APPENDIX K

THE 9 PRINCIPLES OF MST

1. **Fit:** MST families and therapists try to find the "fit" of the problems we see. What we mean is:
   - What causes the problem behaviors?
   - How do problems "make sense" (fit) with what's happening in the family, school, or community?

2. **Strengths:** MST families use their strengths to decrease problems. Families can emphasize the positive and build on what is working in order to change the things that aren't. Often we can use strengths in the community (school or probation, for example) to help us.

3. **Responsibility:** Every member of MST families is expected to increase responsible behavior and decrease irresponsible behavior. When we all work at taking on more responsibility (including the therapist), things can improve quickly.

4. **Present Problem Focus:** MST works with youth families by focusing on specific problems, asking:
   - What is the problem ***right now?*** (present-focused)
   - What can we ***do*** about it ***right now?*** (action-oriented)

   So instead of talking about a "bad attitude," for example, MST families would clearly define what the specific behaviors are and then work on specific and achievable goals around changing the identified behaviors.

5. **Sequences:** Problem behaviors don't occur all by themselves. They're usually part of a "sequence"—a string of events that have become a pattern for the family. For example, if an adolescent throws temper tantrums, it's just as important to find out what happens ***before*** the tantrum as it is to help manage the youth's anger ***during*** the tantrum. Then we might work on how the parents react ***after*** the tantrum. In other words, looking at the sequence often helps lessen the problem behavior.

6. **Developmental:** Adolescents' brains, bodies and emotions work differently than adults'. What helps an adult stop a problem behavior might not work at all with a child. Furthermore, adolescents may exhibit natural, normal behaviors that parents don't like, but aren't necessarily "problems." We like to take into account the normal growth and development stages the youth is living out at the moment and work with the youth and family to make healthy transitions through these growth stages.

7. **Effort:** Good change is often hard work at first. MST families are given homework which they are expected do every day. Most of the work happens when the therapist isn't in the home. MST is hard work, but the more effort MST families put in at the beginning, the easier it will be at the end.

8. **Evaluation:** MST families evaluate what's working and what isn't. If we don't get it right the first time, we find out why, change what we're doing, and try again. Then we do more of what does work, and do less of what doesn't. Sometimes our therapists suggest doing a certain thing, and the family says, "We've tried that already." We may suggest trying certain things again, but this time with the support of the MST therapist and community supports to see if we can get better results this time. Sometimes we have to make healthy changes in lots of small measurable steps.

9. **Long-Term Results:** MST families and therapists want healthy changes to be permanent. Long-term results are most likely when families practice all these principles, even after treatment finishes. We all need help sometimes, and MST families find the help they need in their own environment—extended family, friends, church, school, etc. In the end, MST families find they have the strengths and resources to effectively manage their problems in the long term.

THE UNIVERSITY OF COLORADO HOSPITAL
MULTISYSTEMIC THERAPY (MST) TEAM

MULTISYSTEMIC THERAPY (MST) IS:

- MST Services is based out of South Carolina and is an international organization with **well-documented** (ongoing) **data proving the success of the MST model.** It is recognized nationally as a **best practices model** for adjudicated youth and their families. We are site licensed by MST Services.
- MST is a **Strengths-Based family therapy** that focuses on making use of **positive community supports** for the youth and his or her family to create behavioral **change.**
- MST is based out of **Cognitive Behavioral Therapy** and uses a **brief intervention format** (around 90 Days).
- Agencies that are typically involved include: **parents, family, school, work, probation, diversion, social services** (if applicable), **mental health services, church, pro-social peers, extended family**, and **any other identifiable positive relationships.**
- Therapy is designed to be **action-oriented** with **well-defined** (measurable) **goals** that require **increased responsibility** from the youth and his/her family.
- The youth and family have **"homework" goals each week**, which are **developmentally appropriate** to the youth working toward the overarching goals of the intervention.
- There are **built in evaluation and accountability measures** for the youth and family as well as the therapist with the intended **goal of achieving behavioral changes that are sustainable by the youth, family and community over time.**

DISTINCTIVES OF OUR MST PROGRAM:

- ⇒ **Full Fidelity to the Multi Systemic Therapy model** as designed and improved by the University of South Carolina School of Medicine.
- ⇒ **All Therapists are Masters Degree level trained.**
- ⇒ **Dr. Carter is a Child Psychiatrist fully trained in the MST model** and is dedicated to the team for the purposes of advising and assisting with assessment and support of MST clients and their families.
- ⇒ **ABC Family Resource Coordinator assisting in data collection and supportive resources**

TEAM COMPOSITION:

- Randy Braley, LMFT
- Mark Miller, MA LPC CAC I
- Jeff Siegel, MA LPC
- Debbie Carter, MD
- Maria Semeraro, ABC Family Resource Coordinator
- Jon Steinmetz, MA LPC LAC
- Gary Kushner, MA LPC CAC III

REFERRAL CRITERIA:

- ✓ Legally Involved youth
- ✓ Age 10-17
- ✓ An existing Family structure to work with
- ✓ The youth currently living in the home or transitioning home in less than 45 days

EXCLUSION CRITERIA:

- o Class 1 Felony
- o Adjudication For 1st Or 2nd Degree Assault
- o Sexual Assault

TEAM SUPERVISOR: JON STEINMETZ **CONTACT NUMBER: (303) 315-9918**

SOME THINGS YOU CAN EXPECT IN MULTISYSTEMIC THERAPY:

1. Your counselor will want to **hear from everyone** each time we meet to hear how things are going for everybody.

2. We (the counselor and the family) will be doing **fit circles each week** to figure out if we're really using our energies in the best way possible.

