Journal of Social Science Humanities and Literature, Vol.6, Issue 5, (Oct)
ISSN 2277-842X **2023**
DOI: 10.53469/jsshl.2023.06(05).16

The Implementation of the Functional Family Therapy in China

Zifei Zhang

The University of Warwick

Abstract: ***Nowadays, disruptive behaviour disorders and substance use disorders are issues frequently identified among adolescents and may have adverse effects on adolescents' lives and eventually lead to catastrophic consequences if people fail to address them in time. In China, the number of juvenile offenders under eighteen has also increased for the past 15 years. However, the laws and regulations in China are not sufficiently detailed and specific, so the actual implementation of community correction is not effective enough. Functional Family Therapy (FFT) is an evidence-based family therapy for pre-adolescents and adolescents (10-18 years) to treat their behavioural problems and substance misuse, which is widely implemented in Western countries. So, this article aims to explore the implementation of FFT in China by following the National Implementation Research Network (NIRN) and considering the reality of China, to try to help Chinese adolescents and society in the future.***

Keywords: Implementation, Functional Family Therapy, China, Disruptive Behaviour, Juvenile Delinquency.

1. BACKGROUND & INTRODUCTION TO FFT

Nowadays, disruptive behaviour disorders and substance use disorders are issues frequently identified among adolescents. International epidemiological research showed that 6% of adolescents had disruptive behaviour disorders, and 5% had substance use disorders (Nakamura & Kessler, 2009). These disorders are problematic because, if people fail to address them in time, they may have negative effects on adolescents' lives and eventually lead to catastrophic consequences (Hartnett et al., 2017a). To be more specific, drug abuse is strongly linked to a wide range of detrimental outcomes, including traffic accidents, STIs, and even suicide (Filges et al., 2018). Furthermore, these two disorders may also lead to comorbid psychiatric disorders which cause higher risks of health problems (Hartnett et al., 2017a). To make it worse, social issues arising from them like violent behaviours and delinquency are also significant (Filges et al., 2018; Hartnett et al., 2017a). All these then place a heavy financial load on government institutions, for example, healthcare and social services (Hartnett et al., 2017a). Therefore, these disorders need to be intervened and minimized as early as possible.

A variety of research showed a strong association between juvenile delinquency and family factors. Therefore, a family-based approach, Functional Family Therapy (FFT), is widely applied in the treatments for disruptive behaviours among teenagers (Watkins et al., 2020).

FFT is an evidence-based family therapy for pre-adolescents and adolescents (10-18 years) to treat their behavioural problems and substance misuse (EIF Guidebook, 2018). It was developed by James Alexander in the early 1970s (Celinska, 2015). When young people are convicted of crimes, the juvenile court usually refers them and their families to FFT in the U.K. (EIF Guidebook, 2018).

Being qualified and well-trained, therapists offer family therapy to alter the interactional patterns contributing to the problematic behaviours and assist family members to acquire skills fostering positive interactions, such as effective communication, and conflict resolutions (Filges et al., 2018). Following that, they encourage the youth to generalise the desired behavioural changes in other settings like schools. The goal of FFT is to help families to realign positive interactions, strengthen family bonds, and eventually achieve positive changes for the youths (Alexander et al., 2013). The FFT contains five phases, they are Engagement in Change, which involves activities encouraging families to attend the FFT sessions; Motivation to Change, which creates positive foundations and conditions for changes; Relational Assessment and Change Planning, in which therapists address the adolescents' problem behaviour patterns and characteristics of other family members, then demonstrate overall frameworks for the changes; Behavioural Change, under which therapists offer concrete and viable behavioural interventions to make corrections and changes to the behaviours; and Generalization; in which therapists apply community resources to generalise and sustain changes (Alexander et al., 2013, as cited in Filges et al., 2018). The youth and at least one parent or caregiver are required to participate in eight to thirty weekly sessions as per their conditions, and twelve sessions would be conducted over a three-to-four-month period on average (Alexander et al., 2013).

