From Research to Practice: The International Implementation of Multidimensional Family Therapy

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Abstract

To address a growing public health problem with youth cannabis use, five Western European countries – Belgium, France, Germany, the Netherlands and Switzerland – collaborated on a cannabis treatment research effort. After deliberation, the research priority chosen was to implement and rigorously evaluate a treatment program for adolescents with cannabis use disorders – virtually unavailable in Western Europe at the time. Adolescent cannabis use disorders were even denied by some policy makers as bona fide public health problems. The most promising candidate for the treatment program to be studied, based on cross-national expert analyses and an exhaustive review of research findings to date, was Multidimensional Family Therapy (MDFT), developed in the USA. When pilot training with candidate clinicians began, some claimed it was "too American." Some did not understand its innovation at first glance, stating that aspects of MDFT interventions were already part of daily clinical work. Others worried whether the senior role of psychiatrists would be jeopardized, and if the approach engaged in too much outreach, and would be a threat to in-office work. Still others said the model might be too practical, and ignore the need for depth-oriented, psychodynamic treatment – still dominant in parts of Europe. While at the outset MDFT presented as a cultural shock, concerns disappeared when the approach was taught, attempted and integrated into the regular practice settings. The multi-country randomized controlled trial was designed with considerable discussion and collaboration. Referred to as INCANT (International Cannabis Need of Treatment), this study, the first independent replication of MDFT, showed that most adolescents with cannabis use disorders in these five countries have multiple behavioral problems, including criminality, truancy and mental co-morbidity. MDFT proved to be more effective than a high level treatment as usual in reducing cannabis dependence and on other problem behavior measures as well. Positive outcomes were seen in all the five countries. And given the clinical outcomes, the therapist competence and fidelity outcomes, and the capacity of the sites to absorb this new clinical approach, MDFT was found to be feasible and adaptable to representative regular clinical care Western Europe settings, adding expanded treatment alternative to standard care. The challenges

of conducting a multi-national randomized controlled trial in real world, non-research settings foreshadowed subsequent efforts to sustain implementation of this evidence-based treatment program. While retaining the core principles, structure and interventions of the approach, the MDFT implementation strategy has been adapted in each of these European countries, as they vary in accreditation requirements, reimbursement rules, public and private position of treatment centers for youth with multiple problem behavior, regard for certain professional groups (e.g., social workers), and referral processes. Facilitating MDFT implementation in Europe has been like executing an EU financial crisis policy, but we are getting there.

54.1 Introduction

Adolescent health, substance misuse and correlated problem behaviors have become indisputable priorities on the global public health landscape (The Lancet 2012). But due to many intersecting issues at multiple influence levels, over two decades of scientific advances in adolescent intervention specialties have failed to yield widespread dissemination of evidence-based approaches. Standard clinical practice for drug involved youth around the world remains disconcertingly dissimilar from the evidence-based interventions reported in research journals, practitioner reviews, policy recommendations, and science-based intervention registries. Effectiveness studies and implementation trials in the adolescent treatment specialty are more frequent in recent years (Becker and Curry 2008). And, cross-national surveys and basic science research on youth substance misuse have added significantly to a useable knowledge base. But relative to need, the research-rooted knowledge about effective interventions remains underdeveloped, and at least in the treatment realm, collaborative transnational controlled trials are rare. The multisite study of Multidimensional Family Therapy (Multidimensional Family Therapy 2014a; Liddle 2010) is the first independent replication of MDFT as well as, to the best of our knowledge, the only study of its kind to date (Rigter et al. 2010, 2013; Schaub et al. 2014) – a multi-national controlled trial of an evidence-based therapy for youth substance misuse. Although an instrumental part of the contemporary process to be sure, controlled studies cannot guarantee transfer or dissemination of a program past a research project's endpoint. This article describes the implementation history, plan and outcomes of MDFT in Western Europe (Rowe et al. 2013), a research-based treatment with significant dissemination activity in the United States (Multidimensional Family Therapy 2014a) evolving into an internationally established treatment program (European Monitoring Centre for Drugs and Drug Addiction 2014b).

