A Model Program for Treating Adolescents with Significant Behavioral Health Concerns: Multisystemic Therapy: MST

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Breaking the cycle of criminal behavior

by keeping teens at home, in school and out of trouble
• A community-based, family-driven treatment for antisocial/delinquent behavior in youth
• Focuses on “Empowering” caregivers (parents) to solve current and future problems
• MST’s “client” is the entire ecology of the youth - family, peers, school, neighborhood
• Uses highly structured clinical supervision and quality assurance processes
• MST focuses on families as the solution
• Families are full collaborators in treatment planning and delivery with a focus on family members as the long-term change agents
• Giving up on families, or labeling them as “resistant” or “unmotivated” is not an option
• MST has a strong track record of client engagement, retention, and satisfaction
Breaking the cycle of criminal behavior by keeping teens at home, in school and out of trouble.
• 34 states in the US
• Statewide infrastructures in Connecticut, Hawaii, New Mexico, North Carolina, Ohio, Pennsylvania, and Louisiana
CIP was created by the state Department of Mental Health in 2000. It was a part of a state-wide MH initiative to promote best practices. Several Centers of Excellences (COE) were created. CIP specifically for MST, initially. Only COE focused on youth and families.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Counties</th>
<th># of Teams</th>
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<tbody>
<tr>
<td>Applewood Center</td>
<td>Cuyahoga and Lorain</td>
<td>1* (soon to be 2)</td>
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<tr>
<td>Nationwide Children’s Hospital</td>
<td>Franklin</td>
<td>1</td>
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<tr>
<td>Crisis Center</td>
<td>Stark, Medina, Wayne, Carroll and Holmes</td>
<td>2</td>
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<tr>
<td>Counseling Center</td>
<td>Columbiana</td>
<td>1</td>
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<tr>
<td>Buckeye Ranch</td>
<td>Franklin</td>
<td>2</td>
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<tr>
<td>Zepf Center</td>
<td>Lucas</td>
<td>1</td>
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<td>Cuyahoga County Juvenile Court</td>
<td>Cuyahoga</td>
<td>2</td>
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<tr>
<td>Dept Child and Family Services-</td>
<td>Cuyahoga</td>
<td>2</td>
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<tr>
<td>DCFS</td>
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<tr>
<td>Homes for Kids</td>
<td>Geauga, Ashtabula, Trumbull and Mahoning</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>14 Counties</td>
<td>14 Teams (soon to be 15)</td>
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• Children’s behavior is strongly influenced by their families, friends and communities (and vice versa)
• Families and communities are central and essential partners and collaborators in MST treatment
• Caregivers/parents want the best for their children and want them to grow to become productive adults
• Families can live successfully without formal, mandated services
• Change can occur quickly
• Professional treatment providers should be accountable for achieving outcomes
• Science/research provides valuable guidance
Causal Models of Delinquency and Drug Use:
Common Findings of 50+ Years of Research

Family
School
Delinquent Peers
Prior Delinquent Behavior
Delinquent Behavior

Neighborhood/Community Context
Common findings of 50+ years of research: delinquency and drug use are determined by multiple risk factors:

- Family (low monitoring, high conflict, etc.)
- Peer group (law-breaking peers, etc.)
- School (dropout, low achievement, etc.)
- Community (down supports, up transiency, etc.)
- Individual (low verbal and social skills, etc.)
Peer Level

- Association with drug-using and/or delinquent peers
- Poor relationship with peers, peer rejection
- Association with antisocial peers is the most powerful direct predictor of delinquent behavior!
School Level

• Academic difficulties, low grades, having been retained
• Behavioral problems at school, truancy, suspensions
• Negative attitude toward school
• Attending a school that does not flex to youth needs
Community Level

• Availability of weapons and drugs
• High environmental and psychosocial stress (violence)
• Neighborhood transience - neighbors move in and out
Youth Level

- ADHD, impulsivity
- Positive attitude toward delinquency and substance use
- Lack of guilt for transgressions
- Negative affect
MST Theory of Change

MST

Improved Family Functioning

Peers

School

Community

Reduced Antisocial Behavior and Improved Functioning
How is MST Implemented?

