

**MultiDimensional**  
*Family Therapy*

# Getting Started with MDFT



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# Message from the Director

Your interest in Multidimensional Family Therapy (MDFT) shows that you care deeply for the youth in your community. Like many others, you want to improve treatment services by bringing effective treatment to those in greatest need, and the need is great—in the United States it is estimated that of youth who need treatment for substance use, only 10% receive it. Of those who need mental health treatment, only 20% receive services. For the small percentage of those who do receive services, only a small fraction of those services is backed by evidence-based research to validate their effectiveness.

MDFT is a proven evidence-based treatment for adolescents and young adults.

Deciding to adopt an evidence-based treatment is an important decision and merits careful consideration. MDFT International is here to help you with the decision-making process. Like you, we want to make sure that MDFT fits well within the culture of your institution or agency before investing time, energy and resources to learn and adopt the MDFT model.

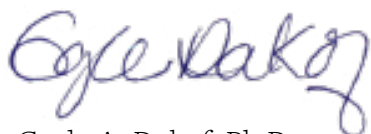
We're also here to help you navigate the potentially confusing world of Evidence Based Treatments (EBTs). What are EBTs? EBTs, also referred to as "Evidence-Based Practices" (EBPs), are treatments with scientific evidence supporting them. A treatment is qualified as being evidence-based if it produces positive outcomes in comparison to the usual care or another alternative treatment in two or more Randomized Clinical Trials (RCTs). RCTs are the gold standard research design to evaluate not only the effectiveness of a given treatment but also its superiority to other treatments.

MDFT's effectiveness is built on the strongest foundation of research. There have been 10 RCTs on MDFT conducted with diverse populations and settings in the United States and Europe. The RCTs were done by developers and independent researchers comparing MDFT to other evidence-based treatments such as Cognitive Behavior Therapy, residential treatment, and manualized group interventions.

MDFT is known not only for its effectiveness and strong scientific foundation, but also for its success in program implementation and sustainability. MDFT has been successfully implemented in a variety of service delivery systems at every level of care (outpatient, in-home, day treatment/intensive outpatient, and residential). MDFT International will work collaboratively with you and your team to create the best possible fit of the model and training program based on your agency's needs.

Thank you for your interest in MDFT. We are excited that you are interested in joining the passionate and dedicated community of MDFT clinicians around the United States and abroad.

If you have concerns or need more information than is provided in this guide, please call me at (786) 668 2088 or email me at [gdakof@mdft.org](mailto:gdakof@mdft.org).



Gayle A. Dakof, Ph.D.

Executive Director, MDFT International, Inc.





# About the MDFT Program







# What is MDFT?

MDFT is a treatment for youth and young adults. MDFT's approach is collaborative, comprehensive, family-centered and scientifically proven to work. MDFT simultaneously addresses substance use, mental health symptoms and disorders, delinquency, violent and aggressive behaviors, and school problems. It improves parental and family functioning and prevents out-of-home placements.







The level of proven effectiveness for MDFT is unsurpassed. MDFT has demonstrated strong and consistent outcomes in 10 randomized clinical trials, the most rigorous test of treatment effectiveness.

## *MDFT is proven to:*

### *Decrease*

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

### *Increase*

-  School Attendance
-  Academic Grades
-  Family Functioning
-  Pro-social functioning
-  Effective Parenting Practices
-  Positive Peer Affiliation

# Why choose MDFT?

## *It Works*

MDFT has proven effective in over 30 years of research and over 20 years of implementation in the United States and Europe. For example, in 2020 in the United States:

- ✓ 94% of families completed treatment
- ✓ 88% of families eliminated reports of child abuse/neglect
- ✓ 90% of youth stayed living at home
- ✓ 86% reported stable mental health
- ✓ 88% had no new arrests
- ✓ 80% were in school or employed
- ✓ 90% abstained from hard drugs

## *It Saves Money*

MDFT lowers community costs by reducing hospitalizations, residential/inpatient treatments, emergency department visits, and short and long-term incarcerations. Research shows that MDFT costs 64% less than residential treatment. After MDFT training and implementation:

- ✓ 50% reduction in hospitalizations in Connecticut
- ✓ 81% reduction of mental health emergency department visits in Riverside County, California

## *It's a One-Stop-Shop*

With MDFT:

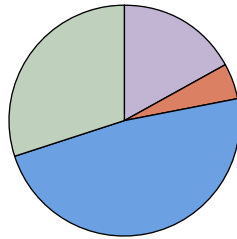
- ✓ You get an effective treatment for both mental health and substance use
- ✓ It provides individual therapy for youth, parent sessions for education, support, and change efforts, and family therapy for youth and parents together
- ✓ It helps families navigate community services and linkages
- ✓ It achieves significant, life-transformative changes within 6 months
- ✓ Its effects are long-lasting into adulthood. Studies indicate that youth and families in MDFT maintain and even build on treatment gains for many years after treatment ends

## *It's for Diverse Populations*

MDFT stands out as the most effective substance use treatment for youth of color, particularly African American men. It's proven successful in engaging and treating very diverse populations of youth and families across the U.S. and Europe.

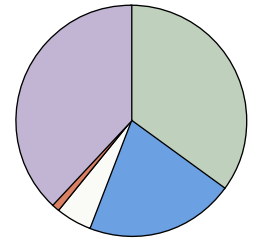
*Race/Ethnicity of MDFT Research Participants*

- 48% Black / AA
- 30% Hispanic
- 17% White Non-Hispanic
- 5% Other



*Race/Ethnicity of MDFT Community Participants*

- 38% Hispanic
- 35% White Non-Hispanic
- 21% Black / AA
- 5% Mixed Race
- 1% Other



## *It's Flexible*

MDFT serves youth with a wide array of challenges and has a welcoming admission criteria to work with all families. It does not exclude families with domestic violence or parents with substance use or mental health disorders; it is particularly well suited to address family conflict. It also broadly defines the "parent/caregiver" role to reflect the variety of family situations and dynamics including parent, foster parent, older siblings, grandparents, and other family members/mentors in guardian roles.

## *Fits into Your Settings*

MDFT can be tailored to a range of programs. It has been integrated into substance abuse, mental health, juvenile justice, and child welfare sectors of care, and in outpatient, in-home, partial hospitalization, residential, drug court and detention/incarceration settings. Today there are over 70 licensed programs in the U.S. and nearly 50 programs in Europe.

