Juvenile Justice Fact Sheet

MULTISYSTEMIC THERAPY (MST): AN OVERVIEW

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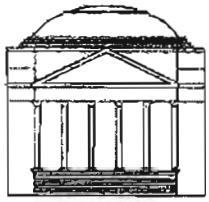

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Supported by JJDP Challenge Grant 97-JE-FX-0051 awarded by
the Virginia Department of Criminal Justice Services

Multisystemic Therapy (MST) is offering new hope to young people with serious behavioral disorders and their families. Too often, traditional mental health approaches for serious, violent, and chronic juvenile offenders and programs for treating adolescent drug and substance abusers have failed to substantiate their effectiveness to reduce or correct undesirable behaviors. The MST model, developed in response to the lack of scientifically validated, cost-effective treatment options, has proven effective in reducing antisocial behavior among diverse populations of serious and chronic juvenile offenders.

WHAT IS MST?

MST is a family- and home-based treatment that strives to change how youth function in their natural settings--home, school, and neighborhood--in ways that promote positive social behavior while decreasing antisocial behavior. This "multisystemic" approach views individuals as being surrounded by a network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors

and recognizes that intervention often is necessary in a combination of these systems. Most significantly, the conceptual framework of MST fits closely with the known causes of delinquency and substance abuse. MST addresses these factors in an individualized, comprehensive, and integrated manner.

Based on the philosophy that the most effective and ethical route to help children and youth is through helping their families, MST views parent(s)or guardian(s) as valuable resources, even when they have serious and multiple needs of their own.

The primary goals of MST are to: (a) reduce youth criminal activity; (b) reduce other types of antisocial behavior such as drug abuse; and (c) achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placement.

TARGET POPULATION

MST targets chronic, violent, or substance abusing male and female juvenile offenders at risk of out-of-home placement. The "typical" MST youth is 14-16 years old; lives in a single-parent home that is characterized by multiple needs and problems; has multiple arrests or is a chronic offender; is deeply involved with delinquent peers; has problems at school or does not attend; and abuses substances (marijuana, alcohol, cocaine).

MST has proven effective in reducing antisocial behavior among diverse populations of serious and chronic juvenile offenders. Research has shown that this approach is effective with youth (and their families) of different ages, socioeconomic status, and cultural backgrounds (i.e., African American and Caucasian). Studies are underway to determine the effectiveness of using the MST model with other populations of youths who have serious clinical problems (e.g., for youths experiencing psychiatric emergencies MST may be used as an alternative to emergency hospitalization.).

HOW ARE SERVICES DELIVERED?

MST typically uses the family preservation model of service delivery, where therapists have small caseloads (4-6 families); are available 24 hours a day, 7 days a week; and provide services in the family's home at times convenient to them. The average length of treatment is about 60 hours of contact provided during a 4-month period. The family preservation model reduces the barriers that keep families from accessing services.

MST therapists focus on empowering parents by using identified strengths to develop natural support systems (e.g., extended family, neighbors, friends, and church members) and remove barriers (e.g., parental drug abuse, high stress, and poor relationships with mates) to improve their capacity to function as effective parents. This process is viewed as a collaboration between the family and therapist, with the family taking the lead in setting treatment goals and the therapist suggesting ways to accomplish these goals.

Once engaged, the parent(s) or guardian(s) consult with the MST therapist on the best strategies to, for example, set and enforce curfews and rules in the home, decrease the adolescent's involvement with deviant peers and promote friendships with prosocial

peers, improve the adolescent's academic and/or vocational performance, and cope with the criminal subculture that may exist in the neighborhood.

Staffing. Treatment teams typically consist of three master's level counselors who receive clinical supervision from a doctoral level mental health professional. Each treatment team provides services for about 50 families a year.

Training. Training in using the MST model is provided in three ways: (1) Five days of introductory training are provided for all staff who will treat and/or clinically supervise MST cases; (2) Treatment teams and their clinical supervisors receive weekly telephone clinical consultation from trained MST experts; and (3) One- and one-half-day training "booster" sessions are provided quarterly.

HOW EFFECTIVE IS MST?

The effectiveness of MST has been supported by several controlled evaluations. Following treatment, youths who received MST reported significantly less aggression with peers and less involvement in criminal activity than youths receiving usual services. Moreover, families receiving MST reported significantly more cohesion than non-MST families. Importantly, MST was equally effective with youths and families with different strengths and weaknesses and with families of divergent socioeconomic and racial backgrounds.

Follow-up studies with children and families 2 years after and 4 years after referral supported the long term effectiveness of MST. In addition, despite its intensity, MST was a relatively inexpensive intervention. With a small client to therapist ratio (4:1) and a course or treatment lasting 3 months, the cost per client for treatment in the MST group was about one fifth the average cost of an institutional placement.