Before addressing implementation, we first outline key features of the clinical approach. MDFT is a comprehensive, family-centered and developmentally-oriented intervention for clinically-referred adolescents (Liddle 2010). The intervention has strong outcomes for adolescent substance abuse and delinquency in

a series of randomized controlled trials. Comparison conditions in these studies included active treatments or usual care in non-research community clinics (Hogue et al. 2014; Von Sydow et al. 2013; Williams and Chang 2000). MDFT treatment process and implementation studies (Hogue and Liddle 2009) support the model's putative mechanisms of change (Henderson et al. 2009, 2010; Hogue et al. 2008; Diamond et al. 2006; Schmidt et al. 1996), and economic analyses indicate MDFT is less expensive than standard care (Zavala et al. 2005).

The MDFT research program began with National Institute on Drug Abuse funded studies in 1985 (Multidimensional Family Therapy 2014c; Sherman 2010; Liddle 1999), and continues today at the Center for Treatment Research on Adolescent Substance Abuse (Center for Treatment Research on Adolescent Drug Abuse 2014), University of Miami, Miller School of Medicine. Core to MDFT is the idea that an adolescent's problems are influenced by interacting factors from interconnected life domains (Fogel and Thelen 1987; Gottlieb 1991; Granic and Hollenstein 2003; Thelen and Smith 1994); hence, the term "multidimensional" (Liddle and Rigter 2013). MDFT addresses four domains/systems in the life of the youth: the adolescent him- or herself, the parent(s), the family, and systems outside of the family such as friends, school, work, prosocial activities, and (when applicable) juvenile justice authorities. Improvement of functioning in all life domains helps the adolescent to abandon problem behaviors including drug taking and heavy drinking.

The approach includes interventions such as:

- Enhancing treatment engagement and motivation of the youth and parent(s)/guardian(s)
- Self examination and generation of alternatives for youth problem behavior (through individual sessions and by utilizing family support and structure)
- Relapse prevention (relative to substance abuse and other problem behaviors)
- Improving communications and relationships between family members
- Strengthening parental functioning, and parenting skills
- Coordination with other systems (school, work, justice) to facilitate positive outcomes for the youth.

MDFT is manualized but flexible. The approach has been tested and exists in different versions that vary according to individual case characteristics, treatment setting, and treatment parameters that might be dictated by the clinical setting. Guiding principles orient the clinician to treatment guidelines and protocols that specify how to conduct core sessions with the four main units of intervention – the youth, parent(s), family, and the systems of influence that are relevant to the youth's and family's current circumstances. Clinical skill and judgment remain critical within these structures. On average, there are 2 sessions per week for 4–6 months, with the adolescent alone, the parent alone, the family (parent plus youth and other family members as needed), and key parties in influential systems (e.g., school or juvenile justice) present. MDFT therapists work in teams of three to six members, including the supervisor and often a therapist assistant, who may assist with a range of community interventions.

54.2 MDFT in Europe: The History

Fifteen years ago, EU member states were debating cannabis policy. Cabinet members from five Western European countries (Netherlands, France, Belgium, Switzerland and Germany) agreed that the discourse was uninformed due to insufficient data on the effects of cannabis. A common cannabis research and development project was commissioned to fill the gaps in knowledge. Rigter was appointed project leader. A Steering Group was convened between 2000 and 2010 with representatives from the federal Ministries of Health in Belgium, Germany, the Netherlands, Switzerland, and from the government substance abuse office in France. Its work began by consulting experts from Australia, Europe, and the USA to identify cannabis research priorities, which were jointly discussed in a conference in Brussels (Spruit 2002). Based on expert recommendations, a literature review, and the Steering Committee's own deliberations, the evaluation and implementation of a treatment program for adolescents with cannabis use disorder was defined as the multi-national group's principal priority.

