

FFT EVIDENCE STUDIES IMPLEMENTATION

FFT began when Dr. James Alexander conducted a series of outcome studies to examine the efficacy and effectiveness of family-based interventions for delinquent adolescents. These early studies shaped the evolution the Functional Family Therapy that was fully described in Alexander and Parsons (1982).

1. **Alexander (1971)**. This randomized study demonstrated the positive impact of family-based interventions on family functioning for youth with disruptive behavior problems (truancy, arrests, “ungovernable”).
2. **Alexander & Parsons (1973)**. This randomized study demonstrated the impact of FFT compared to alternative interventions on recidivism rates for delinquent youth. The positive effects of treatment were sustained over time. Moreover, Klein, Alexander, & Parsons (1977) showed that younger siblings of youth treated in this study were less likely to be arrested 2 ½ to 3 ½ years post-treatment.
3. **Parsons & Alexander (1973), Alexander & Barton (1976, 1980)**. This randomized study showed that youth assigned to FFT showed improvements in patterns of family interactions, while controls did not.
4. **Barton, Alexander, Waldron, Turner, & Warburton (1985). Study 1** demonstrated that FFT services provided by paraprofessionals was associated with an approximately 50% reduction in recidivism compared to juvenile justice base rates.

Study 2 demonstrated that youth at risk for outplacement that were treated by case workers in the child welfare system has significantly lower foster placement referrals (11%) than youth treated by case workers with no or limited training in FFT (49%). Also, there was a significant reduction in the units of service per family (14.7 to 6.2). These findings showed the promise of FFT in child welfare settings, not only with respect to clinical outcomes, but also with respect to costs.

Study 3 demonstrated that FFT as a re-entry model for serious habitual offenders. Specifically, FFT was significantly better than alternative services in reducing re-arrest.

With respect to cultural diversity, the efficacy and effectiveness research has included urban, suburban, and rural youth, including youth from the USA and Sweden. In addition, the samples in randomized controlled trials has included White Hispanic and non-Hispanic youth from diverse regions across the USA. Community-based replications have included large samples of White, Hispanic, African American youth and their families.

In terms of dissemination and training, the FFT model’s adaptability combined with FFT LLC’s training delivery system has demonstrated ongoing success in working with a wide range of different cultures. Currently, FFT LLC is the largest evidence based

training organization in the world. It's sites serves 25,000+ families per year in 39 US States and 7 foreign countries that represent a vast array of ethnic and cultural groups, currently including Maori, Moroccan, Surinamese, Puerto Rican, Haitian, Cuban, Mexican, Norwegian, Dutch, African-American, Asian, members of various Native American tribes in the Northwest and Southwest, etc.

In an independent evaluation of FFT LLC sites in California, **Cohen & Snowden (2008)** found "little contradiction between fidelity to the (FFT) model and how FFT can be implemented with the diverse families." They go on to say:

"There seems to be a close link between cultural competence and **proper** FFT treatment, mainly due to the emphasis during the **engagement phase** on matching to the family and the individuals within the family. Knowledge of the family's culture seems to be a pre-requisite for engagement, or at least that the clinician be honest with the family about their knowledge gaps and open to learning. This close link between a specific treatment intervention and the requirement of cultural knowledge is an exemplar, different from the more typical strategies in governmental agencies to provide training on cultural competence in the abstract, without its direct integration into an intervention model."

Numerous FFT LLC sites trained through FFT LLC specific training, supervisory, assessment and quality assurance protocols have been evaluated for its ability to have positive impact across cultures. For instance, in the Washington State evaluation of FFT LLC sites by the Washington Institute for Public Policy, competent FFT therapists were able to achieve significant felony recidivism reductions across European, non-European, African, and Asian ethnic groups (Barnoski, R., 2005)

Similarly, in a nationwide random sample taken from FFT LLC sites in 2008, which included 4,426 families, successful completion rates were nearly equivalent across ethnic groups: 68% for Caucasians, 72% for African Americans, and 70% for Hispanics. (Alexander et al., 2008). In FFT LLC sites in Norway, completion rates and pre-post changes in youth and families (e.g. percentages of youth retained in home, school attendance, drug use, and decrease of violence in families) mirror the positive outcomes we've come to expect from FFT trials (Thorgersen, 2012).

The effects of FFT have also been observed for youth **treated in multiple settings**, including juvenile justice, child welfare, school, and mental health/psychiatric. Also, the positive effects of FFT have been observed across a wide range of providers, from para-professionals to psychiatrists/psychologists. In general, the results do not show a difference in outcomes by academic training, which may be one of the reasons for the robust effects of FFT across multiple settings. Also, there is some evidence that therapist-family racial/ethnic matching may enhance the effects of FFT for Hispanic

youth. However, positive effects in multiple trials suggest that positive outcomes can be achieved without such matching.

FFT has been studied in replicated study protocols that contain clear outlines of the methodology for implementation, delivery, supervision, training and monitoring of model adherence and fidelity.

In each of the evaluations below, FFT LLC's implementation, training, supervision, assessment and quality assurance protocol was used *in its entirety* to produce the following outcomes from each of selected studies below. These evaluations constitute on-going testing of the FFT LLC training, assessment, supervisory and quality assurance standards and protocols. No FFT LLC deviate from these protocols, all of which are attached. Selected studies include:

