NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

Comparative Effectiveness Research Series

Multidimensional Family Therapy

An Informational Resource

2012

This document about Multidimensional Family Therapy (MDFT) is part of a series on evidence-based practices evaluated in comparative effectiveness research (CER) studies. The document is designed to inform practitioners and other decisionmakers considering the adoption of evidence-based practices in their organization. General information about MDFT and results of studies assessing MDFT efficacy are included, along with details related to training and costs for implementation in community health care settings. The decision to adopt and implement evidence-based practices is guided by many factors that may not be covered here. The authors of this document hope the information can assist in making an informed decision on the adoption and implementation of this treatment model.

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Multidimensional Family Therapy

MDFT intervenes with key persons in the youth's environment, such as parents and caregivers, other family members, peers, and social agencies or systems.

Multidimensional Family Therapy (MDFT) is a comprehensive, family-centered treatment program for adolescents and young adults with drug abuse and related behavioral and emotional problems. MDFT was developed by Dr. Howard Liddle, a psychologist, family therapist, and researcher in adolescent substance abuse. Developmentally and ecologically oriented, the approach enhances youth and parent competencies to meet individual and family developmental milestones. Interventions target known risk and promotive factors and processes in adolescents and parents, in the family, and in the family's interactions with key systems such as school and juvenile justice. MDFT has been evaluated and implemented with youths and families in the United States and abroad from diverse ethnic, racial, and socioeconomic backgrounds. Studies have found MDFT effective as an outpatient alternative to residential substance abuse treatment, as a community-based program for youths with co-occurring substance abuse and mental health disorders or other problem behaviors such as conduct disorder and delinquency, and as a prevention intervention for at-risk adolescents.

The Practice

MDFT considers adolescent drug use to be a problem of development. The therapist spends time understanding the youth, his or her family, and the community to gain an understanding of the youth's network and influencing factors and to develop a treatment plan. Interventions enhance individual and family skills and relationships, as well as the youth's and family's social interactions. MDFT includes both home-based and clinic-based services delivered by trained clinicians.

There are eight dimensions of the multidimensional approach:

Outcome orientation. This guides the therapeutic goals of every interaction between the client and the therapist, or the therapist and the parents. A practical outcome orientation helps the therapist focus on short-, intermediate-, and long-term goals and the means of achieving them.

Process. This refers to the way outcomes are facilitated by the therapist. MDFT offers a logic model that connects developmental theory; basic research on youth and family functioning; and individual, interpersonal, and family processes known to combat risk, solve problems, and promote healing and adaptive development.

Development. This dimension involves understanding and using knowledge about normative development and needed changes in the parent-youth relationship. Developmental content informs and guides the therapist's strategies.

Problem behaviors. Developmental psychopathology—how problems arise and how development goes off course—in the youth or caregivers guides enhancement of individual and family protective factors and the effective reduction of risk factors.

Ecology. Treatment includes considering the youth's social environments outside his or her home so that assessment and interventions go beyond the youth and the family. Youth and family interactions with school, community and neighborhood, and juvenile justice systems are enhanced in MDFT.

Psychotherapy. The early development of MDFT includes influence by client-centered, behavioral, experiential, and humanistic approaches, including drug abuse counseling.

- MDFT is both a tailored and flexible treatment delivery system depending on the needs of the youth and family.
- Sessions can be conducted over the course of 3–6 months in the home, clinic, court, school, or other community locations.
- Session length is generally between 60 and 90 minutes, providing up to 180 minutes per week of face-to-face therapy.

Family therapy. MDFT roots run deep in the systems and family therapy orientations of structural and strategic therapy.

Treatment parameters. Parameters specify the format, organization, and delivery of MDFT. For example, MDFT can be offered as an in-home or clinic-based approach, or as a combination of the two, depending on case and clinic specifics.

