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.
EIF Programme Assessment

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

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.
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, study 3
- Reduced delinquency - based on study 3
- Reduced felony arrests - based on study 3

### Preventing substance abuse

- Reduced substance use problem severity - based on study 1
- Reduced other drug use - based on study 1
- Increased drug abstinence - based on study 1
- Reduced cannabis dependence symptoms - based on study 2a
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
- 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.
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 an 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

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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 | Study rating: 3

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


Available at

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.

<table>
<thead>
<tr>
<th>Study 2a</th>
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<tbody>
<tr>
<td><strong>Citation:</strong> Rigter et al. 2013</td>
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<tr>
<td><strong>Country:</strong> Belgium, France, Germany, Netherlands and Switzerland</td>
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<td><strong>Sample:</strong> 450 adolescents between ages of 13 and 18 years old, all with recently diagnosed cannabis use disorder</td>
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<tr>
<td><strong>Timing:</strong> Change from baseline to 9-months post-intervention</td>
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<tr>
<td><strong>Child outcomes:</strong> Reduced cannabis dependence symptoms</td>
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<tr>
<td><strong>Other outcomes:</strong> None measured</td>
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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 and Switzerland | Study rating: 3

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

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 | **Study rating:** 3

**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


**Available at** [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4917204/](https://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.


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

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