

Chapter 11

Multidimensional Family Therapy: An Evidence-Based Treatment for Juvenile Justice Involved and Substance Abusing Adolescents

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BACKGROUND AND OVERVIEW

This chapter begins by examining (1) the clinical characteristics of juvenile-justice involved youth (including recent research suggesting high prevalence rates of psychiatric comorbidity, HIV/STD risk behavior, and traumatization in this population); (2) the

current system of substance abuse treatment service delivery; and (3) the research-supported elements of effective intervention with this population (e.g., family involvement in treatment, comprehensive services spanning multiple systems). These new perspectives on the treatment of substance abusing, justice involved youth, suggest the need for a new version of Multidimensional Family Therapy (MDFT), called MDFT Cross-Systems (MDFT-CS), which is presented at the end of the chapter (see “Putting Theory Into Practice: The Criminal Justice-Drug Abuse Treatment Studies Detention to Community Study”). The MDFT-CS model builds on the strong empirical foundation and association with MDFT as well as its transportability into a range of clinical contexts in the United States and abroad (e.g., community agencies and juvenile justice programs such as drug courts). MDFT-CS works across mental health, substance abuse, juvenile justice, child welfare, and education systems, providing a continuity of care for adolescents; it begins at the point of a juvenile’s incarceration in a detention facility. Addressing areas often neglected by other treatment models, the treatment is designed to impact human immunodeficiency virus/sexually transmitted disease (HIV/STD) risk behaviors as well as substance use, psychiatric comorbidity, and delinquent behaviors. The structure of the chapter is centered around the following salient questions:

- 1 What are the service needs of juvenile offenders?
- 2 How are these service need typically addressed?
- 3 Which approaches, if any, have effectively served these youth?
- 4 How well do these approaches bridge justice and community systems?
- 5 How can effective, cross-systems interventions be implemented on a wide scale?

NEW PERSPECTIVES ON SERVICE NEEDS OF JUSTICE INVOLVED YOUTH

Mental health impairment and psychiatric disorders are common among justice involved youth (Abrantes, Hoffmann, & Anton, 2005; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), with prevalence rates exceeding those in the general population by as much as 60 percent (Cocozza & Skowrya, 2000; Kazdin, 2000). In addition, substance abuse continues to increase steadily among justice involved youth (Golub & Johnson, 2001), with a large proportion (60 percent) exhibiting drug problems severe enough to require intervention (Aarons, Brown, Hough, Garland, & Wood, 2001; Farabee, Shen, Hser, Grella, & Anglin, 2001). Further, adolescents are the generation most at risk for acquiring STDs and HIV, which are even more prominent among youth involved in the juvenile justice system (approximately 15-20 percent of youth; Pack, DiClemente, Hook, & Oh, 2000). Finally, many youth enter justice facilities having experienced victimization and trauma (Abram et al., 2004; Lederman, Dakof, Larrea, & Li, 2004); indeed, trauma may predispose youth to developing delinquent behavior (Finkelhor & Dziuba-Leatherman, 1994).

In addition to the vulnerabilities that youth bring with them into custody, life within the institution presents additional risks. In describing their experiences, incarcerated youth emphasize their felt vulnerability to violence, the need to defend their strength or status, and their hopelessness about their abilities to redirect their life course (Cesaroni & Pererson-Badali, 2005; Lane, Lanza-Kaduce, Frazier, & Bishop, 2002). Although such feelings may be normative among most juvenile detainees, the situation can be

considerably worse for youth with mental health needs (e.g., heightened depression, anxiety, and hopelessness; interruption in medication and therapeutic services).

