Published July 2024

Multidimensional Family Therapy

Review: September 2017

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.

Multidimensional Family Therapy (MDFT) is primarily for adolescents who have substance misuse, behavioural, delinquency, mental health, educational/school, family mental health problems or disorders.

MDFT is an integrated and flexible multi-component programme. Families work with a qualified MDFT therapist to develop problem-solving skills for dealing with issues that are occurring at the level of the adolescent, parent, family and community. It includes sessions focused on the youth, as well as sessions focused on the parents, and sessions directed towards the family overall. In addition, a community-focused component is available.

MDFT aims to improve education outcomes, reduce substance misuse, delinquency and involvement in the criminal justice system.

Evidence rating: **4**

Cost rating: **4**

EIF Programme Assessment

Multidimensional Family Therapy has **evidence of a long-term positive impact** on child outcomes through multiple rigorous evaluations.

Evidence rating: **4**

What does the evidence rating mean?

Level 4 indicates **evidence of effectiveness**. This means the programme can be described as evidence-based: it has evidence from at least two rigorously conducted evaluations (RCT/QED) demonstrating positive impacts across populations and environments lasting a year or longer.

Please note that this evidence rating is based on three robust studies where MDFT outperforms three alternate treatments (individual cognitive behavioural therapy, individual psychotherapy, and adolescent group therapy) when targeted at young people with substance abuse issues, in the context of the US system. Readers interpreting this evidence should carefully consider the generalisability of these results to the delivery context in the UK (and what treatment-as-usual services are typically offered in the UK to this group).

Cost rating

A rating of 4 indicates that a programme has a medium-high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of £1,000–£2,000.

Cost rating: **4**

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 externalising symptoms

Based on study 2b

0.48-point improvement on the Youth Self-Report (externalising subscale)

Improvement index: **+10**

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 60% and worse outcomes than 40% of their peers, if they had received the intervention.

Long-term A year later

Based on study 3

1.18-point improvement on the Youth Self-Report (externalising subscale)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term A year and a half later

Reduced delinquency

Based on study 3

0.22-point improvement on the National Youth Survey Self-Report Delinquency Scale (general delinquency and index offenses subscales)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term A year and a half later

Reduced felony arrests

Based on study 3

0.45-point reduction in felony arrests (administrative data from a justice system database maintained by the State of Florida)

Improvement index: **+33**

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 83% and worse outcomes than 17% of their peers, if they had received the intervention.

Long-term A year and a half later

Preventing substance abuse

Reduced substance use problem severity

Based on study 1

1.47-point improvement on the Personal Experience Inventory (Personal Involvement with Chemicals Scale)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

6 months later

7.77-point improvement on the Personal Experience Inventory (Personal Involvement with Chemicals Scale)

Improvement index: **+22**

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 72% and worse outcomes than 28% of their peers, if they had received the intervention.

Long-term A year later

Reduced other drug use

Based on study 1

0.86-point improvement on the Time-line Follow-back Method

Improvement index: **+13**

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 63% and worse outcomes than 37% of their peers, if they had received the intervention.

Long-term A year later

Increased drug abstinence

Based on study 1

20-percentage point increase in proportion of participants reporting only minimal substance use (measured using the Time-line Follow-back Method)

Improvement index: **+19**

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 69% and worse outcomes than 31% of their peers, if they had received the intervention.

Long-term A year later

Reduced cannabis dependence symptoms

Based on study 2a

0.6-point reduction in number of symptoms of cannabis dependence (Adolescent Diagnostic Interview-Light)

Improvement index: **+45**

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 95% and worse outcomes than 5% of their peers, if they had received the intervention.

Long-term A year later

Key programme characteristics

Who is it for?

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

- 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:

- Home
- Secondary school
- Out-patient health setting

The programme may also be delivered in these settings:

- Home
- Community centre
- In-patient health setting
- Out-patient health setting

How is it targeted?

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

- Targeted indicated

Where has it been implemented?

