

MULTISYSTEMIC THERAPY
ESSENTIAL ELEMENTS OF AN EFFECTIVE THERAPY

Presented by Jeff Randall, Ph.D.

MISSION

Our mission at the Family Service Research Center in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina is to develop and validate clinically and cost effective mental health and substance abuse services for youth presenting serious clinical problems and their families. This includes youth that have substance abuse and co-existing mental health problems.

OUTCOMES

Multisystemic Therapy (“MST”) has been around for approximately 20 years and over the last 20 years we have published 8 randomized clinical trials. Over 850 families have participated in these trials. The problems that the projects have focused on have been quite diverse and range from substance abuse, violent youth offenders, sexual offenders, and psychiatric emergencies to maltreatment.

We have many projects currently underway. MST is in about 25 states and 3 countries, Canada, Norway and the U. S. The problems that the projects are dealing with again are quite diverse and the age range has been extended to include middle school youth.

Over the past 20 years the outcomes have been quite consistent. MST, relative to usual service or the comparison treatment, has resulted in improved family relations and functioning, increased school attendance, decreased substance use, decreased parent psychopathology, decreased child psychopathology and decreased rates of out of home placements and re-arrests. Retention rates have been well above 95% and services have produced on average a decrease in out of home placement of about 50%. The services also have been found to be cost effective. A study done by the Washington State Institute on Public Policy compared programs that had both research and evaluation components and who were treating juvenile offenders and found that MST, relative to 20 other programs, ranked number one in cost savings. On average, MST had

cost savings of around \$21,000. That number was computed by taking the cost of being a victim of a violent crime, which is roughly \$13,000, adding the cost to taxpayers because we pay for associated medical costs, and then subtracting the cost of MST, which is roughly \$4,500, to come up with that figure of \$21,000.

BASIS OF MST SUCCESS

MST addresses the multiple determinants of serious clinical problems in children. The problems that adolescents and their families experience have multiple causes, whether on the individual level, the family level, or the community level. Traditional mental health treatment has only focused on pieces and MST focuses on the whole broad array. MST services are high in ecological validity. Ecological validity is the notion that in order to evaluate and treat a problem effectively, we need to observe the problem and treat the problem in the environment in which it occurs. Our services have high treatment fidelity and there are extensive quality assurances. We use interventions that have an empirical basis, because the trajectory of our kids often is prison or even death, so we feel a very limited opportunity to actually make a difference and we want to make sure what we use works. We view caregivers as the key to long-term outcome. About 70% of our efforts are devoted to developing caregiver capacity. Our therapists and program directors are accountable not only for the engagement of families but for the outcomes as well.

MULTIDETERMINED NATURE OF SERIOUS CLINICAL PROBLEMS

Decades of rigorous research done by eminent researchers, such as Dale Elliott and his group at the University of Colorado, have indicated some things that we already know - that when we have an adolescent come into our office with substance abuse problems, often times there are other associated problems. The problem itself is actually caused by multiple determinants.

Let us take, for example, a typical adolescent substance abuser. When we look at what is happening on an individual level, we might find some adolescents actually have a favorable attitude toward using drugs, they have co-morbid conditions such as anxiety and depression or they have poor school performance. When we look at the family functioning level, we might find problems such as domestic violence, poor monitoring strategies, or poor discipline strategies.

And when we look at the caregiver, we often find problems such as substance abuse, depression and anxiety that have actually compromised their ability to parent. The biggest predictor of deviant behaviors we find is association with deviant peers.

Many of these problems are interrelated. A lot of the youth we deal with do not perform well academically or have behavioral problems in school, which leads to suspensions, which gives them an opportunity to hang out with deviant peers. Often times the parents do not have a strong response to that and they do not monitor their kids well.

Many families do not have strong social support. Single mothers who do not have many resources can be a predictor of problem behaviors. Finally, a lot of the youth might come from neighborhoods where there is a high availability of drugs and a high rate of crime.

Now, if this is the landscape, then it makes sense from a clinical perspective that in order to be effective as treatment providers, we need to be able to address all of these issues. MST addresses these issues in a very comprehensive way and builds in protective factors. This is accomplished on an individualized basis because we need a treatment model that is not a “one-size fits all” but one that actually can be flexible to address what is actually there so that the work is clinically relevant.

HIGH ECOLOGICAL VALIDITY

Services Provided Where Problems Occur

We need services that are high in ecological validity. The services are provided where the problems occur, within the home, school and community environments. For the most part, our therapists do not have offices. They have an office where they come and do their paperwork, but the clinical work is in the community settings. In the community they can evaluate what is going on and actually set up interventions where the problems are occurring.