Thus, according to a variety of sources, juvenile offenders are a group requiring effective intervention. However, as the previous summary of recent research developments indicates, achieving positive impact on youths' development or, stated differently, even preventing deterioration of youths' functioning requires that the nature of existing treatment services must change dramatically. Services need to go much further than targeting solely substance abuse and delinquency. These services must be designed to impact previously overlooked clinical needs including comorbid psychiatric disorders and HIV risk behavior as well as making larger systems of influence (e.g., courts, schools, etc.) explicit targets of intervention (Liddle, 1999). Along this line, researchers have suggested that detention is an ideal place to intervene with youth given that they have been removed from their high-risk environments, and as a result the "crisis of detention can be used therapeutically to mobilize the [youth], [his/her] family, and systems of care to address the numerous serious problems evident in detained [adolescents]" (Lederman et al., 2004, p. 332). Given the extensive needs of these youth, interventions must be comprehensive and span justice, community treatment, and public health systems of care (Abram, Teplin, McClelland, & Dulcan, 2003; Center on Addiction and Substance Abuse [CASA], 2004; Teplin et al., 2005). Further, due to the multidimensional nature of these problems, it follows that effective interventions should be more complex and comprehensive than they are at present, and they need to consider not only individual developmental adolescent characteristics, but also core aspects of the key systems in which adolescents live. However, juveniles in justice facilities are among the least adequately served of high-risk populations due to fragmentation of treatment and juvenile justice services, poor coordination of assessment, referral, and treatment activities, and a general lack of resources across multiple systems of care (National Institute on Drug Abuse, 2002; Shelton, 2001). The deficiencies in the service delivery system underattend to the substance use and delinquency problems for most youth, and these problems continue to develop throughout youths' juvenile justice and often times, adult criminal justice careers (Aarons et al., 2001; Garland, Hough, Landsvert, & Brown, 2001; Nissen Butts, Merrigan, & Kraft, 2006).

The development of a new version of MDFT designed specifically as a cross-systems intervention spanning justice and community-based treatment settings is discussed at the end of this chapter (see "Putting Theory Into Practice: The Criminal Justice-Drug Abuse Treatment Studies Detention to Community Study"). In addition to the innovative service delivery, the intervention itself targets clinical needs of justice involved youth that have, by and large, been unaddressed by even empirically supported interventions, namely, psychiatric comorbidity and HIV risk behavior. However, the services typically available to justice involved youth to highlight areas that need improvement are evaluated in the next two sections.

JUVENILE JUSTICE-BASED INTERVENTIONS

Evaluating the services available to justice involved youth requires asking three primary questions:

- 1 What services are available?
- 2 Do youth use existing services?
- 3 What is the quality of the services?

“Treatment as Usual” in Juvenile Justice Settings

The current human services delivery system has failed to meet the needs of at-risk substance abusing and delinquent youth (Skowrya & Coccozza, 2006). A critical deficit identified by several studies is that youth mental health care needs (including substance abuse) are typically not recognized, and most youth served by the justice system do not receive the care they need (Lyons, Baerger, Quigley, Erlich, & Griffin, 2001; Rawal, Romansky, Jenuwine, & Lyons, 2004). Further, early intervention programs designed to address emerging substance abuse and delinquency problems before they increase in severity are sorely lacking (Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004). Because youth often underutilize services in their home communities, the juvenile justice system has become the primary point of access for many youths in need of treatment services as well as the setting where a substantial number of youth receive treatment (Nissen et al., 2006; Office of Applied Studies, 2001). Although some proportion of youth are mandated to community-based residential programs (e.g., therapeutic communities), among those who remain in correctional settings, the typical services provided consist of drug and alcohol education and case management services, with more intensive types of treatment being much less common (Young, Dembo, & Henderson, 2007). In addition, while youth may begin receiving services while incarcerated, many youth “fall through the cracks” separating the justice and community treatment systems when released to their home communities (Altschuler, 2005; Henderson et al., 2006; Lopez-Williams, Vander Stoep, Kuo, & Stewart, 2006). Given the cumulative nature of juvenile sanctions, and changes in national sentiment and judicial procedures, as these youth become more deeply entrenched in the justice system, they are often transferred out of juvenile justice and into the adult corrections system (Brannen et al., 2006; Heilbrun, Leheny, Thomas, & Huneycutt, 1997). Available evidence suggests that the adjustment of these youth to the adult corrections system is poor. These teens are much more prone to disciplinary actions, along with having more criminal risk factors and more severe mental health and substance abuse problems than their adult counterparts. Further, the environmental risks to which youth are exposed in the adult corrections system are typically greater than what they are exposed to in the juvenile justice system (Beyer, 1997; Forst, Fagan, & Vivona, 1989; Schiraldi & Zeidenberg, 1997).