## *It's Rewarding for Clinicians*

MDFT receives high satisfaction ratings from clinicians and agencies. In an independent study by The Children's Hospital of Philadelphia and Chestnut Health Systems, 85% of MDFT clinicians reported that MDFT training gave them skills to be more effective therapists. MDFT allows clinicians to work in a variety of settings, to work with both families and young adults, and to collaborate with non-familial members of the community.

## *It Fosters Agency Autonomy*

MDFT International, Inc. trains agency trainers in order to lower program costs, increase sustainability, and foster agency autonomy.

# How Does it Work?

MDFT's approach is collaborative, comprehensive, and family centered. MDFT intervenes in four connected domains: 1. Youth 2. Parents 3. Family 4. Community. Just as problems overlap, MDFT facilitates change in each of these areas to stimulate changes in all of the others. Sessions can be conducted from one to three times per week over the course of four to six months in the home, community or clinic.

## Treatment is Organized in Three Stages

### Stage 1:

#### *Build a foundation for change*

Therapists create an environment in which the youth and parents feel respected and understood. Therapists meet individually with the youth, individually with the parents, and with all family members together. Community advocates are also engaged during this phase to maximize support and increase leverage for change. Stage 1 goals are to develop strong therapeutic relationships, achieve a shared developmental and contextual perspective on problems, enhance motivation for individual reflection and self-examination, and begin the change process.

### Stage 2:

#### *Facilitate Individual and Family Change*

Specific and individualized goals in the youth, parent, family, and community domains (see next page) are established, evaluated, and revisited throughout this phase. Accomplishments in each individual domain activate and support change in the others.

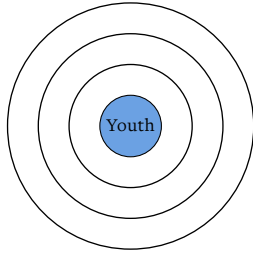
### Stage 3:

#### *Solidify Changes*

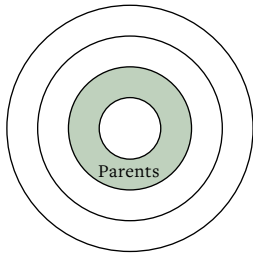
The last few weeks of treatment strengthen the accomplishments parents and youth have achieved together. The therapist amplifies changes and helps families create concrete plans for responding to future problems. Family members reflect on the changes made in treatment, see opportunities for a brighter future, and end treatment with hope and empowerment.



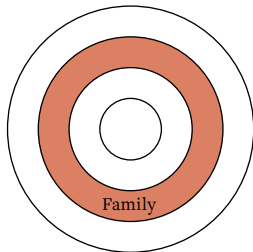
# Goals Within the 4 MDFT Domains



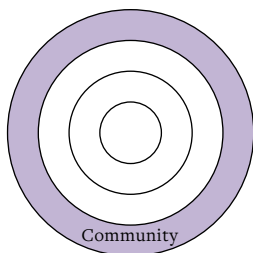
- ✓ Increase self-awareness and enhance self-worth and confidence
- ✓ Develop meaningful short-term and long-term life goals
- ✓ Improve emotional regulation, coping, and problem-solving skills
- ✓ Improve communication skills
- ✓ Promote success in school/work
- ✓ Promote pro-social peer relationships and activities
- ✓ Reduce substance use, delinquency, and problem behaviors
- ✓ Reduce and stabilize mental health symptoms



- ✓ Strengthen parental teamwork
- ✓ Improve parenting skills and practices
- ✓ Enhance parents' individual functioning



- ✓ Improve family communication and problem-solving skills
- ✓ Strengthen emotional attachment and connection among family members
- ✓ Improve everyday functioning and organization of the family unit



- ✓ Improve family members' relationships with social systems such as school, court, legal system, workplace, and neighborhood
- ✓ Build families' capacity to access and utilize needed resources

# Recognition



MDFT received the highest possible rating for scientific support from the California Evidence-Based Clearinghouse for Child Welfare.



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.



The Early Intervention Foundation (EIF) is 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. EIF gave MDFT the highest possible evidence rating in the areas of preventing substance abuse, crime, violence, and antisocial behavior.



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.



The Pew-MacArthur Results First Initiative created the Results First Clearinghouse Database to provide users with an easy way to access and understand the evidence base for programs in social policy areas such as behavioral health, criminal justice, education, and public health. MDFT is listed under the "highest rated" category as a program that had a positive impact based on the most rigorous evidence.



Title IV-E Prevention Clearinghouse reviews programs and services intended to provide enhanced support to children and families and to prevent foster care placement. In reviewing MDFT, they considered only 2 of the 11 MDFT clinical trials and implementation studies. In their review process and categorization system, the Clearinghouse only includes studies comparing models to treatment as usual. The Clearinghouse does not review any research comparing a treatment model to another evidence-based or active intervention. Nine studies in which MDFT was found to be more effective than other strong treatments, including manualized Cognitive Behavior Therapy, high quality residential treatment, and manualized peer group therapy, were not considered, resulting in an incomplete review of MDFT's effectiveness. If you have any questions regarding this Title IV-E classification, please contact us.



Drug Strategies is 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.



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.



MDFT is listed in the United Nations Office on Drugs and Crime's Compilation of Evidence-Based Family Skills Training Programs, the Family-Based Treatment Training Package (UNFT) and was named an effective approach in their publication International Standards for the Treatment of Drug Use Disorders.



The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) provides independent evaluations of available scientific evidence on drug treatment to policymakers and practitioners throughout the European Union and its member states. 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.



The National Association of Drug Court Professionals (NADCP) named MDFT as an effective treatment for implementation in drug courts in their research review on family drug courts.



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.



The Dutch Youth Institute gave MDFT its highest rating of efficacy based on 'strong evidence' in their database of youth interventions.



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.



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.



Youth.gov (formerly FindYouthInfo.gov), was created by the Interagency Working Group on Youth Programs (IWGYP), which is composed of representatives from 21 U.S. federal agencies that support programs and services focusing on youth. Youth.gov rated MDFT as Effective in their Program Directory.



The Health Research Board, the government agency responsible for medical research in the Republic of Ireland, found MDFT to be effective in reducing adolescent drug use in an evidence review of interventions for illicit drug use.



The Clearinghouse for Military Family 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 Effective-RCT, their highest rating of effectiveness.



The Florida Department of Juvenile Justice ranked MDFT an 'Evidence based Practice' with proven recidivism reduction in their Sourcebook of Delinquency Interventions.



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.



