Multisystemic Therapy (MST) Overview

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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
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

- Community
- Provider Agency
- School
- Neighborhood
- Peers
- Extended Family
- Caregiver
- CHILD
- Family Members
- Siblings
Causal Models of Delinquency and Drug Use: Common Findings of 50+ Years of Research

- Family
- School
- Delinquent Peers
- Prior Delinquent Behavior
- Delinquent Behavior

Neighborhood/Community Context
Research on Delinquency and Drug Use

Family Level

- Poor parental supervision
- Inconsistent or lax discipline
- Poor affective relations between youth, caregivers, and siblings
- Parental substance abuse and mental health problems
Peer Level

- Association with drug-using and/or delinquent peers
- Poor relationship with peers, peer rejection
- Association with antisocial peers is the most powerful direct predictor of delinquent behavior!
Research on Delinquency and Drug Use (Cont.)

School Level

- Academic difficulties, low grades, having been retained
- Behavioral problems at school, truancy, suspensions
- Negative attitude toward school
- Attending a school that does not flex to youth needs
Community Level

- Availability of weapons and drugs
- High environmental and psychosocial stress (violence)
- Neighborhood transience - neighbors move in and out
Youth Level

- ADHD, impulsivity
- Positive attitude toward delinquency and substance use
- Lack of guilt for transgressions
- Negative affect
MST Theory of Change

MST

Improved Family Functioning

Peers

School

Community

Reduced Antisocial Behavior and Improved Functioning

Multisystemic Therapy (MST)
Overview
MST Assumptions

- Children’s behavior is strongly influenced by their families, friends and communities (and vice versa)
- Families and communities are central and essential partners and collaborators in MST treatment
- Caregivers/parents want the best for their children and want them to grow to become productive adults
MST Assumptions (Cont.)

- Families can live successfully without formal, mandated services
- Change can occur quickly
- Professional treatment providers should be accountable for achieving outcomes
- Science/research provides valuable guidance
How is MST Implemented?

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? (Cont.)

- 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: on call system
- 3 to 5 months is the typical treatment time (4 months on average across cases)
- Work is done in the community, home, school, neighborhood: removes barriers to service access
How is MST Implemented?

(Cont.)

- MST staff deliver all treatment - typically no or few services are brokered/referred outside the MST team
- Never-ending focus on engagement and alignment with primary caregiver and other key stakeholders (e.g. probation, courts, children and family services, etc.)
- MST has strong track record of client retention and satisfaction with MST
- MST staff must be able to have a “lead” clinical role, ensuring services are individualized to strengths and needs of each youth/family
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
Key Points:

- MST Treatment Principles
- MST Analytic Process
- MST Quality Assurance System
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.

Kim’s Substance Abuse

- Low monitoring by mother
- Drug using Peers
- Access to marijuana
- Kim can buy drugs with cash given to her by relatives
- Uses after conflicts with mother
- Lack of consequences for use
- Boredom, doesn’t have other things to do
- Modeling of use in community (peers and adults)
2. Positive & Strength Focused

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

Mom asks youth to do homework and clean room

Youth says he’ll do it in a minute

Mom makes a second request; youth ignores

Youth states “get out of my face, you’re not my dad”

Step-father starts shouting: “you live in my house, do it now”

Step-father intervenes: “listen to your mom”

Mom gets in the middle to stop verbal argument and gets pushed

Mom hits her head, step-father is furious

Youth runs to room, and locks door

Step-father calls police

Youth arrested for assault charge
6. Developmentally Appropriate

Interventions should be developmentally appropriate and fit the developmental needs of the youth.
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.
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.
Environment of Alignment and Engagement of Family and Key Participants

Desired Outcomes of Family and Other Key Participants

MST Conceptualization of “Fit”

Assessment of Advances & Barriers to Intervention Effectiveness

MST Analytical Process

Referral Behavior

Overarching Goals

Re-evaluate

Prioritize

Intermediary Goals

Measure

Do

Intervention Implementation

Intervention Development

Overarching Goals
<table>
<thead>
<tr>
<th>At Home</th>
<th>90%</th>
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</thead>
<tbody>
<tr>
<td>In School/Working</td>
<td>85.6%</td>
</tr>
<tr>
<td>No Arrests</td>
<td>86.2%</td>
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</tbody>
</table>

These results are based on a comprehensive review of the 11,958 cases* (85.4% of 13,995 cases referred for treatment) that were closed for clinical reasons (i.e., completed treatment, low engagement, or placed).
MST Staff Training

**Purpose:** To achieve positive outcomes through the implementation of training and supervision protocols used in the clinical trials of MST.

