

MULTISYSTEMIC THERAPY (MST)

Multisystemic Therapy (MST) – Youth

Definition

Multisystemic therapy (MST) is an intensive family and community-based treatment that addresses multiple aspects of serious antisocial behavior in adolescents. MST typically targets chronic, aggressive juvenile offenders who are at high risk of out-of-home placement away from their families. The multisystemic approach views the youth's behavior as being influenced by the surrounding "systems" – family, peer, school and neighborhood – as well as by the youth's thoughts and feelings about those systems.

MST addresses the many factors that are known to contribute to delinquency across the key settings, or systems, within which youth live, work and play. MST strives to promote behavior changes in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood) to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change.

The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems - to give parents the skills and resources necessary to help them independently address the difficulties that arise in raising teenagers - to improve functioning by empowering youth to cope with family, peer, school and neighborhood problems - and to achieve these outcomes at a cost savings by reducing the use of out-of-home placements (e.g., incarceration, residential treatment, hospitalization).

MST incorporates empirically-based treatments insofar as they exist. MST programs include cognitive behavioral approaches, the behavior therapies, behavioral parent training, pragmatic family therapies, and certain pharmacological interventions that have a reasonable evidence base.

MST is a home-based therapy. It is designed to overcome barriers to service, to increase family retention in treatment, to allow for the provision of intensive services (i.e., therapists have low caseloads), and to enhance the maintenance of successful behavior changes. MST intervention is available to youth and families 24 hours a day, 7 days a week via an on-call system that is staffed by MST team members. The usual duration of MST treatment is an average of four (4) months with an expected range of three (3) to five (5) months.

Criteria	
Admission Criteria	<p><i>The youth must meet 1, 2 and 3 and at least ONE from 4 through 8.</i></p> <ol style="list-style-type: none"> 1. The youth is between the ages of 12 and 17. 2. The DCBHS Assessment and other relevant information indicate that the youth needs MST treatment. 3. The youth manifests behavioral symptoms consistent with a DSM IV-TR (Axis I through V) diagnosis that requires MST intervention (e.g., Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, etc.). <p><i>The youth meets any ONE of the following:</i></p> <ol style="list-style-type: none"> 4. The youth manifests delinquent or antisocial behaviors which may include any of the following: <ol style="list-style-type: none"> a. The youth is physically aggressive at home, at school or in the community. b. The youth manifests verbal aggression which may include verbal threats of harm to others. 5. The youth is at imminent risk of out-of-home placement due to the delinquent or antisocial behaviors. 6. The youth is adjudicated. 7. The youth is a chronic or violent juvenile offender 8. The youth manifests substance abuse issues in the context of the delinquent or antisocial behavioral problems.
Psychosocial, Occupational, Cultural and Linguistic Factors	<p><i>These factors may change the risk assessment and should be considered when making level of care decisions.</i></p>
Exclusion Criteria	<p><i>Any of the following is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The DCBHS Assessment and other relevant information indicate that the youth needs a more (or less) intensive level of care. 2. The youth is at imminent risk of causing serious harm to self or others.

	<ol style="list-style-type: none"> 3. The youth is actively psychotic or in need of crisis psychiatric hospitalization or stabilization. 4. The youth has been diagnosed with schizophrenia. 5. The youth is experiencing problems that are primarily psychiatric rather than behavioral. 6. The youth has been diagnosed with Autism or a Pervasive Developmental Delay. 7. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors. 8. The youth is living independently or in a long term residential treatment setting. 9. There is no identifiable primary caregiver to participate in treatment despite efforts to locate all extended family, adult friends and other potential surrogate caregivers. 10. The youth can be safely maintained and effectively treated in a less intensive level of care. 11. The youth and/or the parent/custodian/guardian do not voluntarily consent to treatment and there is no court order requiring such treatment. 12. The youth has a sole presenting diagnosis of Substance Abuse. 13. The youth's level of cognitive ability does not allow him/her to benefit from the MST therapeutic interventions.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The DCBHS Assessment and other relevant information indicate that the youth continues to need the MST level of care. 2. The severity of the behavioral disturbance continues to meet the criteria for this level of care.

	<ol style="list-style-type: none"> 3. The youth’s treatment does not require a more intensive level of care and no less intensive level of care would be appropriate. 4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth’s clinical condition, his/her response to treatment and the strengths of the family. 5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice. 6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress. 7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment. 8. When clinically necessary, appropriate psychopharmacological treatment has been initiated. 9. There is documented evidence of active, individualized discharge planning.
<p>Discharge Criteria</p>	<p><i>Any of the following criteria is sufficient for discharge from this level of care:</i></p> <ol style="list-style-type: none"> 1. The youth and family have met and sustained a majority of the overarching treatment goals. 2. The DCBHS Assessment and other relevant information indicate that the youth no longer needs the MST level of care. 3. The youth has few significant behavioral problems and the family is able to effectively manage any recurring problems.

4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with prosocial peers and is not involved with (or is minimally involved with) problem peers. The therapist and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment.
7. The youth meets criteria for a more (or less) intensive level of care.