Core Components and Understanding the MDFT Approach

Therapists integrate competence-enhancing and problem-solving interventions across *four* interdependent treatment domains: the adolescent, parent, family, and community. Throughout treatment, therapists meet alone with the adolescent, alone with the parent(s), jointly with the adolescent and parent(s), and with representatives of social systems important to youth development (e.g., schools, courts, recreation), depending on the treatment domain and the problem being addressed.

Each treatment domain is addressed in three stages:

Stage 1: Building a Foundation for Change. Assessment in MDFT occurs in a way in which both the youth and parents feel understood, respected, and esteemed. In this stage, the themes, focal areas, and goals of therapy are established, and the therapist works closely with youth and parents to craft therapeutic content that is personally meaningful to each. Primary goals are developing strong therapeutic alliances, achieving a shared perspective on the presenting problems, and enhancing motivation for self-examination, program participation, and change.

Stage 2: Facilitating Individual and Family Change. Significant change strategies are made during this stage. The therapist offers new communication and problem-solving skills to the youth, addresses peer relationships, and establishes alternatives to substance abuse, truancy, and delinquency. Parents enhance family management and parenting skills and communicate more effectively with their teen to address drug use and antisocial lifestyles. Youth and parents together are taught how to decrease family conflict, deepen emotional attachments, improve family communication and problem-solving skills, and enhance their effectiveness in interactions with school, juvenile justice, recreation, and other important community systems. Individual functioning of the youth and the parent(s) is also enhanced during this stage. For the parents, the focus includes functioning outside of their family or parent role, and for the youth, it includes exploration of self development and enhancement of coping, emotion regulation, communication, and decisionmaking skills.

Stage 3: Solidify Changes and Launch. This stage addresses how the platform created in MDFT can be sustained and used by the teen and family to cope with everyday life events and challenges. The sessions focus on how to sustain treatment gains by creating concrete plans for responding to future problems. This reinforces strengths and competencies necessary for a successful graduation from the program. The family is supported to continue its own work and make progress.

MDFT intervention domains include interventions with the adolescent, interventions with the parent, interventions to change the parent-adolescent interaction, and interventions with systems external to the family. The goals for the domains are summarized in Table 1.

Table 1. Goals Within the MDFT Domains[1]

Adolescent Domain	Parent Domain	Family Domain	Community Domain
Reduce drug use and behavior problems	Enhance parent's emotional commitment to youth	Create positive changes in family relational patterns	Improve family members' functional relationships with influential social systems (e.g., school, court, legal system, and work place)
Address personal development topics	Improve parenting skills (i.e., monitoring, limit setting, expectations)	Strengthen emotional attachments and feelings of love and connection among family members	Build family members' capacity to assess and actualize resources for stress reduction or daily life needs
Promote involvement in prosocial activities	Strengthen parental teamwork	Improve family communication and problem-solving skills	
Develop personally meaningful short-term and long-term life goals	Assist parents to know about the youth's life outside the family	Improve everyday functioning of the family unit	
Promote success in school or work	Enhance parent's individual psychological functioning		

What the Evidence Tells Us About MDFT's Effectiveness

Comparative Effectiveness Research and Systematic Reviews

MDFT is recognized as an evidence-based practice because it has been scientifically evaluated and demonstrates significant positive outcomes in the treatment of adolescent substance abuse and related problems. Several entities such as the National Institute on Drug Abuse, the Center for Substance Abuse Treatment, the National Registry of Evidence-based Programs and Practices, the Office of Juvenile Justice and Delinquency Prevention and the Center for Substance Abuse Prevention's Strengthening America's Families initiative, and Drug Strategies have recognized MDFT as an effective treatment model for adolescent substance abuse.[3–9] In Europe, the health ministries of France, Germany, Switzerland, Belgium, and The Netherlands have funded MDFT research and the establishment of MDFT clinical teams.[10,11]

The Agency for Healthcare Research and Quality defines CER as a way to develop, expand, and use a variety of data sources and methods to conduct research and disseminate results in a form that is quickly usable by clinicians, clients, policymakers, and health plans and other payers.[2]