- Single therapist working intensively with 4 to 6 families at a time
- Team of 2 to 4 therapists plus a supervisor
- 24 hr./7 day/week team availability: on call system
- 3 to 5 months is the typical treatment time (4 months on average across cases)
- Work is done in the community, home, school, neighborhood: removes barriers to service access
• MST staff deliver all treatment - typically no or few services are brokered/referred outside the MST team
• Never-ending focus on engagement and alignment with primary caregiver and other key stakeholders (e.g. probation, courts, children and family services, etc.)
• MST has strong track record of client retention and satisfaction with MST
• MST staff must be able to have a “lead” clinical role, ensuring services are individualized to strengths and needs of each youth/family
Inclusionary Criteria

- Youth at risk for placement due to anti-social or delinquent behaviors, including substance use
- Youth involved with the juvenile justice system
- Youth who have committed sexual offenses in conjunction with other anti-social behavior

Exclusionary Criteria

- Youth living independently
- Sex offending in the absence of other anti-social behavior
- Youth with moderate to severe autism (difficulties with social communication, social interaction, and repetitive behaviors)
- Actively homicidal, suicidal or psychotic
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems
Goal of MST Implementation:
• Obtain positive outcomes for MST youth and their families

QA/QI Process:
• Training and ongoing support (orientation training, boosters, weekly expert consultation, weekly supervision)
• Organizational support for MST programs
• Implementation monitoring (measure adherence and outcomes, work sample reviews)
• Improve MST implementation as needed, using feedback from training, ongoing support, and measurement
MST QA/QI Overview

MST Coach
MST Expert/Consultant
CAM Consultant Adherence Measure
Output to - MST Coach
SAM Supervisor Adherence Measure
Output to - MST Expert
TAM Therapist Adherence Measure
Output to - MST Supervisor and MST Expert
PIR Program Implementation Review and other reports

Output to – Organization, Program Stakeholders and MST Coach

Organizational Context

MST Supervisor
MST Therapist
Youth/Family

Input/feedback via internet-based data collection
Training/support, including MST manuals/materials
34
Published Outcome, implementation and benchmarking studies

7,800 +
Families Participating across all studies

23
randomized trials

70+
published, peer-reviewed journal articles

17
independent evaluations
(not involving an MST model developer)

500
MST related publications

Breaking the cycle of criminal behavior by keeping teens at home, in school and out of trouble
These results are based on a comprehensive review of the 11,958 cases* (85.4% of 13,995 cases referred for treatment) that were closed for clinical reasons (i.e., completed treatment, low engagement, or placed).

<table>
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<tr>
<th>AT HOME</th>
<th>90%</th>
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<tr>
<td>IN SCHOOL/WORKING</td>
<td>85.6%</td>
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<tr>
<td>NO ARRESTS</td>
<td>86.2%</td>
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Long-term Outcomes

Breaking the cycle of criminal behavior by keeping teens at home, in school and out of trouble

- 54% Fewer Arrests
- 59% Fewer Violent Arrests
- 57% Fewer Days In Adult Confinement
- 43% Fewer Days On Adult Probation

14 year post treatment
(n=165, 94% tracking success)
Very Long-Term Outcomes

Breaking the cycle of criminal behavior by keeping teens at home, in school and out of trouble

- 36% Fewer Arrests
- 75% Fewer Violent Arrests
- 33% Fewer Days in Adult Confinement
- 38% Fewer Issues With Family Instability (divorce, paternity, child support suits)
- 3% Fewer Financial Problems (credit, contact, rent, suits)

