multidimensional
FAMILY THERAPY

Program Guide for MDFT Implementation and Sustainability

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PROGRAM OVERVIEW

Multidimensional Family Therapy (MDFT) is an integrated, comprehensive, family-centered treatment for teens and young adults. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health symptoms, and school problems. It improves parental and family functioning and prevents out-of-home placement. MDFT has been researched in over ten studies. Since 2001, MDFT has been implemented in over 150 programs in North American and Europe.

MDFT has demonstrated strong and consistent outcomes in 9 randomized controlled trials, the most rigorous test of intervention effectiveness. These studies have been conducted with diverse populations and settings in the United States and Europe by the model developer as well as independent researchers. The level of proven effectiveness for MDFT is unsurpassed.

MDFT is proven to DECREASE:

- ✓ Substance Use
- ✓ Crime & Delinquency
- ✓ Violence and Aggression
- ✓ Anxiety and Depression
- ✓ Out-of-Home Placement
- ✓ Sexual Health Risk

MDFT is proven to INCREASE:

- ✓ School Attendance
- ✓ Academic Grades
- ✓ Family Functioning
- ✓ Pro-Social Functioning
- ✓ Effective Parenting Practices
- ✓ Positive Peer Affiliation

Best Practice Recognition

NREPP SAMHSA's National Registry of Evidence-based Programs and Practices	NREPP gave MDFT an evidence-quality rating of 3.8 out of 4 for recovery from substance use, and a 3.6 out of 4 for delinquency. The overall rating for readiness for dissemination (e.g., quality of implementation materials and support) was 3.6.
NIJ National Institute of Justice	The National Institute of Justice, the research branch of the U.S. Department of Justice, gave MDFT the highest available rating, "Effective (More than one study)", on CrimeSolutions.gov.
NIH National Institute on Drug Abuse	MDFT is listed as an effective treatment for adolescent drug treatment in two NIDA publications: *Principles of Drug Addiction Treatment: A Research Based Guide* (the NIDA "Blue Book" on effective treatments) and *Principles of Drug Abuse Treatment for Criminal Justice Populations – A Research Based Guide.*
UNODC United Nations Office on Drugs and Crime	MDFT is listed in the United Nations Office on Drugs and Crime's Compilation of Evidence-Based Family Skills Training Programs, and was named an effective approach in their publication *International Standards for the Treatment of Drug Use Disorders*.
OJJDP Office of Juvenile Justice and Delinquency Prevention	MDFT is listed as an exemplary program on the Office of Juvenile Justice and Delinquency Prevention's list Strengthening Families: Effective Family Programs for Prevention of Delinquency.
European Monitoring Centre for Drugs and Drug Addiction	In their evaluation of treatment options for cannabis users, EMCDDA rated just one treatment as beneficial: MDFT. It is the only evidence-supported family-based treatment included in their Best Practice Portal on Treatment Options for Cannabis Users.
AMERICAN PSYCHOLOGICAL ASSOCIATION	The Society of Clinical Child and Adolescent Psychology, Division 53 of the American Psychological Association, identified MDFT as an effective child therapy.
CEBC THE CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE	MDFT received the highest possible rating for scientific support from the California Evidence-Based Clearinghouse for Child Welfare.
National Crime Prevention Centre / Centre nationale du prévention du crime	MDFT was carefully evaluated and recognized as a Model Crime Prevention Program by Canada's National Crime Prevention Centre (NCPC).
EARLY INTERVENTION FOUNDATION	The Early Intervention Foundation (EIF), a UK-based organization that promotes programs and policies that help children and young people develop the social and emotional skills they need to succeed, gave MDFT the highest possible evidence rating in the areas of preventing substance misuse, enhancing school achievement, improving mental health, and preventing violent and antisocial behavior.
DrugStrategies	Drug Strategies in a non-profit research organization devoted to identifying and promoting the most effective approaches to substance abuse treatment. MDFT is featured in two publications from Drug Strategies: Treating Teens: A Guide to Adolescent Drug Programs and Bridging the Gap: A Guide to Treatment in the Juvenile Justice System.

THE FINNISH ASSOCIATION FOR MENTAL HEALTH	The Finnish Association for Mental Health (FAMH) chose MDFT for a special project designed to prevent social marginalization among at-risk adolescents. FAMH describes MDFT as "an effective and flexible clinical approach for adolescents experiencing multiple problems" and provided essential program coordination and assistance in MDFT training and implementation in Finland.
Nederlands Jeugd instituut	The Dutch Youth Institute gave MDFT its highest rating of efficacy based on 'strong evidence' in their database of youth interventions.
info drog	Infodrog advocates for effective addiction treatment and risk reduction on behalf of the Swiss Federal Office of Public Health. MDFT is one of just two family therapies evaluated as 'Successful' by Infodrog for early treatment intervention.
EUSKO JAURLARITZA GOBIERNO VASCO	Gurasotasuna is an initiative of the Basque Department of Employment and Social Policies that connects professionals to family intervention resources. MDFT is included in their list of international, evidence-based programs.
CLEARINGHOUSE FOR MILITARY FAMILY READINESS	The Clearinghouse for Military Readiness helps military families choose the best evidence-based practices to address a wide range of family and mental health issues. They list MDFT as a promising intervention.
Florida Department of JUVENILE JUSTICE	The Florida Department of Juvenile Justice ranked MDFT an 'Evidence-based Practice' with proven recidivism reduction in their Sourcebook of Delinquency Interventions.
Child TRENDS®	Child Trends is a non-profit, non-partisan research organization that provides information and analysis on programs for children and youth. MDFT is listed in their Lifecourse Interventions to Nurture Kids Successfully (LINKS) database as being "more effective than other treatments at decreasing drug use, delinquency, internalized distress, and affiliation with delinquent peers, increasing academic performance, and improving family functioning."
NCJFCJ NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES	The National Council of Juvenile and Family Court Judges (NCJFCJ) lists MDFT as a validated treatment in its Adolescent-Based Treatment Database. The database provides profiles on interventions that have been empirically validated in juvenile justice settings.
NATIONAL DROPOUT PREVENTION CENTER/NETWORK	The National Dropout Prevention Center (NDPC) promotes programs and practices that contribute to student success and dropout prevention. The NDPC lists MDFT as a Model Program.
UNIVERSITY of WASHINGTON ADAI Alcohol & Drug Abuse Institute	The Alcohol and Drug Abuse Institute at the University of Washington gave MDFT the highest rating of 'evidence-based' in their report, Treating Youth Substance Use: Evidence Based Practices & Their Clinical Significance. The report looked specifically at the treatment of adolescent cannabis use.

ESSENTIALS FOR STARTING A PROGRAM

Site Requirements

- A team of a minimum of two therapists with master's degrees in social work, marriage and family therapy, counseling, or other related clinical fields.
- Adequate recording and playback equipment for recording supervision and therapy sessions.
- Internet access and use of Google Chrome browser for entering data into the MDFT Clinical Portal, an online database for tracking outcomes. Read more about the Clinical Portal.
- On-site space to conduct live supervision with families. Read more about live supervision.
- For program serving youth who use substances or are at high risk: Urine testing to monitor substance use. Read more about urine testing.
- Cell phones for easy contact between clients and other therapists.

Case Eligibility Criteria

- Between the ages of 9 and 26 (note that the treatment approach adjusts to different developmental and biological ages)
- Have at least one parent/guardian, or parental figure able to participate in treatment (Note that the parent/guardian can be another family member or adult. They may not always reside together, but the parental figure is a person of significant influence in the youth's life).
- Not actively suicidal (ideation and plan) requiring immediate stabilization
- Not suffering from a psychotic disorder (unless temporary and due to drug use)

Individual MDFT programs can restrict program eligibility beyond these guidelines. For example, some programs are not able to serve people over the age of 18, and others do not have the capability to serve opiate users. MDFT International, Inc. will work with programs to help them find the best eligibility criteria for their particular circumstances.

Therapist Prerequisites and Requirements

- Therapists must have a Master's degree in a clinical field (e.g., social work, mental health counseling, family therapy) or be enrolled in such a program.

  Note: *MDFT therapists do NOT need to be licensed in their profession by their state. Please note that many providers/agencies require licensure for therapists; this is not required by MDFT.*

- Therapists must participate fully in the MDFT therapist training and coaching program outlined below in order to become certified and maintain certification.

- Therapists must re-certify annually. They must complete all therapist recertification requirements between 9 and 12 months after their previous certification or recertification date. MDFT International, Inc. will give a 2-month grace period after which time, therapists who are not in compliance will no longer be certified and will not be able to provide MDFT services. Once therapist re-certification requirements are completed, the therapist's re-certification status will be reinstated and they may see MDFT cases. Extensions will be granted for special circumstances such as medical or parental/family leaves. Extension requests must be obtained from the MDFT Executive Trainer (ET) assigned to the program.

Supervision Prerequisites and Requirements

- [x] Supervisors must have Master's degree in a clinical field (e.g., social work, mental health counseling, family therapy).

  Note: *MDFT clinical supervisors do NOT need to be licensed in their profession by their state. Please note that many providers/agencies require licensure for supervisors; this is not required by MDFT.*

- [x] Supervisors must participate fully in the MDFT supervisor training and coaching program in order to become certified and maintain certification.

- [x] Only MDFT-certified or in-training supervisors can supervise MDFT therapists on clinical issues. It is acceptable for a supervisor not trained in MDFT to provide administrative supervision only (e.g. paperwork, regulatory/reporting issues). Supervisors who are not certified in the MDFT model cannot provide model-syntonic clinical guidance and feedback to MDFT therapists on MDFT families. Only a MDFT certified or in-training supervisor knows the model well enough to provide adequate clinical supervision. Supervisors without such training create confusion for the therapists and decrease fidelity to the model, resulting in poor outcomes. *Having trained MDFT supervisors is essential to maintain MDFT fidelity.*

- [x] Supervisors MUST be certified as an MDFT therapist before being certified as a supervisor.

- [x] Supervisors must re-certify annually. They must complete all supervision recertification requirements between 9 and 12 months after their previous certification or recertification date. MDFT International, Inc. will give a 2-month grace period after which time, supervisors who are not in compliance will no longer be certified and will not be able to supervise MDFT therapists. Once supervision re-certification requirements are completed, the supervisors' re-certification status will be reinstated. Extensions will be granted for special circumstances such as medical or parental/family leaves. Trainers and supervisors must request extensions from their Executive Trainer.

Therapist Assistant (TA) - *Optional*

The therapist assistant (TA) serves a function very similar to a case manager or family advocate, but works under the direction of the therapist. The TA helps reduce barriers to treatment participation and success, such as helping families procure needed social and health care services, and teaches parents how to advocate successfully for their family in school, juvenile justice, and other systems. TAs are trained along with the therapists but in less intensive ways and in relation to their specific TA duties.

MDFT Training Requirement: Live Supervision

Live Supervision allows therapists to receive guidance and oversight in a live clinical setting. While the therapist conducts a session with the youth or family, the trainer or supervisor and clinical team observe from another room (with the family's consent and knowledge, of course). The trainer or supervisor can observe and, if needed, intervene by calling in with suggestions for keeping the session on track and achieving session goals, as well as advancing therapist development. All Live Supervision sessions should be recorded; they can also be used for Recorded Session Review Supervision at a later date.

Live Supervision Checklist

A viewing screen or window with one-way mirror glass to see the therapy room. The session will take place in the therapy room while the supervisor and team look on from a second location, the viewing room. At many MDFT sites, these rooms are adjacent to each other for ease of viewing and equipment set-up, however, new wireless technologies allow for viewing in any room that is connected to the system – even in remote locations.

Some sites have an old-fashioned one-way mirror that the team can gather around to watch. However, most teams today watch video feed of the sessions on a monitor or television screen as it happens, since sessions need to be recorded anyway.

Video recording equipment in the therapy room to record the session.
All Live Supervision sessions should be recorded. A video camera should be installed or placed on a tripod in the therapy room for this purpose. Some sites also use additional separate microphones for better sound quality.

Cables connecting the camera/microphones to the viewing screen can be easily run through the ceiling if your office has drop-ceiling panels. Other sites use HDMI ports installed in the walls of the two rooms, and some sites use Ethernet cables (Cat5 or Cat6) to carry HDMI over longer distances.

The higher the quality of the video recording the better, but what matters most is that the dialogue is clear, all participants are on-screen, and background noise is kept at a minimum.

A direct-line phone from viewing room to therapy room.
The supervisor will intervene in the session by calling the therapist while they are doing the session (hence, live supervision). The best way to do this is to have a direct-line phone into the therapy room that they can use to call the therapist. This allows the supervisor to speak with the therapist with minimal interruption to the session.