This decision was not undisputed. Initially, some reported that in their countries, adolescent cannabis use disorder was rarely seen, yet these countries lacked treatment services specifically for youth or mechanisms to identify adolescents with these problems. The Steering Committee opted for the aforementioned priority, understanding that most adolescents with a cannabis use disorder also manifest other problem behavior such as criminality and school failure, necessitating a treatment program to focus not only on cannabis use, but on commonly related problems as well (Spruit 2002).

Which treatment program was to be chosen? A systematic literature review was conducted (Rigter et al. 2004), from which MDFT emerged as the superior treatment candidate on the basis of its research evidence and clinical scope (Brannigan et al. 2004; Vaughn and Howard 2004). Cannabis was targeted effectively in MDFT studies in the US, and other elements of adolescent problem behavior were changed as well (Rowe 2010). The Steering Committee opted for MDFT, and MDFT developer Liddle agreed to collaborate. The Steering Group organized a meeting in Zurich in 2004, where Liddle presented MDFT to a critical jury of high ranking European addiction scientists. MDFT passed the test; the Steering Group decided to test the effectiveness of MDFT in Western Europe, and if study results warranted, follow the trial with implementation in practice. This research effort was named INCANT – International Cannabis Need of Treatment study. Steering Group members nominated outpatient clinical sites in their countries for participation in the study. To assess site interest, and viability in terms of case flow and appropriateness, clinicians' background, research capacity, and infrastructure stability, Rigter, the study Principal Investigator, Liddle and MDFT researcher and trainer Rowe made screening visits to each prospective clinical center in early Summer 2004. The selected sites for the multisite research included: Brugmann Hospital (an outpatient substance abuse treatment department of a university hospital in Brussels, Belgium), Centre Emergence (substance abuse treatment in Paris, France), Therapieladen

(substance abuse treatment in Berlin, Germany), the partnering Dutch centers of De Jutters (forensic youth [mental health] care) and Parnassia-Brijder (substance abuse treatment) in The Hague, and centers in Basel and Bern in Switzerland. All sites had links with university-based or other research institutes.

Government departments in the five countries funded a pilot study in 2005. It addressed three questions: (a) Could clinicians from the selected clinical sites be trained as MDFT therapists and supervisors, (b) Did the selected sites have sufficient access to adolescents with cannabis use disorder for INCANT recruitment purposes? and (c) Could these clinical settings conduct a rigorous community-based randomized controlled trial? These challenges were all met successfully by the clinical sites (Rigter 2005). All European candidate MDFT therapists had experience treating youth and many had strong foundations in family-based interventions. Their backgrounds varied from social workers with additional therapist training (Berlin, The Hague) to psychologists (all sites), a child and adolescent psychiatrist (Paris), and a psychiatric nurse (Brussels). In preparing for the pilot, sites debated the appropriate educational degrees of the MDFT therapist candidates (such as social work, as one example), but in the end, no specialties were excluded. Using the same standardized training methods, materials, and certification procedures developed in U.S. based controlled trials (Hogue et al. 2008), senior MDFT trainers from the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami trained the diverse cohort of European clinicians in MDFT. Candidates were trained to adequate levels of adherence to MDFT protocols during the pilot study (Rigter 2005). The initial two Swiss sites had difficulties identifying appropriate referral sources for the trial and were replaced for INCANT by Phénix, an outpatient substance abuse treatment center in Geneva.

The Steering Group was satisfied with the findings of the pilot study, advising their respective government departments to fund the larger scale INCANT randomized controlled trial. The INCANT trial, initiated in 2006 and completed in 2010, compared MDFT to active individualized treatment as was routinely delivered in each site (Rigter et al. 2010). The control treatment, Individual Psychotherapy (IP), shared common elements across the five sites: therapy sessions were held only with the adolescent and targeted substance abuse and other problem behaviors. Despite commonalities, details of the IP's theoretical orientation differed among the five sites/countries. In The Hague and Brussels, IP was cognitive behavioral therapy. Psychodynamic ideas were influential with the IP clinicians in Geneva and Paris. And, IP therapists in Berlin followed a more eclectic treatment approach, borrowing from both mentioned treatment orientations.

