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“All Roads Lead to...”: (Real*) Work with Families in Juvenile Justice Programs

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"Real "work with families means..."

- More than a brochure
- Family as a resource
- Family as a unit of analysis
- Family as a unit of change
- Family as a key part of the program theory or logic model
- Providers are knowledgeable and trained
- Providers work therapeutically
- Work settings support the essential role played by families in crafting solutions
- And, exemplify corresponding policies and practices

Center for Treatment Research on Adolescent Drug Abuse

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[Multidimensional Family Therapy](#)

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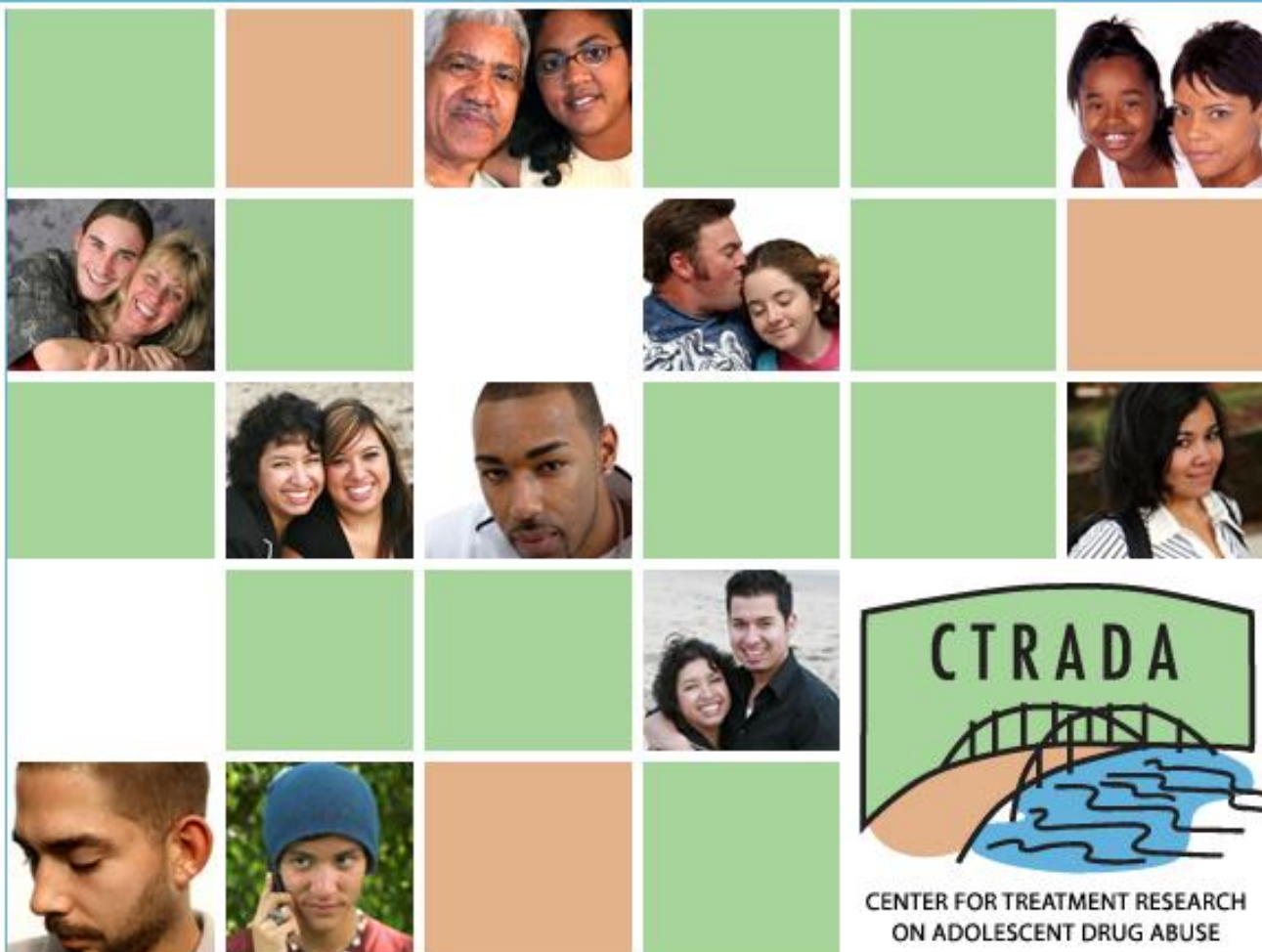
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Themes and Message

- Adolescent specialties
 - Professional activities
 - Media / public attention
- Explosion of knowledge and research
 - Basic – risk and protective, developmental knowledge, the contextual or ecosystemic perspective
 - Applied – prevention and treatment, the positive youth development movement, evidence based treatments and evidence informed practices

Themes and Message

- Significant advances in mental health, substance abuse, and juvenile justice
- Juvenile justice reform redux
 - Philosophy and mandate
 - Activity and success at broad and local levels
 - The intersection - basic science findings, evidence based practice movement, best practices Zeitgeist (concern with outcomes), and the available practical knowledge and opportunities presented by evidence based family focused interventions

The Landscape

- Majority of juvenile justice involved youths have multiple impairments
 - Substance abuse, mental health, criminal behavior, HIV and STD risk, school failure, antisocial and drug using peers, family difficulties, economic disadvantage, high risk neighborhoods
- Existing services
 - Availability limited
 - When available, frequently substandard
 - Evidence-based practice principles or interventions are rarely implemented



We work here...



**...in the real world of youths,
families, cultures, communities,
schools, institutions.
In an era focused on accountability,
outcomes, stakeholders, policies,
reform, & resource shortages.**





MAY 10, 2004



**TROY:
THE MAKING
OF AN EPIC**

SECRETS OF THE TEEN BRAIN

Research is revolutionizing our
view of the adolescent mind—and
explaining its mystifying ways

www.time.com AOL Keyword: TIME

May 20, 2004



"Gee, Tommy, I'd be lost without your constant peer pressure."



...everybody should have a chance to do well and they shouldn't be picked on because they're not rich enough to afford stuff."

Stewart McAdams, 16, and Ray Mowrer, 18 of Jolo, W. Va;

Jeremy Ball, 17, of Bradshaw, W.Va; Mathew Phillips, 17, of Paynesville, W.Va.



**I would kill my sister if she was in a gang ...
I don't want her following what I do."**

Ebony Wilson, 15, Bronx, N.Y.

"The easiest thing about being a teenager is still having a sort of romantic perspective or outlook on the world: not being jaded or disillusioned; and knowing — hoping — that you have time to do what you want and to achieve what you want."



Maybe I was wrong that that's specific to being a teenager. I think you have to work hard, though, not to let yourself forget that feeling of having dreams and aspirations and knowing that there's nothing that can stop you."

Patrick Roberts, 19, of Lawrence, Kan.



*“Your mother and I are feeling overwhelmed,
so you’ll have to bring yourselves up.”*



"What's this they say, Billy, about a new, more virulent strain of teen-ager?"

Do all roads lead to Rome?

Gosia Podgorska

UNFORTUNATELY, Catholic priests and allegations of sexual abuse have become the stuff of bad jokes these days. Still, a joke (be it good or bad) normally stems from something that is popular and regarded as holding some form of truth (no matter how exaggerated). So when another Vatican-versus-Sex-Abuse-Victim story was released six years ago, people took notice and negative press spread, well, like a bad joke.

The story goes like so: In 2004, a case was filed in the American town of Louisville by three men who claimed to have been abused by Catholic priests. The plaintiffs claimed that the US bishops should be considered employees of the Vatican, and thus the lawsuit aimed to subpoena Pope Benedict XVI in connection.

This was the first case in the US to come directly to the Vatican regarding alleged abuse. On 10 August this year, the case was dropped. Should something more be done about the situation, or is it simply a matter of stuffing old worms back into their rusty can?

Let's consider the plaintiffs' options here. Firstly, in order to win the case, the three men would have to "prove that the Roman Catholic bishops in the US were acting as Vatican 'employees' and carrying out the will of their employer by covering up the abuse".

This was not likely to happen. Additionally, the Vatican also argued that its US bishops act independently, control their own budgets and are not employees of the Holy See. Good point.



SCOT-FREE - Many wonder if the Vatican will be held responsible for its actions.

Also, the Catholic Church ensured they weren't neglecting the abused, when Jeffrey Lena, an attorney for the Vatican, pointed out that "although the case has nothing to do with the Vatican, the plaintiffs' actual complaints of abuse will not be immediately dismissed". So, one can't argue that the Church is disregarding the situation completely.

Ultimately, the case from the plaintiffs was narrow, and they had to acknowledge that they were up against some "insurmountable hurdles", seeing as the Vatican would be immune from most of the lawsuit due to its status as a sovereign nation.

Now the fact is, we can't act too surprised - suing the Vatican is

"Those three men were done wrong, and it's unfortunate that they chose to fight a very powerful institution."

pretty ambitious when there isn't a whole lot of evidence to back up the claim. Since then, the US Supreme Court has refused to reconsider the ruling. So it should be done and dusted, and that's how most people have seen it - as another by-gone media scoop.

However, when one takes a moment to consider the bias of it

all, it can take on another shade. The fact that the case was dropped is good news for the Vatican, since it has lasted six years and brought on more negative public opinion. However, the unhappy plaintiffs still have to deal with the fact that it's difficult to get justice in a world of power.

One can't even imagine that admitting sexual abuse, and attempting to stand up for yourself by approaching the law, is a very difficult step to take. Those three men were done wrong, and it's unfortunate that they chose to fight a very powerful institution.

While the case may be over, the issue is very much still on-going. Even if the Vatican has nothing to do with the 2004 case, they should

begin taking some responsibility for the link between sexual abuse, paedophilia and Catholic priests. They have the power, which is exactly what the plaintiffs were missing. Judging by the amount of sexual abuse cases in connection with the Catholic church over the past decades, something is wrong with the system.

Celibacy may have worked a thousand years ago, but in this day and age, it's clearly a practice that is becoming outdated and highly harmful. And while the topic may have turned into a bad joke, no one is laughing anymore.

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Lymph Node Study Shakes Pillar of Breast Cancer Care

By DENISE GRADY

Published: February 8, 2011

Q. & A.: Breast Cancer and Lymph Nodes

Denise Grady, is taking questions about this study and its implications for breast cancer treatment.

[Submit your question.](#)

Multimedia



[Less Surgery for Breast Cancer?](#)

A new study finds that many women with early [breast cancer](#) do not need a painful procedure that has long been routine: removal of cancerous lymph nodes from the armpit.

The discovery turns standard medical practice on its head. Surgeons have been removing lymph nodes from under the arms of breast cancer patients for 100 years, believing it would prolong women's lives by keeping the [cancer](#) from spreading or coming back.

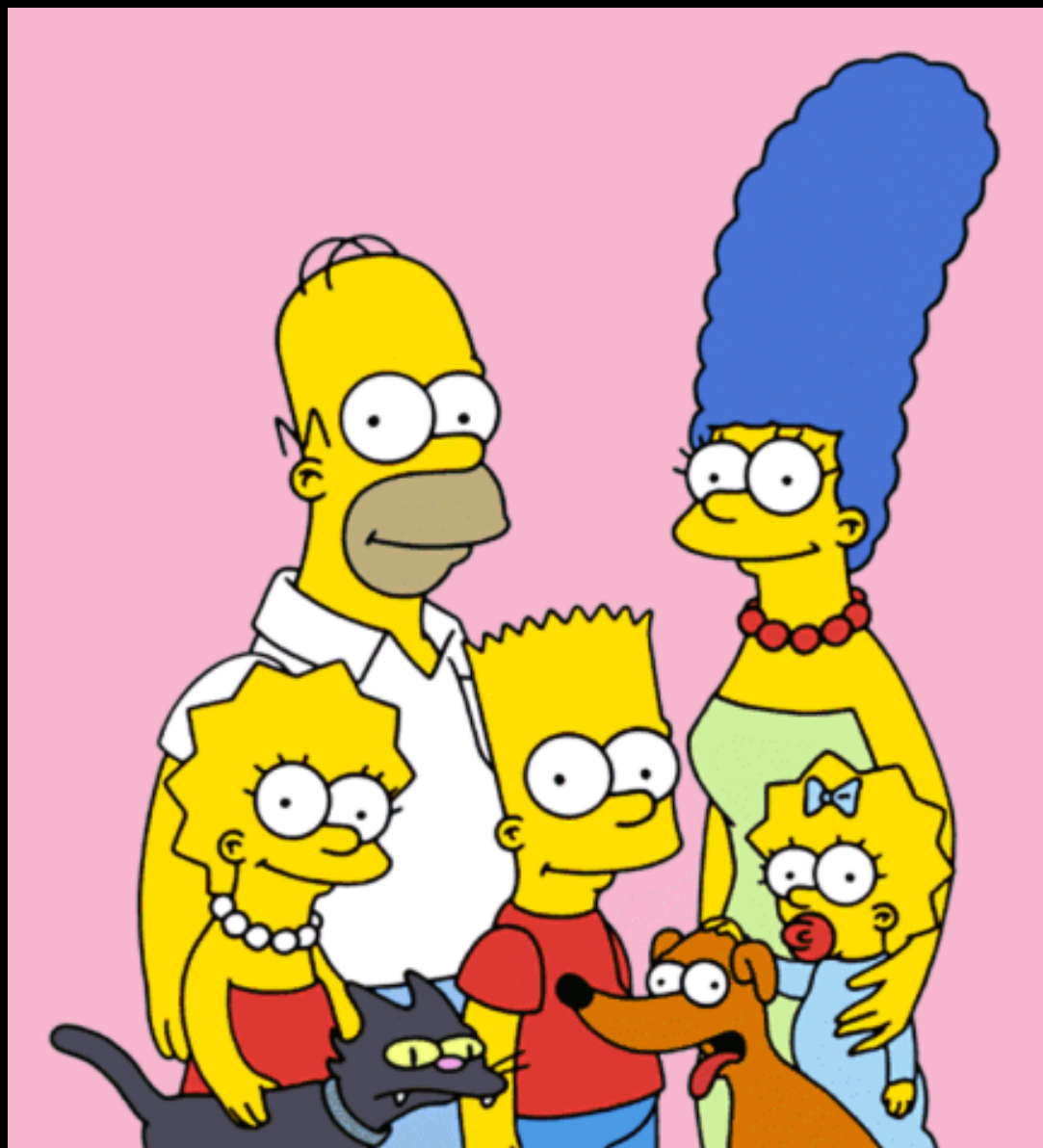
Now, researchers report that for women who meet certain criteria — about 20 percent of patients, or 40,000 women a year in the United States — taking out cancerous nodes has no advantage. It does not change the treatment plan, improve survival or make the cancer less likely to recur. And it can cause complications like infection and [lymphedema](#), a chronic [swelling](#) in the arm that ranges from mild to disabling.

Removing the cancerous lymph nodes proved unnecessary because the women in the study had [chemotherapy](#) and radiation, which probably wiped out any disease in the nodes, the researchers said. Those treatments are now standard for women with breast cancer in the lymph nodes, based on the realization that once the disease reaches the nodes, it has the potential to spread to vital organs and cannot be eliminated by surgery alone.









