Getting Started With MDFT
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Message From the Director

Welcome to the cutting edge of treatment for young people and their families.

Your interest in Multidimensional Family Therapy shows you are interested in being part of a growing group who want to improve treatment services for youth by bringing evidence-based treatment to those in need. It is estimated that in the United States only 10% of youth who need substance abuse treatment and only 20% who need mental health treatment receive these services—and only a tiny fraction of available services are evidence-based. MDFT is an evidence-based treatment for adolescents and young adults with a host of problems.

Deciding to adopt an evidence-based treatment is an important decision and merits careful consideration. MDFT International, Inc., a non-profit organization, is here to help you with the decision-making process. Like you, we want to make sure that MDFT fits well within the culture of your institution or agency.

We also want to help you understand the potentially confusing world of Evidence Based Treatments. Interventions with scientific evidence supporting them are called “Evidence-Based Treatments” (EBTs), “Evidence-Based Practices” (EBPs), or “Evidence-Based Models” (EBMs). A treatment is qualified as being evidence-based if it produces positive outcomes in comparison to usual care or another alternative treatment in two or more randomized clinical trials, preferably conducted by more than one research group and independent researchers.

MDFT’s effectiveness is built on the strongest foundation of research. There have been 10 randomized clinical trials (RCTs) on MDFT conducted with diverse populations and settings in the United States and Europe by the model developer as well as independent researchers.

MDFT is known not only for its effectiveness and strong scientific foundation but also for its success in program implementation and sustainability. MDFT has been successfully implemented in a variety of service delivery systems at every level of care (outpatient, in-home, day treatment/intensive outpatient, and residential). **MDFT International will work with you to make MDFT fit into your system and tailor the training program to your agency’s needs.**

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

If you have concerns or need more information than is provided in this guide, please call me at (305) 749-9332 or email at gdakof@mdft.org.

Sincerely,

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

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

**MDFT is proven to DECREASE:**
- ✓ Substance Use
- ✓ Crime & Delinquency
- ✓ Violence and Aggression
- ✓ Anxiety and Depression
- ✓ Out-of-Home Placement
- ✓ Sexual Health Risk

**MDFT is proven to INCREASE:**
- ✓ School Attendance
- ✓ Academic Grades
- ✓ Family Functioning
- ✓ Pro-Social Functioning
- ✓ Effective Parenting Practices
- ✓ Positive Peer Affiliation
Proven effectiveness: MDFT has over 30 years of supporting research in U.S.-based and international studies, presenting significant and consistent clinical outcomes in 10 trials.

Rewarding for clinicians: MDFT receives high satisfaction ratings from clinicians and agencies. In one study, 85% of MDFT clinicians reported that MDFT training gave them skills to be more effective therapists.

Fits well into existing clinical settings: MDFT can be tailored to any program. 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.

Learnable and sustainable: Since 2001, MDFT has been implemented in over 150 programs, 85% of which have been sustained. 95% of clinicians who start MDFT training complete it to certification.

Lowers service costs: MDFT costs significantly less than standard outpatient treatment delivered across the U.S. and even its most intensive version is only a third of the cost of residential treatment. It also saves costs by preventing out-of-home placements and the costs to the juvenile justice system of re-arrests/incarcerations.

Lowers training and implementation cost: Costs for initial training and ongoing implementation and fidelity services provided by MDFT International, Inc. are significantly lower than comparable evidence-based programs.

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

Puts families first: MDFT International, Inc.—the organization that promotes, trains, and certifies clinicians in MDFT treatment—is a 501(c)(3) public charity. Providing the best possible treatment for youth and families is our ONLY priority.
Multidimensional Family Therapy (MDFT) intervenes in four connected areas: the adolescent, the parents, the family, and the community. Just as problems overlap, MDFT uses changes in each of these areas to stimulate changes in all the others. Sessions can be conducted from one to several times per week over the course of three to six months in the home or clinic.

