CSEC Lunch & Learn

Multisystemic Therapy

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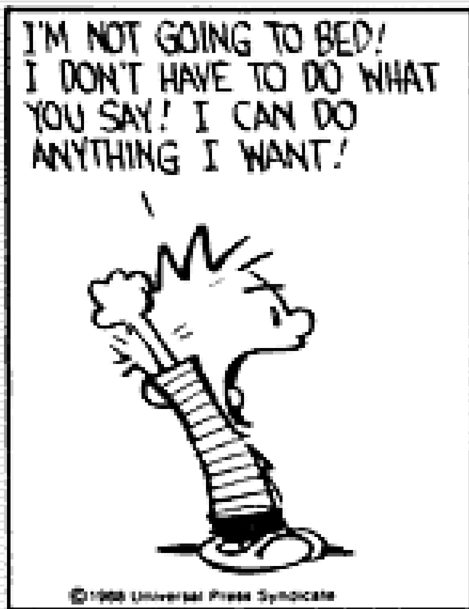
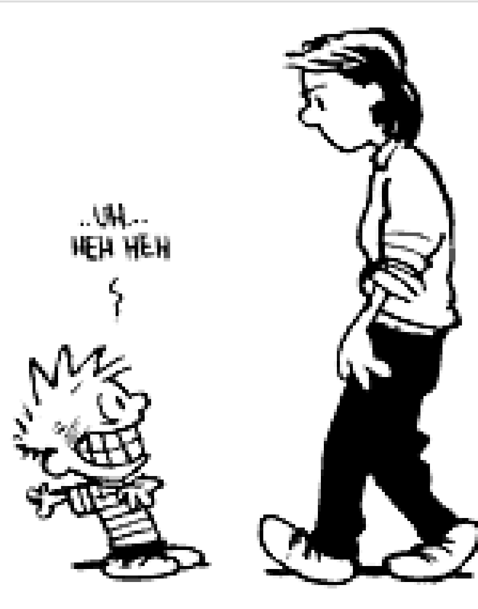
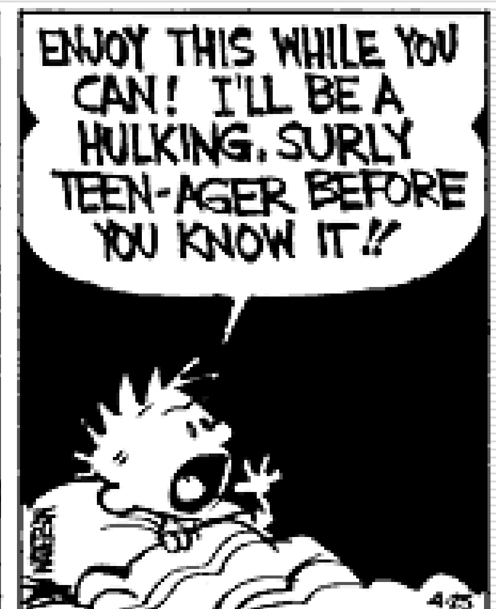
MST
Services

Our youth now love luxury. They have bad manners, contempt for authority, they show disrespect for their elders … they contradict their parents."

Socrates (c. 470-399 BC)


I'M NOT GOING TO BED! I DON'T HAVE TO DO WHAT YOU SAY! I CAN DO ANYTHING I WANT!