All sites had sufficient access to adolescents with cannabis use disorder – per their usual case referrals, and sometimes via outreach and collaboration with other treatment centers (Berlin), juvenile judges (Switzerland) or media calls (Brussels). The sites would need to recruit 60–120 adolescents/families each for the INCANT trial. In the pilot and the subsequent randomized trial, sites differed in primary referral routes (Phan et al. 2011). Belgium and France recruited mainly through schools and families. In The Hague and Switzerland, most study adolescents were mandated to treatment by probation officers or other justice-related authorities.

In Berlin, the authorities offered troubled youth a sheltered living arrangement with pocket money, and some coercion to accept treatment as well (Rigter 2005).

Results of the randomized trial (n = 450) showed that across sites, irrespective of IP theoretical orientation, MDFT outperformed IP on major outcome measures. Most prominent was the larger reduction of the rate of cannabis disorder for MDFT participants compared with IP youth up to the 1 year follow-up (Rigter et al. 2013; Schaub et al. 2014). Retention rates for MDFT participants were twice as high than for IP adolescents (Rowe et al. 2013). This effect was consistent across all sites, and these clinical outcomes and retention rates are consistent with the U.S.-based trials. INCANT MDFT therapists demonstrated adherence and competence on treatment fidelity measures, suggesting that MDFT could be adopted with strong adherence in diverse cultures and systems in Western Europe (Rowe et al. 2013).

54.3 Facilitating MDFT Acceptance in European Youth Care Practice

In INCANT, MDFT proved to be transferable to the Western European locales that were part of the trial. This finding, of course, does not confirm that MDFT can be implemented and sustained in any practice setting. Making implementation work requires manpower, funding capital, persistence and tenacity, and continuous support for treatment agencies adopting the treatment program.

Next we discuss several implementation challenges, drawing from our experience with MDFT in the Netherlands, where implementation has advanced most rapidly and broadly, but also painting a broader European picture.

54.3.1 Facilitating Interest Among Therapists

For many therapists, MDFT means stretching beyond one's comfort zone: from conducting one session once every 2 or 3 weeks to doing several sessions per week; from scheduling sessions at the office to also seeing the family at their home and in the community; from a focus on one disorder or problem behavior to a comprehensive approach; from solely treatment sessions to treatment plus case management extending to all major domains in the life of an adolescent.

Difficulties in changing practice patterns are always a worry in evidence based therapy transfer. In the case of the Netherlands, for instance, we met with genuine interest from therapists all over the country. Some clinicians had their interest piqued by word-of-mouth, or by video-intensive presentations by INCANT MDFT therapists. Dissatisfaction with the outcomes and limited scope of their own professional work might have been another reason therapists were curious about and open to MDFT. The appeal of working in teams – as defined in MDFT – was another influential factor. Clinicians also learned that they could have a role in expanding MDFT services, which helped in committing them to the treatment program. Our subsequent experience with Finland has been similar in these ways.

In discussing the challenges and worries about the transfer potential of North American based prevention intervention programs in Europe, Burkhart (2013) sheds considerable light on a still to be fully illuminated process. We have also concluded that these idiosyncratic responses to an intervention's philosophy, clinical features, even training requirements and methods are among the probably many germane intervention characteristics. In France and Switzerland, for instance, we found psychodynamic traditions to remain influential and that adoption of more practical, family systems, and outcome-oriented treatment programs such as MDFT can be a stretch. Initially, concerns were voiced that one's freedom as a therapist could be curtailed by following a treatment manual. Clinical presentations by INCANT MDFT staff emphasized the how-to aspects of the approach. Aspects of clinicians' current thinking, practice habits, and previous training were used as ways to learn about a new approach. But vital to the clinician change process was a supportive and guiding type of supervision to help therapists with cases in their own clinical settings. Hardly a simple administrative decision, implementation involves multiple and intersecting processes within an organization or system of care. At the therapist level, changing a clinical mind set may involve direct or indirect challenges to ingrained views, and transforming treatment paradigms by offering training in and considerable support to learn new methods.