*Treatment is organized in three stages:*

**Stage 1: Build a foundation for change:** Therapists create an environment in which the youth and parents feel respected and understood. Therapists meet alone with the youth, alone with the parents, and with the family. Stage 1 goals are to develop strong therapeutic relationships, achieve a shared developmental and contextual perspective on problems, enhance motivation for individual reflection and self-examination, and begin the change process.

**Stage 2: Facilitate individual and family change:** Goals for youth, parent, and family functioning (see below) are established, evaluated, and revisited throughout this phase. Accomplishments in each individual domain activate and support change in the others.

**Stage 3: Solidify changes:** The last few weeks of treatment strengthen the accomplishments parents and youth have achieved. The therapist amplifies changes and helps families create concrete plans for responding to future problems. The family members reflect on the changes made in treatment, see opportunities for a brighter future, and regain hope.

### Goals Within the 4 MDFT Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADOLESCENT</strong></td>
<td>- Increase self-awareness and enhance self-worth and confidence</td>
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<tr>
<td><strong>DOMAIN</strong></td>
<td>- Develop meaningful short-term and long-term life goals</td>
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<td></td>
<td>- Improve emotional regulation, coping, and problem-solving skills</td>
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<td></td>
<td>- Improve communication skills</td>
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<td></td>
<td>- Promote success in school/work</td>
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<tr>
<td></td>
<td>- Promote pro-social peer relationships and activities</td>
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<tr>
<td></td>
<td>- Reduce substance use, delinquency, and problem behaviors</td>
</tr>
<tr>
<td></td>
<td>- Reduce and stabilize mental health symptoms</td>
</tr>
<tr>
<td><strong>PARENT</strong></td>
<td>- Strengthen parental teamwork</td>
</tr>
<tr>
<td><strong>DOMAIN</strong></td>
<td>- Improve parenting skills and practices</td>
</tr>
<tr>
<td></td>
<td>- Enhance parents' individual functioning</td>
</tr>
<tr>
<td><strong>FAMILY</strong></td>
<td>- Improve family communication and problem-solving skills</td>
</tr>
<tr>
<td><strong>DOMAIN</strong></td>
<td>- Strengthen emotional attachment and connection among family members</td>
</tr>
<tr>
<td></td>
<td>- Improve everyday functioning and organization of the family unit</td>
</tr>
<tr>
<td><strong>COMMUNITY</strong></td>
<td>- Improve family members' relationships with social systems such as</td>
</tr>
<tr>
<td><strong>DOMAIN</strong></td>
<td>school, court, legal system, workplace, and neighborhood</td>
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<tr>
<td></td>
<td>- Build families' capacity to access and utilize needed resources</td>
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NREPP gave MDFT an evidence-quality rating of 3.8 out of 4 for recovery from substance use, and a 3.6 out of 4 for delinquency. The overall rating for readiness for dissemination (e.g., quality of implementation materials and support) was 3.6.

The National Institute of Justice, the research branch of the U.S. Department of Justice, gave MDFT the highest available rating, "Effective (More than one study)", on CrimeSolutions.gov.

MDFT is listed as an effective treatment for adolescent drug treatment in two NIDA publications: Principles of Drug Addiction Treatment: A Research Based Guide (the NIDA “Blue Book” on effective treatments) and Principles of Drug Abuse Treatment for Criminal Justice Populations – A Research Based Guide.

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

MDFT is listed as an exemplary program on the Office of Juvenile Justice and Delinquency Prevention's list Strengthening Families: Effective Family Programs for Prevention of Delinquency.

In their evaluation of treatment options for cannabis users, EMCDDA rated just one treatment as beneficial: MDFT. It is the only evidence-supported family-based treatment included in their Best Practice Portal on Treatment Options for Cannabis Users.

The Society of Clinical Child and Adolescent Psychology, Division 53 of the American Psychological Association, identified MDFT as an effective child therapy.