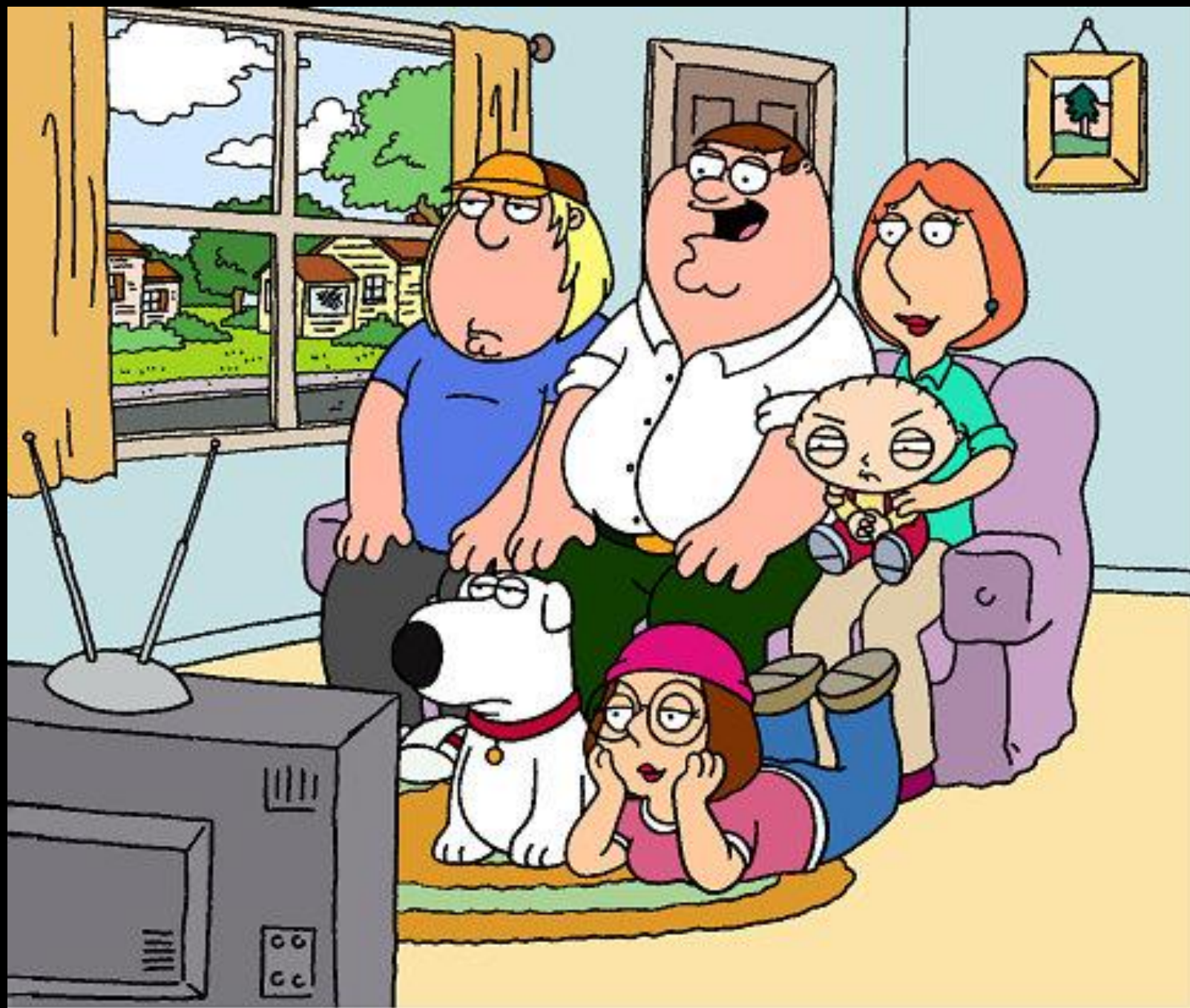
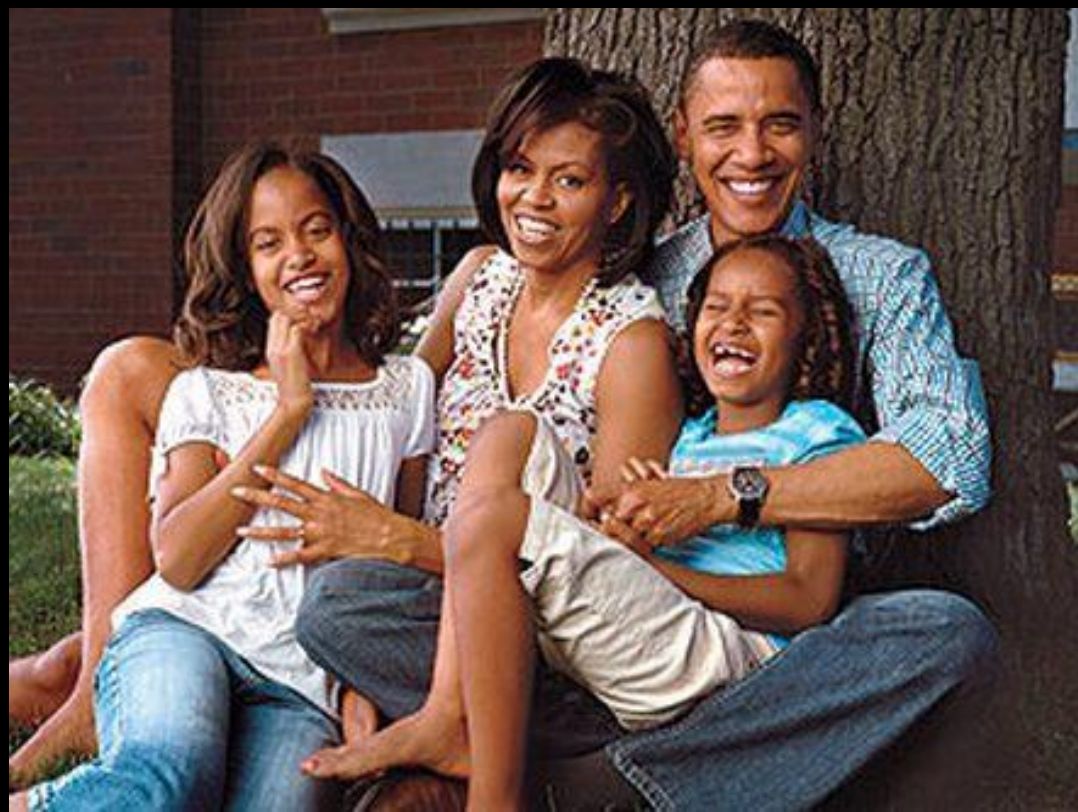






Photo: G. BALLARD
www.calie.org







Jennifer Loomis

Pathways to Desistance

Adolescents who have committed serious offenses are not necessarily on track for adult criminal careers.

- Only a small proportion (8.5%) of the offenders studied continued to offend at a high level throughout the follow-up period.
- The great majority reported low levels of offending after court involvement, and a significant portion of those with the highest levels of offending reduced their reoffending dramatically.
- Desisters (vs. persisters) had lower levels of substance use and greater stability in their daily routines, as measured by stability in living arrangements and work and school attendance.
- Incarceration may not be the most appropriate or effective option, even for many of the most serious adolescent offenders.
- Longer stays in juvenile facilities did not reduce reoffending; institutional placement even raised offending levels in those with the lowest level of offending.

Pathways to Desistance (2)

- Youth who received community based supervision and aftercare services were more likely to attend school, go to work, and avoid further offending during the 6 months after release, and longer supervision periods increased these benefits.
- Substance use is a major factor in continued criminal activity by serious adolescent offenders.
- Substance abuse treatment for young offenders reduces both substance use and non-drug-related offending in the short term if the treatment period is long enough and if families take part in the treatment with the offender.
- Given that community-based supervision may reduce reoffending and promote prosocial attitudes and behaviors, and that continued substance abuse treatment may be needed to prevent longer term relapses, integrating substance abuse treatment into community-based services may realize greater benefits in reducing serious adolescent offending while providing more efficient and effective delivery of services.

"Pathways to Desistance" (MacArthur Foundation)

- Research study is a large, multi-site research project following 1,354 serious juvenile offenders for seven years.
- Treating youth for at least 90 days, with their family members involved, cut both their substance abuse and their offending during the six months after treatment.
- But, only 25% of the serious juvenile offenders in its sample received treatment that included family members.
- Results indicate that drug treatment significantly reduced substance use for about six months, and that this reduction was more than simply an effect of the adolescents being locked up in a controlled environment.
- Subsequent criminal offending also was reduced – but only when treatment included family involvement.
- Ongoing substance use treatment for serious juvenile offenders appears to pay off. The key is including family in the intervention.

<http://www.macfound.org/atf/cf/%7Bb0386ce3-8b29-4162-8098-e466fb856794%7D/PATHWAYSREPORT.PDF>

<http://www.pathwaysstudy.pitt.edu/>

**Mulvey & Repucci (1984). Perceptions of
Appropriate Services for Juvenile Offenders.
Criminal Justice and Behavior, 11, 401-422.**

- 168 Staff members 49 court service unit workers, 66 social service department social workers, 53 cmh center personnel
- Consistently highest scores
- Family therapy 28%, outpatient individual therapy general or substance abuse 20% and outpatient group therapy accounted for 58% of the choices for the most effective service (ideal and effective)



[Home](#) » [Program](#) »

Multidimensional Family Therapy (MDFT)

Scientific Rating:

1

Well-Supported by Research Evidence
[See scale of 1-5](#)

Child Welfare Relevance Rating:

2

Medium
[See scale of 1-3](#)

Brief Description

The information in this program outline is provided by the program representative and edited by the CEBC staff. The **Multidimensional Family Therapy (MDFT)** program has been rated by the CEBC in the area of: [Substance Abuse Treatment \(Adolescent\)](#).

- **Child Welfare Outcome:** [Child/Family Well-Being](#)
- **Type of Maltreatment:** *Does not target any specific kind of maltreatment*
- **Target Population:** Adolescents 11 to 18 with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school and other behavioral problems, and both internalizing and externalizing symptoms.

Learn More

[For information on implementation:](#)

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[For information on research:](#)

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Questions to Ask (PDF) as you explore the possible use of this intervention.

Intervention

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Summary

Multidimensional Family Therapy (MDFT)

Date of Review: June 2008

Multidimensional Family Therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth 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.

<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=16>

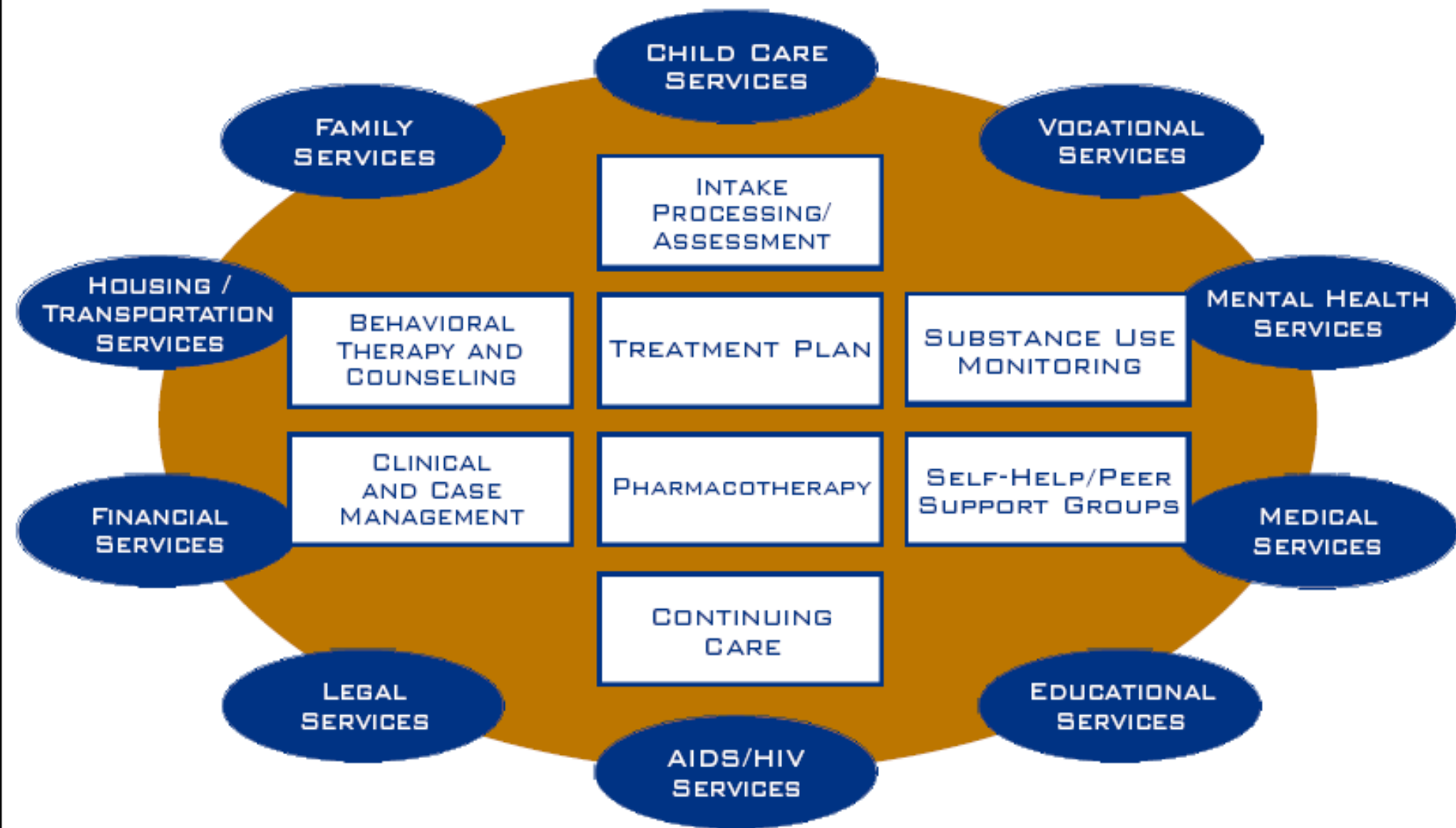


PRINCIPLES OF DRUG ADDICTION TREATMENT

A RESEARCH-BASED GUIDE

National Institute on Drug Abuse
National Institutes of Health

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

MULTIDIMENSIONAL FAMILY THERAPY

(MDFT) FOR ADOLESCENTS is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings.

Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

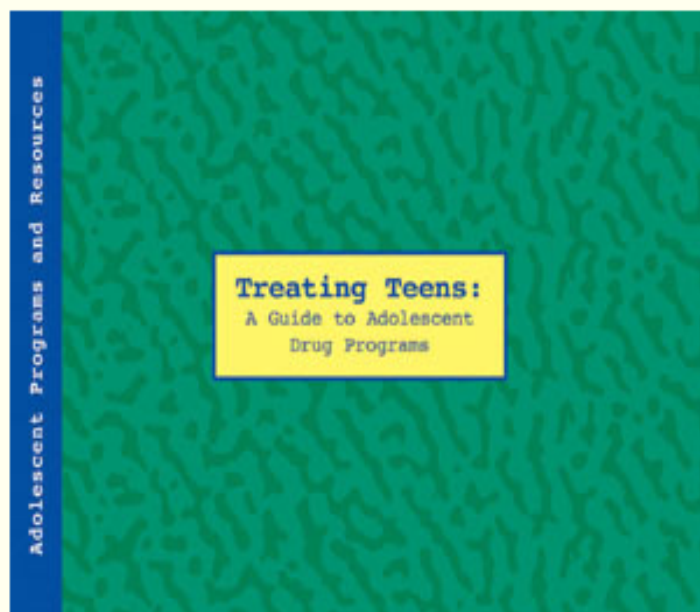
During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decisionmaking, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

The background of the cover is a blue-tinted photograph of classical building columns. The top half shows the upper part of the columns with decorative capitals. The bottom half shows the full height of the columns, which are partially obscured by a large, white, hand-drawn 'X' mark.

National Institute on Drug Abuse

Principles of Drug Abuse Treatment for Criminal Justice Populations | A Research-Based Guide

National Institutes of Health
U.S. Department of Health
and Human Services



This website is a companion to the Drug Strategies publication *Treating Teens: A Guide to Adolescent Drug Programs*, which was supported by a grant from the Robert Wood Johnson Foundation. The guide is designed to help parents, teachers, judges, counselors and other concerned adults make better choices about teen substance abuse treatment. To order the 60-page *Treating Teens* publication, which includes practical resources for parents such as Ten Important Questions to Ask a Treatment Program, [CLICK HERE](#).

The **PROGRAMS** section provides a searchable database with extensive information on how 144 teen substance abuse treatment programs across the country implement the nine key elements of effective adolescent treatment determined by Drug Strategies' panel of specialists.

Bridging the Gap:

A Guide to Drug
Treatment in the
Juvenile Justice System

www.drugstrategies.org

Family Involvement in Treatment

Multidimensional Family Therapy

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Multidimensional Family Therapy (MDFT) outpatient therapy concentrates on

the individual adolescent, the parents, the family and youth together, and systems that affect the youth's life, including schools, juvenile justice, peer groups and the community. Based on a strong theoretical structure of developmental psychological principles, MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Three-quarters of the program's clients are referred by the juvenile justice system. The program has been implemented in more than a dozen sites nationwide and six other countries. Federally funded since 1985, MDFT costs one-third

less on average than standard outpatient or residential treatment.

FAMILY INVOLVEMENT

MDFT believes that a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills and addressing the family environment as a whole. An MDFT therapist conducts an initial assessment of various risk factors, including familial drug use, family relationships, communication and conflict. Observation, interaction and clinical interviews are used to assess individual and family functioning. In order to gain parental cooperation, therapists acknowledge participants' past efforts and encourage them to express their frustrations with their children's drug use and behavioral problems. Earlier hopes and dreams of parents for their children are discussed, which often motivate parents to try once more. Therapists refer families to any needed services, and remain in close contact with the juvenile justice system, schools, peer

groups, and other community services in order to coordinate services and monitor progress.

Family sessions, individual sessions with parents and adolescents, and meetings with relevant social service agencies and the teen and parent occur one to four times a week for four to eight months, depending on the level of treatment intensity. Phone calls are used extensively both to check in on progress and to give new tips on how to effect changes between face-to-face sessions. Topics addressed in family therapy include the family's mental health and substance use, how to adjust parenting strategies based on the child's developmental level, and how family relationships can support the developmental challenges of adolescents and parents. Adolescents and families also work on relapse prevention strategies following completion of treatment.

RESULTS

Located in a research center at the University of Miami, MDFT has been found to be effective in four separate randomized clinical trials as well as several therapy process studies over

the past ten years. MDFT participants in one randomized study from 2001 showed a clinically significant reduction of drug use at one year post-treatment and improvement in family functioning when compared to two alternative treatment approaches. Outcome measures were taken at 6 and 12 months post-treatment with abstinence confirmed through urinalysis. At one-year post-treatment, 45 percent of youths who had received MDFT reported clinically significant reductions in drug use, compared to 32 percent and 28 percent of adolescents in the other two groups. Grade point average (GPA) also improved significantly. At intake, 20 percent of the MDFT population had a GPA of 2.0 or better. At one-year follow-up, the percentage increased to 76 percent.

Challenges: MDFT researchers are currently seeking to facilitate the adoption of the program in a variety of non-research clinical settings. The challenges of applying MDFT in real world environments are largely related to staff training issues and providing the necessary time and resources to teach clinicians how to implement MDFT.