Most detained youth who need treatment do not receive it, within or outside of institutional settings. The majority of facilities that house juveniles do not provide on-site treatment services (Office of Applied Studies, 2000). However, even when institution-based treatment programs adopt some elements of effective treatment practices (Drug Strategies, 2005; Henderson et al., 2006), many youth who cycle through facilities never receive treatment (Johnson, Simons, & Conger, 2004; Young et al., 2007). Johnson and colleagues (2004) reported that only 35 percent of their sample of youth in the Illinois Department of Corrections who were in need of treatment received it. In a broader national survey (Taxman, Young Wiersema, Mitchell, & Rhodes, 2006), less than 5 percent of youth housed in residential facilities, jails, or in community corrections custody received even a minimal dose of treatment (Young et al., 2007).¹

A fundamental question in evaluating justice-based interventions is how well they work. A good deal of research suggests that access is only part of the problem;

¹ Minimal dose is defined as at least one to four hours of group counseling, which is equivalent to the intensity of most outpatient treatment programs.

treatment as usual (TAU) is not very effective in decreasing substance use or preventing either juvenile recidivism or adult criminal behavior, even when measures have been taken to improve youths' engagement and retention in services (Bickman, 2002; Florsheim, Behling, South, Fowles, & DeWitt, 2004). Indeed Florsheim and colleagues (2004) found that some types of programs (i.e., detention facilities, work programs, and group homes) may actually facilitate adult criminal behavior. While on the face of it, these findings seem to contradict results from meta-analyses suggesting that some models of institution-based treatment reduce the likelihood of recidivism (Lipsey & Wilson, 1998), these results may provide a truer picture of TAU, as the largest effects in these meta-analyses are associated with evidence-based treatment approaches (e.g., Cognitive Behavioral Therapy, family-based therapies) that show a high degree of implementation fidelity, which is clearly not the norm in justice facilities (Lipsey, 2005). Not surprisingly Florsheim and colleagues (2004) advocate for improving the quality of treatment received by youth specifically in detention facilities, a point echoed by investigations conducted by the U.S. Department of Justice and other juvenile justice policy makers (Roush, 1996).

Empirically Supported Treatments Implemented in Juvenile Justice Settings

In response to deeper understanding of the clinical needs of justice involved youth, the inadequacies of treatment services currently available in juvenile facilities, and the opportunities and challenges of demonstrating effectiveness in naturalistic settings, developers of empirically supported treatments have attempted to transport their interventions to community-based agencies offering substance abuse treatment and other mental health services to juvenile offenders. Indeed, recently, a number of research-supported treatments, most notably family-based, multiple-systems—oriented treatments have been successfully transported to representative community agencies (Henggeler, 2003; Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Liddle et al., 2002; 2006a). Although these advances have been made in the community, little progress has been achieved in implementing these state-of-the-art treatments with youth in juvenile facilities (Johnson et al., 2004; Teplin, Mericle, McClelland, & Abram, 2003), and in the situations where implementation has occurred, its effectiveness has not been adequately evaluated (St. Lawrence, Crosby, Brasfield, & O'Bannon, 2002; Teplin et al., 2003). Given that previous interventions emphasizing offender surveillance and social control have been proven to be ineffective in reducing recidivism and improving general functioning (Altschuler, Armstrong & MacKenzie, 1999; Florsheim et al., 2004), models for implementing science-based interventions to enhance service delivery to juveniles are sorely needed (Dembo & Pacheco, 1999).

MULTIDIMENSIONAL FAMILY THERAPY: A PROMISING INTERVENTION FOR JUSTICE INVOLVED YOUTH

Overview of Multidimensional Family Therapy

MDFT (Liddle, 2002), is a family-based, multiple systems treatment designed to work collaboratively with the most important systems that impact the teen's and family's life (e.g., juvenile justice authorities, school personnel, social service agencies).

Evidence also exists to support MDFT as a cost-effective and programmatically sustainable model (Dennis et al., 2004; French et al., 2002). MDFT has been implemented in community clinical settings (Liddle et al., 2002; Liddle et al., 2006a). Taken together, MDFT has potential as an integrative intervention for substance abusing, juvenile justice involved youth, given its strong empirical base, cost savings in comparison to standard treatments (French et al., 2002), successful adoption in practice (Liddle, et al., 2002; Liddle et al., 2006a), and its well-articulated guidelines/protocols for effective intervention in the juvenile justice system.