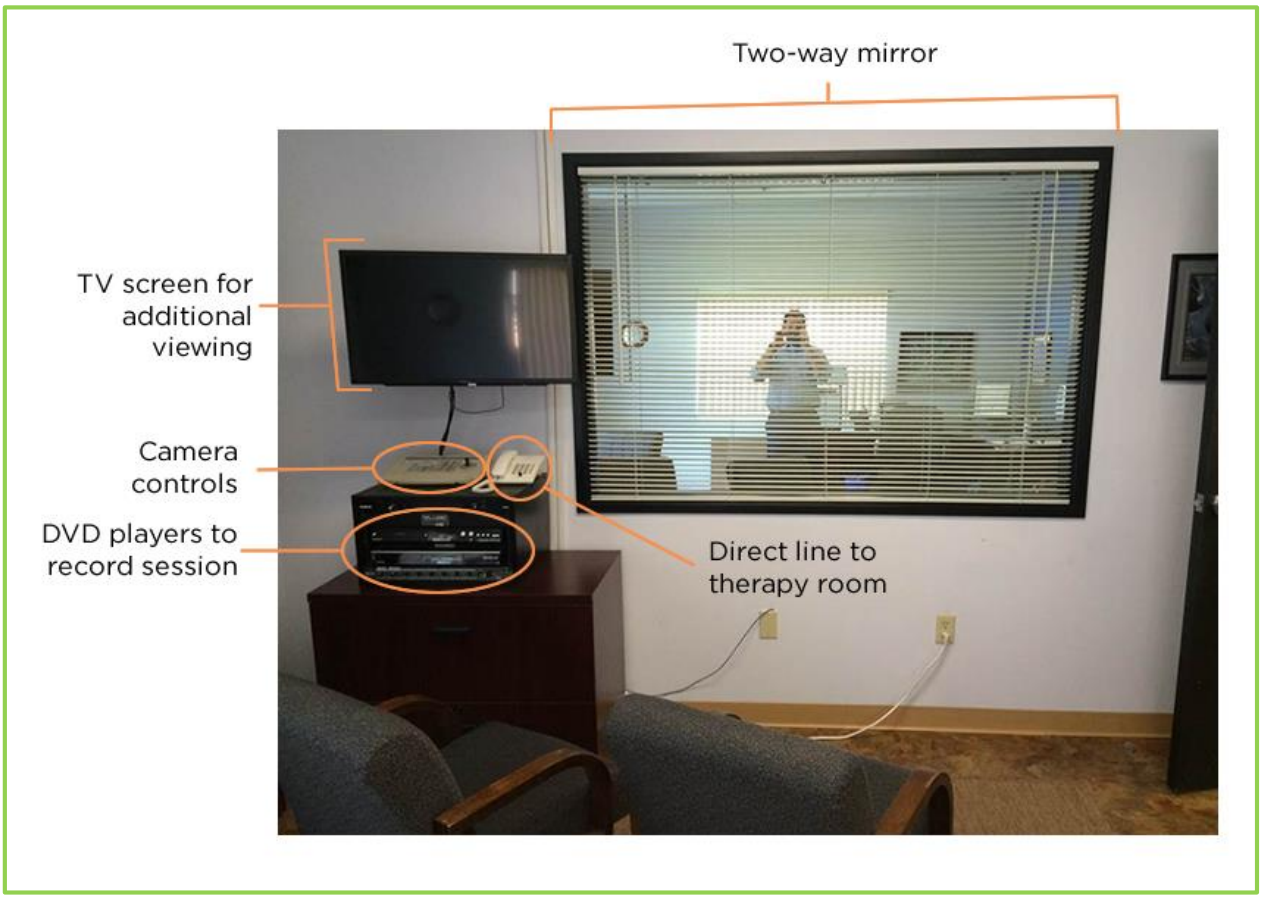
Some sites use cell phones, but this opens up the possibility of the session being interrupted by unrelated calls or messages, and often the clients can hear the supervisor's comments through the cell phone, so this is not recommended if it can be avoided.

A data storage system.
Once sessions are recorded, you need to be able to store them as well as submit some recordings to MDFT International for fidelity rating. Some sites record sessions directly onto discs using DVD players and then store those discs. Some store sessions digitally on a hard

drive or a networked shared drive. A typical video of a session can be anywhere from 1 to 5GB, so your camera hard drive/SD card should be large enough to accommodate this. Any permanent storage should be large enough to hold several videos of this size.

Videos submitted to MDFT International for fidelity can either be uploaded to a secure online database (we used ShareFile) or physically mailed on discs/flash drives.

Sample Set-Up of Viewing Room



MDFT Therapy Requirement: Urine Testing Guidelines

When serving youth who use drugs and alcohol or are at high risk, drug testing is one of many tools used to start a therapeutic dialogue. In addition to encouraging honesty and ensuring accurate assessment by the therapist, drug testing can be an opening to discussing the youth's substance use.

In general, MDFT therapists follow the principle of "more use – more testing." For polysubstance users, most therapists will test 1–2 times per week until the youth becomes clean (or is testing positive for marijuana only). For youth who use marijuana only, therapists typically test every 2–3 weeks. Of course, therapists will test more frequently if they believe the youth is not being honest with them, and less frequently if they believe the youth does not use drugs. Common sense should prevail!

Most MDFT programs use the following 5-panel "instant" test ("instant" means you can see the results immediately and you don't need to send it to a laboratory for analysis):

- marijuana/THC
- opiates
- amphetamine/methamphetamine
- benzodiazepine
- cocaine

However, you should use a 5-panel or greater depending on use patterns in your community. We recommend that you review use patterns regularly to adjust the test if necessary. Instant alcohol tests are only effective during or shortly after consumption, which limits their use in a counseling environment. Lab testing that can detect alcohol use within the past 80 hours is available, but expensive.

Types of Tests

Instant urine tests come in many forms: urine test strips; "cassettes", which are used similarly to a pregnancy test; saliva swabs; and self-contained cups. The most popular test among MDFT sites is the iCup, manufactured by Alere Toxicology. The advantages of the iCup are that it is relatively inexpensive, fast, and minimizes the tester's exposure to urine by being self-contained. It can also be packaged and sent to a lab for further testing if needed. It can be configured to test for a variety of drugs in addition to the five listed above.

You can also purchase adulterant strips to help determine whether a sample is legitimate or has been tampered with.

Keep in mind that an instant test is not as accurate as a full lab test – false positives or negatives are a possibility. Some MDFT sites send samples to a toxicology lab for testing to determine the exact level of use (this can be useful for determining whether use has decreased or increased), or if they suspect that the instant test has been tampered with.

Purchasing Urine Test Kits

Urine tests can be purchased online; it is recommended that you speak with a sales associate about your specific site needs before you buy anything. Creating a company account may also be necessary and will likely lower the price. Listed are some of the companies that existing MDFT sites use. The

number of tests you need will vary depending on your caseload and how frequently you intend to test them. Most sites purchase one hundred to several hundred at a time. Factors to consider when deciding how many to order are your caseload, how frequently you intend to test clients, and the shelf life of the test.

Instant urine tests:

Redwood Toxicology Laboratory (most popular among MDFT sites – a subsidiary of Alere Toxicology, maker of the iCup)
Henry Schein, Inc
Rapid Detect

Lab testing services:

Redwood Toxicology Laboratory
Omega Laboratories

Prices vary depending on whether you order in bulk, whether you have a company account, and how many substances you want to test for. The following are range estimates based on the rates of some MDFT sites:

The iCup (5 to 8-panel) ranges from $1 to $11 dollars per test. Most sites pay under $5.

Lab tests (5 to 8-panel) run around $6 per test.

Specialty tests (which you would probably not order in bulk) for less common drugs such as ecstasy, bath salts, or LSD run $11- $35 per test.

The 80-hour alcohol test runs around $17 per test.

MDFT Therapist & Supervisor Training

All training is done at the agency/provider site or over the telephone or internet. The MDFT trainer travels to the program location.

MONTHS 1-6

THERAPIST CERTIFICATION

THERAPIST TRAINING

Study written and video material, complete exercises, review feedback

Onsite 2.5-3.5 Day Introduction

12-15 Weekly Team Consultation Calls

Written Assessment 1

2 Onsite Intensives (Video Review and Live Supervision for each therapist, trainer presentation/demonstration)

Written Assessment 2

MONTHS 6-12

SUPERVISOR CERTIFICATION

SUPERVISOR TRAINING

Onsite Introduction to Supervision

Supervision Written Assessment

Onsite Supervision Intensive

Review Case Review Supervision Sessions

Review feedback to Therapists on Weekly Case Plans

Review Therapist Development Plans

Review Video Review Supervision Sessions

Review & Instruct on how to use the MDFT Clinical Portal Reports to improve fidelity, competence and clinical outcomes

Therapist Training Components & Estimated Time Commitments

Activity	Duration of Activity	Suggested Preparation Time
✓ **Introductory Training.** Therapists should study written and video materials beforehand. Complete written exercise.	2.5 – 3.5 days	4 hours of study
✓ **Weekly Study Time:** Read materials and view video.	Throughout training	1-2 hours of study per week
✓ **12-15 Consultation Calls.** The team does one call per week with the trainer to review progress on training cases.	1-1.5 hours per call	30-60 minutes of training case preparation
✓ **Written Midterm Exam**	2 hours to complete	4 hours of study time
✓ **First Intensive On-site Visit.** Video Review & Live for each therapist. Clinical Portal Training	2.5–3.5 days for team of 4-5	None
✓ **Second Intensive Onsite Visit.** Video Review & Live for each therapist.	2.5–3.5 days for team of 4-5	None
✓ **Written Final Exam**	1.5-2 hours	4 hours of study time

Therapist Caseloads During Training

When new therapists begin the MDFT training program, it is recommended to increase their caseload slowly in order to facilitate the learning process and to set the foundation for a stable caseload.

To assist clinics in this process, a sample case assignment flow is presented below. This assumes a caseload of 8, a length of treatment of 5 months, and no premature terminations. Of course, programs will adjust as necessary given their circumstances.

It is recommended that programs begin therapists with no more than 2 MDFT cases. It is important that therapists end training with a full caseload so that MDFT trainers can help them learn how to manage a full caseload. This is why we recommend a full caseload by month 5 of the initial training.

	# of New Assignments	Total # of Cases
Month 1	2	2
Month 2	1	3
Month 3	2	5
Month 4	1	6
Month 5	2	8

Supervisor Training Components & Estimated Time Commitments

Activity	Duration of Activity	Suggested Preparation Time
✓ **Introductory Training.** Supervisors should study written and video materials beforehand.	1 day	2 hours
✓ **Weekly Study Time**	Throughout certification training	
✓ **Written Exam**	2 hours	2 hours of study time
✓ **Intensive Site Visit.** Live demonstration of 3 types of MDFT Supervision, Training on Therapist Development Plans and Portal	1 day	1 hour
✓ **Submission of video of 1st Case Review Supervision** followed by **Consultation call**	1 hour	1 hour
✓ **Submission of video of 2nd Case Review Supervision** followed by **Consultation Call**	1 hour	1 hour
✓ **Submission of 1st Recorded Case Review** followed by **Consultation Call**	1 hour	1 hour
✓ **Submission of 2nd Recorded Case Review** followed by **Consultation Call**	1 hour	1 hour

Train-the-Trainers Program

Train-the-Trainer (TTT) training, where trainees master a particular method and go on to train others in the approach, has been used in a wide variety of fields. Although Train-the-Trainers programs have not been widely studied, there is a growing consensus concerning their advantages over Expert/Purveyor-Led Training, including **increased access to training, reduced costs and time required for training, increased program sustainability, and benefits of having on-site trainers who are knowledgeable of local, agency, and systems issues**. The MDFT training program, whether Expert/Purveyor-Led or Train-the-Trainers, is multicomponent. Herschell, Kolko, Baumann, & Davis (2010) report that multicomponent training programs have the best training outcomes in comparison to other training methods. MDFT includes all the components of multicomponent training: comprehensive treatment manual, intensive didactic and experiential workshops, expert consultation on actual work, live or recorded review of client sessions, supervision training, booster training, and completion of at least one training case.

MDFT began providing TTT in 2006 in the State of Connecticut with two state-level trainers. Connecticut now has 6 state trainers who train therapists in over 20 publically funded individual programs throughout the State. Since 2006, MDFT's TTT program has grown to over 40 agencies, county, regional, state, or county-based trainers around the U.S. In our experience, it has enabled agencies to sustain MDFT more effectively and reduce costs of MDFT implementation.

MDFT International, Inc. provides TTT to individual provider agencies or groups of agencies. We call these trainers Agency-Based Trainers. Once trained, they are granted permission by MDFT International to train new staff at their agency (e.g., Children's Aid Society in New York). We also train county (e.g. Riverside County Department of Mental Health), regional (e.g., Western Pennsylvania) state (e.g., Iowa), and national trainers (e.g., the Netherlands). These trainers continue to work closely with MDFT International to deliver the highest quality training to new therapists.

Trainers at the Annual MDFT Trainers' Meeting

Each spring, MDFT International hosts a Trainers Conference in Miami, FL. The meeting gives trainers a chance to share their work, build relationships with other trainers in both work and casual settings, and work directly with MDFT developer Howard Liddle and MDFT International trainers.

Despite the ongoing collaboration and support from MDFT International, it is very important to recognize that individuals who successfully complete the intensive TTT are able to train new therapists on their own and do not need MDFT International trainers every time they want to expand their services or need to train replacement therapists. The cost savings can be enormous! MDFT International still provides ongoing coaching and implementation support services, but these are much less expensive than training new therapists. In MDFT, the first year of training new therapists and supervisors is the most expensive. Subsequent year's services are less intensive and less expensive. This is true for programs with or without the TTT program.

The MDFT TTT, like its clinician training, is multicomponent and includes intensive workshops, live and video review of training, consultation calls, and at least one TTT training case (i.e., the trainer in training must have at least one therapist to train). The training process is identical to having MDFT International trainers conduct the training, but for a fraction of the costs.

The Train-the-Trainers program is not for everybody, but it is extremely useful for agencies, counties, regions, states or countries that are committed to MDFT over the long-term, have dedicated high-level MDFT supervisors who are good candidates to become trainers, anticipate or have experienced clinician turnover, and/or plan to expand their MDFT services into new regions, arenas, or for more youth and families than they currently serve.

Herschell, A.D., Kolko, D.J., Baumann, B.L., Davis, A.C., The role of therapist training in the implementation of psychosocial treatment: A review and critique with recommendations. Clinical Psychology Review, 30, 448-466.

TRAINER CERTIFICATION

TRAINER CERTIFICATION

Observe and give feedback on MDFT Introduction

Observe and give feedback on weekly Case Consultation Calls

Review and give feedback on Case Reviews and Video Reviews

Observe and give feedback on Intensive Onsite Training

Review and give feedback on Weekly Case and Therapist Development Plans

Review and give feedback on Written Assessments 1 & 2

Note: The trainer will also participate in the Annual MDFT Trainer's Meeting each year in Miami, FL.