2. CRITICAL ANALYSIS OF THE LITERATURE

FFT gradually became a well-known program in helping to reduce juvenile delinquency and substance abuse over the past few decades. Subsequently, there was a large body of literature examining the effectiveness and or efficacy of FFT implementation. Some studies indeed showed FFT could have significantly positive impacts on adolescents' growth and development. For instance, in their pioneer studies, Alexander and Parsons (1973) illustrated that, following the conclusion of the therapy, three family interaction indicators altered greatly, and recidivism rates dropped dramatically. In stark contrast, some other research showed that no satisfactory outcomes were obtained. In a quasi-experimental design (QED) research on African American and Latino adolescents, researchers demonstrated there were no statistically significant gains for program participants (Darnell & Schuler, 2015). Putting aside FFT outcomes being contentious, this part of the paper below would endeavour to present a critical analysis of some of those studies.

In the study evaluating FFT implementation in New Jersey (Celinska et al., 2013), the researchers used QED to compare the respective outcomes of adolescents who got FFT and those who received individual therapy or mentoring. FFT was delivered by the local Children at Risk Resources and Interventions-Youth Intensive Intervention Program for an average of three to four months, whereas individual therapy or mentoring was provided by Youth Case Management and lasted for four to five months typically. The yearly completion of FFT training, periodic oversight, support from off-site FFT consultants, and on-site supervision all served to assure therapists' fidelity to the FFT model. The research participants were 72 adolescents with thirty-six of them in the FFT group and the other thirty-six in the comparison group. The treatment group consisted of youths referred to the program by Probation (42%), Family Crisis Intervention Unit (25%), Family Court (14%), etc. The average age of them was fifteen, with 67% male and most of them were Latino and African American.

To start data collection, the Strengths and Needs Assessment (SNA) tool was deployed to score the adolescents and their carers both before and after the intervention by the FFT therapists. The SNA included seven dimensions: Life Domain Functioning, Child Strengths, Acculturation, Caregiver Strengths, Caregiver Needs, Child Behavioral/Emotional Needs, and Child Risk Behaviors. The Services Tracking Form created by the researchers was also employed to offer essential information about the treatment.

The results indicated that there were major beneficial improvements in several areas (Life Domain Functioning, Child Strengths, and Child Risk Behaviours) for both the treatment group and the comparison one. More importantly, solely young people in the FFT group showed a substantial decrease in emotional and behavioural needs and risk behaviours, which could help prevent delinquent conduct and recidivism. As the researchers concluded, the intervention's efficacy may differ based on adolescents' gender, age, and ethnicity.

Compared to prior studies, this research enriched the literature by examining FFT using a more diversified sample and presented a greater variety of outcomes. The advantages and distinctiveness of FFT were amply demonstrated by the researchers, by contrasting the results of two different interventions. The findings also showed that teenagers' emotional and behavioural demands and risky behaviours decreased, suggesting that the long-term impact of FFT was also encouraging. Fruitful as it was, the research still had multiple drawbacks due to its nature. First and foremost, there were disparities in the gender and ethnicity of the sample, and its size was relatively small too, which may reduce the research's objectiveness and eventually jeopardise its quality and credibility. Secondly, as of the QED itself, sample selection bias was usually hard to rule out completely.

However, a randomized controlled trial (RCT) of FFT implementation in the UK, carried out by Humayun et al. (2017), illustrated some contradicting results. That study was the first independent RCT conducted outside of the US, to get a comparison between FFT and other interventions. To start, participants were 111 youths (70% male and 90% white), who were ten to eighteen years old. Their caregivers were chosen from the Youth Offending Services (67%), Targeted Youth Support Services (22%), and other agencies (11%). Families were randomized into the FFT group (sixty-five youths) and or the control group (forty-six youths).

According to British law, Management As Usual (MAU) was required in the country and was provided by referral institutions. Before family therapy, MAU, which involved typical local care provided in various combinations of services, included mental health, juvenile justice, social care, and education (Fonagy et al., 2020), was widely applied in the UK, to aid youths with their substance abuse, anger control, and other issues. Thus, the FFT group of the study received both FFT (twelve sessions) and MAU. To guarantee that both groups received equivalent intervention dosages, extra MAU was also provided to the control group. The FFT implementation team included

three certified psychotherapists. All the therapists had a master's degree or higher in education and a variety of experiences working with different families. They went through initial training followed by phone supervision and in-person training sessions. The FFT consultant regularly checked therapists' records of their clinical sessions, to further guarantee their fidelity.