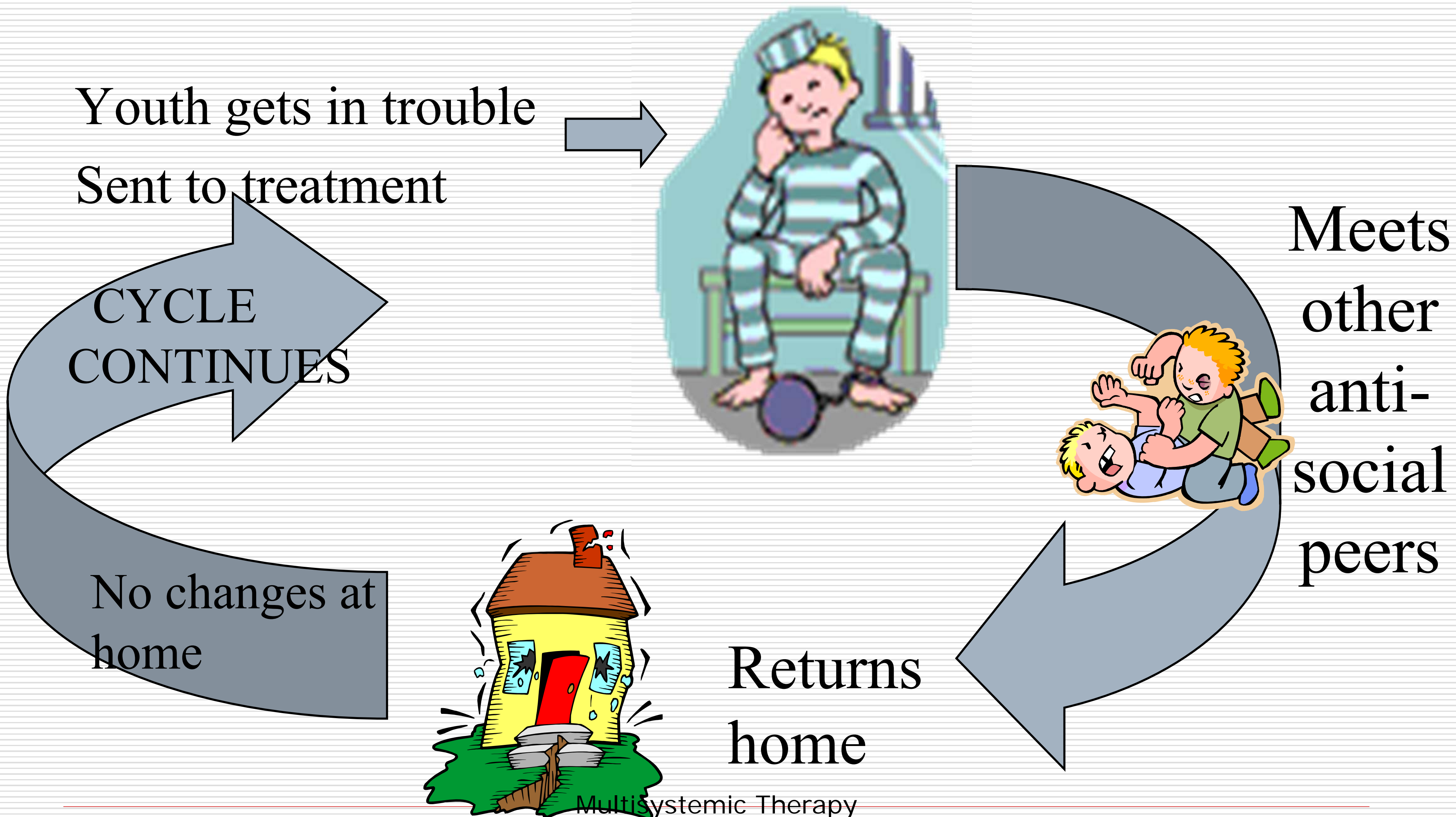

..UH.. HEH HEH


ENJOY THIS WHILE YOU CAN! I'LL BE A HULKING, SURLY TEEN-AGER BEFORE YOU KNOW IT!!

How would you work with?

- 15 year old who refuses to go to school?
- 15 year old who refuses to go to school due to bullying?
- 15 year old who refuses to go to school because s/he was the babysitter for his/her baby brother
- 15 year old who refused to go to school because s/he was dealing drugs?
- 15 year old who refused to go to school because s/he wasn't getting up in the morning
  - --going to bed late at night playing video games
  - --Parents having parties late at night?

What usually happens to youth?



What is “MST”?

- Community-based, family-driven treatment for antisocial/delinquent behavior in youth
- Focus is on “Empowering” caregivers (parents) to solve current and future problems
- MST “client” is the entire ecology of the youth - family, peers, school, neighborhood
- Highly structured clinical supervision and quality assurance processes

Standard MST Referral Criteria (ages 12-17)

Inclusionary Criteria

- Youth at risk for placement due to anti-social or delinquent behaviors, including substance abuse
- Youth involved with the juvenile justice system
- Youth who have committed sexual offenses in conjunction with other anti-social behavior

Exclusionary Criteria

- Youth living independently
- Sex offending in the absence of other anti social behavior
- Youth with moderate to severe autism
  (difficulties with social communication, social interaction, and repetitive behaviors)
- Actively homicidal, suicidal or psychotic
- Youth whose psychiatric problems are primary reason leading to referral, or have severe and serious psychiatric problems

Families as the Solution

- **MST focuses on families as the solution**
- **Families are full collaborators in treatment planning and delivery with a focus on family members as the long-term change agents**
- **Giving up on families, or labeling them as “resistant” or “unmotivated” is not an option**
- **MST has a strong track record of client engagement, retention, and satisfaction**

How Does MST Work?

Key Points:

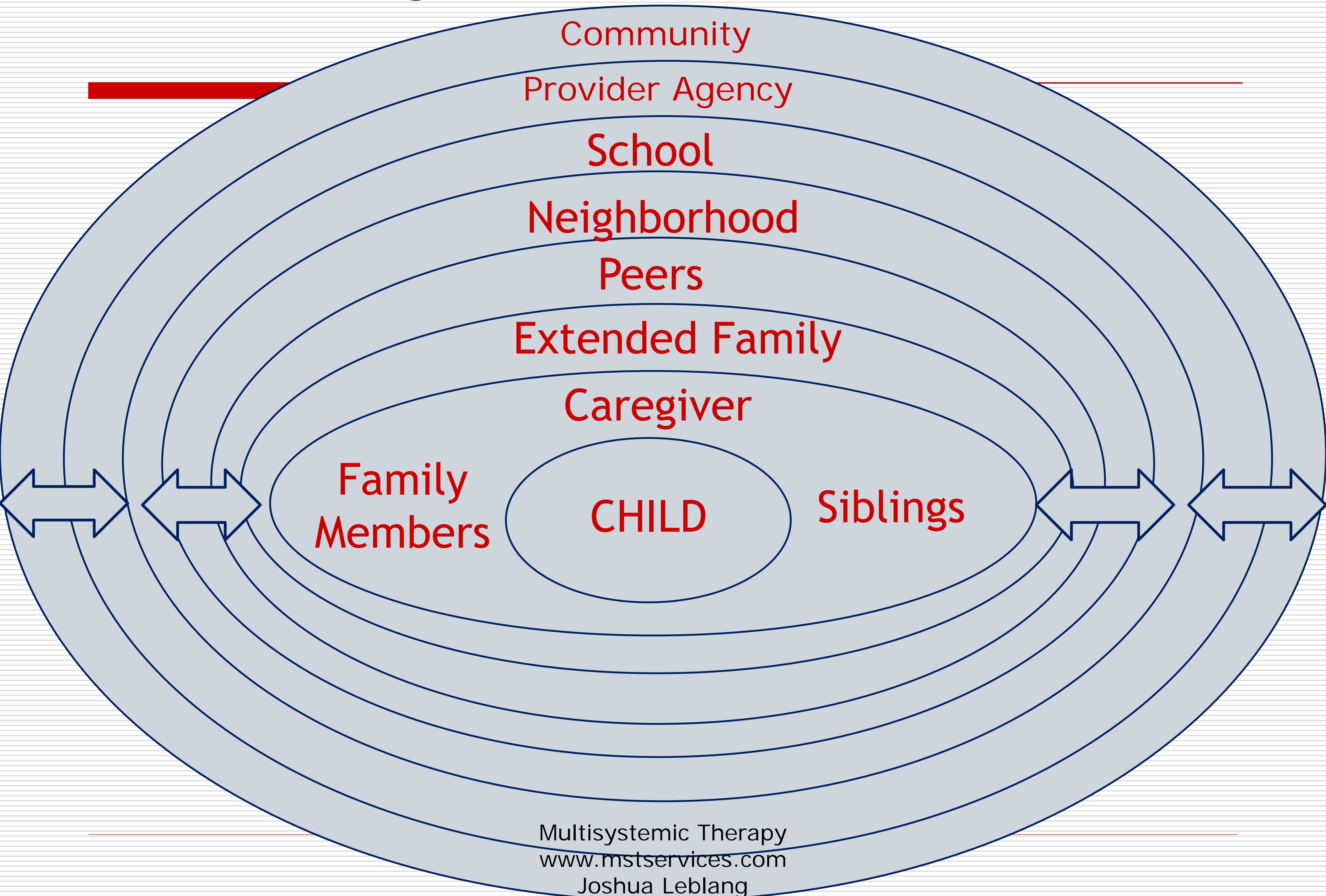
- Theoretical And Research Underpinnings
- MST Theory of Change and Assumptions
- How is MST Implemented?