QUALITY ASSURANCE (QA) & FIDELITY

Overview

Quality assurance (QA) procedures — fidelity, competence, and clinical outcomes -- are measured and utilized in the spirit of helping clinicians and programs better adhere to MDFT and offer the best possible treatment to youth and families. They are not used to police programs or punish therapists or programs falling below benchmarks. Not all aspects of the MDFT treatment and supervision are monitored — only variables that have been shown to be powerful determinants/correlates of fidelity, competence and clinical outcomes. This does not mean that unmeasured variables, such as therapist assistant time, team meetings, or individual youth sessions are unimportant, but simply that some dimensions are so powerful that we do not need to measure every component of MDFT treatment and supervision in order to maximize fidelity, competence, and outcomes. We make every effort to minimize required reporting to obviate therapist and supervisor burden. The MDFT Fidelity System is implemented as has been done in the numerous randomized clinical trials on MDFT, and that is to alert trainers, supervisors, and therapists to potential problems and to encourage collaborative solutions to help the therapists, supervisors and programs maintain the highest possible level of fidelity to MDFT to achieve excellent client outcomes.

Annual Quality Assurance (QA) Activities

- Onsite Booster Training: Video Review and Live Supervision for each therapist, Video Review of Supervision, Consultation on Therapist Development Plans (TDP) and overall program implementation. Instructional Presentation by Trainer on relevant topic(s) to the team
- Therapist competency and adherence evaluations by Trainer
- Review, Rating, & Feedback on Supervision Session video for each supervisor
- 3 Consultation calls with Supervisor and/or Team throughout the year (trainer and supervisor determine agenda)
- Bi-annual reviews of Therapist Development Plans (TDPs)
- Bi-annual reviews of MDFT Clinical Portal Reports (January – June Report, and January – December Report)
- Review of compliance with site requirements

MDFT Clinical Portal

The MDFT Clinical Portal is an online database for tracking MDFT treatment outcomes, training and consultation activities and progress, and fidelity. Everything that is measured in MDFT is on the Clinical Portal, including information on the agency/provider, MDFT program, cases, therapists, supervisors, and trainer activities.

MDFT Portal Reports are provided twice per year: for the period covering January through June, and then January through December; or July through December and July through June if the program requests. Reports can be generated more frequently if a program or funder desires.

See a detailed walkthrough of the Portal.

Fidelity to MDFT Parameters

- **Therapists** enter data regarding their MDFT cases into the MDFT Clinical Portal. They enter data on therapeutic contacts for treatment sessions, including type (family, adolescent, parent, or community), length and location. They also complete the Intake and Discharge Evaluation (See Fidelity to Outcomes section below). It takes approximately 10 minutes to open a new case on the Portal, and then less than 3 minutes per case weekly to update contact time. At discharge, it takes approximately 15 minutes to close a case on the Portal. Fidelity to MDFT parameters are evaluated based on research-developed benchmarks on ideal therapeutic intensity (see Rowe et al., 2013).

- **Supervisors** enter data into the MDFT Clinical Portal on all supervision sessions with their MDFT therapists. They enter the type of supervision session (case review, live supervision, or video review) and length. They also complete regular reviews of all therapists working with MDFT cases, which include quantitative ratings on a range of markers of therapist fidelity as well as "Therapist Development Plans" to note strengths, weaknesses, and plans to address gaps in therapist fidelity.

In addition, there are also program-level parameters that MDFT programs are expected to meet. These benchmarks are reviewed at least annually. Parameter benchmarks at the program, therapist, and supervisor level are as follows:

- Meets all relevant site requirements
- Therapists are certified MDFT therapists or currently participating in the MDFT therapist training program
- Supervisors are certified as MDFT supervisors or currently participating in the MDFT supervisor training program
- Average case duration is 3–6 months, depending on severity of the case and other programmatic factors (e.g., 3 months for lower risk)
- 85% of cases receive a minimum of 8 or more therapy sessions
- Average of 3 case review supervision sessions per month per therapist (60-90 minutes of individual supervision weekly)

- Average of 6 video supervision sessions per year per therapist
- Average of 3 live supervision sessions per year per therapist

Fidelity to Clinical Outcomes

Clinicians complete the MDFT Intake-Discharge Evaluation form in the Portal for every case at the beginning of treatment and again at discharge. This evaluation asks clinicians to rate on a 5-point Likert-type scale the status of the youth and family on key outcomes variables: substance use, delinquency, aggression, peer affiliation involvement in pro-social activities, school attendance, school performance, mental health functioning, family violence, family functioning, and sexual health risk. At discharge, therapists evaluate the youth and family on these same dimensions plus additional items that assess status at discharge: out-of-home placements, arrests, work or school status, child abuse reports, open welfare case, and probation status. Benchmarks derived from research are used to judge fidelity on outcomes (e.g. 80% working or in school at treatment discharge is comparable to outcomes in our clinical trials).

Hogue, A., Liddle, H. A., & Rowe, C. L. (1996). Treatment adherence process research in family therapy: A rationale and some practical guidelines. *Psychotherapy: Theory, Research, Practice, & Training, 33*, 332-345.
Liddle, H. A., Dakof, G. A., Henderson, C. E., & Rowe, C. L. (2011). Implementation outcomes of Multidimensional Family Therapy-Detention to Community: A reintegration program for drug-using juvenile detainees. *International Journal of Offender Therapy and Comparative Criminology, 55*, 587-604.

Rowe, C. L., Dakof, G. A., & Liddle, H. A. (2009). *Scoring manual for the Multidimensional Family Therapy Intervention Inventory*. Miami, FL: Center for Treatment Research on Adolescent Drug Abuse, University of Miami.

Rowe, C. L., Rigter, H., Gantner, A., Mos, K., Nielsen, P., Phan, O., & Henderson, C. (2013). *Implementation fidelity of Multidimensional Family Therapy in an international trial.Journal of Substance Abuse Treatment, 44*(4), 391-9.

Annual Quality Assurance Estimated Time Commitments For Clinicians

Activity	Duration of Activity	Suggested Preparation Time
✓ **Onsite Booster Training Visit.**	3 days for team of 4-5	2 hours
✓ **3 Consultation Calls.** Each team can have 3 calls a year. The team decides who is on the call and what is discussed.	60-90 minutes/ call	1 hour of preparation/call
✓ **Supervisor Recording Submission Followed by Consultation Call (every year).** The supervisor may choose to submit either a recorded case review OR a recording review.	60-90 minute call	1 hour

Caseloads

The size of caseloads depends on the severity of the clinical problems and the service delivery setting as well as other program parameters. Programs decide on length of treatment, sessions per week and therapist caseloads. MDFT International Inc. will provide guidance and recommendations to each program.

- Length of treatment generally runs from **3 to 6 months**
- Number of **weekly sessions can range from 1 to 3**, with an overall average of 2
- Full-time MDFT therapists who hold some or all sessions in the home have **caseloads of 6-10 families** (depending on case severity, number of sessions per week, percent of sessions in the home, travel time, amount of time therapists need to spend in court, TA help).
- Full-time MDFT therapists who work in office-based outpatient programs have **caseloads of 10-20 families** (depending on case severity, number of session per week, etc.).

In order to implement MDFT with fidelity and maintain caseloads on the higher end of the range, it is essential that therapists have a caseload that includes cases at different phases of treatment: a few new cases, a few cases in the middle of their treatment episode, and a few cases who are in the final phase. Weekly session dose is typically lower in the last 6 weeks of treatment.

Supervision Requirements and Workload

Three types of MDFT Clinical Supervision are provided by the MDFT Supervisor: Case Review, Recorded Session Review, and Live Supervision. Full-time MDFT supervisors can supervise between 6–8 full-time MDFT therapists depending on therapist caseload, severity of the cases, and non-MDFT administrative duties. Programs decide on caseloads for supervisors with guidance and consultation from MDFT International, Inc.

MDFT **REQUIRES** that the following types/amounts of supervision be provided to each MDFT therapist:

- Weekly **Case Review Supervision** (3 per month; 60–90 minutes per week of individual case review supervision, which also involves 30-60 minutes for supervisors to prepare for the case review)

- 6 **Recorded Session Review Supervision** sessions per year with each therapist (45-60 minutes per session)

- 3 **Live Supervision** sessions per year with each therapist

- Weekly **Team Meeting/Case Conference/Group Supervision** (45-90 minutes per week) to coordinate referrals/intakes and Therapist Assistant tasks, address implementation issues, case coverage and other administrative matters. Some MDFT programs also use this time as a case conference or group supervision; this is acceptable but not required by MDFT International, Inc.

Therapist Hiring & Interviewing: What to Look For

We offer 3 tools to help you make the best decisions in hiring MDFT therapists:

1. Therapist Intervention Inventory
2. Therapist Self-Assessment
3. Case Vignettes

Effective MDFT therapists have the following characteristics:

- Optimistic about change and a genuinely positive outlook about people (believes that her/his clients, youth and parents can and will change)
- Completes paperwork adequately: turns it in on time and is careful and thoughtful about it.
- Adheres to the MDFT model
- Manages time, stressors, and demands well
- Follows supervisor's guidance and suggestions
- Open to learning and enhancing his/her therapy and MDFT skills; looks for opportunities to improve skills
- Committed to helping his/her clients
- Positive teamwork orientation: likes to be part of a team and collaborates well

Therapist Intervention Inventory: Candidates may complete this inventory during the initial application or interview stage. Items that indicate the greatest resonance with MDFT are D, F, I, J, L, and N. Items that are not consistent with MDFT are C, G, H, and M. ***An ideal candidate will already think like a MDFT therapist and endorse most/all of these items.*** You may also use their responses to stimulate conversation about how they think about youth and families and their theories of how people change. Ask the therapist to explain why they responded the way they did. The more you understand how a therapist thinks about youth, families, and therapy, the better equipped you will be to evaluate their potential as an MDFT therapist.

Therapist Self-Assessment: Candidates also complete the Self-Assessment. Items 1-5 and 10 are ideal characteristics in an MDFT therapist, and items 6-9 and 11-15 are characteristics that we would not be looking for. **Of course nobody is perfect, and everybody has the potential to change, but clearly the more like an MDFT therapist the candidate is when they start the job, the better. Some of these items capture core beliefs and attitudes that are challenging to overcome in training.**

Case Vignettes: Case vignettes invite therapists to describe the clinical situation, how they conceptualize what is happening, and how they would intervene to change it. You can give them one or two to write out before the interview or simply have them think on the spot during the interview. You may have them do one before the interview to give the therapist time to think, and then another one on the spot to see how the candidates thinks on their feet.

Questionnaire for MDFT Therapist Candidates

Name of Therapist:
Date:

Part 1: Therapist Intervention Inventory

Instructions: Think about an adolescent client you have worked with during the past 6 months.

This case should be a good example of the way you usually provide treatment. With this client in mind, review the following interventions therapists commonly use in working with adolescents. Select the 5 interventions from this list that you feel were *most* important in achieving good outcomes with this case. Next, select the 5 interventions you feel were *least* important in helping this teen and family (interventions you rarely used or avoided).

There are no "right" or "wrong" answers ("good" or "bad" interventions); these items are examples of standard ways that therapists work with adolescents, and the use of interventions depends to some extent on the particulars of your case.

Interventions

A. Helped the adolescent to recognize "self-talk," to develop awareness of his/her thoughts and how these thoughts affect behaviors.

B. Helped the teen and/or parents develop insight about the causes of the adolescent's current problems.

C. Helped the adolescent recognize that he/she is the only one who can make the changes needed for a better future.

D. Motivated and engaged the adolescent in therapy by discussing with the teen what he/she wants to see changed in the family, in themselves, and in his/her life.

E. Educated teens and their parents about the dangers of drug use, its consequences, and/or strategies for reducing use.

F. Enhanced parents' feelings of love and commitment toward their adolescent and reinforced parents' expressions of interest in and concern for the teen.

G. Gave concrete directions about changes that the adolescent needs to make to be successful in his/her recovery.

H. Used adolescent skills training, such as anger management, social skills, and coping skills development, using structured activities and/or role playing.

I. Addressed interparental conflict and helped parents work as a team (even if separated or divorced).

J. Helped family members have a different experience of each other by guiding interactions in session; helped adolescents and parents to talk to each other in new ways.

K. Used structured behavioral reinforcement systems as part of the treatment program (e.g., voucher, token or levels system).

L. Worked directly with systems outside of the family (e.g., school authorities, court, community contacts, health and mental health care providers).

M. Directly confronted the adolescent and/or parent to reduce denial about the teen's substance abuse and related problems.

N. Affirmed the adolescent's and/or parents' strengths, potential, and efforts to change.

With this particular case, select the 5 most important interventions you used to achieve good outcomes:

1. _____
2. _____
3. _____
4. _____
5. _____

List any interventions that you think were important with this case but were not listed as exemplar interventions in this scale:

With this particular case, select the 5 least important interventions for this particular case (interventions you used rarely or not at all):

1. _____
2. _____
3. _____
4. _____
5. _____

Part 2: Therapist Self-Assessment

Rate yourself on the following items:

1	2	3	4
Strongly Disagree	*Disagree*	*Agree*	*Strongly Agree*

1. _____ I complete paperwork well. It is generally on time and carefully done.
2. _____ I follow the instructions and suggestions offered to me by my clinical supervisors.
3. _____ I am willing to adhere precisely to the procedures, practices, and rules of an evidence-based program, even if I think I have a better idea.
4. _____ I am open to feedback on my clinical work.
5. _____ I am well organized and good at time and stress management.
6. _____ I tend to be sensitive and sometimes have some difficulty taking hard criticism.
7. _____ I am happy with my clinical work and like having the freedom to follow my own structure and inner guidance about my work.
8. _____ I believe that teenagers must "hit bottom" to be ready and open to change in therapy.
9. _____ It seems from my experience that many clients will not change regardless of what the therapist does.
10. _____ I think teens are more likely to follow their parents' rules if they understand that their parents have the rules because they love them.
11. _____ I think parents often don't know how to best parent their teens, and therapists, and one of the most important things a therapist should do is teach parents how to implement certain parenting practices.
12. _____ I think people change only when they are ready to change, and you can't really make someone more receptive to therapy if they are resistant.
13. _____ I think for acting out teens, parents need to have very strong consequences such as taking down the teen's bedroom door, locking the teen out of the house if he/she misses curfew, etc.
14. _____ I believe that clients should lead the direction of sessions, and therapists should follow wherever the client wants to go.
15. _____ If teens or parents aren't changing in therapy, it generally reflects on their level of resistance and their own psychopathology or extent of problems in the family.

A. List your 2 greatest strengths as a therapist:

1.