3. Please **turn off all distractions** (like the television, radio, etc.) for the therapy sessions so that we can focus on the things we're working on.

4. Please **tell your counselor about important events** that have happened (school problems, legal problems, a big fight in the home, the police were called last night, my kid ran away from home, etc.). Don't wait for your counselor to figure it out or find out about it on their own. They are there to help.

5. Expect to **call your counselor once every week day** to let them know how things are going (good or bad) so that you can "stay on the same page". Improvements in behavior come much more quickly when there are no communication gaps.

6. At the time of the scheduled therapy session please **be ready to sit down and work** on things. We want to respect your time and busy life. Our goal in MST is to "Get in, get busy and get out" providing enough help so that you can get on with your life. In order to do this everybody has to be ready to do some work.

7. We will be discussing **the 9 principles of MST** because we will use them to measure our progress as we work on the behaviors that brought your child into treatment. And you will be measuring your counselor on how well they implement the MST model in therapy.

8. Each Family will develop a **Crisis Plan** with their counselor. Our ultimate goal is to help each family (and especially parents) learn how to manage your own crises. If you are struggling call the crisis line and they will help you try again. If things still aren't working after multiple attempts then the Crisis counselor (Psych Social Liaison) will contact me.

9. Expect that we're going to be **acting out some of the scenarios** that have been problematic at home (or elsewhere). This helps us make healthy changes where the real problems exist.

10. Don't worry if some of the things we work on feel foreign to you, or you don't immediately see where they are going to help. Some things have to be learned sequentially, so it will kind of be like a "**Guided Mystery**", but things will begin to come together and make sense as we go along. Parents will get to coach their child through the same process.

SOME THINGS YOU CAN EXPECT IN MULTISYSTEMIC THERAPY:

11. Please **speak respectfully to each other** while in session. Your counselor will help when you don't.

12. **Every thing said in session is confidential** and family members are expected to maintain each others confidentiality unless the family agrees to share certain information in certain instances (such as telling the courts about healthy changes and progress made in therapy).

13. There are **exceptions to confidentiality**. Examples include:
    - If someone is in **danger of harming himself/herself** or **others**.
    - If someone is **incapable of caring for his or her own basic needs**.
    - If there is the **suspicion of child** or **elder abuse**.

    In some cases, the MST therapist may ask the family to participate in reporting such incidents.

14. Every family helps **create a Genogram** (a map of family relationships) in order to see how the relationships in the family are working and what things might be made healthier.

15. **Everyone is responsible for their own mental health**. (To parents: How you deal with your mental health affects how your child deals with theirs). Our ultimate goal is to support parents in teaching their children how to self manage their own mental health.

16. A good deal of **paperwork is necessary** in MST therapy. Thanks for your help in getting through it.

17. Your counselor will ask you to keep track of specific details while receiving MST services. Please **use the calendar** pages enclosed or the calendar of your choosing to monitor what changes take place on a daily basis. Use the calendar to keep track of what you discuss and decide upon with your counselor.

18. **Expect to expend a lot of effort**, especially in the beginning with increased monitoring of what your child is doing (positive and negative) and evaluation of how things are working as you try to make healthy changes.

19. Remember: **It's the parents' job to make the rules and the child's job to test the rules** (a developmental characteristic of adolescence). **Expect to be challenged** until your child knows you are serious about the new healthy changes.

20. When people start making healthy changes **things may feel like they are getting worse before they start to get better.** This is normal.

Denver, CO 80207

July 23, 2004

To Whom It May Concern:

I am writing to let you know how the family therapist from the University of Colorado Hospital has helped my family immensely. I am a single mother with two teenage children. At the time I started to receive the help, I was feeling like I could not survive the stresses of my life and my children. I needed help, but I did not know what to do. My family was recommended to receive help using a family therapist through the Multi Systemic Treatment (MST) program.

Before the help, I expected my children's behavior to change to what I needed and the expectation was immediate. When they did not have the behavior that I thought they should have, I would get very upset, yell at them, and have a fit because it was not going right for me. The problem was that I wanted the change right away, which was unrealistic. I just went around in circles with my children, and I was the one that was miserable.

The family therapist helped me to see that I had to go at it in little steps to get where I wanted. At first, I was not happy with this condition, but I was reminded repeatedly that it was not working the way I had done it before. I realized this was so true. As I got used to the process of little steps, I knew it was the only way I could go. The MST was there to counsel me and, most importantly, to give support whenever I did well or fell short of my expectations.

Another problem that I encountered was inconsistency with my children. They thought that they could pretty much do what they wanted. Yes, I would rant and rave, but then I would give up and do nothing else. I was inconsistent because at the time I was working, going to college, and trying to discipline two teenagers without any structure in this whole process. My thoughts were that I could not continue with all the things going on in my life. I learned from the therapist that again it is done in little steps and to pick which battles were more important to me.

The most important thing that I learned is to reward my children. This was hard for me because I wanted my children to help, but I was unsure how to get them to help and keep on helping. I saw that by rewarding my children for their good behavior, they would continue the behaviors. On the other hand, I learned not to give them what they asked for right away. I needed to expect something from them for their reward. They have also learned that they need to do something to help me to get what they want, even if it is a little task. I do admit, though, that I still forget to reward them for the things they do for me, but I am still working on it.

There are many ways the MST program has helped my family and especially myself. I just want to let you know that we needed this help more than I could have thought. I definitely would recommend that the program continue helping other families.