1. **Aos, Phipps, Barnoski, & Lieb (2001); Barnoski (2002)**. The Washington State Institute for Public Policy conducted a formal evaluation of FFT for juvenile offenders who had been remanded for probation services. Approximately 600 rural and urban youth in 14 Washington counties were randomly assigned to receive either FFT or probation services as usual. The 40 participating FFT therapists all had at least 90 days of FFT experience under the supervision of the FFT LLC program. The study revealed that only half of the therapists adhered competently to the FFT model and that model adherence was linked to outcome such that significant reductions in recidivism were achieved only by therapists who implemented FFT with fidelity. When cases for adherent therapists were combined with those for non-adherent therapists, no differences were found between FFT and probation services as usual. These results were obtained even though the adherent therapists tended to be assigned more severe cases. **Barnoski (2002)** estimated that competent delivery of FFT could reduce recidivism rates for felonies and violent crime by as much as 35%. Cost analyses indicated that for competent FFT therapists, the estimated financial benefits of the dissemination were \$7.50 for each dollar of program cost (**Aos, Lieb, Mayfield, Miller, & Pennucci, 2004**).
2. **Jones, Bumbarger, et al (2008)**. Based on FFT LLC sites in Pennsylvania and using the Blair County FFT LLC program as the examples, the authors project a 14.56\$ for each dollar spent on FFT. The estimate Blair County's FFT LLC program has saved its citizens over \$3.5 million. Projected across 11 FFT LLC sites in PA and the 4,156 families served annually, it's projected FFT LLC sites save the Commonwealth of PA over \$136 million economic benefits from FFT LLC site outcomes.

3. **Rhoades, Campbell, Bumbarger (2010).** In their evaluation of 2010 outcomes for FFT LLC sites in the State of Pennsylvania, the authors found that of the 1,175 youth discharged from FFT across 2010 95% of the youth had no new criminal charges during treatment. 73% remained drug-free (as evidenced by negative drug screen[s] during their last three months in FFT). 60% improved on school attendance* and 60% improved on school performance*. Of the 1245 parents/caregivers discharged from FFT across 2010, 80% exhibited desired change and 71% showed improvement in their parenting skills.
4. **Philliippi, Below, Cuffie (2010).** In their Models for Change report, the authors that FFT LLC's Louisiana FFT programs have a 6% re-arrest rate and an 84% completion rate. They note that the historical recidivism rate for Louisiana juveniles has been approximately 50%.
5. **Sexton and Turner (2010).** Expanding Barnoski's (2002) sample (above) to 917 families, re-examined FFT effectiveness for juvenile offenders in Washington State. As in Barnoski's preliminary study, positive outcomes were found only for competently adherent therapists. It should be noted that both the Barnoski and Sexton and Turner studies represent an initial evaluation of the impact of the Alexander and Parsons (1982) version of FFT, as described in the Blueprints for Violence Prevention (Alexander et al., 1998; Alexander et al., 2000). As such, these studies are specific to the established model rather than adaptations that have included new techniques (such as Organizing Themes) to the FFT model.
6. **Brooks, Janer, Early, and Mason (2012).** For more than five years, FFT LLC has provided statewide training in FFT to Florida's Juvenile Redirections Project for youth in the juvenile justice system who are at immediate risk for outplacement. This evaluation, which was presented at the Blueprints for Violence Prevention's Annual Conference, demonstrates not only that FFT is effective with this population, but also how the systematic performance monitoring that FFT LLC uses (including standard Quality Assurance and Quality protocols) can enhance process and outcome indicators for youth and families. In this evaluation, FFT was associated with a 32% lower rate of adjudication and a 69% lower rate of juvenile and adult outplacement. (compared to matched controls and all residential services). The results also demonstrate how intensive QA/QI can improve service delivery as measured by key process indicators over time which parallels the reductions in recidivism and adjudication. For example, Figures 1-3 below shows the systematic improvement in time

from referral to open date (Engagement Phase goal), average sessions per month), and successful completion rates over time. This data provides support for the training and monitoring procedures that are used by the FFT LLC to ensure that community practitioners are delivering FFT in a way that matches (process and outcomes) the intervention that was delivered in the controlled trials.

Figure 1. Time from Referral to Open Date in FFT

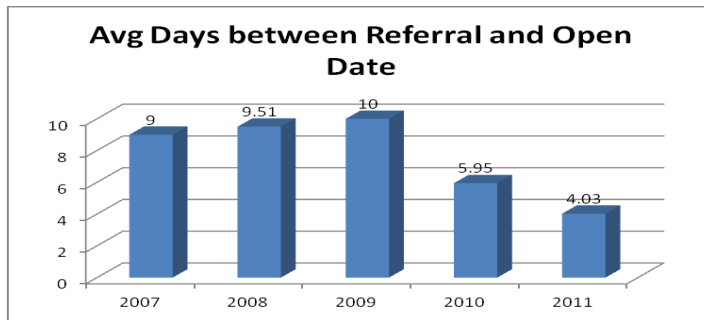


Figure 2. Average Number of Sessions per Month

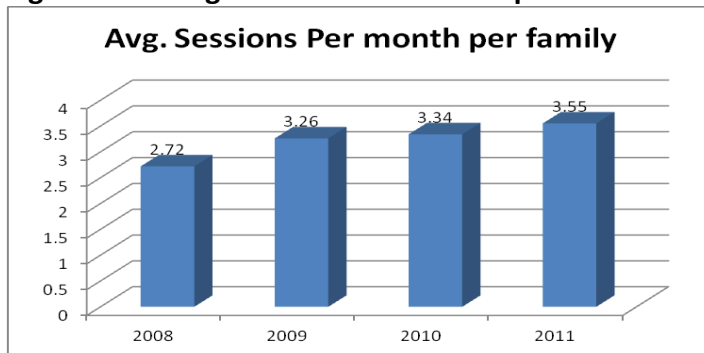
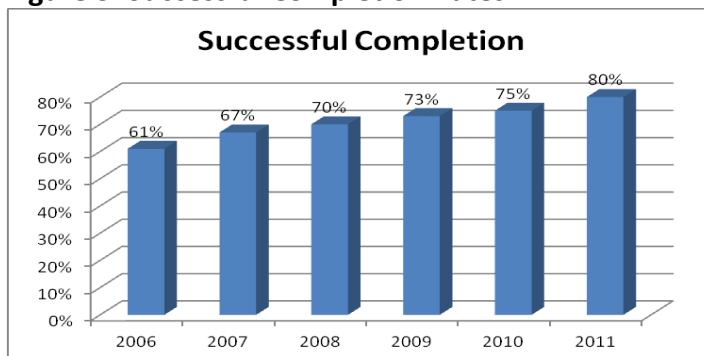


Figure 3. Successful Completion Rates



7. Price, Lindsey, et al, (2012). Evaluation of 634 youth in this FFT LLC site in Ohio found reduced recidivism of participants by over 60%. Two thirds of the youth who completed the program reported less frequent contacts with police; reported use of alcohol, marijuana and cocaine was cut by more than 50%;

trauma symptoms including anxiety, depression, anger, were all significantly decreased; and functioning in the home as reported by both the youth and parents was significantly improved.