2.

B. List your 2 biggest weaknesses or challenges as a therapist:

1.

2.

Case Vignettes

1. The youth has been in therapy for a few months, and has been doing well for about 6 weeks. Last weekend, however, he relapsed. He says he wants to stop using drugs and change his life, but it is very difficult. The parents are very upset and want to put the youth in residential treatment.

2. Divorced parents have a very conflicted relationship; constantly fighting. Not surprisingly, they also fight about their daughter. They keep secrets from each other concerning the daughter, and have never agreed on how to parent her. Thus, the girl has very few rules and the expectations are unclear. The girl's behavior is very out of control: a lot of drug use, not going to school, not coming home at night, etc.

3. In the past (including the recent past) the parents have been neglectful of the youth, leaving him with grandparents for years and generally not being there for their son. Now the parents have gotten their lives together, and want to be parents to their son. The son, however, is very skeptical and is reluctant to trust their change.

4. The youth reports that his parents never listen to him. He feels that they do not care about his opinions. They just want to talk and talk and make the boy listen to their opinions. He feels that they may say they want to listen, but then when he starts talking they drown him out with their own thoughts.

5. A boy is not going to school. He sleeps through his alarm almost every morning, and does not go to school. In the last few months, he has only gone to school on 10 days. He also has a history of getting in trouble at school, and is somewhat low functioning.

Tips for Increasing Referrals

No new service will be successful without an adequate number of appropriate referrals. It is very important for MDFT Programs, especially new programs, to devote attention to the referral process. We suggest programs review their current referral process to make sure it is up-to-date and adequate. Programs should consider if and how the addition of MDFT fits into the currently existing referral process, specifically considering if there will be enough referrals, whether any adaptations need to be made to the current referral process, and what methods will be used to make referral sources aware of the MDFT program. Most MDFT programs receive the bulk of their referrals from juvenile probation or other department of juvenile justice programs (e.g., diversion, probation schools, directly from Judges), child welfare systems, substance abuse or juvenile justice assessment centers, and schools. Some MDFT programs only serve child welfare families or youth on probation, and others serve anybody who meets the eligibility requirements regardless of referral source. Certainly, the outreach strategy will be somewhat different depending on service delivery context of the MDFT program, funding stream, and youth and families served.

Referral System

- ✓ Have a clear and simple system for taking referrals.
- ✓ Get clients assessed and in treatment quickly. Referral sources will be more likely to keep referring to your MDFT program if referrals are seen quickly (not just an intake but intake plus first session).

Promotional Materials

- ✓ Update brochures, website, and other resource materials to include information about the new MDFT program.
- ✓ Create a MDFT specific brochures, flyers and page on agency website that describes the program, including what it is, who it is for, and how to make a referral.
- ✓ Put the MDFT International, Inc. website and Facebook page link on your brochures and business cards, so referral sources know you are a part of a large and successful evidence-based network. Also, the MDFT website and Facebook page have useful resources for referral sources and others.

Outreach

- ✓ Follow-up with referral sources on all referrals and collaborate with them, if necessary and appropriate, to engage clients. Let them know when and how you reached out to client. If appropriate, let them know when client started services and the name and contact information of the therapist.
- ✓ Identify your key referral sources, and focus your energy there. Don't let them forget about your MDFT program. Identify secondary referral sources who should get some focus but not as much as key sources.
- ✓ Regularly send reminder emails to referral sources to remind them of your MDFT program. Attach your brochure, highlight recent successes, attach a recent issue of the MDFT Newsletter, create your own program-specific newsletter, highlight something posted on the MDFT International, Inc. website or Facebook page.
- ✓ Call referral sources regularly to remind them of the program and that you are accepting new clients.

- ✓ When referrals are low, have clinicians call and visit referral sources to increase awareness of the program. Meet with them monthly to review their referrals and identify MDFT cases.
- ✓ Provide outreach to community organizations, health fairs, youth centers, religious organizations.
- ✓ Send contact information of key referral sources to MDFT International, Inc. and we will add them to our mailing list for the quarterly MDFT newsletter and periodic updates.

Events & Services

- ✓ Invite referral sources to "open house" events. Do a "meet and greet" with referral sources, program directors, and MDFT clinicians. Provide food if possible. For established MDFT programs, you might want to invite satisfied former clients to the open house.
- ✓ Provide in-service training to referral sources not only on MDFT but also on other relevant topics such as how to engage youth and parents in treatment, the adolescent brain and how this knowledge can be useful to referral sources, updates on opiates, etc.
- ✓ Provide training to referral sources at their location about MDFT, how it addresses community and referral source needs, and how to make a referral.
- ✓ Offer a service to important referral sources such as probation departments, courts, or schools. Some programs will have a clinician spend a few hours per week at the referral source to be available for consultation and to accept referrals.

Strong Relationships

- ✓ Form personal relationships with referral sources. Let them get to know the program staff. The more key referral sources know the therapists and therapist assistants and supervisors, the more they will recognize their competence and trustworthiness. Never underestimate the power of personal relationships.
- ✓ If a referral sources asks you to do something for them such as participate in a training or attend a local conference, attend a community meeting, or write a letter, **do it.** Be a good partner. Let the referral source know that they can always count on the staff from your MDFT program.
- ✓ Send thank you notes, birthday cards, and holiday cards directly to staff who have referred clients.

Use of Interpreters

Dissemination of MDFT is based on practices used during research studies that have established MDFT as an effective evidence-based treatment model. In these studies, clinicians were fluent in the language of their clients. While there is no research on the influence of interpreters on MDFT outcomes, we have observed that the use of interpreters can have a negative impact on engagement, case contacts, dosage and session pacing. In addition, poor translation sometimes leads to delays in addressing safety issues or challenges in addressing complex emotional issues.

Therefore, in an attempt to obtain the best possible outcomes for the families we serve in our MDFT programs, it is strongly recommended that MDFT therapists speak the language of their clients and that interpreters be used only sparingly.

It should also be recognized that use of an interpreter creates barriers to the therapeutic process such as: (1) Families are not able to directly call the therapist in emergencies, and therapists are not able to directly call the family for "phone check-ins." MDFT therapists frequently conduct phone check-ins with parents and youth to reinforce behavioral change in-between sessions. (2) It is difficult to form a meaningful therapeutic alliance through an interpreter. (3) The language of therapy and MDFT is often complex, nuanced and emotionally laden, and hence easily misinterpreted through translation.

In communities where there is one predominant second language (e.g., Spanish) it is important that programs have sufficient bilingual MDFT clinicians to serve the community. However, there are times when temporary interpreters may be needed to serve the youth and family. Often in these situations, the program may have bilingual staff (e.g., MDFT therapist assistant or other staff) who can step in and translate.

In addition, there are certain programs in which it is not feasible to have clinicians fluent in all the languages of their community. These programs have no option but to turn to interpreters.

MDFT programs should NOT rely on the adolescent or other family members to function as the interpreter. This is highly discouraged except in the most exceptional and rare circumstance.

While we discourage the use of interpreters, we understand that sometimes either because of a temporary absence of bilingual therapists or because the community is multi-lingual, a program may turn to interpreters. In such circumstances, we recommend that the number of cases served with an interpreter be limited. In situations where there are no other options, we offer the following guidelines on the maximum number of cases where an interpreter is used.

Therapist Caseload	Number of Cases with Interpreter
6 - 7	1
11 - 15	3
16 - 20	4

Guidelines for Booster Sessions

As always, the provider must do what is practical and feasible in their individual context. These are guidelines and suggestions to help the provider create policy and procedures. ***This is not a dictate or requirement from MDFT International, Inc.***

1. **Open Door Policy**: Boosters session can be very useful, if practical and feasible. In general, we recommend that in Stage 3, the therapist let the family know that "my door is always open," and encourage youth and parents to feel free to reach out to the MDFT therapist and program if they have a questions, there is a new problem, and so on. This open-door policy eases the termination process, and in the many years of MDFT research and implementation, very few youth or families call after termination, so the burden on therapists is not great. However, when a youth or family does call it can be a tremendous help. The therapist might be able to provide support in a simple call and that is all that is necessary, or perhaps the therapist suggests the youth or family come in the clinic for a booster session or two, or sometimes a referral to another appropriate treatment or other service is warranted (e.g., group therapy, vocational counseling, GED preparation program, parenting classes).

2. **Checking on youth and families after discharge:** Another recommendation, which again may not be feasible for all MDFT programs, is for the clinician to call the youth and parents 4 – 6 weeks after discharge to say hello and to assess (briefly) how things are going with an eye towards assessing the need for ongoing services or to suggest they have some booster sessions with the MDFT therapist if needed.

3. **MDFT booster sessions:** It can be very useful, in certain cases, to have 1 to 3 booster sessions with a family who is experiencing problems such as family conflict, the youth getting in trouble at school, the parent thinks the youth is using drugs again, etc. We find in these circumstances that 1 – 3 (youth, parent and family session) can prevent the problem from escalating. Many times, just one multi-part family session is all that is needed to resolve the problem, create an action plan, or make the necessary referrals to other services. It is important to recognize that not all MDFT programs can do booster sessions because of therapist caseload demands or provider policies.

Guidelines to Re-Open Cases for a Full Course of MDFT

As always, the provider must do what is practical and feasible in their individual context. These are guidelines and suggestions to help the provider create policy and procedures. ***This is not a dictate or requirement from MDFT International, Inc.***

1. **Re-Referral to MDFT**: When a youth is re-referred to MDFT after discharge from a previous course of MDFT, the program should institute their usual process for assessing whether the referral is appropriate for MDFT. The program's usual assessment process should be used regardless of whether the family received MDFT at the same program as the re-referral or received MDFT at another provider program, and regardless of prior outcomes.

   The case can be opened for a standard, complete course of treatment with MDFT given that: 1) inclusionary and exclusionary criteria for that particular MDFT program have been met, 2) the youth and family understand that they will be receiving the same treatment (MDFT) that they received previously and indicate that this is acceptable to them, and 3) the MDFT supervisor, after reviewing the referral documents and if possible conferring with the first MDFT therapist and supervisor, determines that the case is appropriate for a second course of MDFT

2. **Referral to MDFT for youth who have participated in another EBP (e.g., MST, BSFT, FFT, ACRA, IICAPS)**: When a youth is referred to MDFT after discharge from a previous course of another EBP, the program should institute their usual process for assessing whether the referral is appropriate for MDFT.

   The case can be opened for MDFT given that: 1) inclusionary and exclusionary criteria for that particular MDFT program have been met, 2) the youth and family understand that they will be receiving a treatment (MDFT) that is different from what they received previously and indicate that this is acceptable to them, and 3) the MDFT supervisor, after reviewing the referral documents determines that the case is appropriate for a MDFT even though they previously received another type of EBP.

Boosters and re-referrals are the exception and not the rule: If a program experiences a high rate of families requiring MDFT booster sessions or re-presenting for a full course of treatment, further assessment and intervention should be implemented by the program and MDFT trainer. In the normal course of events, relatively few cases should require booster sessions or a second course of MDFT.

Preventing Staff Burnout & Turnover

Taking care of clinical staff is an important part of MDFT, particularly when therapists are seeing complex families with multiple problems and many needs. Here are some suggestions for agencies/program directors, clinical supervisors, and therapists on how to prevent staff burnout and turnover and increase job satisfaction.

Remember these are suggestions and not MDFT requirements.

This document is organized into 3 sections:

1. What agencies and programs can do
2. What supervisors can do
3. What therapists can do

For Agencies and Programs

- **Allow for flexible work schedules.** Encourage therapists to create their own work schedule with guidance as necessary. Allow therapists to work from home. Therapists should not have to physically come to the office each day if doing home-based work. It might be more time efficient to go right from home to clients and back home. Find ways for therapists to complete agency and MDFT notes/logs/paperwork from home wherever possible. Some therapists would rather do their paperwork at home instead of in the office, and this should be allowed.

- **Allow the MDFT supervisor to have the discretion to reduce a therapist's caseload for a month or two between periods of particularly difficult/demanding cases or stressful work conditions** (e.g., audits, intensive workloads when staff resources are lower). If a therapist has a full and difficult caseload for a period of time, allow them to carry a reduced caseload for a month or two afterward to help them regain their balance and get back into relatively normal routines and self-care.

- **Provide each therapist and supervisor with a laptop** so they can work from home and in the field (see item 1 above).

- **Send therapists and supervisors out of town to attend professional conferences, trainings or workshops.** This can be invigorating and energizing for therapists to meet others, connect to the larger professional network, and share and learn about treatment strategies and special topics that are challenging in their daily work. Presenting about MDFT makes therapists feel proud about what they do and gives them a chance to "show off" their great work to others.

- **Provide financial bonuses for achievements** such as being certified, and as incentives for retention, especially at 18, 24, and 36 months after the initial MDFT training. Our research indicates that if therapists remain in MDFT beyond two years, then they tend to stay with MDFT for the long-term and continue to grow and learn.

- **Provide staff with room for advancement and participation in decision-making.** Our research shows that staff who remain with MDFT for several years have had opportunities to advance from therapist assistant to therapist, from therapist to supervisor, and/or from supervisor to trainer.

- **Ask for a 2-Year Commitment Prior to Hiring**. Some agencies ask new hires to MDFT to give a 2-Year commitment to work in the MDFT program. Of course, programs want MDFT clinical staff to stay longer than 2-years since competency increases with practice. However, some agencies hire staff directly out of Master's programs, with little experience, and no clinical license. These staff often have relatively low salaries, and once they receive the MDFT training and/or their license will leave the agency and MDFT program for positions that offer them a higher salary. Asking for a minimum two-year commitment can help with staff retention.

For MDFT Supervisors

- **Assign therapists to particular regions or neighborhoods to minimize travel between clients**. As much as possible, designate certain therapists to certain locales within your catchment area. For example, in Miami, since the MDFT clinic is in the central part of the county, central cases go to all therapists, but we divide cases by north and south. Certain therapists are designated for cases in the north and others for cases in the south based on where they live. Some programs are hesitant to do this because one particular neighborhood might be tougher (more poor, more gang involvement) than other neighborhoods in the catchment area. One way to deal with this and still minimize travel time is that all therapists will receive clients from this neighborhood but will stick to their designated areas for remaining cases.

