

Adapting and Implementing an Evidence-Based Treatment with Justice-Involved Adolescents: The Example of Multidimensional Family Therapy

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For over four decades family therapy research and family centered evidence-based therapies for justice-involved youths have played influential roles in changing policies and services for these young people and their families. But research always reveals challenges as well as advances. To be sure, demonstration that an evidence-based therapy yields better outcomes than comparison treatments or services as usual is an accomplishment. But the extraordinary complexity embedded in that assertion feels tiny relative to what we are now learning about the so-called transfer of evidence-based treatments to real world practice settings. Today's family therapy studies continue to assess outcome with diverse samples and presenting problems, but research and funding priorities also include studying particular treatments in nonresearch settings. Does an evidence-based intervention work as well in a community clinic, with clinic personnel? How much of a treatment has to change to be accepted and implemented in a community clinic? Perhaps it is the setting and existing procedures that have to change? And, in those cases, do accommodations to the context compromise outcomes? Thankfully, technology transfer notions gave way to more systemic, dynamic, and frankly, more family therapy-like conceptions of the needed process. Implementation science became the more sensible, as well as the theoretically and empirically stronger overarching framework within which the evidence-based family based therapies now operate. Using the example of Multidimensional Family Therapy, this article discusses treatment development, refinement, and implementation of that adapted approach in a particular clinical context—a sector of the juvenile justice system—juvenile detention.

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The author is the developer of Multidimensional Family Therapy (MDFT), and Chairman of the Board of Directors of MDFT International, a 501(c) (3) public charity dedicated to the implementation of MDFT.

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I doubt that there is an influence on the development of antisocial behavior among young people that is stronger than that of the family. (Steinberg, 2000)

It is terrific when long-term collaborations are satisfying, productive, and mutually beneficial. Each of these outcomes has been achieved in the nexus of family therapy and the specialties of substance abuse and antisocial behaviors (Stanton, 1979; Tolan, Cromwell, & Brasswell, 1986). Prescient, early family therapy's most influential projects (MacGregor, 1962; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Stanton & Todd, 1982) addressed today's mandates—studies of well-defined, theory-driven, clinically feasible treatments that address common, complex, and pressing public health problems in public sector settings (Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012). Offering treatment blueprints, promising outcomes, and no small dose of inspiration, the first wave of family therapy research built a foundation that extended to four decades of systematic treatment development. Over those years, family centered treatments for youth drug taking and delinquent behaviors joined the evidence-based practice movement through programmatic clinical trials (e.g., Henggeler & Sheidow, 2012; Rowe, 2012; von Sydow, Retzlaff, Behr, Haun, & Schweitzer, 2013). Individual approaches and the overall body of empirical work gradually influenced service systems and policy recommendations. But even with clinical innovation and basic science knowledge interacting in these studies, favorable empirical data on family based treatment outcomes, high profile reports on system of care reform, and a growing youth and family advocacy movement, change in practice is slow (National Research Council, 2013).

Though deemed unacceptable in terms of an ultimate outcome, the rate of change has been normalized by some as the nature of therapy and system reform clarifies. The implementation science specialty brings an empirical and dynamic systemic framework to evidence-based therapy development and dissemination (Craig et al., 2008). An implementation focus relates to treatment development as process research does to outcome studies. Process research is a necessary tool; it can illuminate therapy dimensions not visible via other designs. Implementation inquiry does the same thing—it reveals how and why an intervention program fits or fails in nonresearch settings (Fixsen, Blase, Naoom, & Wallace, 2009).