Key Elements of Effectiveness

Both treatment research and clinical practice suggest that certain elements are critically important in providing effective drug treatment to adolescents in the juvenile justice system. Drug Strategies, guided by an expert advisory panel, has identified the following eleven key elements:

-  **Systems Integration**
-  **Assessment and Treatment Matching**
-  **Recognition of Co-Occurring Disorders**
-  **Comprehensive Treatment Approach**
-  **Qualified Staff**
-  **Developmentally Appropriate Program**
-  **Family Involvement in Treatment**
-  **Engage and Retain Teens in Treatment**
-  **Gender and Cultural Competence**
-  **Continuing Care**
-  **Treatment Outcomes**

Family Environment Factors and Substance Abuse Severity in an HMO Adolescent Treatment Population

Nancy S. Wu, Yun Lu, Stacy Sterling and Constance Weisner

CLIN PEDIATR 2004 43: 323

DOI: 10.1177/000992280404300403

Summary: To examine how parental limit setting, family conflict, and perception of family experience influence severity of alcohol and drug problems, and important gender differences in these relationships, we interviewed consecutive intakes, aged 12 to 18 years, at 4 chemical dependency programs of a large group-model nonprofit health maintenance organization (HMO) (n=419). The Family Conflict, Limit Setting, and Positive Family Experience scales correlated with substance dependence ($p<0.01$, $p<0.01$, $p<0.05$, respectively). Depression also correlated with family conflict ($p<0.01$), absence of limit setting ($p<0.01$), poor family experience ($p<0.01$) and dependence symptoms ($p<0.01$). Number of substance-using friends correlated with number of dependence symptoms ($p<0.01$). Gender differences included the following: (1) girls scoring higher in family conflict ($p=0.0002$), negative perceptions of family experience ($p<0.0017$), and lower in absence of limit setting ($p<0.0001$); (2) how family environment predicted problem severity: absence of limit setting was significant for boys and girls but family conflict for boys only; (3) girls had more dependence symptoms ($p<0.0001$), psychiatric diagnoses (e.g., depression ($p<0.0003$), anxiety ($p<0.0002$), conduct disorder ($p=0.07$)), and substance-abusing family members (53 % versus 39%; $p=0.006$). To conclude, family and peers influence severity of alcohol and drug problems in adolescents. *Clin Pediatr.* 2004;43:323-333

Wu et al., 2010: Family Environment

- Family environment - an important factor affecting adolescent substance use
- Parental substance use correlates with adolescent substance use
- Parental use is also related to an adolescent's choice of friends - adolescents living in families whose members have a drug problem are more likely to have friends who use drugs
- Family conflict is related to greater adolescent substance use
- And, more alcohol use in families goes with greater conflict
- Negative parent-child interactions to be a risk factor for alcohol and drug dependence
- Family conflict mediates the relationship between peer pressure and adolescent drug use and influences the severity of substance use

Wu et al., 2010: Family Protective Factors

- Certain family factors are protective against adolescent substance use initiation and continued use
- Parental support and connectedness, which include emotional support and expressions of interest in the child, affect the development of adolescent substance use behaviors
- Teenagers with a high level of support have a lower incidence of alcohol-related problems and are also less likely to initiate smoking.
- Family bonding and parent-family connectedness are associated with less frequent cigarette, alcohol, and marijuana use

Wu et al., 2010: Parental Monitoring

- Parental monitoring, (knowing where, how, and with whom the child spends time) is an important factor in adolescent substance use
- Adolescents perceiving less parental monitoring were more likely to have a history of alcohol and marijuana use and more frequent use in the past 30 days
- Children in the lowest quartile of parent monitoring initiated drug use at earlier ages
- Parental monitoring is an important predictor of drinking, delinquency, and problem behaviors
- Parental monitoring protects against the selection of substance-using friends
- Positive parental monitoring reduces drug severity at intake, help prevent initiation of drug use, and decreases affiliation with substance-using peers

Drug abuse and developmental psychopathology

MEYER D. GLANTZ AND ALAN I. LESHNER

National Institute on Drug Abuse, National Institutes of Health

“There is little question that drug abuse results from both intraindividual and environmental factors. For this reason, unidimensional models of drug abuse are invariably inadequate and multidimensional research and intervention approaches are necessary. For example, multidimensional treatment of drug abuse is more effective and has become common practice.”

(Glantz & Leshner, 2000, p. 796)

Protecting Adolescents From Harm

Findings From the National Longitudinal Study on Adolescent Health

Michael D. Resnick, PhD; Peter S. Bearman, PhD; Robert Wm. Blum, MD, PhD; Karl E. Bauman, PhD; Kathleen M. Harris, PhD; Jo Jones, PhD; Joyce Tabor; Trish Beuhring, PhD; Renee E. Sieving, PhD; Marcia Shew, MD, MPH; Marjorie Ireland, PhD; Linda H. Bearinger, PhD, MS; J. Richard Udry, PhD

JAMA, September 10, 1997—Vol 278, No. 10

Context.—The main threats to adolescents' health are the risk behaviors they choose. How their social context shapes their behaviors is poorly understood.

Objective.—To identify risk and protective factors at the family, school, and individual levels as they relate to 4 domains of adolescent health and morbidity: emotional health, violence, substance use, and sexuality.

Design.—Cross-sectional analysis of interview data from the National Longitudinal Study of Adolescent Health.

Participants.—A total of 12 118 adolescents in grades 7 through 12 drawn from an initial national school survey of 90 118 adolescents from 80 high schools plus their feeder middle schools.

Setting.—The interview was completed in the subject's home.

Main Outcome Measures.—Eight areas were assessed: emotional distress; suicidal thoughts and behaviors; violence; use of 3 substances (cigarettes, alcohol, marijuana); and 2 types of sexual behaviors (age of sexual debut and pregnancy history). Independent variables included measures of family context, school context, and individual characteristics.

Resnick et al., 1997: Main findings

- High levels of connectedness to parents and family members were associated with less frequent alcohol use among both [7th-8th and 9th-12th grade] groups of students.
- Among older students, more frequent parental presence in the home was associated with less frequent use.
- With notable consistency across the domains of risk, the role of parents and family in shaping the health of adolescents is evident.
- While not surprising, the protective role that perceived parental expectations play regarding adolescents' school attainment emerges as an important recurring correlate of health and healthy behavior.
- Likewise, while physical presence of a parent in the home at key times reduces risk (and especially substance use), it is consistently less significant than parental connectedness (e.g., feelings of warmth, love, and caring from parents).

Family Involvement in Pennsylvania's Juvenile Justice System

Family Involvement Subcommittee of the
Mental Health/Juvenile Justice Workgroup for
Models for Change-Pennsylvania
and
Family Involvement Workgroup of the
Pennsylvania Council of Chief Juvenile
Probation Officer's Balanced & Restorative
Justice Implementation Committee
(Merged March 2009)



ModelsforChange
Systems Reform in Juvenile Justice

"Perhaps more than any other at-risk group, youth in the juvenile justice system need meaningful relationships and supportive guidance from the adults in their lives. Everyone who has a personal stake in the healthy development of each child's life can and should play a role. The importance of family involvement before and during the juvenile justice experience is acknowledged within the system. However, what has yet to be developed is the system-wide adoption of effective, evidence-based strategies and services that support the family role at both the individual child and the larger policy and planning levels."

**Wendy Luckenbill, *Chair*
Family Involvement Subcommittee of the
Mental Health/Juvenile Justice Workgroup for
Models for Change-Pennsylvania**

Lack of Early Help Engenders Alienation for All (p. 8)

- This history of difficulty in accessing effective community services and supports can negatively affect the way families interact with systems, including juvenile justice. Lack of trust and a sense of futility replace earlier willingness to engage with resources and systems. After years of such experiences, families can bring a justifiable feeling of alienation and victimization to encounters with juvenile justice staff.
- A family's lack of success with prior system efforts can be interpreted as a history of uncooperativeness and even pathology on the part of family members. Juvenile justice staff is at risk of carrying a feeling of alienation and yes, victimization, after they meet with repeated distrust and hostility from the families with whom they are trying to engage.
- Families may be simply exhausted by the time the child has reached the level of juvenile justice involvement. Youth who have not had their needs met by previous interventions and the best, if insufficient, efforts of their families can see that failure in an unsympathetic light, particularly where a juvenile justice staff steps in to "rescue" the child from the apparent chaos and negative influences.

Recommendations for Preventing Juvenile Justice Involvement (p. 9)

The juvenile justice system should collaborate with local and state prevention programs, partnerships, and coalitions including families and family advocates to:

- Continue its commitment to developing and providing early intervention and prevention programs that are centered on the benefit of family involvement and are outcomes- and evidence-based.
- Identify, develop, and sustain evidence-based programs such as Positive Behavioral Interventions and Supports and Anti-Bullying Programs in schools and Nurse Family Partnerships and Communities That Care in the community.
- Engage with the community to reinforce the value of evidence-based programs and practices that support children's wellness and resiliency through positive, competency-based supports and interventions

A Foundation of Respect among All

(p. 10)

- “Involving families in the juvenile justice process needs to be based in respect for their role as caretaker and the knowledge and relationship that is central to that role. It is critical for the juvenile justice system to ensure that all families are given the opportunity to engage in a mutually respectful relationship with juvenile justice staff. For families to convey respect and collaborate effectively, *they must believe they are in turn respected and valued. Where families are unable or unwilling to respect the juvenile justice system and its representatives, effective partnership is unlikely.*”

A System to get Lost in (p. 16)

- “The anecdotal experiences described by participants paint an image of a juvenile justice system either overly burdened, with family involvement not regarded as part of its mission, or simply lacking sufficient resources to build and sustain effective and ongoing communications with family members of juveniles involved with the system.” (p. 10)

Reducing the Transportation Barrier (p. 12)

- Every effort should be made to support timely and appropriate visitation by family members during their child's out of home placement.
- Family visitation should not be used as reward or punishment but should be regarded as an essential and necessary tool for effective intervention and treatment.
- Family-centered practices should be part of visits, with access to supports, information, and partnering relationships with staff.
- Where family visitation is not possible, flexible alternatives should be developed with family input, such as video conferencing and local meetings with clinical and probation staff.

Recommendations for Building Respect through Communication (p. 13)

- **Local jurisdictions should identify and promote family involvement and engagement practices and processes, which support communication between families and the juvenile justice system.**
- At the systems level these could include system/ community advisory groups (County Children's Interagency Service Planning Committees, Communities That Care, System of Care/Children's Reform Grants).
- At the individual family level, such practices include Family Group Decision Making, Restorative Conferences, Multi-Systemic Therapy, Functional Family Therapy, Therapeutic Foster Care, and High Fidelity Wraparound.
- Locally grown promising practices include programs that stakeholders, including families, have identified as effective in supporting their involvement in the juvenile justice process and include Family Peer Advocates and family educational projects.

Families and the Juvenile Justice System (p. 14)

- For families to be part of the planning for the treatment and rehabilitation of their child, practices and policies must be in place to support that involvement.
- Families want to partner with and be respected by juvenile justice officials. They want to be regarded by the juvenile justice system as partners and resources, rather than extraneous, burdensome obstacles or even co-conspirators.
- Families want to partner with and be respected by juvenile justice officials. They want to be regarded by the juvenile justice system as partners and resources, rather than extraneous, burdensome obstacles or even co-conspirators. Families want to partner with and be respected by juvenile justice officials. They want to be regarded by the juvenile justice system as partners and resources, rather than extraneous, burdensome obstacles or even co-conspirators.

A Definition and Principles for Family Involvement (p.19)

- Family Involvement is empowering families, based on their strengths, to have an active role in their child's disposition and treatment.
- Effective and authentic family involvement supports the principles and practice of balanced and restorative justice and engages the family and juvenile justice system together with the youth in repairing the harm and moving the youth to become a competent and responsible community member.
- All families will act in the best interest of their child, and fulfill their role, when they have the knowledge, skills, and supports necessary to provide ongoing and developmentally appropriate guidance and interaction.
- Where families are unable to act in the best interest of their child, this should be seen as a complex phenomenon that the family would choose to counteract, if an avenue to do so presented itself.
- A juvenile justice system committed to family involvement ensures that there are flexible and authentic opportunities for families to partner in the design, implementation, and monitoring of their child's plan, as well as juvenile justice system policy, program, and practices which support responsive, effective outcomes for youth.

The Relationship Between Parenting and Delinquency: A Meta-analysis

Machteld Hoeve · Judith Semon Dubas ·
Veroni L. Eichelsheim · Peter H. van der Laan ·
Wilma Smeenk · Jan R. M. Gerris

Published online: 5 March 2009

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Abstract This meta-analysis of 161 published and unpublished manuscripts was conducted to determine whether the association between parenting and delinquency exists and what the magnitude of this linkage is. The strongest links were found for parental monitoring, psychological control, and negative aspects of support such as rejection and hostility, accounting for up to 11% of the variance in delinquency. Several effect sizes were moderated by parent and child gender, child age, informant on parenting, and delinquency type, indicating that some parenting behaviors are more important for particular contexts or subsamples.

Although both dimensions of warmth and support seem to be important, surprisingly very few studies focused on parenting styles. Furthermore, fewer than 20% of the studies focused on parenting behavior of fathers, despite the fact that the effect of poor support by fathers was larger than poor maternal support, particularly for sons. Implications for theory and parenting are discussed.

Keywords Child-rearing · Delinquency · Meta-analysis · Moderators · Development

The Relationship Between Parenting and Delinquency: A Meta-analysis

Hoeve et al (2009)

This meta-analysis demonstrates that a significant relationship exists between parenting and delinquency and confirms previous research that behavioral control, such as parental monitoring is negatively linked to delinquency (Barber [1996](#); Patterson and Yoerger [1993](#)). Moreover, this meta-analysis revealed that negative aspects of support including rejection, hostility and neglect and psychological control had the strongest links to delinquency. Furthermore, several indicators of parental monitoring, including parental knowledge, child disclosure, and active monitoring by parents, had similar links to delinquency.

Chassin et al (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders. JSAT.

- Criminal offending is the outcome of most direct interest in terms of justice system policy implications
- Only interventions with family involvement produced statistically significant reductions in nondrug offending (compared to treatments without family involvement).
- Our findings are consistent with those that have supported the use of family therapy (multidimensional family therapy, multisystemic therapy, functional family therapy) in reducing antisocial behavior among adolescents (Liddle, 2004) and Woolfenden et al, 2002).
- Moreover, some evidence of effect was still detectable 1 year after the termination of treatment. Thus, although alcohol use was reduced in treatments without family involvement, broader impact on important outcomes (cigarette smoking and nondrug offending) was only obtained with family involvement.
- Given the rather low prevalence of family involvement in treatment in our sample (approximately one quarter of the treated cases), justice system policies that help to engage families might be useful in promoting desistance from criminal offending.

Chassin et al (2009). Substance use treatment outcomes in a sample of male serious juvenile offender. Journal of Substance Abuse Treatment 36 (2009) 183 – 194.

Adolescents & Families

“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)

Families

“The most successful programs are those that emphasize family interactions, probably because they focus on providing skills to the adults who are in the best position to supervise and train the child.” (Greenwood, 2009)

Families

“In this era of an increased focus on public sector accountability, one of the important questions posed to policymakers and elected officials may be *‘Why are you waiting so long to support families?’*” (Duchnowski, Hall, Kutash, & Friedman, 1998)



“Families play the most important role in determining how children handle the temptations to use alcohol, cigarettes, and illegal drugs.”

Source: “Keeping Children Drug Free: Using Family-Centered Approaches—A Parent and Community Guide,” The Center for Substance Abuse Prevention (CSAP) and Substance Abuse and Mental Health Services Administration (SAMHSA), 1998.

Adolescent drug treatment since 2002

- Conclude that the programmatic research on family-based approaches consistently improves upon previous research and findings demonstrating positive outcomes
- Vaughn and Howard's (2004) hybrid meta-analysis/quality of evidence review, Multidimensional Family Therapy (MDFT; Liddle, 2002) and cognitive behavioral group treatment (CBT) emerged as most efficacious. Becker and Curry's (2008) quality of evidence review revealed that multiple systems-oriented family therapies (MDFT and Mutisystemic Therapy, MST; Henggeler & Borduin, 1990) were among only three approaches (CBT and brief motivational interviewing included) to demonstrate comparatively superior treatment effects in the highest quality adolescent drug treatment studies.
- Finally, a meta-analysis by Waldron and Turner (2008) reported that only three of 46 adolescent drug treatments could be classified as "well-established," including MDFT, Functional Family Therapy (FFT; Alexander & Parsons, 1982), and CBT.
- Three additional family-based models in this meta-analysis were considered "probably efficacious" (BSFT, MST, and behavioral family therapy).
- A fourth review by Austin, MacGowan, and Wagner (2005) focused specifically on family-based interventions for substance use problems and categorized MDFT and BSFT as "probably efficacious" and three other models (MST, FFT, and behavioral family therapy) as "possibly efficacious."
- Thus, family-based treatments are well established among the most effective treatments for adolescent drug abuse.

Developmental Status of this Specialty

- Liddle and Dakof JMFT (1995): “Promising but not definitive” findings in both the adolescent and adult specialty areas
- Rowe & Liddle JMFT (2002): Family therapy recognized among most effective interventions with drug abusing teens; also encouraging new research with adults
- Current status: Family therapy firmly established as among the most powerful treatments for both adolescent and adult drug abuse
- Carroll & Onken (2005): “The body of work on family and couples approaches is marked by the consistency of positive findings regarding the efficacy of these approaches.”