Thank you for listening,

PARENT OF MST CLIENT

CITY AND COUNTY OF DENVER

DENVER HUMAN SERVICES

Family and Children's Division

Accredited by Child Welfare League of America Since 1949

July 21, 2004

John W. Hickenlooper
Mayor

1200 FEDERAL BOULEVARD
DENVER, COLORADO 80204
TELEPHONE: 720/944-1098
FAX: 720/944-1716

July 21, 2004

Jon Steinmetz
University of Colorado Health Sciences Center
Multisystemic Therapy Services
4455 East 12th Avenue
Denver, CO 80220

Dear Mr. Steinmetz,

I am writing to state how University Multi Systemic Therapy (MST) is beneficial to adjudicated youth in the delinquency system. As a youth delinquency specialist for Denver Human Services, I have assessed and referred numerous delinquent youth for various services. The University of Colorado's Multisystemic Therapy approach is a treatment approach that is effectively works with helping children remain in the community while refraining from illegal behavior.

Often times the Courts and juvenile justice system utilize residential treatment facilities to contain children. The problem with this approach is that children eventually return to the same community and family and the issues have not been address in that environment. The result is that recidivism rates for these delinquent youth are high. These children often end up in another residential treatment center or the Division of Youth Corrections at a high cost to tax payers. MST is cost effective, has low recidivism rates based on empirical data and is most importantly best for children and the community.

MST is able to identify weaknesses or areas that are missed in an extremely complicated system. The program enhances communication between numerous people in the system including probation, social services, Court, treatment providers, schools, physicians, and family. The program is effective at maintaining high risk children in their homes while maintaining safety for the community. This program is effective because it works with everyone involved with the child's life and is physically located in the environment where the family will live when the system leaves their life. This results in children remaining in the home and community with a lower risk of re-offending.

An example of a successful case I have worked with Dr. Randy Braley was a youth who was an adjudicated sex offender with a weapons charge. When I read the file on this case, I was concerned that the child was in the community with in home services. It seemed too high of a risk to maintain the child in the community. I reluctantly agreed to try this and have been pleasantly surprised by how effective MST was. Dr. Braley was able to look at the concrete

services and how the structure of the child's day was impacting the child and community safety. Dr. Braley communicated with probation, social services, school, and the family to identify gaps in supervision and needs for the child to be successful. The child has since turned eighteen, successfully completed MST. The child is in compliance with probation and will likely successfully complete probation.

I have since referred numerous cases to MST services and believe it is the most efficient and effective treatment approach available for youth in the juvenile justice system. It would behoove the entire system who works with adjudicated delinquents to utilize a less expensive model that has outcome measures that support children remaining in their homes and communities while behaving in a fiscally responsible manner.

Sincerely yours,

Susan Radaelli, MSW
Senior Social Caseworker
Denver Department of Human Services
720-944-1098

MULTISYSTEMIC THERAPY

Program Overview

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

Program Targets:

MST targets chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement, and the offenders' families.

Program Content:

MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded. MST strives to promote behavior change in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.

The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Intervention strategies are integrated into a social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

MST is provided using a home-based model of services delivery. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists have low caseloads), and enhances the maintenance of treatment gains. The usual duration of MST treatment is approximately 60 hours of contact over four months, but frequency and duration of sessions are determined by family need.

Program Outcomes:

Evaluations of MST have demonstrated:

- ✓ reduced long-term rates of criminal offending in serious juvenile offenders,
- ✓ reduced rates of out-of-home placements for serious juvenile offenders,
- ✓ extensive improvements in family functioning,
- ✓ decreased mental health problems for serious juvenile offenders

Costs:

MST has achieved favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services, such as incarceration and residential treatment. The cost in one major clinical trial was $4,000 per youth, converted to 1996 dollars, compared to $10,000 per youth in usual services.

When it comes to violence prevention...

U.S. Surgeon General Blueprints agree

MODEL (EFFECTIVE) PROGRAMS & STRATEGIES

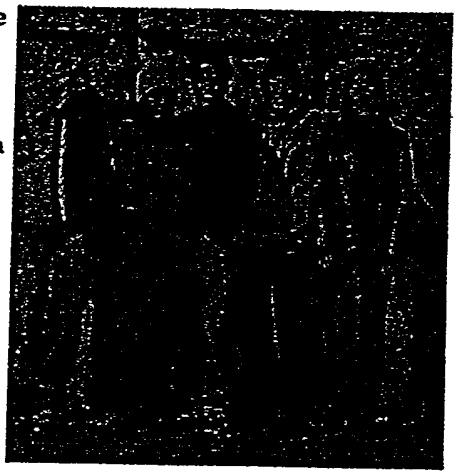
- **Multisystemic Therapy (MST)** - an intensive family- and community based treatment that addresses multiple determinants of antisocial behavior.
- **Multidimensional Treatment Foster Care (MTFC)** - multisystemic clinical intervention targeting teens with histories of chronic and severe criminal behavior as an alternative to incarceration, group or residential treatment, or hospitalization.
- **Functional Family Therapy (FFT)** - a multi-step, phasic intervention of direct service for youths and their families.
- **Nurse-Family Partnership (NFP)** - effective family-based approach to preventing youth violence, in which a nurse provides support through home visitation.

INEFFECTIVE PROGRAMS & STRATEGIES

- **Boot camps**—boot camps produced no significant effects on recidivism
- **Residential programs**—interventions that take place in psychiatric or correctional institutions show little promise of reducing subsequent crimes and violence in delinquent youths.
- **Waivers to adult court**—evaluations of these programs suggest that they increase future criminal behavior rather than deter it.
- **Shock programs**—numerous studies of Scared Straight have demonstrated that the program does not deter future criminal activities.

