



CONSORTIUM

ON CHILDREN, FAMILIES, AND THE LAW

FACT SHEET

Multisystemic Therapy: An Overview

Introduction

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 extrafamilial (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 incar-

ceration 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 mental health emergencies MST may be used as an alternative to psychiatric 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 (e.g., Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Mann, Cove, Henggeler, Fucci, Blaske, & Williams, 1995; Henggeler, Borduin, Melton, Mann, Smith, Hall, Cone, & Fucci, 1991; Henggeler, Melton, Brondino, Sherer, & Hanley (1997); Henggeler, Melton, & Smith, 1992; Henggeler, Rodick, Borduin, Hanson, Watson, & Urey, 1986).

Following treatment, youths who received MST reported significantly less aggression with peers and less involvement in criminal activity than youths receiving usual services (Henggeler et al., 1992). 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 referral (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993) and 4 years after referral (Borduin et al., 1995) 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 of treatment lasting 4 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.

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 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

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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 to 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.