Your selected document

Send email address for updates
your.email@address
SEND About update service

This entry is our account of a selected by Drug and Alcohol Findings as particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original was not published by Findings; click on the Title to obtain copies. Free reprints may also be available from the authors – click prepared e-mail to adapt the pre-prepared e-mail message or compose your own message. Links to source documents are in blue. Hover mouse over orange text for explanatory notes. The Summary is intended to convey the findings and views expressed in the . Below is a commentary from Drug and Alcohol Findings.

Title and link for copying Comment/query to editor Tweet 0

Multidimensional Family Therapy for young adolescent substance abuse: twelve-month outcomes of a randomized controlled trial.

Liddle H.A, Rowe C.L., Dakof G.A. et al.

Journal of Consulting and Clinical Psychology: 2009, 77(1), p. 12–25.

DOWNLOAD PDF for saving to your computer

Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Liddle at hliddle@med.miami.edu. You could also try this alternative source.

Holistic family therapy helped younger teens and their families get back on track before problems escalate, but was substance use really their focal problem?

Multidimensional Family Therapy addresses problem drug use and related problems among adolescents not through a set regimen, but by applying principles and a therapeutic framework to the individual young person situated within a particular set of environmental influences and constraints. It can be centre- or home-based or both, residential or non-residential, and can be delivered from one to three times a week over three to six months, depending on setting, problem severity, and family functioning. What distinguishes it from some other family therapies is that the intervention extends beyond the child and family to all the social systems (school, juvenile justice, etc) in which the child is involved, according to the particular vulnerabilities and strengths of the child and their family.

Research on such approaches has mainly targeted teenagers around 16 years of age. The featured study extended this down to 11–15-year-olds referred (mainly by juvenile justice or schools) for outpatient substance use treatment at a treatment agency in Miami, whose problems were not so severe as to require intensive or inpatient care, and who lived with a parent or parent-figure who could participate in their treatment. The 83 children were mainly boys from poor African-American or Hispanic families whose substance use problems fell short of dependence; nearly half were on probation or awaiting a court hearing.

With family consent they were randomly assigned to Multidimensional Family Therapy or group therapy based on cognitive-behavioural principles. The latter differed from the family therapy by treating groups of four to six youngsters together and working exclusively with them rather than directly with their families and social environments. Both treatments were manual-guided, conducted by trained and supervised therapists from the treatment agency twice a week for 12–16 weeks, and supplemented case management services. Family therapy was conducted mainly in the home, group therapy at the clinic, and the family option involved about half an hour a week more contact time, a difference adjusted for in the analyses.

Nearly all the family therapy children completed treatment as did three quarters in group therapy, unusually high. Outcomes were assessed during treatment, at discharge, and six and 12 months after treatment started. Trends across this period consistently favoured the family therapy children and tended to be sustained in the post-treatment period. Before treatment, 72% of children assigned to family therapy admitted substance use in the past month compared to 45% in group therapy. The number who abstained increased more rapidly in and after family therapy until 12 months later just 13% said they had used in the past month compared to 54% in group therapy. Among those who did use at some stage, frequency of use also declined faster among the family therapy children. These statistically significant differences were accompanied by a greater decline in children's accounts of the frequency with which they experienced substance-related problems, associated with delinquent peers, or committed delinquent acts, confirmed by court records showing that over the 12 months of the follow-up, fewer family therapy children were arrested (23% v. 44%) or placed on probation (10% v. 30%). Family therapy children also improved more in psychological health and reported greater and sustained improvements in the quality of family interactions. Finally, school records indicated that academic (but only slightly) and disciplinary grades improved in and after family therapy but declined in group therapy.

Another report on the same study concluded that better relations with parents gained during both treatments helped curb post-treatment substance use. What partly made the difference between them was that (to judge by the child's accounts) during treatment, family therapy parents started to monitor their children more closely. This seemed to account for more of their children becoming or remaining abstinent than after group therapy.

COMMENTARY This latest study extends a series often demonstrating greater positive impacts from Multidimensional Family Therapy than from alternative treatments for teenage substance use problems. Compared to other non-residential therapies for youth problem substance use, family-based therapies which (like the featured intervention) also intervene in the child's life beyond the family have been relatively rigorously tested against alternatives and emerged with a good record – presumably, and sometimes demonstrably, because they alter critical aspects of the environment within which the child's behaviour is generated, which on their own these children and families are relatively powerless to alter. A bonus is that these alterations can also lead to wider benefits (eg, delinquency, school record, psychological health) and also improve the prospects for other children in the family (1 2).

Multidimensional Family Therapy in particular has distinguished itself by the sustainability (and even the growth; for example, 1 2) of the gains made during treatment; typically the reverse is the case in

adolescent substance use treatment. A plausible explanation is that the therapy initiates a mutually reinforcing set of interactions between the child, their family and the wider environment.

Promising as it is, Multidimensional Family Therapy has not always outperformed well structured alternatives. In one US study, it was slightly (but not significantly) *less* effective at promoting recovery from substance use problems than two other therapies and substantially less cost-effective. Unlike most other studies of the therapy including the featured study, this study was led by an executive team which did not involve its developers; fully independent studies are an important test of whether an intervention's impacts can be maintained in routine practice. A partially independent test has been conducted in five European countries with some positive results for young cannabis users but in the Dutch arm of the study researchers concluded that individually-focused cognitive-behavioural therapy was overall just as effective as multidimensional family therapy. The issue of independence and some other methodological issues are detailed below.

