MultiDimensional
Family Therapy

Implementation and Sustainability Guide

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About the MDFT Program

What is MDFT?

MDFT is an evidence-based treatment for youth and young adults. MDFT's approach is collaborative, comprehensive, family-centered and scientifically demonstrated to work with diverse populations of young people ages 10 to 26. MDFT simultaneously addresses substance use, delinquency, violent and aggressive behaviors, and educational challenges. It improves parental and family functioning, increases positive peer affiliation, prevents out-of-home placements, and reunifies families when a youth returns from an out-of-home placement.

The level of proven effectiveness for MDFT is unsurpassed. MDFT has demonstrated strong and consisten 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

MDFT Levels of Care and Treatment Settings

MDFT is an adaptable intervention that has been researched and successfully implemented in a variety of settings and levels of care. MDFT can be tailored to a range of programs. It has been integrated into mental health, substance use, juvenile and criminal justice, and child welfare sectors of care.

MDFT can be applied in outpatient, in-home, hybrid outpatient and in-home programs, partial hospitalization/day treatment, residential, drug court and detention/incarceration settings.

The MDFT International training and support team helps providers integrate the approach to their specific circumstances including level of care and treatment settings. Specific guidelines and protocols are available, and trainers work with their teams to address implementation questions and challenges as they arise.

How Does it Work?

MDFT's approach is collaborative and comprehensive. Using integrative methods, MDFT clinicians provide individual therapy to the youth, one-on-one parent sessions, family therapy, and case management services. Thus, MDFT intervenes systematically in four connected domains: 1. Youth, 2. Parents, 3. Family, and 4. Community.

Just as problems overlap, MDFT facilitates change in each of these areas to inspire changes in all of the others. Sessions are conducted from one to three times per week over the course of four to six months in the home, clinic, or community. Intensity of treatment dosage depends on the severity of youth and family problems, and tends to taper off at the end of treatment.

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. Stage 1 goals are to develop strong therapeutic relationships, achieve a shared developmental and contextual perspective on problems, enhance motivation for self- examination and behavioral change, help family members connect emotionally and commit to working together in therapy, collaborate with influential members of social systems involved with the youth and family, and begin the change process.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

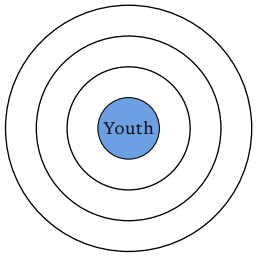
Building on and leveraging the alliance and motivation established in stage 1, therapists work with youth and family members to reduce risk factors and bolster protective factors throughout the stage 2 change process. Specific and individualized goals in the youth, parent, family, and community domains are established, evaluated, and revisited throughout this phase. Relational and therapeutic themes organize and bridge the work across the four domains. Accomplishments in each of the domains activate and support change in the others.

Stage 3:
Solidify Changes

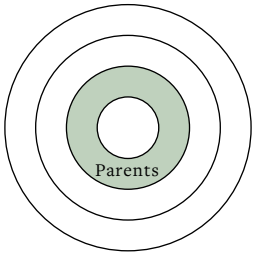
In the last phase of treatment, accomplishments are strengthened. The therapist amplifies changes made and helps families create action plans for responding to future problems. Family members reflect on the progress made in treatment, express appreciation and acknowledge each other for their hard work, see opportunities for a brighter future, and end treatment with hope and empowerment based on the changes they have made together.

MDFT studies show that many youths continue to get better after ending treatment, which supports our central tenet: that families are the medicine and can become the therapeutic environment youth need to maintain positive development into young adulthood and beyond.

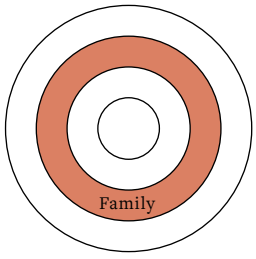
Goals Within the 4 MDFT Domains



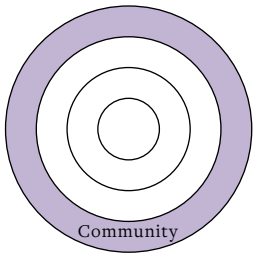
- ✓ Increase self-awareness and enhance self-worth and confidence
- ✓ Develop meaningful short-term and long-term life goals
- ✓ Improve emotional regulation, coping, and problem-solving skills
- ✓ Improve communication skills
- ✓ Promote success in school/work
- ✓ Promote pro-social peer relationships 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

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

MDFT offers:

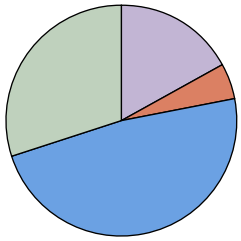
- ✓ An effective treatment for both mental health and substance use
- ✓ Individual therapy for youth, parent education and support, and family therapy for youth and parents together
- ✓ Help for families to navigate community services and linkages
- ✓ Significant, life-transformative changes within 6 months
- ✓ Improvement 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 one of the most effective substance use treatment for youth of color. It has proven success in engaging and treating very diverse populations of youth and families across the U.S. and Europe.

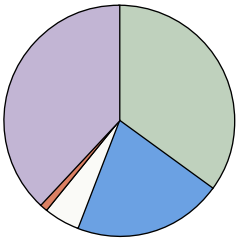
Race/Ethnicity of MDFT Research Participants

- 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 biological parents, foster parents, grandparents, and other family members and mentors in guardian roles.

It 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 120 licensed programs in North America and 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. MDFT quality assurance, ongoing training consultation and supervision methods offer clinicians opportunities to develop and grow long after initial certification is achieved.

MDFT Treatment Delivery Essentials

Site Basics

- ✓ A team of at least 3 (2 therapists and 1 supervisor; the supervisor can also work as a therapist or devote themselves fully to supervision)
- ✓ Recording equipment for each clinician to record supervision and therapy sessions.
- ✓ On-site office space to conduct live supervision with families. *Read Live Supervision Set Up on page 19.*
- ✓ Authorization and capacity to use HIPAA compliant services utilized by MDFT: Zoom for videoconferencing and ShareFile for file sharing of recorded therapy and supervision sessions.
- ✓ For programs serving youth who use substances or are at high risk: Urine testing to monitor and address substance use proactively and therapeutically. *Read Drug Testing in MDFT on page 35 and Urine Testing Guidelines on page 70.*

Case Eligibility

MDFT serves youth with a wide array of challenges and has a welcoming admission criterion to work with all families. For example, it does not exclude families with IPV (Intimate Partner Violence) or parents with substance misuse or mental health disorders. *Basic criteria are outlined below. Agencies may fine tune the criteria for their own target populations.*

- ✓ 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 may be another family member or adult. The parental figure is a person of importance and influence in the youth's life regardless of whether they reside together.
- ✓ For non-residential programs, not actively suicidal (ideation and plan) or requiring immediate stabilization (note that once the youth is not actively suicidal and does not need immediate stabilization or hospitalization, they can be enrolled in an MDFT program)
- ✓ 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, outreach materials, procedures and guidelines, 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.

> *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 may consult with MDFT implementation experts prior to launching a program that includes therapists without master's degrees in a clinical field. For example, in certain circumstances interns may be part of an MDFT team.*

✓ Therapists participate fully in the MDFT therapist training and coaching program in order to become certified and maintain certification.

✓ Therapists recertify annually. They 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).

> *MDFT clinical supervisors do NOT need to be licensed in their profession by their state to provide MDFT supervision. Many providers/agencies require licensure for supervisors; this is not required by MDFT International.*

- ✓ Supervisors participate fully in the MDFT supervisor training program.
- ✓ Only MDFT-certified or in-training supervisors can supervise MDFT therapists on the clinical model.
- ✓ Supervisors need to be certified as an MDFT therapist before being trained and certified as an MDFT supervisor.
- ✓ Supervisors recertify annually. They complete all supervision recertification requirements between 9 and 12 months after their previous certification or recertification date.

Therapist Hiring & Interviewing Guide

Effective MDFT requires therapists who are particularly motivated to go "above and beyond" to help youth and families, and to grow as clinicians. MDFT therapists who master the model tend to be strengths-based, systemic / developmental thinkers, and action-oriented. We offer 3 tools (*see Tools, Resources and Guides on page 44*) 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 possess a positive outlook about people (believes that youth and parents can and will change with the right help)
- ✓ Completes session planning 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 clinical skills; looks for opportunities to improve
- ✓ Committed to helping youth and families
- ✓ Positive teamwork orientation - likes to be part of a team and collaborates well both within the agency and with partners in the community/systems

Therapist Intervention Inventory

Candidates may complete this inventory during the initial application or interview stage. An ideal candidate will already think like a MDFT therapist and endorse most/all of these items. You may also use their responses during the interview process 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.

