

**MULTISYSTEMIC THERAPY
POLICY AND IMPLEMENTATION ISSUES**

Presented by Jeff Randall, Ph.D.

WEAKNESSES IN OUR PRESENT SERVICE SYSTEM

Presently, we all agree that the need for mental health treatment outweighs the availability. There are youth out there who really need service who are not getting it. We also probably would agree that there is a grossly disproportionate number of dollars being spent on costly out-of-home services, services that are not necessarily effective and, in some cases, actually do more harm than good.

When we look at our communities, we find few community-based programs that are available to help our kids. So we use whatever is available. This creates an interesting situation because we end up justifying the very existence of these programs simply because they are used, not due to their effectiveness.

Another weakness in our service system is that we duplicate ourselves. We have so many agencies; we end up doing the same things. We have these fragmented services and we do not necessarily talk to each other. We end up spending a lot of time duplicating our efforts in actually trying to figure out where to go to get what.

And another problem is how programs are funded. If you are a drug and alcohol program, you are not necessarily funded to take care of the mental health needs of the children. Similarly, if you are a mental health program, you are not necessarily funded to take care of the substance abuse needs of the children. Our programs therefore are set up based on the structure of the organization or system and not necessarily the clinical needs of our kids. And, sometimes we end up blaming families for some of the problems that they walk into our office with.

There have been some initiatives to help us coordinate our services better. One is the Fort Bragg Project in Fort Bragg, North Carolina. It is a multimillion-dollar project, an effort to create a seamless system of service delivery. All agencies were brought to the table and one service for

children and families was created and it seemed great. We got rid of the duplication and red tape and families had better access to services. The treatment outcomes, however, were not better. People starting looking at why? The problem was that there were a lot of programs in North Carolina that actually were using approaches that were not effective in the first place. What happens when you put programs together and none of them are really effective? You have one program that is not really effective. A twenty million-dollar lesson was learned with that particular project.

REASONS FOR INEFFECTIVE SERVICES

So the question is - why aren't these services effective? There are two reasons we need to examine. First of all, they are low in ecological validity. Ecological validity is the notion that to best understand a problem we need to observe it within the environment in which it is actually occurring. And to best treat a problem, we need to treat it in the environment in which it is occurring.

The other reason is that when we are looking at adolescents using substances, there are many other problems associated with that and a lot of problems have multiple determinates. It could be there are family conflicts going on in the home environment, it could be a huge peer association, etcetera. Now, if we know that there are multiple determinates to the problems that we face, it makes sense that in order to be effective clinically, we need a treatment approach that is going to give us a structure and the resources to actually address these problems in a very comprehensive way. Multisystemic Therapy ("MST") is based on these premises.

MULTISYSTEMIC THERAPY

Three MST Organizations

There are three organizations that are associated with MST. The first is the Family Service Research Center, which is the research and development center. The Director is Scott Henggeler, Ph.D., who is also the creator of MST. MST has been around for over 20 years. To date, there have been over 50 million dollars spent in the development and refinement of this treatment. The Family Service Research Center is located at the Medical University of South Carolina.

Another organization is MST Services. It is responsible for disseminating the treatment model. It works with out-of-state agencies, such as Sweetser here in Maine, to disseminate the treatment model.

The other organization, MST Institute, is responsible for working with policy-level people and ensuring that there is quality control with everything that we do. The goal of the organization is to reduce criminal activities, to reduce other anti-social behaviors such as drug abuse, and to do this at cost-savings. We do that by saving money. On average it costs us roughly \$4,000 per child to treat and by doing so we save the money that it would have cost to have a child in an out of home placement. By reducing the number of children that are going into out of home placements, we can pay for our program. What we have found overall is that we are able to cut the number of children going into out of home placement roughly in half.

Effectiveness

Our supporters include the families that we treat, the Office of Juvenile Justice and Delinquency Programs, the Washington State Institute of Public Policy, which has done a cost analysis, and the Blueprints for Violence Prevention, which has studied effective juvenile offender programs.