Belgium, Finland, France, Germany, Netherlands, Switzerland, United States

UK provision

This programme has not been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

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

About the programme

What happens during delivery?

How is it delivered?

- MDFT is delivered by a qualified MDFT therapist. The youth-focused component of MDFT is typically delivered over the course of 8-20 individual therapy sessions (approx 45-60 mins long). The parent-focused component of MDFT is typically delivered over the course of 4-10 sessions (approx 1-1.5 hours long). The family-focused component of MDFT is typically delivered over the course of 4-10 sessions (approx 1-1.5 hours long). In addition, there is a community-focused component which is delivered over 4-10 community sessions/meetings (approx 1-1.5 hours long).
- Families work with the therapist for a period typically lasting four to six months.

What happens during the intervention?

- MDFT intervenes in four connected areas: the adolescent, the parents, the family, and the community.
- Behavioural change is produced through a series of conversations between the therapist and youth in individual therapy sessions, between the therapist and parents in parent sessions, in family sessions where the therapist facilitates meaningful conversations among the family members who are presented, and in sessions between the family and social systems in their community.
- Homework is given to promote out of session changes, and phone calls to youth and parents are conducted to encourage change and problem solve through difficulties.
- Treatment is organised in three stages:
    - Stage 1, Build a foundation for change: Therapists create an environment in which the youth and parents feel respected and understood. Therapists meet alone with each to establish a collaborative foundation for the changes to be sought. Stage 1 goals are to develop strong therapeutic relationships, achieve a shared developmental and contextual perspective on their problems, enhance motivation for individual reflection and self-examination, and begin the change process.
    - Stage 2, Facilitate individual and family change: The focus of stage 2 is on behavioural and interactional change within youth and parents in their relationships. In the adolescent domain, MDFT focuses on improving youth self-awareness, self-worth and confidence; developing meaningful short-term and long-term goals; and improving emotional regulation, coping, problem-solving and communication skills. In the parent domain, the focus is on strengthening parental teamwork, improving parenting skills and practices, rebuilding parent-teen emotional bonds, and enhancing parent's individual functioning. In the family domain, MDFT works to improve family communication and problem-solving skills, strengthen emotional attachments and feelings of love and connection among family members, and improving everyday functioning of the family unit. In the community, the focus is on improving family members' relationships with social systems including school, court, legal workplace and neighbourhood and building capacity to access needed resources.
    - Stage 3, Solidify changes: The last few weeks of treatment strengthen the accomplishments achieved. The therapist amplifies changes and helps families create concrete plans for responding to future problems such as substance use relapse, family arguments, or any other kinds of setbacks or disappointments. Family members reflect on the changes made in treatment, acknowledge each other for the efforts they have made, see opportunities for a brighter future, and express hope for the next phase of their lives together.

What are the implementation requirements?

Who can deliver it?

- This programme is delivered by an MDFT Therapist with QCF-7/8 level qualifications.

What are the training requirements?

- Therapists have 65 hours of programme training. Booster training of practitioners is recommended.

How are the practitioners supervised?

- It is recommended that practitioners are supervised by on host-agency supervisor (qualified to QCF-7/8 level), with 15-20 hours of programme training.

What are the systems for maintaining fidelity?

Programme fidelity is maintained through the following processes:

- Training manual
- Other printed material
- Other online material
- Video or DVD training
- 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?