Perhaps there was a time when researchers believed that publication of study outcomes will yield recommendation adoption. But experience and the burgeoning literature in specialties such as implementation science demonstrate the complexity of practice change. Scientific journals do not target clinicians. Therapists need to be informed in terms relevant for daily practice. We have written MDFT materials in Dutch, English, German and French. We also produced a DVD with basic facts about MDFT and with interviews with an adolescent and his mother, therapists, and a juvenile judge (in Dutch, with English and German subtitling; see video at Multidimensional Family Therapy 2014d). Country-specific websites offer information for therapists and centers (and for teenagers and parents); see for instance (Multidimensional Family Therapy 2014e). Following a community of practice model, we update MDFT information through e-mails, e-newsletters, social media, and face to face substantive clinical meetings for therapists. But as has been the case in MDFT's dissemination in North America, materials play only a supporting role in influencing clinicians. Therapists and managers of treatment agencies experience the worth of MDFT during on-site visits. Videos demonstrate the approach in action, and live sessions with local clinicians being coached in the main MDFT methods seem critical to address their particular realities and questions. As in MDFT itself, relationships and gaining hands-on experience with the approach are instrumental.

54.3.2 The Treatment Agency

Multiple factors and levels of process interact with therapist variables to create a context of receptivity and change in adopting an evidence-based program.

The treatment agency, particularly the *manager* of the department where the MDFT team will be housed, are key in this regard. Although often interested in MDFT, managers are challenged to integrate this program, or any program for that matter, into local routines and financial structures. We facilitate this integration, a *systems intervention* in and of itself, in various ways. Implementation staff visit the management of a treatment center a few times before the contract for training is signed, and afterwards once every 6 months. In the Netherlands, we also convene regular meetings with all managers together. Topics of discussion include: (a) reimbursement of MDFT; (b) where and how to enroll cases to be treated with MDFT (referral policies, relationships with other treatment sectors); (c) how to arrange coverage for MDFT therapists to be available after regular working hours without violating labor regulations; (d) ethical and legal issues, including the protection of the privacy of clients; and (e) treatment innovation. This is all critical for implementation success. We are extending this systematic approach of administrative collaboration to other European countries.

In all Western European countries where MDFT is being implemented, treatment agencies are facing a mix of public and private policies. In the Netherlands, an agency has some leeway to choose its own course in offering treatments. In Belgium, MDFT was to be paid through federal or regional government budgets as long as the treatment was deemed 'experimental' – and anything not performed by a medical doctor will remain experimental for a long time. In Flanders at least, treatment agencies now have more freedom to opt for MDFT if insurance companies agree to pay the bill. In Germany in 2012, the federal government opened positions for treatment centers to take part in an MDFT implementation project. Major adolescent substance abuse treatment centers did apply (in Cologne, Dresden, Hamburg and Munich) and are now part of a four-center implementation effort. Without the government subsidy, these agencies would not have signed up for MDFT. Treatment innovation is difficult in Germany, because local, state and federal authorities and insurance agencies – although all supporting MDFT by now – are in deadlock about who is to take the initiative to get MDFT established and financed. An additional complication is that in Germany, therapists are expected to pay from their own pocket for any training in a new treatment program. In all other Western European countries, the treatment agency pays to train an entire MDFT team. Implementation of MDFT in Germany is proceeding, but future prospects – when the federal subsidy ends – are uncertain. Of note, too, is the position of national professional organizations, such as in Germany, the German Association for Systems Therapy and Family Therapy (DGSF). In a systematic literature review carried out under the umbrella of DGSF (Von Sydow et al. 2007), MDFT was found to be an effective therapy. DGSF is in favor of giving MDFT a place within the DGSF framework, but MDFT concepts need to be harmonized with DGSF concepts first, and this will take time. Terms like 'supervisor' have different meanings in MDFT and DGSF contexts. MDFT accreditation by DGSFT is necessary to convince therapists to personally pay for training in MDFT.