Family Approaches Among Most Effective Drug Treatments for Teens

**Vaughn & Howard
(2004) meta analysis/
quality of evidence
review: most
efficacious treatments**

- **Multidimensional Family Therapy (MDFT)**
- **Cognitive Behavior Therapy (CBT)**

**Becker & Curry (2008)
quality of evidence
review: superior
effects in highest
quality studies**

- **Multiple Systems Oriented Therapies (MDFT/MST)**
- **Cognitive Behavior Therapy**
- **Brief Motivational Interviewing**

**Waldron & Turner
(2008) meta analysis:
well established
adolescent drug
treatments**

- **Multidimensional Family Therapy**
- **Functional Family Therapy**
- **Cognitive Behavior Therapy**

Adolescent Development: ***A Quick Tour***

The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs

Results of an In-depth National Survey

Rosalind Brannigan, MPH; Bruce R. Schackman, PhD; Mathea Falco, JD; Robert B. Millman, MD

Background: Drug and alcohol abuse and dependence are the most prevalent causes of adolescent morbidity and mortality in the United States. Effective, accessible treatment for adolescents with substance abuse problems is urgently needed.

Objective: To conduct the first systematic evaluation of the quality of highly regarded adolescent substance abuse treatment programs in the United States.

Methods: An advisory panel of 22 experts defined 9 key elements of effective treatment for adolescent substance abuse based on a review of the literature. In-depth telephone and written surveys were conducted with 144 highly regarded adolescent substance abuse treatment programs identified by panel members and by public and private agencies. There was a 100% response rate to the initial interviews, and a 65% response rate to the follow-up surveys. The open-ended survey responses were coded by defining 5 components deemed to be crucial in addressing each of the 9 key elements, and quality scores were calculated overall and for each of the 9 key elements.

Results: Out of a possible total score of 45, the mean score was 23.8 and the median was 23. Top-quartile programs were not more likely to be accredited. The majority of programs scored at least 4 of a possible 5 on only 1 of the 9 key elements (qualified staff). The elements with the poorest-quality performance were assessment and treatment matching, engaging and retaining teens in treatment, gender and cultural competence, and treatment outcomes.

Conclusions: Most of the highly regarded programs we surveyed are not adequately addressing the key elements of effective adolescent substance abuse treatment. Expanded use of standardized assessment instruments, improved ability to engage and retain youths, greater attention to gender and cultural competence, and greater investment in scientific evaluation of treatment outcomes are among the most critical needs. Expanding awareness of effective elements in treating adolescents will lead the way to program improvement.

Arch Pediatr Adolesc Med. 2004;158:904-909

National Institute on Drug Abuse Behavioral Therapies Development Program - Effective Drug Abuse Treatment Approaches

Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT) for Adolescents is an outpatient family-based drug abuse treatment for teenage substance abusers (Liddle, 1992; Liddle, in press). From the perspective of MDFT, adolescent drug use is understood in terms of a network of influences (i.e., individual, family, peer, community). This multidimensional approach suggests that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts and through different mechanisms. The therapeutic process is thought of as retracing the adolescent's development in the multiple ecologies of his or her life. The therapy is phasically organized, and it relies on success in one phase of the therapy before moving onto the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions. The approach has been tested in three major randomized trials (two treatment and one prevention/early intervention), and in several process studies. A treatment manual (Liddle, 1998) and adherence scales have been developed (Hogue, Liddle & Rowe, 1996; Hogue et al., 1997). Current tests of this outpatient family therapy approach include its comparison against a residential treatment program and a twelve week version of the model that is the only family therapy approach being tested in the CSAT Cannabis Youth Treatment Multisite Collaborative Study.

The MDFT treatment format includes individual and family sessions, and sessions with various family and extrafamilial sessions. Sessions are held in the clinic, in the home, or with family members at the family court, school or other relevant community locations. Change for the adolescents and parents is intrapersonal and interpersonal, with neither more important than the other. The therapist helps to organize treatment by introducing several generic themes. These are different for the parents (e.g., feeling abused and without ways to influence their child) and adolescents (e.g., feeling disconnected and angry with their parents). The therapist uses these themes of parent-child conflict as assessment tools and as a way to identify workable content in the sessions.

During individual sessions, the therapist and adolescent work on important developmental tasks such as decision-making and mastery. The teenager is helped to acquire skills in communicating his or her thoughts and feelings. Also taught are

In-Depth Look:

Multidimensional Family Therapy

**Center for Treatment Research
on Adolescent Drug Abuse**
School of Medicine
University of Miami
Dominion Tower, Suite 1108
1400 NW 10th Avenue
Miami, Florida 33136
(305) 243-6434
www.miami.edu/ctrada

Multidimensional Family Therapy (MDFT) is an outpatient family-based program to treat adolescents with drug abuse and behavioral problems. The program works intensely at the same time with the individual adolescent; the family apart from the adolescent; the family and teen together; and social systems that affect both, such as schools, courts, peer groups and the community. MDFT has a strong theoretical structure based on

manuals allow replication of the program, which has been implemented in 16 other sites across the country.

**Assessment and Matching**

Therapists assess each adolescent's risk factors such as school failure, parental drug abuse, connection with drug using peers, and family conflict as well as protective factors, including strong bonds to family, school and religious organizations and clear, consistent parental discipline. Observation and clinical interviews are used to determine individual and family functioning. The approach is applied at various levels of intensity depending on individual needs. Because the teen's and family's functioning in their everyday environment is so important to positive development, therapists help families

depending on the intensity of the intervention being used. MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Therapists and client/family members attend school meetings, wait in court rooms, ride in elevators or sit in parks. The interaction and insights provided in these informal settings are critical for increasing trust between therapists and clients and for improving family dynamics. MDFT incorporates multiple social systems into its therapeutic work. Its operations involve family, peer groups, courts, schools, psychiatric and other community services. Therapists are in constant contact with all these institutions to help coordinate services and to assess treatment progress. For example, therapists work with schools to obtain

**Family Involvement**

Since MDFT seeks to improve the parent/child relationship, therapists work diligently to involve parents in the treatment. MDFT understands how a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills, and addressing the family environment as a whole. Therapists have frequent telephone contact with families to follow up on issues raised in counseling and to monitor the home environment.

**Developmentally Appropriate**

MDFT strives to foster the adolescent's functioning in multiple domains



Best Practice Initiative

from the Assistant Secretary for Health
U.S. Department of Health and Human Services



Multidimensional Family Therapy (MDFT) for Adolescent Substance Abuse

(Center for Treatment Research on Adolescent Drug Abuse,
University of Miami School of Medicine, 2002)

Project Accomplishments

Multidimensional family therapy (MDFT) has been recognized as one of the most promising interventions for adolescent drug abuse in a new generation of comprehensive, multicomponent, theoretically-derived and empirically-supported treatments (CSAT, 1999; NIDA, 1999; Drug Strategies, 2002; Waldron, 1997; Weinberg et al., 1998; Williams & Chang, 2000). MDFT has demonstrated efficacy in four randomized clinical trials, including three treatment studies (one of which was a multisite trial) and one prevention study. Investigators

27

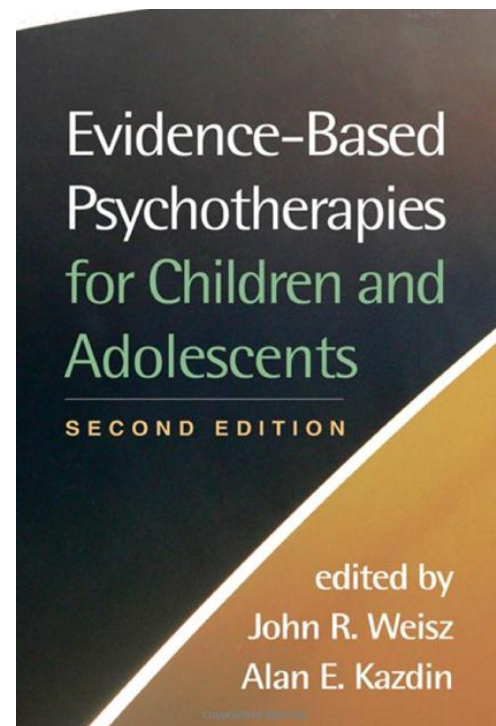
Treating Adolescent Substance Abuse Using Multidimensional Family Therapy

HOWARD A. LIDDLE

Overview of the Clinical Problem

The nature of a clinically referred adolescent's presenting problems makes treating teen drug abuse challenging. These problems are multivariate, such as the often secretive aspects of drug use; involvement in illegal and criminal activities with antisocial or drug-using peers; despairing, stressed, and poorly functioning families; involvement in multiple social agencies; disengagement from school and other prosocial contexts of development; and lack of intrinsic motivation to change. Many new developments in the drug abuse and delinquency specialties provide guidance and hope. We have witnessed an unprecedented volume of basic and treatment research, increased funding for specialized youth services, and a burgeoning interest in the problems of youths from basic

research and applied prevention and treatment scientists, policymakers, clinicians and prevention programmers, professional and scientific societies, mass media and the arts, and the public at large. Developmental psychology and developmental psychopathology research has revealed the forces and factors that combine and contribute to the genesis of teen drug experimentation and abuse. Perhaps a consensus about a preferred conceptualization and intervention strategy has been reached. Leading figures in the field now conclude that drug abuse results from both intraindividual and environmental factors. For this reason, unidimensional models of drug abuse are inadequate and multidimensional research and intervention approaches are necessary.



Liddle, H. A., Rodriguez, R. A., Dakof, G. A., Kanzki, E., & Marvel, F. A. (2005). Multidimensional Family Therapy: A science-based treatment for adolescent drug abuse. In J. Lebow (Ed.), *Handbook of clinical family therapy* (pp.128-163). New York: John Wiley and Sons.

[Download this chapter --](#)

[http://med.miami.edu/ctrada/documents/MDFT_Epacket/Liddle%20et%20al%20\(2005\)%20Multidimensional%20Family%20Therapy,%20Lebow.pdf](http://med.miami.edu/ctrada/documents/MDFT_Epacket/Liddle%20et%20al%20(2005)%20Multidimensional%20Family%20Therapy,%20Lebow.pdf)

[MDFT Film – 10:28](#)

<http://www.youtube.com/watch?v=SkRk6fCdlng&feature=youtu.be>

[Short videos --](#)

<http://www.youtube.com/user/CTRADA>

CHAPTER 6

Multidimensional Family Therapy: A Science-Based Treatment for Adolescent Drug Abuse

Howard A. Liddle, Rosemarie A. Rodriguez, Gayle A. Dakof, Elda Kanzki, and
Francoise A. Marvel

Substance use and abuse during adolescence is strongly associated with other problem behaviors such as delinquency, precocious sexual behavior, deviant attitudes, or school dropout . . . Any focus on drug use or abuse to the exclusion of such correlates, whether antecedent, contemporaneous, or consequent, distorts the phenomenon by focusing on only one aspect or component of a general pattern or syndrome (Newcomb & Bentler, 1989).

MDFT is a Treatment System

- Different adaptations – versions
- Context
- Time and dose
- Client characteristics
- Examples: In-detention + post release; residential + post discharge; Intensive outpatient vs. residential; Katrina; HIV / STD prevention

MDFT Research Program - Features & Themes

- Began in **1985** - NIDA 90%; CSAT 8%; Private Foundations 2%
- Defining and testing **different versions** - MDFT as **treatment system**
 - Variations (versions) according to stage & nature of dysfunction, age, gender, cultural / ethnic factors, clinical setting
- **Research-based** knowledge about development and dysfunction
 - Own and others use; delinquency; school problems
- Therapeutic **ingredients and processes**
 - Alliance, parenting, culture, in-session conflict
- **Therapist** competence and development
 - Stages and methods of training, context factors
- **Efficacy:** Rigorous treatment evaluation under “ideal” conditions
- **Effectiveness:** Rigorous treatment evaluation in regular clinical settings
 - Drug court, residential vs. intensive outpatient, community clinics
- **Economic / cost** studies
- **Transportation / implementation** studies

Juvenile Justice Involved Youths in Multidimensional Family Therapy

- RCTs
 - Juvenile Drug Court
 - MDFT vs. Group vs. Multi-Family (61% adolescents on probation)
 - CBT vs. MDFT (73% adolescents on probation, 77% parents involved in criminal justice)
 - MDFT as an Outpatient Alternative (Residential vs. MDFT)
 - Civil Citation Program (Miami Dade JAC) + MDFT
 - Detention to Community
 - JJ Day Treatment
- Implementation Studies
 - Detention to Community – Implementation

NOTE:

Completed

Ongoing

MDFT vs. Individual Cognitive Behavioral Therapy for the Adolescent

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*.

Treating adolescent drug abuse: a randomized trial comparing multidimensional family therapy and cognitive behavior therapy

Howard A. Liddle¹, Gayle A. Dakof¹, Ralph M. Turner², Craig E. Henderson³ & Paul E. Greenbaum⁴

University of Miami Miller School of Medicine, Miami, FL, USA,¹ University of the Sciences, Philadelphia, Pennsylvania, USA,² Sam Houston State University, Huntsville, TX, USA³ and University of South Florida, Tampa, FL, USA⁴

ABSTRACT

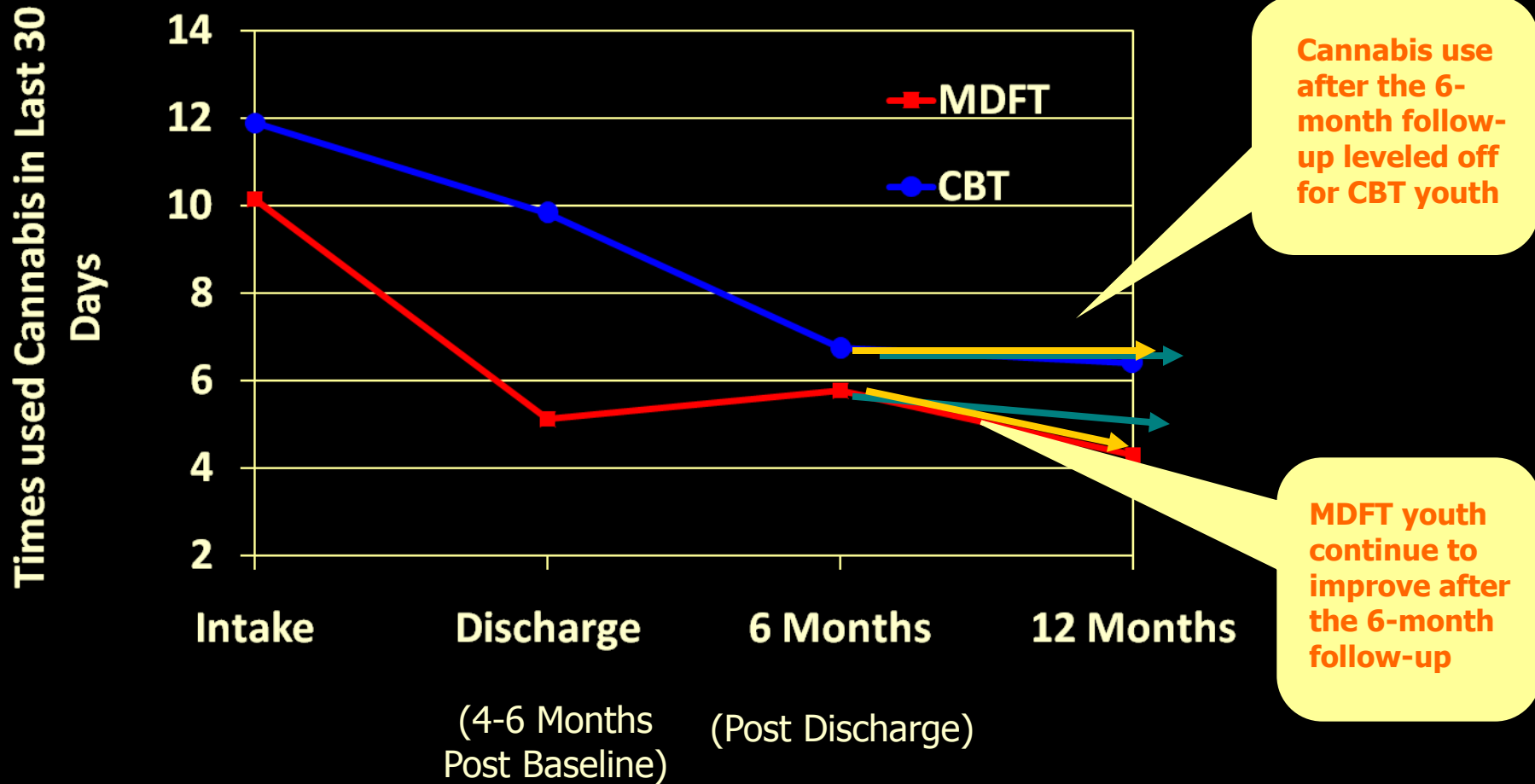
Aim To examine the efficacy of two adolescent drug abuse treatments: individual cognitive behavioral therapy (CBT) and multidimensional family therapy (MDFT). **Design** A 2 (treatment condition) x 4 (time) repeated-measures intent-to-treat randomized design. Data were gathered at baseline, termination, 6 and 12 months post-termination. Analyses used latent growth curve modeling. **Setting** Community-based drug abuse clinic in the northeastern United States. **Participants** A total of 224 youth, primarily male (81%), African American (72%), from low-income single-parent homes (58%) with an average age of 15 years were recruited into the study. All youth were drug users, with 75% meeting DSM-IV criteria for cannabis dependence and 13% meeting criteria for abuse. **Measurements** Five outcomes were measured: (i) substance use problem severity; (ii) 30-day frequency of cannabis use; (iii) 30-day frequency of alcohol use; (iv) 30-day frequency of other drug use; and (v) 30-day abstinence. **Findings** Both treatments produced significant decreases in cannabis consumption and slightly significant reductions in alcohol use, but there were no treatment differences in reducing frequency of cannabis and alcohol use. Significant treatment effects were found favoring MDFT on substance use problem severity, other drug use and minimal use (zero or one occasion of use) of all substances, and these effects continued to 12 months following treatment termination. **Conclusion** Both interventions are promising treatments. Consistent with previous controlled trials, MDFT is distinguished by the sustainability of treatment effects.