Today's evidence-based treatment development contextualizes adaptation, refinement, and evaluation. For example, there is strong attention to study details, study quality per se (e.g., Becker & Curry, 2008; Sprenkle, 2012), as well as conflicting interpretations of findings from a single study or, usually via meta-analysis, from a set of studies (Kazdin, 2013). Controversies exist about program effectiveness (Drug and Alcohol Findings, 2014; Henggeler, Schoenwald, Borduin, & Swenson, 2006; Littell, 2006, 2008; Littell, Popa, & Burnee, 2005; Ogden & Hagen, 2006; The Campbell Collaboration, 2013), approach evaluations (discussed in Lindstrøm et al., 2013; Gambrill & Littell, 2010; and van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014), transporting family based interventions across cultures (Burkhart, 2013), trademarking and brand naming of established therapies (Bean, 2012; Eisler, 2007; Imber Black, 2014), and the unavailability of evidence-based therapy training for most practitioners (Barth et al., 2011; Hogue, Henderson, Ozechowski, & Robbins, 2014). And, these discussions inform suggestions about needed work. With this backdrop of contextual currents, there can be no doubt that the systematic adaptation of an evidence-based treatment to a new setting is complicated. And, whether the treatment refinement and adoption concerns culture, family, or context, the field today seeks effective treatments that advance adaptation through systematic and empirical means without outcome compromises.

This article uses the example of MDFT to describe implementation keys and treatment development of an evidence-based treatment within a particular facet of criminal justice—juvenile detention. First, to set the stage in orientation (Weisz & Hawley, 2002) and illustrative content (Holmbeck, Devine, & Bruno, 2010), we review briefly fundamental and clinically informative aspects of the existing knowledge base on justice-involved youth, juvenile detention, and existing services.

CLINICALLY USEFUL, RESEARCH-DERIVED KNOWLEDGE ABOUT JUSTICE-INVOLVED ADOLESCENTS

Overview

In comparison with community samples, justice-involved youths show drastically higher rates of overall health problems, mental health impairment, and psychiatric disorders. These adolescents report heightened sexual activity, drug and alcohol use, problematic behaviors at school (aggressiveness, disobedience) and poorer academic performance, interpersonal problem-solving skills and less family involvement. In clinical samples, comorbidity is normative. For instance, the link between juvenile criminal offending and teen substance use is well documented—the estimated prevalence of substance abuse disorder and juvenile offending approaches 67% across studies in justice settings. Further, in a large study of juvenile detention center youths, nearly three quarters of girls and two thirds of boys have one or more psychiatric disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). These rates are almost four times that of the general adolescent population.

High-Risk Sexual Behaviors—HIV and STD Risk

Young people have the highest rates of HIV/AIDS onset and are more likely than adults to engage in high-risk behaviors such as unprotected sex with multiple partners and poor health care practices. Substance abuse, delinquency, and high-risk sexual behavior begin in adolescence, problems in one area predict problems in others, and an accumulation of risk and problem behaviors often yields a compounding deleterious effect on later developmental outcomes. Problem behaviors affect each other. For instance, the presence of substance abuse and behavior problems elevates the likelihood of early and risky sexual behaviors due to increased impulsivity and impaired judgment.

Although HIV seropositivity is infrequent among detained youths, studies of adult detainees suggest that detained adolescents are at great risk for developing HIV as they age. These teens are an extremely high-risk group for acquiring HIV and STDs due to early age at first intercourse, infrequent use of condoms, more permissive attitudes about sex, and low self-efficacy to practice safe sex. In fact, incarcerated adolescents are the largest concentration of youths infected with or at high risk for HIV and STDs due to drug use and unsafe sexual behaviors (Teplin et al., 2005).

Victimization and Trauma

Nearly all youth who enter detention facilities have experienced victimization and trauma. In one urban sample, 92% of juvenile detention adolescents had experienced one or more traumas (e.g., witnessed violence, threatened with weapons), 84% had experienced more than one trauma, and 56.8% were exposed to trauma six or more times (Abram, Teplin, McClelland, & Dulcan, 2003).

