negative functions of family behaviours (including the young person's antisocial behaviour) and develop strategies for changing them within the family system.
- In the short term, family members will experience less conflict and improved communication and the young person will be better able to manage his emotions and behaviour.
- In the longer term, the young person will be less likely to reoffend and misuse substances and be more likely to remain with his family and attend school.

Intended outcomes

Supporting children's mental health and wellbeing
Preventing crime, violence and antisocial behaviour
Preventing substance abuse

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About the evidence

Functional Family Therapy (FFT) has evidence from at least one rigorously conducted RCT (Waldron et al. 2001) along with evidence from an additional comparison group study (Alexander & Parsons, 1973). These studies identified statistically significant positive impact on a number of child outcomes.

This programme does not receive a rating of 4 as it has not yet replicated its results in another high-quality study (where at least one of the high-quality studies suggests long-term impact, and at least one of these studies uses assessment measures independent of study participants).

Study 1

Citation: Waldron et al. 2001

Design: RCT

Country: United States

Sample: 120 young people, between ages of 13 and 17 (mean age 15)

Timing: -

Child outcomes:

- Reduced days using marijuana
-

Other outcomes:

- None measured
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Study rating: 3

Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

Available at

http://www.cibhs.org/sites/main/files/file-attachments/waldron_2001_treatment_outcomes.pdf

Study design and sample

The first study is a rigorously conducted RCT.

This study involved urn randomisation to balance groups on gender, age, level of substance use, ethnicity, psychiatric severity, and family constitution. Youth were assigned to one of four groups: Individual CBT, Family Therapy, Combined CBT and Family Therapy, or Group intervention.

This study was conducted in the USA, with a sample of 120 youth. There were 96 boys and 24 girls in the sample, who were between the ages of 13-17 (mean 15). Most adolescents mandated to treatment by court order, by probation officers in lieu of court order, or by schools in lieu of suspension or other consequence.

Measures

The timeline follow-back interview was used to assess quantity and frequency of substance use (youth self-report).

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

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

Findings

This study identified statistically significant positive impact on a child outcomes. This includes reduced number of days using marijuana.

Study 2

Citation: Alexander & Parsons, 1973

Design: RCT

Country: United States

Sample: 99 young people aged 13-16

Timing: 6-18 month period following intervention

Child outcomes:

- Reduced recidivism
-

Other outcomes:

- None measured
-

Study rating: 2+

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

Available at <http://psycnet.apa.org/record/1973-31658-001>

Study design and sample

The second study is an RCT.

This study involved random assignment of 99 young people to an FFT group, to a no-treatment control group, and to alternative treatments (client-centred family groups, and psychodynamic family programmes).

This study was conducted in the USA with a sample of young people who were arrested or detained at a juvenile court for a behavioural offense. The young people ranged in age from 13 to 16; 38 were male and 48 were female.

Measures

Recidivism rates (i.e. re-referral for behavioural offenses) was measured using juvenile court records (administrative data).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes reducing recidivism.

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

Study 3

Citation: Darnell et al., 2015

Design: QED

Country: United States

Sample: 8,713 African American and Latino youth in the juvenile justice system, aged 11-18

Timing: Over 36-month period post-release

Child outcomes:

Other outcomes:

- None measured
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Study rating: NE

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.chidyouth.2015.01.013
Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4354807/>

Study design and sample

The third study is a rigorously conducted QED.

Propensity score weights were generated using a set of variables expected to be related to both group membership and recidivism outcomes, including: gender, race/ethnicity (African American, Latino, White, other), age at release from current placement, age at first arrest, age at first felony, age at first OHP, count of prior arrests, count of prior OHPs, two variables representing geographic divisions of the service area, counts of prior petitions of various types (i.e., battery, assault w/ deadly weapon, burglary, petty theft, robbery, and vandalism).

This study was conducted in the USA, with a sample of youth recently released from placement and receiving FFT and/or FFP between July 2007 and January 2012. The sample was divided into three groups.

Measures

Number of out of home placements was measured using data were extracted from administrative data systems for juvenile justice and child welfare departments (administrative data).

Findings

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

Study 4

Citation: Humayun et al. 2017

Design: RCT

Country: United Kingdom

Sample: 111 young people between the ages of 10-17

Timing: Post-intervention; 12-month follow-up

Child outcomes:

Other outcomes:

- None measured
-

Study rating: NE

Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. *Journal of child psychology and psychiatry*.