Items that indicate the **Greatest Resonance** with MDFT:

D, F, I, J, L, and N.

Items **not** consistent with MDFT:

C, G, H, and M.

Therapist Self-Assessment

Candidates also complete the Self-Assessment. Of course, no one is perfect; many candidates will be coming straight out of graduate school, and everyone has the potential to change. Generally, the more like an 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.

Items with **ideal characteristics** in a MDFT therapist:

1-5, 10

Items with characteristics we are not looking for:

6-9, 11-15

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 might give applicants 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 them time to think, and then another one on the spot to see how they 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 only on individual change), and consider relational, emotional, attitudinal, cognitive, as well as behavior change.

Live Supervision Equipment and Setup

Live Supervision is one of the key methods used by MDFT trainers and supervisors. It 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 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. Some Live Supervision setups currently being used by some of our providers are described in the *Tools, Resources and Guides* section.

Preparing for 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. We do not recommend this approach because it 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 a video feed of the session on a monitor or television screen as it happens. Note that relying on Zoom or other video conferencing for live supervision requires high speed internet with reliable bandwidth. Sound quality may also vary over internet-based systems, therefore external mics are helpful. Sessions 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 video recorded. A video camera should be installed or placed on a tripod in the therapy room for this purpose. Using Zoom or other video conferencing has the advantage of easy recording. Some sites also use additional separate microphones for better sound quality - this is highly recommended not only for the live supervision experience, but for review of the recording after the session!

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 noice is kept at a minimum.

✓ *Calling 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). There are manyh ways to do this including (a) having a direct phone into the therapy room, (b) using cell phones with headphones or earbuds, or (c) text messaging.

✓ *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.

MDFT Training

Therapist and Supervisor Training Overview

MDFT Therapist Training. MDFT training is an intensive 5-6 month process that uses multidimensional training and consultation methods. MDFT clinicians begin training with an Introduction, held virtually or in person over the course of 2 - 4 days depending on the wishes of the teams. Weekly consultations on training cases begin shortly thereafter, thus it is ESSENTIAL that each therapist have a training case ready to begin around the time of the Introduction. The certification process for therapists involves the first intensive video review (individual and virtual) in month 1 or 2, an on-site booster in month 3 or 4 (live supervision with each clinician, done as a group, with brief video review only to prepare for live), and a second intensive video review (individual and virtual) in month 5 or 6. There are two Knowledge Assessments: the first to be completed between 4 - 6 weeks after the Introduction, and the second in the final month.

Weekly Consultations on Training Cases. Each clinician in training will need a training case that will be followed throughout the training process in weekly consultation calls. Trainers discuss potential training cases with the program leader (supervisor, administrator or coordinator) in initial calls before the Introduction as well as in more depth with all clinicians during the Introductory training. Training cases will ideally be moderately difficult. If possible, it is good to have at least one of the training cases for the team with substance misuse because it can be very helpful in training therapists to learn all of the MDFT interventions to address substance misuse, including urine screens. Training cases aren't meant to be so severe or complex that the therapist has great difficulty implementing core MDFT interventions. Youth and parents will hopefully have agreed to family-based therapy during the agency's intake process so that the clinician is able to get right to work to set the foundation for change. Engagement and motivation will of course be part of this stage 1 work, so this isn't to say that everyone needs to be highly motivated, yet youth and parents will need to be willing to have their sessions recorded, be observed in live supervision, and have their issues be discussed with the supervisor and trainer as part of ongoing MDFT training. Essentially, training cases need to be challenging enough to provide adequate learning opportunities for MDFT training, but not so overwhelming that learning is delayed or hindered by a complex engagement process or other issues.

Weekly consultations, focusing for approximately 30 minutes per trainee/case, are generally done on Zoom as a group of 2 (60 min.) or 3 (90 min.). Those who will be supervising should be on all calls, even if their consultations are held separately. Trainers generally meet with those who will become supervisors separately from their team for 45 minutes per week.

MDFT Supervision Training. The 5-6 month MDFT supervision training process involves walking supervisors through each aspect of MDFT supervision and ensuring that they meet minimum standards in all MDFT supervision methods. It begins with the supervision introduction, followed closely by the supervisor exam. Supervisors then put into practice the methods they have read and written about, practicing case review supervision first and submitting recorded samples of their work for the trainer's review. Trainers review the recorded case reviews along

with weeklies and provide written feedback, followed by video calls to discuss key learning points and "take aways" for them to address as they move forward. Supervisors submit until they pass the minimum threshold in the rating system. They then move on to video review and receive feedback on their therapist development plans (TDPs), following the same submission, review and feedback procedures as with case review. The on-site intensive is held about halfway through training, which is the supervisor's opportunity to learn live supervision methods with the direct guidance of the trainer. After all benchmarks have been passed, they are certified.

A note about our training system: *We have strong evidence from randomized trials on MDFT, conducted since 1985, that our training system is effective. We also draw from our success in disseminating MDFT since 2000 that the implementation guidelines and procedures work well in practice. For instance, of the 134 programs in the U.S. and Europe that started at least 2 years before collecting data on sustainability, the rates are very impressive. Ninety percent sustain MDFT for at least 2 years, 88% at least 5 years, and 70% at least 8 years. This compares favorably to what is reported in the literature on other evidence-based models (Dakof et al., 2022).*

Therapist & Supervisor Training Time Commitments

Months 1–6 → Therapist Certification

Therapist Certification

- ✓ Study written and video material, complete exercises, review feedback
- ✓ On-site or Virtual Introduction
- ✓ 12-16 Weekly Team Consultation Calls
- ✓ Knowledge Assessment 1
- ✓ 2 Intensive Video Reviews with each therapist (Virtual)
- ✓ On-site Intensive (Live Supervision for each therapist)
- ✓ Knowledge Assessment 2
- ✓ Certification!

Months 6–12 → Supervisor Certification

Supervisor Certification

- ✓ On-site or Virtual Introduction to Supervision
- ✓ Supervision Knowledge Assessment
- ✓ On-site Supervision Intensive to train in Live Supervision
- ✓ Review Case Review supervision sessions
- ✓ Review feedback to therapists on Weekly Case Plans
- ✓ Review Therapist Development Plans
- ✓ Review Video Review supervision sessions
- ✓ Certification!

Therapist Certification Time Commitments

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

Delivering MDFT

Caseloads & Workloads

Therapist Caseloads

For Therapists-In-Training

When 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. New MDFT therapists are more likely to excel when given ample time for studying, weekly session planning, consultations, and treatment delivery!

To assist programs 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 or few 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 therapists 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 therapist caseloads.

Caseloads After Initial Training

- ✓ Length of treatment generally runs from 4 to 6 months, with an 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 typically have caseloads of 15 – 20 families (depending on case severity, number of sessions, etc.).
- ✓ Therapists must serve a minimum of **3 MDFT cases per year** in order to be eligible for re-certification.

  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 caseloads, 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 (about 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.
- ✓ Facilitates youth participation in recreational, educational, and vocational activities
- ✓ Guides and supports parents in learning to advocate successfully for their family in school, juvenile justice, and other systems
- ✓ Assists MDFT therapists and supervisors in various tasks as needed

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 recertify to provide services.

Estimated Post-Training Time Commitments for Therapists and Supervisors

MDFT therapist post-certification time commitments (not including direct service time):

Weekly Estimated Time Commitment

	Total Commitment	Commitment Per Week	Notes
Individual Case Review Supervision	20 minutes to review each case	90 minutes	Review each MDFT case in-depth at least every other week and with an updated weekly. Estimate approximately 20 minutes to review each case.
Team Meeting	60 minutes every other week	30 minutes	Discuss referrals, priorities, coordination of team activities, Therapist Assistant (TA) tasks for programs with TAs, engage in team building and therapist self-care activities, address implementation and/or clinical challenges.
Clinical Portal	10 minutes to open/close a case. 3 minutes to enter weekly contacts per case	30 minutes	30 minutes per week for a caseload of 8 families.
Case Notes/ Update Weekly/ Plan Sessions/ Work on Case Conceptualization (CC)	20 minutes per case for preparation. 60 minutes for case conceptualization at the beginning of the case	90 minutes	90 minutes for a caseload of 8 families. Weeklies are prepared for supervision in detail on half the cases each week (sessions for the other cases are still planned in weeklies but in less detail). Generally 4 cases are thoroughly reviewed per week in case review supervision.