Trauma may predispose youth to develop delinquent behavior. Interacting with the vulnerabilities that youth carry with them into custody, life within the institution presents

additional risks. Confinement often exacerbates symptoms of mental disorders, including PTSD. In describing their incarceration experiences, youth emphasize their felt vulnerability to violence, the need to defend their strength or status, and hopelessness about their ability to redirect their life course (Abrams, 2011).

Developmental Outcomes Over Time

The personal costs of these problems are daunting. In addition to their illegality, and placing adolescents at a greatly increased chance of rearrest and continued involvement with crime committing peers, substance abuse has negative consequences for their immediate and long-term physical health and development. Youth with heavy substance abuse have markedly compromised educational, occupational, relationship, financial, and psychological outcomes.

Longitudinal studies suggest that justice-involved adolescents continue to have substantial impairment in their day-to-day functioning as they age. Approximately two thirds of these teens recidivate within 4.5 years of release from detention. One study found that fewer than half had been working or had been in school 6 months after release from detention (Benda, Corwyn, & Toombs, 2001). Up to half of young adults reported frequently using illicit drugs within 4.5 years of release from detention and 34–60% reported frequent drinking or abuse of alcohol. In another study that followed a sample of 97 incarcerated boys and 21 girls for 12 years, at follow-up, most had criminal records, poor relationships, poor parenting skills, unstable jobs, meager education, drug addictions, and high rates of suicidality and mortality (Dembo et al., 2000; Wilson, Rojas, Haapanen, Duxbury, & Steiner, 2001). Researchers Cernkovich and Giordano (2001) followed 254 serious juvenile offenders for 13–14 years. As young adults, most still engaged in criminal activities, had not graduated from high school, and were earning annual incomes below the poverty level. Roughly half of females and three quarters of males either had lost or had never had custody of their biological children.

Detention samples show multiple impairments and compromised developmental outcomes. These teens are at great risk for early violent death. In a representative study, three years after detention, most teens struggle significantly in one or more life domains (Abram, Choe, Washburn, Romero, & Teplin, 2009). More than one in five has impairment in functioning at a level that requires multiple kinds of care. These adolescents struggle to occupy age appropriate social, occupational, and interpersonal roles. Among youth with marked global impairment, nearly two thirds were severely impaired in three or more functional areas. School expulsions, committing further crimes, and involvement in drug use and drug abuse were normative.

In another study, 7 years after a Los Angeles, California, court referral to long-term residential group-home care, 12 of the sample of 449 youths were dead before turning 25, almost one third were in prison or jail, close to one half did not have a high-school diploma, two thirds reported ongoing criminal activity, and almost two thirds reported illegal drug use in the previous year, with over half of this group acknowledging hard drug use (Ramchand, Morral, & Becker, 2009).

Status of Interventions for Justice-Involved Adolescents

Youth mental health care needs (including substance abuse) are typically not recognized, and most youth involved in the justice system do not receive the care they need. Because adolescents typically underutilize services in their home communities, and after a decade or more of an expanding juvenile justice net, the juvenile justice system has become the primary setting where youth receive treatment. Florsheim, Behling, South, Fowles, and Dewitt (2004) found that some types of programs (i.e., detention facilities,

work programs, and group homes) may actually facilitate adult criminal behavior. Florsheim et al. advocate for improving the quality of treatment received by youth specifically in detention facilities, a point echoed by investigations conducted by the United States Department of Justice (US Department of Justice, 2005) and other juvenile justice policy groups over the years (Juvenile Detention Alternatives Project, 2014).

Lipsey (2009) conducted an extensive meta-analysis that included 548 independent juvenile justice study samples from 1958 to 2002. Predictors of effectiveness included a program factor called a “therapeutic orientation” (counseling vs. control or coercive orientations [surveillance, deterrence, and discipline]), the capacity of well run programs to impact *high-risk offenders*, and the *quality of the program’s implementation* (including staff training, monitoring, supervision, and timely problem solving).