8. Thorgerson (2012) The Norwegian Center for Child Behavioral Development over the last four years to provide FFT to an ethnically diverse population of child welfare involved youth. Since its inception and using the FFT LLC training, supervision and assessment protocol, completion rates have increased by 22% and 2011 saw a reduction in risk level from 13.0 (moderate range) to 5.8 (low range) as measured on the Youth Level of Service (YLS).

In the **FFT LLC training protocols a variety of core elements** (beyond the focus and methods of training) inform and are applied in all projects and in the outcome studies noted above. These include:

- 1) In all the studies above, **therapist training and quality assurance is provided, face-to-face, by 4 or more different FFT LLC staff over time**. Multiple trainer perspective during implementation provides, first, better understanding of and intervention in therapist or site challenges. Second, it offers more opportunities for different trainer styles to match with learning needs of therapists and supervisors. Third, multiple eyes on a project work against the tendency for trainers to drift from training and implementation standards in the face of sometimes fierce local implementation challenges.
- 2) **To create critical context, momentum and structure for supervisor preparation and development**, all outcome studies above included, as a pre-requisite for supervisor candidates, an off site externship of 6 days spread over three months with behind the screen observation of FFT work with families. This element (and the next below) acknowledges the key position supervisors have in a site's success and focuses implementation work early to enhance supervisor selection and development.
- 3) In all the outcomes above, **local supervisors are trained in teams of 4 or more supervisors**. Mutual responsibility and accountability amongst a team of supervisors enhances learning and provides a peer support for new supervisors.
- 4) In all of the outcomes studies above, FFT LLC **matches trainers and consultants with specific site needs**. Training responsiveness, and trainer credibility and effectiveness are key, particularly in early stages of implementation. For instance, multi-agency sites are matched with consultants who are experienced with these unique implementation challenges. Child welfare FFT LLC sites are matched with trainers who have actively worked in child welfare contexts with FFT. It requires FFT LLC to sustain and support a deep pool of diverse trainers to match to the specific needs of a training site
- 5) Because loss of a therapist can imperil team stability and progress, **replacement training series for therapists are available monthly** for sites who have need to immediately bring a new therapist into their team. Less time to train new

therapists has meant less disruption to the local FFT team.

- 6) In the outcome studies above, ***training is conducted on site and face-to-face***. While FFT LLC is experimenting and evaluating the effectiveness of webinar formats, there is no evidence that outcomes can be achieved by this approach.

The FFT research that exists is supported by replications in different settings and populations over time.

Independent replications of FFT effectiveness studies have been undertaken by a number of investigators. These replications were of the model described by Alexander and Parsons (1982).

Donald Gordon and his colleagues with juvenile offenders in Southeastern Ohio

In several studies, Gordon and colleagues established the effectiveness of FFT with rural, poor Appalachian youth and their families.

1. **Gordon, Arbuthnot, Gustafson, & McGreen (1988)**. The recidivism rate associated with FFT was 11%, compared to 67% for the probation only group. A cost benefit analysis indicated that the direct costs from out-of-home placements and cost of treatment for the two groups were higher for the probation only group (**Gustafson, Gordon & Arbuthnot, 1985**). In a 3-year follow-up study of the families in the original study, **Gordon, Graves, Arbuthnot (1995)** found that 41% of youths in the probation only condition continued offending, compared to less than 9% in the FFT condition.
2. **Gordon & Arbuthnot (1990)**. This study evaluated FFT combined with intensive probation supervision for serious multiple offenders released from state institutions. A 21-month follow-up revealed a 30% recidivism rate. A statistical comparison of youth matched on number of prior offenses and age at first offense would have had an expected recidivism rate of 60%-75%, providing further independent evidence for the effectiveness of FFT for delinquent youth.

Kjell Hansson and his colleagues in Sweden

Hansson and colleagues have systematically examined the efficacy and effectiveness of FFT with youth and families in Sweden. The positive effects of FFT were observed not only in controlled university-based research, but also in a community-based replication. In addition, these results showed that both youth and parents benefit from FFT (which further supports the robust impact of FFT for all family members, e.g., Klein et al.'s finding that siblings were less likely to be arrested).

3. **Hansson, Cederblad, & Hook (2000).** This randomized study examining the efficacy of FFT compared to treatment as usual indicated that FFT was significantly more effective than treatment as usual in reducing behavior problems both at one- and two-year follow-up according to official registers. FFT was also shown to have a positive influence on psychiatric health both on the young people and their mothers. The authors concluded that FFT seems to be an effective method for treating early juvenile delinquency by diminishing the relapse rate by 50%.
4. **Hansson and colleagues (2004).** This effectiveness study established the impact of FFT in a community-based setting. In this replication, FFT was delivered within a framework of cooperation between social welfare, child psychiatry, and a drug treatment unit. Compared to treatment as usual, the FFT condition showed improved family functioning and fewer psychiatric symptoms (both internalizing and externalizing) after treatment. Both parents and youth showed higher optimism and valued the treatment high. The pattern of results in this community-based replication was similar to the earlier university based research with the same method.