Several popular juvenile justice approaches to preventing further criminal behavior in delinquent youths have been shown to be consistently **ineffective.**

Blueprints for Violence Prevention at the Center for the Study and Prevention of Violence and the U.S. Surgeon General agree that the majority of juvenile justice programs available are ineffective and limiting in their results.



In addition to their agreement about ineffective strategies available through the system, they also agree that there are model programs and strategies available for our at-risk youth. Both have thoroughly examined violence prevention programs and have identified those programs that serve as model programs for our communities.

The identification of effective programs has been in the forefront of the national agenda on violence prevention for the last decade. Federal funding agencies have increasingly emphasized the need to implement programs that have been demonstrated effective. The emphasis on research-based practices has led communities to search for the best practices and to determine what types of programs would be most effective and appropriate for their problems and population. As a result, identifying effective prevention and intervention programs has become a top priority for both federal and private agencies. (*Blueprints for Violence Prevention Replications: Factors for Implementation Success, 2002*)

Best Practices for Violence Prevention as indicated by U.S. Surgeon General and Blueprints for Violence Prevention
Multisystemic Therapy (MST)
Multidimensional Treatment Foster Care (MTFC)
Functional Family Therapy (FFT)
Nurse-Family Partnership (NFP)

To read the reports, visit www.surgeongeneral.gov/library/youthviolence & www.colorado.edu/cspv/blueprints.

For information about the model programs listed above, contact Evidence-based Associates at info@evidencebasedassociates.com.

Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Shay Bilchik, Administrator
May 1997
JUVENILE JUSTICE BULLETIN

Treating Serious Anti-Social Behavior in Youth: The MST Approach

Scott W. Henggeler, Ph.D.

The Multisystemic Therapy (MST) approach to the treatment of serious antisocial behavior in adolescents represents a significant departure from more traditional strategies. MST is a home-based services approach that was developed in response to the lack of scientifically proven, cost-effective treatment.

The majority of funding currently available for children's mental health needs in the United States is spent on expensive out-of-home placements such as residential treatment facilities, psychiatric inpatient treatment, or incarceration. However, no scientific evidence has shown that these treatments are effective in ameliorating or reducing the serious behavioral difficulties demonstrated by juvenile offenders. Other less restrictive treatments that do not involve out-of-home placements, such as outpatient or clinic-based services, also have failed to demonstrate desired levels of effectiveness. Furthermore, research on adolescent substance abuse has failed to substantiate the effectiveness of any treatment in curtailing that problem. Thus, MST was developed as a means to provide scientifically validated, cost-effective, community-based treatment as a viable alternative to expensive, ineffective treatments that have traditionally been provided to youth with serious behavior disorders.

This Bulletin highlights evaluations of several programs that have implemented the MST approach. In particular, success demonstrated by the Simpsonville, South Carolina, program has led to major funding by the National Institute of Mental Health (NIMH)—targeting violent and/or chronic juvenile offenders and youth with serious emotional disturbance—and the National Institute on Drug Abuse—targeting substance-abusing delinquents. The Bulletin also includes an overview of federally funded controlled evaluations of MST projects that are currently under way.

The MST Treatment Approach

Program Overview

The goal of the MST approach is to provide an integrative, cost-effective family-based treatment that results in positive outcomes for adolescents who demonstrate serious antisocial behavior. MST focuses first on improving psychosocial functioning for youth and their families so that the need for out-of-home child placements is reduced or eliminated. To accomplish this task, MST

From the Administrator

Traditional mental health approaches for serious, violent, and chronic juvenile offenders have all too often failed to yield the successful results we desire. Adolescent drug and substance abuse has also proven to be remarkably resistant to treatment.

The multisystemic therapy (MST) approach was designed to provide communities with affordable and effective remedies for these difficult problems. Best of all, MST offers new hope to young people with serious behavioral disorders.

If we are going to help troubled youth, we must strengthen the support systems that surround them so that they may continue to benefit long after immediate intervention has ended. With its focus on family preservation through home-based services, MST shows real promise of achieving such lasting results.

This Bulletin features evaluations of programs that have implemented the MST approach. Of particular interest is the Simpsonville, South Carolina, program, which services serious, violent, and chronic juvenile offenders at imminent risk of out-of-home placement. The Simpsonville program has significantly reduced recidivism rates at substantial savings in terms of both human and financial considerations.

I am pleased to share this excellent program design with the juvenile justice field.

Shay Bilchik
Administrator

addresses the known causes of delinquency on an individualized, yet comprehensive, basis. MST interventions, therefore, focus on the individual youth and his or her family, peer context, school/vocational performance, and neighborhood/community supports. For example:

- Family interventions often seek to promote the parent's capacity to monitor and discipline the adolescent—MST counselors must determine the barriers to effective parental discipline and intervene accordingly. Commonly observed barriers include parental drug abuse, psychiatric conditions, and low social support.
- The central thrust of MST peer interventions is to remove offenders from deviant peer groups and facilitate their development of friendships with prosocial peers, with the parent viewed as the key to accomplishing such goals.
- School and vocational interventions seek to enhance the youth's capacity for future employment and financial success.

Across all interventions, MST attempts to change the real-world functioning of youth by changing their natural settings—home, school, and neighborhood—in ways that promote prosocial behavior while decreasing antisocial behavior.

Program Results

MST defines success in terms of reduced recidivism rates among participating youth, improved family and peer relations, decreased behavioral problems, and decreased rates of out-of-home placements. Research has demonstrated that MST is more effective than usual community treatment for inner-city juvenile offenders, specifically in improving intrafamilial relations and decreasing youth behavioral difficulties.