- Adolescent substance misuse, mental health and behavioural problems are multi-determined by processes occurring at the level of the child, parent, family and community. Specifically, adolescent problems are predicted by individual adolescent factors such as poor emotional regulation, parental factors such as individual functioning and inconsistent or ineffective parenting practices, disconnected or conflicted family relationships, and limited access to positive community supports and resources (eg peers, school, recreation), among others.
- The programme aims to improve adolescent self-awareness, life goal development, emotional and behavioural regulation, and communication skills; parental functioning (both individual and parenting team) and parenting practices; family emotional attachments and interactions, communication and problem solving skills; and family members' capacity to access and implement needed resources and positive community supports (eg school, work, pro-social peers, social services).
- In the short term, youth emotional and behavioural regulation and communication skills are improved; youth have more purpose, meaning and hope for their lives; parenting functioning and parenting practices are improved; and family relationships and bonds are stronger by having closer emotional attachments and improved everyday functioning and problem-solving in the family unit as a whole. Involvement in pro-social peer relationships and activities and collaboration and negotiation with community systems also increase.
- In the longer term, the youth does better in school (academically and behaviourally); has reduced substance misuse, delinquency and involvement in the criminal justice system; reduced out-of-home placements; and has improved mental health.

Intended outcomes

Supporting children's mental health and wellbeing Enhancing school achievement & employment Preventing crime, violence and antisocial behaviour Preventing substance abuse

Contact details

Gayle A. Dakof, Ph.d (Director)gdakof@mdft.org

http://www.mdft.org

About the evidence

MDFT's most rigorous evidence comes from three RCTs which were conducted in the USA, and across Belgium, Germany, France, the Netherlands and Switzerland.

This programme has evidence from three rigorously conducted RCTs, with at least one study demonstrating long-term impact, as well as demonstrating impact on assessment measures independent of study participants (not self-reports). Subsequently, the programme receives a level 4 rating overall.

Study 1

Citation: Liddle et al. (2008)

Design: RCT

Country: United States

Sample: 224 drug-using adolescents between the ages of 12 and 17.5 years old (mean = 15)

Timing: Between baseline and 12-months follow-up

Child outcomes:

- Reduced substance use problem severity
- Reduced other drug use
- Increased drug abstinence

Other outcomes:

- None measured

Study rating: 3

Liddle, H. A., Dakof, G. A., Turner, T. M., Henderson, C. E., Greenbaum, P. E. (2008). Treating adolescent drug abuse: a randomized trial comparing multidimensional family therapy and cognitive behavior Therapy. Addiction, 103, 1660-1670. doi: 10.1111/j.1360-0443.2008.02274.x

Available at

https://s3.amazonaws.com/academia.edu.documents/30631552/Liddle_et_al_%282008%29_Addiction.pdf?AWSAccessK

Study Design and Sample

The first study is a rigorously conducted RCT.
This study involved random assignment of children to an MDFT group and an individual cognitive behavioural therapy group.
This study was conducted in the USA with a sample of adolescents between the ages of 12 and 17.5 years old (mean = 15) who were using drugs.

Measures

Substance use problem severity was assessed using the Personal Experience Inventory PEI (adolescent self-report). 30-day frequency of cannabis use, alcohol use, other drugs, and 30-day abstinence was assessed using the Time-line Follow-back Method (adolescent self-report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes substance use problem severity, other drug use, and drug abstinence.

Study 2a

Citation:	Rigter et al. 2013
Design:	RCT
Country:	Belgium, France, Germany, Netherlands, Switzerland
Sample:	450 adolescents between ages of 13 and 18 years old, all with recently diagnosed cannabis use disorder
Timing:	Change from baseline to 9-months post-intervention

Child outcomes:

- Reduced cannabis dependence symptoms

Other outcomes:

- None measured

Study rating: 3

Rigter, H., Henderson, C. E., Pelc, I., Tossmann, P., Phan, O., Hendriks, V., Rowe, C. L. (2013). Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings. Drug and Alcohol Dependence, 130, 85-93. doi: 10.1016/j.drugalcdep.2012.10.013

Available athttp://www.sciencedirect.com/science/article/pii/S0376871612004139

Study Design and Sample

The second study is a rigorously conducted RCT.
This study involved random assignment of children to an MDFT group and an individual psychotherapy group.
This study was conducted across five western European countries (Belgium, Germany, France, Netherlands, Switzerland) with a sample of adolescents between ages of 13 and 18 years old, all with recently diagnosed cannabis use disorder.