Theoretical Underpinnings

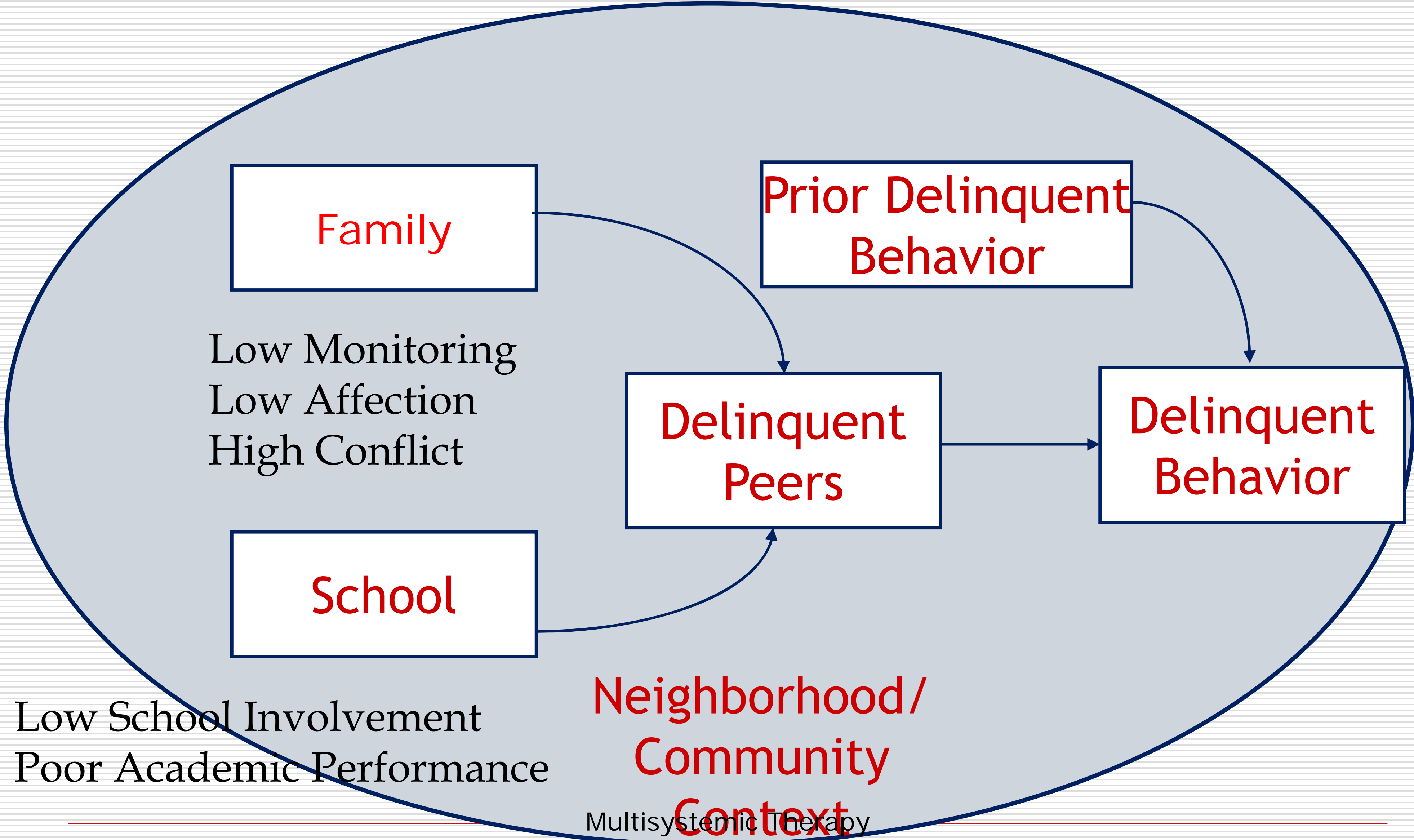
Based on social ecological theory of Uri Bronfenbrenner

- Children and adolescents live in a social ecology of interconnected systems that impact their behaviors in direct and indirect ways
- These influences act in both directions (they are reciprocal and bi-directional)