The reason why families are proponents of MST is because it is a family focused model. We spend 70% of our time and energy empowering families to deal with the problems that their youth present. We focus on what the family would like to see changed and creating strategies to help them meet their ends. For that reason, because they're full collaborators. Over 95% of families who enter our programs actually complete the MST treatment, which lasts anywhere from 4 to 6 months.

The Washington State Institute of Public Policy did a cost analysis of 16 programs that treated juvenile delinquents and that had research and evaluation components. They found that MST, relative to the other programs, was the most cost effective. The saving for each child was on average \$21,000. That figure was computed by taking the cost to a victim of a violent crime,

\$13,000, plus the cost to the taxpayers for the medical related costs for people who are uninsured and others associated costs, and subtract the cost of MST, \$4,000, and end up with a net cost saving of \$21,000.

The Blueprint for Violence Prevention Program examined those programs treating juvenile offenders to determine which programs are clinically effective. To date, they have examined over 500 programs and picked out 10 that were gold standards. MST is one of the programs that was selected as a gold standard.

MST Theory

The MST model is based on the theoretical work of people like Haley and Manuchin - family therapists. The notion behind their theoretical work is that children are actually embedded in multiple systems and these systems have bi-directional and reciprocal impacts on each other. It is like tossing a pebble in a pond and watching the ripples. The pebble actually has an impact on the entire pond. From our treatment perspective, your client is not the individual child, it is not the family, it is actually the entire ecological model.

Basis of Success

From research we have found that most problems have multiple determinants. For example, take a child who is using substances. When we look on an individual level, some of the factors that may relate to substance use as indicated by research include adolescents who have a favorable attitude toward using drugs and adolescents who are using drugs to self medicate for anxiety and depression. From a family perspective, we often run into situations with adolescents who are using drugs where there is domestic violence, where the parents have poor skills in terms of monitoring their child and poor discipline or ineffective strategies such as yelling. There might be low affect between the child and the parent. When you look at caregivers themselves, often times they are using drugs or have anxiety, depression or other psychiatric conditions.

Then we look at the school environment. A lot of the children are not doing well academically. Some are being kicked out for behavioral problems that set them up to hang out with the number one predictor of problems - deviant peers. You can see the circular nature of

these problems. You have an adolescent who has been kicked out of school, hangs out with deviant peers and mom knows it. They are getting into trouble but there are few consequences at home. And oftentimes there is a neighborhood environment where there is higher crime and ready availability of drugs.

In order to be effective, we need to be able to address these problems in a very comprehensive way. We need to have services that are individualized because treatment is not a “one size fits all.” We want a model that is flexible enough to clinically deal with what is on our table. We need a model that has families as full partners. Parents are the driving forces in terms of interventions as you intervene with the natural ecology where the problems are occurring.

CRITICAL ELEMENTS OF MST

What are some critical elements to implement a MST program? First of all, MST focuses on outcomes. Second is treatment fidelity and the third is families having accessibility to treatment.

OUTCOMES

The Missouri Delinquency Project studied over 200 offenders and their families who were treated. On the average each child had over 4 arrests, about a third of the clients were females and about a third were African Americans. The families within the MST who had undergone individual therapy had increased family cohesion, decreased parental psychopathology and decreased child psychopathology. But what about the ultimate outcomes? MST resulted in fewer youth committing violent crimes, lower levels of drug use, and of the crimes that actually were committed, they were significantly less serious than the crimes committed by youth in the comparison individual treatment. These post-test successes continued at follow-up. Data show that 5 years after MST completers still have a lower number of re-arrests than youths who completed individual therapy. What also is interesting is that even the youth who dropped out of MST are doing better than the youth who underwent individual therapy.

What we have found in general after 8 randomized clinical trials and working with 850

families is that the outcomes have been very consistent in families who finish MST. They have better family relations, the children attend school more often, parents have decreased psychopathology, children have decreased psychopathology and the number of days in out of home placements has been cut in half.