The Pathways to Desistance Study, a large, multisite, collaborative project following 1,355 juvenile offenders for 7 years postconviction, identified elements that can combine to redirect serious youth offenders (Mulvey et al., 2010). Many things account for changes in the life course of young offenders, including maturing; assuming adult roles (e.g., work and family); changing one’s self-conception coupled with a new resolve; or a turning point in life. Research in the Pathways study has found, consistent with other studies, that parenting practices and substance use treatment predict reoffending. As seen in community samples of adolescents, offenders who described their parents as warm and firm (sometimes labeled authoritative) were more mature, more academically competent, less prone to internalized distress, and less likely to engage in problem behavior than their peers. In contrast, justice-involved adolescents who described their parents as neglectful (neither warm nor firm) were less mature, less competent, and more troubled. Youth who characterized their parents as authoritarian (firm but lacking warmth) or indulgent (warm but not firm) fell somewhere between the two extremes. Contemporary family centered interventions use this knowledge base and specialize in targeting these areas.

Policy and Treatment Implications of the Massive Basic Research Literature

According to a voluminous and still growing body of empirical evidence, the conclusions of reform experts, policy makers, state legislatures, and the public themselves are uniform. Juvenile justice-involved youths require comprehensive interventions. However, as the previous summary of research developments indicates, achieving positive impact on youths’ development, or stated differently, preventing deterioration of youths’ functioning, requires that the nature of existing treatment services and systems must change dramatically. Services need to go much further than targeting solely substance abuse and delinquency. These rehabilitation efforts need to impact previously overlooked needs including comorbid psychiatric disorders and HIV risk behavior, and make the youth and family’s interactions with larger systems of influence (e.g., courts, schools, etc.) explicit intervention targets.

CRIMINAL JUSTICE-DRUG ABUSE TREATMENT STUDIES (CJ-DATS): DETENTION TO COMMUNITY (DTC) STUDY

To facilitate research on criminal justice and drug abuse and addiction, the National Institute on Drug Abuse (NIDA) created the Criminal Justice-Drug Abuse Treatment Studies research cooperative (National Institute on Drug Abuse [NIDA], 2014). CJ-DATS is a network of correctional agencies linked with treatment research centers and community treatment programs. Completed in the first wave of the CJ-DATS initiative, the Detention to Community Study (DTC) was a two site randomized controlled trial that tested a cross-systems (substance abuse—criminal justice), family based, drug abuse and

HIV/STD intervention for adolescent offenders (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009). We tested a refined and expanded MDFT—Detention to Community (MDFT-DTC), evaluating it with two secure, pretrial/hearing, short-term FL Department of Juvenile Justice detention facilities (Miami Dade and Pinellas Counties, FL) with youth pending adjudication. MDFT-DTC was compared with enhanced services as usual. Detention center services that were available to youth in both conditions included a school component, crisis intervention for mental health concerns, and health care as needed.

Detention is an ideal time and place to intervene with youth, and to begin work with the youth's parent(s). Removed temporarily from their high-risk environments, the "crisis of detention can be used therapeutically to mobilize the [youth], [his/her] family, and systems of care to address the numerous serious problems" evident in detained adolescents (Lederman, Dakof, Larrea, & Li, 2004, p. 332). Given youths' multiple needs, the interventions are comprehensive and span justice, community treatment, and public health systems of care (National Center on Addiction and Substance Abuse [CASA], 2004; National Research Council, 2013). Nevertheless, juveniles in justice facilities remain the least adequately served of high-risk populations due to fragmentation of treatment and juvenile justice services, poor coordination of assessment, referral, and treatment activities, and a general lack of resources across multiple systems of care (NIDA, 2002).