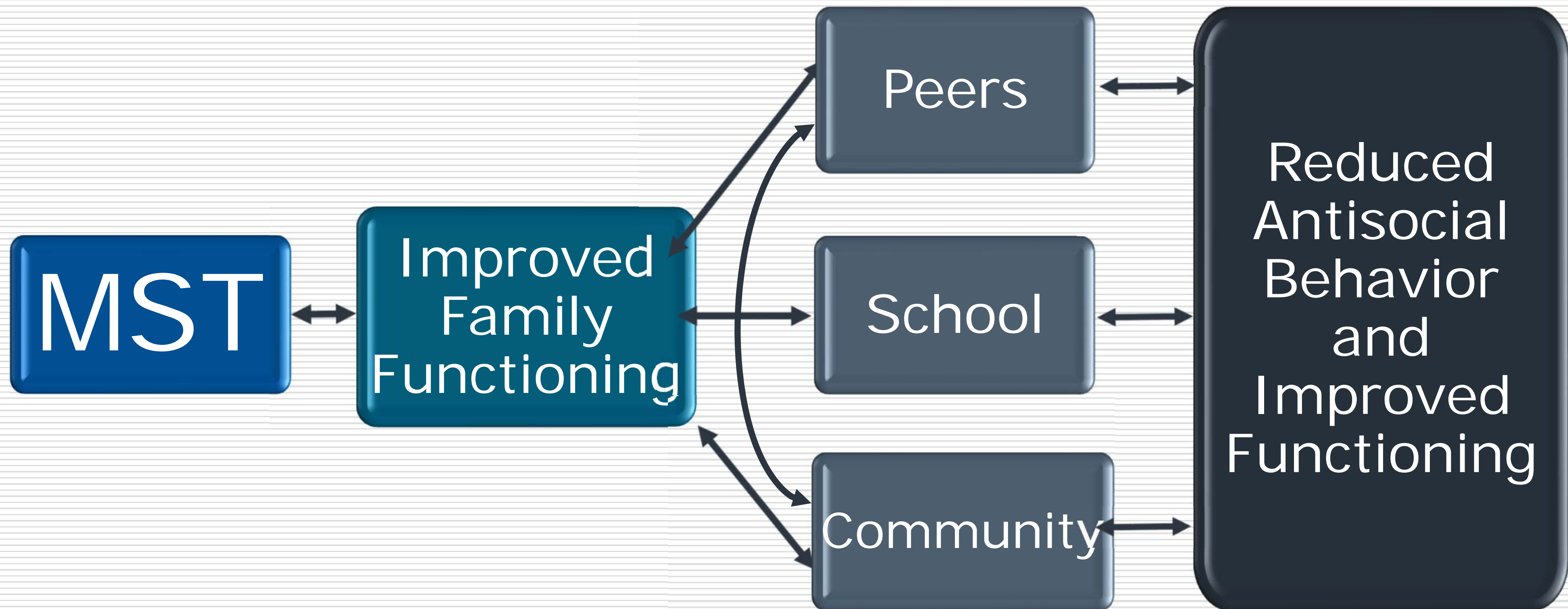
Social Ecological Model



Causal Models of Delinquency and Drug Use: Common Findings of 50+ Years of Research



MST Theory of Change



MULTISYSTEMIC THERAPY

- Youths' behaviors are influenced by their families, friends, and communities (and vice versa).
- Families are the key to success, so all aspects of treatment are designed with full collaboration from the family.
- Change can happen quickly, but it demands daily and weekly efforts from the youth and all the important people in his/her life.
- Families can live successfully without involvement in social service agencies.

How is MST Different?

- **Discipline:** Offers a combination of "best practice" treatments within a disciplined structure
- **Accountability:** At all levels, providers are held accountable for outcomes through MST's rigorous quality assurance system
- **Ecological validity:** Working in the youth's natural environment with existing family supports, thereby ensuring cultural sensitivity
- **Focus on long-term outcomes:** Empowerment of caregivers to manage future difficulties; focus on sustainability

How Does MST "Work?"

Intervention strategies: MST draws from research-based treatment techniques

- Behavior therapy
- Parent management training
- Cognitive behavior therapy
- Pragmatic family therapies
  - Structural Family Therapy
  - Strategic Family Therapy
- Pharmacological interventions (e.g., for ADHD)

How is MST Implemented?

- Single therapist working intensively with 4 to 6 families at a time
- "Team" of 2 to 4 therapists plus a supervisor
- 24 hr/ 7 day/ week team availability
- 3 to 5 months is the typical treatment time (4 months on average across cases)
- Work is done in the community: home, school, neighborhood, etc.

How is MST Implemented? (continued)

- MST staff deliver all treatment – typically no services are brokered/referred outside the MST team
- Never-ending focus on engagement and alignment with the primary caregiver and other key stakeholder (e.g. probation, child welfare, etc.)
- MST staff must be able to have a “lead” role in clinical decision making for each case
- Highly structured weekly clinical supervision and Quality Assurance (QA) processes

Quality Assurance and Continuous Quality Improvement in MST

Goal of MST Implementation:

- Obtain positive outcomes for MST youth and their families

QA/QI Process:

- Training and ongoing support (orientation training, boosters, weekly expert consultation, weekly supervision)
- Organizational support for MST programs
- Implementation monitoring (measure adherence and outcomes, work sample reviews)
- Improve MST implementation as needed, using feedback from training, ongoing support, and measurement

QA/QI Process: Training and Support

- Training and support to help therapists, supervisors, and experts implement the model as designed
  - Training processes (5-day Orientation, Supervisor Orientation, Boosters, Consultation, Group Supervision, and additional supervision and feedback for all staff as needed)
  - Training materials (MST text, 5-day training materials, Supervisory Manual, Supervisor Orientation materials, and Consultation Manual)

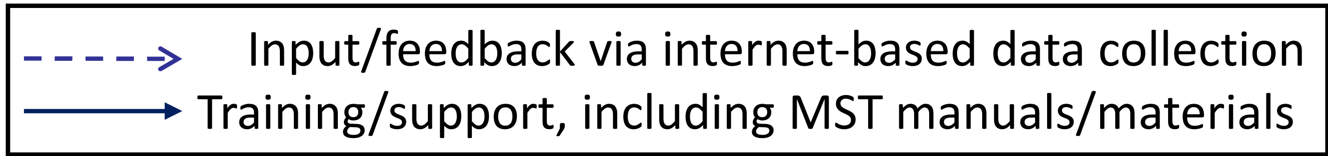
QA/QI Process: Monitor Implementation of the Model

- Measure Adherence to the Model
  - Adherence measures entered and monitored via the MSTI Website (TAM-R, SAM, CAM, Program Review Form)
  - Work sample review (e.g. session recordings and field visits, group supervision recordings)
- Measure Outcomes
  - Discharge Review Form data entered and monitored via the MSTI Website