Brief History of Multidimensional Family Therapy Treatment Development and New Applications

Conceived as a treatment system rather than a narrowly constructed model of therapy, MDFT is a flexible approach with varied elements such as *treatment length* (e.g., four to twenty-five sessions over a variable number of months, depending upon the site and study); *dosage* or *intensity* (the amount of therapist contact per week); *intervention locale* (in-clinic or a combination of in-clinic/home-based locales); inclusion of *particular therapeutic methods* (e.g., clinical use of within-treatment drug screens and case management); and *formats* (e.g., using a single therapist or a therapist and therapist's assistant [case management assistant]). MDFT has been used effectively by both experienced family therapists and clinicians with no previous family therapy experience. The MDFT approach has been developed and tested since 1985 in five randomized clinical trials (other studies are in progress), a randomized prevention trial, and several treatment development and process studies, which have illuminated core change-related aspects of the therapeutic process (Rowe, Liddle, Dakoff, & Henderson, 2009). The study populations were from diverse cultural backgrounds (African American, Hispanic/Latino, and white Non-Hispanic youth between the ages of 11 and 18) in urban, suburban, and rural settings, with diverse socioeconomic backgrounds.

To understand the development and evolution of MDFT, it is helpful to examine how the field of family therapy itself has matured. First-generation family therapy models were characterized by invoking a unit of analysis and intervention that honed in specifically (and some would argue exclusively) on the family. Over time, new family therapy models developed (e.g., MDFT, Functional Family Therapy [FFT], Multisystemic Therapy [MST], Brief Strategic Family Therapy [BSFT]), the theoretical boundaries of which were more comprehensive and took youths' multiple ecologies, as well as their intrapersonal functioning and development, into consideration. In part, these changes were due to exciting empirical discoveries in the field of developmental psychopathology (Hawkins, Catalano, & Miller, 1992; Sroufe & Rutter, 1984), the practical discoveries of what was necessary to bring about change in multiproblem youth and families as family therapy models were systematically evaluated (Liddle, 1999; Stanton & Shadish, 1997), and family therapy's enthusiasm for theoretical integration, leading to the development of integrative family therapy models (Lebow, 1987).

Likewise, the development of MDFT began as an integration of first-generation structural and strategic family therapies (Liddle, 1984, 1985) and has been shaped by the premise that "Our primary treatment goal is to alter the developmental trajectory of the adolescent and his or her social context in a way that establishes health and

prosocial socialization and development. If adolescent drug abuse is a manifestation of a particular lifestyle (Newcomb & Bentler, 1989), then it is the lifestyle, in its many manifestations, that needs to change” (Liddle, 1999, p. 528). Over the years we have discovered that modifying an adolescent’s lifestyle involves access and immediacy (home-based, ecologically valid services); comprehensiveness (intervening in multiple domains of functioning and with multiple problem behaviors including psychiatric comorbidity, and involving case management services; Liddle & Dakof, 2002; Rowe, Liddle, McClintic, & Quille, 2002); and integration (e.g., incorporating concepts and methods from drug counseling).

New perspectives on the clinical needs of justice involved youth, as well as a deeper understanding of the justice system itself, have been used to help MDFT meet the needs of justice involved youths. Thus, as we have done with other projects (development of a Brief Therapy version of MDFT, a version for early adolescents, or a version that creates an outpatient alternative to residential treatment), a new version of MDFT has been developed that connects justice and community treatment settings and takes important, but previously untargeted, behaviors into account (HIV/STD risk behavior).