UnidosUS (formerly known as the National Council of La Raza) advocates for Latino families and communities in the United States in the areas of civic engagement, civil rights and immigration, education, workforce and the economy, health, and housing. They identified MDFT as a substance abuse treatment with proven efficacy for Latino youth in their publication, Mental Health Services for Latino Youth: Bridging Culture and Evidence.



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



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.



The Association for Family Therapy and Systemic Practice described the MDFT research program as "one of the most comprehensive" in their report, The Evidence Base of Family Therapy and Systemic Practice.



The Urban Institute performs research on solving problems in an increasingly urbanized world. They recommend family-based interventions for combatting youth homelessness, and included MDFT on their list of evidence-informed interventions.





The Healthy Capital District Initiative works to increase access to coverage, provides health planning expertise, and supports health prevention programs across the Capital Region of the state of New York. They gave MDFT their highest ranking of “Evidence-Based Practice.”



Public Safety Canada / Sécurité publique Canada

MDFT was carefully evaluated and recognized as a Model Crime Prevention Program by Canada’s National Crime Prevention Centre (NCPC).



The South Carolina Center of Excellence in Evidence-Based Intervention evaluates interventions for youth and family well-being. They included MDFT on their list of evidence-based treatments in their report on interventions for youth with behavioral and substance abuse problems.

# History

MDFT was developed by Howard Liddle, Ed.D., Professor of Public Health Sciences, Psychology, and Counseling Psychology at the University of Miami Miller School of Medicine. MDFT originated from a desire to transform the treatment services landscape in youth substance use and delinquency. A core objective of MDFT has been to create a personally engaging, science-based, clinically effective, and practical approach.

Liddle was inspired by and trained by Salvador Minuchin, Jay Haley and others at the Philadelphia Child Guidance Clinic in the mid-1970s. A decade later, he worked with Braulio Montalvo to refine clinical supervision methods that would become a core part of MDFT. While working and teaching in community-based clinics over these foundational years, Liddle was struck by the multiple risks, difficulties and complex clinical needs of clinically referred youth. He saw that treating youth and helping their families requires therapists to go beyond either family therapy or individual therapy alone.

MDFT became a new kind of family therapy - a comprehensive, systemic, and developmentally oriented approach. Liddle's determination to help youth and families create a positive life trajectory, coupled with concerns about the absence of available science-supported youth interventions, led to the development of MDFT.

Over several decades, Liddle and colleagues Gayle Dakof, Cindy Rowe, and others have tested the program in randomized controlled trials with demographically, socioeconomically, ethnically and culturally diverse populations around the United States and in Western Europe.

In 2001, MDFT implementation began in the state of Connecticut in collaboration with the Department of Children and Families and five community-based agencies. Since this initial statewide collaboration, MDFT implementation has grown considerably. Today there are more than 20 MDFT programs employing over 100 full time clinicians in Connecticut.

In 2003, MDFT training and implementation began in Western Europe with the INCANT study (International Need for Cannabis Abuse Treatment). Dr. Liddle and colleagues collaborated to design and execute this randomized controlled trial with partners in 5 countries, and directly trained providers in MDFT at community-based agencies in Berlin, Brussels, Geneva, The Hague, and Paris. The European partners went on to establish their own MDFT training academy, which now operates in the Netherlands through [Stichting Jeugdinterventies \(SJI\)](#).

MDFT International, a 501(c)(3) non-profit, was established in 2009 to facilitate quality replication of the MDFT program. MDFT International provides initial and ongoing implementation support to community settings in substance use, mental health, juvenile justice, and child welfare practice settings. Over 150 MDFT teams currently operate in the U.S. and Europe.

In addition to training providers through MDFT International, Liddle and colleagues at the University of Miami Miller School of Medicine continue to develop new variations of the approach, study the model's long-term effects, and conduct research to improve MDFT.



# Training

# Therapist & Supervisor Training

Months 1 – 6 → Therapist Certification

## *Therapist Certification*

- ✓ Study written and video material, complete exercises, review feedback
- ✓ On-site or Virtual 3-Day Introduction
- ✓ 16 Weekly Team Consultation Calls
- ✓ Written Assessment 1
- ✓ 2 Intensive Video Reviews with each therapist (Virtual)
- ✓ 1 On-site Intensive (Live Supervision for each therapist)
- ✓ Written Assessment 2
- ✓ Certification!

Months 6 – 12 → Supervisor Certification

## *Supervisor Certification*

- ✓ On-site or Virtual 1-Day Introduction to Supervision
- ✓ Supervision Written Assessment
- ✓ On-site Supervision Intensive
- ✓ Review Case Review supervision sessions
- ✓ Review feedback to therapists on Weekly Case Plans
- ✓ Review Therapist Development Plans
- ✓ Review Video Review supervision sessions
- ✓ Certification!



# Train-the-Trainers

Our Train-the-Trainers (TTT) program, where trainees master a particular method and go on to train others in the approach, has been used in a wide variety of fields. In order to reduce costs for providers, increase sustainability and promote agency autonomy, MDFT International provides TTT to individual provider agencies. We call these trainers Agency-Based Trainers.

Once trained, they are certified by MDFT International to train new staff at their agency.



## What are the benefits?

Although TTT 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
- ✓ Variety of benefits of having on-site trainers who are knowledgeable of local, agency, and systems issues

In MDFT, the cost savings can be significant because agency trainers can train new therapists, helping teams address staff turnover efficiently and keep teams going.

MDFT International will still provide ongoing coaching and implementation support services, but these are much less expensive than training new therapists. TTT enables agencies to train new therapists in-house.

## Will we still work with MDFT International if we have an Agency-Based Trainer?

Yes. MDFT International still provides coaching and implementation support services.

# What kinds of programs are good candidates for the TTT program?

The Train-the-Trainers program is not for everybody, but it is successful with organizations that are:

- ✓ Committed to MDFT over the long-term
- ✓ Have dedicated high-level MDFT supervisors who are good candidates to become trainers
- ✓ Anticipate or experience clinician turnover
- ✓ Plan to expand their MDFT services

# What does the training involve?

The 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.