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

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

The Early Intervention Foundation (EIF), a UK-based organization that promotes programs and policies that help children and young people develop the social and emotional skills they need to succeed, gave MDFT the highest possible evidence rating in the areas of preventing substance misuse, enhancing school achievement, improving mental health, and preventing violent and antisocial behavior.

Drug Strategies in a non-profit research organization devoted to identifying and promoting the most effective approaches to substance abuse treatment. MDFT is featured in two publications from Drug Strategies: Treating Teens: A Guide to Adolescent Drug Programs and Bridging the Gap: A Guide to Treatment in the Juvenile Justice System.
The Finnish Association for Mental Health (FAMH) chose MDFT for a special project designed to prevent social marginalization among at-risk adolescents. FAMH describes MDFT as “an effective and flexible clinical approach for adolescents experiencing multiple problems” and provided essential program coordination and assistance in MDFT training and implementation in Finland.

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

Infodrog advocates for effective addiction treatment and risk reduction on behalf of the Swiss Federal Office of Public Health. MDFT is one of just two family therapies evaluated as ‘Successful’ by Infodrog for early treatment intervention.

Gurasotasuna is an initiative of the Basque Department of Employment and Social Policies that connects professionals to family intervention resources. MDFT is included in their list of international, evidence-based programs.

The Clearinghouse for Military Readiness helps military families choose the best evidence-based practices to address a wide range of family and mental health issues. They list MDFT as a promising intervention.

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

Child Trends is a non-profit, non-partisan research organization that provides information and analysis on programs for children and youth. MDFT is listed in their Lifecourse Interventions to Nurture Kids Successfully (LINKS) database as being “more effective than other treatments at decreasing drug use, delinquency, internalized distress, and affiliation with delinquent peers, increasing academic performance, and improving family functioning.”

The National Council of Juvenile and Family Court Judges (NCJFCJ) lists MDFT as a validated treatment in its Adolescent-Based Treatment Database. The database provides profiles on interventions that have been empirically validated in juvenile justice settings.

The National Dropout Prevention Center (NDPC) promotes programs and practices that contribute to student success and dropout prevention. The NDPC lists MDFT as a Model Program.

The Alcohol and Drug Abuse Institute at the University of Washington gave MDFT the highest rating of 'evidence-based' in their report, Treating Youth Substance Use: Evidence Based Practices & Their Clinical Significance. The report looked specifically at the treatment of adolescent cannabis use.
MDFT arose from a desire to transform the treatment services landscape in the adolescent substance abuse and delinquency specialties. A core objective has been to make widely available a personally engaging, science-based, clinically effective, and doable approach.

**The story of how MDFT became a leading model of adolescent treatment**

MDFT was developed by Howard Liddle, a Professor of Public Health Sciences, Psychology, and Counseling Psychology at the University of Miami Miller School of Medicine. A counseling psychologist and family therapist, Dr. Liddle brought together interests in treatment research, intervention development, and therapist training. Liddle was inspired by and trained under Salvador Minuchin and Jay Haley at the Philadelphia Child Guidance Clinic in the mid-1970s. A decade later, he worked with Braulio Montalvo to refine clinical supervision methods that would become a core part of MDFT. While working and teaching in community-based clinics over the years, Liddle was struck by the multiple risks and difficulties, and complex clinical needs of clinically referred adolescents. Liddle realized “...in their own ways, the parents and adolescents themselves were teaching us what treatment needed to be, and how it could be effective.”

MDFT became a new kind of family therapy - a comprehensive, systemic, and developmentally oriented approach. This way of working coordinates individual work and interventions with the youth and the parent(s), direct family relationship interventions, as well as interventions that focus on changes in the relationship systems outside of the family that influence the daily lives of the adolescent and family. Liddle’s determination to help adolescents and families find a healthy life path, coupled with concerns about the absence of available and science-supported adolescent interventions, led to his development of MDFT, a family-based treatment program for adolescents with substance abuse and serious behavior problems. More recently MDFT has been expanded to work with youth as young as 9, and young adults as old as 26.