Research Evidence Supporting Multidimensional Family Therapy With Juvenile Offenders

MDFT has demonstrated efficacy in a series of randomized clinical trials in reducing substance use and delinquency, and in increasing the prosocial behaviors of substance abusing, juvenile justice involved adolescents (Dennis et al., 2004; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002; Liddle et al., 2001; Liddle et al., 2002; Liddle et al., 2006a; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2006b). Delinquent behavior and association with delinquent peers decreases with youth receiving MDFT, whereas youth receiving peer group treatment reported increases in delinquency and affiliation with delinquent peers, changes that are maintained through a twelve-month follow-up (Hogue et al., 2002; Liddle et al., 2001; Liddle et al., 2004). Additionally, objective records obtained from youths’ Department of Juvenile Justice records indicate that youth receiving MDFT are less likely to be arrested or placed on probation as well as having fewer findings of wrongdoing during the study period. MDFT dissemination studies have also shown that association with delinquent peers decreases more rapidly after therapists have received training in MDFT (Liddle et al., 2004).

Multidimensional Family Therapy: A Flexible Approach for the Juvenile Justice Setting

MDFT is a comprehensive and flexible family-based program for substance abusing adolescents or those at high risk for substance use and other problem behaviors. MDFT interventions target the research-derived risk factors and processes that have created and perpetuate substance use and related problems such as conduct disorder and delinquency (Hawkins et al., 1992; Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005). MDFT also intervenes systematically to help individuals and families develop empirically derived protective and healing factors and processes that offset substance use and behavioral problems (Hawkins et al., 1992; Liddle et al., 2005). MDFT is

a multicomponent and multilevel intervention system. It assesses and intervenes multisystemically with the (1) adolescent and parents individually, (2) family as an interacting system, and (3) individuals in the family relative to their interactions with influential social systems that impact the adolescent's development. Interventions are solution-focused and strive to obtain immediate and practical outcomes in the most important individual and transactional domains of the adolescent's everyday life—home, school, and justice system. MDFT is a three-stage intervention system that has been designed, adapted, and tested in a variety of different versions. It has been applied according to the clinical characteristics of the adolescent client group and treatment setting. In all of its versions, MDFT operates from ten therapeutic principles designed to guide a therapist's overall mindset toward change and, ultimately, making changes at different system levels, in different domains, and with different people inside and outside of the family, on behalf of the treated youth. These principles are as follows:

- 1 Adolescent drug abuse is a multidimensional phenomenon.
- 2 Problem situations provide information and opportunity.
- 3 Change is multidetermined and multifaceted.
- 4 Motivation is malleable.
- 5 Working relationships are critical.
- 6 Interventions are individualized.
- 7 Planning and flexibility are two sides of the same therapeutic coin.
- 8 Treatment is phasic, and continuity is stressed.
- 9 The therapist's responsibility is emphasized.
- 10 The therapist's attitude is fundamental to success.

Treatment is also phasic, involving three primary stages. Stage 1 includes a comprehensive assessment of problem areas and pockets of untapped or underutilized strength. Strong therapeutic or working relationships are established with all family members and influential persons such as school or juvenile justice personnel. Stage 2 is the working phase of treatment where significant change attempts are made within and across the interlocking subsystems that are assessed at the outset of treatment. Stage 3 seals the changes and prepares the youth and family for their next stage of development, using the knowledge, experience, and skills gained in the treatment. Each stage includes core work in each of the four MDFT assessment and intervention domains—the individual, the adolescent and parent, the family interaction system, and the extrafamilial social system (school, neighborhood, social services, medical, and legal). (See Liddle [2002] and Liddle et al. [2005] for more detail on the basic MDFT model.)

MDFT is an example of a contemporary family-based treatment that in contrast to the one-size-fits-all approach to treatment taken by some manual-guided therapies, is principle driven and structured as well as flexible in delivery. Clinicians have noted their satisfaction with MDFT and similar models that provide flexibility within a principle-based structure (Godley, White, Diamond Passetti, & Titus, 2001). To maximize its adoption and dissemination potential (Sanderson 2003), several different versions of MDFT have been developed and tested: (1) as a weekly, twelve- (three-month) or sixteen-session

Table 11.1
Guidelines for Multidimensional Family Therapy Therapist's Effective Intervention in the Juvenile Justice System

Establish Positive Relationships With Juvenile Justice Officials

- It is important for the therapist to establish collaborative relationships with judges, probation officers, and attorneys, both for the state and defense. These relationships set the stage for advocating for the adolescent and avenues for discussing the effectiveness and procedures of MDFT.