Available at <https://onlinelibrary.wiley.com/doi/full/10.1111/jcpp.12743>

Study design and sample

The fourth study is a rigorously conducted RCT.

This study involved constrained adaptive random assignment of children to a Functional Family Therapy (+MAU) group, and a Management as Usual group.

This study was conducted in the UK with a sample of 111 children. All youth had been sentenced for offending or were receiving agency intervention following contact with the police for anti-social behaviour. Young people were between 10–17 years of age (mean = 15). 70% of the sample was male, and 90% were British.

Measures

Self-report delinquency scale from Edinburgh Study of Youth Transitions and Crime was used to assess delinquency (self-report).

UK Police National Computer database records of offending was used to assess offending including community sentences, custodial sentences and police cautions for minor offenses (admin data).

Adolescent Parent Account of Child Symptoms was used to assess symptom counts and diagnoses of oppositional defiant disorder and conduct disorder (diagnostic interview).

Alabama Parenting Questionnaire, short version was used to assess parent-youth relationship (parent-report).

'Hot Topics' measure was used to assess parent-youth interactions (direct observation).

Findings

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

Other studies

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

Baglivio, M. T., Jackowski, K., Greenwald, M. A., & Wolff, K. T. (2014). Comparison of multisystemic therapy and functional family therapy effectiveness: A multiyear statewide propensity score matching analysis of juvenile offenders. *Criminal Justice and Behavior*, 41(9), 1033-1056. doi:10.1177/0093854814543272 - **This reference refers to a quasi-experimental design, conducted in the USA.**

Barnoski, R. (2002). Washington State's Implementation of Functional Family Therapy for Juvenile Offenders: Preliminary Findings, Olympia: WA: Washington State Institute for Public Policy - **This reference refers to a quasi-experimental design, conducted in the USA.**

Barnoski, R. (2004, January). Outcome evaluation of Washington State's research-based programs for juvenile offenders (Document No. 04-01-1201). Olympia: Washington State Institute for Public Policy - **This reference refers to a quasi-experimental design, conducted in the USA.**

Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. *The American Journal of Family Therapy*, 13, 16-26 - **This reference refers to a randomised control trial, conducted in the USA.**

Celinska, K., Furrer, S., & Cheng, C. C. (2013). An outcome-based evaluation of functional family therapy for youth with behavioral problems. *Journal of Juvenile Justice*, 2(2), 23 - **This reference refers to a quasi-experimental design, conducted in the USA.**

Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *The American Journal of Family Therapy*, 17(4), 335-347 - **This reference refers to a randomised control trial, conducted in Canada.**

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

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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 - **This reference refers to a quasi-experimental design, conducted in the USA.**

Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of Functional Family Therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior*, 22(1), 60-73 - **This reference refers to a quasi-experimental design, conducted in the USA.**

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 - **This reference refers to a cost-benefit analysis, conducted in Canada.**

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

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

Hansson, K., Johansson, P., Drott-Emnglen, G., & Benderix, Y. (2004). Funktionell familjeterapi i barnpsykiatrisk praxis: Om behandling av ungdomskriminalitet utanfor universitesforskningen. *Nordisk Psykologi*, 56(4), 304-320.

Hops, H., Ozechowski, T. J., Waldron, H. B., Davis, B., Turner, C. W., Brody, J. L., & Barrera, M. (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 - **This reference refers to a randomised control trial, conducted in the USA.**

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

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.

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

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.

Rohde, P., Waldron, H. B., Turner, C. W., Brody, J., & Jorgensen, J. (2014). Sequenced Versus Coordinated Treatment for Adolescents With Comorbid Depressive and Substance Use Disorders. *Journal of Consulting and Clinical Psychology*. doi:10.1037/a0035808 - **This reference refers to a randomised control trial, conducted in the USA.**

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 - **This reference refers to a quasi-experimental design, conducted in the USA.**

Slesnick, N. & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy*, 35 (3), 255-277 - **This reference refers to a quasi-experimental design, conducted in the USA.**

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(2), 170-191. <http://dx.doi.org/10.1037/0033-2909.122.2.170> - **This reference refers to a meta-analysis.**

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 - **This reference refers to a time series analysis, conducted in the USA.**

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 - **This reference refers to a pre-post study, conducted in the USA.**

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

[How to read the Guidebook](#)

[EIF evidence standards](#)

[About the EIF Guidebook](#)

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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