## → Trainer Certification

### *Trainer Certification:*

- ✓ Observe and give feedback on reading comprehension quizzes and the 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 On-site Training
- ✓ Review and give feedback on Weekly Case and Therapist Development Plans
- ✓ Review and give feedback on Written Assessments 1 & 2

# Therapist Certification Time Commitments

Activity	Duration of Activity	Suggested Preparation Time
<p><b>Introductory Training:</b> Therapists study written and video materials beforehand and complete a written reading comprehension quiz.</p>	2.5 – 3 days	4 hours of study
<p><b>Weekly Study Time:</b> Read materials and view video.</p>	Throughout training	1 – 2 hours of study per week
<p><b>Up to 16 Consultation/ Coaching Calls:</b> The team has one call approximately every week with the trainer to review progress on training cases.</p>	1 – 1.5 hours per call	30 – 60 minutes of training case preparation
<p><b>Written Knowledge Assessment</b></p>	2 hours to complete	4 hours of study time
<p><b>First Intensive Video Review</b></p>	1.5 – 2 hour individualized video call to review session	1.5 hour to review session prior to the call
<p><b>Intensive Onsite:</b> Live Supervision with each therapist</p>	2 days	None
<p><b>Second Intensive Video Review</b></p>	1.5 – 2 hour individualized video call to review session	None
<p><b>Written Knowledge Assessment</b></p>	2 hours to complete	4 hours of study time

# Supervisor Certification Time Commitments

Activity	Duration of Activity	Suggested Preparation Time
Introductory Training: Supervisors should study written materials beforehand	1 day	2 hours
Weekly Study Time	Throughout training	1-2 hours per week
Supervision Knowledge Assessment	2 hours	2 hours of study time
Intensive Onsite Visit: Live demonstration of MDFT Supervision; training on Therapist Development Plans and Portal	1 day	1 hour
Review of Therapist Development Plans	2 hours	1.5 hours
Review of comments on Therapist Weekly	2 hours	1.5 hours
Review of submission of video of 1st Case Review Supervision followed by Consultation call	1.5 hours	1.5 hours
Review of submission of video of 2nd Case Review Supervision followed by Consultation Call	1.5 hours	1.5 hours
Review of submission of 1st Recorded Case Review followed by Consultation Call	1.5 hours	1.5 hours
Review of submission of 2nd Recorded Case Review followed by Consultation Call	1.5 hours	1.5 hours





# Delivery Requirements

# Site Requirements



## For all programs

- ✓ A team of at least 3 (2 therapists and 1 supervisor; the supervisor can also function as an MDFT therapist).
- ✓ Adequate recording and playback equipment for recording supervision and therapy sessions.
- ✓ On-site space to conduct live supervision with families. [Read more about live supervision.](#)
- ✓ Cell phones for easy contact between therapist and clients, supervisor and other therapists.
- ✓ A laptop computer for each therapist.
- ✓ Authorization and capacity to use HIPAA compliant services utilized by MDFT: Zoom for videoconferencing and ShareFile for file sharing.
- ✓ For programs serving youth who use substances or are at high risk: Urine testing to monitor substance use. [Read our urine testing FAQ.](#)



# Case Eligibility

- ✓ Between the ages of 10 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 importance 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 young adults over the age of 18, and others do not have the capability to serve opiate users. MDFT International will work with programs to help them develop the best eligibility criteria and identify referral sources for their particular circumstances.*



# Therapist Prerequisites & Requirements

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

*Notes: Exceptions can be made for rural and other programs where it may be difficult to staff a full team of Master's level therapists. Programs need to consult with MDFT implementation experts prior to launching a program that includes therapists without Master's Degrees in a clinical field.*

- ✓ Therapists must participate fully in the MDFT therapist training and coaching program 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.



# Supervisor Prerequisites & Requirements

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

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

- ✓ Supervisors must participate fully in the MDFT supervisor training and coaching program in order to become certified and maintain certification.
- ✓ Only MDFT-certified or in-training supervisors can supervise MDFT therapists on clinical issues.
- ✓ Supervisors **MUST** be certified as an MDFT therapist before being certified as a supervisor.
- ✓ Supervisors must re-certify annually. They must complete all supervision recertification requirements between 9 and 12 months after their previous certification or recertification date.



# Therapist Hiring & Interviewing Guide

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
- ✓ 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 Hiring & Interviewing Guide

## *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 a MDFT therapist.

## *Therapist Self-Assessment*

Candidates also complete the Self-Assessment. Items 1–5 and 10 are ideal characteristics in a MDFT therapist, and items 6–9 and 11–15 are characteristics that we would not be looking for. Of course, no one is perfect, and every one has the potential to change, but clearly the more like a MDFT therapist the candidate is when they start the job, the more they will resonate with the model and the greater the likelihood they will learn and deliver it well. 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 think on their feet. Here we look for therapists to hone in on strengths, evaluate the situation through a developmental and systemic lens, focus on family-based solutions (rather than individual change), and consider relational as well as behavior change.

# Questionnaire for MDFT Therapist Candidates

Name of Therapist:

Date:

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## 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.

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### 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 adolescent.
- G. Gave concrete directions about changes that the adolescent needs to make to be successful in their 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 adolescent's substance use 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:*

/ / / / /

---

*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):*

/ / / / /

---

# Part 2: Therapist Self-Assessment

*Rate yourself on the following items:*

1

Strongly Disagree

2

Disagree

3

Agree

4

Strongly Agree

- \_\_\_\_\_ I complete paperwork well. It is generally on time and carefully done.
- \_\_\_\_\_ I follow the instructions and suggestions offered to me by my clinical supervisors.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ I am open to feedback on my clinical work.
- \_\_\_\_\_ I am well organized and good at time and stress management.
- \_\_\_\_\_ I tend to be sensitive and sometimes have some difficulty taking hard criticism.
- \_\_\_\_\_ I am happy with my clinical work and like having the freedom to follow my own structure and inner guidance about my work.
- \_\_\_\_\_ I believe that teenagers must “hit bottom” to be ready and open to change in therapy.
- \_\_\_\_\_ It seems from my experience that many clients will not change regardless of what the therapist does.
- \_\_\_\_\_ I think teens are more likely to follow their parents’ rules if they understand that their parents have the rules because they love them.
- \_\_\_\_\_ I think parents often don’t know how to best parent their teens, and one of the most important things a therapist should do is teach parents how to implement certain parenting practices.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ 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.
- \_\_\_\_\_ I believe that clients should lead the direction of sessions, and therapists should follow wherever the client wants to go.
- \_\_\_\_\_ 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.



*List your 2 greatest strengths as a therapist:*

*List your 2 biggest weaknesses or challenges as a therapist:*

# Case Vignettes

01. 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.

02. 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.

03. 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.

04. 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.