Yearly Estimated Time Commitment: Video Review and Live Supervision
(5 video review supervision sessions and 3 live supervision sessions per therapist are required each year)

	Requirement	Commitment	Notes
Video Review Supervision	1.5 hrs for each video review supervision	7.5 hrs per year / 37.5 mins per month / 9 mins per week	Although most of the Video Review Sessions should be done alone with the therapists, it is acceptable to do up to two of the reviews in a group format with other MDFT therapists.
Live Supervision	1.5 hrs for each live supervision (prep and post-session)	4.5 hrs per year per therapist / 23 mins per month / 6 mins per week	
TOTAL SUPERVISION, PREPARATION, PAPERWORK (INCLUDING CASE NOTE):			255 minutes or 4.25 hours per week per therapist with a caseload of 8 MDFT families

MDFT Therapist Total Time Commitment: Session Planning and Documentation, Supervision, MDFT Sessions, Travel Time (based on a caseload of 8)

Assumptions:

- 2 sessions per week: One 90-minute session and one 60-minute session weekly per family (150 mins/2.5 hours weekly) for 8 cases = **1200 minutes / 20 hours of direct service**
- Session Planning / Documentation, Supervision, Team Meeting = **4.25 hours** (see above)
- Travel time: Estimate 16 sessions @30 minutes round trip/session = **8 hours**

Total Therapist Work Hours Weekly (rounding up) = **32 hours/week**

(NOTE: This is a high estimate given that not all families will receive 2.5 hours, or two sessions weekly given cancelled sessions due to illness, vacations/holidays, and missed appointments. We estimate that a therapist will provide 16 sessions per week and that all sessions will be in the home with 30 minutes average travel time, but of course many sessions may be held in the clinic. We use this conservative estimate to ensure we are not underestimating time commitments.)

MDFT Supervisor post-certification time commitments:

Weekly Estimated Time Commitment

	Total Commitment	Commitment Per Week	Notes
Individual Case Review Supervision	90-mins with each therapist	6 hrs	Estimate to supervise a team of 4 therapists to review all cases at least every other week.
Preparation and Follow-up to Case Review Supervision	60-mins per therapist	4 hrs	Estimate to supervise a team of 4 therapists. Preparation and follow up includes written feedback on weeklies, including regular reviews of therapist's cases to include: review of contacts on the Portal, 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

Team Meeting	60-mins every other week	30 mins	Discuss referrals, priorities, coordination of team activities, Therapist Assistant (TA) tasks for programs with TAs, engage in therapist self-care activities, address implementation or clinical challenges
Clinical Portal	3-mins per therapist	12 mins	Estimate for a team of 4 therapists. Enter Portal information on supervision sessions, including type of supervision and length.
Communications with therapists in between Supervision Sessions and Team Meetings	30-mins per therapist	2 hrs	Supervisors typically have email, text, phone, or in-person communication with therapists outside of scheduled supervision or meetings. This occurs on an as needed basis.

Yearly Estimated Time Commitment: Video Review, Live Supervision, Therapist Development Plans (TDPs)

	Requirement	Commitment	Notes
Video Review Supervision	5 sessions p/therapist p/year	2 hrs p/video review p/therapist 10 hrs p/yr p/therapist Average of 83 mins p/mo or 21 mins p/wk Total of 84 mins p/wk for 4 therapists.	Although most of the Video Review Sessions should be done alone with the therapist, it is acceptable to have no more than two of the reviews/therapists to be held in a group format with other MDFT therapists.
Live Supervision	3 sessions p/therapist p/year	1.5 hrs p/live p/therapist 4.5 hrs p/yr p/therapist 23 mins p/mo or 6 mins p/wk Total of 24 mins p/wk for 4 therapists.	
Therapist Development Plans	4 times p/yr p/therapist	30 mins p/therapist x 4 times p/yr 2 hrs p/yr p/therapist 2.5 mins p/wk Total of 10 mins p/wk for 4 therapists.	
TOTAL WEEKLY SUPERVISON TIME PER THERAPIST			3.67 hours, abt 4 hrs of supervision p/wk p/therapist 15 hrs p/wk for 4 therapists

SUMMARY

MDFT Therapist Weekly Preparation, Paperwork (including Case Note), Supervision Time for a caseload of 8 families = 4.25 hours

MDFT Therapists Weekly Preparation, Paperwork (including Case Note, supervision, and Direct Service Time = 32 hours (estimate of 20 hours of direct service for a caseload of 8 families)

MDFT Supervisor Time Commitment for a team of 4 therapists with 8 cases each (24 total cases) = 15 hours

Drug Testing in MDFT

Goals of Drug Testing in MDFT

MDFT uses drug screens to facilitate open dialogue with the youth about substance use and to move the conversation away from guessing or debating whether the youth is using. Drug screens also reduce family arguments about the youth denying use and the parents accusing him/her of use. In MDFT, the drug screen is used as a therapeutic tool to help youths be straightforward and clear first with themselves, and then with their parents and significant others. This sets the foundation for lasting change in this area. Because dialogue and not accuracy per se is the key reason to test in MDFT, therapists do not use state-of-the-art procedures to assure untainted drug screens (e.g., watch the youth urinate, pat them down to see if they are bringing in somebody else's urine, blue the water in the toilet). Thus, the results from the urine screens conducted by MDFT could be inaccurate. *See the Urine Testing Guidelines on page 70.*

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!

Sharing Results of Drug Screens

Questions sometimes arise about when to share drug screen results when adolescents are involved with other systems. Communities and jurisdictions vary, so each agency must collaborate with their own stakeholders and make policies and procedures very clear to youth and families they serve in terms of what will and will not be shared with the courts, child welfare or other institutions. We offer the following general guidelines below to provide guidance from years of doing MDFT within many different systems.

When Not to Share Results of Drug Screens

In most situations, MDFT programs should not offer to share drug screen results with courts, probation and parole officers, child welfare workers and school counselors and other similar organizations.

MDFT does not use the drug testing in the way that courts, schools, employers or child welfare typically drug tests. We do not test in order to protect the public safety, hold youth accountable for his actions, "catch" the youth in a lie, or implement consequences or punishments. We use drug screens to reveal the reality of the youth's use and focus the treatment on what youths need (and perhaps has not been getting so far in therapy) to retrack their life.

Organizations that ask for the MDFT drug test results should be encouraged to do their own drug testing.

Essential Procedures When Sharing Drug Screen Results

- ✓ **Transparency.** The youth and parents must know from the beginning of treatment with whom, if anybody, drug screen results will be shared. This information should be part of the consent to treatment form that parents and youth sign at the start of treatment. Complete transparency is essential.

- ✓ **Knowledge.** Courts, juvenile/criminal justice officials, child welfare and others with whom the MDFT therapists share the information must be made aware of how and why MDFT administers urine screens. They must recognize that state-of-the art drug testing procedures to assure an untainted drug screen are not implemented in MDFT and thus the results might not be accurate. Institutions should rely on their own testing instead of MDFT test results if they need evidence to make important decisions regarding the youth's life, such as placement or disposition.

- ✓ **Collaborative Relationships.** The MDFT program and organizations and institution with whom it shares results of urine testing must have a trusting collaborative working relationship. The MDFT therapist must be assured that the organization will not use the results in a punitive and non-therapeutic manner to, for instance, charge the youth with a probation/parole violation (VOP), remove the youth from the home, place the youth in residential treatment, or expel the youth from school. When MDFT programs share results, there must be an agreement about how the test will be used. For example, with drug courts or probation, the agreement is typically that no VOP will be filed; instead the court/probation will use this knowledge to work collaboratively with the MDFT therapist to help the youth refrain from using drugs (e.g., the court or probation might have the youth write an essay about drug use, increase the dose of MDFT, increase the number of drug tests, intensify court monitoring, or require more community service). Child welfare as well as juvenile/criminal courts and probation/parole also should agree that they will not use drug tests from MDFT as the basis on which the youth is placed in residential treatment, a long-term commitment facility, or otherwise removed from the home.