The demonstrated success of the MST model has led to several randomized trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youth with serious clinical problems and their families.

MST TREATMENT PRINCIPLES

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
3. Interventions are designed promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions are present focused and action oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

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 MST approach views individuals as being surrounded by a network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. In MST, this "ecology" of interconnected systems is viewed as the "client."

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

MST GOALS AND TREATMENT TECHNIQUES

The ultimate goals of MST are to provide parents with the skills and resources that they need to address independently the difficulties that arise when rearing teenagers and to give youth skills to cope with family, peer, school, and neighborhood problems. This is done, in part, by mobilizing individual, family, and community resources that support and maintain the long-term behavioral changes that occur during MST treatment.

MST is a pragmatic, goal-oriented treatment program that targets factors in a youth's social network that contribute to his or her antisocial behavior. Thus, MST interventions typically aim to:

- Improve caregiver discipline practices
- Enhance family relations
- Decrease a youth's association with deviant peers
- Increase a youth's association with prosocial peers
- Improve a youth's school or vocational performance
- Engage youth in positive recreational outlets
- Develop a natural support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes

Specific treatment techniques that facilitate these gains are integrated from therapies with the most empirical support, such as cognitive behavioral, behavioral, and pragmatic family therapies.

THE ROLE OF THE THERAPIST AND THE FAMILY

- MST is delivered in the natural environment (e.g., home, school, community). Family members help therapists to design the treatment plan, which ensures that it will be family driven rather than therapist driven.

- Therapists are responsible for engaging the family and other key participants in the youth's environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). Similarly, therapists and the provider agency are held accountable for achieving change and for positive case outcomes.

- For MST therapists, treatment is an ongoing process of understanding the "fit' between identified problems and their broader systemic context. Therapists view family members' behavior as "making sense" from that individual(s) perspective of the world. The therapist's job is to understand the "fit" of the targeted behavior and to devise strategies that help caregivers to address family members' needs.

- With a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family to behave responsibly. Therapists emphasize the positive and use a family's or individual's strengths to bring about change.

- Interventions always target specific, well-defined problems, focus on present conditions, and are action oriented.

- This "multisystemic" approach views individuals as being surrounded by a network of inter-connected systems that encompass individual, family, and extra-familial (peer,

school) factors and recognizes that interventions may be necessary in any one or a combination of these systems to bring about a desired behavior change.

MST SERVICE DELIVERY

- Therapists work with family members daily or weekly to achieve behavior changes that can be observed and measured. The effectiveness of these therapeutic efforts is evaluated continuously from multiple perspectives (e.g., caregivers, identified youth, school teachers, supervisor, MST consultant).

- MST uses a home-based model to deliver services. This helps to overcome barriers to accessing services, increases the likelihood that families will stay in treatment, provides families with intensive services (i.e., therapists are full-time staff who have low caseloads of four to six families per therapist), and helps to maintain treatment gains.

- MST treatment typically lasts about 4 months, with multiple therapist-family contacts occurring each week. Families usually see therapists less frequently as they get closer to being discharged from treatment.

MST TREATMENT FIDELITY

Adherence to the MST treatment model is essential for positive results. MST has been proven to be a cost-effective program that reduces rearrests and out-of-home placements for chronic, violent, juvenile offenders. Research conducted on the effectiveness of MST has demonstrated consistently that strong adherence to the model is correlated with strong case outcomes, and poor adherence is associated with substantially poorer outcomes. Training, which is key to the success of the model, is intensive and ongoing. Clinical staff training includes a week of introductory and orientation training, weekly consultation with an expert in MST, and quarterly booster training.

Adherence is the primary focus of the weekly consultation process, and heavy emphasis is placed on establishing on-site supervision practices to ensure that therapists adhere to the MST program.

CONCLUSION

MST was developed to address several limitations of existing mental health services for serious juvenile offenders, such as minimal effectiveness, high costs, and low accountability of service providers for outcomes. It has proven effective in reducing long-term rates of criminal offending in serious juvenile offenders and in reducing rates of out-of-home placements for serious juvenile offenders. The model has achieved favorable cost-saving outcomes compared to usual mental health and juvenile justice services. In

addition, results are promising in studies of the use of MST with other populations that present complex clinical problems (e.g., youths experiencing several psychiatric emergencies; substance-abusing parents of young children).

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has funded the MST Institute through the Consortium on Children, Families, and the Law (through its administrative hub, the Institute for Families in Society at the University of South Carolina) to produce supervisory and organizational manuals and measurement methods that will 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.

FOR FURTHER INFORMATION ABOUT MST

For more information about research-related issues, contact:

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Acknowledgments

This fact sheet was funded in part by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

SUGGESTED READING

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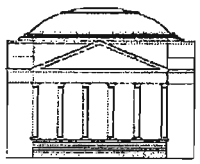

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