Humayun et al. (2017) first measured the demographic information, participants' IQ and therapists' treatment fidelity rated by the FFT consultant. Then for the primary outcomes, they chose the self-report delinquency by the adolescents. Illicit activities from the previous year were inquired about, and the frequency of each crime was added together. Data from six months and twelve months after the therapy were collected when follow-up. For the secondary outcomes, researchers accessed the official documentation of convicted crimes. Data were collected over three different periods, they were six months before the research; six-month follow-up after the research; and eighteen-month follow-up, focusing on twelve months after the research separately. In addition, Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), parent-youth relationships and interactions were also measured by interview, questionnaire, and direct observation respectively.

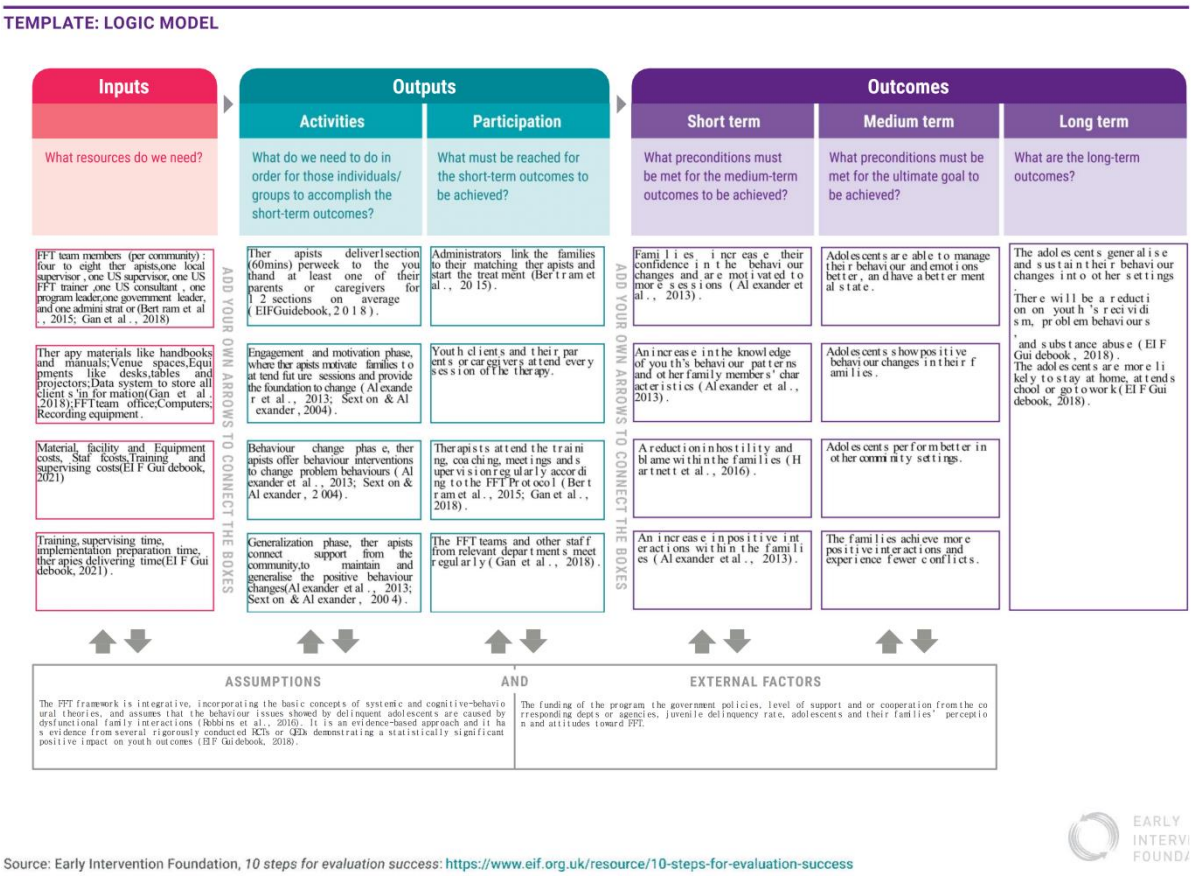
Surprisingly, there were no significant variances between the intervention and control groups at six and eighteen months on self-reported delinquency, police records of criminal activities, symptoms of conduct disorders, parental monitoring, or supervision, directly observed child negative behaviours, or parental positive or negative behaviours, even though FFT group received more therapy hours overall than the control group and the fidelity to the FFT model was adequate or higher for most cases. But there was a disturbing difference showing up at the time of eighteen months, the FFT group, in contrast to the control group, displayed a lower percentage of positive behaviours.