Research with Drug Using Youth (Friedman, Waldon, Slesnick)

5. **Friedman (1989).** In this randomized trial, FFT and parenting groups showed significant reductions in substance use of more than 50% at follow-up, with improvements in other areas of functioning as well. However, the rates of engagement in treatment differed dramatically, with 93% engagement in FFT versus 67% in the parenting condition. In a re-analysis of the entire "intent-to-treat" sample in which families who terminated treatment prematurely were included as failures, **Stanton and Shadish (1997)** found significantly greater substance use reductions for FFT than the comparison condition.

Holly Waldron and her colleagues in New Mexico and Oregon

Waldron has conducted several studies examining the efficacy of FFT with drug using youth. This program of research has included ethnically diverse samples from New Mexico and Oregon.

6. **Waldron, Slesnick, Brody, Turner, & Peterson (2001)** randomly assigned to one of four intervention conditions: FFT, individual CBT, FFT offered in combination with individual CBT (FFT+CBT), or a group skills-based intervention. Adolescents in the two FFT conditions

showed significant reductions in the percent days using marijuana from baseline to each of the follow-up assessments and were more efficacious and cost effective than the other two conditions at post-treatment (**French, Zavala, McCollister, Waldron, Turner, & Ozechowski, 2008**).

7. **Waldron and Turner (2008)**. The second trial, which is reported in this meta-analysis, extended the work of Waldron et al. (2001) by testing the efficacy of FFT, individual and group CBT, and an integrated intervention involving 8-9 FFT and 5-6 CBT sessions (FFT+CBT) for adolescent alcohol abuse and dependence. All four conditions were associated with significant reductions in the percent days of alcohol use from pre- to post-treatment. Significant reductions in marijuana use were also shown for all treatments except the integrated FFT+CBT intervention. The findings indicate that there are multiple pathways to change in adolescent substance use and provide further empirical support for FFT for this population.

A third trial, also reported in the Waldron and Turner meta-analysis, evaluated the two 14-session interventions examined in the previous study, individual CBT or integrated FFT+CBT Anglo and Hispanic youth and their families (**cf. Waldron & Turner, 2008; Hops et al., in press**). Both treatments showed significant reductions in marijuana use through the 18-month follow-up, with Hispanic youth responding significantly better to FFT+CBT than CBT. Anglo youth also improved equally well in both interventions throughout the follow-up period. These findings are consistent with the earlier trials and demonstrated that Hispanic substance-abusing adolescents and their families have as good or better outcomes with interventions involving FFT than Anglos. In a more fine-grained examination of ethnicity outcomes, **Flicker and her colleagues (2008)** showed that while both Hispanic and Anglo youth achieved significant drug use reductions, ethnically matched Hispanic adolescents demonstrated greater decreases in their substance use relative to Hispanic adolescents with Anglo therapists. Ethnic match was unrelated to treatment outcome for Anglo youth. Compared to Anglo therapists, Hispanic therapists may be more attuned to core cultural values in Hispanic families and may be more able to tailor the way they interact with Hispanic adolescents and parents in accordance with such values. Taken together the findings suggest that FFT is a particularly good fit for Hispanic youth and families, especially when delivered by a therapist similar in ethnic background.

8. **Slesnick & Prestopnik (2009).** This study compared a home-based ecological family therapy approach (EBFT) to office-based FFT and services as usual (SAU) for runaway youth with problem alcohol use. Both EBFT and FFT were associated with significant reductions in alcohol and other drug use. However, more families in the home-based EBFT engaged in treatment, relative to the office-based FFT, and completed significantly more sessions than those in FFT, respectively. Because both EBFT and FFT are multisystemic family-based treatments and there was a treatment condition by setting confound in the design of the study, it is unclear whether the better engagement and session completion for EBFT was due to something unique about the intervention or simply to the impact of meeting with families of runaway youth in their homes. Nevertheless, the marked impact of both EBFT and FFT on reducing alcohol and drug use, relative to SAU, provides additional evidence in support of FFT.

Taken together, the studies reported above have included examinations of treatment effects as well as sustained effects over time. Pre- to post-treatment change was examined in all of these studies and most included at least a one-year post-treatment follow-up. The Gordon et al. (1995) study included a 3-5 year follow-up into early adulthood. As such, the findings provide support for both the immediate and long-term effects of FFT on delinquency, substance use, and family functioning.

FFT uses outcome measures and objectives that are reliable and validated and supported by various studies.

In both the early research led by James Alexander as well the replications conducted by Gordon, Hansson, Waldron, Friedman, and Slesnick, the research designs included well established methods/measures for capturing change. In several of these peer-reviewed publications, objective criminal records were obtained from the juvenile justice system. In most of these studies, additional measures of youth behavior problems and family functioning were also collected. The studies include information about the reliability and validity of these measures. In addition, consistent assessment protocols were applied in all of the successful FFT LLC site evaluations noted above.

Every published article demonstrating the effectiveness of FFT after the earliest research studies (e.g., Alexander and Parsons, 1973; Parsons & Alexander, 1973) has included all of the elements of the five-phase Anatomy of Intervention Model (AIM) described in Alexander, Barton, Waldron, and Mas (1983). This includes the studies published by Friedman, Gordon, Hansson, and Waldron as well as the study published by Sexton and Turner (2010). **This five phase model includes a distinct 1) Engagement phase, 2) Motivation Phase, 3) Assessment Phase, 4) Behavior Change Phase and 5) Generalization Phase.**

To date, no evaluations have been published on any adapted version of the FFT Model.