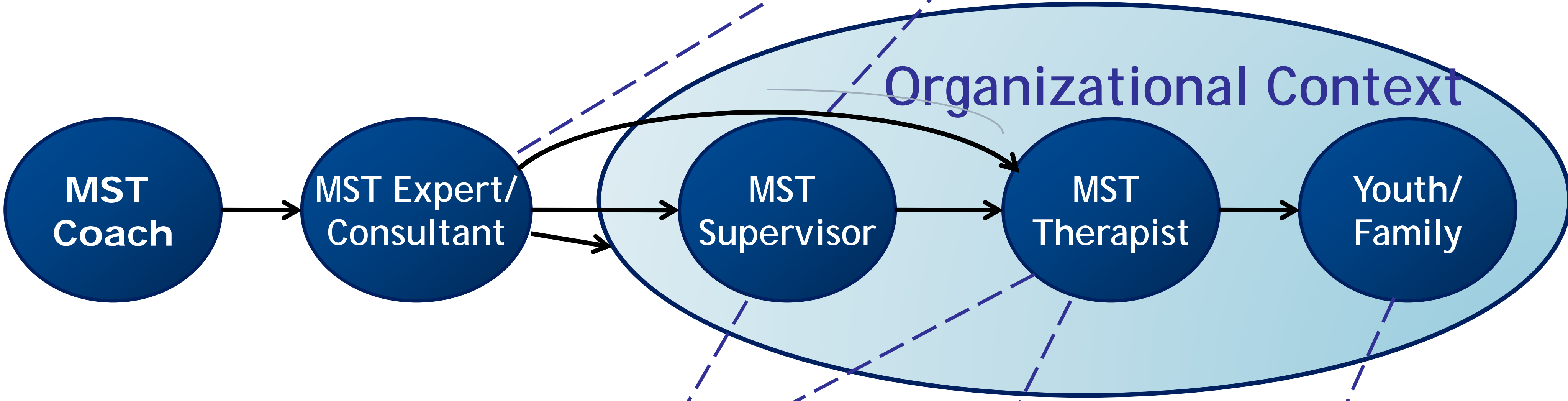
QA/QI Process: Improve Implementation of MST as Needed

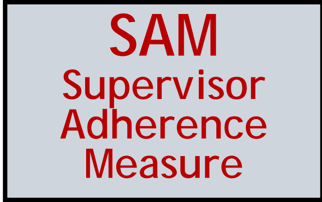
- Improve implementation as needed, based on the information provided via measurement of adherence, outcomes, and staff's strengths and needs
  - Group supervision, consultation, and additional supervision and feedback as needed
  - Program Implementation Review
  - Professional development planning
- Follow an ongoing cycle of utilizing trainings and materials to guide implementation, measuring, and improving implementation

MST QA/QI Overview



Output to –
Organization, Program Stakeholders and MST Coach





Output to –
MST Coach

Output to –
MST Expert

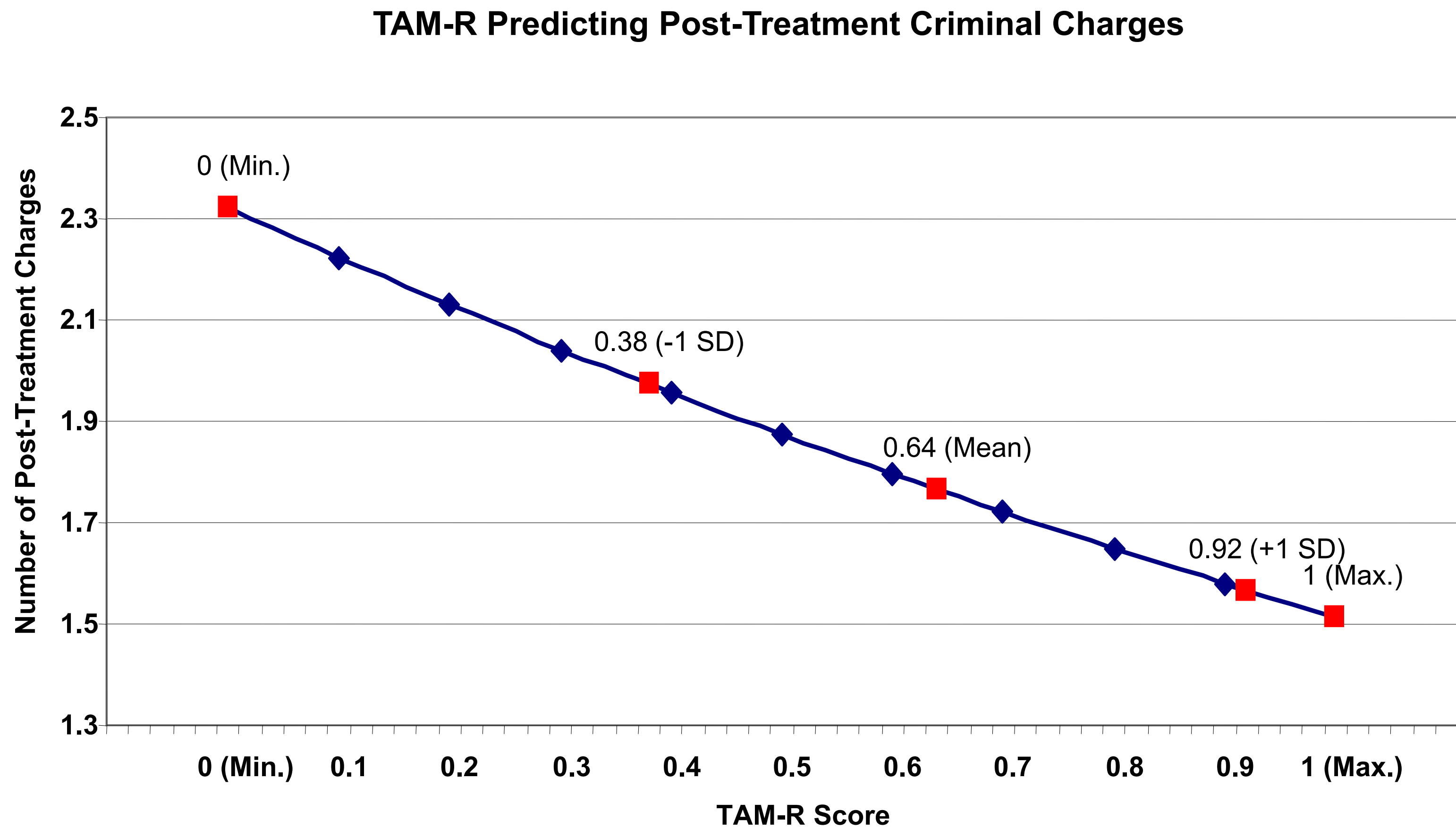
Output to –
MST Supervisor and MST Expert