MDFT Overview

Multidimensional Family Therapy (MDFT) is a family based, developmentally oriented, comprehensive treatment for adolescent drug abuse and antisocial behavior (Liddle, 2015). The model is recognized by government agencies, independent reviews, and best practice compilers as an effective science-based treatment for youth substance use disorders and delinquency. Recent studies focus on effectiveness and treatment adaptation, not only in terms of intervention features or clinician skills, but also relative to the characteristics, processes, and details of the settings in which the treatment is offered. MDFT studies have been done in juvenile justice system operated day treatment centers, juvenile drug court, and in collaboration with juvenile detention settings and diversion programs that offer MDFT as part of a package to deter youth involvement in the criminal justice system.

Theoretical frameworks of different kinds inform the approach. Self-efficacy and family systems theory, developmental psychopathology, transactional and contextual perspectives, and the risk and protective model of adolescent substance abuse and related problems all influence case formulation and intervention (Liddle, 1999). MDFT incorporates key elements of effective adolescent drug treatment, including comprehensive, multiperson, multisetting assessment; substantive family involvement with developmentally oriented interventions; specialized and individualized engagement and retention protocols; therapeutic use of urine screens; rigorous attention to staff qualifications and their ongoing supervision; gender and cultural responsiveness; and focus on a broad range of (overlapping and interlinked) outcomes including substance use, antisocial behavior, mental health/psychiatric symptoms, school outcomes, family functioning, fulfillment of individual developmental tasks and competencies, and high-risk sexual activity.

MDFT is a structured (e.g., "core session" protocols) and flexible treatment delivery system. Depending on youth and family needs and session goals, sessions occur in the home, clinic, or at convenient locales ranging from one to three times per week over the course of 3–6 months. Therapists work simultaneously in four treatment domains—the adolescent, parent, family, and extra-familial. Each of these is addressed in three Stages: Stage 1: Building a Foundation for Change, Stage 2: Facilitating Individual and Family Change,

and Stage 3: Solidifying Changes. Interventions in each domain are interdependent and linked to interventions and the proximal mini-outcomes in other domains (Liddle & Rigter, 2013). Throughout treatment, therapists meet individually with the adolescent as well as the parent(s), and together with the youth and parent(s), depending on the specific problem being addressed, and most of all, on the immediate therapeutic objectives.

An Intersystems Intervention: MDFT-DTC

MDFT was adapted for the DTC study in two ways. First, an in-detention module was added so that the individual and family interventions could begin immediately after arrest. This work began during the 3–14-day period in which youth were held in the detention. Critical ingredients and predictors of postrelease community integration and recidivism reduction included prerelease planning (postdetention activities including school), mobilizing family involvement, and addressing legal supervision requirements effectively. The in-detention module involved interventions with detention center and juvenile court personnel, including judges and attorneys (public defender and state attorney). Briefing justice professionals about the program and openly addressing concerns and doubts fostered a collaborative process. Although not therapy per se, these interventions used therapeutic principles developed in earlier implementation research (Liddle et al., 2002). Examples of working principles included a reasoned open-mindedness about the possibility of youth and family change with focused therapeutic effort and the scientific support for this notion, demonstrating the MDFT program's commitment to comply with juvenile justice supervision and reporting requirements while providing an intensive, comprehensive, therapeutic, positive, parent-involved system of services. These interventions push hard to secure practical, developmentally meaningful outcomes beginning with day-to-day changes, and collaboration that improves services without increasing the workload of justice personnel.

The DTC study included a new family oriented HIV/STD prevention module combined with the MDFT protocol (Marvel, Rowe, Colon-Perez, DiClemente, & Liddle, 2009). Youth and their parents participate in three 2-hour multifamily groups. These meetings: (1) enhance adolescents' and parents' awareness about the nature of STDs and HIV; (2) personalize their sexual and drug-associated risk behaviors that increase adolescents' likelihood for exposure and infection with HIV/STDs; and (3) provide communication (parent(s) and partner) and condom-use skills for HIV/STD prevention. This intervention adaptation responds to public health experts' recommendations about the need to develop new treatments that concurrently address substance abuse, mental health of youths, HIV risk, and related problems among juvenile offenders with integrated, comprehensive approaches that involve families (Chassin, Knight, Vargas-Chanes, & Losoya, 2009) and offer these treatments directly in, and in collaboration with, juvenile justice settings (Drug Strategies, 2005).