Introduce MDFT Work Objectives

- Therapist educates juvenile justice officials on the MDFT model and how the therapist plans on bringing about change in the families' lives.

Obtain Records

- Therapist should obtain the adolescent's record (e.g., list of charges, police report of charges, psychological reports done by court officials) to learn about the current status and history of their client's juvenile justice involvement. It is important that the therapist be as informed as the justice personnel.

Attend Court Appearances

- Therapist should attend court sessions involving their clients as having a treatment representative is crucial to having an influence in court decisions, much easier accomplished when in person.

Advocate for Adolescents ("Use MDFT in the court system.")

- Therapist should influence the court to be more understanding and sensitive to the adolescent by informing them about the youths' life experiences.
- Therapist will help the court to see the adolescent in a different light, and by doing so may influence the court to be more willing to grant the outcomes the therapist seeks for their client.

Teach Parents How to Advocate for Their Adolescent.

- Although the therapist may assume the advocacy position early in treatment, it is key to help parents to eventually take over this function. Therefore, the therapist models and teaches parents how to establish positive relationships with court officials and effectively advocate for their adolescent.

Closely Monitor Judicial Situation, and Make Adjustments as Necessary.

- Therapist needs to be well informed of all the details of the client's case (e.g., new charges, results of drug tests, other court-related details) to avoid surprises.

Apply MDFT Principles in the Justice System.

- MDFT interventions designed to establish relationships with youth and parents are also applicable to judges, probation officers, and attorneys.

(four-month) outpatient therapy that includes a small amount of extrafamilial intervention or case management (Liddle et al., 2001; Dennis et al., 2004); (2) as an intensive outpatient alternative to residential treatment for dual-diagnosed teens, delivered several times a week over an average of six months (Rowe et al., 2002); (3) as a prevention approach for teens at high risk of substance abuse but not yet clinically diagnosed (Hogue et al., 2002); and (4) as a treatment system designed for integration into existing treatment programs such as day treatment or residential care settings (see Liddle et al., 2002).

Using the principles and working within the systems outlined above, MDFT researchers have developed specific intervention protocols and guidelines for MDFT therapists for working with substance abusing, justice involved youth (see Table 1). These interventions involve building collaborative relationships with probation officers and judges and helping the youth successfully meet probation and similar requirements.

PUTTING THEORY INTO PRACTICE: THE CRIMINAL JUSTICE-DRUG ABUSE TREATMENT STUDIES (CJ-DATS) DETENTION TO COMMUNITY STUDY

The Detention to Community Study (DTC) is a two-site study that develops and tests a cross-system, family-based, drug abuse and HIV/STD intervention for juvenile offenders, based on MDFT (Liddle, Dakof, Henderson, & Rowe, 2011). The treatment administered (MDFT-CS) varies from previous versions of MDFT in three ways. First, service delivery commenced in detention; second, the MDFT treatment package was augmented to coordinate services across justice and community systems; and third, a two-session, five-hour, multiple family group-based HIV/STD prevention module occurred during the course of therapy. As such, MDFT-CS was crafted to meet the diverse service needs of juvenile offenders and their families as well as the challenges of implementing evidence-based treatments in the justice system.

In MDFT-CS, a therapist began assessment and working on engagement and foundation-building with an adolescent and his/her family during the youth's detention. Upon release, therapy focused on the core problem areas of drug use, delinquent behavior, and high-risk sexual behaviors. Protective factors present in the youth's environment (e.g., love and commitment [and facilitation of same] of parents) were mobilized as well. A typical course of MDFT included a combination of individual- and family-based interventions aimed at changing the adolescent, parent-figures, family interaction, and family functioning. Therapists also worked to facilitate cross-system collaborations (e.g., by establishing and maintaining contact with judges, probation officers, and key school personnel). Also, as a component of the overall intervention, therapists delivered a new, science-based, state-of-the-art family-based HIV/STD intervention component targeting high-risk sexual behavior (see Figures 11.1 and 11.2). Youth randomized to the comparison condition received an HIV/STD intervention during detention (which youth receiving MDFT-CS also received) and upon release were referred to a high-quality, outpatient substance abuse treatment located in the community (enhanced services as usual).