In addition, recent research indicates that when compared with youth who received "usual services"—court-ordered stipulations such as curfew, school attendance, and participation in various agency programs that were typically monitored by probation officers—youth who received MST had fewer arrests, reported fewer criminal offenses, and spent an average of 10 fewer weeks in detention during a 59-week followup.

Results from other followup studies indicate that the effects of MST treatment are long lasting, with reduced recidivism rates for sexual and criminal offenders who received MST versus individual outpatient counseling. Ongoing research is also evaluating the effectiveness of MST in community settings and with other difficult populations—adolescent substance abusers and youth with serious psychiatric emergencies such as suicidal, homicidal, or psychotic presentations.

MST's program strengths include its cost-effectiveness, proven success in treating difficult clinical populations, and relative ease of implementation across geographic locations and community agencies.

The Family Preservation Model of Service Delivery

Philosophy

MST's family preservation model of service delivery is based on the philosophy that the most effective and ethical route to helping children and youth is through helping their families. MST views families as valuable resources, even when they are characterized by serious and multiple needs. Services are directed toward the psychological, social, educational, and material needs that face families in which a child is in imminent danger of out-of-home placement.

Service Delivery Approach

While the particular treatment modalities used in family preservation programs vary, certain critical service delivery characteristics, described below, are shared by all of them. Summarized in table 1, these characteristics distinguish treatment programs delivered in a family preservation model from traditional mental health and juvenile justice services.

- **Length of Service.** Service duration ranges from 3 to 5 months in MST, with the average duration of treatment being approximately 60 hours of contact over 4 months, with the final 2 to 3 weeks involving less intensive contact to monitor the maintenance of therapeutic gains.

Table 1: Differences Between Traditional Mental Health Services and Family Preservation Using Multisystemic Therapy

Service Element	Traditional Services	Family Preservation
Treatment Sites	In the clinic (outpatient) In the hospital, RTC* (inpatient)	In the field (home, school, neighborhood, community)
Treatment Modality	Individual psychotherapy Group therapy Medication	Total care
Provider	Individual clinician (outpatient) Multidisciplinary teams (inpatient)	Generalist team
Clinical Staff: Patients	1:60–100 (outpatient) Varies in inpatient settings	1:4–6
Staff Availability	Working office hours (outpatient) Highly variable (inpatient)	Team available 24 hrs/7days/week
Frequency of Contact	Weekly or biweekly (outpatient) Highly variable (inpatient)	Daily in most cases
Family Contact	Occasional	Daily in most cases
Treatment Outcome	Responsibility of patient and family	Responsibility of staff
Case Management	Broker of services	Services provider
Expectations of Outcome	Gradual change	Immediate, maximum effort by staff and family to attain goals

*RTC = Residential Treatment Centers

Tuesday, February 01, 2005 (3).max

- **Staffing Pattern.** A typical staffing pattern for the provision of intensive home-based MST is a treatment team consisting of one doctoral-level supervisor and three to four master-level therapists, with each therapist carrying a caseload of four to six families. Each youth referred to the program is assigned a therapist who designs individualized interventions in accordance with MST treatment principles that address specific needs of the youth and family. Each treatment team provides services for about 50 families per year.
- **Hours of Service.** Staff are available 24 hours per day, 7 days per week, and can usually meet at the families' convenience, resulting in many evening and weekend appointments. In consideration of treatment efforts to empower families to solve their own problems and the attenuation of counselor burnout, however, use of services at unusual times (e.g., 10 p.m. to 8 a.m.) is discouraged except in cases of emergency.
- **Location of Services.** MST is typically delivered in home and community settings to increase cooperation and enhance generalization. Sessions are usually held in the family's home at a convenient time, although meetings in community locations, such as a school, recreation center, or project office, are often needed. Moreover, the specific family members who attend will vary with the nature of the particular problem that is being addressed (e.g., youth are usually not included in sessions that address lax parental discipline, so as not to undermine parental authority).

Training

Training in the MST model of family preservation is provided in the following ways:

1. Five days of introductory training are provided for all staff who will engage in treatment and/or clinical supervision of MST cases to familiarize participants with the scope, correlates, and causes of the serious behavior problems addressed with MST; describe the theoretical and empirical underpinnings of MST; describe family, peer, school, and individual intervention strategies used in MST; train participants to conceptualize cases and interventions in terms of MST principles; and provide participants with practice in delivering multisystemic interventions.

2. Quarterly booster sessions are designed to provide training in special topics, such as marital therapy, treatment of parental depression, or early childhood intervention, and to address issues that may arise for individuals and agencies using the approach. Booster sessions are also designed to allow discussion of particularly difficult cases.
3. Weekly telephone consultations via 1-hour conference calls allow the treatment team and supervisor to consult with an MST expert regarding case conceptualization, goals, intervention strategies, and progress. Such ongoing consultation is critical for maintaining therapist adherence to the MST treatment protocol.

In South Carolina, the Family Services Research Center (FSRC) is under contract with the South Carolina Department of Health and Human Services to provide training and consultation services to public and private providers of Medicaid-reimbursed home-based treatment services. FSRC is responsible for conducting certification reviews of these providers to ensure compliance with Medicaid standards.

Training in MST using home-based services is also provided to sites outside South Carolina. Several training sites involve randomized trials and pilot projects in State and county agencies (e.g., departments of juvenile justice, mental health, and social services). Training and quality assurance are provided to out-of-State entities by MST Services, Inc., of Charleston, South Carolina.

