What Is MST?

Executive Summary

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple influences that contribute to serious antisocial or illegal behavior in youth. The MST approach views individuals as being part of, and influenced by, a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. In MST, this “ecology” of interconnected systems is viewed as the “client.” To achieve successful outcomes with these youth, interventions are generally necessary within and among a combination of these systems.

MST addresses the multiple factors known to be related to juvenile delinquency across the key settings, or systems, within which youth are embedded. MST uses the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to promote behavior change in the youth’s natural environment.

The ultimate goal of MST is to empower parents, that is, assure they have or develop the skills and resources needed, to address the difficulties that arise in raising children and adolescents and to similarly empower youth to cope with family, peer, school, and neighborhood problems. This is done in part through the mobilization of indigenous (i.e., naturally occurring or preexisting) child, family, and community resources that support the long-term generalization and maintenance of changes that take place during MST treatment.

How Is MST Different?

Describing the differences between MST and other treatment approaches is difficult without a clear understanding of the program or treatment with which MST is being compared. Generally however, there are four major points that separate MST from other treatments for antisocial behavior:

- Research: Proven long-term effectiveness through rigorous scientific evaluations
- Treatment theory: A clearly defined and scientifically grounded treatment theory
- Implementation: A focus on provider accountability and adherence to the treatment model
- Focus on long-term outcomes: Empowering caregivers to manage future difficulties

Research: Proven Long-term Effectiveness Through Rigorous Scientific Evaluations

- MST is a well-validated treatment model (Kazdin & Weisz, 1998) with 16 published outcome studies (14 randomized, two quasi-experimental) and several others underway.
- Studies with violent and chronic juvenile offenders showed that MST reduced long-term rates of rearrest by 25 percent to 70 percent compared with control groups.
- Studies with long-term follow-ups showed that MST reduced days in out-of-home placements by 47 percent to 64 percent compared with control groups.

Treatment Theory: A Clearly Defined and Scientifically Grounded Treatment Theory

- MST, which is described in a treatment manual (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), is put into operation through adherence to nine treatment principles.
- This research has shown that youth antisocial behavior is multi-determined from factors across the youth's social network. Thus, treatment must have the capacity to address a broad range of problems.

Implementation: A Focus on Provider Accountability and Adherence to the Treatment Model

- The MST therapist, the MST team, and the host agency are responsible for removing barriers to service accessibility and for achieving outcomes with every case (e.g., responsibility of the therapist to engage the family, accountability of the therapist and provider organization to achieve sustainable outcomes that the family can maintain after treatment ends).
- Treatment adherence is optimized by stringent quality assurance mechanisms that include goal-oriented, on-site supervision; measurement of adherence to the treatment model using research

validated instruments; and intensive training for all MST staff, including a five-day orientation training, weekly case consultation with an MST expert, weekly on-site clinical supervision for treatment teams and supervisors, and quarterly booster training.

- In practice, MST is analytical yet pragmatic and goal-oriented. By building on individual, family, school, and community strengths, MST therapists focus on designing interventions that will have the most immediate and powerful impact on the problem behavior. Before each intervention is implemented, MST therapists document the anticipated effect of the intervention by describing the observable and measurable outcomes that they are aiming to achieve. This information is used to assess the advances made or the barriers encountered during treatment.
- Specific treatment methodologies that are used as part of MST interventions are empirically-based (e.g., cognitive behavior therapies, behavioral parent training, and the pragmatic family therapies, such as structural family therapy and strategic family therapy).

Focus on Long-term Outcomes: Empowering Caregivers to Manage Future Difficulties

- The ultimate goals of MST are to provide the youth's primary caregivers with the skills and resources they need to independently address the difficulties that arise when rearing teenagers with behavioral problems and to give youth the skills to cope with family, peer, school, and neighborhood problems.
- MST focuses on changing the known determinants of offending, including characteristics of the individual youth, the family, peer relations, school functioning, and the neighborhood.
- MST treatment plans are designed jointly with family members and are family-driven rather than therapist-driven.

MST in Leeds

In 2008 Leeds City Council successfully applied for funding from the Department of Health for a Pilot MST project. This project contributed to a randomised control trial of MST. The project in Leeds has been cited as a national model of excellence and we have been successful in a recent application for further funding from the DFE to support the development of an additional two MST teams.

Initial findings in respect of MST in Leeds are supportive of this model as an effective edge of care preventative approach.

Each team is expected to work with 40 families per year. The potential cost of the MST intervention based on 3 teams is approximately £860k pa. As each team would support 40 families, 120 families in total, the cost per young person would be £7k pa.

In 6 cases MST was used to assist children to return home safely after a period of time in care. A comparative group were given 'services as usual'.

The MST cohort returned home on average after 300 days in care and the Services as usual cohort after 700.

Of the children deemed to be on the edge of care, 3 of the MST sample did require some time in Local Authority care, however 6 of the services as usual sample required days in care.

An expectation of the service provision is that each team will work to return 6 appropriate young people home from an external residential placement, the full year effect of the saving would be £2.8m.