Since 1985, Drs. Howard Liddle, Gayle Dakof and Cindy Rowe, as well as other colleagues across the U.S. and Europe, tested the program in randomized controlled trials with demographically, socioeconomically, ethnically and culturally diverse populations. Process studies focused on refining the treatment, testing its components, and applying new versions of the approach in a range of real-world settings. The research shows that MDFT helps restore healthy development to adolescents’ lives, and enables parents and teens to heal and renew their relationships with each other.

In 2001, systematic MDFT implementation began in the state of Connecticut with the Department of Children of Families and five community-based agencies. Clinicians were trained using the same methods and to the same level of fidelity required in MDFT clinical trials. Since this initial statewide collaboration, MDFT implementation has grown considerably across North America and Europe.

MDFT International, a national non-profit, was established in 2009 to facilitate quality replication of the MDFT program across the U.S. and Canada. Under the leadership of Dr. Gayle Dakof, MDFT International provides initial and ongoing implementation support to community settings in substance abuse, mental health, juvenile justice, and child welfare practice settings. MDFT Academie, based in the Netherlands, supports MDFT implementation throughout Europe.
Today, Liddle and colleagues at the University of Miami Miller School of Medicine continue to vary and study the approach, and conduct research to refine the MDFT program for new populations.
MDFT Training Process
THERAPIST CERTIFICATION

- Study written and video material, complete exercises, review feedback
- Onsite 2.5-3.5 Day Introduction
- 12-15 Weekly Team Consultation Calls
- Written Assessment 1
- 2 Onsite Intensives (Video Review and Live Supervision for each therapist, trainer presentation/demonstration)
- Written Assessment 2

SUPERVISOR CERTIFICATION

- Onsite Introduction to Supervision
- Supervision Written Assessment
- Onsite Supervision Intensive
- Review Case Review Supervision Sessions
- Review feedback to Therapists on Weekly Case Plans
- Review Therapist Development Plans
- Review Video Review Supervision Sessions
- Review & Instruct on how to use the MDFT Clinical Portal Reports to improve fidelity, competence and clinical outcomes
Train-the-Trainer (TTT) training, where trainees master a particular method and go on to train others in the approach, has been used in a wide variety of fields. In order to reduce costs for providers, increase sustainability and promote agency autonomy, MDFT International, Inc. provides TTT to individual provider agencies or groups of agencies. We call these trainers Agency-Based Trainers.

Once trained, they are certified by MDFT International to train new staff at their agency (e.g., Children’s Aid Society in New York). We also train county (e.g., Riverside County Department of Mental Health), regional (e.g., Western Pennsylvania) state (e.g., Connecticut), and national trainers (e.g., the Netherlands). These trainers continue to work closely with MDFT International to deliver the highest quality training to new therapists.

**What are the benefits?**

Although Train-the-Trainers programs have not been widely studied, there is a growing consensus concerning their advantages over Expert/Purveyor-Led Training, including increased access to training, reduced costs and time required for training, increased program sustainability, and benefits of having on-site trainers who are knowledgeable of local, agency, and systems issues.

In MDFT, the cost savings can be enormous. MDFT International still provides ongoing coaching and implementation support services, but these are much less expensive than training new therapists. TTT enables agencies to train new therapists in-house, which is absolutely essential to effectively addressing staff turnover.

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

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

Additionally, each year, MDFT International hosts a meeting for all Agency-Based Trainers in Miami, FL. The meeting gives trainers a chance to share their work, build relationships with other trainers in both work and casual settings, and work directly with the model developer Dr. Liddle and MDFT International national trainers.