Keywords Adolescent drug abuse, adolescent treatment research, cognitive behavioral therapy, family-based interventions, multidimensional family therapy, randomized controlled trial.

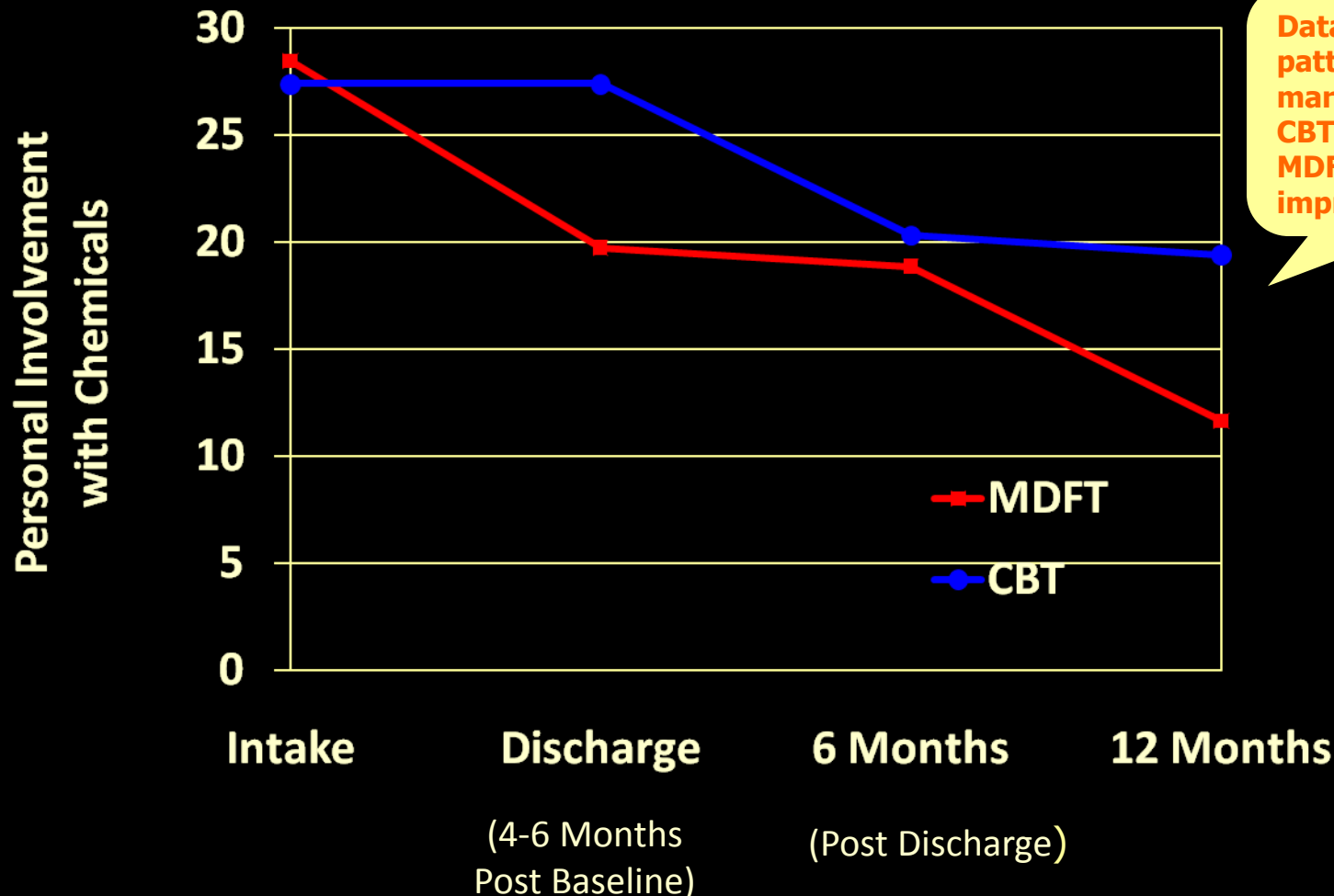
MDFT vs. Individual Cognitive Behavioral Therapy for the Adolescent

- 224 young people randomized to MDFT or Cognitive Behavioral Therapy (CBT)
- Sample Characteristics
 - Between 13 and 17 years (M=15.4)
 - Primarily Male (81%) and African American (72%)
 - 88% diagnosed with substance dependence, 32% with substance abuse
 - Average of 2.5 different DSM-IV diagnoses
 - 66% pending adjudication or on probation at intake.

MDFT and CBT Average Change in Cannabis Use from Intake to 12 Month Follow-Up

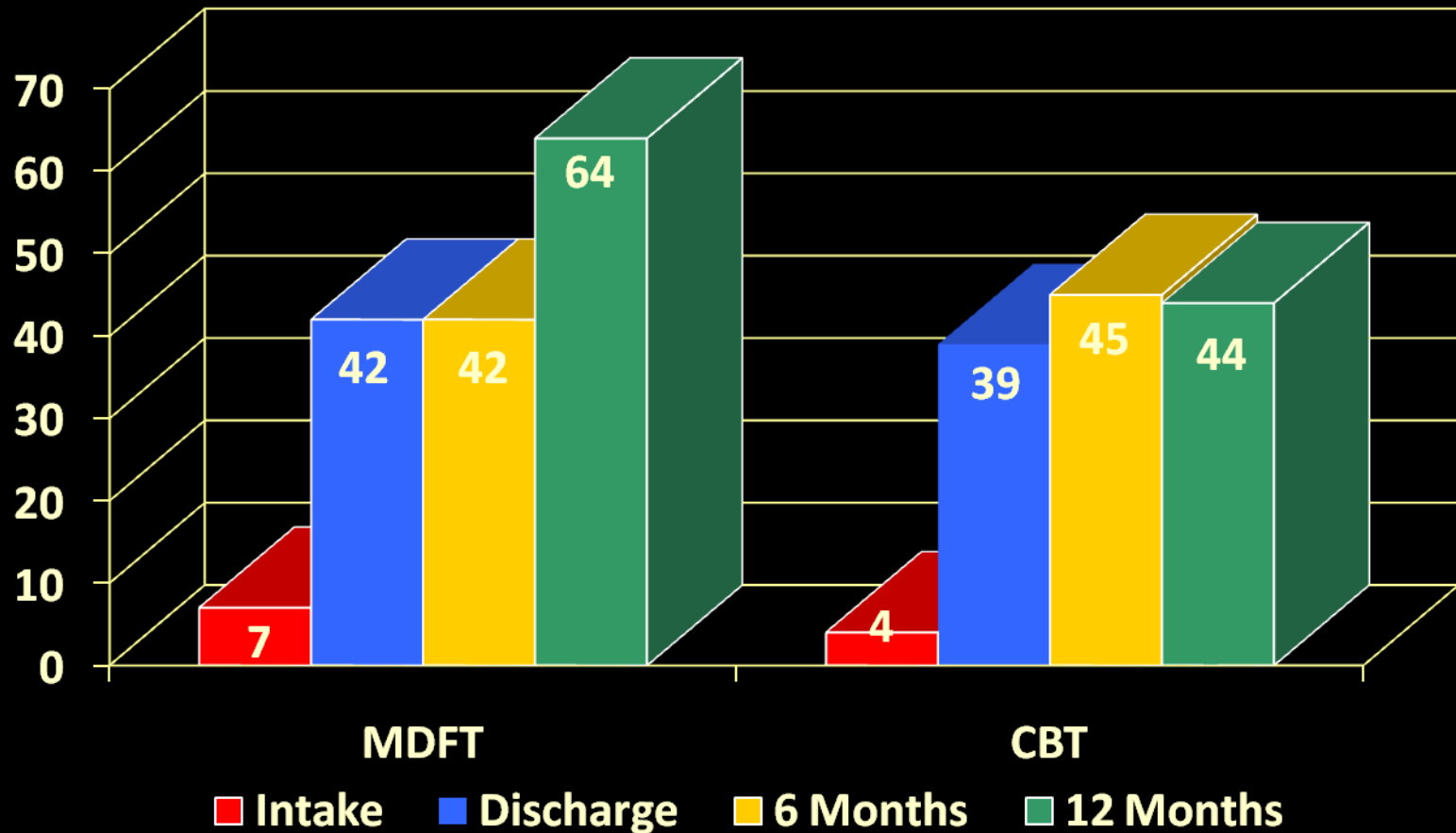


MDFT and CBT Average Change in Psychological Involvement with Drugs from Intake to 12 Month Follow-Up



Data show similar pattern as marijuana use, with CBT leveling off and MDFT continuing to improve

Proportion of Adolescents Abstaining from Cannabis Use



DTC Study Impetus and Background

- Juvenile justice involved youths have multiple and interrelated impairments – substance abuse, criminal behavior, HIV and STD risk, and school failure
- Existing services are fragmented, uncoordinated and not comprehensive
- They fail to incorporate evidence based practice principles or interventions
- Research shows mixed outcomes or effectiveness on a single or limited range of outcomes
- State of the science, integrative interventions can be developed to meet system and client needs
- Intervention and research strategies must be multisystems oriented

DTC Study Aims & Design

- Aims – Effectiveness of new intervention compared to Enhanced Services as Usual on youths substance abuse, delinquent behavior, HIV / STD risk, economic, and system collaboration outcomes
- Design – Randomized controlled trial (RCT) provides a rigorous comparison of the acceptability, effectiveness, benefits and costs, and systems-level impact of the experimental treatment – multidimensional family therapy (MDFT) and enhanced services as usual (ESAU)

DTC Study Design

- Two study sites - Miami-Dade Co. and Pinellas Co. Fla.
- Participants – 154 youths in two juvenile detention centers
- Participants randomized to MDFT-DTC or ESAU
- Two study / intervention phases

Phase 1 – In-Detention

- Both conditions receive same CDC Standard HIV group
- MDFT youth receive individual and family session(s)
- ESAU receive detention services as usual

Phase 2 – Post Release - Outpatient (in community)

- MDFT youth receive Family, Adolescent, Parent, Extrafamilial, Social System interventions, and MDFT Family Based HIV Prevention
- ESAU Community Treatment Services as Usual and HIV Prevention as usual

Study Design

Youth Screened on Substance Abuse & Placement Risk

MDFT-DTC 76

43 Miami

33 Pinellas

T1-Baseline Assessment & Randomization

N = 154

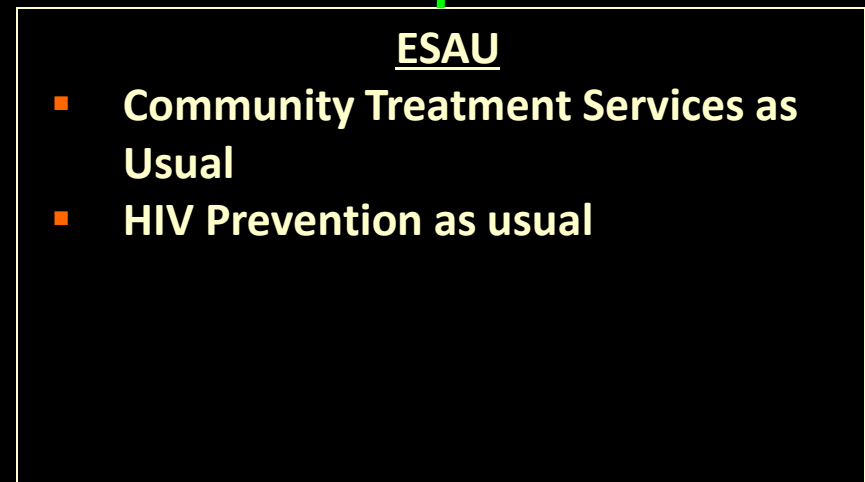
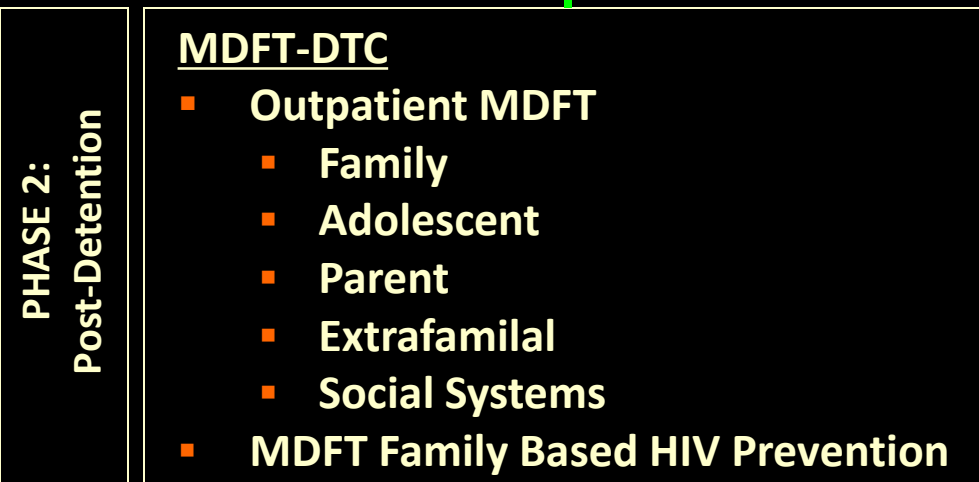
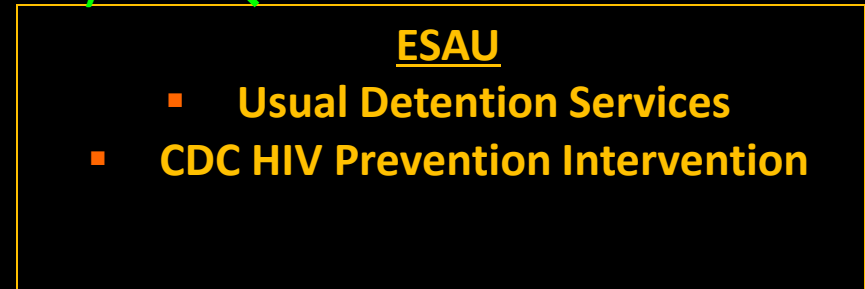
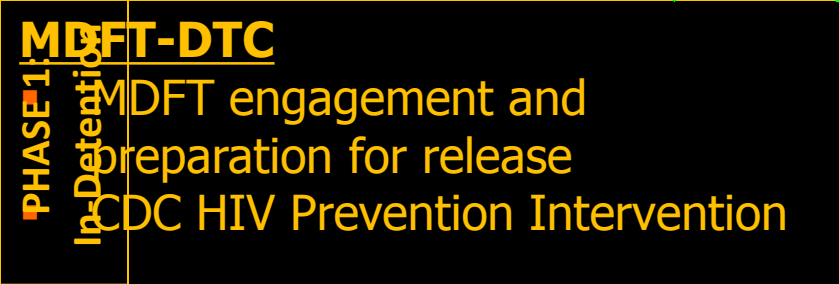
(Miami = 85)

(Pinellas = 69)

ESAU 78

42 Miami

36 Pinellas



T2 3 months

T3 6 months

T4 9 months

Sample

- 154 youths (13-17) detained in a juvenile detention facility
 - Sample was pre-adjudicated thus NOT mandated to tx
- African-American (60%), Hispanic (22%), White, Non-Hispanic (17%)
- Male (82%), Female (18%)
- Age range 13-17; average age 15
- 4 average lifetime arrests
- 40% had been detained previous to this incarceration
- 30% were already on probation when incarcerated

Sample

- 61% cannabis use disorder; 20% alcohol use disorder; 10% other drug dependence/abuse
- 43% conduct disorder; 20% ADHD
- 74% engaged in high risk sex behaviors
- 50% history of victimization
- 3rd and 4th grade math and reading
- 64% of sample were from single parent homes
- \$18,000 annual income
- 39% parents with alcohol/drug problems
- 77% parents involved in criminal justice system

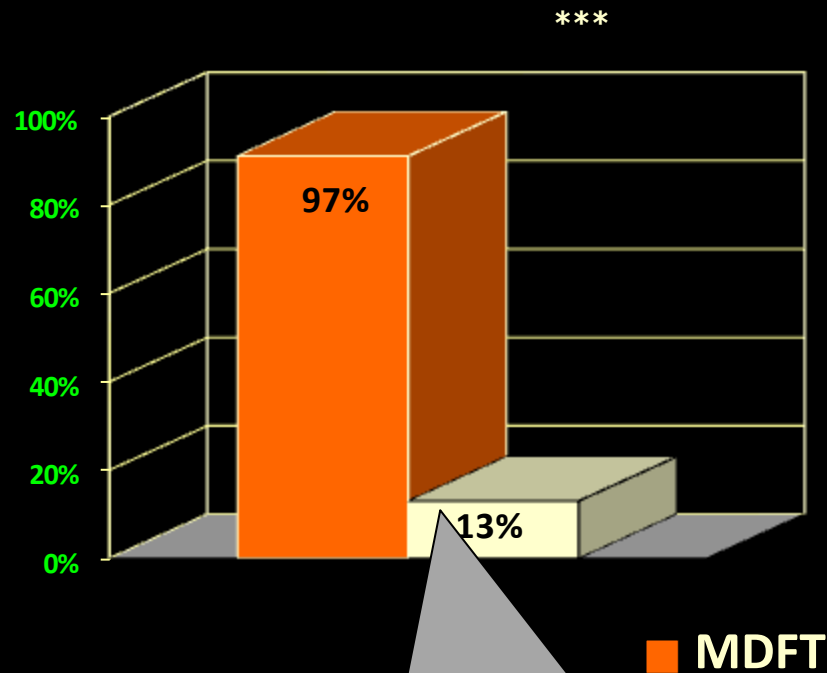
DTC Study – Experimental Intervention Overview

- Developed an unique cross-system, two stage family-based intervention with HIV/STD prevention for substance abusing juvenile offenders
 - Multidimensional Family Therapy (MDFT; Liddle, 2002).
- Targets youths' substance use, criminal behavior, and HIV/STD risk.