Measures

Prevalence of cannabis use disorder was measured using the Adolescent Diagnostic Interview-Light (clinical interview).
90-day frequency of cannabis consumption was measured using the Time-line Follow-back Method (adolescent self-report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes cannabis dependence symptoms.

Study 2b

Citation: Schaub et al. 2014

Design: RCT

Country: Belgium, France, Germany, Netherlands, Switzerland

Sample: 450 adolescents between ages of 13 and 18 years old, all with recently diagnosed cannabis use disorder

Timing: Change from baseline to 9-months post-intervention

Child outcomes:

- Reduced externalising symptoms

Other outcomes:

- None measured

Study rating: 3

Schaub, M. M., Henderson, C. E., Pelc, I., Tossmann, P., Phan, O., Hendricks V., Rowe, C. L., & Rigter, H. (2014). Multidimensional family therapy decreases the rate of externalising behavioural disorders symptoms in cannabis abusing adolescents: outcomes of the INCANT trial. BMC Psychiatry, 14, 26. doi: 10.1186/1471-244X-14-26

Available athttps://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-26

Shaub et al. 2014 describes additional outcomes from study 2a described above. In this case:

- Internalising and externalising symptoms were measured using the Youth Self-Report (adolescent self-report).
- Internalising and externalising symptoms were also measured using the Child Behaviour Checklist (parent report).
- Family conflict and cohesion were assessed using the Family Conflict and Cohesion subscales of the Family Environment Scale (adolescent self-report).
- This study identified statistically significant positive impact on a number of child outcomes. This includes externalising symptoms (youth self-report).

Study 3

Citation: Dakof et al. (2015).

Design: RCT

Country: United States

Sample: 112 adolescents between the ages of 13 and 19 (mean = 16.1) diagnosed with substance abuse problems or dependency

Timing: Post-test to 18-month follow-up

Child outcomes:

- Reduced delinquency
- Reduced externalising symptoms
- Reduced felony arrests

Other outcomes:

- None measured

Study rating: 3

Dakof, G. A., Henderson, C. S., Rowe, C. L, Boustani, M., Greenbaum, P., Wang, W., Hawes, S., Linares, C., & Liddle, H. A. (2015). A randomized controlled trial of multidimensional family therapy in juvenile drug court. Journal of Family Psychology, 29, 232-241. doi: 10.1037/fam0000053

Available athttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC4917204/

Study Design and Sample

The third study is a rigorously conducted RCT.
This study involved random assignment of children to an MDFT group and an adolescent group therapy group.
This study was conducted in the USA with a sample of adolescents between the ages of 13 and 19 (mean = 16.1) diagnosed with substance abuse problems or dependency.

Measures

- Delinquent behaviours were measured using the National Youth Survey Self-Report Delinquency Scale (general delinquency and index offenses subscales) (adolescent self-report).
- Externalising symptoms were measured using the Youth Self-Report (externalising subscale) (adolescent self-report).
- Arrests were measured using administrative data from a justice system database maintained by the State of Florida.
- Psychological and behavioural depth of substance use involvement and related consequences was measured using the Personal Experience Inventory (Personal Involvement with Chemicals scale) (adolescent self-report).
- Substance abuse in the previous 90 days was measured using the Timeline Follow-Back Method (adolescent self-report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes delinquency (self-reported), externalising behaviour and felony arrests (in the post-test to 18-month follow-up period).

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.

Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. American Journal of Drug and Alcohol Abuse, 27 (4), 651-688 - **This reference refers to a randomised control trial, conducted in the USA.**

Schmidt, S E., Liddle, H. A., & Dakof, G. A. (1996). Changes in parenting practices and adolescent drug abuse during Multidimensional Family Therapy. Journal of Family Psychology, 10, 12 - 27. doi: 10.1037/0893 - 3200.10.1.12 - **This reference refers to a pre-post study, conducted in the USA.**

Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., & Henderson, C. E. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing multidimensional family therapy and peer group treatment. Journal of Psychoactive Drugs, 36, 49 - 63. doi: 10.1080/02791072.2004.10399723 - **This reference refers to a randomised control trial, conducted in the USA.**

Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. (2009). Multidimensional family therapy for young adolescent substance abuse: twelve-month outcomes of a randomized controlled trial. Journal of consulting and clinical psychology, 77(1), 12 - **This reference refers to a randomised control trial, conducted in the USA.**

Henderson, C. E., Rowe, C. L., Dakof, G. A., Hawes, S. W., Liddle, H. A. (2009). Parenting practices as mediators of treatment effects in an early-intervention trial of multidimensional family therapy. American Journal of Drug and Alcohol Abuse, 35, 220-226. doi: 10.1080/00952990903005890 - **This reference refers to a randomised control trial, conducted in the USA.**

Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., Funk, R. (2004). The Cannabis Youth Treatment (CYT) study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27, 197-213. doi: 10.1016/j.jsat.2003.09.005 - **This reference refers to a randomised control trial, conducted in the USA.**

Henderson, C. E., Dakof, G. A., Greenbaum, P. E., Liddle, H. A. (2010). Effectiveness of multidimensional family therapy with higher severity substance abusing adolescents: Report from two randomized controlled trials. Journal of Consulting and Clinical Psychology, 78, 885-897. doi: 10.1037/a0020620 - **This reference refers to a randomised control trial, conducted in the USA.**

Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2011). Implementation outcomes of multidimensional family therapy detention to community (DTC) A re-entry program for drug using juvenile detainees. International Journal of Offender Therapy and Comparative Criminology, 55, 587-604. doi: 10.1177/0306624X10366960 - **This reference refers to a quasi-experimental design, conducted in the USA.**

Rowe, C. L., Alberga, L., Dakof, G. A., Henderson, C. E., Ungaro, R., & Liddle, H. A. (2016). Family-based HIV and sexually transmitted infection risk reduction for drug-involved young offenders: 42-month outcomes. Family Process, 55 (2), 305- 320. doi: 10.1111/famp.12206 - **This reference refers to a randomised control trial, conducted in the USA.**

Marvel, F., Rowe, C. L., COLON?PEREZ, L. I. S. S. E. T. T. E., DiClemente, R. J., & Liddle, H. A. (2009). Multidimensional Family Therapy HIV/STD Risk?Reduction Intervention: An Integrative Family?Based Model for Drug?Involved Juvenile Offenders. Family process, 48(1), 69-84 - **This reference refers to a randomised control trial, conducted in the USA.**

Liddle, H. A., Rowe, C. L., Gonzalez, A., Henderson, C. E., Dakof, G. A., & Greenbaum, P.E. (2006). Changing provider practices, program environment and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. The American Journal of Addictions, 15, 102-112. doi: 10.1080/10550490601003698 - **This reference refers to a pre-post study, conducted in the USA.**

Greenbaum, P. E., Wang, W., Henderson, C. E., Kan, L., Hall, K., Dakof, G. A., & Liddle, H. A. (2015). Gender and ethnicity as moderators: Integrative data analysis of multidimensional family therapy randomized clinical trials. Journal of Family Psychology, 29(6), 919 - **This reference refers to a randomised control trial, 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.

www.EIF.org.uk | @TheEIFoundation

10 Salamanca Place, London SE1 7HB | +44 (0)20 3542 2481

Disclaimer

The EIF Guidebook is designed for the purposes of making available general information in relation to the matters discussed in the documents. Use of this document signifies acceptance of our legal disclaimers which set out the extent of our liability and which are incorporated herein by reference. To access our legal disclaimers regarding our website, documents and their contents, please visit eif.org.uk/terms-conditions/. You can request a copy of the legal disclaimers by emailing info@eif.org.uk or writing to us at Early Intervention Foundation, 10 Salamanca Place, London SE1 7HB.