MST Quality Assurance System

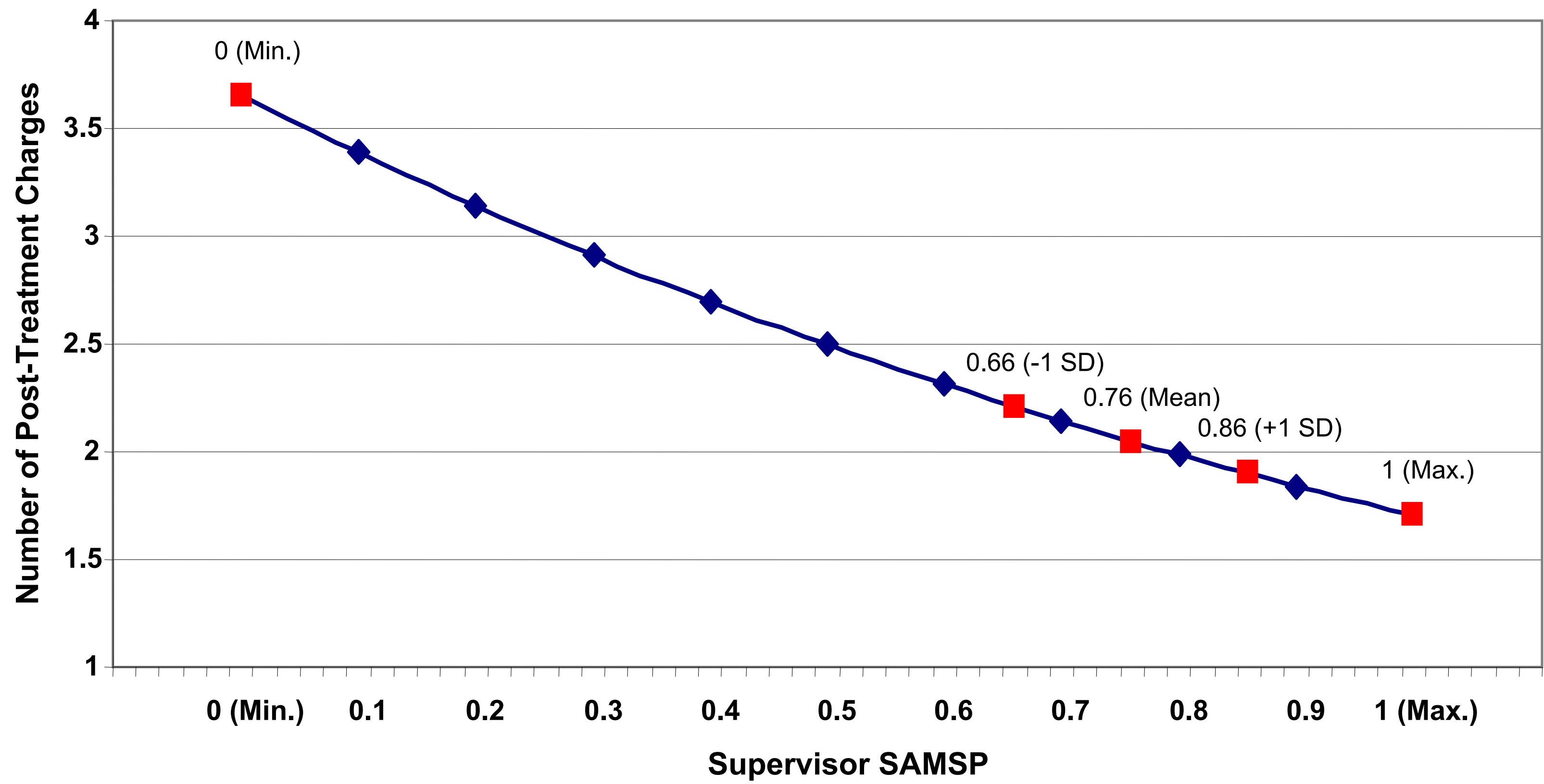
Research-based adherence measures:

- TAM – youth criminal charges 36% lower for families with maximum adherence score (1) than for families with minimum adherence score (0)
- SAM – youth criminal charges 53% lower for families with maximum SAMSP score (1) than for families with minimum SAMSP score (0)
- CAM – consultant/MST expert adherence predicts improved therapist adherence and improved youth outcomes

MST Transportability Study: Relationship between TAM-R and Youth Criminal Outcomes (2.3 year follow-up)



MST Transportability Study: Relationship between SAM and Youth Criminal Outcomes (2.3 year follow-up)



