Advanced Supervisor Training

April 8–9th, 2014
Sacramento, California
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“Without supervision, adherence, fidelity, and clinical outcomes are negatively affected.”
What to Expect

- Focus on Supervision Tasks and Skills in each phase
- Analyzing behaviors and data to select supervision targets
- Relapse Prevention Planning
- Fidelity and Dissemination Adherence Ratings
Supervision Goals

- Develop FACE
- Provide QA/QI
- Facilitate group / agency support
- Continue therapist development
Core Elements of FFT

- Respect-based
- Integrated/Multisystemic
- Phase-Based
- Relational/Systemic
- Data Driven

“Family First”
Super Summary of the FFT Model and “FFT Attitude:”

- A Philosophy / Belief System about people which includes a core attitude of Respectfulness; of individual difference, culture, ethnicity, family form

- A family focused intervention involving alliance and involvement with all family members (Balanced alliance) with therapists who do not “take sides” and who avoid being judgmental.
Super Summary of FFT Model and “FFT Attitude (Continued)

–A change model that is focused on risk and (especially) protective factors – “Strength Based”

–With interventions that are specific & individualized for the unique challenges, diverse qualities, and strengths (cultural, personal, experiential, family forms) of all families and family members.

–And an overriding Relational (versus individual problem) focus
Supervision Related to “FFT Attitude”

- In all three phases of the model you must listen for and address strengths, challenges and struggles with the FFT way of viewing people and problems
- How do you know a therapist is seeing the family in a strength-based, relational way?
- What questions can you ask to assess this during a group or individual supervision?
Phases in FFT

PRETREATMENT

MOTIVATION

RELATIONAL ASSESSMENT

BEHAVIOR CHANGE

GENERALIZATION

SESSION

1 2 3 4 5 6 7 8 +
Engagement Phase

- Enhance perception of responsiveness and credibility
- Immediate responsiveness
- Strength and relational-based
- Availability, telephone reach out, matching, frequency

- Superficial qualities, persistence, matching

Goals

Skills

Focus

Activities
The Referral Process

- What is an appropriate Referral – making supervisory decisions
- Entering a Case into the CSS – tracking and monitoring
  - Referral Date
  - First Contact
  - First Session
Who Should Attend?
Who Are The “Major Players?”

1 – Family member(s) seen as part of the “problem” or “problem sequence” according to referral source(s).

2 – Family members we think (based on referral info and first calls to the family) are likely to “shut the process down” - and who probably can!

3 – Family members we think are necessary to begin change in the referral youth(s)

4 – Important nonfamily members who will participate and are “appropriate” participants vis-à-vis retaining a highly influential role with the youth / family (e.g., Grandma)

Who Doesn’t Need to Be There? - Anyone who doesn’t fit above
The Spacing of Sessions During the Motivation Phase

The spacing, or number of days between the first, second, and third FFT sessions, depends primarily on:

1 – the severity of risk factors,
2 – the immediate availability of protective factors, and
3 – your overall judgment of how long the family can go without a major disruption. With high risk families we would expect 3 sessions in the first 10 days of FFT.
Safety Issues

- Risk Assessment – use of your risk assessment tool as a means to determine safety issues
  
  As a supervisor how do you review risk assessment with the therapist?
  
  What information is it important for you to review?
Developing a safety plan

- The goal of a safety plan is not to change behavior.
- The goal of a safety plan is to create a safe environment for individuals and families.
Supervising Risk Assessment and Safety Planning

- First you must teach your therapist to complete a risk assessment and how to analyze that for safety planning needs.
- Second you must teach therapist to develop safety plans.
- Lastly, you must monitor the risk assessment and safety plans for quality and compliance.
Motivation Phase

- Create context for change
- Decrease conflict
- Increase hope
- Balanced Alliances
- Strength-based
- Relational
- Non-judgmental
- Respectful
- Interpersonal
- Clinical
- Contingent
- Responsive
- Change Focus
- Change Meaning

Goals
Skills
Focus
Activities
Creating a Motivational Context

- Consistent and contingent responding to disrupt blame and create hope
- Accommodate to the family without challenging individuals or relational functions
  - Matching
Techniques of the Motivation Phase

Change Focus

- Interrupt and divert
- Point process / Sequence
- Selectively attend to positive
- Strength–based, relational focus
- Do something

Change Meaning

- Theme hints / Relabels
- Reframes
- Reframe +
- Themes
Supervision in the Engagement and Motivation Phases