From the perspective of evidence-based studies, there were several factors resulting in such different outcomes of the above evaluations of FFT implementation. Firstly, some issues were identified with FFT implementation itself. The researchers noticed a possibility that not all therapists in FFT were skilled and adherent to the FFT model enough. Another outstanding defect could be that only 60% of participants completed the whole FFT sessions in that study, compared to completion rates of 77 to 89% in the US (Collyer et al., 2021). Secondly, the design of the FFT group receiving both FFT and MAU during the treatment may also cast some influences on the outcomes. Thirdly, the study was more inclusive and thorough than some similar studies in this field, considering it had a protocol for analysis, and more objective measures like direct observation, self-report, and official documents. It also had a follow-up lasting much longer and was done without the program developers, which limited the allegiance bias. Finally, the combination of FFT and MAU failed to perform better together than MAU alone, which might be explained by the fact that MAU was more acknowledged and accepted in the UK due to its unique cultural background and useful approach to reduce recidivism.

In short, the study was the first RCT of FFT for juvenile delinquency and behaviour problems, executed outside the U.S. and independently from the program developers. Being the first outside of the US was a milestone itself and could act as a model for the researchers following. Equally important, it adopted a variety of high-quality measurement techniques to assess teenage behaviour in various contexts, which could all add up to the objectiveness of results. Besides, the study tried to choose those therapists who were trained by the program developer and supervised weekly to ensure the quality of implementation. Strong as it was, the study also had several limitations. Firstly, although the therapists were carefully selected, FFT was new to them in the UK, which could cast shadows on the fidelity of the FFT model. Secondly, given the fact that the sample was predominantly white male, and its size was not large enough, the study could still fall into some racial biases.

Overall, a great variety of research contributed to various outcomes, which all provided the possibilities for a better FFT. When implementing it, the corresponding practitioners and or therapists could take advantage of this past literature and thus try to eliminate the borne shortcomings of their programme.

3. THE LOGIC MODEL



Source: Early Intervention Foundation, *10 steps for evaluation success:* https://www.eif.org.uk/resource/10-steps-for-evaluation-success

4. CASE STUDY OF FFT IMPLEMENTATION IN CHINA

In China, Criminal Law regulates that children be not held accountable for criminal responsibility unless they are over 14 and commit a felony, like rape, drug trafficking and or homicide (Mo & Wan, 2020).

According to statistics, in China, the number of juvenile offenders under eighteen has been increasing at a rate of 14.5% per year for the past 15 years. More than 50,000 youths are sentenced every year, and more than 1.5 million have behaviour problems and are at the rim of breaking the law (Tang, 2019). Theft, robbery, intentional injury, drug offences, and mobbing are all common youth crimes. Young males, rural and low-education population account for most juvenile crimes (Xiong, 2014).

A report by the Supreme People's Court claimed that, of the recent juvenile crime cases concluded by the courts nationwide, youth from migrant families, divorced families, left-behind families, single-parent families, and remarried families ranked the top five (Lin et al., 2021). Thus, it is a clear fact that family plays a critical role in the healthy growth of minors, and the lack of family care eventually exposes the youth to more chances of delinquency.

In dealing with juvenile offenders, Chinese law adopts a non-penalised approach. As a result, most youths are not sentenced to imprisonment even if they break the law (Tang, 2019). To compensate, Community Correction Law was enacted in 2020 and provided basic guidelines for the implementation of community corrections, targeting offenders being under control, probation, parole, or provisional release from prison (Lin et al., 2021). Serving as a penalty, special provisions have been set up and corrective measures are adopted for adolescents, considering their immature physiological and psychological characteristics. Simultaneously, community correctional institutions can provide psychological counselling and legal assistance to adolescents in various ways (Lin et al., 2021). Plus, moral education is carried out too, to help the youth establish a correct outlook on life and values, and thus return to society successfully in future (Tang, 2019).