The Simpsonville, South Carolina, Project

Funded by NIMH, Henggeler et al. conducted an evaluation of the Simpsonville, South Carolina, MST program, which used the family preservation model of service delivery. Participants were 84 violent and chronic offenders at imminent risk of out-of-home placement and their families, who had multiple needs. Each offender had at least one felony arrest (54 percent had been arrested for violent crimes). The mean number of arrests was 3.5, and the average number of weeks of prior placement in correctional facilities was 9.5. The average age of the juveniles was 15.2 years, 77 percent were male, and the average social class score was 25 (i.e., semiskilled workers). Twenty-six percent of the offenders lived with neither biological parent. Fifty-six percent were African American, and the remainder were Caucasian.

In a rigorous, controlled evaluation, youth were randomly assigned to receive either MST using family preservation ($n = 43$) or usual services from the Department of Youth Services ($n = 41$). These usual services included incarceration and/or referral for mental health, educational, or vocational services. The MST therapists were three master-level counselors with an average of 2 years of experience and caseloads of four families each. The average duration of treatment was 13 weeks. Assessment batteries, composed of standardized measurement instruments, were administered pre- and posttreatment.

Findings indicate that MST, using family preservation, was more effective than usual services at reducing long-term rates of criminal behavior and also considerably less expensive. At the 59-week postreferral followup, youth receiving MST had significantly fewer rearrests (averages = .87 versus 1.52) and weeks incarcerated (averages = 5.8 versus 16.2) than did youth receiving usual services. Results at a 59-week followup are shown in figure 1, with numbers representing the average for each treatment condition. Moreover, standardized evaluations showed that families receiving MST services, compared with offenders receiving

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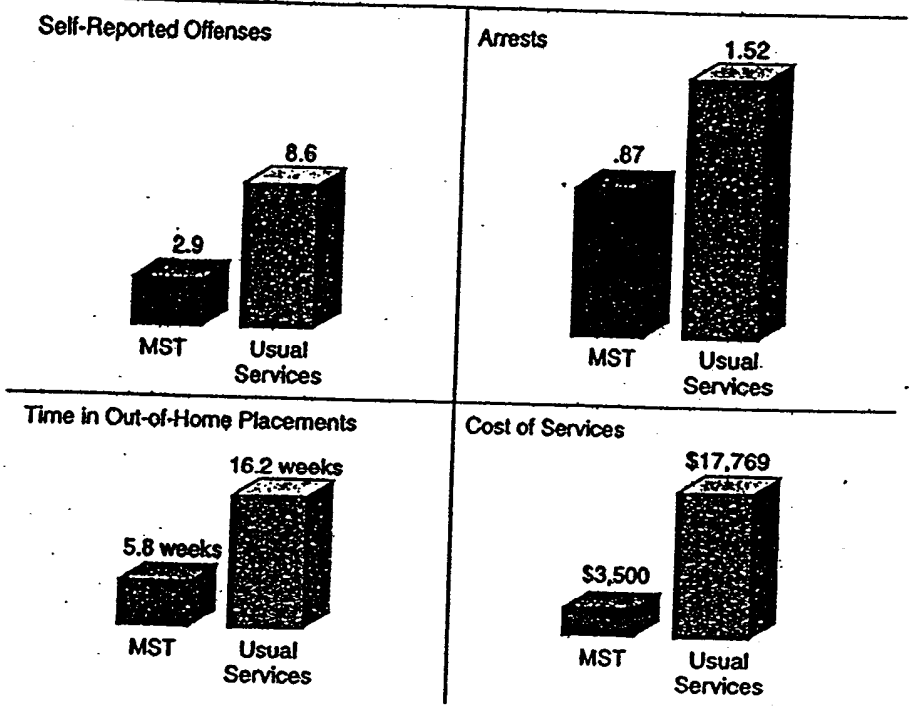
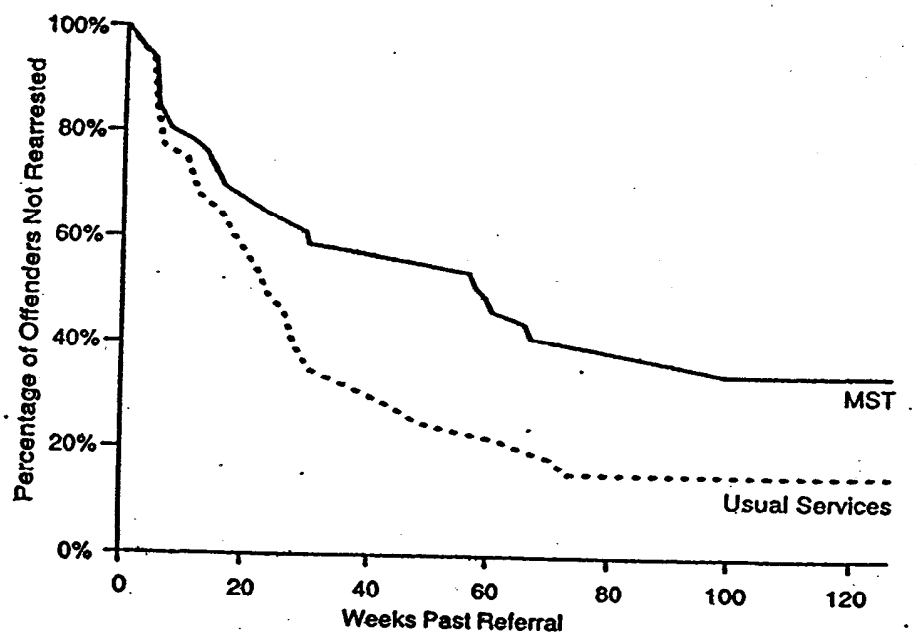
Figure 1: 59-Week Followup



usual services, reported increased family warmth and cohesion and decreased youth aggression with peers. In addition, youth receiving MST reported less criminal activity than their counterparts receiving usual services.