05. A 14-year old 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 10 days. He also has a history of getting in trouble at school, and is somewhat low functioning.

# Live Supervision

Live Supervision is invaluable because it allows therapists to receive guidance and oversight of their therapeutic interventions 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 observe the session and, as needed, intervene by calling in with suggestions for keeping the session on track to achieve 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 monitor/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, 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. This has the slight disadvantage of youth and parents potentially hearing some of the noise in the adjacent room, or even perceiving that they are being watched if the viewing room is lit even slightly. Most teams watch video feed of the sessions on a monitor or television screen as it happens, since sessions also need to be video recorded for later review.

✓ *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 – this is highly recommended!

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 family members may hear the supervisor's comments through the cell phone. This is not recommended if it can be avoided. Texting may seem a good alternative to actual phone calls, however it may confuse family members to see their therapist texting in the middle of a session – and a call is a clear signal that the therapist is taking guidance from the supervisor or trainer (rather than an unrelated call).

### ✓ *A data storage system*

Once sessions are recorded, they need to be stored securely until reviewed. While sites may record on disks or portable devices, cloud storage is more common. 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. The camera may be set to record at a lower resolution to reduce file size. Any permanent storage should be large enough to hold several videos of this size.

## Information About Live Supervision Systems

The following section provides information for setting up live supervision and recording sessions. Please be aware that suggestions for equipment/software do not represent an endorsement by MDFT International, nor is this an exhaustive list of potential solutions.

If your agency has an IT team or IT support, please consult with them prior to purchasing any equipment or downloading any software. Your IT team will be in the best position to recommend equipment/software based on the existing capabilities and/or potential resources at your site. Estimated costs are approximates and may vary by vendor.

The three possible connectivity scenarios presented in the next few pages may easily be adjusted based on your site needs, existing equipment, and configuration. Please note that in option #1 below, the internet connection must be quite strong to have clear audio and video throughout the entire session. Losing internet connection before or during live supervision handicaps the therapist and supervisor because viewing is disrupted. A back-up plan is recommended when internet connectivity is weak.

### 01.

Webcam and Software — if the therapy room and observation room are physically separate, or the observer is at another location. Software to establish communication may be needed.

### 02.

Camera for Adjacent Rooms (no software needed) — if the therapy and observation rooms are near or next to each other, the connection may be made directly from a camera to a laptop/TV/monitor/screen in the observation room. Connection may be made via HDMI cables through the ceiling, USB, or wireless.

### 03.

Security System NVR (software is part of the system) — some of our MDFT providers currently use cameras traditionally used for video surveillance systems.

# Webcam & Software

## (connection between rooms via software)

### *1. Laptop for therapy room*

The laptop will be connected to the webcam and running the connection software, which works with Windows 7 and above.

### *2. Laptop for observation room*

The laptop will be used for the observer(s) to watch the session simultaneously. This laptop will be running the connection software as well.

### *3. Screen for observation room (optional) —*

Observer(s) may watch directly through the laptop on #2 if the screen is large enough. Alternatively, the laptop may be connected to a projector with speakers or a larger monitor/TV screen for easier viewing of the therapy session. Use the most feasible and/or existing option based on your resources:

#### *a. Projector —*

Many conference/meeting rooms are now set up with projectors. If purchasing a projector, ensure you buy an LCD projector, 1080p with HDMI. SUGGESTED: Epson Pro EX9220, AAXA M6 Native 1080p HD LED. ESTIMATED COST: \$500-\$700. Less expensive options are available. If watching therapy sessions is the only use of the projector, then a portable small LCD projector may be used. Check with your IT support for recommendations.

#### *b. TV Screen –*

If your agency has a TV screen, it may be connected directly to a laptop via HDMI, USB or wireless. Check with your IT support for available options at your site and inquire about how to configure your laptop to project/mirror to a TV.

### *4. Business webcam*

It should shoot and stream in full HD (1080p). Some additional features that you may want to consider are: zoom quality capabilities (3X or 4X digital), microphone quality (noise reduction technology built in), certified for business. SUGGESTED: 1) Logitech C930e, 2) Microsoft LifeCam Studio for Business. ESTIMATED COST: \$100

### *5. USB microphone*

This microphone will be plugged in to the laptop in the therapy room. It is important to select a USB mic that is “omnidirectional” to pick up sound from every direction, not just in front of or behind the mic. It is recommended to search for “USB omnidirectional conference mic.” Recommended resolution of 24-bit depth and 96kHz. SUGGESTED: 1) Sound Tech CM-1000USB 3.5mm Table Top Conf Mtg Mic w/ Omni-Directional Stereo USB, 2) Kaysuda USB Speaker Phone 360 Omnidirectional Mic Portable Conf Speakerphone. ESTIMATED COST: \$50 – \$60



## *6. Software*

You will need software for a private, HIPAA-compliant video connection. This provides a point-to-point connection between two machines in the network. It should be able to record the session (video and audio) for video review. SUGGESTED: 1) Zoom Pro (a HIPAA-compliant option used by MDFT International for video conferencing) costs \$14.99 per month/per host, including 1GB of cloud recording; 2) BlueJeans Network-MyTeam is \$16.65 per month/per host, including 10 hours of cloud meeting recording; 3) GoToMeeting-Business is \$16 per month, including unlimited cloud storage.

## *7. Recording sessions*

Ensure that recordings are saved to a secure drive on your site's server. The drive should be restricted only to the MDFT team and administrators.

# Camera for Adjacent Rooms (connection with cables or wireless, no software needed)

## *1. Screen for observation room*

The screen will be connected to the camera/webcam in the therapy room using cables through the ceiling or a wireless connection. Use the most feasible and/or existing option based on your resources:

### a. Projector —

Many conference/meeting rooms now have built-in projectors. If purchasing a projector, ensure you buy an LCD projector, 1080p with HDMI. SUGGESTED: Epson Pro EX9220, AAXA M6 Native 1080p HD LED. ESTIMATED COST: \$500-\$700. Less expensive options are available. If watching therapy sessions is the only use of the projector, a portable small LCD projector may be used. Check with your IT support for additional recommendations.

### b. TV Screen —

If your agency has a TV screen, it may be connected directly to a laptop via HDMI, USB or wireless. Check with your IT support for available options at your site and inquire about how to configure your laptop to project/mirror to a TV.