DTC Study – Experimental Intervention Overview

- Stage 1 establishes relationships, assesses needs, and builds a platform for post-detention, multisystems interventions with the teen and family
 - MDFT is provided to youths and their families in juvenile detention settings
- Stage 2 occurs after the youth returns home, with family therapy, individual work with the teen and parent(s), HIV/STD prevention, and case management for 4 months.

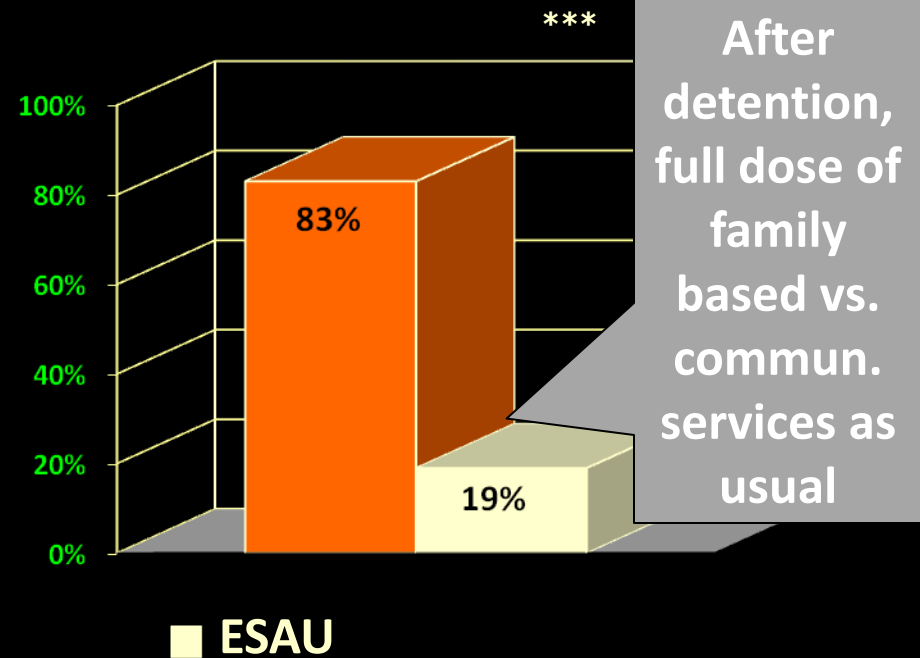
Service Retention: Percentage of Clients Retained for 3 Months of Treatment



- DATOS-A Grella et al 27% receive 3 mo.
- Comparative engagement and retention rates

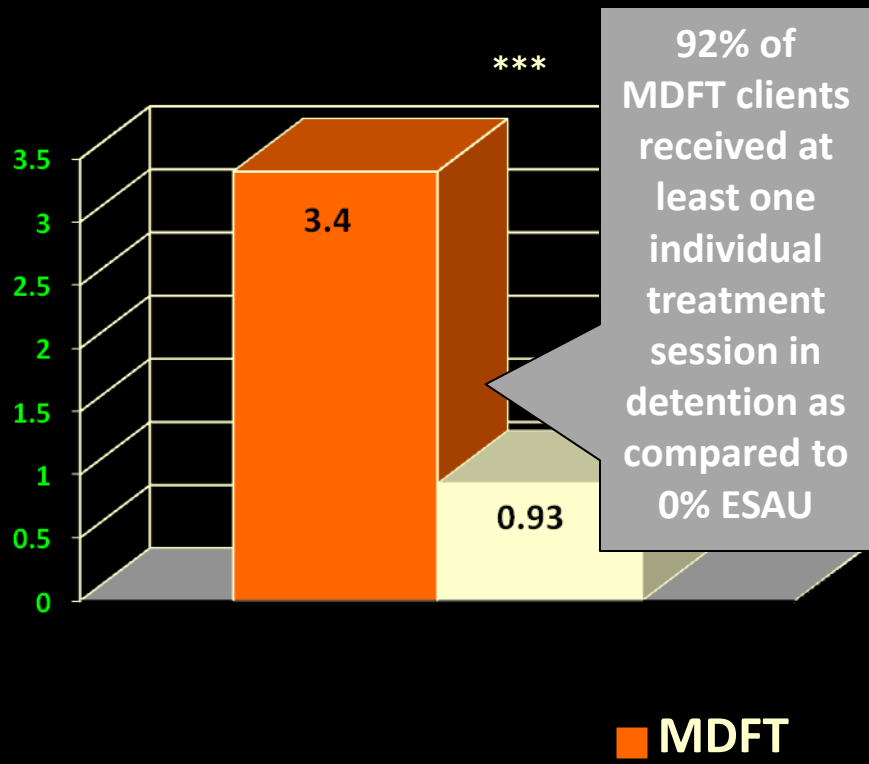
***p<.001

Amount of Services Received: Percentage of Clients Receiving Full Dose of Treatment in the Community Post-Release



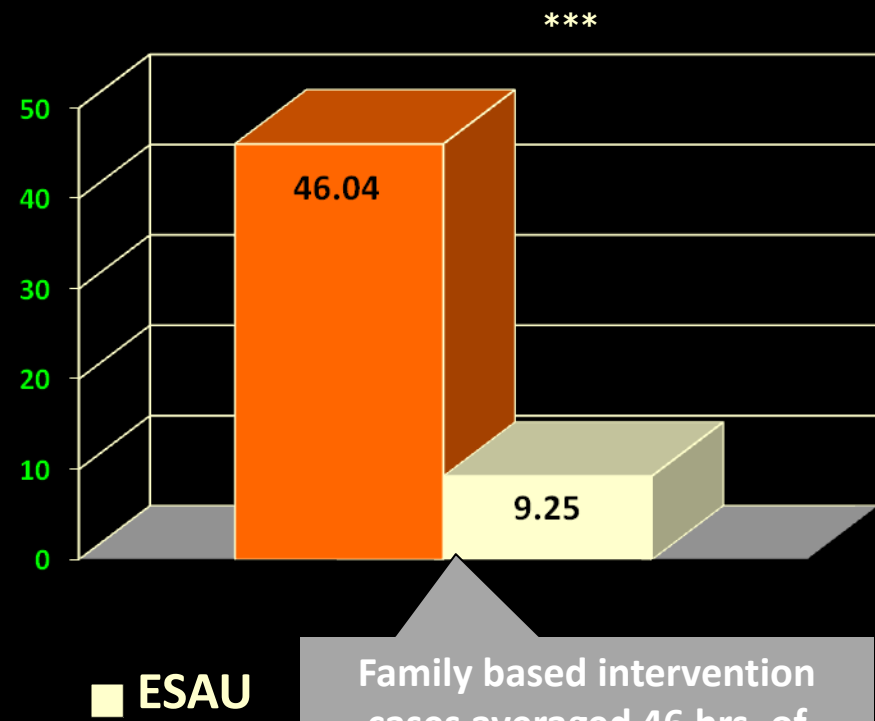
After detention, full dose of family based vs. commun. services as usual

In-Detention Services Received (in Hours)



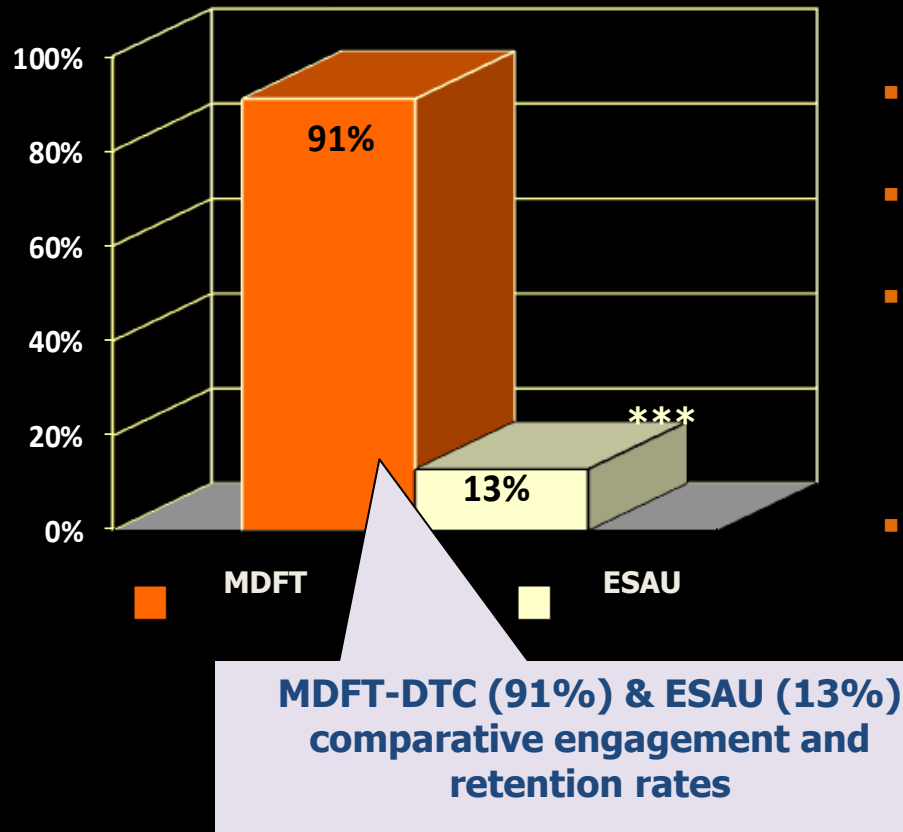
*** $p < .001$

Post Detention Community Services Received (in Hours)



Engagement and Retention Outcomes

Percentage of Clients Retained for 3 Months of Treatment



Engagement & Retention Rates in Context

- Kazdin et al (1997) adolescent therapy studies: 40-60% drop out rate
- DATOS-A 3 mo. retention 27% (Grella et al 2001)
- CSAT data base (Dennis, 2008)
 - All levels of care 3 mo. retention 25%
 - IOP 3 mo. retention 36%
 - OP 3 mo. retention 35%
- MDFT-DTC 3 mo. retention 91%
- Previous studies - MDFT retention
 - MDFT IOP 3 mo. retention 95%
 - MDFT IOP 6 mo. retention 88%
 - MDFT OP 4 mo. retention 96%

9-Month Outcomes

Drug Use, Delinquency,
Mental Health Symptoms, Sexual Risk

Youth in both treatments improved significantly on
all outcomes from intake through 9 months
following baseline

Drug Use & Delinquency: 9 Months

- Drug use decreased more in MDFT than ESAU in Pinellas ($d=.75$) but not in Miami ($d=.14$)
- Self-reported delinquency decreased more in MDFT than ESAU in Pinellas ($d = .63$) and Miami ($d = .69$)
- Fewer days detained for MDFT than ESAU in Pinellas ($d = 2.79$) but not in Miami ($d = .28$)

HIV Risk & Mental Health Symptoms: 9 Months

- HIV Risk (unprotected sex acts) decreased more among MDFT youth than ESAU youth across both sites ($d = 2.18$).
- Internalizing symptoms decreased more among MDFT youth than ESAU youth in Miami ($d = 1.17$), but not in Pinellas ($d = .03$)

Summary of Treatment Outcomes

- Overall, MDFT more effective than ESAU
- The effects were often stronger in Pinellas than in Miami

Possible Explanation of Site Effects

- A pattern of MDFT being more effective than ESAU with more seriously impaired youth (youth in Pinellas more severe than youth in Miami)
- Among MDFT youth, greater JPO and therapist collaboration in Pinellas in comparison to Miami at release ($d = 1.90$) and discharge from outpatient treatment ($d = 2.83$).
- Across both sites, greater collaboration during outpatient treatment was related to greater decrease in drug use ($d = .23$)

MDFT Detention to Community Intervention Outline

- **Overview:** Liddle, H.A., G.A. Dakof, C.E. Henderson, and C.L. Rowe, Implementation Outcomes of Multidimensional Family Therapy-Detention to Community (DTC) -- A Reintegration Program for Drug-Using Juvenile Detainees. *International Journal of Offender Therapy and Comparative Criminology* in press.
- **Phase 1 In-Detention/In-Facility**
 - Use as a pause, a respite, a time to calm down, and re-group, and as a time to create urgency (now or never; all hands on deck)
 - Creates a platform for ongoing work on an outpatient basis
 - Focus on developing multiple therapeutic alliances and enhancing motivation to participate in treatment and to change behavior
 - Prepare for successful release--youth, family, school & legal systems

MDFT Detention to Community Intervention

- Phase 2
 - Community Based MDFT

MDFT Detention to Community Treatment Overview

- Step 1
 - Initial phone call to parents at home
 - Introduce program
 - Begin engagement process
 - Determine who should be present at first parent session, and location of session
 - Schedule first parent session

MDFT Detention to Community Intervention Overview

- First Session with Parents Alone
 - In home or clinic
 - Introduce program
 - Explain confidentiality
 - Solicit parent view of the problem
 - Develop therapeutic alliance
 - Instill hope
 - Highlight seriousness and urgency
 - Obtain releases to talk to attorney, PO, school etc

MDFT Detention to Community Intervention Overview

- First Session Alone with Adolescent, In detention
 - Introduce program
 - Explain confidentiality
 - Develop therapeutic alliance
 - Help youth reflect on self—current reality; past, present, future; options; goals
 - Prepare youth for first session with family
 - Obtain releases to talk to attorney, PO, school, etc
 - Take advantage of in-detention psychiatric services if indicated

MDFT Detention to Community Intervention Overview

- Initial Work in Extrafamilial Realm
 - Contact attorney and JPO
 - Introduce self and explain role
 - Address any urgent issues
 - Get records (face sheet, upcoming court dates, status, etc)
 - Begin collaboration with juvenile justice and court partners

MDFT Detention to Community Overview

- First Family Session in Detention
 - Welcome the family to program, address questions and concerns
 - Develop themes established in Sessions 1 and 2
 - Develop multiple therapeutic alliances
 - Facilitate family conversations (enactment) highlighting strengths, competencies, & concerns
 - Reduce blame and guilt
 - Emphasize seriousness and urgency
 - Enhance motivation to participate in treatment and change behaviors
 - Lend optimism
 - Prepare for release back home
 - Introduce TA

MDFT Detention to Community Intervention Overview

- Core Work: Adolescent Alone, In detention
 - Continue to develop therapeutic alliance
 - Enhance motivation to participate in treatment and change behavior
 - Further develop themes established in Sessions 2 & 3
 - Deepen focus on self-examination, life review, hope & dreams, immediate challenges
 - Deepen focus on legal issues/delinquency, drugs, family

MDFT Detention to Community Intervention Overview

- Core Work: Parents Alone, In – Detention Phase
 - Continue to develop therapeutic alliance
 - Further develop themes established in Sessions 2 & 3
 - Address concerns about youth's release home
 - Strengthen beliefs about parental influence
 - Empower parents
 - Launch the Parental Re-connection Interventions
 - Develop plan for release home (realistic expectations, fresh start, reduce parental negativity)

MDFT Detention to Community Intervention Overview

- Core Work: Adolescent Alone, In Detention
 - Discuss in a focused and practical way anticipated problems and challenges
 - Develop a simple plan to minimize problems and challenges
 - Bring into relief the consequences of failure
 - Enhance therapeutic alliance
 - Enhance motivation to participate in treatment and change behavior
 - Lend hope and optimism

MDFT Detention to Community Intervention Overview

- Core Work: First Session with Family at Home, at release
 - Should occur within 2-days of release, preferably on day of release
 - Celebrate that we have gotten to this point
 - Develop alliance
 - Enhance motivation
 - Review anticipated problems and challenges and plans to minimize
 - Enhance love and connection between youth and parents
 - Punctuate this as a fresh start, new beginning
 - Schedule next sessions

4-Month Residential + 6- Month Community Based / Outpatient

- Pilot Program in State of Connecticut
- 8-bed boys unit opened in December 2010; girls program will open in July 2011
- MDFT Residential Program
 - MDFT from day 1
 - Entire program is infused with MDFT thinking and interventions
 - Substantial change in youth and parents/parenting accomplished while in residential, and further developed and deepened in the outpatient phase

Preliminary Results

- Interim analyses - changes from intake, to 3 and 6-month follow-ups
- Report between-treatment effect sizes (Cohen's d) rather than significance tests given that the results are based on an incomplete sample at present
- *Treatment Engagement and Retention*: MDFT engaged 99% of youths and their families into treatment in detention, and retained 97% in the post-detention outpatient phase.