MDFT's effectiveness has been evaluated in outcome studies, therapy process and implementation studies, systematic reviews, and comparative effectiveness research (CER). CER studies compare the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor community health and the nation's health care system. MDFT has been evaluated in CER studies comparing its effectiveness to well established and commonly used treatment approaches for adolescent substance use, such as cognitive behavioral therapy, adolescent group therapy, multifamily education, and residential treatment.[12–19] Systematic reviews[20–27] comparing the effectiveness of adolescent drug use interventions across studies found that MDFT—

- Reduces substance use
- Reduces delinquency
- Reduces behavior problems
- Reduces symptoms of anxiety and depression
- Improves educational performance

MDFT Adaptations for Implementation in Real-World Settings

MDFT has been primarily evaluated in outpatient substance abuse treatment settings. However, implementation is carried out in a variety of programs, including State and local behavioral health, juvenile justice, mental health, substance

MDFT has been successfully implemented and sustained in public and private settings throughout the United States, Canada, and Europe.

abuse, child welfare agencies, and juvenile drug court. MDFT is delivered in residential treatment settings, home-based counseling agencies, and child research centers by community-based substance abuse and mental health providers.

Organizational Readiness To Adopt MDFT

MDFT implementers have found that agencies that embrace a culture that strives for excellence and has a commitment to accountability are especially likely to establish and sustain strong MDFT programs. There are several factors for an organization to consider when deciding whether to adopt a new practice. The Institute of Behavioral Research at Texas Christian University has identified five broad categories of organizational readiness for change based on extensive research findings related to technology transfer and the adoption of evidence-based practices.[28] These include—

- Motivational readiness: program needs, training needs, pressures for change
- Institutional resources: offices, staffing, training, equipment
- Staff attributes: growth, efficacy, influence, adaptability, orientation
- Organizational climate: clarity of mission and goals, cohesion, autonomy, openness to communication, stress, openness to change
- Costs: cost of materials, training, supervision, loss of billable hours associated with training and supervision, reimbursement practices

Dissemination and Implementation Resources

Those interested in MDFT can readily access resources on the MDFT International Web site, http://www.mdft.org. Users can obtain the history of the practice, a detailed explanation of MDFT, treatment objectives, case studies, training information, success stories, patient and agency requirements, practice techniques, and clinical and research literature. The MDFT YouTube channel, http://www.youtube.com/user/CTRADA, includes videos of trainers, supervisors, clinicians, family members, State and local administrators, and community advocates discussing personal experiences with the program.

Implementation Materials

The Multidimensional Family Therapy for Adolescent Drug Abuse: Clinician's Manual[29] focuses on the core ideas and clinical methods specific to MDFT and provides a brief synopsis of the latest research findings on teen substance use disorders and adolescent development. The manual provides an overview of youth substance abuse and an exploration of the importance of family in helping teens overcome drug use and related problems. The manual describes in detail and in practical terms the

clinical practice of MDFT and the challenges of adolescents involved in the juvenile justice system with regard to substance abuse treatment. The manual is provided to agencies as part of the MDFT training program. Supplemental texts, DVDs, and other resources can be downloaded from the MDFT International Web site.

Supplemental texts include—

Liddle, H. A. (2008). *Multidimensional family therapy.* DVD. Washington, DC: American Psychological Association.

Liddle, H. A., (2010). Treating adolescent substance abuse using Multidimensional Family Therapy. In J. Weisz & A. Kazdin (Eds.). *Evidence-based psychotherapies for children and adolescents* (Second Edition). New York, New York: Guilford Press.

Training Resources for Providers

The MDFT clinical system includes three levels of staff: therapist, supervisor, and trainer. Certification requirements at one level must be met before promotion to the next, so regardless of previous experience, every individual begins MDFT training as a therapist. Graduation to the next level is based on objectively assessed and observed clinical competence and certification as designated by MDFT International. Four or more trainees are required to begin implementation and training. Of the four, an agency supervisor or team leader must be identified who will ultimately be trained as an MDFT supervisor.

