

## **NEW TREATMENT TECHNOLOGY Position Statement**

### **Multi-Systemic Therapy**

The Clinical Advisory Committee of Colorado Health Networks support this guideline based on available literature of Multi-Systemic Therapy (MST), a consideration of current interest in changing systems in Colorado, and a review of this service offered at Midwestern Mental Health Center. Presently, the implementation of this program is considered to be an optional service at each CMHC. There is an annual franchise fee charged to The Center for the use of the title Multi-Systemic Therapy (MST) and services provided.

#### **Program Overview**

The goal of the MST approach is to provide an integrated, cost-effective, family-based treatment which 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 placements is reduced or eliminated. To accomplish this task, MST addresses the known causes of delinquency on an individualized, yet comprehensive basis. MST interventions focus on the individual youth and his/her family, peer context, school/vocational performance, and neighborhood/community supports. 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 pro-social behavior while decreasing antisocial behavior.

Family interventions seek to promote the parent's capacity to monitor and discipline the adolescent. MST therapists determine the barriers to effective parental discipline and intervene accordingly. Peer interventions remove offenders from deviant peer groups and facilitate their development of friendships and pro-social 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.

#### **Service Delivery Approach**

Length and Frequency of Service-Service duration ranges from three to five months. The average duration of treatment is approximately 60 hours of contact over four months, with the final two to three weeks involving less intensive contact to monitor the maintenance of therapeutic gains. On the average there are three intensive sessions per week.

Staffing Pattern-MST treatment teams minimally consist of a licensed doctoral or, master's level supervisor and three to four master-degreed therapists (each therapist carries a caseload of four to six families). All MST team members have been trained in MST and receive MST-specific consultation and supervision.

Weekly telephone consultations occur via one-hour conference calls. The consultation allows the treatment team and supervisor to talk with an MST expert regarding case conceptualization, goals, intervention strategies, and progress.

Hours of Service-Staff are available 24 hours per day, seven days a 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, use of services at unusual times (e.g., 10 pm to 8 am) is discouraged except in cases of emergency.

Location of Services-MST is typically delivered in the 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).

### **Referral/Assessment Process**

Inclusionary guideline criteria for admission to the MST program are: a history of criminal or delinquent behavior; the youth at risk of out-of-home placement; he/she is experiencing school truancy or school failure associated with behavior problems; he/she exhibits physical or verbally aggressive behaviors in the home, at school or in the community; he/she exhibits threatening behaviors to others; and/or he/she abuses substances in the context of previously mentioned problems.

Exclusionary guideline criteria for the MST program include: if the youth is living independently or the primary caregiver cannot be identified; if the adolescent is in need of crisis stabilization because of active suicidal, homicidal, or psychotic behavior. In these instances, youths may be admitted to the MST program if sexual offenses are the only targeted behaviors. Those adolescents diagnosed with autism are also excluded from the program. Certain organic and developmental disorders may also exclude youth from this program.

Using the above guidelines, referral sources are asked to make the initial screening. The referral is then screened by the MST staff for appropriateness and acceptance into the program. If a referral is deemed not appropriate, recommendations for treatment are made for the referral source.

A thorough intake assesses the client's emotional, physical, behavioral, and social needs. Information for the intake assessment is gathered from the client, family, and referral source. The MST therapist providing the assessment is responsible for the client's treatment and case coordination throughout the course of treatment. It is expected that all other clinical supports will transition to the lead clinician while a youth is in MST.

Approval for additional clinical supports (i.e. group) is relatively rare in the MST model. Additional supports will only be established/reestablished when the treating clinician and the MST team agree that additional supports are required.

After the client's functioning level and service needs are identified, specific goals and outcomes are determined by all major participants: the youth, his/her family, the referral source, and the MST therapist. Case specific goals are written in a manner so that an outside observer can easily determine whether or not the goals have been met. The MST therapist works to ensure that the overarching goals (the goals of the referral agency) are consistent with the case-specific goals.

### **Evaluating Case Outcomes/Discharge**

The evaluation of case outcomes is based on the client and family meeting the overarching and program goals. There must be evidence that there is improvement in the youth's target behaviors; that there is a change in the systemic factors that support the adolescent's positive behavior and diminish the likelihood of the target behavior recurring; that the primary caregivers have developed the necessary skills for handling subsequent problems; and the youth and family have improved their network of informal social supports in the community and have successfully demonstrated accessing a range of supports (formal and informal) as needed.

The general criteria for termination from the MST program are: the youth is residing in the home of the parents and/or caregivers; the youth is attending school; and the youth remains out of trouble with authorities in the community. The termination process is based on evidence from multiple sources such as: youth, parent, probation officer, and/or DSS caseworker. Specific criteria for discharge are as follows: 1) the youth has few significant behavioral problems and the family is able to effectively manage any problems that may re-occur. 2) The youth is making reasonable education/vocational efforts, is involved in prosocial peers and the MST clinician, supervisor and consultant feel the caregivers have the knowledge, skill, resources and support needed to manage subsequent problems. 3) The overarching goals have not been met after reasonable efforts have been made and the treatment has reached a point of diminishing returns.

### **References**

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