MDFT Clinical Portal and System of Fidelity

MDFT Clinical Portal and System of Fidelity

The MDFT Clinical Portal is a proprietary online database for tracking MDFT treatment fidelity and outcomes. It is not an electronic record of MDFT treatment, as identifying information and progress notes of sessions are not entered. The purpose of the MDFT Clinical Portal is to collect the essential information needed to enhance fidelity and monitor treatment outcomes while simultaneously not adding undue burden to clinicians. Only a few minutes per week are needed for entry.

MDFT Portal Reports summarizing each program's fidelity and outcomes are provided once per year. Reports may be generated more frequently or for different periods if requested.

Fidelity to MDFT Parameters

Therapists

Therapists enter information 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 page 40*). 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 (Rowe et al., 2013).

Supervisors

Supervisors enter data into the MDFT Clinical Portal on all supervision sessions. They enter information on the type of supervision session (case review, live supervision, or video review) and length. They also complete regular reviews of 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
- ✓ Delinquency
- ✓ Aggression
- ✓ Peer affiliation
- ✓ Involvement in pro-social activities
- ✓ School attendance, school performance
- ✓ Mental health functioning
- ✓ Family violence
- ✓ Family functioning
- ✓ Sexual health risk
- ✓ Parenting Practices

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

Entering Data in the Portal

Case Basics

The Case Basics cover demographics and general details about the case, including, mental health diagnoses, substances used by the youth, family socioeconomic status, etc. If a therapist is uncertain of these answers at the start of treatment, that is fine – they can update the basics at any time. Basics typically only take a few minutes to enter. ***We do not collect any personally identifiable information about participants in the MDFT Portal.***

Intake and Discharge Forms

The Intake Data and Discharge Data Forms allow clinicians to provide an assessment and track change on the primary intervention targets of MDFT: mental health, substance use, delinquency, school/ vocational, peer affiliation, involvement in pro-social activities, aggression, sexual health, family functioning, and parenting practices. The therapist aims to make the most accurate assessment possible, and the supervisor helps to verify the data before closing each case. This helps us generate regular reports and provide findings from the data on how well therapists are doing with their MDFT cases.

All Intake and Discharge questions are multiple choice questions, and typically take between 10 and 20 minutes to complete.

Key points to remember in completing Intake and Discharge Data:

- ✓ Complete Intake Data initially to open the case.
- ✓ Revisit Intake Data and complete Discharge Data before you close the case and have your supervisor review to make sure you both concur on the evaluations.
- ✓ **Use your best judgment based on all sources of data.** Consider the youth, family members, school, and juvenile justice personnel. Sometimes you will struggle between two answers. Use your best judgment and make the choice that seems the closest representation of youth and family functioning given everything that you know.
- ✓ **Intake Data should measure the time before the start of treatment that led to referral.** This should be when the youth was at his/her worst – before s/he was involved in situations that might artificially suppress acting out behaviors such as being arrested, placed on probation, detention, inpatient, or residential treatment. Usually 120-30 days prior to intake. When you make your ratings, take into consideration circumstances that can suppress symptoms and negative behaviors on both the part of youth and parents, and try to rate the problems at their peak. When entering less than perfect ratings, make sure to enter briefs comments to explain the rating.

- ✓ **When you learn new information about a case, adjust Intake Data as needed.** For instance, it commonly occurs that a youth only reveals a limited amount of substance use when you first begin treatment, but when you engage and explore the youth's world more deeply, they admit to more use in the time leading up to treatment. Continue to make these updates to all of the data until the case is closed.
- ✓ **Supervisors MUST review Intake and Discharge Data and approve them before closing each case.** If the supervisor disagrees with any of the ratings, then the supervisor and therapist should discuss their differences and come to a resolution.
- ✓ **Change between Intake and Discharge will be used to evaluate effectiveness of treatment,** so accurate Intake and Discharge data will ensure accurate Portal Reports.

Case Contact Information

Therapists log each session they have with the youth and/or family in the Contacts section in the Portal. They enter the date of the session, duration, who was present, where it took place, and whether the session was recorded. If the youth/family did not show up, a reason can be also included. It typically only takes a few minutes to enter these contacts.

When entering information on multi-part family sessions, log total session time as a family session, even if the time includes breakouts with individual family members. MDFT is at its core a family approach and we expect at least one third of the sessions to be with the family.

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 (TDPs), 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 with each supervisor of TDPs
- ✓ Bi-annual reviews of MDFT Clinical Portal Reports
- ✓ Case and program implementation consultations as needed
- ✓ Therapist competency and adherence evaluations
- ✓ Review of compliance with site requirements and implementation of MDFT

Tools, Guides, and Resources

About MDFT: FAQs

I understand that MDFT is a family-based treatment that includes sessions alone with the youth, alone with the parent, and family sessions with the youth and parent together. Does this mean that I need a commitment to participate from both the youth and parent before beginning MDFT?

You are correct in describing MDFT, and ideally, we do begin MDFT with key family members. However, we start with what we get. This means that if the youth refuses to participate, we begin with the parents, and if the parents cannot participate in initial sessions, we will begin with the youth. MDFT has specialized and highly successful treatment engagement and retention interventions which will be gradually applied to convince the reluctant youth or parent to participate in the program.

Does MDFT treat trauma?

MDFT treats trauma and trauma symptoms, but it is not recognized as an EBP for post-traumatic stress disorder (PTSD). Youth meeting diagnostic criteria for PTSD are usually recommended to participate in eye movement desensitization and reprocessing (EMDR) or trauma-focused cognitive behavioral therapy (TF-CBT) before treatment in MDFT. Teams may decide the timing of MDFT and a separate trauma treatment. However, if a MDFT therapist is also trained in EMDR or TF-CBT, they can integrate those interventions into the MDFT treatment. MDFT trainers will assist with this process.

Can a youth participate in other behavioral health treatments at the same time they are receiving MDFT?

It depends. They can receive medication services from a health care professional, and some youth also participate in self-help activities such as 12-Step meetings or very specific counseling services such as a grief/loss support group. Since MDFT includes individual therapy as part of its program, youth should not participate in MDFT and also a different individual therapy with another therapist, given that other therapists may work at cross purposes. MDFT therapists who are also trained in eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy (CBT)

or dialectical behavioral therapy (DBT) can integrate these interventions into their MDFT work. MDFT trainers will assist therapists with this process. Anger management or drug treatment may be ordered by a court official who is not familiar with MDFT's depth and breadth, and in these cases, it may be helpful to explain that MDFT provides these services very effectively. Since MDFT is a very flexible and adaptable approach, programs should reach out to their trainer to decide whether or not it is beneficial to have a youth participate in MDFT and other behavioral health services at the same time.

Can a youth be in MDFT and substance use treatment at the same time?

MDFT is a substance use treatment so there is no need to send a youth to another substance use treatment while they are receiving MDFT. As noted above, drug treatment may be ordered by a court official who is not familiar with MDFT's depth and breadth, and in these cases, it may help to present data on MDFT's effectiveness (*see Fact Sheets*).

Can families where the parent abuses drugs or alcohol be enrolled in MDFT?

Yes. And there are specific MDFT protocols to help parents enroll in their own substance use or mental health treatment.

Does my program need to achieve perfect fidelity to MDFT to have excellent outcomes?

No. Of course all MDFT programs should aim to meet or exceed the established fidelity benchmarks, and we know from research that the closer a program is to meeting the benchmarks the better overall outcomes. However, life is not perfect, and there are times when programs may struggle to meet the benchmarks. We have found that programs still have positive outcomes even during periods when their fidelity might be slightly below par. MDFT trainers provide extra help when fidelity is faltering.

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, and we can see therapists work with families in live therapy sessions.

Can MDFT be delivered in outpatient settings?

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.

Can MDFT be delivered in residential settings?

Yes. There are special MDFT protocols and guidelines for integrating it into residential or other congregate care settings.

Are there additional training or startup costs?

No. The cost for the training includes all materials and fees, including travel costs. 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 competent 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. See hiring tools to help you make the best hiring decisions and to retain staff.

We are preparing a grant application to implement MDFT, can MDFT International 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. After using the drug screens therapeutically in sessions, therapists wonder what they did without them!

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. To stay informed, kindly consider joining the MDFT distribution list or following MDFT on Facebook.