Most therapists using the MDFT approach have a master's degree in counseling and an average of 2 years of experience. Ideally, the person who trains and/or supervises MDFT implementation should have a background in family therapy and/or child-adolescent development. MDFT therapists learn an overarching developmental-contextual conceptual framework that guides their appraisal and responses to diverse and challenging clinical situations. All aspects of MDFT training can be provided in English, Spanish, or French

MDFT Therapist: Training as a therapist progresses over a 6—8 month period:

- Onsite trainings (typically three)
- Weekly case consultation phone calls
- DVD/videotape supervisions and live supervision at site visits
- Written examinations
- Work samples

Once certified, an MDFT therapist must be recertified yearly.

MDFT Supervisor: Only certified MDFT therapists are eligible to be MDFT supervisors. They must complete an intensive training program over 4 to 5 months that includes—

- Onsite training
- A written examination
- Review of two to four DVD recordings of supervision work samples
- Monthly consultation phone calls

Once certified, an MDFT supervisor must be recertified yearly.

MDFT Trainer: To be certified as a trainer, one must first become certified as an MDFT therapist and supervisor. Trainer training is only provided by MDFT International to individuals who have reached the highest level of MDFT therapy and supervision skills. Trainers are able to train new clinicians in their agency in the MDFT model, facilitating the sustainability and expansion of their MDFT program. The trainer training program includes the following:

- Shadowing certified training coaches and cofacilitating in training sessions
- Leading a team of trainees and submitting progress notes, recordings, and weekly case consultations by the trainer candidate to the coach (certified trainer)
- Reaching mastery of all MDFT training components: introductory, comments on weekly meetings, comments on written examinations, case review consultation, DVD review consultation, and live supervision consultation

Quality Assurance Tools

Fidelity to the MDFT model is integral to the success of the program. Resources are provided to every site to help monitor program fidelity, including a Web-based clinician portal that offers feedback on therapist and supervisor activity, rating sheets that help evaluate recorded clinical sessions, and ratings on clinical outcomes at the case level. Feedback and site evaluation forms for monitoring implementation at the site level are also provided. Quality assurance tools are provided by the MDFT training program.

Resources for Agency Directors

MDFT tools are available to assist agency directors to identify the ideal qualities and competencies of MDFT therapists. The tools are brief questionnaires and vignettes designed to assess case conceptualization and the potential to be an effective MDFT therapist:

- Therapist Intervention Inventory
- Therapist Self-Assessment
- Case Vignettes

In consideration of the complexity of working with families and the multiple problems faced by the adolescent client, the MDFT model provides support to clinicians to help prevent staff burnout and turnover and increase job satisfaction. A tip sheet for agency directors, supervisors, and clinical staff helps ensure the sustainability of the MDFT program at a new site.

Recommendations to implement and sustain the MDFT model successfully include—

- At a minimum, four clinicians with master's degrees in social work, marriage and family therapy, counseling, or other related clinical field
- Willingness and ability to conduct sessions in the home, clinic, and school
- Flexible schedule to accommodate the needs of the clients and their families
- Capacity to record therapy (DVD) sessions in the home and clinic for ongoing MDFT supervision and adherence monitoring
- Capacity to conduct onsite live supervision by recording and viewing client sessions in real time
- Access to drug testing to address drug use directly in sessions with teens and families
- Mobile phones for each team member to facilitate communication with the site, the client and his/her family, and community agencies
- Travel reimbursement for clinical staff for mileage to and from homes and other sites for service delivery

Costs

The costs associated with MDFT appear in Table 2.