- Did the therapist respond rapidly to contact the case?
- Did the therapist attempt to engage key family members into the clinical process?
  - Were there indications of difficulties engaging key members?
  - Was the therapist flexible in adapting to the unique needs of the family?
  - What strategies did they use to engage reluctant family members?
- Did the therapist display appropriate interpersonal skills (such as warmth, etc.) above in a way that matches to the individuals and the family?
- Did the therapist monitor and adjust interventions to moment by moment interactions in the early contacts?
- Did the therapist utilize change focus and change meaning interventions to disrupt within family conflict and enhance motivation for change?
- Did the therapist monitor their interventions to ensure that they facilitated balanced alliances with family members?
With respect to relational functions:

- Did the therapist acquire the appropriate information (e.g., observations in session, descriptions of interactions outside of session) necessary to complete the relational assessments?
- Did the therapist assess relational functions prior to starting the Behavior Change Phase?
- Did the therapist base their assessment of relational functions on the outcomes of core family patterns or interactions?
- Did the therapist assess each dyad in the family?
Supervision in Behavior Change
Behavior Change Phase

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1 2 3 4 5 6 7 8 +

POST TREATMENT

FFT Functional Family Therapy
Therapist Skills

- Directive
- Teaching
- Structuring

...shift from interpersonal to structured and directive

...targets at multiple levels, including family, individual, and domains
Supervisor Skills

- Directive
- Teaching
- Modeling
- Structuring
- Assessment
Behavior Change

- As a supervisor you must apply the behavior change skills and techniques that you use with families to the therapists that you work with.
- A key difference is that you have a different degree of hierarchy and a need for holding a therapist accountable (they could lose their job) than you have with a family.
Structure of Sessions

1. Rationale
2. Present Task
3. Behavioral Rehearsal Modeling
4. Feedback Coaching
5. Homework

FFT Functional Family Therapy
Functional Analysis

- Method for breaking down the immediate context that precedes behaviors and the consequences that follow
- Goals of Functional Analyses
  - Identify triggers and consequences to develop targeted treatment plans to address problem behaviors
- Considerations
  - A behavior can be both a stimulus and a response
  - In FFT, we are concerned with the stimulus and responses for multiple family members (e.g., when a child throws a temper tantrum what are the child and parent reinforcers/punishments that are at play?)
  - A functional analysis is merely a tool for therapists to help them breakdown potential targets for change
Functional Analysis as a Supervision Tool

- What skills do you as a supervisor have to use when analyzing therapist knowledge, performance and effectiveness?

- Where do you gather information for the analysis?
ABC Assessment of Therapist Behaviors

- What specific behavior puts the therapist at risk of not implementing the model with adherence and competence?
  - Examples might be – thinking individually rather than relationally focused, not thinking thematically with regards to problems, lack of planning and preparation in each phase, moving to quickly to problem solving

- How frequently does this behavior occur?

- Is there a particular phase or type of family in which this behavior occurs?
What does the therapist seem to be thinking before this behavior occurs?

What is the therapist feeling before this behavior occurs?

- Thoughts and feelings that surround the therapist behaviors need to be acknowledged in a full analysis of what leads to behaviors.
- Specifically what situations lead to this behavior – fear of conflict, self-doubt, conflict with personal values/beliefs.
Replacing negative behaviors with more positive skills

- In your role as a supervisor you must develop a plan to address thinking errors or negative thoughts/feeling as well as teaching new techniques to help the therapist develop in adherence and competence.
Developing a plan to improve therapist performance
There are three main types of learning styles: auditory, visual, and kinesthetic. Most people learn best through a combination of the three types of learning styles, but everybody is different.
Visual Learners

- take numerous detailed notes
- tend to sit in the front
- are usually neat and clean
- often close their eyes to visualize or remember something
- find something to watch if they are bored
- like to see what they are learning
- benefit from illustrations and presentations that use color
- are attracted to written or spoken language rich in imagery
- prefer stimuli to be isolated from auditory and kinesthetic distraction
- find passive surroundings ideal
Auditory Learners

- sit where they can hear but needn't pay attention to what is happening in front
- may not coordinate colors or clothes, but can explain why they are wearing what they are wearing and why
- hum or talk to themselves or others when bored
- acquire knowledge by reading aloud
- remember by verbalizing lessons to themselves (if they don't they have difficulty reading maps or diagrams or handling conceptual assignments like mathematics).
Kinesthetic Learners

- need to be active and take frequent breaks
- speak with their hands and with gestures
- remember what was done, but have difficulty recalling what was said or seen
- find reasons to tinker or move when bored
- rely on what they can directly experience or perform
- activities such as cooking, construction, engineering and art help them perceive and learn
- enjoy field trips and tasks that involve manipulating materials
- sit near the door or someplace else where they can easily get up and move around
- are uncomfortable in classrooms where they lack opportunities for hands-on experience
- communicate by touching and appreciate physically expressed encouragement, such as a pat on the back
Apply to Team

- What is your learning style?
- What are the learning styles of your team members?
- How can you use this information to improve supervision?
Sample Functional Analysis

- Therapist has a high drop-out rate in the motivation phase of therapy
- Therapist consistently struggles to meet goal of average sessions per month
- Therapist struggles to complete FFT and agency paperwork in a timely manner
Components of the Plan

- Rationale
- Presentation of Task
- Behavior Rehearsal/Modeling
- Feedback
- Coaching
Supervision in the Behavior Change Phase

- Did the therapist implement behavior change interventions in a way that was appropriate:
  - to this case?
  - to the referral behaviors, either directly or indirectly?
  - to address specific risk factors within the family?
  - to the relational functions?