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 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	2	3	4
Strongly Disagree	Disagree	Agree	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:

Part 3: 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 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.

Preventing Staff Burnout and 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. Below are some suggestions for agencies/program directors, clinical supervisors, and therapists on how to prevent staff burnout and turnover and increase job satisfaction.

This document is organized into three 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 when possible. 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 see clients and back home. Find ways for therapists to complete agency and MDFT notes/logs/paperwork from home whenever 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 to help them regain their balance and get back into relatively normal routines and self-care.

- ✓ Invite therapists and supervisors 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 and good outcomes, 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 or from therapist to supervisor.
- ✓ Ask for a two-year commitment prior to hiring. Some agencies ask new hires to MDFT to give a two-year commitment to work in the MDFT program. Of course, programs want MDFT clinical staff to stay longer than two years since competency increases with practice. However, some agencies hire staff directly out of graduate school, 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, they may be tempted to 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. Some programs are hesitant to do this because one particular neighborhood might be tougher (e.g., more poverty, violence, and 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 meal. One MDFT team shared that a mid-day ice cream break 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 two 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 therapists who 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). Let youth and families know that these are the set appointments. 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. An 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. 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. Request that your supervisor helps you in a way that works for you. With tough cases, ask your supervisor for a video review, live supervision, or perhaps to do an especially challenging session together.
- ✓ Have regularly scheduled monthly or quarterly 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.

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 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.

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/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. 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, 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.

Tips While in Training

Some tips to reduce time spent and increase efficiency and excellent preparation:

- ✓ Weeklies are done to help you feel prepared for coming sessions – remember that time spent in planning is time saved in doing unproductive sessions.
- ✓ Reduce duplicate (agency/MDFT) paperwork as much as possible – detailed case notes are not needed in the weekly and can be done in the format your agency requires.
- ✓ Review overarching goals every week and note progress (or stage 1 goals if a new case).
- ✓ Follow the logic model: 1) where the case is now, 2) what next shifts/changes are needed, and 3) what sessions (goals/interventions) need to happen to make those shifts/changes.
- ✓ If short on time focus mainly on writing excellent session goals – this is the key!
- ✓ Keep it simple –not much case detail is needed to convey the main points.
- ✓ During training you may find you write more in your session planning and your trainer asks more questions – but once certified your weeklies can be even simpler.
- ✓ Weeklies are meant to stimulate discussion –save the important details for supervision.
- ✓ Use the MDFT Clinical Protocols, Guides and Resources for help. These are available on the Clinical Portal under "Documents."
- ✓ Pages 8—19 in MDFT Clinical Protocols, Guides and Resources specifically address Case Formulation and Session Planning. Refer to these pages often!
- ✓ Review the MDFT Website for webinars, case studies, articles and other resources.

Use of Interpreters - Optional

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 when there is no other option.

It should also be recognized that use of an interpreter may create 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 language in addition to English (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, or they have access to professional translators.

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, such as a crisis situation in which no other options are available in the moment.

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 multilingual, 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	# of Cases with Interpreter
6-7	1
11-15	3
16-20	4

MDFT

MULTIDIMENSIONAL FAMILY THERAPY (MDFT)
REFERRAL FORM

MDFT is a family centered, community based treatment for youth struggling with mental health, complex clinical (including substance use and other issues), social and educational challenges. MDFT intervenes in 4 related areas: youth, parents, family and community. It includes individual therapy for youth, parent education and support, family therapy and community interventions and collaborations. From a foundation of improved family relationships, MDFT emphasizes behavioral change in the natural environment and uses interventions to promote the parent's capacity to monitor and interact positively with their youth. To make a referral, please email or fax this form to the provider in your area along with a release of information.

Youth: **Referral Date**:

First name:	Last name:	Date of birth:
Age:	Race/ethnicity:	Email:
Address:		Cell phone:
Youth resides with:		Relationship:
School:	Grade:	Primary language:

Caregiver/Guardian:

Caregiver name:	Last name:	Primary language:
Phone number:	Email:	Cell phone:
Address:		
Legal guardian's name:	Last name:	Primary language:
Phone number:	Cell phone:	Email:
Address:		
Legal guardian's name:	Last name:	Primary language:
Phone number:	Cell phone:	Email:
Address:		

Is the youth currently on probation or court/JRB involved? ☐ Yes ☐ No Comment:

Is the youth currently DCF involved? ☐ Yes ☐ No ☐ Unknown

Youth Concerns

Has the youth experienced any of these challenges in the last 90 days? Check all that apply.

☐ Substance use:
List Substances:
☐ Family Conflict
☐ Anxiety (e.g., excessive worry or fear, social anxiety, panic attacks)
☐ Depression (e.g., irritability, loss of interest in things, sad affect)
☐ Verbal aggression
☐ Physical aggression
☐ Homicidal Ideation
☐ Suicidal Ideation
☐ Delinquent/Conduct/Oppositional Behaviors
☐ School Problems (Truancy, behavior, performance)
☐ Violence
☐ Impulsivity
☐ Emotional dysregulation
☐ Trauma
☐ Runaway/AWOL behaviors
☐ Housing instability / homelessness

Has the youth ever experienced any of the following? Check all that apply

- ☐ Suicide attempt
  Comment:
- ☐ Psychiatric Hospitalization
  Comment:
- ☐ Episode(s) of psychosis or psychotic symptoms
  Comment:
- ☐ Suspected Sex Trafficking
  Comment:
- ☐ Trauma
  Comment:
- ☐ Drug or alcohol overdose
  Comment:
- ☐ Drug rehabilitation / Detox
  Comment:
- ☐ Removal from the home due to child maltreatment
  Comment:
- ☐ Living in congregate care / out of home placement
  Comment:
- ☐ Other:

Diagnosis, if known:

Is the family: ☐ willing to accept treatment ☐ somewhat resistant, or ☐ resistant to treatment?

Identified supports/strengths (family, friends, faith, community etc.)

List other pending referrals:

List current providers:

Reason for referral and other important information:

Form Completed By:

First name:	Last name:	Email:
Agency (if applicable):	Title at agency:	Phone number:
Supervisor's name (if applicable:		Supervisor phone:

Urine Testing Guidelines

Drug Testing Recommendations for Clients Who Use or Are at Risk of Using Opioids

What to Test For

We recommend you test for these substances:

- Cannibis / Marijuana
- Amphetamine
- Methamphetamine
- Cocaine
- Opiates: includes heroin, codeine, morphine, hydrocodone, hydromorphone. Any of these drugs will trigger a positive test for 'opiates' as they are indistinguishable on an instant test.

  Note on cutoff levels: Tests for opiates typically have the option of a 300 ng/mL or 2,000 ng/mL cutoff level. Most clinical providers use 300 ng/mL
- Oxycodone & oxymorphone
- Benzodiazepines (e.g., Xanax, Valium)
- Buprenorphine – only for cases using buprenorphine for MAT. See comment below.

We recommend tests that come with specimen validity to prevent tampering. You may test for other substances as required by your clinical population (see more on fentanyl below).

What Kind of Test to Buy

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 common test among MDFT sites is the iCup, manufactured by Abbott Toxicology (formerly 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 ones listed above.

Urine test kits may be purchased online, but we recommend that you speak with a sales associate about your specific site needs before purchasing. Creating a company account is necessary for pricing information. The number of tests you need will vary depending on your caseload, how frequently you intend to test, and the shelf life of the test. The iCup testing kit come in boxes of 25.

We recommend an 8-panel iCup with specimen validity that covers all substances listed above except buprenorphine. If purchasing through Redwood Toxicology Laboratory (RTL), the product we recommend is:

> *Item ID: 01102 2069 -*
>
> *iCup A.D. 08 AMP1000/BZO/COC300/MAMP1000/MOP300/OXY/PCP/THC with adulteration (OX, CR, PH)*

- Buprenorphine testing is typically only available in large panel tests (10 or more drugs), or as a stand-alone test, so it may be more cost effective to buy buprenorphine tests separately to be used only as needed.

Fentanyl

Instant fentanyl tests are not currently cleared for the public by the FDA. Redwood Toxicology does offer lab testing for fentanyl. The RTL recommended product is:

Vendors

Most common vendors to purchase test kits:

- Redwood Toxicology
- Henry Schein, Inc.
- Rapid Detect, Inc.