FFT LLC uses the Outcome Questionnaire/Youth Outcome Questionnaire to capture pre- to post-change as a result of treatment. The Youth Outcome Questionnaire (YOQ) is routinely collected from families at the beginning and end of treatment throughout the 270 sites supported by the FFT LLC so that a very large comparison sample exists to evaluate the response to treatment of the FFT CW clients. This measure assesses the parent's and adolescent's self-perception as well as the parent's perception of the adolescent. The instrument has 64 items that assess six subscales reflecting **intrapersonal distress** (e.g., anxiety, depression, hopelessness; 18 items), **somatic complaints** (e.g., headaches, dizziness, stomachaches; 8 items); **interpersonal relations** (e.g., arguing, defiance, communication problems; 10 items); **social problems** (e.g., delinquent or aggressive behaviors; 8 items), **behavioral dysfunction** (e.g., organization, concentration, handling frustration, and ADHD-related symptoms; 11 items); and **critical items** (e.g., paranoid ideation, hallucinations, mania, and suicidal feelings; 9 items). This instrument has been shown to be sensitive to the types of changes that would be expected to occur during treatment (Burlingame et al., 2004) The measure was collected at baseline and again at 3 months after receiving FFTCW services. Norms for community and clinical samples (including outpatient, residential, and partial hospitalization) are provided by the test authors (Ridge et al., 2009; Wells et al., 1996; Wells et al., 2003).

Results of Functional Family Probation Services: Support for FFT-CW Low Risk

As noted, the interventionist activities in the FFT-CW Low Risk track (FFT-LR) were modeled after Functional Family Probation-Parole Services (FFPS) as developed and delivered by FFT LLC.

Washington State Department of Social and Health Services (2009). FFPS has been implemented statewide as the case management model for juvenile parole counselors since 2004. In their December 2009 Report to the Washington State Legislature, the Juvenile Rehabilitation Administration identifies the following FFPS outcomes.

- At 12 months post release from facilities, youth in the FFPS group had significantly fewer parole revocations as compared to traditional parole services. FFPS youth had 14.7% fewer parole revocations.
- At 12 months post parole, those youth with above average pre-crime severity index scores who received the FFPS intervention had significantly lower post-parole crime severity behavior indicating that the most difficult youth received more benefit from FFPS. Parents and youth who received FFPS report improvements in their overall family functioning, youth behavior, parental supervision, family communication, as well as reductions in family

conflict.

- At 18 months following release from an institution there is a 15.31% reduction in recidivism rates for those youth who received highly adherent FFPS as compared to a matched control group.
- The most difficult youth received more benefit from FFPS. Overall, those youth with above average pre-crime severity index scores who received the FFP intervention had significantly lower post-parole crime severity behaviors.
- Parents and youth who received FFPS report improvements in their overall family functioning, youth behavior, parental supervision, family communication, as well as reductions in family conflict.

Lucenko, B., Mancuso, D. & Felver, M. (2011). Employment and school attendance for youth receiving FFPS was evaluated as compared to parole services where youth has not received FFPS. The study found:

- * Youth who are provided FFPS are 48% **less** likely to be arrested than youth without FFPS.
- * Youth who are provides FFPS youth have 43% employment rates, 33% higher than youth without FFPS.

Rist, M. (2011). Support for the effectiveness of FFPS in Yolo County, California has been demonstrated with respect to out of home care (see Figures 1 and 2 below). Moreover, FFPS was associated with a 38% reduction in caseload sizes as well as a 16% reduction in juvenile justice expenditures.

Figure 1. Out of Home Care (FFPS Implemented in Dec 2008)

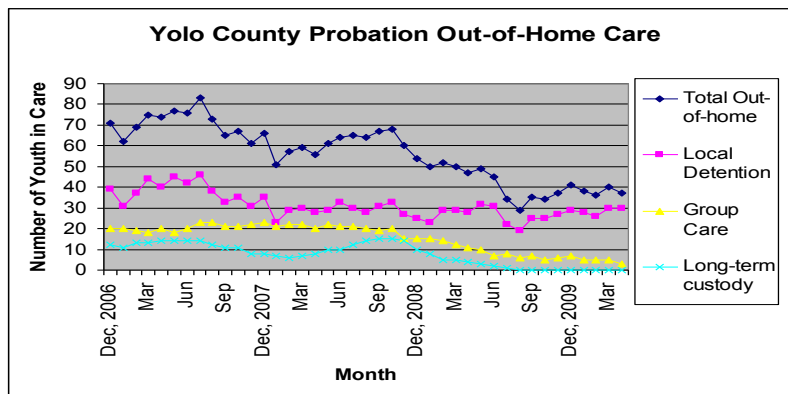
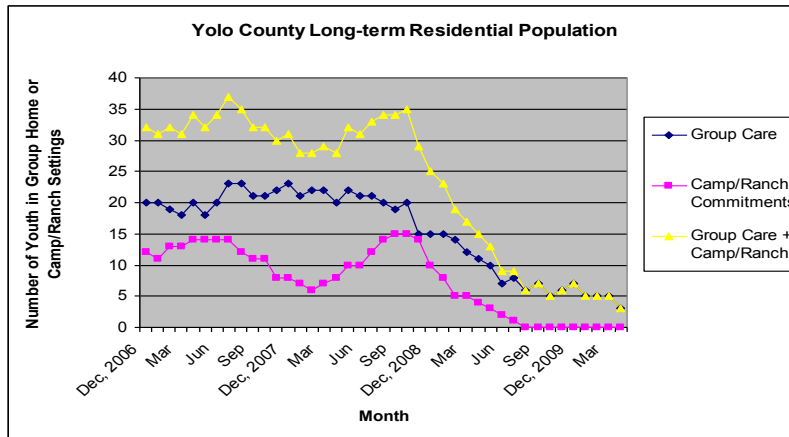


Figure 2. Number of Youth in Group Home or Camps/Ranches (FFPS implemented in December of 2008).



Preliminary Results of FFT-CW in NYC

The full FFT-CW model, which includes High and Low Risk tracks that are modeled after FFT and FFPS, represents a novel adaptation of the FFT model, has been implemented in New York City for the past three years. To date, FFT-CW has been implemented by New York Foundling with interventionists (FFT-LR) and therapists (FFT-HR) from all five boroughs.