Overcome Most Barriers to Service Access

Now, when you come to the home environment, you overcome a number of barriers. First of all, it is pretty hard for families to get rid of us when we are sitting there on their doorsteps

communicating to them that we really care. This sends a strong message to the family that you are really concerned about them and 95% treatment completion rates demonstrate this.

Increased Validity of Assessment Data

Our assessment data tends to be more valid. You actually go to the home and observe the interactions and arguments – you look at what they argue about and at the sequence of events.

Increased Validity of Outcome Data

Your outcomes are more valid, because whatever interventions you are able to put in place, you are actually teaching parents how to handle the child's problem in the home environment. And being there, you can identify the barriers that may prevent parents from being able to carry out the things you want them to do. For example, a mother does not have any social support. We have to hook her up with some social support to help her deal with her teenaged son who tends to be aggressive.

Helps Engage Family in Treatment

Being in the home environment helps to engage families in treatment. It sends a very powerful message that you care when you are willing to go to the home environment. It shows that you want to try to understand their world.

Enhances Treatment Generalization

Being in the home helps generalization. We are better able to teach families what to do in their environment with problems that happen there. We have a sense of understanding that when we leave the scene, families may be able to do what it is that we have taught them because we have done it within the home environment.

INTENSIVE SERVICES

Our services are very intense. In order to provide our therapists with the resources to do this type of work they carry a very low caseload. Our therapists, on average, carry between 4 and 6 families. Therapists are available 24 hours a day, 7 days a week. The logic behind this is that problems do not necessarily occur in the 9 to 5 window when most offices are open and it makes

sense that when a problem is actually occurring, we should have a clinical response to that problem. The therapists work as a team and a team usually consists of 4 therapists and a supervisor. It is the team that offers the 24 hours availability and all teammates have knowledge of all cases through team supervision.

EXTENSIVE QUALITY ASSURANCE PROTOCOLS

One of the reasons for our success is treatment fidelity. We have done a study and looked at our therapists' adherence to our treatment model and principles – of being parent focused, empowering parents to actually address the problems the kids are having, giving them the resources and the talents to do that, linking them up with pro-social supports to actually help them do that. Therapists who follow these principles get better outcomes. In order to insure treatment fidelity we have a number of procedures in place.

We have manuals that lay out MST protocols. For clinicians, we have a treatment manual. For our supervisors, we have a supervisor manual. For our consultants, we have a consultant manual. There is a rigorous 5-day on site training program that teaches you our motto, the principles on which it's based, how to carry out interventions within the various sub systems, within the peer sub system, the family sub system, breaking association with deviant peers, and some limited individual therapy for kids and adults. Quarterly booster sessions follow to fine tune areas that the team feels needs to be strengthened. Weekly phone conversation with an expert also provides on-going consultation. The consultant will give advice on case by case in terms of how this would be done from a MST perspective. Our goal with consultants is to be able to empower an organization within a one to two year time frame to be able to do the treatment independent of the consultant. We also are able to identify organization challenges and problem-solve the issues to support MST. Adherence to MST therapy is evaluated in research sites through expert coding of audiotaped sessions.

INTERVENTION STRATEGIES

We use empirically based interventions. The reason why we use the empirically based interventions is that we have a small window of opportunity to work with children who are very near the deep end.

There are proven treatments in the literature that we tend to use when we are dealing with specific problems – behavior therapy, cognitive behavior therapy, family therapy, Menuchin’s work, and Haley’s work. For some conditions, such as attention deficit disorder, schizophrenia, bipolar disorders, we will augment it with medication. We also use community reinforcement approaches developed by Budney and Higgins and their colleagues at the University of Vermont. This model is getting results with youth and adults who are using substances. The model is based on frequent random urinalysis where contingencies are applied, rewards and sanctions, based upon the results of the urinalysis. When the urinalysis is positive for substances, the triggers for use are identified and interventions developed to address those triggers. A project in Charleston has adapted this model to be able to work with adolescents who are substance abusing. The goal is to teach the parent to be able to use this model to help their children.

So what makes MST different from other treatment approaches that are out there? The difference is in the context of the application of the technologies. We apply them in a social ecological context - that is, we go into the home environment with an emphasis on building the caregiver capacity. We are available more intensively, 24 hours a day, 7 days a week. The social ecological approach enables us to eliminate a lot of the barriers that are related to access to care. And importantly, the provider assumes responsibility for engagement and responsibility for outcome.