## *2. Business webcam or any camera*

It should shoot and stream in full HD (1080p). Some additional features that you may want to consider are: zoom quality capabilities (3X or 4X digital), microphone quality (noise reduction technology built in), certified for business. SUGGESTED: 1) Logitech C930e, 2) Microsoft LifeCam Studio for Business. ESTIMATED COST: \$100

## *3. USB microphone*

This microphone will be plugged to the laptop in the therapy room. It is important to select a USB mic that is “omnidirectional” to pick up sound from every direction, not just in front or behind the mic. It is recommended to search for “USB omnidirectional conference mic.” Recommended resolution of 24-bit depth and 96kHz. SUGGESTED: 1) Sound Tech CM-1000USB 3.5mm Table Top Conf Mtg Mic w/ Omni-Directional Stereo USB, 2) Kaysuda USB Speaker Phone 360 Omnidirectional Mic Portable Conf Speakerphone. ESTIMATED COST: \$50 – \$60

## *4. Recording sessions*

Ensure that recordings are saved to a secure drive on your site's server. The drive should be restricted only to the MDFT team and administrators.

# Security System Cameras (typically software is included as part of the system)

## *1. Screen for observation room*

The screen will be connected to the camera in the therapy room typically through a wireless connection. Use the most feasible and/or existing option based on your resources:

### a. Laptop and Projector —

The laptop will need to have the software installed to project. A good business projector may be an expensive investment but useful for conference rooms and meetings. If purchasing a projector, an LCD projector is recommended, 1080p with HDMI. SUGGESTED: Epson Pro EX9220, AAXA M6 Native 1080p HD LED. ESTIMATED COST: \$500-\$700. Less expensive options are available. If watching therapy sessions is the only use of the projector, a portable small LCD projector may be used. Check with your IT support for recommendations.

### b. TV Screen —

If your agency already has a TV screen, it may be connected to the device running the connection software (e.g., laptop) via HDMI, USB or wireless. Check with your IT support for available options at your site and inquire about how to configure your laptop to project/mirror to a TV.

## *2. NVR Camera*

A network video recorder (NVR) is a specialized computer system that includes a software program that records video in digital format to a drive, USB, memory card or other mass storage device. NVR is typically used in video surveillance systems. The camera should be mounted in the room to ensure it captures the participant(s). Specs recommended include: HD, 1080p, wide angle, live streaming capability, software supports encryption. SUGGESTED: Ubiquiti UniFi; Samsung SmartCam. ESTIMATED COST: \$100– \$185

## *3. Software and Connection*

Most likely the NVR camera will come with software for live viewing and recording, or it will include instructions about how to download it from the vendor's site. This option requires a very reliable internet connection at your site.

## *4. Recording sessions*

Ensure that recordings are saved to a secure drive on your site's server. The drive should be restricted only to the MDFT team and administrators.

# Urine Testing Guidelines

## When serving youth who use drugs or are at high risk,

drug testing is one of many tools used to start a therapeutic dialogue and to monitor outcomes so that adjustments may be made to interventions as needed. 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. Relapses and slips are not punished in MDFT but instead seen as a signal that more help, support, focus and possibly greater intensity or new approaches for intervening with the youth and family are needed.

In general, MDFT therapists follow the principle of “more use – more testing.” For polysubstance users, therapists may test 1–2 times per week until the youth test results are negative for all or certain substances (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 forthcoming about their use, and less frequently if they believe the youth does not use drugs. Once producing negative drug tests, youth and parents may celebrate negative screens. 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, a program may need to test for other substances depending on use patterns in the community.

## 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 be configured to test for a variety of drugs in addition to the five listed above



# Delivering MDFT



# Caseloads & Workloads

## Therapist Caseloads

### *For Therapists-In-Training*

When new therapists begin the MDFT training program, it is recommended to increase their caseload slowly 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. A caseload of 8 is recommended for most intensive in-home versions of MDFT. Of course, programs may 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.

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

The size of caseloads depends on the severity of the clinical problems and the service delivery setting as well as other program parameters. MDFT International provides guidance and recommendations to each program on the appropriate length of treatment, number of sessions per week, and therapists caseloads.

### *Caseloads After Initial Training*

- ✓ Length of treatment generally runs from 4 to 6 months, average of 5 months.
- ✓ Number of weekly sessions can range from 1 to 3, with an overall average of 2 per week.
- ✓ 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, as well as Therapist Assistant help).
- ✓ Full-time MDFT therapists who work in office-based outpatient programs have caseloads of 15 – 20 families (depending on case severity, number of sessions per week, etc.).
- ✓ Therapists must serve a minimum of 3 MDFT cases per year in order to be re-certified.

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 stage of treatment, 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, Video Review, and Live Supervision. Full-time MDFT supervisors can supervise between 6–8 MDFT therapists given typical therapist caseload, severity of the cases, and minimal demands from non-MDFT administrative duties. Programs decide on caseloads for supervisors with guidance and consultation from MDFT International.

Regardless of caseload and severity of cases, MDFT REQUIRES that the following types/amounts of supervision be provided to each MDFT therapist:

- ✓ Weekly Case Review Supervision (60–90 minutes per week of individual case review supervision with each therapist, which also involves 30 – 60 minutes for supervisors to prepare for the case review)
- ✓ At least 5 Recorded Session Review Supervision sessions per year with each therapist (45 – 60 minutes per session)]
- ✓ At least 3 Live Supervision sessions per year with each therapist
- ✓ Team Meeting every 2 weeks to coordinate referrals/intakes and Therapist Assistant tasks, address implementation issues, case coverage and other administrative matters.

## 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.
- ✓ Teaches parents how to advocate successfully for their family in school, juvenile justice, and other systems.

TAs are trained along with the therapists but only in relation to their specific TA duties. TA training does not lead to MDFT certification, and TAs do not need to certify or re-certify to provide services.

# Annual Quality Assurance Activities

## Annual Quality Assurance (QA) Activities

- ✓ Onsite Booster Training: 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
- ✓ MDFT Online “Refreshers” (therapists must participate in at least 1 per year and supervisors must participate in at least 2 per year)
- ✓ Review, Rating, and Feedback on one recorded therapy session for each therapist
- ✓ Review, Rating, and Feedback on one recorded supervision session for each supervisor
- ✓ Bi-annual reviews of Therapist Development Plans (TDPs)
- ✓ Bi-annual reviews of MDFT Clinical Portal Reports
- ✓ Case and program implementation consultations as needed
- ✓ Therapist competency and adherence evaluations by Trainer
- ✓ Review of compliance with site requirements and overall implementation of MDFT

# MDFT Clinical Portal & System Fidelity

## MDFT Clinical Portal & System of Fidelity

### *MDFT Clinical Portal*

The MDFT Clinical Portal is an online database for tracking MDFT treatment fidelity and outcomes.

