The Nuts and Bolts of Supervision in FFT
Consultation Tasks

• Helping therapists practice FFT with high levels of FACE

\[ \text{Fidelity} = \text{Adherence} + \text{Competence} \]

• Provide ongoing quality assurance and quality improvement
• Maintaining a working group of therapists
• Facilitating a site context that will sustain implementation
Clinical Adherence is defined as the degree to which the therapist applies the model as intended. Basically, do the right thing(s) at the right time in terms of phase based goals and techniques.
Clinical Competence is defined by the creativity, flexibility, and breadth of alternative “avenues” the therapist takes to match to the uniqueness of each family’s language and ways of experiencing their world. Essentially, competence refers to the depth or skill with which the therapist applies the model.
Adherence and Competence are Phase-Based

• Goals, tasks, and outcomes vary by treatment phase
  • As such, QA/QI activities also vary by phase
• Adherence is represented by the “amount” of recommended phase-based interventions
• Competence is represented by…
  • the quality of these interventions,
  • the appropriateness/responsiveness/depth of interventions,
  the extent to which interventions address immediate, intermediate, and long term goals
Adherence and Competence: Knowledge vs. Performance

- Adherence and competence have a knowledge and a performance component
- **Knowledge** reflects the therapist’s basic working understanding (and commitment to) of the core principles of FFT and the degree to which the therapist uses the FFT lens to understand youth and families.
- **Performance** reflects the degree to which therapists “do the model”
Compliance with Model Implementation

Dissemination Adherence

Degree to which the FFT therapist is following the dissemination protocol for FFT

Documentation
Completes Progress Notes
Completes contact Notes
Completes Pre and Post Assessment measures
Completes FSR and TSR

Service Delivery
Provides services consistent with family needs, risk and protective factors. ie spacing of sessions
Flexible when scheduling sessions
Responsive to contacts from community partners (probation officers, child welfare, referral source)
Using the CSS to Support Supervision

A data-driven process....
CSS is the primary tool for providing data and is critical to all aspects of the supervision process

- Preparation for meeting
  - Review Progress Notes
  - Strategic selection of cases (therapist/team development)
- Narrow to broad focus (family to therapist to team)
- Guide through case discussions
- Review during call
- Completion of adherence and fidelity ratings
- Generation of reports
Structuring Supervision to Achieve QA/QI Goals
Core Assumptions

• The impact of FFT is driven by what therapists do with family members.
• Supervision is the mechanism for enhancing the quality of what therapists do.
• The more cases that are reviewed in supervision, the broader the impact of supervision on therapist fidelity, and – in turn – on clinical outcomes (e.g., more can be better).
• Therapists learn as much from their successes as their failures; as such, supervision (and fidelity review) cannot solely focus on difficult cases.
• What defines fidelity varies by phase of treatment; as such, fidelity review should include a range of cases across phases.
Supervision requires effective leadership

- Leadership style must be flexible, responsive and contingent to families, therapists, and supervision group
  - Planful and goal-directed
  - Mix of relational and structuring skills
Zeroing in on Fidelity

• Relevance of fidelity ratings to:
  • Families / Sites / Stakeholders
• Variability in how fidelity ratings are generated
  • Can underestimate site performance (difficult cases, supervisor ratings)
• Guidelines
  • Three fidelity ratings per consultation
    • Will vary from 2 to 3 by skill of the group
  • Three ratings per case (over time);
    • Second session in each phase
    • Timed to when Family Assessments are completed
Weekly Group Consultation

Content Areas

- Catch-up (5”)
- Case Review (30”)
- Staffing/Planning (20”)
- Site Issues (5”)
- Time may vary by needs of group
• Focus of fidelity ratings are on therapist performance (NOT case planning)
  • Weekly ratings are based on what therapists did in the session not their discussion of the case
  • Note: Global ratings will continue to capture general knowledge and performance indicators
• The tasks and questions will vary by the phase of case
Elements of Assessing Fidelity

- Planning component for that session
  - Is the plan appropriate by phase and family

- Assessment
  - Did the therapist monitor and adjust interventions to moment to moment interactions in the session?

- Intervention Component
  - What is the quality of interventions, were they appropriate to phase and family, and current interactions

- Assessing depth
  - Asking follow-up questions to gather details about each element
Engagement and Motivation

• Did the therapist have a clear plan for this session?
  • Was the plan appropriate to this phase?
• Did the therapist respond rapidly to contact the case?
• Did the therapist attempt to engage key family members into the clinical process?
• Did the therapist utilize change focus and change meaning interventions to disrupt within family conflict and enhance motivation for change?
• Did the therapist display appropriate interpersonal skills (such as warmth, etc.) above in a way that matches to the individuals and the family?
Behavior Change

• Did the therapist have a clear plan for this session?
  • Was the plan appropriate to this phase?
  • Was the plan linked to the presenting problem?
  • Does the plan incorporate and match the relational assessment?
• Are behavior change targets clear and focused?
• Are the skills targeted focused and appropriate?
Assigning Tasks