SCREENING METHODOLOGY AND CUTOFF LEVELS — *CUTOFF LEVELS UPDATED PERIODICALLY.*		
DRUGS OF ABUSE	**METHODOLOGY**	**CUTOFF**
Amphetamines *(Amphetamine/Methamphetamine)*	EIA	500/1000 ng/mL*
Barbiturates	EIA	200 ng/mL
Benzodiazepines	EIA	200 ng/mL
Buprenorphine *- Naloxone*	EIA *LC-MS/MS*	5 ng/mL *5 ng/mL*
Cocaine Metabolite (Benzoylecgonine)	EIA	150/300 ng/mL*
Cotinine	EIA	250 ng/mL
Dextromethorphan (DXM)	ELISA	125 ng/mL
Ecstasy (MDMA)	EIA	500 ng/mL
Ethanol	EA	0.04 gm/dL
Ethyl Glucuronide (EtG)	EIA	100/500 ng/mL*
Fentanyl	EIA	1/2 ng/mL*
LSD (Lysergic Acid Diethylamide)	ELISA	0.5 ng/mL
6-MAM (Heroin Metabolite)	EIA	10 ng/mL
Meperidine	EIA	200 ng/mL
Meprobamate (Carisoprodol Metabolite)	EIA	100 ng/mL
Methadone	EIA	150 ng/mL
Methadone Metabolite	EIA	100 ng/mL
Methaqualone	EIA	300 ng/mL
Mitragynine (Kratom)	EIA	50 ng/mL
Opiates (Morphine and Codeine)	EIA	300 ng/mL
Oxycodone	EIA	100 ng/mL
Phencyclidine (PCP)	EIA	25 ng/mL
Propoxyphene	EIA	300 ng/mL
THC (Cannabinoids)	EIA	20/50 ng/mL*
Tianeptine	LC-MS/MS	10 ng/mL
Tramadol	EIA	200 ng/mL

* Agency has the ability to choose cutoff levels indicated.

Providing MDFT Sessions Through Teletherapy

Clinicians and families alike have become increasingly comfortable conducting productive MDFT sessions remotely through virtual technologies, particularly since the COVID-19 pandemic. For some families and in some circumstances, an MDFT therapist might decide to hold virtual sessions. We encourage clinicians to use this option when necessary. We do not suggest that all sessions be held virtually because undoubtedly, face-to-face interactions are beneficial, however, in certain situations or with certain cases, moving to virtual sessions can be a benefit. An obvious example is when one of hte parents lives out of town, or the youth is temporarily away from the parents such as in detention, or during a pandemic, or commuting distances pose a serious enough challenge for the family and therapist that sessions would not be possible without remote technology.

Recent research has indicated that vitual sessions can be as effective as face-to-face therapy sessions.

Some advantages of virtual MDFT sessions include:

- ✓ To have sessions with very busy families who struggle with making or keeping appointments due to school, work, or other family obligations. Sometimes having a virtual session is the only option, and, of course, having a session is better than not having a session even if it is virtual. Even video calls may be used for a session that cannot wait for the chance to be in person. These meetings are important and helpful.
- ✓ The therapist may be more available to their families due to reduced travel time to the clinic and/or homes, and the flexibility of working from home.
- ✓ Youth and young adults are quite familiar with, and some may even be more comfortable engaging via “screens,” given that social media and technology platforms are an integral part of their lives.

Tips for online sessions:

- ✓ Make sure the youth/parent/family have a quiet, private and safe place to hold the virtual sessions.
- ✓ MDFT therapists are **active, engaged** and **present**. When working online, be even more so!
- ✓ **Be aware of amplifying your emotions more clearly** by your tone and facial expressions. Remember emotions (yours and the clients) appear a little muted through screens. Thus, assume there is a little more emotionality than what you observe on the screen.
- ✓ We know from research that physical presence enhances the neurobiology of connection in our brains. The same research shows that **seeing people online also affects neurochemistry**. Although you cannot physically touch somebody virtually, **you can reach out virtually on the screen.**
- ✓ Don't forget to **focus on facial expression:** Ask clients openly to report what they feel. These questions are also possible with meetings online, or just say: "*I think I saw an expression on your face but I'm not sure how you're feeling. Can you tell me what your experience is?"*
- ✓ **Use even more admiration, respect, and encouragement:** Be specific and explicit about your appreciation that they are willing to meet virtually. Praise, compliment, agree!
- ✓ You can also use the **whiteboard, available through Zoom,** to write or to draw something.
- ✓ **Be creative:** You can use the "screen time" together to show little clips, including psychoeducational videos, pictures, educational games, YouTube resources, etc.
- ✓ **Encourage the youth to show you their world:** You can use this valuable "screen time" to let them show you their online world. For instance, you might listen to their favorite music or videos.

With families, suggest that they sit so that they can face each other and not worry that they may not be facing you throughout the entire session. The most important thing is that they are having a new experience together, not as much that they speak directly to you.

Telehealth Visit Etiquette Checklist

The American Medical Association developed this checklist and is included in one of their playbooks. It is intended for clinicians and care team members who will be hosting the telehealth visit to ensure that the professional standards of in-person care is maintained in a virtual environment.

The list below is not exhaustive but rather some key considerations to make when preparing to conduct telehealth visits.

Environment

- Ensure privacy (HIPAA)
- Clinically appropriate exam room location, size, and layout
- Avoid background noise
- Adequate lighting for clinical assessment

Equipment

- Desktop computer vs. tablet
- High-speed internet
- Web camera
- Microphone
- Dual screens for EHR documentation note taking
- RPM dashboard (if using)
- Headphones
- Dress
- The same level of professional attire as in-person care

Communication

- Turn off other web applications and all notifications
- Review patient complaints and records before beginning call
- Adjust webcam to eye level to ensure contact
- Narrate actions with patient (if you need to turn away, look down to take notes, etc.)
- Verbalize and clarify next steps, such as follow-up appointments, care plan, prescription orders
- Pause to allow transmission delay
- Speak clearly and deliberately
- Choose empathetic language
- Use non-verbal language to signal that you are listening

Guidelines for MDFT Aftercare and Booster Sessions

Brief MDFT Aftercare, including Phone Check-Ins and Booster Sessions, can be very effective for some MDFT youth and families. Many programs can keep their MDFT cases open in MDFT Aftercare for some time, allowing for evaluation of possible re-referral to MDFT or referral to other services if needed. We recognize that not all MDFT programs can provide MDFT Aftercare Services because of therapist caseload demands, provider policies, or no aftercare capability. And, of course, Aftercare Services are not needed for all MDFT youth and families. As always, the provider must do what is practical and feasible in their individual context. Below are guidelines and suggestions to help providers create their own policies and procedures. This is not a dictate or requirement from MDFT International, Inc.

The primary components of MDFT Aftercare, if implemented, typically include the following:

1. Open Door Policy: Prior to discharge, the therapist should 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 questions or if there is a new problem or a relapse. This open-door policy eases the potential stress and concern about the termination process. In fact, over many years of MDFT research and implementation, very few youths or families have been known to call for boosters after discharge, so the burden on therapists is not great. However, when a youth or family does call, it can be a tremendous help, potentially averting a crisis, relapse, or need for inpatient stabilization. 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 have a booster session or two, or sometimes a referral to another appropriate treatment or other service is warranted if problems have intensified (e.g., group therapy, vocational counseling, GED preparation program, parenting classes).

2. Checking on youth and families after discharge: The clinician calls the youth and parents separately after discharge 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. We recommend that the first call occur 2 weeks after the final MDFT session, and that brief check-in calls occur over the first 3 months after discharge. If there is no indication of any significant problems, we suggest the following call schedule:

   ✓ 2 weeks after final MDFT session

   ✓ 2 weeks after 1st Aftercare Check-in Call

   ✓ 3 weeks after 2nd Aftercare Check-in Call

   ✓ 4 weeks after 3rd Aftercare Check-in Call

3. MDFT booster sessions: It can be very useful, in certain cases, to have 1 to 3 booster sessions with a family that is experiencing problems such as family conflict, the youth getting in trouble at school or suspected of using drugs again. We find in these circumstances that 1 – 3 sessions (e.g., 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, mobilize the family to work together again, create an action plan, or make the necessary referrals to other services.