- **Schedule regular relaxation time**. Meet as a team once every 6 – 8 weeks for relaxation and support: going out for lunch or dinner, getting together after work, having a potluck dinner at somebody's house. One MDFT team shared that a mid-day ice cream breaks down the street from the agency became a welcome opportunity for fun and relaxation in the midst of long days.

- **Follow the MDFT Supervision Protocol, including helping therapists manage their time and stress**. Help therapists take care of themselves. Show that you care about their well-being. Be available to them as you deem it necessary and beneficial. Show flexibility.

- **Use the phone to keep in touch with therapists when they are out in the field.** Don't go more than 2 days without some contact with your therapists. A simple call at the end of one day or the beginning of another can go a long way to show that you are supportive and available. Encourage therapists to call you often to get help, to report how a session went, to vent, or just to receive support. Check in with them before or after a particularly challenging session.

- **Help therapists relax and not put undue pressure on themselves**. While using MDFT will result in improved outcomes, it doesn't mean that a therapist is expected to succeed with every case. Some therapists feel like failures if they have cases that get re-arrested, placed in residential care, or just don't change as much as the therapist would like. Others feel that they must have tremendous success of every case. Help your therapists realize that there will always be disappointments and situations where looking back they may wish they had done things differently. This is part of being a therapist, even with an EBP such as MDFT. Therapy is a dance and it requires two partners: therapeutic team and the family.

For MDFT Therapists

- **Schedule regular weekly appointments with youth and family for the same day, same time**. Even for MDFT therapist who you do in-home work and need to be flexible, schedule regular appointments with your clients in the same manner that you would schedule outpatient clients — i.e., on the same days and hours each week. In MDFT, you generally have 2 appointments each week with clients—one for youth alone, and one involving parents/family. Let clients know that

these are the set appointments, even though you may only use one of them in a given week, or you may need to add an additional appointment at times, or you might have two family sessions and no adolescent or parent-only session in a given week (depending on circumstances and priorities). Try very hard to keep the appointments even when challenges arise with other clients.

Sometimes a family cannot schedule regular appointment times. This often happens with parents who have temporary or on-call jobs. When they get called, they need to work. In this case, make tentative appointments and be in close contact so you can find a time to meet with youth and family. A MDFT therapist with many families in this situation explained how she makes it work*: "I look at my calendar a lot. I check it first thing in the morning and in the evening. I call them a lot to schedule for the week, and I just need to be very flexible."*

- **Localize your appointments**. Even if you have a designated catchment area, it can still be challenging because your area might be large. You should schedule your appointments by neighborhood knowing that, for example, Thursdays will be in one part of your catchment area seeing most/all your cases who live there, and so on.

- **Learn the family's routine and schedule well so you can pick appointment times (or show up at home) when they are likely to be available**. Know when and how they take and pick up their children from school, know when they eat dinner, work schedules, etc.

- **Have a day each week designated for paperwork**. Many therapists will do it on Mondays, working 9:00 – 1:00 on paperwork and then seeing families after 1 pm, for example. This will help avoid the trap of ending up doing paperwork on weekends or at the end of long days.

- **Put in the necessary time in the beginning of the case especially in writing your case conceptualizations, overarching therapeutic goals, weekly reports and session plans**. Time spent in the beginning will pay off in the middle and end. Time spent in the beginning thinking and planning saves time throughout the running of a case because you are more focused, efficient, proactive, and on target. Bottom line, the case will go better.

- **Be highly organized**. Use your calendar. Have daily "to-do lists" including calls to make, things to discuss with clients, resources to find, things to discuss with a TA or supervisor. Have due dates/times on your list.

- **Teamwork is important—use your teammates to vent, to share information about cases, and to solicit help**. When you are out in the field, keep in touch with your teammates: call to say hello, see how they are doing, and get support. A strong team stays in touch!

- **Team members should take responsibility for helping each other**. If you see a co-worker is struggling, reach out to help him/her even before they ask for help. If you do something particularly well, then share the knowledge (without preaching). Use your expertise to help your teammates. Give help to your co-workers and also solicit help from them.

- **Reach out to your supervisor. Don't be afraid to ask for help**. Admit where you struggle and seek help. Demand that your supervisor helps you in a way that works for you.

- **Have regularly scheduled monthly fun time with your co-workers** (e.g., out to lunch or a snack or dinner after work, potluck dinner or games at somebody's home, day at the spa for well-deserved massages, etc.). The point is to schedule it in as part of your routine and make it non-negotiable.

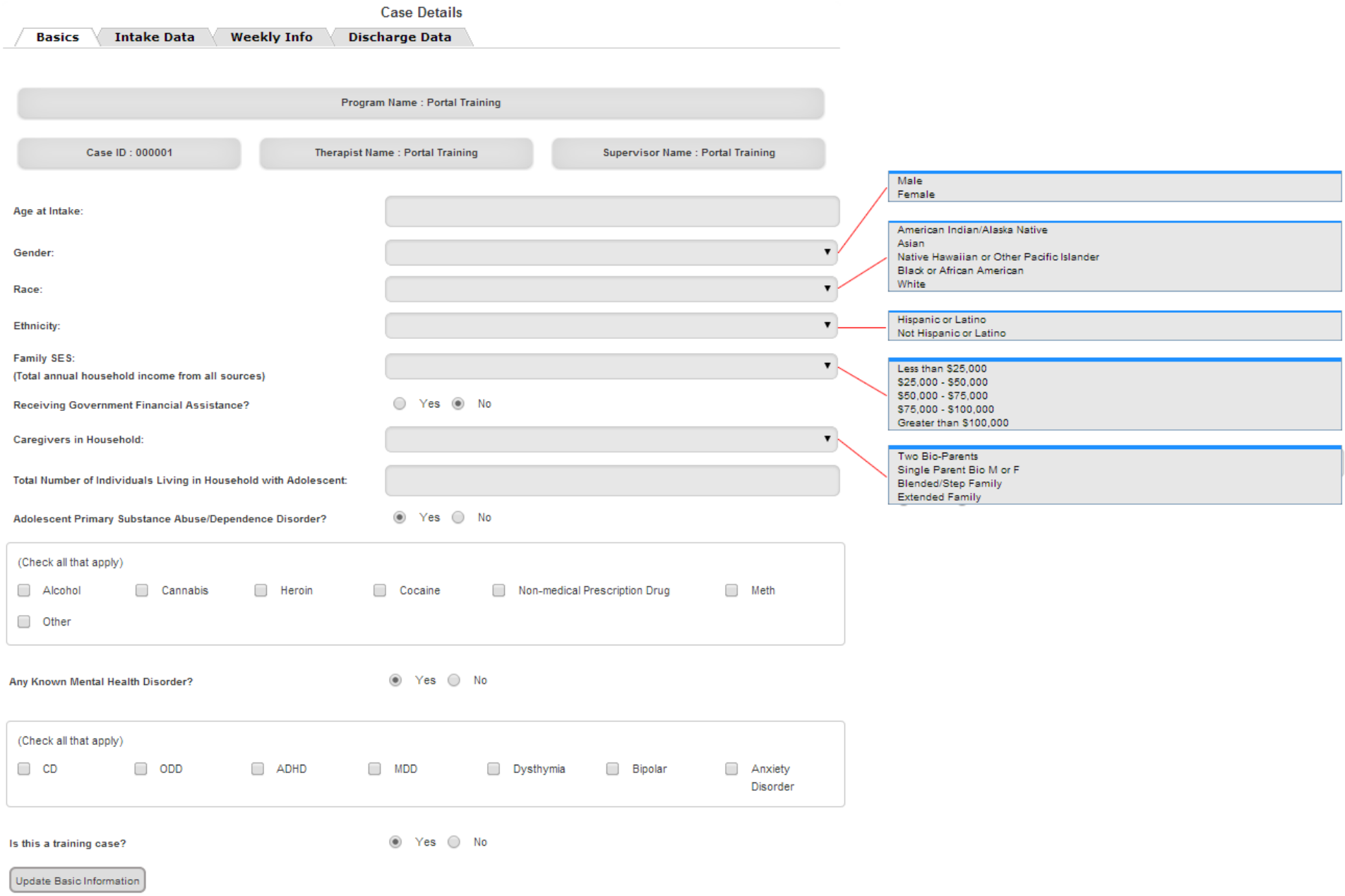
MDFT Clinical Portal Walkthrough

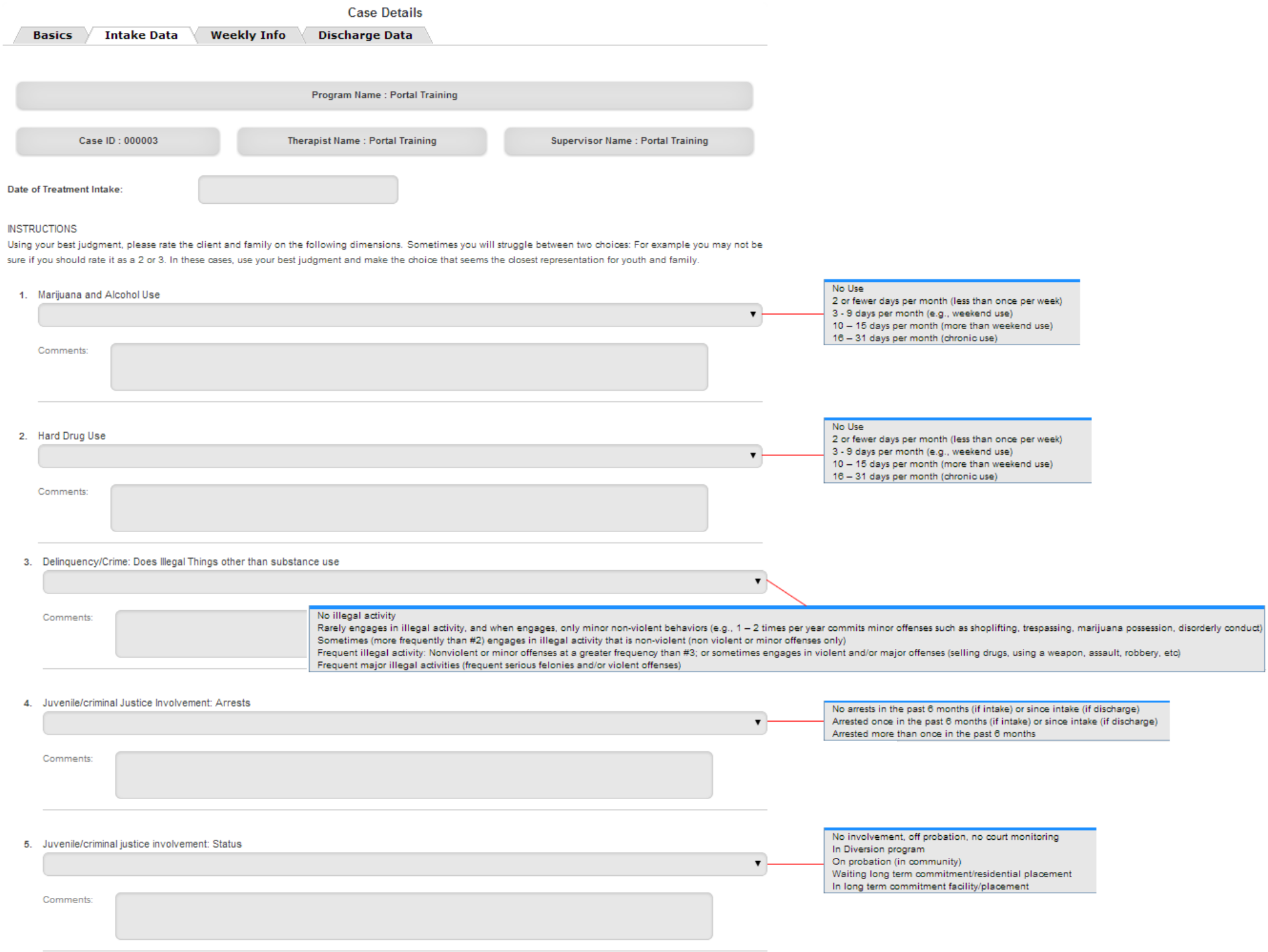
Cases (filled out by therapists)

- Basic Information
- Intake Data
- Weekly Sessions
- Discharge Data

Therapists (filled out by trainers and supervisors)

- Basic Information
- Certification
- Weekly Supervision
- Overall Evaluation
- Development Plan


Case Details
Basics
Intake Data
Weekly Info
Discharge Data
Program Name : Portal Training
Case ID : 000001
Therapist Name : Portal Training
Supervisor Name : Portal Training
Age at Intake:
Gender:
Race:
Ethnicity:
Family SES:
(Total annual household income from all sources)
Receiving Government Financial Assistance?
Yes
No
Caregivers in Household:
Total Number of Individuals Living in Household with Adolescent:
Adolescent Primary Substance Abuse/Dependence Disorder?
Yes
No
(Check all that apply)
Alcohol
Cannabis
Heroin
Cocaine
Non-medical Prescription Drug
Meth
Other
Any Known Mental Health Disorder?
Yes
No
(Check all that apply)
CD
ODD
ADHD
MDD
Dysthymia
Bipolar
Anxiety Disorder
Is this a training case?
Yes
No
Update Basic Information
Male
Female
American Indian/Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic or Latino
Not Hispanic or Latino
Less than $25,000
$25,000 - $50,000
$50,000 - $75,000
$75,000 - $100,000
Greater than $100,000
Two Bio-Parents
Single Parent Bio M or F
Blended/Step Family
Extended Family