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

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

**What does the training involve?**

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

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**TRAINER CERTIFICATION**

Observe and give feedback on MDFT Introduction

Observe and give feedback on weekly Case Consultation Calls

Review and give feedback on Case Reviews and Video Reviews

Observe and give feedback on Intensive Onsite Training

Review and give feedback on Weekly Case and Therapist Development Plans

Review and give feedback on Written Assessments 1 & 2

*Note: The trainer will also participate in the Annual MDFT Trainer’s Meeting each year in Miami, FL.*
<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration of Activity</th>
<th>Suggested Preparation Time</th>
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<tbody>
<tr>
<td><strong>Introductory Training.</strong> Therapists should study written and video materials beforehand. Complete written exercise.</td>
<td>2.5 – 3.5 days</td>
<td>4 hours of study</td>
</tr>
<tr>
<td><strong>Weekly Study Time:</strong> Read materials and view video.</td>
<td>Throughout training</td>
<td>1-2 hours of study per week</td>
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<tr>
<td><strong>12-15 Consultation Calls.</strong> The team does one call per week with the trainer to review progress on training cases.</td>
<td>1-1.5 hours per call</td>
<td>30-60 minutes of training case preparation</td>
</tr>
<tr>
<td><strong>Written Midterm Exam</strong></td>
<td>2 hours to complete</td>
<td>4 hours of study time</td>
</tr>
<tr>
<td><strong>First Intensive On-site Visit.</strong> Video Review &amp; Live for each therapist. Clinical Portal Training</td>
<td>2.5–3.5 days for team of 4-5</td>
<td>None</td>
</tr>
<tr>
<td><strong>Second Intensive Onsite Visit.</strong> Video Review &amp; Live for each therapist.</td>
<td>2.5–3.5 days for team of 4-5</td>
<td>None</td>
</tr>
<tr>
<td><strong>Written Final Exam</strong></td>
<td>1.5-2 hours</td>
<td>4 hours of study time</td>
</tr>
<tr>
<td>Activity</td>
<td>Duration of Activity</td>
<td>Recommended Prep Time</td>
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<td>----------------------------------------------</td>
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<tr>
<td><strong>✓ Introductory Training.</strong> Supervisors should study written and video materials beforehand.</td>
<td>1 day</td>
<td>2 hours</td>
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<tr>
<td><strong>✓ Weekly Study Time</strong></td>
<td>Throughout certification training</td>
<td></td>
</tr>
<tr>
<td><strong>✓ Written Exam</strong></td>
<td>2 hours</td>
<td>2 hours of study time</td>
</tr>
<tr>
<td><strong>✓ Intensive Site Visit.</strong> Live demonstration of 3 types of MDFT Supervision, Training on Therapist Development Plans and Portal</td>
<td>1 day</td>
<td>1 hour</td>
</tr>
<tr>
<td><strong>✓ Submission of Therapist Development Plan</strong></td>
<td>2 hours</td>
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<tr>
<td><strong>✓ Submission of comments on Therapist Weekly</strong></td>
<td>2 hours</td>
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<tr>
<td><strong>✓ Submission of video of 1st Case Review Supervision followed by Consultation call</strong></td>
<td>1 hour</td>
<td>1 hour</td>
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<tr>
<td><strong>✓ Submission of video of 2nd Case Review Supervision followed by Consultation Call</strong></td>
<td>1 hour</td>
<td>1 hour</td>
</tr>
<tr>
<td><strong>✓ Submission of 1st Recorded Case Review followed by Consultation Call</strong></td>
<td>1 hour</td>
<td>1 hour</td>
</tr>
<tr>
<td><strong>✓ Submission of 2nd Recorded Case Review followed by Consultation Call</strong></td>
<td>1 hour</td>
<td>1 hour</td>
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Requirements to Deliver MDFT
• A team of a minimum of two therapists with master's degrees in social work, marriage and family therapy, counseling, or other related clinical fields.

• Adequate recording and playback equipment for recording supervision and therapy sessions.

• Internet access and use of Google Chrome browser for entering data into the MDFT Clinical Portal, an online database for tracking outcomes.

• On-site space to conduct live supervision with families. Read more about live supervision.

