Multidimensional Family Therapy (MDFT; Liddle, 2002) is an evidence-based, state-of-the-science, nationally and internationally recognized treatment for adolescent substance abuse. Dr. Howard Liddle developed this family-based treatment 25 years ago within a NIDA-funded clinical research project. MDFT is broad-based and involves multiple systems to help the adolescent and family get back on developmental track. MDFT is a “treatment system” rather than a “one size fits all” approach. Different versions of MDFT have been developed and tested according to study aims, client needs, and treatment setting characteristics. Overall, MDFT has been recognized in numerous scholarly reviews and independent sources including international and United States government funding agencies, private foundations, and media outlets as among the best approaches for treating adolescent substance abuse. It has also recently been named a model program by SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP).

**Multidimensional Family Therapy is an Effective and Flexible Clinical Approach**

- Superior outcomes in comparison to several state-of-the-art, widely used treatments
- Engages teens and families in treatment and motivates them to complete the program
  - 95% of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in residential
  - 88% of clients in intensive outpatient MDFT completed treatment (180 days) as compared to 24% in residential
  - 96% of young teens in MDFT completed treatment (120 days), as compared to 78% of youth in group therapy
- Recent U.S. national figures indicate that 58% of adolescent drug abusers stay in standard residential for 90 days and 27% stay in standard outpatient for 90 days (Hser et al. 2001)
- Lower cost than standard outpatient or residential treatment
  - Average weekly costs of treatment are significantly less for MDFT ($164) than community-based outpatient treatment ($365; French et al. 2003).
  - An intensive version of MDFT designed as an alternative to residential treatment provides superior clinical outcomes at 1/3 the cost (average weekly costs of $384 vs. $1,068) (Liddle & Dakof, 2002).
- Culturally-responsive to a diverse client population (e.g., different ethnicities, genders, ages, severity of problems)
  - Inner-city minority (African-American and Hispanic) youth and families with few resources and serious and pervasive problems
  - Urban and rural Caucasian drug abusing teens and families
  - Young adolescents at high risk for drug abuse problems
  - Adolescent drug abusers with co-morbid psychiatric disorders
  - Adolescent drug abusing and delinquent females
- Extensive empirically-based knowledge about how MDFT works
  - Studies have demonstrated how therapists successfully build therapeutic relationships with teens and parents (Diamond, Liddle et al. 1999; Shelef, Diamond, Diamond, & Liddle, 2005), and that MDFT therapeutic alliances are linked to and predict treatment completion and success (Robbins, Liddle et al., 2006)
- Flexibly adapts to existing program factors and providers’ resources and needs
  - MDFT developers see “transportation” as a collaborative adaptation process in which MDFT experts and program staff and administrators develop a multifaceted strategy that can address the needs of each stakeholder and barriers to implementation

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Consistent Clinical Outcomes in Controlled Studies

- MDFT has demonstrated more favorable outcomes than several other state-of-the-art treatments, including family group therapy, peer group treatment, individual cognitive-behavioral therapy (CBT), and comprehensive residential treatment (Liddle et al. 2001; Liddle, 2002b; Liddle & Dakof, 2002; Liddle, Rowe, Dakof, Ungaro & Henderson, 2004; Rowe, Liddle, Dakof & Henderson, 2004).
- MDFT studies have included samples of teens with serious drug abuse and delinquency - typically heavy marijuana users, with alcohol, cocaine, and other drug use; mainly referred from juvenile or drug court.
- In addition to successfully treating adolescents who are heavy drug users, MDFT has worked effectively as a community-based prevention program (Faw, et al. 2005; Hogue, Liddle et al. 2002) and has successfully treated younger adolescents who are initiating drug use (Liddle et al. 2004; Rowe, et al. 2004a).
- Substance use is significantly reduced in MDFT to a greater extent than all comparison treatments investigated in 5 controlled clinical trials (between 41% and 82% reduction from intake to discharge) (Liddle et al. 2001; Liddle, 2002; Liddle et al. 2004; Liddle et al., 2004b; Rowe et al., 2004a; Rowe, Liddle et al. 2004b).
- Substance related problems are significantly reduced in MDFT to a greater extent than comparison treatments (Liddle, 2002b; Rowe et al., 2004a).
- Treatment gains are enhanced in MDFT after treatment discharge: MDFT clients continue to decrease substance use after discharge up to 12 month follow-up (58% reduction of marijuana use at 12 months; 56% abstinent of all substances and 64% abstinent or using only once per month; Liddle, 2002b; Liddle & Dakof, 2002; Rowe et al., 2004).
- Youth receiving MDFT often abstain from drug use: MDFT studies (Liddle, 2002b; Rowe et al., 2004a) have indicated high proportions of youth receiving MDFT report abstinence from all illegal substances at 12 months post intake (64% and 93% respectively). Participants receiving comparison treatments report lower abstinence rates (44% for CBT and 67% for peer group treatment).
- Psychiatric symptoms show greater reductions during treatment in MDFT (range of 35% to 80% within treatment reduction) than comparison treatments – MDFT clients also continue to improve following discharge while teens in CBT show relapse of emotional and behavioral problems after treatment (Liddle et al. 2004; Rowe et al., 2004a; Rowe et al., 2004b).
- School functioning improves more dramatically in MDFT than comparison treatments – For instance, MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy) (Liddle et al. 2001; Rowe et al., 2004a).
- Family functioning improves to a greater extent in MDFT than family group therapy or peer group therapy using observational measures and these improvements are maintained up to 12 month follow-up (Liddle et al., 2001; Liddle et al. 2004).
- Delinquent behavior and association with delinquent peers decreases to a greater extent in MDFT than peer group treatment; these changes are maintained through a 12-month follow-up. MDFT transportation studies have also shown that association with delinquent peers decreases more rapidly after therapists have received training in MDFT (Liddle et al., 2004; Rowe et al., 2004a; Rowe et al., 2004b).
- Arrests, convictions, and probation placements are less likely to occur during 12 month follow-up for youth receiving MDFT than youth receiving peer group treatment (Rowe et al., 2004a).

For more information about Multidimensional Family Therapy

- For a list of resources and publications, please visit our website: http://med.miami.edu/ctrada/
- To download the Multidimensional Family Therapy Manual (used in the Cannabis Youth Treatment Multisite Study), visit: http://www.chestnut.org/LI/cyt/products/MDFT_CYT_v5.pdf
- For general inquiries (including publication requests), please call 305-243-5851
- For direct MDFT training inquiries, contact Dr. Gayle Dakof at gdakof@mdftinternational.com