DTC Study Conclusions

- 1) A comprehensive, family based, systems spanning intervention that included a structured HIV prevention module, can be implemented successfully and found highly acceptable by teens, families and juvenile justice system personnel
- 2) Multiproblem juvenile justice involved youths and their parents can be engaged and retained in a short term community based therapy that meets their needs
- 3) MDFT-DTC is considerably more effective on all outcome domains than Enhanced Services As Usual
- 4) MDFT is the first intervention to demonstrate positive outcomes in all four target areas - substance abuse, criminal behavior, high HIV risk sexual behavior and STD incidence
- 5) These outcomes add to previous findings about MDFT's clinical effectiveness with ethnically, geographically and age diverse samples of male and female teens
- 6) Findings support further MDFT dissemination and implementation efforts and research

Adapting and Implementing MDFT in Practice

Liddle, H. A., Rowe, C.L., Gonzalez, A., Henderson, C.E., Dakof, G.A., & Greenbaum, P.E. (2006). Changing provider practices, program environment, and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. *American Journal on Addictions, 15*, 102-112.

Liddle, H. A., Rowe, C. L., Quille, T. J., Dakof, G. A., Mills, D. S., Sakran, E., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. *Journal of Substance Abuse Treatment, 22*, 231-243.



ELSEVIER

Journal of Substance Abuse Treatment 22 (2002) 231–243

Journal of
Substance
Abuse
Treatment

Regular article

Transporting a research-based adolescent drug treatment into practice

Howard A. Liddle, Ed.D.^{a,*}, Cynthia L. Rowe, Ph.D.^b, Tanya J. Quille, Ph.D.^a,
Gayle A. Dakof, Ph.D.^a, Dana Scott Mills, Ph.D.^a, Eve Sakran, M.S.^c, Hector Biaggi, M.D.^c

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Initial article ("Transporting MDFT..."):

1. Conceptual framework (a logic model, principles & change methods)
1. Approach that was transferred / adopted
2. Critical events and processes

Abstract

This article describes the key ingredients in transporting an empirically supported, research-developed family therapy for adolescent drug abusers, Multidimensional Family Therapy (MDFT), into an intensive day treatment program. Using the same systems change principles that guide this treatment approach, the technology transfer process has been, from its inception, a collaborative, multidimensional, systemic intervention aimed at changing organizational structures, and attitudinal and behavioral patterns with multiple staff members at several levels of the program. This article describes: (1) the conceptual and empirical basis for these technology transfer efforts; (2) the technology being adapted and transferred; and (3) the critical events and processes that have shaped the transfer of MDFT into this program. We discuss this process and the outcomes thus far through the lens of Simpson's organizational change model and specify the implications of this experience for the expansion of current conceptualization of technology transfer. © 2002 Elsevier Science Inc. All rights reserved.

Changing Provider Practices, Program Environment, and Improving Outcomes by Transporting Multidimensional Family Therapy to an Adolescent Drug Treatment Setting

Howard A. Liddle, EdD,¹ Cynthia L. Rowe, PhD,¹ Alina Gonzalez, PhD,¹
Craig E. Henderson, PhD,² Gayle A. Dakof, PhD,¹ Paul E. Glick, PhD,³

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³Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, FL

Outcomes:

1. Program environment
2. Staff / Provider level
3. Client outcomes

Effective interventions for drug abusing adolescents are underutilized. Using an interrupted time series design, this study tested a multicomponent, multi-level technology transfer intervention developed to train clinical staff within an existing day treatment program to implement multidimensional family therapy (MDFT), an evidence-based adolescent substance abuse treatment. The sample included 10 program staff and 104 clients. MDFT was incorporated into the program and changes were noted in the program environment, therapist behavior, and in most (e.g., drug abstinence, and out of home placements) but not all (e.g., drug use frequency) client outcomes. These changes remained after MDFT supervision was withdrawn. (Am J Addict 2006;15:102–112)

and legal involvement. These circumstances have commanded the attention of policy makers, managed care organizations, third-party payers, and local, state, and federal funding agencies to expedite the movement of research-based adolescent drug treatments to community settings.⁴

But dire need does not mean that the task is simple. Transporting research-based therapies to non-research environments is complex and difficult.⁵ We have learned a great deal about the challenges of this kind of work. Although effective, characteristics of the models themselves and provider factors interact to create formidable

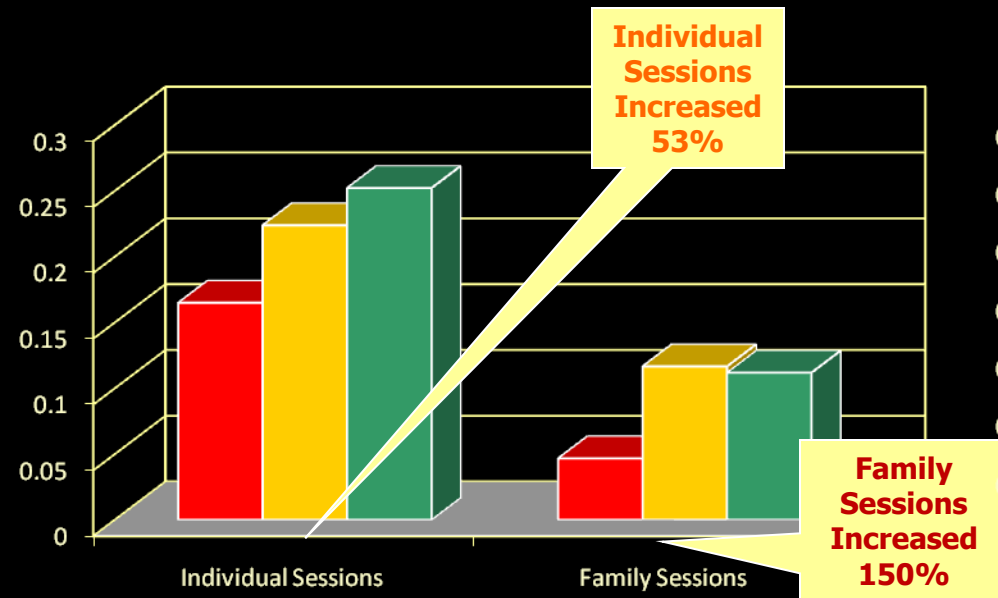
Adapting and Implementing MDFT in Practice

- Transportation study investigating implementation and sustainability of MDFT in an adolescent day treatment program
 - Utilized interrupted time series design with four phases:
 - Baseline-Assessment of provider practices, program environment, and client outcomes.
 - Training-Work with all staff in day treatment program and larger system.
 - Implementation-Continue expert supervision and booster trainings as needed. Assess impact of training.
 - Durability-MDFT experts withdraw. Assess sustainability of approach.

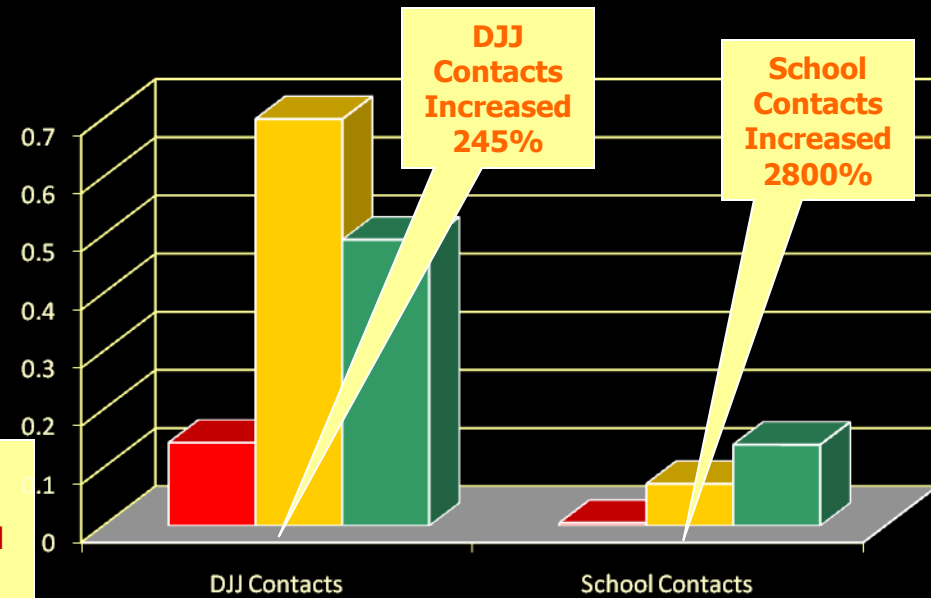
Adapting and Implementing MDFT in Practice

- Sample Characteristics (n=126)
 - Primarily Male (74%) and Hispanic (76%)
 - Average age = 15.3 years
 - 83% diagnosed with substance dependence, 21% with substance abuse
 - 51% conduct disorder; 19% depression; 8% ADHD
 - Referrals from juvenile justice (34%), addiction crisis unit (31%), schools (6%), and other programs (29%)

Increases in Treatment Provided over Study Phases



Increases in Extrafamilial Contacts Over Study Phases



■ **Baseline**

■ **Implementation**

■ **Durability**

Parenting Practices as Mediators of Treatment Effects in an Early-Intervention Trial of Multidimensional Family Therapy

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Online Publication Date: 01 July 2009

The current study demonstrated that MDFT improves parental monitoring—a fundamental treatment target—to a greater extent than group therapy, and these improvements occur during the period of active intervention, satisfying state-of-the-science criteria for assessing mediation in randomized clinical trials. *Conclusions and Scientific Significance:* Findings indicate that change in MDFT occurs through improvements in parenting practices. These results set the foundation for examining family factors as mediators in other samples.

The results we report here are consistent with Kraemer et al.'s (13) criteria for assessing mediation in that: (1) MDFT improves parental monitoring, (2) increases the proportion of youth abstaining from drug use to a greater extent than group therapy, and (3) parental monitoring improves during treatment and to a greater extent for youth receiving MDFT. Importantly, improvements in parental monitoring also precede increases in the proportion of youth abstaining from drug use, empirically demonstrating that parental monitoring may not only statistically mediate treatment effects, but that it may also be an MDFT mechanism of change (21).



Parenting Practices as Mediators of Treatment Effects in an Early-Intervention Trial of Multidimensional Family Therapy

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Background: Contemporary intervention models use research about the determinants of adolescent problems and their course of symptom development to design targeted interventions. Because developmental detours begin frequently during early-mid adolescence, specialized interventions that target known risk and protective factors in this period are needed. **Methods:** This study ($n = 83$) examined parenting practices as mediators of treatment effects in an early-intervention trial comparing Multidimensional Family Therapy (MDFT), and a peer group intervention. Participants were clinically referred, low-income, predominantly ethnic minority adolescents (average age 14). Assessments were conducted at intake, and six weeks after intake, discharge, and at 6 and 12 months following intake. **Results:** Previous studies demonstrated that MDFT was more effective than active treatments as well as services as usual in decreasing substance use and improving abstinence rates. The current study demonstrated that MDFT improves parental monitoring—a fundamental treatment target—to a greater extent than group therapy, and these improvements occur during the period of active intervention, satisfying state-of-the-science criteria for assessing mediation in randomized clinical trials. **Conclusions and Scientific Significance:** Findings indicate that change in MDFT occurs through improvements in parenting practices. These results set the foundation for examining family factors as mediators in other samples.

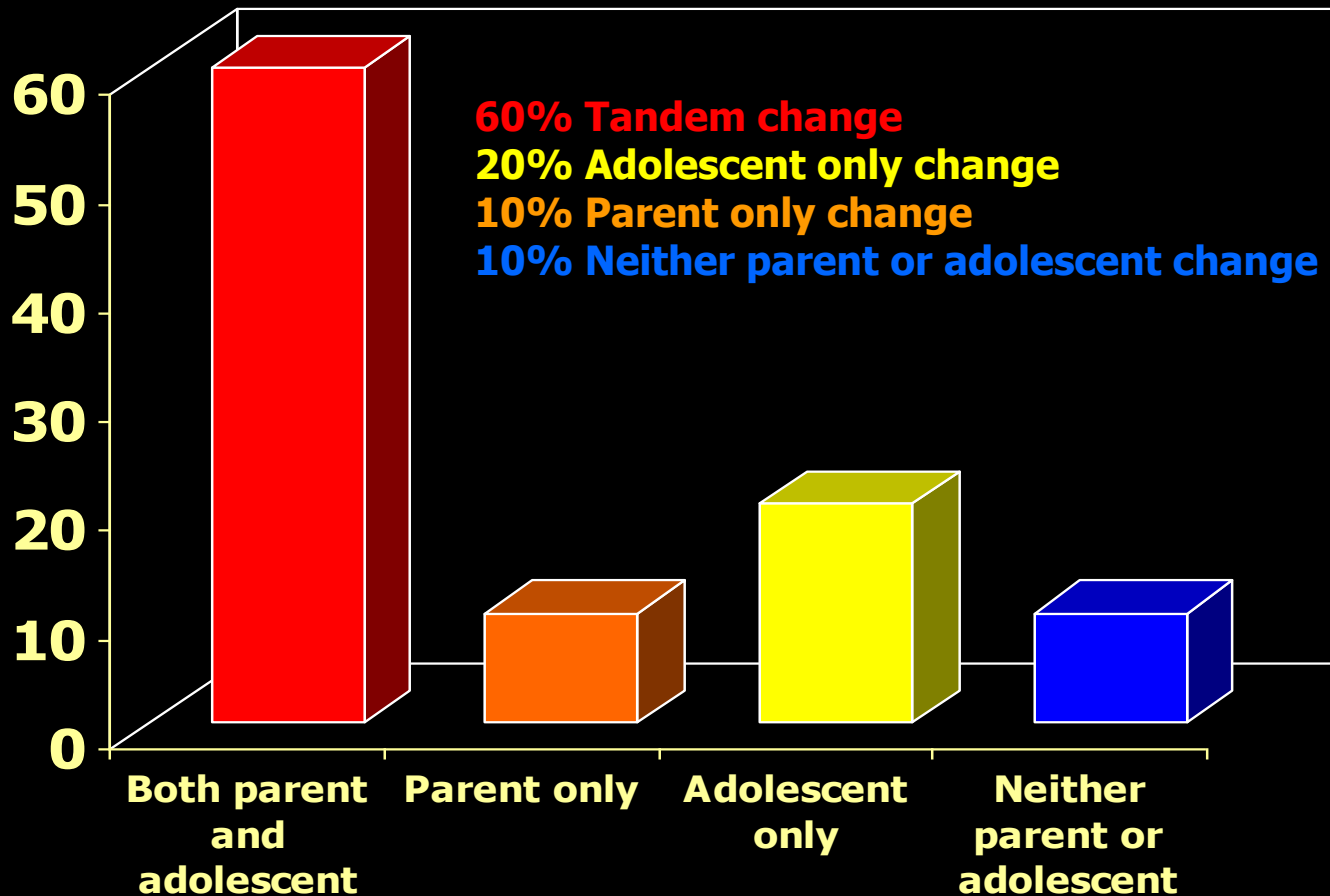
INTRODUCTION

Parenting, family management, and parent–adolescent relationship factors are instrumental to healthy adolescent adjustment and are implicated in a range of negative developmental outcomes. Research consistently demonstrates that family and parenting factors are among the strongest predictors of substance abuse and delinquency in adolescence (1).

Developmental psychopathology research also shows that the more individual and environmental risk factors accumulate early in life, the more vulnerable a child is to developing problems. The presence of early emotional and/or behavioral disorders predicts problem formation in other areas, including school, peer relationships, and delinquency and substance abuse (2). Longitudinal research convincingly demonstrates that the earlier delinquency and drug abuse develop, the more likely it is that without effective intervention, these problems can become chronic and contribute to deepening dysfunction into adulthood (3). Thus a public health perspective supports early intervention programming that targets those evidencing highest risk at certain windows of development, such as early adolescence (4).