MDFT Portal Reports are provided twice per year (for the first 6 months of the year and the full year). Reports can be generated more frequently or for a different period if a program or funder desires.

## 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 of session (family, youth, parent, or community), length and location. They also complete the Intake and Discharge Evaluation (See Fidelity to Clinical Outcomes on the next page). It takes approximately 10 minutes to open a new case on the Portal, and less than 3 minutes per case weekly to update contact time. At discharge, it takes approximately 15 minutes to close a case in the Portal. Fidelity to MDFT parameters is evaluated based on research-developed benchmarks (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 the supervisor's 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:

- ✓ Therapists are certified MDFT therapists or currently participating in the MDFT therapist training program
- ✓ Each MDFT therapist serves a minimum of 3 cases per year
- ✓ Supervisors are certified as MDFT supervisors or currently participating in the MDFT supervisor training program

- ✓ Average case duration is 4 – 6 months, depending on severity of the case and other programmatic factors (e.g., 4 months for lower risk)
- ✓ 85% of cases receive a minimum of 8 or more therapy sessions (successful engagement)
- ✓ Average of 3 case review supervision sessions per month per therapist (60 – 90 minutes of individual supervision weekly)
- ✓ Average of 5 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   | ✓ Mental health functioning |
| ✓ Delinquency   | ✓ Family violence           |
| ✓ Aggression  | ✓ Family functioning        |
| ✓ Peer affiliation involvement in pro-social activities | ✓ Sexual health risk        |
| ✓ School attendance, school performance                 |                             |

At discharge, therapists evaluate the youth and family on these same dimensions as well as additional items that assess status:

- ✓ Out-of-home placements
- ✓ Arrests
- ✓ Work or school status
- ✓ Child abuse reports
- ✓ Open welfare case
- ✓ Probation status



# Sample MDFT Fidelity & Outcomes Report

Reporting Period From: \_\_\_\_\_ To: \_\_\_\_\_  
Program Name \_\_\_\_\_  
Agency Name: \_\_\_\_\_  
Date of Report: \_\_\_\_\_  
Number of Closed Cases: \_\_\_\_\_

## Service Delivery Report

1. Percentage of therapy sessions held in clinic:	3.47%
2. Average case duration (in months):	5.35
3. Total number of cases served during reporting period:	32
4. Total number of cases closed during reporting period:	20
5. Percentage of cases closed that completed at least 8 sessions (Benchmark 85% or higher):	100.00%

## Therapy Session Report

1. Average round-trip travel time per case contact (in minutes):	18.47
2. Percentage of sessions video recorded (Benchmark 10% or higher):	2.24%
3. Average monthly therapist contacts (in minutes) (Benchmarks: Outpatient 270 mins/4.5 hrs; In-Home/IOP/Residential 420 mins/7 hrs):	512.64
4. Average monthly therapist family sessions (in minutes) (Benchmarks: Outpatient 90 mins/1.5 hrs; In-Home/IOP/Residential 140 mins/2.3 hrs):	151.87

## Supervision Report

1. Average monthly case reviews per therapist (Benchmark 3 or more per month, at least 36 per year):	4.12
2. Average monthly live supervisions per therapist (Benchmark 0.25 or more per month, at least 3 per year):	0.57
3. Average monthly video reviews per therapist (Benchmark 0.4 or more per month, at least 5 per year):	1.04

# Percent Improvement Report

*(Only includes cases closed during the reporting period)*

Benchmark 30% or more

1.	Marijuana and/or Alcohol Use	39%
2.	Drug Use Other than Marijuana/Alcohol	56%
3.	Delinquency/Crime	60%
4.	Aggressive and Violent Behavior	60%
5.	School Attendance	54%
6.	Mental Health Functioning	47%
7.	Family Violence	74%
8.	Family Functioning	47%
9.	School Grades/Performance	47%
10.	Peer Affiliation	26%

# Behavioral Outcomes Report

*(Only includes cases closed during the reporting period)*

Benchmark 80% or more

1.	Percent of youth living at home/not in placement	80%
2.	Percent of youth in school/working	95%
3.	Percent of youth with no new arrests	75%
4.	Percent of families with no new child abuse/neglect reports	85%
5.	Percent of youth with marijuana/alcohol use less than 10 days per month	65%
6.	Percent of youth with no drug use other than marijuana or alcohol	95%
7.	Percent of youth who never or rarely engage in illegal activities other than drug/alcohol use, shoplifting, trespassing, loitering, truancy, etc.	90%
8.	Percent of youth who never or rarely engage in violent behavior	85%
9.	Percent of youth with stable mental health functioning	90%
10.	Percent of youth who do not affiliate mostly or exclusively with anti-social peers	80%
11.	Percent of youth not at high risk for STDs and pregnancy	85%
12.	Percent of families who are not characterized by poor family functioning	90%
13.	Percent of families who do not regularly resort to family violence	100%
14.	Percent of youth not on probation	80%
15.	Percent of youth with no open child welfare case	55%
16.	Percent of cases closed successfully	90%
17.	Reason for treatment discharge:	
	a. Percentage met most treatment goals	90%
	b. Percentage discharged to juvenile justice facility	0%
	c. Percentage moved out of area/unable to locate	0%
	d. Percentage discharged to residential/inpatient treatment care	5%
	e. Percentage youth/family dropped out of treatment before goals were met	5%
	f. Percentage unknown	0%

# Summary

## *Service Delivery & Therapy Sessions*

- ✓ 100% of the cases closed received 8 or more sessions, which is which is outstanding.
- ✓ Case duration was on target at an average of 5.3 months.
- ✓ The dose met the benchmarks for both overall and family sessions, which is great! Average session dose was 513 minutes or nearly 9 hours of MDFT per month per case. Family sessions also met the expectation with an average of 152 minutes, or 2.5 hours, per month. Although this program met the minimum dosage benchmarks, as a reminder, MDFT is meant to be a short-term, intensive intervention, averaging 2 weekly sessions or approximately 2–3 hours per week of treatment. We commend this program for spending sufficient time with cases.