The initial stage of work occurs in detention and focuses on the crisis of arrest and incarceration. It is also important to address the practicalities of postdetention tasks such as complying with justice system supervision requirements. Therapeutic use of drug screens, curfew, and school attendance are attended to with every case. Initially, using the crisis of the recent arrest and incarceration to mobilize, focus, and motivate youth and parent(s), clinicians focus on during detention objectives of therapeutic relationship formation and motivation enhancement. Postdetention is community-based; it uses the orientation and engagement outcomes achieved in earlier work as building blocks for change. Clinical work emphasizes successful reintegration in the youth's community and family, family relationships, parenting practices and most fundamentally, establishment of a turning point (Oyserman & Markus, 1990). Treatment's first phase launches work not

only with the youth and family, but also with other important social system personnel. Meeting justice representatives in court, at a probation officer's office, and going to the youth's school for joint meetings with the adolescent and parent(s) set a treatment foundation and communicate a professional and change-focused advocacy position of the therapist relative to the youth and family. Early stage work also involves accessing (with permissions, of course) current legal and school records, and gaining clarity on the youth's charges and obligations from this point forward relative to the justice system.

Therapists regularly accompany the youth and parents to court hearings and meetings with probation officers or other juvenile justice personnel. It is critical to help the teen and family succeed with supervision requirements such as curfew and submitting urine screens. Therapists facilitate linkages of parents and youths to juvenile justice advocacy and legal networks to empower them with information about legal rights and responsibilities, the details and steps of complying with the justice system's legal requirements, and available resources. These actions develop agency and fight pessimism, an all too frequent companion on the journeys made by justice-involved families. Although clinicians assume an advocacy posture early in treatment, this stance must transform. Parents develop these behaviors over the course of the work. Clinicians model and teach parents how to establish businesslike, positive, but outcome-oriented relationships with justice officials and advocate effectively for their child.

Implementing evidence-based therapies in juvenile justice and community substance abuse treatment settings involves identifying and solving normative challenges early on in the process. In the DTC study, an early task involved instituting in-detention screening and recruitment of study participants. We established a process with the detention intake workers that permitted researchers to review files and interview potential study participants within hours of intake processing. Second, detention administrators created new youth access procedures and made meeting space available. It was no small accomplishment in crowded, security-minded facilities for MDFT clinicians to meet with the youth and with the adolescent's family in detention. Third, detention administrators and staff collaborated with the research teams to integrate the new in-detention HIV prevention groups into the setting's daily programming. Again, and we believe critically, therapeutic contact begins quickly—in detention—and continues after release. Finally, close but efficient collaboration was vital in the intervention's community phase. Clinicians rate their collaboration with juvenile justice colleagues as substantive, active, case focused, and instrumental to the family's engagement and positive response to treatment (Liddle, Dakof, Henderson, & Rowe, 2011). Frequent text messages, e-mails, phone calls, impromptu and short meetings before or after a court hearing maintained a proactive problem-solving focus, prevented misunderstandings and the escalation of small matters, and facilitated a positive, forward-looking, case-focused collaboration. This *modus operandi* demanded consistency of effort between therapist and family and the fuel for this effort came from the partnership of clinician and family members—a noteworthy aspect of the MDFT approach. Juvenile probation personnel, the public defenders' and state attorneys' offices, and juvenile court judges were engaged to support youths' treatment participation, and were influenced to retain youth in the juvenile system and avoid or delay adult system transfer. Clinicians must understand the criminal justice process and the juvenile's supervision requirements, and help the youth and families comprehend these issues in detail as well. On the other side of the coin, through the collaborative process with the MDFT providers, criminal justice professionals gain new knowledge about adolescent substance use and abuse, delinquency. Critically, these colleagues become involved in and then witness how changes in family relationships materialize protective and rehabilitative processes, and thus, how community treatment can work (Rowe et al., 2013).