22 year post treatment
(n= 148, 84% tracking success)
Key Points

- **MST & System Partner Collaboration (Schools, Child Welfare, Juvenile Court, Psychiatrists)**
- **Youth at Imminent Risk of Placement**
  - Aggression & Safety planning
  - Runaway = Monitoring & Retrieval
  - Substance Use
• MST therapists can send weekly case reports to referral person

• MST therapists can be present for each court hearing, staffing and will prepare statements to provide to the judge, etc. at the time of the hearing

• MST therapists and families will work together to develop safety and monitoring plans to address court or child welfare’s concerns for community and youth safety
MST therapist and family develop and implement extensive safety plan to address physical aggression

- Enlist local police officers, probation officers and/or child welfare workers to assist with safety protocols
- Help parents develop de-escalation skills to manage behaviors safely
- Address all relevant systems in safety plans, including school, community, and home
- Assess safety plans weekly to determine if changes/adjustments are needed
- Share safety plans with case partners as requested
1. Finding the Fit
2. Positive and Strength Focused
3. Increasing Responsibility
4. Present-focused, Action-Oriented & Well-Defined
5. Targeting Sequences
6. Developmentally Appropriate
7. Continuous Effort
8. Evaluation & Accountability
9. Generalization
Mom asks youth to do homework and clean room

Youth says he’ll do it in a minute

Mom makes a second request; youth ignores

Step father starts shouting: “you live in my house, do it now”

Youth states “get out of my face, you’re not my dad”

Step-father intervenes: “listen to your mom”

Mom gets in the middle to stop verbal argument and gets pushed

Mom hits her head, step-father is furious

Youth runs to room, and locks door

Step-father calls police

Youth arrested for assault charge
1. Finding the Fit:

Physical Aggression
MST therapist and family develop and implement an extensive monitoring & retrieval plan

- Develop plans using formal and informal supports to find and bring the youth home as quickly as possible.
- Enlist local police officers and probation officers to assist with monitoring.
- Identify troublesome peers and limit or eliminate access.
- Help parents develop relationships with peers’ parents to strengthen community supports vs. relying on the legal system.
- Share plans with probation officers, child welfare workers and judges as requested.
MST therapist and family develop and implement an extensive monitoring & behavior plan

- Identify negative peers and limit access
- Engage the youth in pro-social activities
- Conduct room searches and drug testing,
- Providing consequences and/or rewards as needed
- Enlist family supports to carry out interventions
1. Finding the Fit: broader systemic context

Kim’s Substance Abuse

- Low monitoring by mother
- Drug using Peers
- Access to marijuana
- Modeling of use in community (peers and adults)
- Boredom, doesn’t have other things to do
- Uses after conflicts with mother
- Lack of consequences for use
- Kim can buy drugs with cash given to her by relatives
• Treatment targets known causes of delinquency: family relations, peer relations, school performance, community factors
• Treatment is family-driven and occurs in each youth’s natural environment
• Significant energies are devoted to developing positive interagency relations
• MST personnel are well trained and supported
• Providers are accountable for outcomes
• Continuous quality improvement occurs at all levels
Case Presentation
Case Example

Marcus is 15 years old and was referred to the MST program by children’s services after he received a domestic violence and assault charge after an altercation with his sister (13), and a domestic violence charge due to a physical altercation with his father shortly afterwards. Dad has serious health issues and Marcus got physically aggressive with him after surgery. He participated in mediation, but the behaviors continue to be a problem. He had both DV charges dropped to unruly, but recently got another DV charge due to an incident of physical aggression between mom and Marcus.

Marcus lives with his mom and 2 younger sisters. Dad sleeps at an apartment, but spends most days at the house with the family. Mom says that the client frequently calls her names and is verbally aggressive towards all family members.

Currently, the client is attending an alternative high school for half days, and has an IEP for ADHD. The client began this schedule after several suspensions due to his verbal aggression towards teachers at school and general disrespect. The client does not participate in any after school activities, and does not currently have a job.