## *Clinical Supervision*

- ✓ Supervision benchmarks were met/exceeded for all 3 areas, which is excellent! Case Review had an average of 4.12 reviews per therapist per month (benchmark is 3).
- ✓ Live Supervision averaged 0.47 per therapist per month (expectation is 0.25). This is excellent, as it is above the benchmark for Live Supervision.
- ✓ Monthly Video Reviews had an average of 1.04, and the expectation is 0.4. Great work in this area!
- ✓ Reminder to address supervision gaps: 1) Enter extended therapist absences under the therapist “Time Off” tab to record when therapists take medical leave, vacations or time away from MDFT for other responsibilities (the supervisor indicated there was a maternity leave, but not recorded in the Portal). 2) When therapists do not have full caseloads or any MDFT cases, supervisors should still meet with them once a week. The individual meeting does not have to be long, but it should be counted as case review supervision even if the focus is more on reviewing protocols or certain sections of the manual, doing role plays of key interventions, and/or reviewing exemplary videos of MDFT sessions. It is especially important to identify gaps in training/supervision and develop plans to address them.

## *Clinical Improvement*

- ✓ Percent Improvement Outcomes from intake to discharge were excellent as 9 of the 10 outcomes met/exceeded the benchmark of 30% or more change.
- ✓ Even though the results are great, we want to remind the supervisor to always revise the Intake and Discharge data with the therapists prior to cases being closed to ensure the data is accurate. In addition, we recommend therapists to revisit their cases intake data once they have earned the participants' trust and more information is gathered.
- ✓ The Behavioral Outcomes at discharge were also excellent as 11 of the 13 (85%) met or exceeded the benchmarks at discharge.
- ✓ In terms of behavioral outcomes, 4 key areas with the most improvement from Intake to Discharge were Drug Use other than Marijuana/Alcohol (56% improvement), Delinquency/Crime (60% change), Aggressive and Violent Behavior (60% change), and Family Violence (74% change). At program end, 95% of youth were not using hard drugs, 90% were not engaging in major illegal activities, 85% were not being violent, and 100% of families were not resorting to violence. Those are great results!
- ✓ Another area with an outstanding result is that only 5% youth were discharged to a higher level of care (residential treatment or juvenile justice facility). At MDFT we like to see that percentage remain below 10%.

## *Recommendations*

This program is performing very well! We would like to commend the supervisor for an excellent job this past year. This program met all the fidelity requirements, and we believe this is one of the reasons the outcomes are so excellent. We have provided some recommendations to continue the good work:

1. Session Dose — Ensure the family sessions account for approximately 33% to 35% of total therapy time, currently that percentage is at 30%. An improvement in this area can result in better youth and family outcomes. Use the Portal during each Case Review supervision to help focus on contact time. Also, continue to work toward an average of 2 sessions, or 2-3 hours, of MDFT treatment (excluding TA work) per week.
2. Video Recording of Sessions — About 2% of the sessions were video recorded last year. Increasing above the suggested 10% may result in more Video Review supervision as well.

# FAQs

## How can I learn more about MDFT?

Call us at 786.668.2088 or email us at [info@mdft.org](mailto:info@mdft.org) to request a personalized phone or video conference call where we can answer all your questions about MDFT.

## Does the trainer visit the site, or will trainees have to travel to the trainer?

Trainees do not need to travel to the trainer's site. All training will take place at the trainee's site or virtually. Training is done at the trainees' sites so that the particulars of the implementation process can be tailored to each program's unique setting.

## Can MDFT be delivered in an outpatient setting?

Yes. MDFT is a comprehensive treatment and not a service delivery system. MDFT can be delivered in all settings, including office-based outpatient, in-home, day treatment, residential/in-patient, and juvenile detention. Studies showing MDFT's adaptability, feasibility and effectiveness have been completed in each of these settings. As part of our training services, our team of experts will help you implement MDFT in your particular setting.

## Are there additional training or startup costs?

No. The cost for the training includes all materials and fees. All start-up costs are delineated.

## Is there an additional fee to be licensed as a MDFT program?

No. MDFT programs that have certified therapists and supervisors are licensed for free by MDFT International.

## Do the costs remain the same from year to year?

The costs are highest during the initial training year, and then are reduced in subsequent years as the program becomes more self-sufficient. Programs with MDFT-certified trainers are allowed to train their own therapists, and hence avoid the cost of training a new therapist with turnover or expansion.

## Are there a minimum number of trainees required for a training?

Yes. A minimum of three trainees is required. This includes an agency supervisor or team leader to ultimately be trained as an MDFT supervisor.

## Are MDFT programs required to have a therapist assistant (TA)?

No. If your clientele does not have significant unmet social, health, and financial needs you will not need a TA, or you may need fewer TAs to get the job done. The TA is there to reduce practical barriers to treatment participation and success. As part of the pre-implementation process, we will help you determine the need for a TA.



## What happens if a trainee doesn't complete the training? Is there an additional cost to train the replacement therapist?

We will help you make the best hiring decisions to avoid turnover. However, even with the best efforts, there is always the risk of turnover. If a trainee leaves the agency and you can hire a replacement within the first three months of the initial training, there are no additional costs to train the replacement. However, if the replacement occurs after the third month, we will have to charge you to train the replacement, given that significant resources will have been expended with the first trainee. We have tools designed to help you make the best hiring decisions and to retain staff.

## We are preparing a grant application to implement MDFT, can MDFT International, Inc. help us in this work?

Yes, we will provide written materials that you can adapt for your grant application. We are happy to review your application and provide written feedback, and of course we will write a letter of support and collaboration.

## We are a mental health agency with no experience with drug testing, and we are reluctant to add this to our program. Is this required in MDFT?

We strongly recommend that MDFT programs have available and use instant drug tests so that therapists can utilize the tests with their clients who use or are suspected of using drugs. In MDFT we use the drug test results in a very specific and therapeutic manner, and not in the way drug tests are used in traditional substance abuse treatment programs, or how they are used by courts or employers. There are specific protocols to teach therapists how to use the drugs tests to promote therapeutic change in teens and parents. It is not unusual for some agencies to be reluctant to do drug testing, however, once they understand the MDFT way of drug testing, they find that it is very useful.

## Can individuals in private practice or working in an agency that doesn't have an MDFT program be trained in MDFT?

No, MDFT is delivered by teams, and at this point we only train teams, and not individuals, to certification. However, each year there are several learning opportunities in MDFT. These workshops and other events are posted on the website ([www.mdft.org](http://www.mdft.org)). To stay informed, kindly consider joining the MDFT distribution list or following MDFT on Facebook.

For more information  
on how to start a MDFT  
program at your site:

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