Strengths of the study include random assignment, a very high follow-up rate, sophisticated analyses controlling for extraneous influences on outcomes, careful data collection from children and parents separately by researchers unaware which treatment they had been assigned to, and the use of the clinic's own therapists treating the usual run of normally referred cases. These last points are an important indication that the findings might translate from the research across to 'real-world' conditions. For example, an allied therapy was found far more effective when delivered by specially hired and closely supervised graduates than in less controlled conditions with usual staff. However, as the authors acknowledged, the study was conducted at a single clinic and among a very particular caseload of poor minority children selected not to have very severe substance use problems – hence its designation as an 'early intervention' trial intended to forestall rather than treat serious problems. Again as the authors acknowledged, the study was not fully independent but led by the researcher who developed the family intervention and who is based at a centre which sells related training and certification. Recently a similar US-based therapy did not sustain its performance in fully independent replication studies in other countries (1 2). Proportionately, almost twice as many family therapy (22 out of 40 or 55%) as group therapy (12 out of 43 or 28%) children claimed not to have used substances over the month before starting treatment, a difference in their starting points which weakens confidence that later differences were entirely due to the treatment which followed. No adjustment was made for the multiple outcomes tested in the study in order to reduce the possibility of chance findings, though the pattern of outcomes makes it highly likely that there was a true beneficial impact from the therapy. The treatment which family therapy outperformed, though typical of much youth drug treatment, was perhaps a weak comparator. Group therapy for adolescent drug users has a poor record compared to other structured approaches, possibly partly because grouping high-risk youngsters together tends to reinforce their delinquency. While this may not overwhelm a well constructed and skilfully implemented therapy, it may weaken its impacts when compared to therapies which do not involve such grouping. Compared to another non-group approach, Multidimensional Family Therapy has led to more persistent gains on some measures of substance use/problems (problem severity, overall minimal use levels, and use of drugs other than cannabis or alcohol) but not in drinking or cannabis use.

Such therapies require a high level of competence on the part of the therapist, who has to be able to exercise judgement and flexibility in working with highly stressed families and to intervene simultaneously in several aspects of the child's life. In turn this mandates a high level of support in the form of training, supervision and opportunities for sharing experiences with other therapists. Though the featured therapy is time-limited, any such therapy is resource-intensive. Perhaps the biggest practical issue raised by the study is whether such expenditure was warranted by the current substance use problems of the children and the risk that these might mushroom in to severe problems, when there are older/other children and families which *already* have severe problems. At intake, 47% of the participants met criteria for substance abuse but just 16% met criteria for substance dependence, leaving over a third without any such diagnosis. Most denied any substance use over the past month, and those who did use, did so on average just over once a week. Among 13–14-year-olds in their neighbourhoods, such behaviour may not have been exceptional. Their general trajectory of delinquency, trouble with criminal justice and other authorities, and poor educational progress within economically stressed (and usually single parent) families, may have been a more appropriate target for intervention by child and family social work teams. Importantly though, Multidimensional Family Therapy has the flexibility to address substance use indirectly if a head-on approach seems for the time being inadvisable or impossible, and the approach it takes has relevance for troubled teens in general, whether or not substance use is a prominent feature.

Recent child drug treatment caseloads are such that many British health areas could justify the kind of service investigated in the study. Family therapy providers and services for children with multiple needs would be the most appropriate locations. Multidimensional family therapists engage systems which should already have been engaged by a coordinated multidisciplinary team, so the approach may have particular relevance where such coordination is imperfect and where a single person orchestrating the various systems may have more success. There seems considerable scope for developing this work. Though commending family work, an audit by the English National Treatment Agency for Substance Misuse found that family therapy is very much a minority response to youth drug and alcohol problems. In Britain, Glasgow has been piloting the feasibility, acceptability and effectiveness of Multidimensional Family Therapy training in changing clinician practices and clinical outcomes in young people's alcohol and drug services.

For more on Multidimensional Family Therapy see the approach's web site, the therapy's entry in the US government's directory of evidence-based therapies, or download the manual used in one of the US studies. For more on family therapy in general see this US expert consensus document.

Thanks for their comments on this entry to Howard Liddle of the University of Miami. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 14 May 2015. First uploaded 21 December 2009

Comment/query to editor
Give us your feedback on the site (two-minute survey)
Open Effectiveness Bank home page
Add your name to the mailing list to be alerted to new studies and other site updates

Top 10 most closely related documents on this site. For more try a subject or free text search

STUDY 2009 Therapist behavior as a predictor of black and white caregiver responsiveness in multisystemic therapy

STUDY 2011 Treatment of adolescents with a cannabis use disorder: Main findings of a randomized controlled trial comparing multidimensional family therapy and cognitive behavioral therapy in The Netherlands

STUDY 2013 Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings

REVIEW 2014 Interventions to reduce substance misuse among vulnerable young people

STUDY 2011 Using a cross-study design to assess the efficacy of motivational enhancement therapy-cognitive behavioral

therapy 5 (MET/CBT5) in treating adolescents with cannabis-related disorders

REVIEW 2011 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

STUDY 2012 Using pay for performance to improve treatment implementation for adolescent substance use disorders

STUDY 2011 Evaluation of the Addressing Substance-Related Offending (ASRO) program for substance-using offenders in the community: a reconviction analysis

STUDY 2012 The effectiveness of Prisoners Addressing Substance Related Offending (P-ASRO) programme: evaluating the pre and post treatment psychometric outcomes in an adult male category C prison

ABSTRACT 2010 Drug Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life