MST Treatment Principles

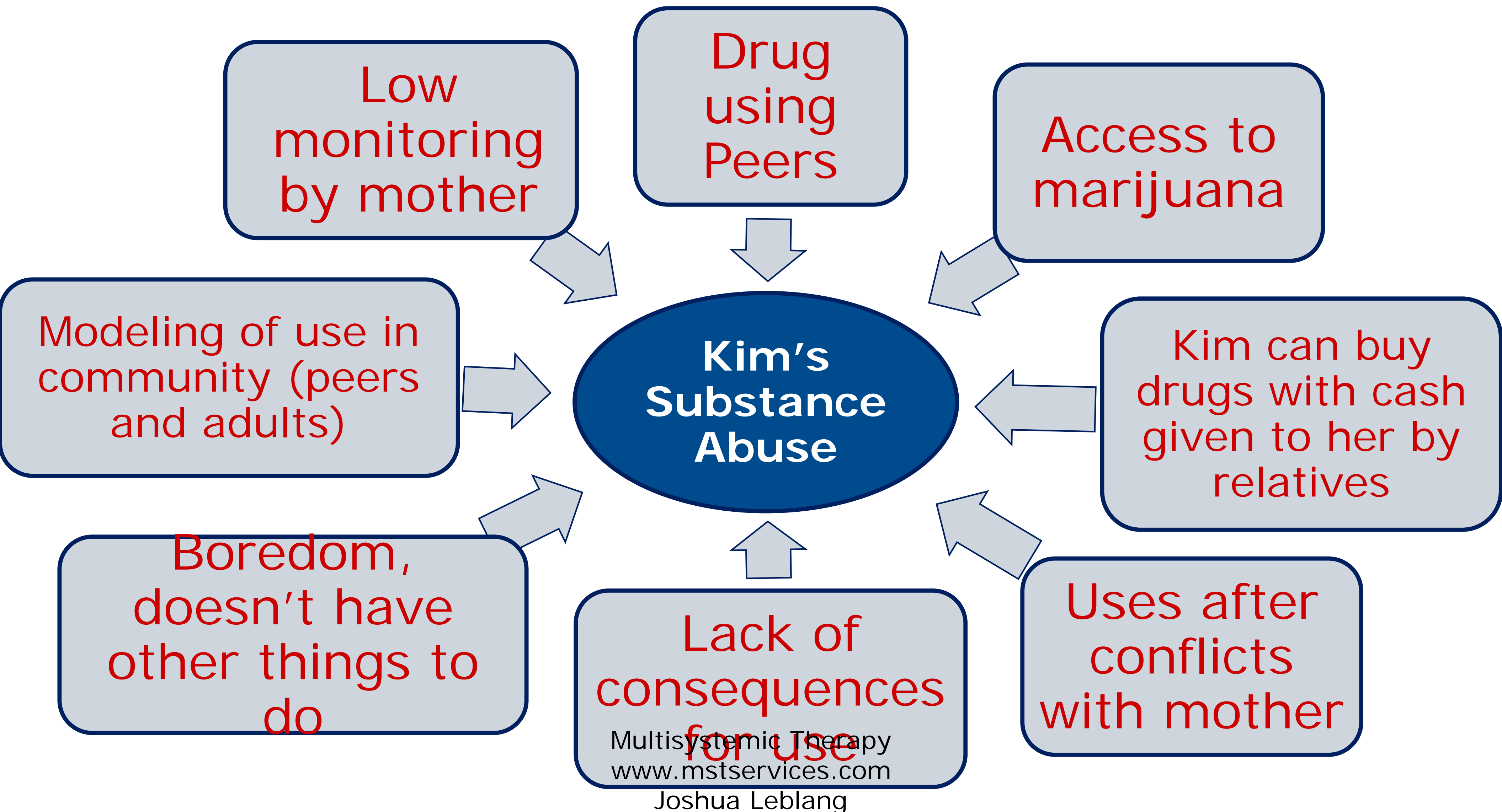
- Nine principles of MST intervention design and implementation
- Treatment fidelity and adherence is measured with relation to these nine principles

9 Principles of MST

1. **Finding the Fit**
2. **Positive and Strength Focused**
3. **Increasing Responsibility**
4. **Present-focused, Action-Oriented & Well-Defined**
5. **Targeting Sequences**
6. **Developmentally Appropriate**
7. **Continuous Effort**
8. **Evaluation & Accountability**
9. **Generalization**

1. Finding the Fit:

The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context



Principles of MST (Cont.)

2. Positive & Strength Focused

   Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.

Principles of MST (Cont.)