- **On-the-job training** (weekly on-site supervision and MST expert case review)
- **5-day Orientation training**
- **Quarterly on-site booster training**
- **Development planning for all professionals**
Influences of Other System Stakeholders

- Clearly defined target population, program goals and referral process
- Funding structure in place
- Ability of MST therapist to take the “lead” in clinical decision making
- Key stakeholders usually include:
  - Juvenile Justice, Family Court, Mental Health, Social Welfare, School systems, parent groups
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 each youth’s natural environment
- Significant energies are devoted to developing positive interagency relations
- MST personnel are well trained and supported
- Providers are accountable for outcomes
- Continuous quality improvement occurs at all levels
# MST in Virginia

<table>
<thead>
<tr>
<th>Provider</th>
<th>Launch Date</th>
<th>CSUs Served</th>
<th>Office Location</th>
<th>RSC</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Preservation Services (FPS)</td>
<td>10/1/2017</td>
<td>26, 20W</td>
<td>Winchester</td>
<td>EBA</td>
<td>Winchester, Woodstock, Harrisonburg, Warren, Frederick, Clarke, Shenandoah, Rockingham, Page, Fauquier, and Rappahannock</td>
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<td>Family Preservation Services (FPS)</td>
<td>10/1/2017</td>
<td>21, 22, 23A</td>
<td>Martinsville</td>
<td>EBA</td>
<td>Danville, Franklin, Pittsylvania, Martinsville, Henry, Patrick, Roanoke City,</td>
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<tr>
<td>Family Preservation Services (FPS)</td>
<td>10/1/2017</td>
<td>23, 23A, Parts of 27, Parts of 29</td>
<td>Montgomery Co.</td>
<td>EBA</td>
<td>Montgomery, Pulaski, Floyd, Radford, Roanoke City, Roanoke County, Salem, Smyth, Giles, Bland, Wythe, Carroll</td>
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<tr>
<td>Family Preservation Services (FPS)</td>
<td>10/1/2017</td>
<td>Parts of 16, Parts of 25</td>
<td>Staunton</td>
<td>EBA</td>
<td>Staunton, Augusta, Waynesboro, Rockbridge County, Lexington, Buena Vista, Charlottesville, Albemarle, Highland, Culpeper, Madison, Green, Nelson, Bath, Rockingham, Harrisonburg, Covington, and Alleghany</td>
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<tr>
<td>Horizon Behavioral Health</td>
<td>6/20/2018</td>
<td>24 and one area in 10</td>
<td>Lynchburg</td>
<td>EBA</td>
<td>Lynchburg, Bedford, Campbell, Amherst, Appomattox</td>
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<tr>
<td>National Counseling Group (NCG)</td>
<td>2, 4, 13</td>
<td>Virginia Beach, Norfolk</td>
<td>AMI</td>
<td></td>
<td>Virginia Beach, Norfolk, Chesapeake, Portsmouth</td>
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<tr>
<td>National Counseling Group (NCG)</td>
<td>7, 8</td>
<td>Hampton</td>
<td>AMI</td>
<td></td>
<td>Hampton, Newport News, Williamsburg, York, Gloucester, James City Poquoson</td>
</tr>
<tr>
<td>Henrico Mental Health (CSB)*</td>
<td>ongoing</td>
<td>14 (EBA CSU 9)</td>
<td>Henrico</td>
<td>AMI</td>
<td>Henrico, which is a continuation of an existing program. New Kent and Charles City</td>
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<tr>
<td>Richmond Behavioral Health</td>
<td>ongoing</td>
<td>13</td>
<td>Richmond</td>
<td>AMI</td>
<td>Richmond City and Chesterfield County</td>
</tr>
</tbody>
</table>
Where to find MST in Virginia

Number of Commitments, FY 2018

- 0
- 1
- 2-4
- 5-9
- 10+

Hospitals and Locations:
- Prince William FFT
- Fredericksburg FFT
- Richmond MST
- Henrico MST
- Henrico/Petersburg FFT
- Hampton/N. News MST
- Norfolk/VA Beach MST
- Woodstock MST
- Lynchburg MST
- Christiansburg MST
- Martinsville MST
- Bon Air JCC
- Suffolk FFT
• “...the engagement between D and his parents has been positive, and that they have all been invested in the service. Mr. and Mrs. C have been engaged and working on implementing consequences. D is working on getting a better grasp on self-control, and needs to continue to work on respecting his parents authority. D recently had his ankle monitoring removed, and his team feels like this will show how his behaviors may or may not change. D has returned back to Liberty, and has improved grades with no disciplinary action...”

• Bedford FAPT meeting, February 2019
MST in Virginia

- "He was able to sever ties with his girlfriend, who was having an extreme negative influence. MST was there to get in the home and mediated some of the bad decisions he made. He [Mickey] came in to 2 or 3 office appointments, and I said that I see how it was a bad relationship. With MST in the house, that was a deciding factor."

- "With MST in the home, she [the mother] had the extra support to see that he has to listen to her."

  -Probation Officer Jerome Avila, 24th District Court Service Unit, January 22, 2019
MST Referrals through CSA

- **Referral criteria:**
  - Youth ages 12-17 with externalizing behavior(s). Some examples may include: verbal/physical aggression, truancy, curfew violations, substance use, involvement with delinquent peer group; may have legal involvement but legal involvement is not required to meet criteria

- **Exclusionary criteria:**
  - Youth living independently
  - Sexual offending behaviors in absence of primary conduct-related behaviors
The Future of MST in Virginia

- Behavioral Health Redesign
  - DMAS and Department of Behavioral Health and Developmental Services
  - Development of a continuum
  - Phased implementation
  - Timeline for MST

Families First
Questions?

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