- Are behavior change targets clear and focused?

- Are the skills targeted focused and appropriate?

- Did the therapist practice and coach family members through their skill development in session?
Supervision in the Generalization Phase
Generalization Phase

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7 8 +

POST TREATMENT

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Generalization Phase

- Maintain individual and family change
- Facilitate change in multiple systems

Goals

- Interpersonal
  - Structuring
  - Case Management

Skills

- Link to formal and informal systems
- Plan for future challenges

Focus

- Extend change
- Exta-familial community resources

Activities
Generalization is the chance to make things “stick”

- Build upon the skills that you taught in behavior change
- Link the family with professional and “natural” resources
- Help families understand and plan for relapse
- Continue to build their hope that they can approach things positively in the future
Goals of Generalization

- Generalization is an “it depends” phase regarding goals worked on.....(Matching)
- We generalize change
- We maintain change
- We support change
- What goal(s) you work on depends on the risk and protective factors of the family and their community
Relapse

- Relapse occurs in every treatment – it is how you define relapse that is different. We don’t want to look at any “step backward” as relapse, but as a “normal” event.
- Relapse is not a failure, but it “feels” like a failure – what will change is how the family approaches these steps.
- Often it is the therapist who has the hardest time with relapse.
- We want to help families plan and prepare for “settling in” and relapse.
Case Closing

- Use of the Case Review to check Case Closing Status
- Successful vs. Unsuccessful
- Post Assessments
The Supervision Process in Generalization

- Were the session activities (internal and/or external family skill generalization; relapse prevention; link to additional resources/supports) in the session linked to the referral behaviors and family behavioral patterns, either directly or indirectly?
- Did the therapist address multiple risk factors external to the family?
- Did the session activities continue to maintain reduction of risk factors internal to the family?
- Did the session activities match the relational assessments?
- Did the therapist include appropriate external systems?
- Were interventions planned and implemented in a manner that matched the family and external systems?
Relapse Prevention Planning
What is Relapse Prevention

- Comes from Alcohol and Drug Treatment
- Brought to the forefront in the mid 1980’s by a man named Terence Gorski, various books, articles, workbooks
- General ideas is that relapse is a process not an event.
- This fits nicely with FFT ideas about behaviors being part of a pattern, not a single event.
- Relapse prevention is about helping family see red flags that they might fall into old patterns of behavior and helping them plan to prevent
Relapse Prevention Plans

1. Identify the warning signs of relapse for this particular youth/family.

2. Identify the feelings and thoughts that surround the warning signs (irrational thoughts, black and white thinking).

3. What are coping strategies or techniques that have been taught in behavior change, or have worked in the past to address these warning signs.

4. Developing ways to remind family members of warning signs, coping strategies and ways to support each other.
Ways to Develop Relapse Prevention Plans

- ABC Assessment – found under Resources section of CSS
- Sample Worksheets found on the internet
- Sample Worksheet included with materials sent
Sample Plan

- Developing a Relapse Prevention Plan –
- Your family has made changes in the way that you handle day to day activities through the course of FFT. List below some of the changes that you have made as a family and as an individual.

- We have learned to communicate better through direct requests and impact statements. Mark has learned to identify thoughts vs. feelings and how to talk to mom and stepdad about these. Stepdad has learned to be more brief in his “lectures”. Sarah has learned to not immediately respond in anger or name calling. We make sure that we schedule family activities.
What is often hard to remember is that you didn’t make these changes overnight and the problems or situations that led to therapy did not happen overnight. It is important to look at patterns that we all have developed and then identify the “triggers” or warning signs that we might fall back into old patterns of behavior. A “trigger” can be a person, place, object, feeling or time/event that leads you to fall back into old behaviors. For example, if you are trying to lose weight – going out with friends could be a trigger to overeat or feeling lonely could be a trigger. Listed below are several emotions/feelings that can be triggers. What can you identify as triggers that would cause your family to fall back into old patterns?