Tasks are essential for facilitating competency and mastery

- Therapist must:
  - Give tasks in the session
  - Stay with it until accomplished
  - Give positive feedback
  - Expect sabotage – Homeostasis
  - Assign and review homework
Setting up Tasks

- Goal (immediate and intermediate)
- Is family ready?
  - Conflict
  - Working emotions
  - Intensify and highlight
- Clear, direct, and brief
- Let family a chance to complete task
  - Directive but not central
Facilitating Completion

- Review process as family completes task
- Do not micro-manage or expect perfection
  - Varies by family
- Highlight positive aspects or behaviors
- Coach (brief, clear, and direct)
- Gently push family beyond where they typically stop
- Redirect by interruption (strategic validation) when family gets off task
Closing the Deal

- Decentralization
  - Allow new patterns to emerge
- Positive feedback
- Process Change
  - Let family experience and “OWN” the new pattern of interaction
Closing the Deal

Decentralization

- Permit family to successfully behave in a new way
- Coach without taking over
- Let positive interactions continue without interruption
  - Do not validate (positive feedback individual behaviors) during a transaction
- Provide opportunities for self-correction
  - Do not immediately jump in and micro-manage transactions
Closing the Deal

Process Change

- Clarity in the immediate goals of session is critical for effective behavior change
  - What does therapist want to see changed?
  - How will it look when it is changed?
- Clear presentation of task
  - Defines start of interaction
- Manage family drift during task
  - Coaching when family gets derailed
- Task ends when family successfully engages in new behaviors
Closing the Deal

Process Change

- Punctuate “change” for the family after task has been completed
  - Slow down or stop interaction and review the process from start to completion of task
    - What changed or did not change?
    - What worked well?
    - What did not work?
    - What were family members experiences (thoughts and emotions) throughout the task?
      - Most importantly, contrast new state with initial state
- Punctuation can occur with failed tasks as well as successful tasks
Closing the Deal

Positive Feedback

- Reinforcement can be a powerful tool in shaping behaviors
- Use reinforcement strategically
  - Early in treatment this may occur in the form of respect and empathy
  - Later in treatment, this can occur when the individual is stuck
- During restructuring, try to avoid over using positive reinforcement
Closing the Deal

Positive Feedback

• Encouragement is not necessarily positive feedback
  • “Keep going. You are doing a great job.”
• Whenever possible, try to utilize family members to “encourage” interactions
• More importantly, try to utilize family members to provide positive feedback
  • Reinforcement from family is more powerful than from therapist (sustainability)
Generalization

• Did the therapist have a clear plan for this session?
  • Was the plan appropriate to this phase?
  • Was the plan linked to the presenting problem?
  • Did the plan incorporate and match the relational assessment?
• Did the therapist include appropriate external systems?
• Were interventions planned and implemented in a manner that matched the family and external systems?
Rating Therapist Fidelity: Weekly Supervision Checklist

Adherence + Competence = Fidelity
**Clinical Adherence** = the degree to which the therapist applies the model as intended (manualized, trained, supervised, etc). Basically, do the right thing(s) at the right time in terms of phase based goals and techniques.

Adherence is rated on a four point Likert scale ranging from 0 (none, minimal to four extensive). Ratings are based on the extent to which (frequency) therapists engage in FFT-model specific behaviors. Anchors on the rating scale are defined as follows:
0 = None/Minimal  Therapist rarely engages in behaviors that are appropriate to the case/session. Therapist has difficulty articulating a plan for the session or describing interventions were used to address phase–specific goals.

1 = Occasional  Therapist occasionally engages in behaviors that are appropriate to the phase of the case/session. Therapist articulates a plan for the session and describes some interventions that were used to address phase-specific goals, but has difficulty maintaining a consistent focus.

2 = Regular/Frequent  Therapist frequently engages behaviors that are appropriate to the phase of the case/session. Therapist articulates a clear plan for the session and describes many interventions were used to achieve phase-based goals.

3 = Extensive  Therapist consistently engages in behaviors that are appropriate to the phase of the case/session. Therapist articulates a clear plan for the session and describes extensive interventions that are implemented to achieve phase-based goals.
Competence = the creativity, flexibility, breadth of alternative “avenues” the therapist takes to match to the uniqueness of each family’s language and ways of experiencing their world.

Competence is rated on a four point Likert Scale ranging from 0-3. Rating are based on the quality – or level of skill – with which therapist implemented FFT model-specific behaviors. Quality reflects the depth and sophistication of interventions, and includes the degree to which the therapist tailors interventions in a contingent and phase-based manner to the unique characteristics of the family. [Note: A competency rating may only be applied when adherence ratings are a 2 or 3. If a therapist is not able to regularly implement FFT related interventions, competency is assumed to be minimal].
0 = None/Minimal

There is **no or minimal evidence** that interventions are delivered with depth or sophistication. Although the therapist describes the presence of phase-based interventions, the description **fails to convey how interventions are matched to** client characteristics or **contingent** on the current interactions. Interventions appear to be **unplanned and lack focus**.