Table 2. Costs Associated With MDFT[1]

Description	Cost (USD)
Year 1. Therapist certification training: Therapist certification (includes all implementation materials, case consultations, DVD review, live supervision, ratings of recorded sessions, adherence monitoring)	$6,000 per trainee
Year 1. Supervisor certification training, supervisor certification (includes all implementation materials, case consultation, DVD review, live supervision, ratings of recorded sessions, adherence monitoring)	$3,000 per trainee
Therapist and supervisor recertification training: Annual recertification activities for therapists, supervisors, and agencies, including one onsite booster session, quarterly consultation calls with supervisors, review of DVD recorded therapy and supervision sessions, and access to the MDFT implementation database	$2,000 per clinician (therapists and supervisors)
Therapist assistant training	Free
Pretraining implementation consultation	Free

References Cited

[1] Personal communication with the developer

[2] Agency for Healthcare Research and Quality. (n.d.) *What is comparative effectiveness research?* Retrieved from http://www.effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/

[3] Drug Strategies (2003), *"Treating Teens: A Guide to Adolescent Drug Programs"* http://www.drugstrategies.com/teens.html.

[4] Drug Strategies (2006), *"Bridging the Gap: A Guide to Treatment in the Juvenile Justice System."*

[5] *California Evidence Based Clearinghouse for Child Welfare* (CEBC) http://www.cebc4cw.org/program/multidimensional-family-therapy/

[6] Evidence-based Mental Health Treatment for Children and Adolescents, Association for Behavioral and Cognitive Therapies and the Society of Clinical Child and Adolescent Psychology (Division 53), American Psychological Association. http://effectivechildtherapy.com/content/specific-manualized-ebts#13

[7] National Institute on Drug Abuse, *"Principles of Drug Addiction Treatment: A Research Based Guide,"* (the NIDA "Blue Book " on effective treatments) http://www.drugabuse.gov/publications/principles-drug-addiction-treatment

[8] U.S. Department of Justice, Office of Justice Programs' CrimeSolutions.gov http://www.crimesolutions.gov/ProgramDetails.aspx?ID=267

[9] *Substance Abuse Mental Health and Services Administration (SAMHSA) National Registry of Evidence Based Programs and Practices (NREPP).* http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=16

[10] Rigter, H., Pelc, I., Tossman, P., Phan, O., Grichting, E., Hendriks, V., & Rowe, C. (2010). INCANT: A transnational randomized trial of Multidimensional Family versus treatment as usual for adolescents with cannabis use disorder. *BMC Psychiatry, 10(28).*

[11] Rigter, H, C Henderson, I Pelc, P Tossmann, O Phan, V Hendriks, M Schaub, and CL Rowe. (2012). Multidimensional Family Therapy lowers the rate of cannabis dependence in adolescents: A randomized controlled trial in Western European outpatient settings. *Drug and Alcohol Dependence. 2012 Nov 7. doi:pii: S0376-8716(12)00413-10.1016/j.drugalcdep.2012.10.013. [Epub ahead of print]*

[12] Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent substance abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse, 27*(4)*,* 651–688.

[13] Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R., & Henderson, C. E. 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*.* 2004.

[14] Liddle, H. A., Dakof, G. A., Turner, R. 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

[15] Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. Early intervention for adolescent substance abuse: 12-month treatment outcomes of family-based versus group treatment. *Journal of Consulting and Clinical Psychology, 77,* 12–25*.* 2009.

[16] Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, … Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*, 197–213.

[17] Hogue, A., Liddle, H. A., Becker, D., & Johnon-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology*, *30*, 1–22.

[18] Hogue, A., & Liddle, H. A. (2009). Family-based treatment for adolescent substance abuse: Controlled trials and new horizons in services research. *Journal of Family Therapy, 31*, 126–54.

[19] Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2010). Implementation outcomes of multidimensional family therapy-detention to community: A reintegration program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology, 55*, 587–604.

[20] Rowe, C. L. (2010). Multidimensional family therapy: Addressing co-occurring substance abuse and other problems among adolescents with comprehensive family-based treatment. *Child and Adolescent Psychiatric Clinics of North America*, *19*(3), 563–576.

[21] Austin, A. M., Macgowan, M. J., & Wagner, E. F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice, 15*(2), 67–83.