4. Re-referral to MDFT or other services: During the Check-in calls or booster sessions, the therapist should always assess for additional treatment or service need. As indicated above, typically a few booster sessions is all that is needed to get the youth and parents back on track, but in other circumstances they may need a referral to MDFT *(see Case Referral Form Sample on page 68)* or a referral to other services. It should be recognized that a referral to MDFT does not necessarily mean they need another 5 -6 months of treatment. In these situations, often the problems can be solved in 2 – 4 months. Referral to other services typically include: individual or group therapy for the youth or parents, tutoring or other educational or vocational programs including career counseling, medication management services, 12-step or other peer support services, and/or couples therapy for the parents.

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

A closed MDFT case or one receiving MDFT Aftercare may need to be re-referred to MDFT. Programs might get referrals for youth who have had MDFT previously, and this treatment episode could have ended weeks or years prior to the new referral. As always, the provider must do what is practical and feasible in their individual context. These are guidelines and suggestions to help providers create their own policies and procedures.

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 may be opened for a standard, complete course of treatment with MDFT given that:

   - ✓ inclusion and exclusion criteria for that particular MDFT program have been met,
   - ✓ 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
   - ✓ 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. Re-Referral to MDFT through MDFT Aftercare: This usually occurs within 3 months of the final MDFT session when an MDFT clinician recommends that more MDFT sessions are needed. In these cases,

while it is possible that a youth and family might require a full episode of MDFT (i.e., 4 – 6 months), often they only need 2 - 3 months of MDFT. As always, the clinical team in collaboration with the family will determine the length of MDFT.

3. Referral to MDFT for youth who have participated in another EBP (e.g., MST, A-ACRA, FFT, BSFT, DBT, 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:

   - ✓ inclusion and exclusion criteria for that particular MDFT program have been met,
   - ✓ 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 acceptable to them, and
   - ✓ the MDFT supervisor, after reviewing the referral documents determines that the case is appropriate for MDFT even though they previously received another type of EBP. Even if the youth and family participated in another family-based EBP, it is possible that the previous approach did not sufficiently meet their needs at that time, and MDFT may still be highly effective for them.

Sample MDFT Fidelity and Outcomes Report

Reporting Period: From: 07/01/2021 To: 06/30/2022
State:
Program Name -
Agency Name:
Date of Report:
Number of Closed Cases: 22

Service Delivery Report

1.	Percentage of therapy sessions held in clinic:	0.34 %
2.	Average case duration (in months):	5.73
3.	Total number of cases served during reporting period:	34
4.	Total number of cases closed during reporting period:	22
5.	Percentage of cases closed that completed at least 8 sessions (Benchmark 85% or higher):	100.00 %

Therapy Session Report

		Actual	Min. Benchmark
1.	Average round-trip travel time per case contact (in minutes):	38.17	-
2.	Percentage of sessions video recorded:	2.10 %	10%
3.	Average monthly therapist contacts (in minutes/hours):	413.53 / 6.89	Outpatient 270 mins/4.5 hrs; In-Home/IOP/Residential 420 mins/7 hrs
4.	Average monthly family sessions (in minutes/hours):	132.31 / 2.21	Outpatient 90 mins/1.5 hrs; In-Home/IOP/Residential 140 mins/2.3 hrs
5.	Percentage of total sessions per case that are family sessions:	32.00 %	35%
6.	Average monthly adolescent only sessions (in minutes):	121.04	-
7.	Percentage of total sessions per case that are adolescent sessions:	29.27 %	-
8.	Average monthly parental sessions (in minutes):	114.10	-
9.	Percentage of total sessions per case that are parent sessions:	27.59 %	-

Supervision Report
(all are averages per therapist)

		Actual	Min. Benchmark
1.	Average monthly case reviews:	5.10	3 p/mo (36 p/yr)
2.	Average monthly live supervisions:	0.26	0.25 p/mo (3 p/yr)
3.	Average monthly video reviews:	0.59	0.40 p/mo (5 p/yr)
4.	Average update of Therapist Development Plan 1:	2.00	2 p/yr
5.	Average update of Therapist Development Plan 2:	2.00	2 p/yr

Percent Improvement Report

(Only includes cases closed during the reporting period)

		Actual (%)	Min. Benchmark
1.	Marijuana Use:	56.00	30%
2.	Alcohol Use:	31.00	30%
3.	Opioid Use:	65.00	30%
4.	Other Drug Use:	100.00	30%
5.	Delinquency/Crime:	63.00	30%
6.	Aggressive and Violent Behavior:	77.00	30%
7.	Educational/Vocational Attendance:	67.00	30%
8.	Mental Health Functioning:	51.00	30%
9.	Parenting:	48.00	30%
10.	Family Violence:	61.00	30%
11.	Family Functioning:	45.00	30%
12.	Educational/Vocational Performance:	54.00	30%
13.	Peer Affiliation:	28.00	30%
14.	Sexual Health:	22.00	30%

Behavioral Outcomes Report

(Only includes cases closed during the reporting period)

		Actual (%)	Min. Benchmark
1.	Percent of youth living at home/not in placement:	95.45	80%
2.	Percent of youth in school/working:	95.45	80%
3.	Percent of youth working part-time or full-time:	40.91	-
4.	Percent of youth with no new arrests:	95.45	80%
5.	Percent of youth without any juvenile/criminal justice involvement:	100.00	-
6.	Percent of youth with no open child welfare case:	86.36	-
7.	Percent of youth not using alcohol (abstinent):	95.45	80%
7a.	Percent of youth using alcohol 3 or fewer days per month: *		80%
7b.	Percent of youth using alcohol 4-8 times per month (weekend use): *		80%
8.	Percent of youth not using marijuana (abstinent): *		70%
8a.	Percent of youth using marijuana 3 or fewer days per month: *		70%
8b.	Percent of youth using marijuana 4-8 times per month (weekend use): *		80%
9.	Percent of youth with no substance use other than marijuana or alcohol:	100.00	70%
9a.	Percent of youth with no substance use (totally abstinent):	50.00	70%
10.	Percent of youth who never or rarely engage in illegal activities other than drug/alcohol use, shoplifting, trespassing, loitering, truancy, etc.:	90.91	80%
11.	Percent of youth who never or rarely engage in violent behavior:	86.36	80%
12.	Percent of youth with stable mental health functioning:	90.91	80%
13.	Percent of youth who do not affiliate mostly or exclusively with anti-social peers:	95.45	80%
14.	Percent of youth not at high risk for STDs and pregnancy:	100.00	80%
15.	Percent of families who are not characterized by poor parenting skills: *		80%
16.	Percent of families who are not characterized by poor family functioning:	81.82	80%
17.	Percent of families who do not regularly resort to family violence:	100.00	80%
18.	Percent of youth continued/discharged to RMS:	0.00	-
19.	Percent of youth discharged to residential/inpatient treatment:	4.55	-
20.	Percent of youth discharged to juvenile/criminal justice facility:	2.50	-
21.	Percent of cases closed successfully:	90.91	80%

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 12 of the 14 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%, the shaded outcomes are key) 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.

MDFT Portal FAQs and Common Problems

This document is for common questions or problems relating to the Portal. For instructions on how to use the Portal, see Video Tutorials.

LOGGING IN

I've lost my login credentials. How can I log in?

Visit the Portal login page – portal.mdft.org – and click "Forgot Password?". Enter your email address in the space provided and click "Retrieve Password." Check your inbox or email junk/spam folder for a message from support@mdft.org with your login credentials. If you don't receive the email, contact support@mdft.org directly.

My login info doesn't work.

Try copying and pasting the login credentials to ensure they are being entered correctly as it is case-sensitive. If this doesn't work, you may be using old credentials that have since changed. Use the "Forgot Password?"function (see previous question) to receive your most recent login info.

Can I change my password to something of my choosing?

Yes. After logging in with your assigned login credentials, click "User Profile" in the upper right-hand corner. Then scroll down to "Change Password" and fill out the requested information.

STAFF CHANGES: NEW HIRES, RESIGNATIONS AND LEAVE

What do we need to do when a new therapist joins our team?

The new clinician needs to be registered on the Portal. Their registration information should be filled out in a New User Registration form, which can be found in the Portal

under the “Documents” tab. At a very minimum, we require a full name and email address for registration.

If there is more than one supervisor at your site, be sure to indicate on the form who will be supervising the new therapist.

If your agency has more than one MDFT program/site, make sure to indicate which program the new therapist will be joining.