1 = Low

There is **some evidence** that interventions are delivered with depth or sophistication. The therapist describes the presence of phase-based interventions that are **matched to** client characteristics or that are **contingent** on the current interactions. Interventions appear to be **planned and focused**. However, the therapist has **difficulty maintaining depth and consistency** throughout the session.
2 = Moderate

Interventions are *frequently* delivered with depth or sophistication. The therapist describes the presence of phase-based interventions that are *matched to* client characteristics or that are *contingent* on the current interactions. Interventions are *planned and focused*. The therapist is able to *regularly* deliver interventions in a manner that is sensitive to the unique characteristics of the family.

3 = High

Interventions are *extensively* delivered with depth or sophistication. The therapist describes the presence of phase-based interventions that are *matched to* client characteristics or that are *contingent* on the current interactions. Interventions are clearly *planned and focused*. 
•The third step is to sum the adherence and competence ratings. Fidelity represents the sum of adherence and competence.

•If the adherence rating equals 0 or 1, no competency rating can be added.
•However, if the adherence rating is 2 or 3, a competency rating can be added to the adherence rating.
  •Raters do not need to add a competency rating. If interventions are viewed as being delivered with no/minimal sophistication, the competency rating should be zero (0).
Global Therapist Ratings
Global Ratings

• Completed every four months
  • Timed to generation of new quarterly reports
• Includes assessment of performance indicators of adherence and competence that are used to generate weekly supervision ratings
• Also, includes knowledge indicators to capture therapists conceptual knowledge and treatment planning
Weekly Group Consultation

Content Areas

- Catch-up (5")
- Case Review (30")
- Staffing/Planning (20")
- Site Issues (5")
- Time may vary by needs of group
Notes on Case Staffing/Planning

• Case staffing and treatment planning also needs to be direct and focused
• Tailor supervision to therapists and group
  • Level of experience
  • Learning style (conceptual or experiential)
  • Permit time to practice/role play
  • Assign homework
• What are the goals for this case during this phase in this session?
  • Lining up immediate, intermediate, and long-term goals
Components of Case Staffing/Planning

• A brief review of the family
  • May include some personal elements (e.g., who is in the family, divorce, history of trauma, etc.) and ecological elements (e.g., justice involvement, school problems); however, the primary focus should always be centered on within family relational functions.

• A cursory review of what has been implemented with the family (e.g., what themes seemed effective in reducing conflict, how has the plan been tailored to match the relational functions?)

• Identify/discuss the relational and behavioral goals for the next session. In part, this means helping the therapist to identify what are the most pressing issues that need to be addressed for the family?

• Develop individualized plans to accomplish the goals in the next session.

• Practice specific skills that are to be used in the next session.
Case Staffing/Planning: Focus on Engagement and Motivation

• Does this family present with high conflict?
• What is the nature of this conflict (hostility, who does it involve, etc.)?
• How have you attempted to address conflict in prior sessions? Impact?
• Let’s brainstorm 5 reframes that may help to disrupt negativity and help toward developing a relational theme
  • Less experienced teams require examples, more experienced teams should be able to generate on their own
Case Staffing/Planning in Behavior Change

- What is the ultimate outcome (e.g., truancy, drug use, delinquency)?
- What intermediate behaviors need to be changed (e.g., communication, skill building, refusal skills)?
- What are the relational functions among key family members?
- How are these incorporated into behavior change strategies?
- What impact has prior behavior change strategies had on behavioral targets?
- What is the next step for the family?
- Do not be afraid to assign homework or reading to the group (e.g., parent training materials, relapse prevention)
Using the CSS to Support Supervision

What are the general expectations or standards?
Sites/Teams

• Team Size
  • All sites will maintain teams of 3-8 therapists
  • Larger teams present challenges for maintaining our focus on regular QA (e.g., fidelity rating)

• Caseloads
  • All therapists will maintain average caseload sizes of 5-6 families per therapists if part time, 10-12 if full time
Sites/Teams

• Clinical Process
  • Average time to first session
    • Should be less than one week from referral date
  • Average number of sessions
    • Should be no less than 8 and no more than 24
      • If greater than 10% of cases have less than 8
        or more than 24 a site action/improvement plan
        must be developed
Sites/Teams

• Clinical Process
  • Average time to close cases
    • Should be no less than 2 months and no more than 6 months
      • If more than 10% have less than 2 months or more than 6 months a site action/improvement plan must be developed
  • Percent Completed
    • 70% successful completion rate (Phase I)
      • Increase severity of cases may take longer to hit this mark
      • Prevention, less severe cases may have a higher rate
    • 80% for Phase II and beyond
      • Again, this is ideal, but we vary around this mark. However, anything less than these rates require intensive QI plans to move the site forward.
Dissemination Adherence

• Consistent CSS usage and entry of all required FFT documentation:
  • Assessments
  • Contact notes
  • Session progress notes
  • FSR/TSR
• Less than an average of 5 requires QI plan
Therapist Fidelity

- Weekly Supervision Ratings
  - Expectation of 3 or higher
  - Note: During the first year for a therapist the expectation would be that the average ratings would be less than three (as in State of Washington QA/QI)

- Global Supervision Rating
  - Expectation of 3 or higher