[22] Becker, S.J., Curry, J.F. (2008). Outpatient interventions for adolescent substance abuse: A quality of evidence review, *Journal of Consulting and Clinical Psychology*,76(4), 531–543.

[23] Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. (2004). The quality of highly regarded adolescent substance abuse treatment programs: Results of an in-depth national survey. *Archives of Pediatrics and Adolescent Medicine*, 158, 904– 909.

[24] Hawkins, E.H. (2009). A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology*, 60, 197–227.

[25] Sherman, C. (2010). Multidimensional Family Therapy for adolescent drug abuse offers broad, lasting benefits: An approach that integrates individual, family, and community interventions outperformed other treatments. NIDA Notes, 23 (3), 13 – 15.Vaughn, M. G., & Howard, M. O. (2004) Adolescent substance abuse treatment: A synthesis of controlled evaluations. *Research on Social Work Practice, 14*, 325–335.

[26] Perepletchikova, F., Krystal, J. H., & Kaufman, J. (2008). Practitioner review: adolescent alcohol use disorders: assessment and treatment issues. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, 49(11), 1131–1154.

[27] Waldron, H.B., & Turner, C.W. (2008) Evidence-Based Psychosocial Treatments for Adolescent Substance Abuse. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 238–261.

[28] Institute of Behavioral Research at Texas Christian University. Available at http://www.ibr.tcu.edu/evidence/evi-orc.html

[29] Liddle, H. A. (2009). *Multidimensional family therapy for adolescent drug abuse: Clinician's manual* and DVD. Center City, MN: Hazelden Publishing Co.

Glossary

Adaptation: A modest to significant modification of an intervention to meet the needs of different people, situations, or settings.

CER (comparative effectiveness research): The Federal Coordinating Council on Comparative Effectiveness Research defines CER, in part, as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies (e.g., medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, delivery system strategies) to prevent, diagnose, treat, and monitor health conditions in real-world settings.

Comparison group: A group of individuals that serves as the basis for comparison when assessing the effects of an intervention on a treatment group. A comparison group typically receives some treatment other than what they would normally receive and is therefore distinguished from a control group, which often receives no treatment or "usual" treatment. To make the comparison valid, the composition and characteristics of the comparison group should resemble the treatment group as closely as possible. Some studies use a control group in addition to a comparison group.

Core components: The most essential and indispensable components of an intervention (core intervention components) or the most essential and indispensable components of an implementation program (core implementation components).

Dissemination: The targeted distribution of program information and materials to a specific audience. The intent is to spread knowledge about the program and encourage its use.

Enactment: Enactment refers to theoretical principles about the change process (including prompting or shaping of new behaviors) and active therapeutic methods to prompt change (actions to foster new kinds of dialog about important topics). Enactment is used throughout MDFT but particularly in the second stage.

Evidence-based practices: Programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the persons receiving the services.

Family Therapy: Structural Therapy and Strategic Family Therapy (SFT) were among the earliest influences on the MDFT approach, which was first called Structural-Strategic Family Therapy. The influences of SFT can be observed in MDFT's adoption of the enactment principles of change and intervention. Problem Solving Therapy, which emphasizes crafting a strategy for treatment, thinking in stages of therapy and of change, and focusing on out-of-session tasks as a complement to in-session change enactments, has also been a major influence on the MDFT approach.

Implementation: The use of a prevention or treatment intervention in a specific community-based or clinical practice setting with a particular target audience.

Intervention: A strategy or approach intended to prevent an undesirable outcome (preventive intervention), promote a desirable outcome (promotion intervention), or alter the course of an existing condition (treatment intervention).

Multidimensional Family Therapy (MDFT): MDFT includes four intervention domains: (1) adolescent, (2) parent, (3) family interaction, and (4) community. MDFT is a manualized intervention that helps the adolescent develop more effective coping and problem-solving skills for better decisionmaking and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems.

Additional Resources

MDFT Channel, YouTube. Available at http://www.youtube.com/user/CTRADA