Initial findings from the study indicated that youth receiving MDFT decreased their unprotected sex acts and days in detention (post-initial detention discharge). Findings regarding drug use and delinquency are more nuanced. Delivered in two sites (Miami-Dade and Pinellas Counties), we needed to take potential variability in treatment effects across the sites into account. In doing so, we found that adolescents in Pinellas County benefitted more from MDFT than youth in Miami-Dade, showing large treatment differences (relative to enhanced services as usual) for substance use, delinquency, and days in detention, whereas youth in Miami-Dade showed much more modest treatment outcomes. We have three plausible explanations for the site differences. First, youth in Pinellas County tended to be more severe than youth in Miami-Dade, and a previous study suggests that youth reporting greater substance use and psychiatric comorbidity benefitted to a greater extent from MDFT than youth reporting less severe symptoms (Henderson, Dakof, Greenbaum, & Liddle, 2010). Second, consistent with the MDFT protocol (see above) in Pinellas County, therapists and juvenile probation officers (JPOs) reported a higher level of collaboration than their counterparts in Miami-Dade. Further, therapist-JPO collaboration was related to greater treatment outcomes. We are currently exploring other adherence-outcome relationships that may be impacting the study results.

Figure 11.1
Multidimensional Family Therapy STD/HIV Prevention Intervention: A Model to Decrease STD/HIV Risk Behaviors
Among Adolescent Substance Abusing Juvenile Offenders
Session One: Risk and Realities of STDs/HIV (Two-Hour Multifamily Group)

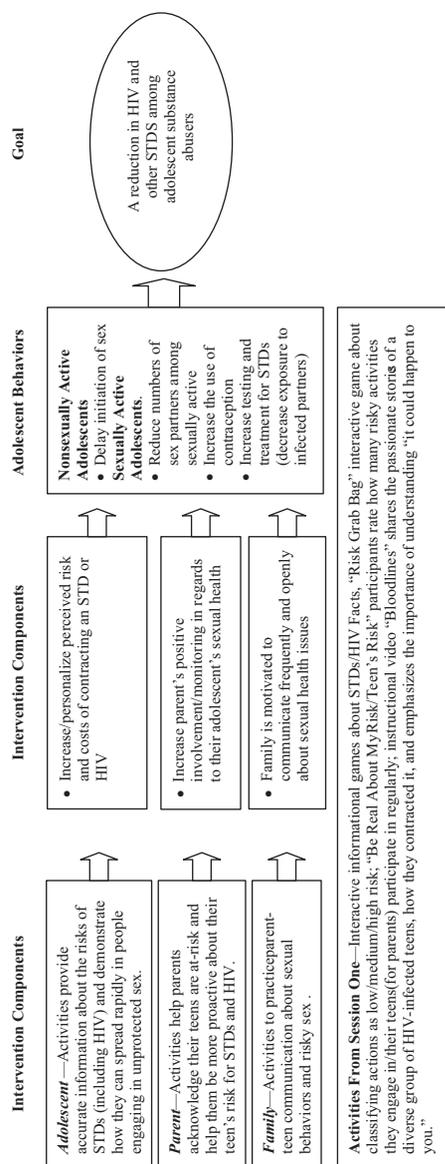
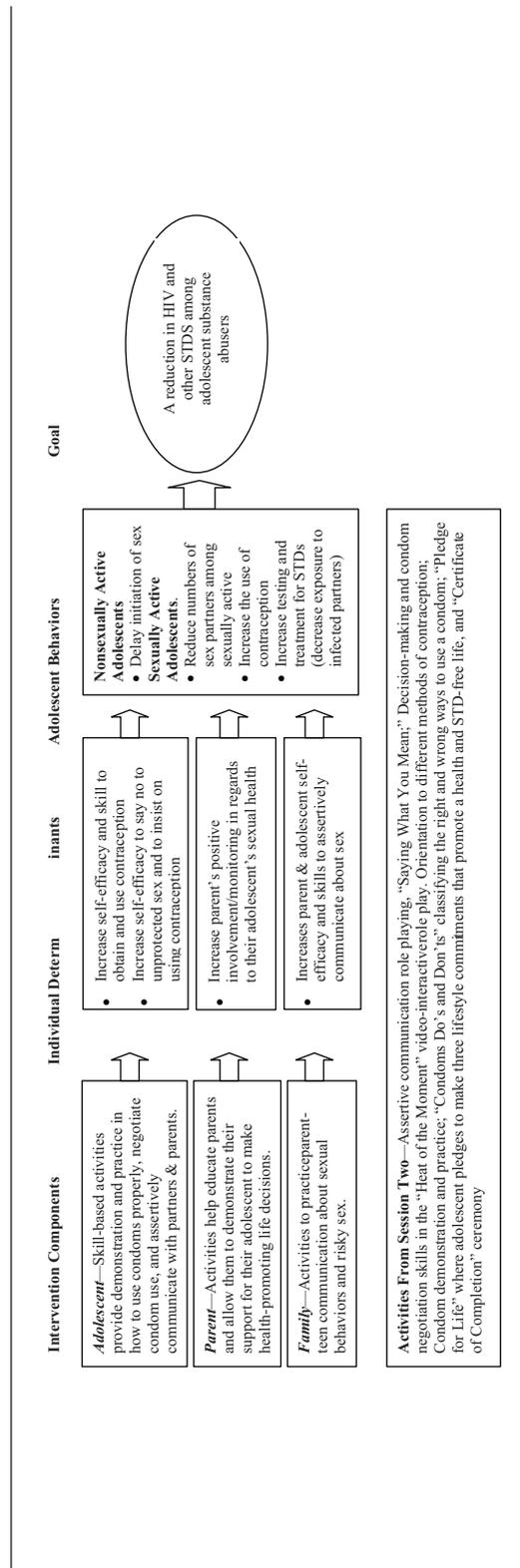