A therapist is going on temporary leave. What do I, as a supervisor, need to do?

Log into the Portal with your supervisor credentials and click on the therapist’s name. Go to the “Time Off” tab on top of the page and “Add New” time off. If you do not know when the therapist will return to the office, you may leave the end date blank, but make sure to enter the date upon the therapist’s return. This feature should be used for vacations, leaves, or temporary transfers to another program within the agency when the intention is for the therapist to return to MDFT.

I’m a supervisor going on temporary leave. What do I need to do?

You should arrange for another supervisor to enter supervision information for your therapists in the Portal while you are gone so that your therapists’ supervision data does not have gaps. Email us at support@mdft.org with the temporary supervisor’s name and email. We will create a Portal account for that person, or reassign your therapists to other supervisors if they already have Portal accounts.

What needs to be done in the Portal when a therapist resigns?

All of the therapist’s cases need to be accounted for before their last day. Either the cases should be closed out with completed contact data and discharge information, or they should be transferred to another therapist. To transfer a case, log in with your supervisor account and find the case that needs to be transferred. At the bottom of the “Basics” tab, there is a section labeled “Case Reassignment.” Click on the drop-down menu and you should see all your therapists. Select the new therapist who will be seeing that case. If the case is going to be referred to another MDFT program, email us at support@mdft.org with the Case ID number, the MDFT program where the case is going to be transferred, and the name of the therapist who will take over the case.

When the therapist leaves, we will also need the date of termination for the therapist. Once all of this is completed, we will deactivate their Portal account. Please email us with this information.

What happens to a clinician's case and supervision data once therapists are removed?

Nothing will happen to the data. Their data is still calculated in Portal reports, and therapists' cases will still appear on the case list. Their name is simply removed from the active therapist/supervisor list, to avoid clutter, and their login credentials will no longer work.

We can re-activate a clinician account at any time if supervision data, development plans, or evaluations need to be added or edited after the therapist has become inactive.

What needs to be done in the Portal when a supervisor resigns?

All of the supervisor's supervisees should be reassigned to another supervisor, if there is one. Any temporary supervisors should be given access to the Portal (see above question about temporary supervisor leave). We will also need a date of termination for the supervisor. Please contact us at support@mdft.org as soon as possible when learning of a supervisor's imminent departure so that we may work with agency administration on coverage for the therapists.

CASES

I'm unable to add/edit any of the information of a particular case.

Under the "Case" tab, go to the "Case Status" drop-down menu and select "All." Find the case and switch the Status drop-down menu, in the far-right column, from "Closed" to "Active." Please note that supervisors must log in as therapists to be able to add and manage cases.

I receive an error message that says "Date of Contact cannot be earlier than Date of Intake" when I try to add a new weekly session.

In the Case profile, click the "Intake Data" tab. The date at the top of that page is your

Date of Intake, and your weekly sessions cannot fall before that date. If it is blank, it means you need to complete the Intake Data page. Case contact cannot be added until the Intake Data is complete.

I need to fill out my Intake Data, but I don't feel I know enough about the client to accurately assess them yet.

We realize that you may not be able to make an accurate evaluation of all the items at the very start of treatment. This is okay. You can—and we expect you to—go back at any time to revise your initial evaluations to best reflect status prior to treatment. Your assessment usually becomes more accurate over time as you get to know the youth and family and they open up more.

For more detailed instructions about how to fill out the Intake Data, click the Case tab and select "Intake and Discharge Ratings Instructions" in the left-hand column.

Can a case be moved from one therapist to another?

Yes. Supervisors may transfer cases to other therapists within their programs by going to the "Basics" tab of each case, and at the bottom of the page reassign the cases (see above). For transfers to therapists in other MDFT programs, e-mail support@mdft.org with the case ID and the MDFT therapist they should be transferred to. Please do not re-enter the case under the new therapist – this will create duplicate data and skewed averages on Portal reports.

A case that we previously discharged is re-entering the program. Should we re-open the case or start a new one?

It depends on whether the therapist feels this is a new episode of treatment that will be addressing new problems. If it has not been a long time since the case was last discharged (less than 2 months), you may want to simply re-activate them in the Portal, as this may constitute a continuation of their previous treatment. If it has been a few months, you may want to treat it as a new case, considering that the situation may be different than when the family was first treated. We do not have a strict policy on this; it is at the discretion of the therapist and supervisor to decide whether the re-activation reflects continuation of the initial treatment process or a new treatment episode.

How do I re-open a previously discharged case?

Start by changing their case status from “Closed” to “Active” (see first question under Cases). Then email support@mdft.org so that we may delete the original discharge data. You may want to save their old discharge page as a PDF for your records. You can do this by clicking “Save as PDF” at the bottom of the Discharge Data page.

I added a case I shouldn’t have. Can it be deleted?

Yes. If you have not yet filled out the case’s Intake data, find the case under the “Case” tab and select the checkbox in the “Delete?” column, to the far right. Then click the “Delete Selected” button below your case list.

If you have already added Intake and contact data and later determine that MDFT is not appropriate for the family, email support@mdft.org with the case ID number to be deleted.

Should we add cases that only attend assessment or evaluation sessions?

No. Only cases that receive one or more sessions of MDFT treatment should be added to the MDFT Portal. If you add a case that turns out to be evaluation-only, email support@mdft.org with the case ID number for it to be deleted.

RATINGS & RECORDED SESSIONS

What do I need to do to submit a recorded session for my trainer to review?

Simply upload the digital file to your trainer via ShareFile.

You may find the ShareFile link to upload videos at www.mdft.org/upload. Be aware that uploads may take some time depending on the size of the file. For large files, try compressing, reducing the resolution of the recording, or splitting into 2 files, as the video does not need to be of the highest quality for our review.

Once reviewed, your trainer will schedule a meeting with you to discuss feedback.

Who will see the session I send?

Only your trainer will see the session. We carefully log and track the handling of all recorded sessions so that your clients' confidential information is totally secure. ShareFile is secure and files are encrypted for transfer using 256-bit SSL (Secure Sockets Layer). Trainers delete any recordings after viewing, and notes are provided to you with initials only and no identifiers.

How do I log a supervision video in the Portal?

Under the Therapist tab, click on the name of the therapist and go to the Weekly Supervision tab. Click "Add New" to add a new supervision session. If the session that was recorded has already been added, click on the correct date of contact in blue in the far-left column and go to the next step. Fill out the requested information in each field and select "Yes" next to "Recording Uploaded."

How can I see the results of my session ratings?

Once the session is reviewed, competency ratings will appear in the appropriate section under Certification or Recertification. Only supervisors can see the competency ratings in the Portal. Trainers will email you directly with detailed comments of therapist and supervision sessions.

CERTIFICATIONS

I completed all my certification requirements, but I haven't received a certificate. How can I get it?

There are two possible reasons why you haven't received your certificate: Either your trainer hasn't entered all of your requirements into the Portal, or the Executive Trainer is still working through the finalization queue and hasn't reached yours yet.

If you very recently finished your requirements, you may just need to wait a couple of days for the process to finish. If it has been a week or more, feel free to contact support@mdft.org or your trainer for a status update. If your training has been finalized and you haven't received your certificate, it may possibly have ended up in your junk/spam email folder, or the message was blocked by the spam filters (most common in large organizations).

I received an email congratulating me on certifying, but there was no certificate attached. There was a bunch of jibberish instead of a certificate.

Certificates should arrive to you automatically from the Portal when your certification has been finalized. If for any reason you are not seeing the certificate in your email, program supervisors and agency trainers are able to download certificates for all therapists. If your supervisor is unavailable, please email support@mdft.org and we will email your certificate to you directly. Occasionally email security settings block attachments sent from the Portal.

REPORTS

Can you run reports on individual supervisors or therapists?

Not typically. The reports that we run provide average supervision across all therapists and average outcomes across all cases. We can do manual calculations on specific clinicians if the circumstances call for it. You may request such an exception through your trainer.

Can you run a report on any time-frame?

Yes. Email us at support@mdft.org with any specific requests for reports from a given period of time. Please allow us a few days to generate the report.

MISCELLANEOUS

I'm trying to download a PDF from the portal, but nothing happens when I click the download button.

Downloaded PDFs will open in a separate window, so check to see if you have a pop-up blocker enabled in your browser. If you do, click "Allow" when your browser notifies you that it has blocked a pop-up.