Figure 2 shows that positive results for MST were maintained to a 2.4-year followup. MST essentially doubled the percentage of youth not rearrested at the long-term followup.

Figure 2: Simpsonville, South Carolina, Project: Survival Analysis



The relative efficacy of MST was neither moderated by demographic characteristics—race, age, social class, gender, arrest, and incarceration history—nor mediated by psychosocial variables—family relations, peer relations, social competence, behavior problems, and parental symptomatology. Thus, MST was equally effective with youth and families of divergent backgrounds.

The findings of this evaluation support the short- and long-term efficacy of MST with serious juvenile offenders and their families. In addition, despite its intensity, MST was a relatively inexpensive intervention. With a client-to-therapist ratio of 4 to 1 and a course of treatment lasting 3 months, the cost per client for treatment in the MST group was about $3,500, which compares favorably with the average cost of institutional placement in South Carolina of $17,769 per offender.

Results of the Simpsonville project, combined with other evaluations discussed below, strongly support MST's effectiveness with types of behavior problems that traditionally are regarded as highly resistant to change. MST has proven effective with chronic juvenile offenders and adolescent sexual offenders in studies conducted in Missouri, and abusive and neglectful families and inner-city delinquents in studies conducted in Memphis.

In each of the following additional controlled outcome studies conducted by Henggeler et al., the samples included both genders and high percentages of economically disadvantaged and minority families.

Evaluations of Other MST Programs

Columbia, Missouri

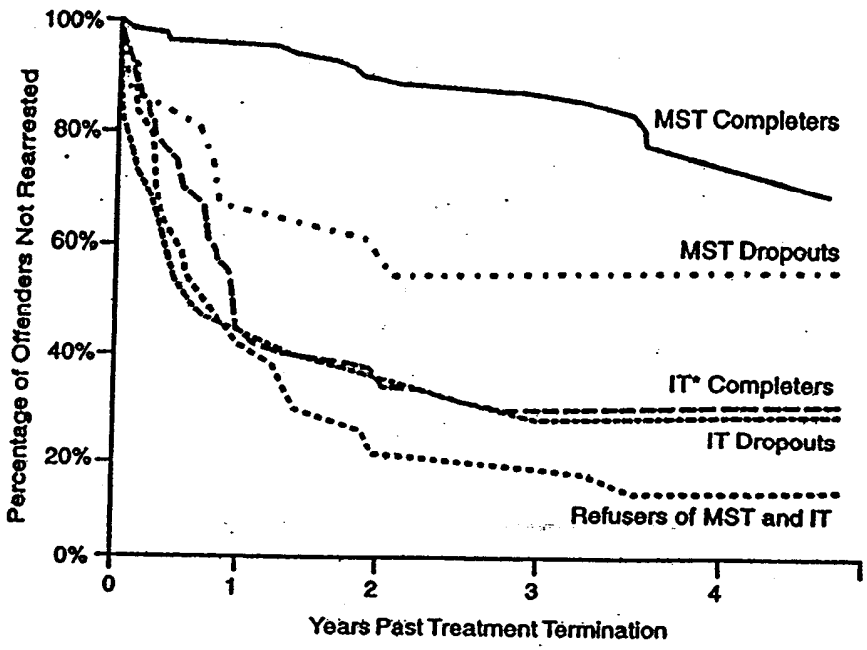
MST With Adolescent Sexual Offenders, 1990. The first controlled outcome evaluation conducted with adolescent sexual offenders to appear in the literature compared MST with individual outpatient counseling. Recidivism data approximately 3 years after treatment showed that significantly fewer participants had been rearrested for sexual crimes (12.5 percent versus 75 percent) and that the frequency of sexual rearrests was significantly lower in the MST condition (average = .12) than in the individual counseling condition (average = 1.62). Moreover, the frequency of rearrest for

nonsexual crimes was greater for adolescents who received individual counseling (average = 2.25) than for the adolescents who received MST (average = .62). Findings from this study should be considered tentative because the sample size was only 16 sexual offenders. A more extensive replication study is currently being prepared in South Carolina.

MST With Chronic Juvenile Offenders, 1995. This study examined the long-term effects of MST versus individual therapy (IT) on the prevention of criminal behavior and violent offending among 176 juvenile offenders at high risk for committing additional serious crimes. Results from multiagent, multimethod assessment batteries conducted pretreatment and posttreatment showed that MST was more effective than IT in improving key family correlates of antisocial behavior and in ameliorating adjustment problems in individual family members.

Moreover, a 4-year followup of rearrest data showed that MST was more effective than IT in preventing future criminal behavior, including violent offending. For example, 4-year recidivism was 22 percent for youth who received MST compared with 72 percent for youth who received IT and 87 percent for youth who refused to participate in either treatment (figure 3).

Figure 3: Columbia, Missouri, Delinquency Project: Survival Analysis



*Individual Therapy

Memphis, Tennessee

MST With Inner-City Juvenile Offenders, 1986. This study evaluated the efficacy of MST compared with usual community treatment for inner-city juvenile offenders and their families. At posttest, the adolescents who received MST evidenced significant decreases in conduct problems, anxious-withdrawn behaviors, immaturity, and association with delinquent peers, based on maternal reports.

Observational measures showed that mother-adolescent and marital relations in these families were significantly warmer, mother-adolescent interactions were less aggressive, mothers' interactions were more supportive, and adolescents were significantly more involved in family interactions. In contrast, families who received usual community treatment evidenced no positive changes and showed deterioration in observed affective family relations.