• For program serving youth who use substances or are at high risk: Urine testing to monitor substance use. Read our urine testing FAQ.

• Cell phones for easy contact between clients and other therapists.
CASE ELIGIBILITY CRITERIA

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

Individual MDFT programs can restrict program eligibility beyond these guidelines. For example, some programs are not able to serve people over the age of 18, and others do not have the capability to serve opiate users. MDFT International, Inc. will work with programs to help them find the best eligibility criteria for their particular circumstances.
Therapists must have a Master’s degree in a clinical field (e.g., social work, mental health counseling, family therapy) or be enrolled in such a program.

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

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

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

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

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

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

Supervisors MUST be certified as an MDFT therapist before being certified as a supervisor.

Supervisors must re-certify annually. They must complete all supervision recertification requirements between 9 and 12 months after their previous certification or recertification date. MDFT International, Inc. will give a 2-month grace period after which time, supervisors who are not in compliance will no longer be certified and will not be able to supervise MDFT therapists. Once supervision re-certification requirements are completed, the supervisors' re-certification status will be reinstated. Extensions will be granted for special circumstances such as medical or parental/family leaves. Trainers and supervisors must request extensions from their Executive Trainer.
We offer 3 tools to help you make the best decisions in hiring MDFT therapists:

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

Effective MDFT therapists have the following characteristics:

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

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

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

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

Name of Therapist:  
Date: 

Part 1: Therapist Intervention Inventory

**Instructions:** Think about an adolescent client you have worked with during the past 6 months. This case should be a good example of the way you usually provide treatment. With this client in mind, review the following interventions therapists commonly use in working with adolescents. Select the 5 interventions from this list that you feel were **most** important in achieving good outcomes with this case. Next, select the 5 interventions you feel were **least** important in helping this teen and family (interventions you rarely used or avoided).

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

**Interventions**

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

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

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

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

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

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

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

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

I. **Addressed interp parental conflict and helped parents work as a team** (even if separated or divorced).
J. Helped family members have a different experience of each other by guiding interactions in session; helped adolescents and parents to talk to each other in new ways.

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

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

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

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

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

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

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

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

1. _____
2. _____
3. _____
4. _____
5. _____
Part 2: Therapist Self-Assessment

Rate yourself on the following items:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>10</td>
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</tbody>
</table>

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

A. List your 2 greatest strengths as a therapist:
1. 
2. 

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

1. 

2. 

Case Vignettes

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

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

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

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

5. A boy is not going to school. He sleeps through his alarm almost every morning, and does not go to school. In the last few months, he has only gone to school on 10 days. He also has a history of getting in trouble at school, and is somewhat low functioning.
Live Supervision allows therapists to receive guidance and oversight in a live clinical setting. While the therapist conducts a session with the youth or family, the trainer or supervisor and clinical team observe from another room (with the family’s consent and knowledge, of course). The trainer or supervisor can observe and, if needed, intervene by calling in with suggestions for keeping the session on track and achieving session goals, as well as advancing therapist development. All Live Supervision sessions should be recorded; they can also be used for Recorded Session Review Supervision at a later date.

Live Supervision Checklist

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

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

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

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

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

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

  Some sites use cell phones, but this opens up the possibility of the session being interrupted by unrelated calls or messages, and often the clients can hear the supervisor’s comments through the cell phone, so this is not recommended if it can be avoided.
A data storage system.
Once sessions are recorded, you need to be able to store. Some sites record sessions directly onto discs using DVD players and then store those discs. Some store sessions digitally on a hard drive or a networked shared drive. A typical video of a session can be anywhere from 1 to 5GB, so your camera hard drive/SD card should be large enough to accommodate this. Any permanent storage should be large enough to hold several videos of this size.

Sample Set-Up of Viewing Room

- Two-way mirror
- TV screen for additional viewing
- Camera controls
- DVD players to record session
- Direct line to therapy room
When serving youth who use drugs and alcohol or are at high risk, drug testing is one of many tools used to start a therapeutic dialogue. In addition to encouraging honesty and ensuring accurate assessment by the therapist, drug testing can be an opening to discussing the youth’s substance use.