SUMMARY AND CONCLUSIONS

The characteristics and needed areas of support and change among justice-involved adolescents, and their service delivery systems, are authoritatively documented. And broad consensus about the promise of evidence-based treatments in these multilevel change efforts has been reached (National Juvenile Defender Center [NJDC], 2009; Drug Strategies, 2005; National Institute on Justice [NIJ], 1999). Treatment approaches which incorporate: (1) comprehensive attention to the diversity of clinical needs, including mental health, school related, and case management needs; (2) services, and juvenile justice supervision that supports an adolescent and family in an individualized way and attends to the youth's needs at different stages of justice system involvement; and (3) substantive, goal-focused and not merely token family involvement, as working with the youth's family has known advantages in outcome, are seen as welcome and indeed expected by many adolescents and families as well (Institute of Medicine and National Research Council, 2001).

Experts agree that interventions incorporating these elements are limited, unacceptably so (CASA, 2004; Nissen, Butts, Merrigan, & Kraft, 2006; Office of Applied Studies, 2001; Teplin et al., 2002). The foundation of basic science research to use in intervention development has never been stronger. Family based treatments have demonstrated promising clinical outcomes (Hogue et al., 2014; Tanner-Smith, Wilson, & Lipsey, 2013; Williams & Chang, 2000), and application in diverse and far reaching settings (Asscher, Deković, Manders, van der Laan, Prins, & Dutch MST Cost-Effectiveness Study Group 4, 2013; Butler, Baruch, Hickey, & Fonagy, 2011; Graham, Carr, Rooney, Sexton, & Wilson Satterfield, 2014; Rigter et al., 2013). But these advances do not reveal the enormous complexity of altering treatment systems, provider behaviors, addressing sustainability, quality assurance, how current dissemination methods contribute to the current rate of reform, and as discussed in this article, the treatment refinement and adaptation process. Previous master plans of reform have been impactful (Coolbaugh & Hansel, 2000; Hawkins, Catalano, & Miller, 1992; Kazdin & Blase, 2011), and given the degree of irrepressible energy and impressive work in multiple spheres of juvenile justice policy, research translation, and workforce reform, as examples, a cautious optimism is apropos.

Implementation is a dynamic, theory-driven, intervention-focused process. Sensitivity to the systems into which a family therapy approach enters is nothing new (Framo, 1976; Haley, 1975). But studying the key principles and methods of adoption, of changes of the approach, of what is needed to sustain these approaches, of synching up outcome data at clinical and organization and provider levels—that is different.

Implementation research requires that we broaden the systemic lens just a bit to conceptualize and evaluate not only treatment models, but the ways in which treatment models are run in service systems. Systems of care reform have required the same contextual vision. As we define and disentangle barriers and opportunities, we accrue, at various levels and across multiple dimensions, useful details about implementation complexity and treatment system change. Family therapy's *North Star* of clinical development has been systemic thinking (Haley, 1962; Jackson, 1967). A systemic framework will not solve all of our treatment refinement and implementation conundrums, but it sure will help. At the same time, we should remember that outside of the bubble of family therapy devotees, there are other stakeholders, other constituents. Remember that many of those folks do not know about the movement that was the family therapy movement, the practice of family therapy, or the research on family therapy. Services research tells us that even with all of its achievements, family therapy is offered infrequently in standard mental health, substance abuse, or juvenile justice care (Chassin et al., 2009; Knudsen, 2009). So, per the systemic view, it is probably best to remember that the system conceptualization endeavor (the *what* of change) is always a *work in progress*, always involves the "interveners", and

naturally, is understood as a fluid, dynamic and moving target of processes—all of which comprise many pieces in the puzzle we call change.

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