In France, the INCANT trial and ongoing liaison efforts of the MDFT team leader (Phan) combined to convince government services (MILDT; and the Ministries of Health and Justice) to support MDFT after the research study ended. Adolescent substance abuse centers were willing to meet a call to have teams of therapists trained in MDFT, with subsidy from MILDT. Teams are in training in Lille and Dijon. Teams focusing on forensic or residential care will follow in the suburbs of Paris. The aim of the French government is to have at least one MDFT team per region (country).

All in all, implementing a treatment program in a country requires adequate knowledge of national, regional and local policies and politics. Local experts must be fully on board. For lasting implementation, it does not suffice to have good research data or to win over therapists; one also needs the enduring support of the management of treatment centers and of policy makers at all levels of the youth care sector. One needs to have staff to make this happen, and to pay for that staff, one needs funding capital. In the Netherlands, we were fortunate to secure charity funding. All other European MDFT countries, except Finland, rely on government subsidies so far, which is insecure in times of economic crisis.

54.3.3 Requirements for a MDFT Program

Implementing MDFT in Europe was a joint aim of the MDFT experts at CTRADA and pioneers in Europe, headed by Rigter. MDFT developers saw throughout the INCANT pilot and trial that MDFT would disseminate throughout Europe only if the MDFT leaders in each country experienced personal ownership – a sense of being pioneers themselves. Rigter established "MDFT Academy" in 2008, a Dutch-based foundation to offer MDFT training to teams of therapists in Europe. Liddle granted MDFT Academy the free-of-charge right to train MDFT teams in Europe, provided training principles and procedures would conform to established MDFT standards developed in research trials and applied in US-based implementation efforts. MDFT representatives from Western European countries founded "MDFT Europe" in 2010, a body for agreeing on MDFT (training) practices in Europe in order to ensure consistency and uniformity.

It is made clear from the outset what it takes for a treatment institute to offer MDFT. MDFT Academy uses a set of MDFT program requirements as formulated in the MDFT manual (Liddle 2007). All MDFT supervisors and therapists must be certified (see below). Candidates for MDFT therapist training must have a university (usually psychiatrist, psychologist, pedagogue) or college (social work) degree, with additional education in psychosocial therapy. They need to have at least 3 years of experience in treating adolescents and have a basic knowledge of family therapy. An MDFT therapist is pragmatic, non-judgmental, skilful in communication, willing to work irregular hours, and receptive to feedback, seeing that there is always more to be learned. He or she is open to teamwork, intervision and supervision. The same is true of a MDFT supervisor, who also should have leadership skills.

54.3.4 Training

Important are (a) the course materials, and (b) the training interventions. The key training document is the MDFT Manual (Liddle 2007) and accompanying protocols, which have been translated in European languages (Dutch, German, French) and adapted to local practice (e.g., regulations, referral mechanisms, assessment tools as used by youth probation officers and other professionals).

American and European trainers use parallel presentation materials, core MDFT videos, and written case vignettes to cover the introductory didactic training. Instruction DVDs target the same topics, but key treatment sessions shown for training purposes are increasingly from local (Dutch, German, etc.) practice. Training interventions include plenary content and protocol review days (all trainees come together); the systematic evaluation of treatment session recordings for MDFT adherence and competence, and of supervision session recordings for supervision skills; regular site visits by the MDFT trainer to the MDFT team for on-site case review and other feedback; regular consultation telephone calls between the trainer and the supervisor and the whole team; annually, fully documenting 1 case by the trainee (session planning, case assessment, treatment plan) with feedback from the trainer; an extensive written exam; and booster training of the team and, separately, of the supervisor.