Although the law is in place, the content of it is not sufficiently detailed and specific, so the actual implementation of community correction varies. Plus, the system lacks support from professionals, such as mental health therapists and intervention practitioners. The supervision mechanism is not systematic and complementary either. Overall, community correction is not yet free from the shadow of traditional penalties (Lin, 2022). Juvenile offenders have an average of 1.8 convictions previously (Xiong, 2014), and the high recidivism rate proves that early intervention and correction are insufficient and highly demanded. Therefore, researchers suggest that community correction cannot be separated from practical and effective early interventions (Tang, 2019). As an evidence-based, manualised approach, FFT would provide a mature family therapy model, integrating with the current community correction system wherever it is already set up, which could have a big impact on Chinese youths' future.

5. THE IMPLEMENTATION OF FFT IN CHINA

As Bertram et al. (2015) suggested in the National Implementation Research Network (NIRN) and considering the reality of China, the implementation could be carried out in four main steps, exploration and pairing with community correction system, installation, initial and full implementation separately.

5.1 Exploration

In the initial process of exploration and adaptation, the organization should consider the potential match between the target population, community resources and the program model's key elements, etc., to assess whether it is feasible to adopt a new program in the country (Bertram et al., 2015).

With the framework mentioned above, FFT could fit well into the local community correction program in China for several reasons. Firstly, in Chinese culture, people value the role of family and reckon parents should raise and support their children till adulthood, and in return, the children need to take care of their parents when they become elderly. This belief could work as a strong cultural foundation for the implementation of FFT, as Chinese families usually have a tighter family bond, which is one of the main cornerstones of FFT. Plus, FFT has been applied to a wide range of clients in multi-ethnic, multicultural contexts, like Singapore (Gan et al., 2018), the Netherlands (Breuk et al., 2006) and so on, which provide helpful insights for FFT implementation in China. Secondly, FFT falls into the same goal as that of the Community Correction Law, to reduce youths' behaviour problems and recidivism. Even more importantly, FFT would perfectly fill in the gap when the current community correction system lacks reliable, evidence-based approach treatments. Lastly, based on the EIF Guidebook (2018), FFT is more cost-efficient than other interventions, like Multisystemic Therapy. Given the large population in China, the cost efficiency of FFT could get more people covered and benefited. More easily the program could be accessed, the more chances it will have to succeed.

5.2 Installation

Exploring the current conditions in China lays a solid groundwork for the installation of FFT. For installation, there are three classes of drivers which are critical for the high fidelity of program delivery. To be more specific, they are competency drivers, including selecting, training, and coaching the staff; leadership drivers, including technical and adaptive leadership; organization drivers, including decision support data systems, facilitative administration, and systems-level intervention (Bertram et al., 2015). The whole treatment and treatment materials will be delivered in Chinese to the families, while the training, coaching and supervising of the therapists will be conducted in English by experts to ensure accuracy.

Competency drivers aim to boost the competence and confidence of staff and increase the likelihood of high fidelity through staff selecting, training, coaching and performance assessing (Bertram et al., 2015).

For staff selection, some traits may affect the model fidelity and are difficult to gain through acquired learning, therefore they must be attended, at the very beginning, as part of planned selection criteria (Bertram et al., 2015). For example, the significance of having and applying fundamental therapeutic abilities including empathy, warmth, and constant positive regard are stressed by many therapists (Hartnett et al., 2017b). Moreover, the successful implementation may be greatly influenced by the attitudes and skills of the therapists to follow the treatment model (Gan et al., 2018). On top of that, putting evidence-based practises into reality calls for the skill and willingness to review the literature, collect data, think critically, and then act on it (Bertram et al., 2015). The whole process is challenging and time-consuming, which needs the therapists to be patient and conscientious. Thus, when selecting staff in China, ideal therapists would need a master's or higher degree in the field of education or psychology, and

better have the experience in dealing with adolescents, to ensure training results. Proficiency in English is important too since they need to study the FFT Protocol, literature and receive trainings in English for better and more accuracy understandings.

Then, for staff training, because FFT is newly introduced in China, and there aren't many certificated therapists in the community correction system, the recruited staff may need more training time than in other countries, to have a greater understanding of the model. To be better prepared, the team may have a five-day introductory training conducted by certified FFT trainers using English. The training will contain a full comprehension of population traits, the justification for selecting the programme model, the model definition, including the main elements, activities, and phases, as well as the theory of change of the model (Bertram et al., 2015). Some example videos from the previous therapies will also be included (Gan et al., 2018). The recruited therapists would need additional time to practise in Chinese and then receive feedback to further polish their skills.