Case Details
Basics
Intake Data
Weekly Info
Discharge Data
Program Name : Portal Training
Case ID : 000003
Therapist Name : Portal Training
Supervisor Name : Portal Training
Date of Treatment Intake:
INSTRUCTIONS
Using your best judgment, please rate the client and family on the following dimensions. Sometimes you will struggle between two choices: For example you may not be sure if you should rate it as a 2 or 3. In these cases, use your best judgment and make the choice that seems the closest representation for youth and family.
1. Marijuana and Alcohol Use
No Use
2 or fewer days per month (less than once per week)
3 - 9 days per month (e.g., weekend use)
10 – 15 days per month (more than weekend use)
16 – 31 days per month (chronic use)
Comments:
2. Hard Drug Use
No Use
2 or fewer days per month (less than once per week)
3 - 9 days per month (e.g., weekend use)
10 – 15 days per month (more than weekend use)
16 – 31 days per month (chronic use)
Comments:
3. Delinquency/Crime: Does Illegal Things other than substance use
Comments:
No illegal activity
Rarely engages in illegal activity, and when engages, only minor non-violent behaviors (e.g., 1 – 2 times per year commits minor offenses such as shoplifting, trespassing, marijuana possession, disorderly conduct)
Sometimes (more frequently than #2) engages in illegal activity that is non-violent (non violent or minor offenses only)
Frequent illegal activity: Nonviolent or minor offenses at a greater frequency than #3; or sometimes engages in violent and/or major offenses (selling drugs, using a weapon, assault, robbery, etc)
Frequent major illegal activities (frequent serious felonies and/or violent offenses)
4. Juvenile/criminal Justice Involvement: Arrests
No arrests in the past 6 months (if intake) or since intake (if discharge)
Arrested once in the past 6 months (if intake) or since intake (if discharge)
Arrested more than once in the past 6 months
Comments:
5. Juvenile/criminal justice involvement: Status
No involvement, off probation, no court monitoring
In Diversion program
On probation (in community)
Waiting long term commitment/residential placement
In long term commitment facility/placement
Comments:

6. School/Educational Attendance

Comments:

Participates regularly and successfully in school or academic program, including GED or voc training (e.g., attends daily, no behavioral problems, passing grades/achievement) – always attends
Attends most of the time
Attends about 50% of the time or less (some of the time)
Infrequently/Rarely attends
Does not attend school (or other program) at all for one month or more
NA – has completed school and works full time

7. School/Educational/Vocational Training Grades/Performance

Comments:

Successful in school or academic program, including GED or voc training (no behavioral problems, very good grades/achievement)
Performance is good, few or no behavioral problems
Performance is average, and/or shows some behavioral problems
Performance is below average, and/or shows regular behavior problems
Performance is poor (failing grades), and/or has been suspended for behavior

8. Employment Status

Comments:

Full-time employment
Part-time employment
Actively seeking work but not currently employed
Not employed and not actively working towards employment

9. Pro-social activites/involvement (e.g., sports, clubs, church, volunteer)

Comments:

Frequently involved in pro-social activities (i.e., multiple activities, very busy)
Regularly involved in pro-social activities
Sometimes involved in pro-social activities
Rarely involved in pro-social activities
Never involved in pro-social activities

10. Aggression & Violence (physical violence, fighting, extreme verbal intimidation, etc)

Comments:

Exhibits no aggression or violence at home or outside the home (intimidation, fighting, throwing things, etc)
Rarely uses violence (1 – 2 times per year)
Sometimes is aggressive or violent (3 – 10 times per year)
Regularly violent or aggressive (1 – 2 times per month)
Frequently violent or aggressive (3 or more times per month)

11. Mental Health

Comments:

No mental health problems, basically stable and emotionally healthy
Minor mental health problems, functioning is stable, and not impaired
Mental health problems - more times stable than not; stability and functioning fluctuate; some impairment
Mental health problems – more often unstable than stable, impairs life functioning
Serious, unstable mental health problems that significantly impair daily functioning

12. Family Safety & Violence

Comments:

Family safety is solid, no violence, no risk, no concerns, family resolves problems without excessive conflict or any violence
Family safety and risk is basically good, safety plan is functional but still a little risk (e.g. stability of safety is basically good but not guaranteed), family typically resolves problems without violence but has the potential to slip (risk is rare but not nonexist
Risk is medium—sometimes resort to violence that can put family members at risk; usually resolve problems without violence but sometimes resort to violence
Risk is high but not major or regular—no immediate child welfare report required but may be necessary in the future
Significant and regular family violence—high risk, warrants immediate child welfare report

13. Peer Affiliation

Comments:

- Affiliates with pro-social, non-deviant peers only
- Affiliates mostly with pro-social, non-deviant peers, but has a few deviant peers
- Affiliates with both pro-social and antisocial peers (about 50 – 50 percent)
- Affiliates with mostly antisocial peers, but has a few pro-social peers
- Affiliates with antisocial peers only

14. Family Functioning

Comments:

- Family functioning is excellent: effective parenting practices, youth generally follows house rules, family problem solving is workable (can solve their own problems in a reasonably healthy way)
- Family functioning is very good: usually implement effective parenting practices, youth generally follows rules, family usually solves its own problems in a healthy way, family is basically happy and content
- Family functioning fluctuates: sometimes family functions well and sometimes not. Both effective and ineffective parenting practices used, youth sometimes follow rules, sometimes family successfully solves own problem but not always (50 – 50 percen
- Family functioning is poor: parents generally implement ineffective or no parenting practices (75% or more of the time), youth rarely follows rules, family rarely uses healthy problem solving strategies; family is more unstable than stable, there is signifi
- Family functioning is very poor: ineffective or no parenting practices, youth does not follow house rules, poor family problem solving, there is considerable instability in the home and considerable discontent and unhappiness

15. Sexual Health Risk

Comments:

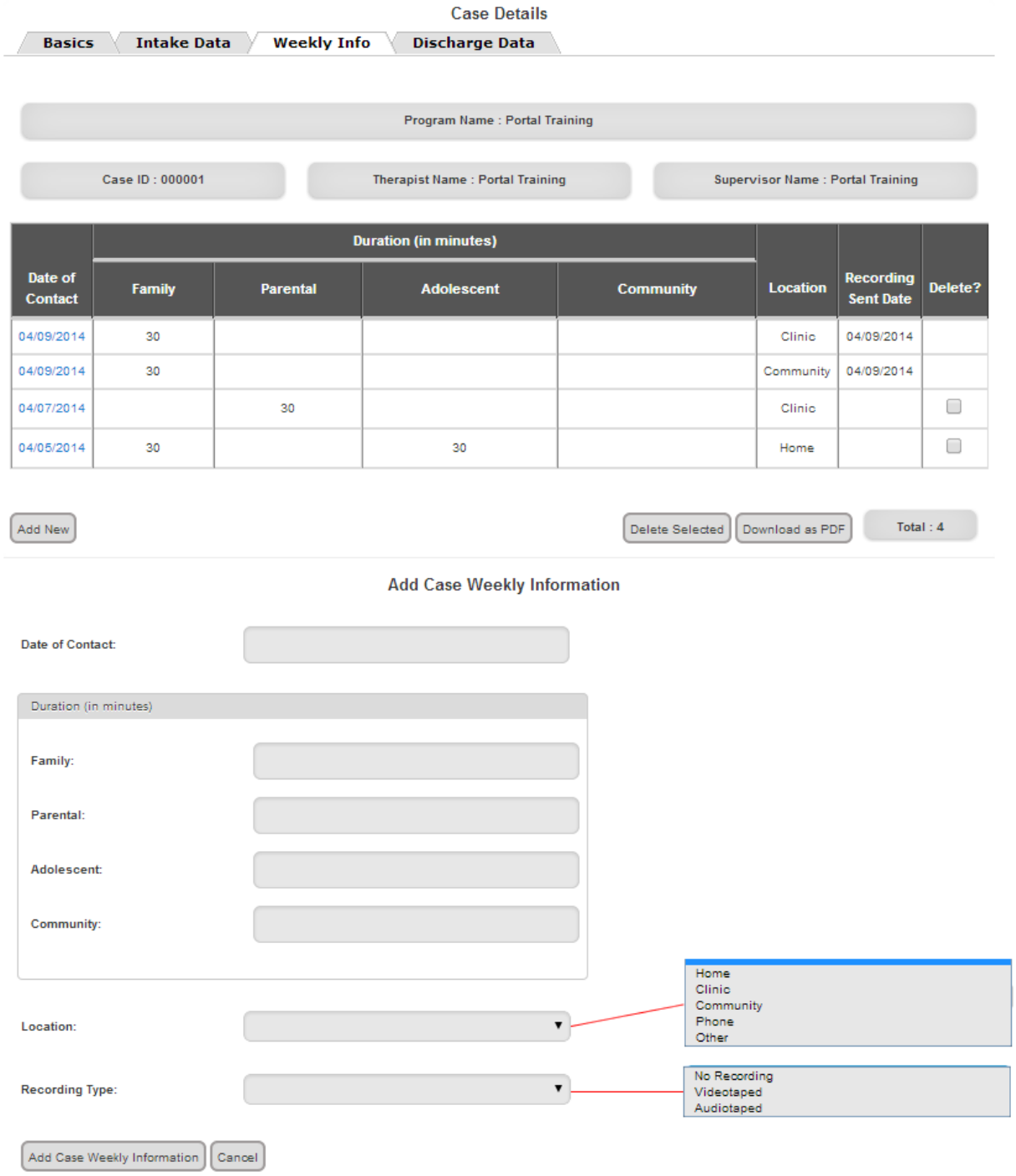
- No risk—abstinent
- Minimal risk—not abstinent but always uses a condom and knows how to use it properly, one sexual partner
- Some risk—Usually uses a condom, knowledge and skills unknown to therapist so can't be sure; but only one partner and seems to be conscientious about protecting oneself and others
- Considerable risk: irregularly uses condoms, more than one partner, known to engage in sexual acts when drunk/high.
- High risk: never or rarely uses a condom, consistently sexually active while drunk/high, several partners, and/or has as sexually transmitted disease

16. Rate the extent to which you think the youth is on a safe and healthy developmental trajectory.

Comments:

- Not at all
- A little
- Some
- Considerably
- Extensively

Update Intake Data | Download as PDF


Case Details
Basics
Intake Data
Weekly Info
Discharge Data
Program Name : Portal Training
Case ID : 000001
Therapist Name : Portal Training
Supervisor Name : Portal Training
Date of Contact
Duration (in minutes)
Family
Parental
Adolescent
Community
Location
Recording Sent Date
Delete?
04/09/2014 30 Clinic 04/09/2014
04/09/2014 30 Community 04/09/2014
04/07/2014 30 Clinic
04/05/2014 30 30 Home
Add New
Delete Selected
Download as PDF
Total : 4
Add Case Weekly Information
Date of Contact:
Duration (in minutes)
Family:
Parental:
Adolescent:
Community:
Location:
Home
Clinic
Community
Phone
Other
Recording Type:
No Recording
Videotaped
Audiotaped
Add Case Weekly Information
Cancel

CASES - DISCHARGE DATA

Case Details

Basics | Intake Data | Weekly Info | Discharge Data

Program Name : Portal Training

Case ID : 000003 | Therapist Name : Portal Training | Supervisor Name : Portal Training

Date of Treatment Discharge:

INSTRUCTIONS

Using your best judgment, please rate the client and family on the following dimensions. Sometimes you will struggle between two choices: For example you may not be sure if you should rate it as a 2 or 3. In these cases, use your best judgment and make the choice that seems the closest representation for youth and family.

Rate youth and family at discharge to rate how they are functioning at the end of therapy (DISCHARGE).

You want to make the most accurate assessment possible. Thus, if when you begin with a client you believe he is using Marijuana 2 or fewer days per month (which would be rated a 1), and then as time goes on you realize he has been smoking between 10 – 15 days per month (which would be rated a 3), the rating you submit should be 3 to reflect the clients status prior to the start of treatment.

It is important that these forms are completed and submitted in a timely fashion—immediately after discharge. Include this as part of your ordinary discharge planning and paperwork.

1. Marijuana and Alcohol Use

Comments:

No Use
2 or fewer days per month (less than once per week)
3 - 9 days per month (e.g., weekend use)
10 – 15 days per month (more than weekend use)
16 – 31 days per month (chronic use)

2. Hard Drug Use

Comments:

No Use
2 or fewer days per month (less than once per week)
3 - 9 days per month (e.g., weekend use)
10 – 15 days per month (more than weekend use)
16 – 31 days per month (chronic use)

3. Delinquency/Crime: Does illegal things other than substance use

Comments:

No illegal activity
Rarely engages in illegal activity, and when engages, only minor non-violent behaviors (e.g., 1 – 2 times per year commits minor offenses such as shoplifting, trespassing, marijuana possession, disorderly conduct)
Sometimes (more frequently than #2) engages in illegal activity that is non-violent (non violent or minor offenses only)
Frequent illegal activity: Nonviolent or minor offenses at a greater frequency than #3; or sometimes engages in violent and/or major offenses (selling drugs, using a weapon, assault, robbery, etc)
Frequent major illegal activities (frequent serious felonies and/or violent offenses)

4. Juvenile/criminal Justice Involvement: Arrests

Comments:

No arrests in the past 6 months (if intake) or since intake (if discharge)
Arrested once in the past 6 months (if intake) or since intake (if discharge)
Arrested more than once in the past 6 months

5. Juvenile/criminal justice involvement: Status

- No involvement, off probation, no court monitoring
- In Diversion program
- On probation (in community)
- Waiting long term commitment/residential placement
- In long term commitment facility/placement

Comments:

6. School/Educational Attendance

- Participates regularly and successfully in school or academic program, including GED or voc training (e.g., attends daily, no behavioral problems, passing grades/achievement) – always attends
- Attends most of the time
- Attends about 50% of the time or less (some of the time)
- Infrequently/Rarely attends
- Does not attend school (or other program) at all for one month or more
- NA – has completed school and works full time

Comments:

7. School/Educational/Vocational Training Grades/Performance

- Successful in school or academic program, including GED or voc training (no behavioral problems, very good grades/achievement)
- Performance is good, few or no behavioral problems
- Performance is average, and/or shows some behavioral problems
- Performance is below average, and/or shows regular behavior problems
- Performance is poor (failing grades), and/or has been suspended for behavior

Comments:

8. Employment Status

- Full-time employment
- Part-time employment
- Actively seeking work but not currently employed
- Not employed and not actively working towards employment

Comments:

9. Pro-social activites/involvement (e.g., sports, clubs, church, volunteer)

- Frequently involved in pro-social activities (i.e., multiple activities, very busy)
- Regularly involved in pro-social activities
- Sometimes involved in pro-social activities
- Rarely involved in pro-social activities
- Never involved in pro-social activities

Comments:

10. Aggression & Violence (physical violence, fighting, extreme verbal intimidation, etc)

- Exhibits no aggression or violence at home or outside the home (intimidation, fighting, throwing things, etc)
- Rarely uses violence (1 – 2 times per year)
- Sometimes is aggressive or violent (3 – 10 times per year)
- Regularly violent or aggressive (1 – 2 times per month)
- Frequently violent or aggressive (3 or more times per month)

Comments:

11. Mental Health

- No mental health problems, basically stable and emotionally healthy
- Minor mental health problems, functioning is stable, and not impaired
- Mental health problems - more times stable than not; stability and functioning fluctuate; some impairment
- Mental health problems – more often unstable than stable, impairs life functioning
- Serious, unstable mental health problems that significantly impair daily functioning

Comments:

12. Family Safety & Violence

Comments:

- Family safety is solid, no violence, no risk, no concerns, family resolves problems without excessive conflict or any violence
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- Risk is medium—sometimes resort to violence that can put family members at risk; usually resolve problems without violence but sometimes resort to violence
- Risk is high but not major or regular—no immediate child welfare report required but may be necessary in the future
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Comments:

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- Affiliates mostly with pro-social, non-deviant peers, but has a few deviant peers
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- Affiliates with mostly antisocial peers, but has a few pro-social peers
- Affiliates with antisocial peers only

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Comments:

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Comments:

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- Some risk—Usually uses a condom, knowledge and skills unknown to therapist so can't be sure; but only one partner and seems to be conscientious about protecting oneself and others
- Considerable risk: irregularly uses condoms, more than one partner, known to engage in sexual acts when drunk/high
- High risk: never or rarely uses a condom, consistently sexually active while drunk/high, several partners, and/or has as sexually transmitted disease

16. Rate the extent to which you think the youth is on a safe and healthy developmental trajectory.

Comments:

- Not at all
- A little
- Some
- Considerably
- Extensively

17. At discharge, was the youth living in (or discharged to) an out-of-home placement such as a group home, residential treatment, foster care, detention, or long-term commitment facility?

Comments:

- Yes
- No

18. At discharge, was the youth participating in school, a vocational program, or working?

Comments:

- Yes
- No

19. Was the youth arrested during the time period between 3 months after intake and the end of treatment?

Yes
No

Comments:

20. Was a new child abuse/neglect report made during the time period between 3 months after intake and the end of treatment?

Yes
No

Comments:

21. At discharge, was the youth on probation?

Yes
No

Comments:

22. At discharge, did the youth/family have an open child welfare case?

Yes
No

Comments:

23. Was this case considered closed successfully? Were the majority of treatment goals met to such extent that discharge was appropriate?

Yes
No

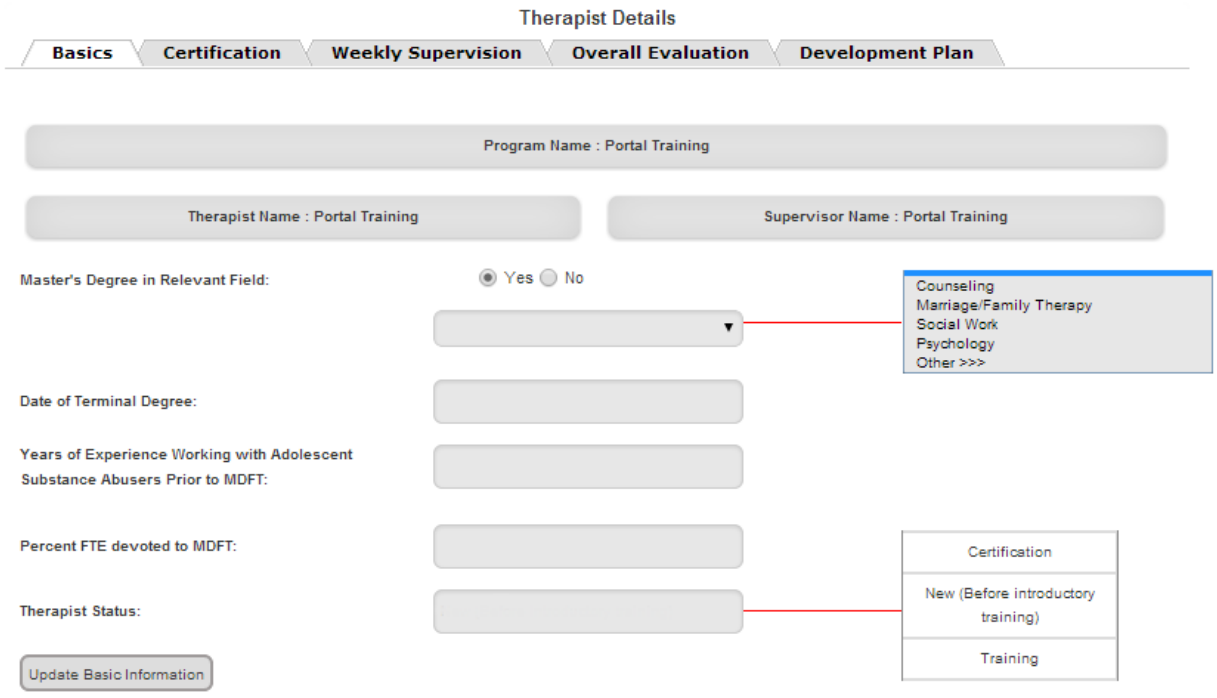
Comments:

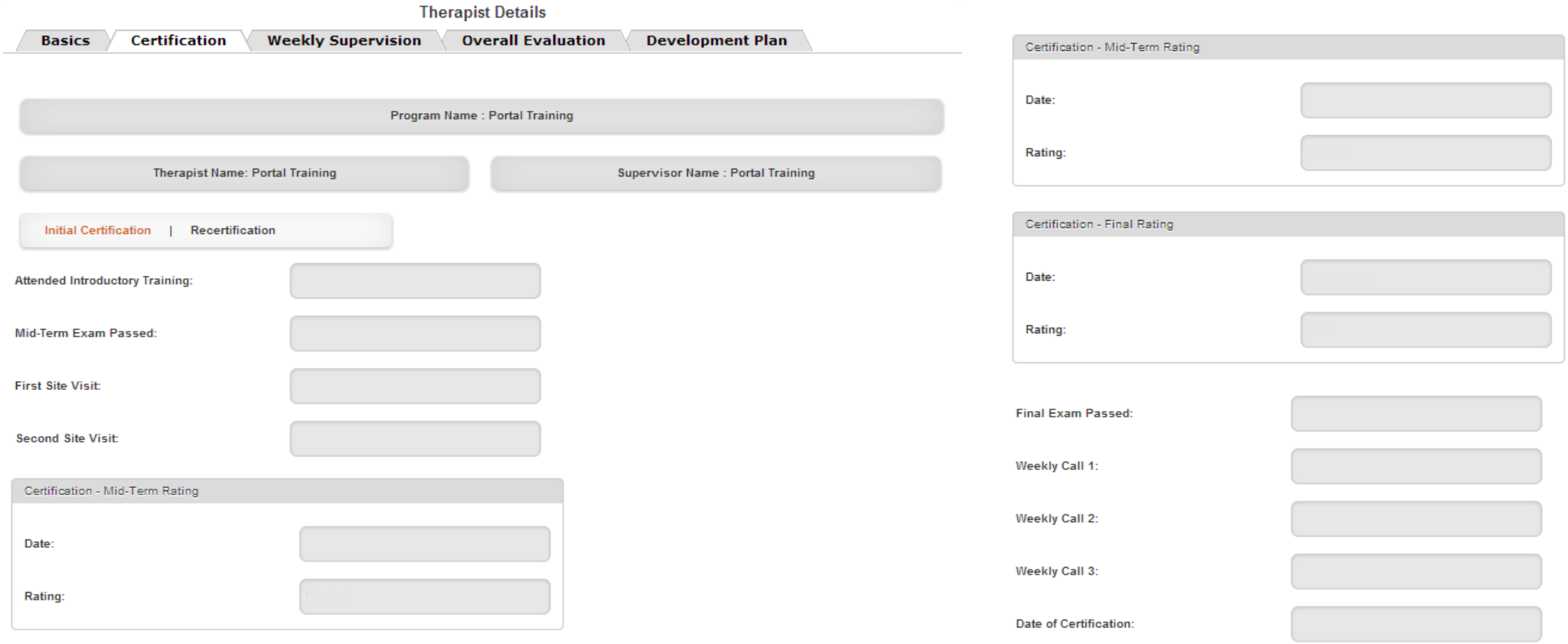
24. Reasons for treatment discharge

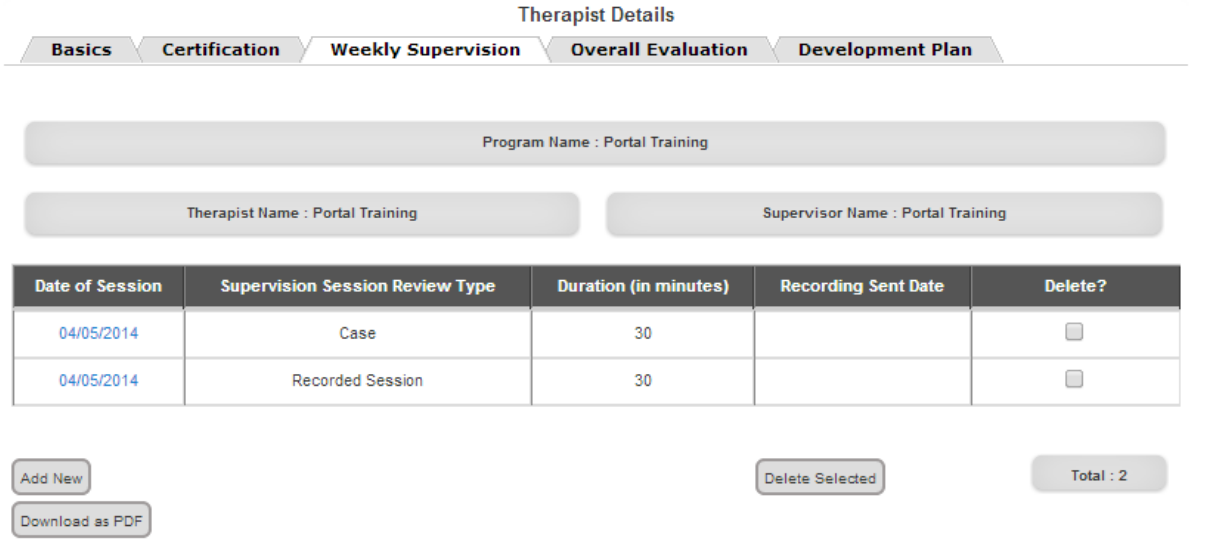
Met Most Treatment Goals
Maximum Gain
Placed In Juvenile Justice System
Moved Out Of Area/Unable To Locate
Placed In Residential Treatment Care
Youth/Family Dropped Out Of Treatment Before Goals Were Met
Unknown

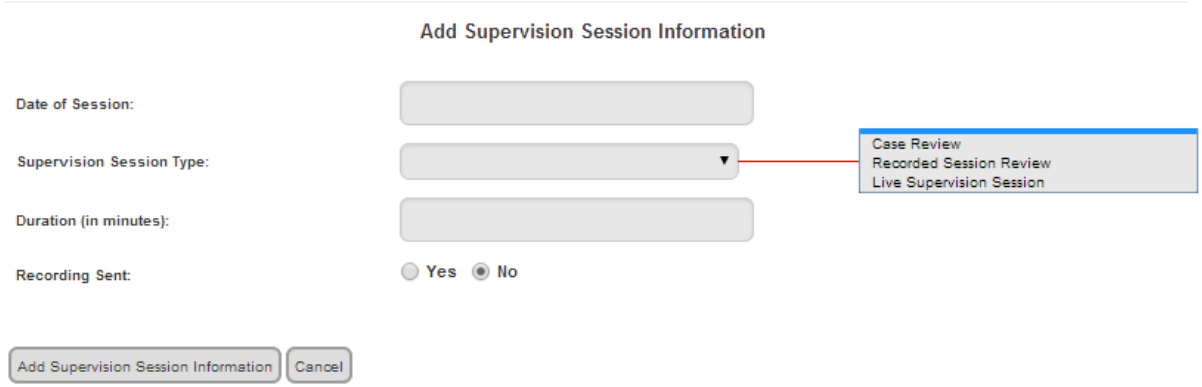
Comments:

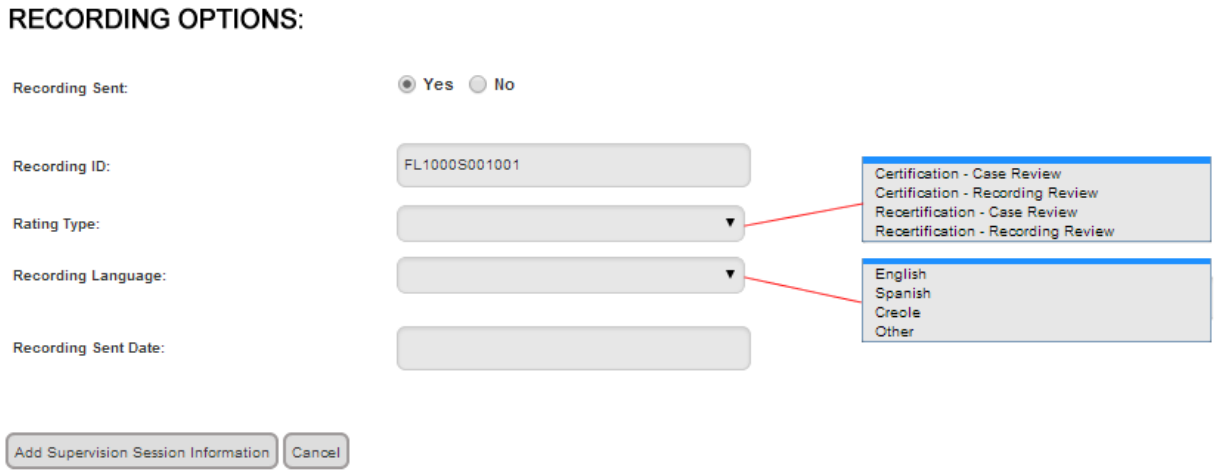
Update Discharge Data | Download as PDF


Therapist Details
Basics
Certification
Weekly Supervision
Overall Evaluation
Development Plan
Program Name : Portal Training
Therapist Name : Portal Training
Supervisor Name : Portal Training
Master's Degree in Relevant Field:
Yes
No
Counseling
Marriage/Family Therapy
Social Work
Psychology
Other >>>
Date of Terminal Degree:
Years of Experience Working with Adolescent Substance Abusers Prior to MDFT:
Percent FTE devoted to MDFT:
Therapist Status:
Certification
New (Before introductory training)
Training
Update Basic Information