Marcus reports he does smoke marijuana, but has recently quit because he knows he will be getting drug screened.
Helpful Interventions

- MST FIT (fit of aggression for Marcus)
  - Can be helpful during family session to anchor in the behavior of concern
- Sequencing/behavior chains (sequence incident of aggression)
  - Helpful in trying to find triggers/warning signs to aggression
- Escalation maps
  - Looking for interaction patterns that lead to escalation
- Ecological safety plans (aggression safety plans)
- Button pushing plans (handouts and activity)
- Psychoeducation
  - Button pushing/trauma response/emotional reactivity/attention seeking behaviors
- And finally... verbal praise, warm conversations, shared positive activities,
  - Reactivating that positive parent-child bond that was present in the past
Expectations related to aggression are not defined

Aggression is modeled at home; sets aggressive norms

Rewards/punishments are not consistently implemented; parents back down from planned response

Parent/child conflict escalates into aggression

Contingencies are now powerful enough to deter aggression; youth is not motivated by lecturing, yelling, etc.

Youth/family members lack skills needed to avoid aggression; lack of impulse control; don’t know how to de-escalate

Violence is encouraged or modeled by peers and neighborhood; physical aggression is ‘normal’

Aggression is reinforced by youth getting way; giving youth power

Poor supervision and monitoring of youth at home when he is with his sisters
Ecological Safety Plan

What to include:
- Triggers for caretakers
- Triggers for client
- Warning signs to escalation for client
- Exit and Wait Plan
- Coping Skills for caretakers
- Coping skills for client
- Who to call in time of crisis

****Safety Plans are living documents, and as events unfold the plan is reviewed and updated****
Family Safety Plan

1. No one will place hands on anyone or anything in an aggressive way.

- **Warning signs for Marcus:**
  * Starts to threaten with words
  * Balls up fists
  * Pacing around the house

- **Triggers for Marcus:**
  * Mom or dad saying “No”
  * Mom or dad being unclear with expectations
  * Mom or dad appearing to favor the girls
  * Mom/dad setting limits with Marcus
Family Safety Plan Continued

2. If you notice these warning signs or will be engaging in a triggering activity:

Mom will...
*Validate Marcus; “Marcus, I get that you’re ____ (mad, frustrated, upset...etc.). Let’s take a break right now.”
*Engage in CBT exercises and utilize thought reframes during escalation
*Utilize stress management strategies
  *Walk away from the situation, and go to bedroom if siblings are not home.
  *If siblings are home go to bedroom with them and turn on movie, or go for a walk with them.
2. If you notice these warning signs or will be engaging in a triggering activity:

Mom will....

*Encourage Marcus to go and ‘chill’ until things have calmed down.

- Marcus will go to bedroom, porch or basement

*Call for support if you can’t walk away:
  - Call your pastor if you need to talk (be sure to do it in a place where Marcus can’t hear)
  - Megan or crisis phone if you feel you cannot walk away from Marcus

- Megan: 614-***-**** (Between 8:30AM and 6PM)
- MST Crisis Phone: 614-***-**** (before 8:30AM or after 6PM)
Dad will:
* Take the younger siblings out of the house or up to the bedroom.
* Call the crisis line
* Reward the other siblings if they follow the plan

Marcus will:
* Not put hands on anything or anyone in an aggressive way.
* Walk away from the situation
* Go to bedroom
* Sit on porch
* Go to basement
*If plan is followed/not followed reward and consequent appropriately:

- Marcus: Reward- $1 for walking away and going to safe place  
  Consequence- No money and must stay home for 24 hours
- Brittany: Reward: Verbal praise and positive attention and gets Starbucks drink, or Chipotle
- Tiana: Reward: Verbal praise, and positive attentions and new markers/crayons/coloring book

**Monitoring:**
- *An adult will always be present when Marcus is home with sisters.
- *Marcus will not go into sisters’ bedrooms.
Role plays
Questions?

Thank you for your time and attention!

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