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

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

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

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

Types of Tests

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

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

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

Urine tests can be purchased online; it is recommended that you speak with a sales associate about your specific site needs before you buy anything. Creating a company account may also be necessary and will likely lower the price. Listed are some of the companies that existing MDFT sites use. The number of tests you need will vary depending on your caseload and how frequently you intend to test them. Most sites purchase one hundred to several hundred at a time. Factors to consider when deciding how many to order are your caseload, how frequently you intend to test clients, and the shelf life of the test.

Instant urine tests:
- [Redwood Toxicology Laboratory](#) (most popular among MDFT sites – a subsidiary of Alere Toxicology, maker of the iCup)
- [Henry Schein, Inc](#)
- [Rapid Detect](#)

Lab testing services:
- [Redwood Toxicology Laboratory](#)
- [Omega Laboratories](#)

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

- The iCup (5 to 8-panel) ranges from $1 to $11 dollars per test. Most sites pay under $5.
- Lab tests (5 to 8-panel) run around $6 per test.
- Specialty tests (which you would probably not order in bulk) for less common drugs such as ecstasy, bath salts, or LSD run $11- $35 per test.
- The 80-hour alcohol test runs around $17 per test.
Delivering MDFT
For Therapists-In-Training

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

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

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

<table>
<thead>
<tr>
<th># of New Assignments</th>
<th>Total # of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td>2</td>
</tr>
<tr>
<td>Month 2</td>
<td>1</td>
</tr>
<tr>
<td>Month 3</td>
<td>2</td>
</tr>
<tr>
<td>Month 4</td>
<td>1</td>
</tr>
<tr>
<td>Month 5</td>
<td>2</td>
</tr>
</tbody>
</table>

Caseloads After Initial Training

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

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

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

Supervision Requirements and Workload

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

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

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

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

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

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

Therapist Assistant (TA) - *Optional*

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

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

Time Commitments from Clinicians

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

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

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

Fidelity to MDFT Parameters

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

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

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

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

Fidelity to Clinical Outcomes

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


**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, via telephone, and on the Internet. Training is much more intensive than a one-time workshop. Training is done at the trainees' sites so that the particulars of the implementation process can be tailored to each program's unique realities.

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

**Are there additional training or startup costs?**
No, the cost for the training includes all materials, travel for the trainer, and fees. All start-up costs are delineated.

**Is there an additional fee to be licensed as a MDFT program?**
No, MDFT programs that meet the site requirements and 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 actually highest during the initial training year, and then are reduced in subsequent years as the program becomes more self-sufficient. Programs with in-house trainers are allowed to train their own therapists, and hence avoid the cost of training a new therapist as there is turnover or expansion.

**Are there a minimum number of trainees required for a training?**
Yes, a minimum of two trainees is required, though a minimum of four is recommended for cost effectiveness. This includes an agency supervisor or team leader to ultimately be trained as an MDFT supervisor. We will train a team that is less than four, but we would have to charge the same fee as we charge for a team of four, so for most agencies this isn't practical.

**Does an MDFT program have to have a therapist assistant?**
No, if your clientele does not have significant unmet social, health, and financial needs you will not need a TA or 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. Some programs use interns as TAs.

**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.

We have tools designed to help you make the best hiring decisions and to retain staff.

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

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

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

We strongly recommend that MDFT programs have available and use instant drug tests so 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 youth and parents. It is not unusual for some agencies to be reluctant to do drug testing, however, once they understand the MDFT way of drug testing, they find that it is very useful.

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

No, at this point we only train groups, and not individuals, to certification. However, each year there are several learning opportunities in MDFT available to individuals. These workshops and other events are posted on the website (www.mdft.org). To stay informed, consider joining the MDFT distribution list or following MDFT on Facebook.