54.3.5 Certification and Licensing

The full training in MDFT takes 2 years. The Basic Level certificate is issued at the end of Year 1, the Master Level certificate after Year 2.

In Europe, teams with at least three Master Level certified members receive a free-of-charge license to practice MDFT. Once every 3 years, teams are required to refresh their license, allowing MDFT Academy to check if MDFT is still carried out properly.

54.3.6 Trainers

MDFT trainers achieve their status by developing through the ranks, first as an MDFT therapist, then supervisor, before being invited for trainership. Trainers are trained by G. Dakof (Multidimensional Family Therapy 2014b) and by MDFT Academy. At present, there are 8 Dutch trainers, 1 Flemish and 1 French-speaking trainer in Belgium, 3 trainers in Germany, 1 in France, and 1 in Switzerland.

54.3.7 MDFT Teams Trained in Europe

Between 2008 and Spring 2013, 35 Dutch teams have been trained in MDFT or are presently in training. Add to this number 2 teams in Belgium, 5 in Germany,

5 in Finland, 5 in France, and 1 in Sweden, and the European total approximates 60. There are 50 teams in the United States, yielding 110 MDFT teams worldwide.

As is the case in the U.S. uptake of MDFT, the European teams originate not only from addiction treatment, but also from youth care, mental health, and forensic settings. In Europe, MDFT has evolved beyond the narrow connotation of being an addiction treatment. In accordance with the evidence base, MDFT is seen as a treatment program for adolescents with diverse, often multiple problem behavior, regularly including delinquency and substance abuse.

54.3.8 Accreditation

'Accreditation' in Europe requires that a treatment program is evidence-based. Although MDFT is included in North American evidence-based practice registries (Substance Abuse and Mental Health Services Administration 2014; Sherman 2010; Crime Solutions 2012; Division 53, American Psychological Association 2012; California Evidence-Based Clearinghouse 2012), European policy makers and scientific bodies are keen to make their own assessments. In the Netherlands, approval by the National Accreditation Committee on Justice-Related Behavioral Interventions is required for the Ministry of Justice to fund forensic treatment settings. This Committee uses ten criteria to evaluate interventions. The treatment program must be effective and should be based on a strong theory explaining how multi-problem behavior arises. Risk and protective factors are to be specified and clearly linked to concrete interventions, including skills training. The treatment program must be phased, with emphasis on motivating cases in the beginning and on providing continuity of care at the end. The program should include quality assurance control, making sure it is carried out competently, and should adhere to the therapy's basic principles. MDFT Academy filed the dossier requested and, in 2011, the Committee mentioned accredited MDFT. The Netherlands Youth Institute (NJI) followed suit, and has accredited MDFT for use in all youth care sectors. Although other European countries have less formal mechanisms of accreditation, they may use, at least in part, the positive verdicts in the Netherlands.

Accreditation is not just an issue of individual European countries. The EMCDDA (European Monitoring Centre of Drugs and Drugs Abuse) is the European Union 'drug tsar' office, so to speak. The EMCDDA reviewed adolescent drug abuse treatment programs and affiliated researchers conducted meta-analyses. MDFT outcomes were judged to be strong (European Monitoring Centre for Drugs and Drug Addiction 2014a), and this independent evaluation is consistent with others that support the individual studies and overall research base of MDFT.

54.3.9 Reimbursement

Accreditation is the green light for funding agencies to pay for a treatment program. MDFT is now being paid from all relevant reimbursement schemes in the

Netherlands and Finland, including government sources and private health and social insurance companies. It is being funded by the (federal) governments in Belgium, Germany and France, yet a challenge here is to convince insurance companies and local authorities to take over reimbursing MDFT.