With respect to the efficacy of FFT-CW, a pilot study evaluated the model with 55 cases that were referred to the FFTCW program from October 2010 through September 2011 (Robbins & Rowlands, 2012). Approximately ½ of the families were classified as high risk and received FFTHR and ½ were low risk and received FFTLR. In this evaluation, the intake worker’s ratings of “risk status” were cross validated against the Youth Outcome Questionnaire (YOQ) which is a standard measure used by FFT LLC. The YOQ is completed by primary caregivers prior to and at the end of treatment. The results indicated that the caregivers in High Risk families rated their most difficult child ($M = 57.5, SD = 35.1$) as significantly more impaired [$F(1,33) = 5.26, p < .05, d = 0.72$] than the low risk families ($M = 28.6, SD = 38.54$). When compared to clinical thresholds for the YOQ, 24% of the low risk youth and 63% of high risk youth received ratings that were above clinical thresholds. YOQ ratings for the high risk families are comparable to the scores obtained from previous samples of adolescents who were referred from juvenile justice or mental health service agencies. The low risk families are below clinical thresholds but significantly higher than community normative samples. These results provide support for the triage process in which youth and families are being assigned to

FFT-LR or FFT-HR.

In addition to supporting the triage process, the results of the pilot study also reviewed several important findings with respect to outcomes: 79% of low risk and 71% of high risk families met all treatment goals while an additional 17% of low risk and 21% of high risk families met at least one treatment goal. As such, 96% of low risk and 92% of high risk cases showed measurable improvement. Also, as expected, the months to close for high risk cases ($M = 7.2, S.D. = 5.45$) was somewhat longer ($d = 0.28$) than low risk cases ($M = 5.87, S.D. = 3.76$). These cases were considered successful by ACS and the case was closed. A target for ACS is to successfully close cases within 6 months, and ACS statistics indicated that 55% of high risk cases and 59% of low risk FFTCW cases were closed within 6 months, a rate that was higher than comparable agencies in Manhattan (24%) or citywide (22%). Only 2% of families required an out of home placement. Collectively, these findings demonstrate the promise of FFTCW with the low and high risk families.

FFT-CW uses outcome measures and objectives that are reliable and validated and supported by various studies.

To evaluate the effectiveness of FFT-CW, numerous measures have been routinely collected as part of the implementation of the model at New York Foundling. These measures are described below.

Program and Interventionists Measures. Interventionists/therapists completed the Organizational Readiness for Change (ORC) measure (Lehman et al., 2002) after they have completed their first level of training. The 129 items TCU Organizational Readiness for Change (Broom et al., 2007; Greener et al., 2007; Joe et al., 2007; Lehman et al., 2002; Saldana et al., 2007; Simpson & Flynn, 2007) [, 92-97] instrument assesses perceptions of the organizational climate. In prior research, the ORC measure was administered to 4,000 providers in 650 organizations, and normative data are available for comparative purposes. The ORC contains 18 scales, grouped in four categories: Agency needs, institutional resources, staff attributes, and organizational climate. Adequate psychometrics have been demonstrated with good factor structure, internal consistency and good predictive validities on indicators of client and program functioning.

Drug Abuse Screening Forms. Another key dependent variable will be baseline and follow-up rates of self-reported substance use. The NYF intake worker first uses a screening instrument to assess for possible substance abuse in the primary caregiver (CAGE; Brown & Rounds, 1995) and in any adolescent in the family (CRAFFT; Knight et al., 2002) for whom use or abuse is suspected. In addition, the intake workers assesses the frequency of drug use using modified questions from the National Youth Survey (Elliott et al., 1989) to create a self-report measure of frequency of substance use in the

past 30 days, lifetime use, number of friends using, and age of first use. This instrument is completed at baseline for individuals over the age of 10 and repeated at a 3 month (end or treatment) follow-up assessment.

Alabama Parenting Questionnaire. NYF is using an abbreviated version (15 items) of the Alabama parenting questionnaire (original 45 items) (Essau et al., 2006; Scott et al., 2011; Shelton et al., 1996). This instrument assesses five dimensions of parenting that are relevant to the etiology and treatment of child externalizing behavior (1) positive parent involvement; (2) supervision and monitoring; (3) positive discipline techniques; (4) inconsistent discipline; (5) corporal punishment. The abbreviated version of the APQ has demonstrated internal and external validity (Scott et al., 2011). This instrument was administered again at a 3 month assessment.

Risky Sexual Behaviors. The New York City Department of Health conducts the Youth Behavior Risk Survey (YRBS) every two years in collaboration with the Center for Disease Control (Brener et al., 2005; Casanueva et al., 2011; Grunbaum et al., 2004). The survey is administered to youth in grades 9-12. The data are available for each borough and permit an assessment of the trends in adolescent risk behaviors within each of the districts targeted in the stepped wedge design. The NYF and FFT LLC project team created a brief version of the YRBS to provide information about sexual risk behavior (7 items), 6 questions about exposure to violence, and bullying for adolescents receiving services as part of the FFT CW project. The items on the YRBS are being administered prior to the family's participation in the intervention and again at a 3 month post intervention assessment point. This instrument will be used as an outcome measure to assess the effects of interventions on changes in risky sexual behavior. An interactive website exists to crosstab a variety of YRBS questions by borough in New York City. Hence, we will be able to compare rates of these measures by age, ethnicity, gender and other measures both within and outside of the FFTCW implementation across the five boroughs over the past 10 years.