CAREGIVERS ARE VIEWED AS THE KEY TO LONG-TERM OUTCOMES

Seventy percent of our resources are devoted to empowering the caregiver to be able to deal with what the child is presenting and generalizing those results by identifying and addressing the barriers that may prevent parents from parenting effectively.

We look at it from an analogy of a football team. The parent is really the quarterback and the play is run through the parent, so if you have a quarterback that is injured, you want to do whatever you have to do to bring that quarterback back up to speed. Because in the long run, unless we are planning on adopting kids, we do not want to be the magic in terms of dealing with problem behaviors. The focus is clearly on the family and parenting versus the youth.

Now, in some cases you may find that the biological parent, for whatever reason, does not want to parent. These cases are rare, because we find for the most part that parents want to keep their kids. They want to parent but they just do not have the resources or the skills. But in those cases where the parent is not going to assume the parenting, we try to find someone else within that social ecology, a relative or a friend who is willing to do the parenting piece, and then we pour our resources into that person. So from our perspective, parenting is not necessarily related to biology. Parenting is related to someone who wants to love and raise the kid.

MST PROGRAMS ARE ACCOUTABLE FOR ENGAGEMENT AND OUTCOMES

Therapists assume accountability for engaging families and for outcomes. This high accountability requires access to the resources to accomplish it. Therefore, caseloads are low. Salaries are high. In the Charleston area salaries are roughly 15% above whatever the current salary range is. Clinical support is strong. You have teammates, supervisors and a consultant, all trained in MST. The organizational supports are strong. Flexibility in scheduling allows for time with the clients and time off.

And this last one our therapists really like - if you are able to reduce the number of out of home placements, and in the State of South Carolina, it's roughly \$32,000 to \$35,000 to house a kid in prison or in detention - we believe that the therapists should be able to share in the program's success. Oftentimes, we offer bonuses. Also, resources are built in to enhance competencies. Not everyone who comes to us comes with all the skills they need, so training opportunities are provided to develop those skills.

POLICY IMPLICATIONS

Our mission is to shift funding from ineffective institution-based services to effective community-based services. What we would like to see happen is that the 70% of our mental health dollars that is currently being spent on costly out of home placements be redirected to effective community based programs. We believe that ultimately the solution to a lot of the problems that youth are facing lies in the community itself and not in out of home placement. We realize in some cases, you are going to have to place a child in out of home placement, but we

believe that that system is overused.

FUTURE DIRECTIONS

Currently we are moving to evaluate the model with different populations. We have a study in Charleston using the Higgins' model to treat adolescents who are abusing substances and who are involved with drug court. We have a study that was just funded where Dr. Cindy Swenson is going to be looking at children who are physically abused and using MST as a treatment model that will address some of the family conflicts that may have led to their abuse. Dr. Merlisa Rowland is working with diabetic and obese children, so we are extending over into the health psychiatric area.

Follow-up studies are tracking our outcomes and costs. We have follow-ups that go out to five years that indicate that MST relative to other services has cut the number of re-arrests and out of home placements in half. A test of any model is not just what you do at post-test but, perhaps even more importantly, what the long-range trajectory is of the intervention outcomes. We are submitting a grant to study children we saw over 12 years ago. We are interested not just in how technology is working here and now but how it is going to work in the future as well.

We are developing MST based continuums of care. In Hawaii and Philadelphia we are developing a continuum of care from inpatient, foster care, respite, to outpatient care based on the MST philosophy. For example, in inpatient care the orientation would shift to the family. You might have mom actually setting up the criteria for the child coming back home and the youth would not be attending group therapy because we know one of the biggest triggers of some of the problem behaviors are associating with deviant peers. There is also a study integrating MST with school-wide prevention programs in inner-city middle schools and one that evaluates neighborhood solutions for neighborhood problems.

And the final question that we're looking at is - what will it take in order to transport effective MST? If we can get these results in Charleston, what are the variables we need to have in order to come to Maine and get similar outcomes? Dr. Sonya Schoenwald has a grant from NIMH to examine our transportability and generalization.

About the Presenter

Jeff Randall, Ph.D., is an Assistance Professor in the Family Services Research Center, Medical University of South Carolina. His primary research interests are Multisystemic Therapy (“MST”) and adolescent substance abuse and anxiety. MST, a model of delivering home-based services, has produced some of the best outcomes of any children’s treatment model.

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