Therapist Details
Basics
Certification
Weekly Supervision
Overall Evaluation
Development Plan
Program Name : Portal Training
Therapist Name: Portal Training
Supervisor Name : Portal Training
Initial Certification | Recertification
Attended Introductory Training:
Mid-Term Exam Passed:
First Site Visit:
Second Site Visit:
Certification - Mid-Term Rating
Date:
Rating:
Certification - Mid-Term Rating
Date:
Rating:
Certification - Final Rating
Date:
Rating:
Final Exam Passed:
Weekly Call 1:
Weekly Call 2:
Weekly Call 3:
Date of Certification:


Therapist Details
Basics
Certification
Weekly Supervision
Overall Evaluation
Development Plan
Program Name : Portal Training
Therapist Name : Portal Training
Supervisor Name : Portal Training
Date of Session
Supervision Session Review Type
Duration (in minutes)
Recording Sent Date
Delete?
04/05/2014
Case
30
04/05/2014
Recorded Session
30
Add New
Delete Selected
Total : 2
Download as PDF


Add Supervision Session Information
Date of Session:
Supervision Session Type:
Case Review
Recorded Session Review
Live Supervision Session
Duration (in minutes):
Recording Sent:
Yes
No
Add Supervision Session Information
Cancel


RECORDING OPTIONS:
Recording Sent:
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No
Recording ID:
FL1000S001001
Rating Type:
Certification - Case Review
Certification - Recording Review
Recertification - Case Review
Recertification - Recording Review
Recording Language:
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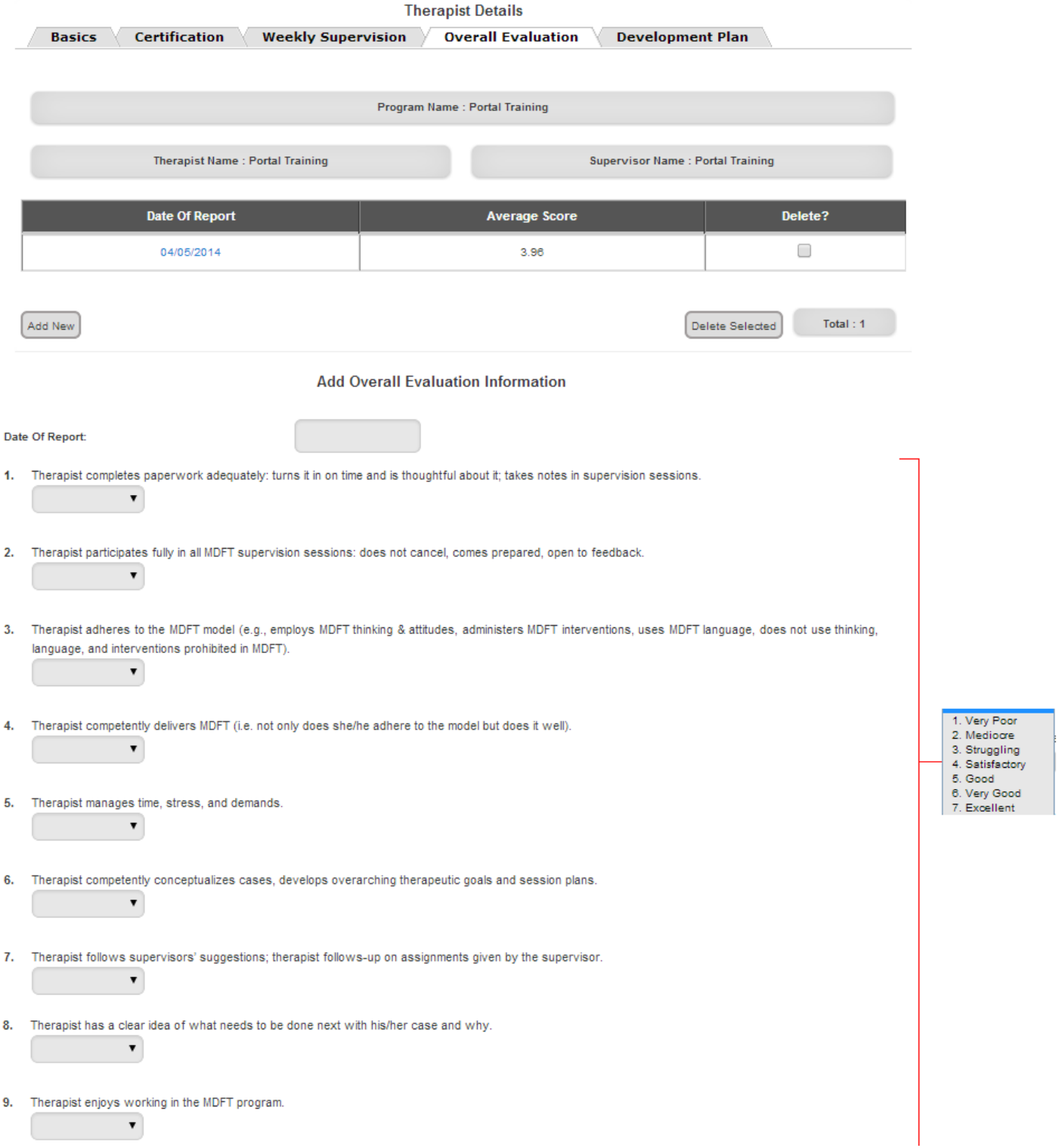
Spanish
Creole
Other
Recording Sent Date:
Add Supervision Session Information
Cancel


Therapist Details
Basics
Certification
Weekly Supervision
Overall Evaluation
Development Plan
Program Name : Portal Training
Therapist Name : Portal Training
Supervisor Name : Portal Training
Date Of Report
Average Score
Delete?
04/05/2014
3.96
Add New
Delete Selected
Total : 1
Add Overall Evaluation Information
Date Of Report:
1. Therapist completes paperwork adequately: turns it in on time and is thoughtful about it; takes notes in supervision sessions.
2. Therapist participates fully in all MDFT supervision sessions: does not cancel, comes prepared, open to feedback.
3. Therapist adheres to the MDFT model (e.g., employs MDFT thinking & attitudes, administers MDFT interventions, uses MDFT language, does not use thinking, language, and interventions prohibited in MDFT).
4. Therapist competently delivers MDFT (i.e. not only does she/he adhere to the model but does it well).
5. Therapist manages time, stress, and demands.
6. Therapist competently conceptualizes cases, develops overarching therapeutic goals and session plans.
7. Therapist follows supervisors' suggestions; therapist follows-up on assignments given by the supervisor.
8. Therapist has a clear idea of what needs to be done next with his/her case and why.
9. Therapist enjoys working in the MDFT program.
1. Very Poor
2. Mediocre
3. Struggling
4. Satisfactory
5. Good
6. Very Good
7. Excellent

10. Therapist is optimistic about people (believes that her/his clients, youth and parents can and will change).

11. Therapist is comfortable working in close emotional proximity with youth and parents.

12. Therapist is open to learning and enhancing his/her MDFT skills; always looking for opportunities to improve skills and abilities.

13. Therapist is committed to helping his/her clients, and has a "do what it takes" attitude toward his/her work.

14. Therapist competently promotes behavioral change in all 4 MDFT domains, demonstrating positive growth and development in MDFT.

15. Therapist accurately assesses his/her progress and challenges as a MDFT therapist, and works with supervisor to improve his/her MDFT knowledge and skills.

16. Therapist frequently and competently facilitates productive conversations between youth and parent (s), successfully creates enactments between family members.

17. Therapist uses the full range of MDFT interventions, varies his/her approach and methods, has and uses a deep and varied repertoire.

18. Therapist's sessions are focused and productive.

19. Therapist has an agenda, therapist is the leader of the session, and always knows what she/he doing and why.

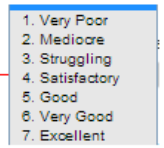
20. Therapist demonstrates professional development and enhancement of MDFT knowledge and skills (continues to become a more highly skilled MDFT therapist).

21. Therapist reaches out to co-workers for practical and emotional support.

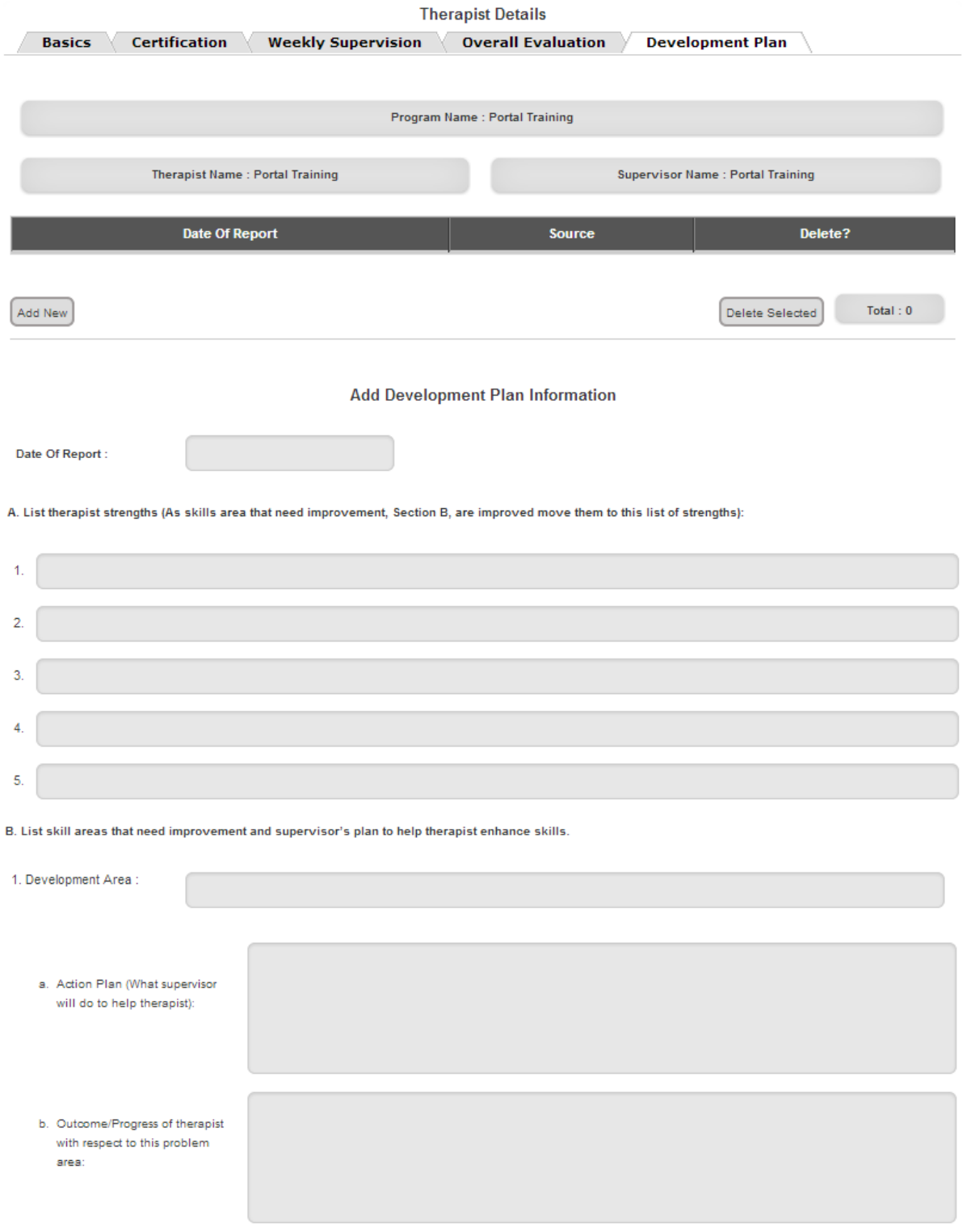
22. Therapist feels that he/she is part of a close and collaborative MDFT team.

23. Therapist attends weekly staff meetings.

24. Therapist participates in self-care activities.



Add Overall Evaluation Information | Cancel


Therapist Details
Basics
Certification
Weekly Supervision
Overall Evaluation
Development Plan
Program Name : Portal Training
Therapist Name : Portal Training
Supervisor Name : Portal Training
Date Of Report
Source
Delete?
Add New
Delete Selected
Total : 0
Add Development Plan Information
Date Of Report :
A. List therapist strengths (As skills area that need improvement, Section B, are improved move them to this list of strengths):
1.
2.
3.
4.
5.
B. List skill areas that need improvement and supervisor's plan to help therapist enhance skills.
1. Development Area :
a. Action Plan (What supervisor will do to help therapist):
b. Outcome/Progress of therapist with respect to this problem area:

2. Development Area :

a. Action Plan (What supervisor will do to help therapist):

b. Outcome/Progress of therapist with respect to this problem area:

3. Development Area :

a. Action Plan (What supervisor will do to help therapist):

b. Outcome/Progress of therapist with respect to this problem area:

4. Development Area :

a. Action Plan (What supervisor will do to help therapist):

b. Outcome/Progress of therapist with respect to this problem area:

Add Development Plan Information | Cancel