Measures of Social and Psychological Functioning. FFT LLC uses the Outcome Questionnaire/Youth Outcome Questionnaire to capture pre- to post-change as a result of treatment. The Youth Outcome Questionnaire (YOQ) is routinely collected from families at the beginning and end of treatment throughout the 270 sites supported by the FFT LLC so that a very large comparison sample exists to evaluate the response to treatment of the FFT CW clients. This measure assesses the parent's and adolescent's self-perception as well as the parent's perception of the adolescent. The instrument has 64 items that assess six subscales reflecting **intrapersonal distress** (e.g., anxiety, depression, hopelessness, 18 items), **somatic complaints** (e.g., headaches, dizziness, stomachaches; 8 items); **interpersonal relations** (e.g., arguing, defiance, communication problems; 10 items); **social problems** (e.g., delinquent or aggressive behaviors; 8 items), **behavioral dysfunction** (e.g., organization, concentration, handling frustration, and ADHD-related symptoms; 11 items); and **critical items** (e.g., paranoid ideation, hallucinations, mania, and suicidal feelings; 9 items). This instrument has been shown to

be sensitive to the types of changes that would be expected to occur during treatment (Burlingame et al., 2004). The measure was collected at baseline and again at 3 months after receiving FFTCW services. Norms for community and clinical samples (including outpatient, residential, and partial hospitalization) are provided by the test authors (Ridge et al., 2009; Wells et al., 1996; Wells et al., 2003).

Treatment-Related Questionnaires and Measures. The *Client Outcome Measure (COM)* is a 6 item questionnaire which assesses the client's perceptions of change in family functioning, communication, personal behavior, improved parenting skills, parental supervision, and change in family conflict. Each dimension is rated on a 6 point scale from 0 (things are worse) to 5 (things are much better). The interventionist completes the *Therapist Outcome Measures (TOM)* to describe perceptions of client and family change during treatment on the same 6 dimensions as the COM. Therapists also rate the families on 9 family factors reflective of positive social relationships, effective supervision, and discipline. *Treatment Utilization data are stored in* the FFT LLC Data Management Software (CSS) which records all clinical appointments including dates, lengths, and type of contact (e.g., session, phone call, cancellations), and detailed progress notes for every treatment session.

Literature Cited

- Alexander, J. F. (1971). *Evaluation Summary: Family groups treatment program*. Report to Juvenile Court, District 1, State of Utah, Salt Lake City
- Alexander, J. F., Frietag, M. Hollimon, A. S., Turner, C. W., Robbins, M. R. (2008). Do the Rules Still Apply in EBTs With High-risk Youth? Presented at American Psychological Association, Boston, MA.
- Alexander, J. F., Barton, C., Waldron, H., & Mas, C. H. (1983). Beyond the technology of family therapy: The anatomy of intervention model. In K. D. Craig and R. H. McMahon (Eds.), *Advances in clinical behavior therapy* (pp. 48-73). New York: Brunner/Mazel.
- Alexander, J. F., & Parsons, B. V. (1982). *Functional family therapy: Principles and procedures*. Carmel, CA: Brooks/Cole.
- Alexander, J. E., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*, 219-225.
- Alexander, J. F., Pugh, C., & Parsons, B. V. (1998). *Blueprints for violence prevention*. Boulder, Colorado: Venture.
- Alexander, J. F., Pugh, C., Parsons, B. V., & Sexton, T. L. (2000). Functional Family Therapy. (2nd Edition.) In D. S. Elliott (Series Ed.), *Blueprints for Violence Prevention* (Book 3). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.
- Alexander, J. F., & Barton, C. (1976). Behavioral systems therapy with families. In D. H. Olson (Ed.), *Treating relationships*. Lake Mills, Iowa: Graphic Publishing Company.
- Alexander, J. F., & Barton, C. (1980). Intervention with delinquents and their families: Clinical, methodological, and conceptual issues. In J. Vincent (Ed.), *Advances in family intervention, assessment and theory*. Greenwich, CT: JAI Press.
- Aos, S., Lieb, R., Mayfield, J., Miller, M. & Penucci, A. (2004). Benefits and Costs of Prevention and Early Intervention Programs for Youth: Technical Appendix. Olympia: Washington State Institute for Public Policy.
- Aos, S., Phipps, P., Barnoski, R. & Lieb, R. (2001). The comparative costs and benefits of programs to reduce crime. Olympia: Washington State Institute for Public Policy.
- Barnoski, R. (2002). Washington State's implementation of Functional Family Therapy for juvenile offenders. Preliminary findings. Washington State Institute for Public Policy, www.swipp.wa.gov.
- Barnoski, R. (2005). Washington State's Experience with Research Based Programs Juvenile Justice Programs. Presented to King County Division of Youth Services, Seattle, WA.
- Barton, C., Alexander, J. F., Waldron, H., Turner C. W. & Warburton, J. (1985). Generalizing treatment effects of Functional Family Therapy: Three replications. *Journal of Marriage and Family Therapy, 13*, 16-26.
- Brener, N.D., et al. (2002). Reliability of the 1999 youth risk behavior survey questionnaire. *Journal of Adolescent Health, 31*(4), 336-342.
- Brooks, E., Janer, N., Early, K., & Mason, K. (2012). *The key ingredients for sustaining quality Functional Family Therapy Services in Florida*. Presented at the Annual Blueprints for Violence Prevention Conference, San Antonio, Tx.
- Broome, K.M., et al. (2007). Program structure, staff perceptions, and client engagement in treatment. *Journal of Substance Abuse Treatment, 33*(2), 149-158.
- Brown, R.L. & Rounds, L.A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wisconsin Medical Journal, 94*(3), 135-140.