54.3.10 Innovation

A treatment program that is inflexible because it is based on just one protocol-dictated model application will not meet lasting approval of therapists in the heat of their daily work. A treatment program that is open to innovations in practice that will both retain model fidelity and address local needs is more likely to be accepted widely by practitioners.

In Europe, we regularly get feedback from trainees such as: MDFT is wonderful, but I work in setting X or Y (for instance, residential youth care, or a day treatment program) or with a special population such as adolescents with sub-normal IQ (mild mental handicap) or with emerging signs of other mental disorders. And then they ask: Can MDFT be made applicable in those settings and for those target groups as well? The answer often is not a simple yes or no. We will carefully assess the possibilities of developing new applications of MDFT, and will accept the challenge if the prospects are good and if we have the proper means (manpower, time, money, interested treatment centers).

Special 'modules' have been developed in the Netherlands for incorporating MDFT in residential settings, such as juvenile detention centers or residential youth care institutes. The aim is to start with MDFT during intramural residency of the youth, and to continue this program on an outpatient basis once the youth has been released. This approach is also pursued in the USA, for instance through the DTC (Detention to Community) project (Liddle 2010). One other novel application of MDFT is to offer the therapy to adolescents/families on an outpatient basis to avoid residential out of home placement of the youth (Henderson et al. 2011). In 2011, the MDFT team of one residential youth care institute in the Netherlands succeeded in convincing 81 % of referred adolescents/families to opt for outpatient MDFT rather than for the indicated residential placement. None of these adolescents who participated in the outpatient alternative required out of home placement post treatment.

54.4 Conclusion

Implementation is complex, hard work. We have given an overview of MDFT implementation hurdles and breakthroughs in Europe. MDFT has been disseminated in the Netherlands more quickly than in other European countries, because there was money to fund training infrastructure and start up activities. Other European countries are now gearing up, with continued MDFT dissemination to be seen in the next few years.

One might say that these other European countries could replicate the Dutch model, but this would be a misapprehension of implementation realities. The exact path traveled in the Netherlands will not necessarily work in Belgium, Finland, France, Germany, Switzerland, or any other country. Implementation should always acknowledge the basic principles of the treatment program but procedures must and can be adapted to local circumstances.

International collaboration can speed up implementation. There is close working relationship between European stakeholders in disseminating MDFT and setting quality standards, and there is tight collaboration between Europe and the source of MDFT, the USA (www.mdft.org). Important here has been the decision of the MDFT personnel to consider this treatment program as a public asset rather than a commercial product.

The implementation outcomes of MDFT in a European context discussed in this chapter and elsewhere (Rowe et al. 2013) add to published reports of MDFT implementation in the U.S. (Liddle et al. 2002, 2006). These studies showed that MDFT can be successfully transported to usual care American juvenile justice, mental health, and addiction care settings with multi-ethnic youth presenting with a range of problem behaviors (substance abuse, delinquency, symptoms of other mental and behavioral disorders), and taught to staff from various professional backgrounds (psychiatrists, psychologists, social workers, nurses, juvenile justice court staff, judges, lawyers) (Liddle et al. 2006).

The pursuit of international projects that have included independent replication of previous outcomes contributes to a treatment system's development, and offers another metric by which its usefulness can be assessed. The knowledge base about how an intervention should and can be adapted, culturally, emerging institutionally (systems of care), or procedurally (intervention structure, methods), are in an early developmental stage. Although guidance is emerging about the international transport of evidence-based interventions, numerous controversies have been specified as well (Andréasson 2010). International work, like travel in general (De Botton 2002), offers perspective and insight unavailable at home. In the case of MDFT, the international implementation described in this chapter offers a case study of the complex and sensitive intervention adoption process. This effort has enriched our knowledge of the change principles that guide clinical work with adolescents and families across cultures and settings, and our dissemination work as well.

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