MST Versus Behavioral Parent Training in the Treatment of Child Abuse and Neglect, 1987. This study randomly assigned abusive families and neglectful families either to MST or behavioral parent training. At posttest, parents who received either treatment showed reduction in emotional distress, overall stress, and severity of identified problems. Analyses of sequential observational measures, however, showed that MST was more effective than parent training at restructuring parent-child relations in those behavior patterns that differentiate maltreating families from nonproblem families.

Following MST, maltreating parents controlled their children's behavior more effectively, maltreated children exhibited less passive noncompliance, and neglecting parents became more responsive to their children's behavior.

Simpsonville, South Carolina, and Columbia, Missouri

The Effects of MST on Substance Use and Abuse in Juvenile Offenders, 1991. Data from two independent evaluations of the efficacy of MST in treating serious juvenile offenders focused specifically on reductions in substance use and abuse. Arrest data in the Missouri project collected for an average of 4 years of posttreatment showed that youth who participated in MST had a significantly lower rate of substance-related arrests than youth who participated in individual counseling (4 percent versus 16 percent). Similarly, in the Simpsonville project, youth in the MST condition reported significantly less soft-drug (alcohol and marijuana) use at posttreatment than did youth who received usual services.

Federally Funded Projects Under Way

Charleston, South Carolina

MST With Substance Abusing/Dependent Delinquents, 1992–1997. This project, funded by the National Institute on Drug Abuse, is evaluating the effectiveness of MST with substance abusing/dependent delinquents and their families in comparison with usual community services. In its fifth year of funding, the project has randomly assigned 118 substance abusing/dependent youth to treatment conditions, and preliminary findings are quite positive. Fully 98 percent of families assigned to the MST condition have completed a full course of treatment, whereas only

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22 percent of families assigned to usual services received any substance abuse or mental health services during their first 5 months in the program.

Data analyses show that, in comparison with delinquents and families receiving usual services, youth in the MST condition evidenced decreased substance use at posttreatment and had 26 percent fewer rearrests and a 40-percent reduction in days incarcerated at an approximately 1-year followup.

Moreover, cost analyses have shown that the costs of MST were nearly offset by savings incurred as a result of reductions in days of out-of-home placement during the year following referral.

MST Using Family Preservation as an Alternative to the Hospitalization of Youth Presenting Psychiatric Emergencies, 1994–1999. This NIMH-funded study evaluates MST as a family-based alternative to the costly and clinically unproven practice of hospitalizing youth presenting psychiatric emergencies such as psychosis and threats of suicide and homicide. Community-based emergency psychiatric services are being blended with MST to safely prevent hospitalization and reduce the symptoms and environmental factors precipitating the crisis. Analyses will focus on the clinical- and cost-effectiveness of this blending.

Blending MST With the Community Reinforcement Approach in Treating Substance Abusing Parents of Young Children, 1996–1998. In collaboration with State substance abuse and mental health authorities and funded by the Center for Mental Health Services, the Family Services Research Center is conducting a quasi-experimental evaluation of an innovative treatment and service delivery model targeting substance-abusing parent figures of young children. The treatment service is based on ecological models of behavior and blends crucial components of MST, the community reinforcement approach, and innovations that have occurred at the local level in treating adult substance abusers.

The Charleston Collaborative Project: A Family-Based Approach to the Safe and Efficacious Reunification of Abused and Neglected Children With Their Families, 1996–1997. Several local and State agencies are collaborating to develop effective family-based services for children who have been taken into custody because of abuse or neglect. Funded by the South Carolina Department of Health and Human Services, the Family Services Research Center is conducting a randomized evaluation of the clinical- and cost-effectiveness of these services.

Orangeburg and Spartanburg, South Carolina

MST Using Family Preservation With Serious Juvenile Offenders Living in Rural Areas, 1991–1997. Funded by NIMH, this study examined the effects of MST on treating violent and chronic juvenile offenders and their families in the absence of ongoing treatment fidelity checks. Across two public sector mental health sites, 155 youth and their families were randomly assigned to MST versus usual juvenile justice services. Although MST improved adolescent symptomatology at posttreatment and decreased incarceration by 47 percent at a 1.7-year followup, findings for decreased criminal activity were not as favorable as observed on other recent trials of MST.

However, analyses of parent, adolescent, and therapist reports of MST treatment adherence indicated that outcomes were substantially better in cases where treatment adherence ratings were high. These results, which are expected to be published later this year, highlight the importance of maintaining treatment fidelity when disseminating complex family-based services to community settings.

Sumter, South Carolina

Meeting the Mental Health and Substance Abuse Needs of Pregnant Adolescents and Adolescent Parents, 1996–2000. In collaboration with Sumter School District 17 and funded by the Head Start Bureau of the U.S. Department of Health and Human Services Administration on Children, Youth and Families, FSRC is conducting a qualitative and quantitative evaluation of a program of integrated substance abuse, mental health, primary care, and educational/vocational services for pregnant adolescents and adolescent parents.

Conclusion

MST has demonstrated decreased criminal activity and incarceration in studies with violent and chronic juvenile offenders, and results are promising in studies of other populations that present complex clinical problems. The success of MST is based on several factors, including its emphasis on addressing the known causes of delinquency; the provision of treatment services where the problems are—in home, school, and community settings; and a strong focus on issues of treatment adherence and program fidelity.

Recognizing the viability of the MST approach, OJJDP will be funding the University of South Carolina Consortium on Children, Families, and the Law to produce materials that will guide the establishment of supervisory and organizational structures necessary to develop, maintain, and evaluate effective MST programs. The consortium will create startup, supervisory, and organizational manuals and measurement methods that promote MST treatment fidelity, and will establish MST programs in several new sites. This project will help to provide a means for effective, large-scale dissemination and evaluation of the MST model.

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