TREATMENT FIDELITY

We did a study where we looked at treatment fidelity and essentially found that it was not treatment fidelity but rather a failure to implement the model that resulted in poor outcomes. Consequently, we believe that the only way to actually get treatment fidelity is to plan for it and to institutionalize treatment fidelity as part of your training protocol. To that end, we have manuals that lay out our treatments based on nine principles and within the manual we teach our therapists how to deal with the different sub-systems - whether it be peer interventions, parent-child interventions, individual interventions for parents alone, or interventions for our youths alone. We also have manuals for our supervisors. We want to make sure that they have guidance in terms of how to supervise our therapists. We have manuals for our consultants who are working with out-of-state sites, such as the one here in Maine, to give them guidance in terms of how to insure that everyone from top to bottom is actually adhering to the treatment model.

To become a MST site an agency has to undergo 5 days of training, where we come in and train you in the various models. Basically, our therapy techniques are those that are in the literature, that have been shown to be effective, such as behavior therapy, cognitive behavior therapy, family therapy, pragmatic family therapy and some of the therapies are working with addicts. One treatment in particular with which you are familiar that has been very effective with cocaine addicts is the community reinforcement approach developed by Higgins and his colleagues at the University of Vermont. This is a treatment approach that entails random urinalysis testing for cocaine use, on average about 2 to 3 times a week, coupled with providing sanctions and rewards for clean or dirty results. The treatment in particular goes after those triggers that are related to use. We have adapted the model to work with adolescents in Charleston.

In addition to the 5 day on site training, our consultants each week calls the team and

goes over the cases to make sure that the therapists are actually using a MST approach. Every three months, one and a half day booster sessions are delivered. The support is a constant relationship that enables MST to sustain or obtain some of the outcomes that we are looking for.

ACCESSIBILITY TO TREATMENT

It is important that families are able to have access to our services. To achieve that, our model is set up so that the treatment site actually occurs within the home environment. Our therapists carry very low caseloads of 4 to 6 families and they are available 24 hours a day, seven days week through a team treatment response. Clinical problems do not happen during a neat time frame of 9 a.m. to 5 p.m. They happen 24 hours a day, so we want to be able to go there. Our therapists work on a team; there's usually about 4 or 5 therapists and a particular therapist might not have to go, but someone from that team would go and address the clinical emergency. Treatment usually lasts from 3 to 5 months.

We take good care of our therapists and pay them 15% higher than comparable organizations. The therapists are viewed as being responsible for the family engagement and the clinical outcomes. That is, when we hire a therapist, we say, "If the treatment fails, we don't blame the family, we blame ourselves. If the family is not engaged in treatment, we don't blame the family, we blame ourselves." We look for the barriers that are keeping the families from being engaged and those factors become our treatment goal.

We treat the entire family. If we see a parent whose parenting ability is compromised because of psychiatric problems, that person becomes our client as well. A younger sibling with his/her own problems- that person becomes our client as well. The entire ecology is actually our client.

THERAPISTS CHARACTERISTICS

To be successful at doing MST, being a bright and motivated therapist helps. Therapists that are successful are willing to learn and are not particularly wedded to one way of thinking or to using interventions that do not have empirical support. Some weaknesses to be aware of when choosing therapists are if they have worked without the MST's level of accountability or if they

are used to doing things that may not be empirically based. These therapist may not be open to peer supervision.

FUTURE DIRECTIONS

We want to take the 70% of mental health dollars that are currently being spent on out of home placements and have them directed toward effective community based programs. That is why we do what we do.

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.

Contact Information:

MST Services
268 West Coleman Blvd., Suite 2E
Mount Pleasant, South Carolina 29464
Telephone (843) 856-8226
or
Jeff Randall, Ph.D.
Medical University of South Carolina
Department of Psychiatry & Behavioral Sciences
Family Services Research Center
67 President Street, Suite CPP
Charlestown, South Carolina 29425
Telephone (843) 876-1816