Figure 11.2
Multidimensional Family Therapy STD/HIV Prevention Intervention: A Model to Decrease STD/HIV Risk Behaviors
Among Adolescent Substance-Abusing Juvenile Offenders
Session Two: STDs/HIV Risk-Reduction Skills (Two-Hour Multifamily Group)



SUMMARY AND CONCLUSIONS

Given the well-documented needs of juvenile offenders and the inadequacies of the care they receive in the juvenile justice system, there is an urgent need to implement evidence-based treatments for these youth (Center on Addiction and Substance Abuse, 2004; Drug Strategies, 2005; National Institute on Justice, 1999; Teplin et al., 2002; Teplin et al., 2005). Research shows that treatment approaches are more effective in rehabilitating and preventing recidivism among these youth when they incorporate (1) comprehensive attention to the diversity of clinical needs with which justice involved youth present; (2) services, support, and supervision that “wrap around” an adolescent and family in an individualized way; and (3) family involvement in the treatment of juvenile offenders, (Drug Strategies, 2005). Unfortunately, current options for interventions incorporating these elements are severely limited (Center on Addiction and Substance Abuse, 2004; Lederman et al., 2004; Nissen et al., 2006; Office of Applied Studies, 2001; Teplin et al., 2002). Comprehensive family-based treatments have shown their effectiveness in clinical studies, and there is evidence that these treatments can be effectively transported to naturalistic community settings (Henggeler et al., 1997; Henggeler, Shoenwald, & Pickrel, 1995; Liddle et al., 2002; Liddle et al., 2006a). However, they have not explicitly focused on bridging justice and community treatment systems, nor have they integrated certain clinically important foci of intervention (e.g., HIV/STD prevention). MDFT is a treatment model that holds promise as an integrative juvenile detention intervention, given its strong empirical base, significant cost savings in comparison to standard treatments (French et al., 2002), successful adoption in practice (Liddle, et al., 2002; Liddle et al., 2006a), and its well-articulated protocols for working collaboratively with juvenile justice (Liddle, 2002). The MDFT-CS intervention was developed as a response to the clinical needs of substance abusing juvenile offenders, the justice system’s need for comprehensive solutions that involve cross-systems integration, and the recognition of the limitations of contemporary family-based therapies. The systems-change possibilities and public policy implications of the MDFT-CS intervention are substantial, as the study targets a void in the treatment delivery system (i.e., interventions spanning detention and community-based treatment) that has received a good deal of attention but little in terms of feasible, effective service models (Armstrong & Altschuler, 1998).

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