Thirdly, the most efficient way to generate a proficient and assuring team is through skilled on-the-job coaching (Bertram et al., 2015). The FFT protocol, which outlines a structured coaching process, will be followed. As per Gan et al. (2018), following the preliminary training in the first year, there will be four further sessions and one follow-up session in each of the next two years. Furthermore, there will be weekly supervision from a US consultant in the first year and in-person supervision with a local supervisor from the second year. Due to the inconvenience of overseas supervision and language differences, audio recordings of the therapies would be turned into transcripts, then translated into English before forwarding to the US specialists.

Lastly, the performance assessment is where the supervisors can evaluate the therapists' session notes, audio recordings and transcripts of treatment, to check their fidelity, provide further advice and foster therapists' growth (Bertram et al., 2015).

Leadership drivers include technical leadership, to solve procedural problems, and adaptive leadership, necessary for complex situations, like identifying and comprehending, and solving the issue through group learning (Bertram et al., 2015). Leadership is particularly a great necessity in China, as the current community correction system does not function well enough. There must be lots of problems arising in the process of implementing a new program and forging it into the current system. For instance, there should be leaders from the corresponding government departments and judicial authorities to provide a top-level design and guide the FFT implementation, to make it a qualified and legal therapy in China. Plus, leaders who are experienced and familiar with the FFT model should also stand by during the initial process.

The decision support data systems have been identified by the NIRN framework as a crucial organisational driver that must be established during the programme installation and initial implementation. As Lin (2022) stated, there isn't a formal management system in the current community correction system in China, let alone systematic information resources. In accordance with the FFT protocol of the US, client data and therapy information must be entered and kept in the Client Services System, an electronic database run by FFT LLC (Gan et al., 2018). Every four months, CSS data is systematically collected and retrieved, allowing for feedback on therapist fidelity as well as other process indicators like treatment dosage and duration, programme completion rates and so on (Gan et al., 2018). Thus, in China, it is high time to establish a data system of FFT to be integrated with the community correction system, for long-term development and oversight of the whole treatment.

Facilitative administration is the second factor in the organisational driver, the goal of which is to improve and or change working circumstances to support and accommodate new duties, to implement FFT successfully and quickly (Bertram et al., 2015). In China, there are vast and remote rural areas under development. To be even worse, the juvenile delinquency rate is higher among the rural population. All these add up to the challenges to implement the therapy there. To make it more accessible, the administrators need to consider the time and location of FFT delivery. For instance, the administrators may make good use of village councils in the remote rural areas and arrange meetings there. Also, to make a good start, therapists better start with families which are easiest to reach (Gan et al., 2018), to minimize the potential costs, improve work efficiency, set up successful examples for pier youths and therefore create momentum for a long-lasting FFT.

System-level interventions, the last part of the organisational driver, are essential for the effective application of evidence-based practice (Gan et al., 2018). This entails working with systems to mobilise the financial, human, and organisational resources necessary for the setup and efficient operation of FFT (Klingner et al., 2003, as cited in Gan et al., 2018). The authors then continuously show that it is vital for the court staff to secure the consistent

flow of referrals. In a study about FFT implementation in Ohio (Watkins et al., 2020), many practitioners discussed the lower-than-expected rate of court staff referrals to FFT. Uncertainty and ambiguity over the FFT eligibility criteria was one hurdle, which was also verified by another study conducted in Australia (Economidis et al., 2023). As Watkins et al. (2020) stated, the confusion was partly ascribed to a breakdown in communication between the FFT team and court staff. Some practitioners also observed that there isn't a uniform referral mechanism between different departments and agencies. Taking this as a lesson, the judges, government officials, and other relevant correction workers should also be well introduced to the FFT model during the initial period. They need to meet with the FFT teams regularly, to prompt problem-solving and enhance their understanding. Moreover, the universal regulation for referral should be set up before the program starts.