- Mark – feeling lonely, having lots to do at school or work, worried about finding a job
- Mom – traveling a lot or feeling overwhelmed
- Stepdad – feeling lonely or unsure how to handle a situation
- Sarah – feeling unappreciated
The best way to deal with triggers is by avoiding them, but as we all know – avoidance isn’t always possible. Therefore we need to identify specific coping strategies that we can use if we recognize these triggers – some examples are listed below to help you get started.

- Relaxation Techniques
- Calling someone you trust
- Exercising
- Using skills learned in therapy

What specific coping strategies can you and your family use when you notice triggers?

1. *Continue to have dinner together as often as possible and discuss upcoming events, travel, etc.*
2. *Mom to make a calendar of when she is traveling and where so everyone knows*
3. *To Communicate with mom via text message when she travels at least daily.*
4. *Dad to make sure dinner occurs together even when mom is gone.*
5. *Sarah and Mark to take time-outs when they fight and not try to solve problems immediately.*
Who in the family is most likely to recognize the triggers?
- Mom and Mark

Who outside of your immediate family can be a support and help to recognize the triggers?
- Brother – Kevin
- Grandparents on both sides of family
Putting it all together:

Our family triggers:
- Feelings of being lonely or overwhelmed
- Mom traveling more than usual

Who will recognize these triggers?
- Mainly mom and Mark
What is our plan when we see these triggers?

- Use family dinner as a time to discuss concerns and plan for the day ahead or week ahead. Use communication skills learned during therapy during these times
- Schedule family activity at least weekly
- Mom to develop a calendar of when she travels and where and place it where family members can see.
- Communicate via text message daily when mom travels.
- Ask grandparents to check in with Sarah and Mark when mom travels.
Dissemination Adherence and Fidelity Ratings
Supervision Goals

- Develop FACE
- Provide QA/QI
- Facilitate group / agency support
- Continue therapist development
Supervision Tasks

• Helping therapists practice FFT with high levels of FACE

Fidelity = Adherence + Competence

Effectiveness

• Provide ongoing quality assurance and quality improvement
• Maintaining a working group of therapists
• Facilitating a site context that will sustain implementation
Weekly Group Consultation

Content Areas

- Catch-up (5”)
- Case Review (30”)
- Staffing/Planning (20”)
- Site Issues (5”)
- Time may vary by needs of group
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
Assessment of Therapist Fidelity

- 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
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)
Features of Competent 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.
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.
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.
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).
Therapist Initial Starting Place(s) (For Most)

Fidelity
- Very High
- High
- Moderate
- Low
- Very Low

Competence

Adherence

Expected Level for "Adequate" FFT

FFT Functional Family Therapy
Evidence Based, Cost Effective, Sustainable, Family, Youth & Culture Sensitive
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”
Utilizing CSS reports in the Supervision Process
Case Review

- Report can be run by Supervisor or Therapist. Lists the Actives, Referrals and Closed cases for a given time period.
- It will also tell you last time progress note entered for active cases, case closing status and date of closing for closed cases.
- The Case Review report for each therapist must match what you submit to Kim Mason each month.
- This report should be utilized weekly to determine cases to staff in individual or group supervision.
Sessions and Contact Report

- This report can be run by therapist or supervisor and documents all contacts and sessions entered into the CSS for a given time period.
- It can be run for one client or all clients – either active, closed or both
Progress Notes

- All supervisors have access to all progress notes entered in the CSS.
- You should be monitoring progress notes for completion as well as quality.
- Quality means that the note provides enough information on what therapist did in session and family response that it can be utilized to plan for the next session.
Family Assessment Summary

- This report can be run by either therapist or supervisor.
- It details what Pre and Post Assessments have been entered for a given case.
- You can use this report to determine reduction in stress factors in youth and family from pre to post on successfully closed families.
Outcome Summary

- This report can be run by therapist or supervisor.
- It details the family response to COM–A and COM–P, therapist response on TOM and pre and post risk factor analysis.
- You can use this report to determine how much change family and therapist believes have been made during the course of FFT.
COM–P, COM–A and TOM reports by therapist, team

- Go to Group Reports Section
- Select one of the COM or TOM reports and then enter date range
- This will give you either averages of scores or scores by family
- You can use this report to average scores and determine levels of change reported by youth, family and therapist
This report is run three times (January, May and September) a year by FFT and reviewed with each supervisor to establish goals for supervision.

It will tell where your team stands in relationship to meeting National Standards of FFT Practice.

It will also be used in addition to the Monthly EBA data to determine the need for team and individual quality improvement plans administered by the FFT Florida Clinical Coordinator.
Case Tracking

- This report can be run by the supervisor or FFT National Consultant
- It is used to give more data regarding team performance and individual therapist performance
- It can be utilized to further analyze therapist performance when developing quality assurance plans or targets for supervision
Wrap-UP – Where do we go from here?
Closing

- Questions
- Review of Decisions made and plans for future