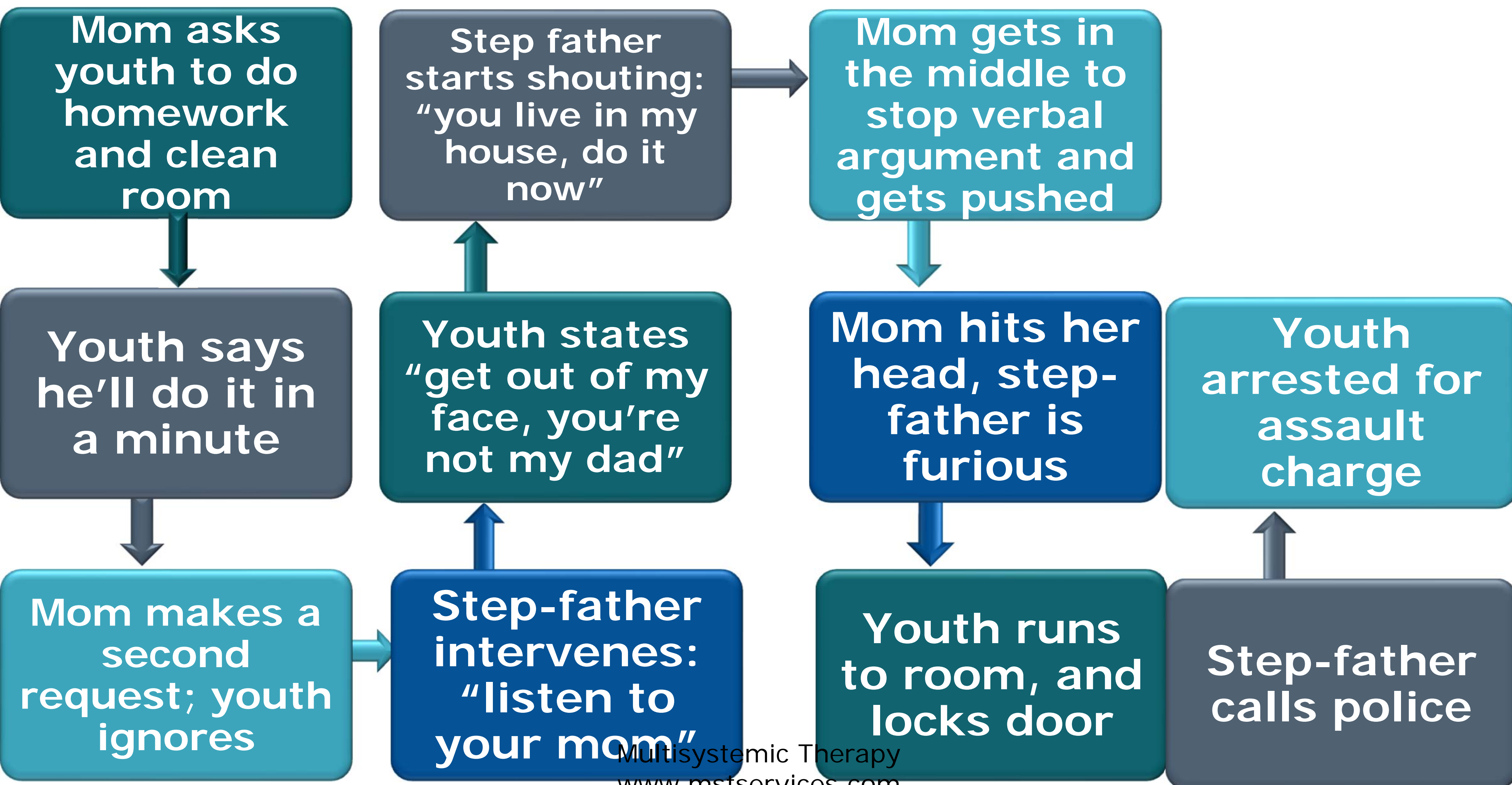
3. Increasing Responsibility

   Interventions should be designed to promote responsibility and decrease irresponsible behavior among family members.

4. Present-focused, Action-oriented & Well-defined

   Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

5. Targeting Sequences: Interventions should target sequences of behavior within and between multiple systems that maintain identified problems (cont.)



Principles of MST (Cont.)

6. Developmentally Appropriate

Interventions should be developmentally appropriate and fit the developmental needs of the youth.

Principles of MST (Cont.)

7. Continuous Effort

   Interventions should be designed to require daily or weekly effort by family members.

8. Evaluation and Accountability

   Intervention efficacy is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.

Principles of MST (Cont.)

9. Generalization

Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering care givers to address family members′ needs across multiple systemic contexts.

Where is MST Being Used?

- Over 34 states in the U.S. and in 15 countries
- Statewide infrastructure in Connecticut,, Hawaii, Louisiana, North Carolina, Ohio, and Pennsylvania
- Other international replications: Australia, Belgium, Canada, Chile, Denmark, England, Germany, Iceland, Northern Ireland, Norway, Scotland Sweden, Switzerland, the Netherlands, and New Zealand.

MST: 30+ Years of Science

55 published outcome, implementation and benchmarking studies including 25 randomized trials (28 independent evaluations)

- 16 studies using standard MST with serious juvenile offenders
- 11 studies using MST with adolescents with serious conduct problems
- 2 studies with substance-abusing or –dependent juvenile offenders (MST-Substance Abuse)
- 3 studies with juvenile sexual offenders(MST-Problem Sexual Behavior)
- 3 studies with youths presenting serious emotional disturbances(MST-Psychiatric)
- 3 studies with maltreating families (MST-Child Abuse and Neglect)
- 6 studies with adolescents with chronic health care conditions (MST-Health Care)
  - Diabetes and obesity
- 13 large-scale implementation studies
- Complete list of MST outcome studies: www.mstservices.com/files/outcomestudies.pdf

Consistent Outcomes

In Comparison with Control Groups, MST:

- Led to higher consumer satisfaction
- Decreased long-term rates of re-arrest 25% to 70%
- 47% to 64% decreases in long-term rates of days in out-of-home placements
- Improved family relations and functioning
- Increased mainstream school attendance and performance
- Decreased adolescent psychiatric symptoms
- Decreased adolescent substance use

But, none of this happens without adherence to MST

Long-term Outcomes

14-year and 22-year post-treatment outcomes

(MST compared to Individual Treatment: individuals treated 1983-1986)

14 years post treatment
(n= 165, 94% tracking success)

- 54% fewer arrests
- 59% fewer violent arrests
- 64% fewer drug-related arrests
- 57%fewer days in adult confinement
- 43% fewer days on adult probation

22 years post treatment
(n= 148, 84% tracking success)

- 36% fewer felony arrests
- 75% fewer violent felony arrests
- 33% fewer days in adult confinement
- 38% fewer issues with family instability
  (divorce, paternity, child support suits)
- 3% fewer financial problems
  (credit, contract, rent suits)

Why is MST Successful?

- Treatment targets known causes of delinquency: family relations, peer relations, school performance, community factors
- Treatment is family driven and occurs in the youths' natural environment
- Providers are accountable for outcomes
- Staff are well trained and supported
- Significant energies are devoted to developing positive interagency relations

King County Superior Court

Youth Skills Training and Family Interventions

Programs to meet the changing needs of youth and families, to help them build the skills to address current challenges, and to move forward with therapeutic support are offered by Juvenile Court Services and in partnership with community providers:

Aggression Replacement Therapy (ART) +

Functional Family Therapy (FFT) +

Multi-Systemic Therapy (MST) −

Multi-Systemic Therapy (MST) in an intensive home and family-oriented treatment program to reduce high-risk acting out behaviors in youth. MST empowers parents with the skills and resources needed to independently address the difficulties that arise in raising youth and empowers them to cope with the family, peer, school and issues outside their home environment.

The therapy offers goal-oriented and practical methods of dealing with family issues. MST can help a family reduce a teen's criminal activity and reduce antisocial behavior, such as poor school performance, poor choice in friends, family conflict and other home issues, substance abuse, and mental health issues. The therapy also helps to keep a teen in their home environment by reducing the barriers that keep families from receiving needed services.

MST participants work with a therapist for 4 to 6 months. The therapist is available 24 hours a day, 7 days a week, and sessions are held in the family's home. The treatment plan is designed with family members and is family-driven rather than therapist-driven. Attention is given to the things in the youth's and family's social network that are linked with antisocial behavior. Interpreters can be used if there is a language barrier.

Referral to MST is by Juvenile Probation Counselors for youth on community supervision who are assessed to be high risk and at risk to be placed outside of their home (either through incarceration or inpatient treatment). These youth are between the ages of 12 and 18 and have a minimum of 4 to 6 months of supervision to complete.

Step-Up Program +

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