5.3 Unique Factors in China

All of the above are already known drivers. To address the unique culture and circumstances of China, there are some special factors to be evaluated. Firstly, cultural challenges like language barriers and emotional suppression often emerged (Gan et al., 2018). As for the language barrier, most Chinese people can't speak and understand English, especially adolescents and their families from rural areas. Thus, the therapists must use Chinese during the treatments. The content of FFT requires some translators to work with the therapists and carefully interpret the materials into Chinese, in which process some finer details might be omitted. And it is the gene of Chinese culture to avoid conflicts and build up harmonious relationships with others. Therefore, people prefer to restrain their emotions and not express their opinions directly, which may make it difficult for the therapists to detect the facts underlying. All these should be addressed as much as possible before starting the implementation. For example, the therapists could choose less sensitive and lighter topics in earlier interviews or questionnaires, to encourage, motivate and facilitate emotional expressions. With careful observation of clients' reactions, heavier topics could be added gradually. Secondly, due to the large population in China, a much larger population of therapists and professionals should be recruited and trained too, to guarantee the quality of FFT implementation.

5.4 Initial and Full Implementation

Even though FFT has already been implemented well in many cultures and countries, there must be unique challenges and difficulties during the initial implementation in China. As per Bertram et al. (2011), new programmes surviving and succeeding till this stage are good at learning from failures and approaching problems methodically and comprehensively. In this case, steady leadership is important to adjust implementation drivers, manage changes, and so on (Bertram et al., 2015). Thereby, the FFT team in China should adhere to the model and implementation framework, work closely with FFT supervisors and consultants, to make necessary adjustments, and persist in the full implementation which will occur only when most practitioners consistently provide FFT model with high fidelity (Bertram et al., 2015). In light of the NIRN framework, at the full implementation stage, the FFT team in China should continuously track and regulate the implementation drivers and further enhance the fidelity and outcomes. The objective throughout this phase is to meet the fidelity and outcome benchmark and then continue moving forward (Bertram et al., 2015).

6. CONCLUSION

In conclusion, FFT is an evidence-based, effective therapy for youth behaviour problems, recidivism, and substance abuse. Taking account of the current conditions in China, FFT may greatly benefit the whole society if it is successfully implemented. But bear in mind, successful implementation of FFT needs the close cooperation of government agencies, community correction departments, FFT practitioners and therapists, FFT supervisors, trainers and consultants, researchers and most of all, the youths themselves and their families, to spare no efforts for a brighter future together.

REFERENCES

[1] 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.
[2] Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional family therapy for adolescent behavior problems. American Psychological Association. https://doi.org/10.1037/14139-000
[3] Bertram, R. M., Blase, K. A., & Fixsen, D. L. (2015). Improving Programs and Outcomes. Research on Social Work Practice, 25(4), 477–487. https://doi.org/10.1177/1049731514537687