- Burlingame, G.M., et al. (2004). *Youth Outcome Questionnaire (Y-OQ)*. The use of psychological testing for treatment planning and outcome assessment, 2, 235-274.
- Casanueva, C. et al. (2011). Lost in transition: Illicit substance use and services receipt among at-risk youth in the child welfare system. *Children and Youth Services Review, 33*(10), 1939-1949.
- Cohen, E. & Snowden, L. (2008). *Functional Family Therapy, Accommodation for California's Diverse Families*. Center for Social Services Research, University of California, Berkeley, 42.
- Elliott, D.S., Huizinga, D. & Menard, S. (1989). *Multiple problem youth: Delinquency, substance use, and mental health problems*.
- Essau, C.A., Sasagawa, S., & Frick, P.J. (2006). Psychometric properties of the Alabama Parenting Questionnaire. *Journal of Child and Family Studies, 15*, 597-616.
- 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.
- French, M. T., Zavala, S. K., McCollister, K. E., Waldron, H. B., Turner, C. W., & Ozechowski, T. J. (2008). Cost effectiveness analysis (CEA) of four interventions for adolescents with a substance use disorder. *Journal of Substance Abuse Treatment, 34*(3), 272-281.
- Friedman, A. S. (1989). Family therapy vs. Parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*, 335-347.
- Gordon, D. A., & Arbuthnot, J. (1990). Individual family and group interventions. In H. C. Quay (Ed.), *Handbook of juvenile delinquency*, pp. 290-324. New York: Wiley.
- Gordon, D. A., Arbuthnot, J., Gustafson, K. E., & McGreen, P. (1988). Home-based behavioural-systems family therapy with disadvantaged juvenile delinquents. *American Journal of Family Therapy, 16*, 243-255.
- Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of functional family therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior, 22* (1), 60-73.
- Greener, J.M., et al. (2007). Influence of organizational functioning on client engagement in treatment. *Journal of Substance Abuse Treatment, 33*(2), 139-147.
- Grunbaum, J.A., et al. (2004). Youth Risk Behavior Surveillance-United States, 2003. *Morbidity and Mortality Weekly Report, 53*, 1-96.
- Gustafson, K., Gordon, D. A., & Arbuthnot, J. (1985). *A cost-benefit analysis of in-home family therapy vs. probation for juvenile delinquents*. Paper presented at the annual Banff Conference on Behavioral Sciences, Banff, Alberta, Canada.
- Hansson, K., Cederblad, M., & Hook, B. (2000). Functional family therapy: A method for treating juvenile delinquents. *Socialvetenskaplig tidskrift, 3*, 231-243.
- Hansson, K., Johansson, Drott-Englén, G, & Benderix, Y. (2004). Functional family therapy in child psychiatric practice. *Nordisk Psykologi, 56*(4), 304-320.
- Hops, H., Ozechowski, T. J., Waldron, H. B., Davis, B. & Turner, C. (in press). Adolescent health-risk sexual behaviors: Effects of a drug abuse intervention. *AIDS and Behavior*.
- Joe, G.W., et al. (2007). Counselor perceptions of organizational factors and innovations training experiences. *Journal of Substance Abuse Treatment, 33*(2), 171-182.
- Jones, D, Bumbarger, B., Greenberg, M, Greenwood, P & Kyler, S. (2008). The Economic Return of PCCD's Investment in Research-based Programs: A Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania. Pennsylvania State University: PCCD.
- Lucenko, B., Mancuso, D. & Felver, M. (2011). Effects of Functional Family Parole on Rearrest and Employment for Youth in Washington State, Washington State Juvenile Rehabilitation, *RDA Report, 2.34: Executive Summary*, Olympia, 1-2.

- Klein, N. C., Alexander, J. F., & Parsons, B. V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*, 469-474.
- Knight, J.R., et al. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine, 156*(6), 607-614.
- Lehman, W.E., Greener, J.M. & Simpson, D.D. (2002). Assessing organizational readiness for change. *J Subst Abuse Treat., 22*(4), 197-209.
- Parsons, B. V., & Alexander, J. F. (1973). Short term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*, 195-201.
- Phillipi, S., Below, L & Cuffie, D. (2010). Evidence Based Practice for Juvenile Justice Reform in Louisiana. *Louisiana State University School of Public Health and Louisiana Models for Change in Juvenile Justice, 20*.
- Price, J., Lindsey, J., Keen-March, B. & White, M. (2012). Improving the Lives of Youth Involved in the Juvenile Justice System. Presented at the Annual Blueprints for Violence Prevention Conference, San Antonio, Tx.
- Rhoades, B., Campbell, L. & Bumgarger, B. (2011). Evidence-based Intervention Programs: 2010 Outcomes Summary. Pennsylvania State University: PCCD.
- Ridge, N.W., et al. (2009). Reliability and validity of the youth outcome questionnaire self-report. *Journal of Clinical Psychology, 65*(10), 1115-1126.
- Rist, M. (2011). Yolo County (California) Probation Department, Report to County Commissioners.
- Robbins, M.S. & Rowlands, S. (April, 2012). *Using data to improve implementation outcomes and sustainability*. Presented at the Annual Blueprints for Violence Prevention Conference. San Antonio, Texas.
- Saldana, L., et al. (2007). The Organizational Readiness for Change scale in adolescent programs: Criterion validity. *Journal of Substance Abuse Treatment, 33*(2), 159-169.
- Scott, S., Briskman, J., & Dadds, M.R. (2011). Measuring parenting in community and public health research using brief child and parent reports. *Journal of Child and Family Studies, 20*(3), 343-352.
- 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.
- Shelton, K.K., Frick, P.J. & Wootton, J. (1996). Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child Psychology, 25*(3), 317-329.
- Simpson, D.D. and Flynn, P.M. (2007). Moving innovations into treatment: A stage-based approach to program change. *Journal of Substance Abuse Treatment, 33*(2), 111-120.
- 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.
- Thorgersen, D. (2012). Implementation of FFT in Norway. Presented at the Annual Blueprints for Violence Prevention Conference. San Antonio, Tx.
- 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.
- Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse: A review and meta-analyses. *Journal of Clinical Child and Adolescent Psychology [Special Issue: Evidence Based Psychosocial Interventions for Clinical Child and Adolescent Disorders], 37*, 1-24.
- Washington State Department of Social and Health Services (DSHS), Intensive Parole

- Model for High Risk Offenders, *Report to the Legislature*, Olympia, (2009). 12-14
- Wells, M.G., et al., (1996). *Conceptualization and measurement of patient change during psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire*. *Psychotherapy: Theory, Research, Practice, Training*, 33(2), 275-283.
- Wells, M.G., G.M. Burlingame, and P.M. Rose (2003). *Youth outcome questionnaire self report*. Youth outcome questionnaire self report.