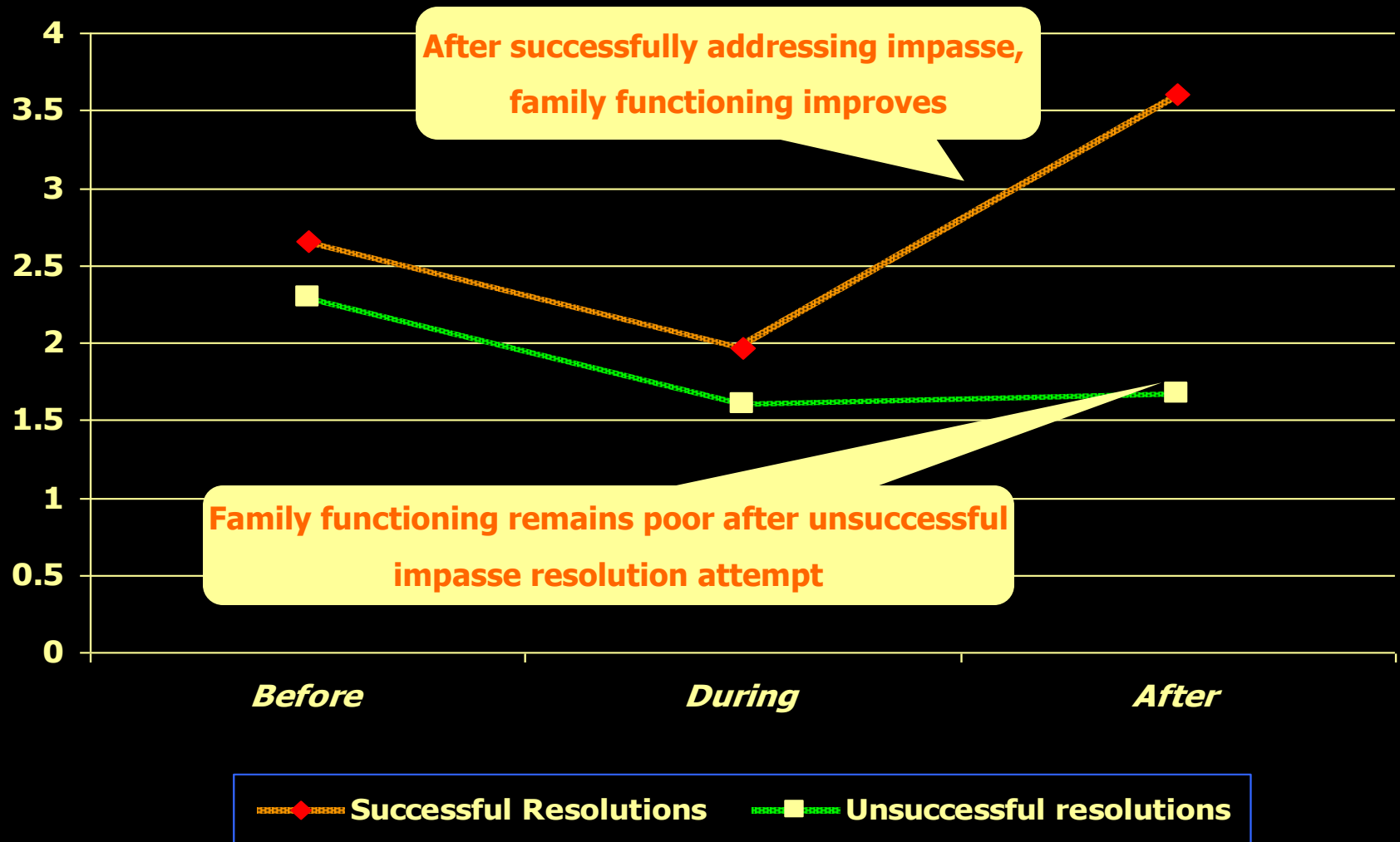
Change in Parenting – Corresponding Change in Adolescent Drug Use

Schmidt, Liddle & Dakof, *J. Family Psychology*, 1996



Family Functioning Before, During, and After the Therapeutic Impasse

Diamond & Liddle (1996). *J Consulting & Clinical Psychology*



Summary and Conclusions

- 26 years of treatment development, outcome & process studies
- Consistent findings across diverse controlled clinical trials (geographic, samples, and contexts)
- Symptom change and promotion of protective factors
- MDFT is effective in its different forms
 - Intensive outpatient version of MDFT is a clinically and economically viable alternative to residential treatment

**Knowing which medicines are effective
represents significant progress.**



Copyright ©2003, James Burns [design]



However.....



...knowing what makes them effective is less known.



Natural Healing Methods



DVD
VIDEO

NATURAL HEALING Vol 1

Healing with the elements through audio and visuals

How do we account for the positive outcomes?

- Multiple aspects of functioning
- Multiple realms of youth' s life
- Family functioning as risk and protection (*relationships*)
- Parenting practices – monitoring
- Parents change for themselves as well
- Family members vis a vis social settings

In conclusion ...

Do Pessimism and Punitiveness Prevail?

- Tradition
- “Nothing works”; “Everything works” (?)
- Understanding of systems issues, yes, and...
- Developmental emphasis
- Alternatives exist
- Reform, as all contemporary interventions, should be multilevel, and multisystems oriented
- Change in stages
- Different change strategies (systems coordination, EBTs, EBPs, are not mutually exclusive)

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**The “Show Me”
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TENNESSEE





How do you get to Carnegie Hall?

There's a story about legendary pianist Arthur Rubinstein who was approached in the street near New York's world-famous Carnegie Hall.

**The stranger asked,
"Pardon me sir, how do I get to Carnegie Hall?"**

Mr. Rubinstein replied,

"Practice, practice, practice!"

Vital signs – Four vital signs which are standard in most medical settings: body temperature, pulse rate (or heart rate), blood pressure, and respiratory rate. Pain rating and emotional distress are additional nominees.



Your work includes policy making, assessment, resource provision, advocacy, lobbying, training, and service provision according to the youth's various *vital signs*.

Be sure that families are included in all of these efforts.





Why a Mental Health Clinic Should Avoid Family Therapy†

Jay Haley

Article first published online: 8 JUN 2007
DOI: 10.1111/j.1752-0606.1975.tb00065.x

Issue



Journal of Marital and Family Therapy

Volume 1, Issue 1, pages
13, January 1975

Additional Information (Show All)

[How to Cite](#) | [Author Information](#) | [Publication History](#)

† *

This article was rejected by the *Archives of General Psychiatry*, the *American Journal of Orthopsychiatry*, *Social Casework*, the *American Journal of Psychotherapy*, and *Psychiatry*.

Abstract

Cited By

Describing the unsettling effects of adding family therapy procedures to the offerings of a mental health clinic, the author argues that changes in the theory of causation, diagnosis, therapeutic technique, and clinical training are required in order to make such an innovation. Consequences are likely to include disorientation of the staff, radically changed administrative procedures, and others, including service to larger numbers of people and better treatment outcome. Editor.

Unsettling effects of change,
theory of causation,
diagnosis, technique,
training, service provision

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Do We Have the National Will to Fight Cancer?

Published: April 4, 2007

To the Editor:

As the articles in "Humans vs. Cancer: Who's Winning Now?" illustrate (Op-Ed, April 1), **there is no shortage of ideas for how to deal with cancer. What appears to be missing, however, is a sense of urgency -- an appreciation of cancer as the grave and growing crisis it is -- and the national will to confront it.**

If terrorists unleashed a biological attack on American soil that started killing more than 1,500 Americans every day, as cancer does, wouldn't we mobilize every national resource to find an antidote or a cure?

It is a national shame that many Americans -- racial and ethnic minorities, the poor and those with little or no health insurance -- are less likely to receive quality cancer care and therefore more likely to die.

As the American public and both political parties did when launching the war on cancer more than three decades ago, we need to summon the will to make cancer a national priority once again.

Nancy G. Brinker

Founder

Susan G. Komen for the Cure

Palm Beach, Fla., April 2, 2007

If you don't work with the families of juvenile justice involved kids...



you'll "miss the boat".

*I was having this discussion in a taxi heading downtown
Rearranging my position on this friend of mine who had a little
bit of a breakdown
I said breakdowns come and breakdowns go
So what are you going to do about it that's what I'd like to know*

Gumboots (1986)
Paul Simon

<http://www.youtube.com/watch?v=MsZQayJiOUw>

References

- IOM (Institute of Medicine) and NRC (National Research Council). 2011. *The Science of Adolescent Risk-Taking: Workshop Report*. Committee on the Science of Adolescence. Washington, DC: The National Academies Press.
<http://www.iom.edu/Reports/2010/TheScience-of-Adolescent-Risk-Taking.aspx>
- National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
http://www.nap.edu/catalog.php?record_id=12480#toc
- National Research Council and Institute of Medicine. (2009). *Adolescent Health Services: Missing Opportunities*. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, R.S. Lawrence, J. Appleton Gootman, and L.J. Sim, *Editors*. Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
<http://www.iom.edu/Reports/2008/Adolescent-Health-Services-Missing-Opportunities.aspx>
- National Research Council and Institute of Medicine. (2009). *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*. Committee on Depression, Parenting Practices, and the Healthy Development of Children. Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
http://www.bocvf.org/parental_depression.html
- National Research Council and Institute of Medicine. (2006). *A Study of Interactions: Emerging Issues in the Science of Adolescence*. A. Beatty and R. Chalk, Rapporteurs. Program Committee for a Workshop on the Synthesis of Research on Adolescent Health and Development, Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
http://books.nap.edu/catalog.php?record_id=11611

References (2)

- Hersch, P. (1999). *A Tribe Apart: A Journey into the Heart of American Adolescence (Ballantine Reader's Circle)* Random House Publishing Group.
<http://www.amazon.com/Tribe-Apart-American-Adolescence-Ballantine/dp/034543594X>
- Liddle, H. A. (2002). *Multidimensional Family Therapy Treatment (MDFT) for adolescent cannabis users: Vol. 5 Cannabis Youth Treatment (CYT) manual series*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. <http://med.miami.edu/ctrada/x129.xml>
- Liddle, H. A. & Rowe, C. L. (Eds.). (2006). *Adolescent substance abuse: Research and clinical advances*. London: Cambridge University Press.
<http://www.cambridge.org/aus/catalogue/catalogue.asp?isbn=9780521530453>
- Liddle, H. A. (2008). *Multidimensional Family Therapy (DVD and Instructional Booklet)*. Washington, D.C.: American Psychological Association. <http://www.apa.org/pubs/videos/4310853.aspx>
- Liddle, H. A. (2009). *Multidimensional Family Therapy for Adolescent Drug Abuse: Clinician's Manual*. Center City, MN: Hazelden Publishing Co.
[http://med.miami.edu/ctrada/documents/Liddle%20\(2009\)%20Adolescent%20drug%20abus-A%20family%20based%20multidimensional%20approach.pdf](http://med.miami.edu/ctrada/documents/Liddle%20(2009)%20Adolescent%20drug%20abus-A%20family%20based%20multidimensional%20approach.pdf)
- Minuchin, S. (1974). *Families and Family Therapy*. Harvard University Press.
<http://www.amazon.com/Families-Family-Therapy-Salvador-Minuchin/dp/0674292367>
- Minuchin, S. & Fishman, H. C. (2004). *Family Therapy Techniques*. Harvard University Press.
http://www.amazon.com/gp/product/0674294106/ref=pd_lpo_k2_dp_sr_1?pf_rd_p=486539851&pf_rd_s=lpo-top-stripe-1&pf_rd_t=201&pf_rd_i=0674292367&pf_rd_m=ATVPDKIKX0DER&pf_rd_r=16HVQJV064C6P91VW3AE
- Steinberg, L.D (2011). *You and your adolescent: The Essential Guide for Ages 10-25*. Simon & Schuster.
<http://www.youandyouradolescent.com/>
- Scott, E. S. & Steinberg, L. D. (2008). *Rethinking Juvenile Justice*. Harvard University Press.
<http://www.amazon.com/Rethinking-Juvenile-Justice-Elizabeth-Scott/dp/0674030869>

Thank you!





Center for Treatment Research on Adolescent Drug Abuse University of Miami School of Medicine

Center website, downloadable MDFT publications, links to MDFT videos,
and e-mail

Website -- <http://med.miami.edu/ctrada/>

Publications and links to YouTube videos (CTRADA channel 9 videos, and MDFT
Dutch video [film on MDFT])-- <http://med.miami.edu/ctrada/x179.xml>

e-mail -- hliddle@med.miami.edu

Charting a New Course

A Blueprint for Transforming Juvenile Justice in New York State

DECEMBER 2009

**A Report of Governor David Paterson's
Task Force on Transforming Juvenile Justice**



A National Survey of Practicing Psychologists' Attitudes Toward Psychotherapy Treatment Manuals

Michael E. Addis and Aaron D. Krasnow
Clark University

Abstract

There has been considerable debate and little empirical data on the role of psychotherapy treatment manuals in clinical practice. Attitudes toward treatment manuals are a potentially important determinant of how likely practitioners are to use manual-based treatments in clinical practice. A total of 891 practicing psychologists nationwide were surveyed about their attitudes toward treatment manuals and their ideas about the content of manuals. Practitioners held widely varying attitudes toward treatment manuals, and ideas about what constitutes a manual were associated with attitudes in a predictable way. Recommendations are made for how to gather more useful information about practitioners' attitudes toward the many changes affecting current models of clinical practice.

Regular article

Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers

Samuel Ball, Ph.D.^{a,*}, Ken Bachrach, Ph.D.^b, Jacqueline DeCarlo^c, Chris Farentinos, M.D.^d,
Melodie Keen, M.A., L.M.F.T.^e, Terence McSherry, M.S.P.H., M.S.P.A.^f,
Douglas Polcin, Ed.D.^g, Ned Snead, M.S.^h, Richard Sockriter, M.S., M.B.A.ⁱ,
Paulen Wrigley, R.N., M.S.^j, Lucy Zammarelli, M.A.^k, Kathleen Carroll, Ph.D.^{a,l}

Abstract

There has been little research on the effectiveness of different training strategies or the impact of exposure to treatment manuals alone on clinicians' ability to effectively implement empirically supported therapies. Seventy-eight community-based clinicians were assigned to 1 of 3 training conditions: review of a cognitive-behavioral therapy (CBT) manual only, review of the manual plus access to a CBT training Web site, or review of the manual plus a didactic seminar followed by supervised casework. The primary outcome measure was the clinicians' ability to demonstrate key CBT interventions, as assessed by independent ratings of structured role plays. Statistically significant differences favoring the seminar plus supervision over the manual only condition were found for adherence and skill ratings for 2 of the 3 role plays, with intermediate scores for the Web condition.

Mental Health Provider Attitudes Toward Adoption of Evidence-Based Practice: The Evidence-Based Practice Attitude Scale (EBPAS)

Gregory A. Aarons^{1,2,3}

Abstract

Mental health provider attitudes toward organizational change have not been well studied. Dissemination and implementation of evidence-based practices (EBPs) into real-world settings represent organizational change that may be limited or facilitated by provider attitudes toward adoption of new treatments, interventions, and practices. A brief measure of mental health provider attitudes toward adoption of EBPs was developed and attitudes were examined in relation to a set of provider individual difference and organizational characteristics. *Methods:* Participants were 322 public sector clinical service workers from 51 programs providing mental health services to children and adolescents and their families. *Results:* Four dimensions of attitudes toward adoption of EBPs were identified: (1) intuitive *Appeal* of EBP, (2) likelihood of adopting EBP given *Requirements* to do so, (3) *Openness* to new practices, and (4) perceived *Divergence* of usual practice with research-based/academically developed interventions. Provider attitudes varied by education level, level of experience, and organizational context. *Conclusions:* Attitudes toward adoption of EBPs can be reliably measured and vary in relation to individual differences and service context. EBP implementation plans should include consideration of mental health service provider attitudes as a potential aid to improve the process and effectiveness of dissemination efforts.



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Measuring Provider Attitudes Toward Evidence-Based Practice: Consideration of Organizational Context and Individual Differences

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Abstract

Mental health provider attitudes toward adoption of innovation in general and toward evidence-based practice (EBP) in particular are important in considering how best to disseminate and implement EBPs. This article explores the role of attitudes in acceptance of innovation and proposes a model of organizational and individual factors that may affect or be affected by attitudes toward adoption of EBP. A recently developed measure of mental health provider attitudes toward adoption of EBP is described along with a summary of preliminary reliability and validity findings. Attitudes toward adoption of EBP are discussed in regard to provider individual differences and the context of mental health services. Finally, potential applications of attitude research to adoption of EBP are discussed.

Attitudes and Beliefs About the Incorporation of EBPs

When children are involved with juvenile justice, the involvement of families is critical to a successful outcome. Yet, family involvement is frequently associated with negative rather than positive perceptions and relationships. Family and system partnership may be difficult, detrimental, or non-existent.

Evidence-Based Psychosocial Treatments for Ethnic Minority Youth

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This article reviews research on evidence-based treatments (EBTs) for ethnic minority youth using criteria from Chambless et al. (1998), Chambless et al. (1996), and Chambless and Hollon (1998). Although no *well-established* treatments were identified, *probably efficacious* or *possibly efficacious* treatments were found for ethnic minority youth with anxiety-related problems, attention-deficit/hyperactivity disorder, depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical problems. In addition, all studies met either Nathan and Gorman's (2002) Type 1 or Type 2 methodological criteria. A brief meta-analysis showed overall treatment effects of medium magnitude ($d = .44$). Effects were larger when EBTs were compared to no treatment ($d = .58$) or psychological placebos ($d = .51$) versus treatment as usual ($d = .22$). Youth ethnicity (African American, Latino, mixed/other minority), problem type, clinical severity, diagnostic status, and culture-responsive treatment status did not moderate treatment outcome. Most studies had low statistical

Substance Use Problems

Multidimensional Family Therapy (MDFT; Liddle et al., 2001) was the only probably efficacious treatment for drug-abusing ethnic minority youth. MDFT is a family-based, multicomponent treatment that targets the multiple systems (e.g., family, school, work, peer) that contribute to the development and continuation of drug use. At the youth level, therapists focus on building youth competencies by teaching communication and problem-solving skills. At the family level, therapists work to change negative family interaction patterns, and coach parents in ways to appropriately engage with their children. Therapists also help family members gain access to concrete resources such as job training and academic tutoring. Liddle, Rowe, Dakof, Ungaro, and Henderson (2004) found MDFT led to more rapid decreases in drug use than group-based CBT for a diverse group of ethnic minority youth.

MST, another family-based treatment, meets criteria for possibly efficacious for drug-abusing African American youth. In a recent clinical trial for juvenile drug offenders, MST was more successful than usual services (wherein youth received only minimal mental health or substance abuse treatment) at decreasing drug use at posttreatment (Henggeler, Pickrel, & Brondino, 1999) and 4 years later (Henggeler et al., 2002). Moreover, ethnicity (African American vs. White) did not moderate treatment outcomes (Henggeler et al., 2002; Henggeler, Pickrel, et al., 1999).