[4] Bertram R. M., Blase K., Shern D., Shea P., Fixsen D. (2011). Implementation opportunities and challenges for prevention and health promotion initiatives. Alexandria, VA: National Association of State Mental Health Directors.
[5] Breuk, R. E., Sexton, T. L., von Dam, A., Disse, C., Doreleijers, T. A. H., Slot, W. N., & Rowland, M. K. (2006). The Implementation and the Cultural Adjustment of Functional Family Therapy in a Dutch Psychiatric Day-treatment Center. Journal of Marital and Family Therapy, 32(4), 515–529. https://doi.org/10.1111/j.1752-0606.2006.tb01625.x
[6] Celinska, K. (2015). Effectiveness of Functional Family Therapy for Mandated Versus Non-Mandated Youth. Juvenile and Family Court Journal, 66(4), 17–27. https://doi.org/10.1111/jfcj.12049
[7] Collyer, H., Eisler, I., & Woolgar, M. (2021). Parent and youth perspectives and retention in functional family therapy. Family Process, 60(2), 316-330. https://doi.org/10.1111/famp.12605
[8] 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. https://doi.org/10.1016/j.childyouth.2015.01.013
[9] EIF Guidebook. (2018, February). Functional Family Therapy. Retrieved April 18, 2023, from https://guidebook.eif.org.uk/programme/functional-family-therapy
[10] EIF Guidebook. (2021). How to Develop a Logic Model. Retrieved May 10, 2023, from https://guidebook.eif.org.uk/programme/functional-family-therapy
[11] Economidis, G., Farnbach, S., Falster, K., Eades, A.-M., & Shakeshaft, A. (2023). Identifying enablers and barriers to the implementation of Functional family Therapy – Child Welfare (FFT-CW®) into the routine delivery of child protection services in New South Wales, Australia. Children and Youth Services Review, 149, 106927. https://doi.org/10.1016/j.childyouth.2023.106927
[12] Filges, T., Andersen, D., & Jørgensen, A.-M. K. (2016). Functional Family Therapy for Young People in Treatment for Nonopioid Drug Use. Research on Social Work Practice, 28(2), 131–145. https://doi.org/10.1177/1049731516629802
[13] Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., Fuggle, P., Kraam, A., Byford, S., Wason, J., Smith, J. A., Anokhina, A., Ellison, R., Simes, E., Ganguli, P., Allison, E., & Goodyer, I. M. (2020). Multisystemic therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): 5-year follow-up of a pragmatic, randomised, controlled, superiority trial. The lancet. Psychiatry, 7(5), 420–430. https://doi.org/10.1016/S2215-0366(20)30131-0
[14] Gan, D. Z. Q., Zhou, Y., Hoo, E., Chong, D., & Chu, C. M. (2018). The Implementation of Functional Family Therapy (FFT) as an Intervention for Youth Probationers in Singapore. Journal of Marital and Family Therapy, 45(4), 684–698. https://doi.org/10.1111/jmft.12353
[15] Hartnett, D., Carr, A., Hamilton, E., & O'Reilly, G. (2017). The Effectiveness of Functional Family Therapy for Adolescent Behavioral and Substance Misuse Problems: A Meta-Analysis. Family Process, 56(3), 607–619. https://doi.org/10.1111/famp.12256
[16] Hartnett, D., Carr, A., Hamilton, E., & Sexton, T. L. (2017). Therapist implementation and parent experiences of the three phases of Functional Family Therapy. Journal of Family Therapy, 39(1), 80–102. https://doi.org/10.1111/1467-6427.12120
[17] Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. Journal of Child Psychology and Psychiatry, 58(9), 1023–1032. https://doi.org/10.1111/jcpp.12743
[18] Katarzyna Celinska, Furrer, S., & Cheng, C.-C. (2013). An Outcome-Based Evaluation of Functional Family Therapy for Youth with Behavioral Problems. The Journal for Juvenile Justice, 2(2), 23–36.
[19] Lin, H. (2022). Risk factors and countermeasures of juvenile community corrections subjects re-offending. Journal of Zhejiang Police College (01), 91-97. doi: CNKI:SUN:GAXK.0.2022-01-011.
[20] Lin, K. X., Liao, W., & Liu, Y. (2021). Functional Analysis and Improvement Measures of Community Corrections on Juvenile Delinquency. Legal Expo (29),119-121. doi: CNKI:SUN:FBZX.0.2021-29-052.
[21] Mo, J. X., & Wan, L. I. (2020). Strengthening the education of juvenile delinquency prevention: structure the Education Center for juvenile delinquency prevention. https://doi.org/10.1109/icmeim51375.2020.00037
[22] Nakamura, E. F., & Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. Dialogues in Clinical Neuroscience, 11(1), 7-20. https://doi.org/10.31887/DCNS.2009.11.1/krmerikangas
[23] Robbins, M. S., Alexander, J. F., Turner, C. W., & Hollimon, A. (2016). Evolution of Functional Family Therapy as an Evidence-Based Practice for Adolescents with Disruptive Behavior Problems. Family Process, 55(3), 543–557. https://doi.org/10.1111/famp.12230
[24] Sexton, T. L., & Alexander, J. F. (2004). Functional family therapy clinical training manual. Baltimore, MD: Annie E. Casey Foundation.

[25] Tang, J. (2019). The Approach to Improve the Community Correction System of Juvenile Offenders under the Concept of Restorative Justice. Juvenile Delinquency (01), 23-29. doi: CNKI:SUN:FZWT.0.2019-01-005.
[26] Watkins, A., Tompsett, C., Diggins, E., & Pratt, M. (2020). Voluntary uptake and continuation of treatment among court-involved youth: Lessons learned from the implementation of Functional Family Therapy in a community setting. Children and Youth Services Review, 114, 105028. https://doi.org/10.1016/j.childyouth.2020.105028
[27] Xiong, M. L.,Hu, Y., Jiang, N.Y., & Zhou, J. (2014). Talking about Juvenile Delinquency and Correction-Taking Six Basic Courts of Deyang City as Samples. Juvenile Delinquency Prevention Research (04), 21-32+66. doi: CNKI:SUN:YFQS.0.2014-04-004