

MST Services

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Program Design & Implementation

Here you will find information about the implementation of Multisystemic Therapy (MST). Assistance with all aspects of program design, development and implementation can be obtained through MST Services, an organization established in collaboration with the Family Services Research Center (FSRC) of and the The Medical University of South Carolina (MUSC). The FSRC is the primary organization conducting ongoing research of the MST treatment model. MST Services provides communities with assistance in all aspects of program development and staff training through licensing agreements with the FSRC and the MUSC. Research has indicated that the successful client outcomes with MST depend upon adherence to the treatment model by program staff. The information included in this section provides an introduction to program design and implementation. For additional information about how MST can be effectively implemented in your community please contact MST Services at 843-856-8226.

Additional site readiness materials:

- [Feasibility Questionnaire](#)
- [Stages of MST Program Development](#)
- [Site Evaluation Checklist](#)

MST programs are most appropriate in those communities in which stakeholders (i.e., juvenile justice, mental health, family court, the schools, social welfare) and funders are interested in reducing rates of out-of-home placement, that is, seeking alternatives to incarceration and residential treatment. Motivations for seeking alternatives can range from the cost savings afforded to the value of preserving family integrity. In addition, MST programs are more likely to be effective in communities where stakeholders are more interested in rehabilitating adolescents presenting high

rates of criminal activity than in punishing them.

Common Community Characteristics

New programs are often started by the efforts of a single Champion or agency looking to make their world a better place. They start by evaluating the needs and services in their community and determining where improvement is needed. Communities that may benefit from implementing MST have many similar characteristics including:

- At least 60 or more youth aged 10-17 that are involved in the juvenile justice system and are at risk of placement in detention, jail or long-term residential centers because of their behavior
- Stakeholders (i.e., the justice system, mental health, education and social welfare) that seek proven methods for reducing juvenile antisocial behavior and are willing to support such programs with adequate funding, program referrals and collaborative implementation
- A broad desire to use financial and other resources in the most cost-effective way – including a willingness to shift existing resources away from services with little or no proven effectiveness (e.g., punitive approaches) toward more evidence-based practices (those with both research and real-world evidence of success)
- An interest in service provider accountability for client engagement and outcomes
- A commitment to support the success and integrity of all families in the community
- A commitment to community safety through reducing juvenile offending behavior

Only a few juvenile justice programs are available to help communities with the above needs. The first step in selecting such a program is conducting a thorough feasibility assessment that includes determining the needs of the targeted population, the availability of sufficient funding and the agreement across stakeholders regarding support for the selected approach.

THE MST PROGRAM DEVELOPMENT METHOD™



MST Services created the Program Development Method™ (PDM) from the successes and challenges of organizations implementing MST over more than a decade of MST dissemination. Because each organization brings a variety of strengths into this process, the PDM is rarely applied

exactly the same way each time. Rather, it is an assembled set of tools that will allow the local program developer to assess the strengths, identify the weaknesses, locate the opportunities and plan for the threats unique to each organization within its own community context.

[How to Start an MST Program](#)

INTERAGENCY LINKAGES AND COLLABORATION

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The success or failure of any program targeting juvenile antisocial behavior impacts many systems and people from the elected policy makers to the citizens who want to feel safe in their neighborhood and community. The support and collaboration of several key systems greatly enhances the chances of success. These systems are commonly referred to as “Stakeholders.” The largest of these stakeholders include juvenile justice, social welfare, mental health, education and the court system. A local MST program developer will devote substantial energy to engaging all relevant systems to collaborate in the development, implementation and support that includes assuring adequate funding, referrals and ongoing operation. Because of change and personnel turnover in each stakeholder agency, the MST provider builds a process of ongoing communication and engagement with each stakeholder to provide a foundation for future problem-solving.

FUNDING

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Communities expend tremendous amounts of financial resources on services for serious juvenile offenders. Unfortunately, many of those resources are allocated to services that are expensive and have no demonstrated effectiveness. Because no new resources are likely in the near future, communities aiming to develop more effective mental health and juvenile justice services must shift the emphasis of funding from incarceration and other out-of-home placements to community-based programs. No one universal funding mechanism exists for MST, so communities across the nation have had to create several mechanisms for funding MST projects.

These include:

- Medicaid reimbursement typically under the rehabilitative services option (e.g., intensive

home-based services);

- shifting state children's services moneys allocated for residential treatment programs or other out-of-home placements (e.g., foster care) to the MST program; and
- making home-based MST a component of the continuum of care provided by a managed care organization that treats youths with serious emotional disturbance under a capitated rate from the state.

The cost savings demonstrated in randomized trials of MST are described in the [MST Treatment Model Section](#). Funding for MST cases should be in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, "productivity", etc.

REQUIRED RESOURCES

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Every quality program requires a sufficient level of resources to support and sustain quality client outcomes. MST is no different. In the section below, requirements for MST programs are presented with associated justification where needed. Underfunded programs tend to experience difficulty in attracting and retaining quality staff, have limitations on their ability to maintain productive working relationships with key community systems, and have little or no resources dedicated to program evaluation and continuous quality improvement – in short, they begin to look more like “business as usual” that we already know doesn’t work. The old adage “pay now or pay more later” has real application here. When adequate resources are dedicated, part of MST’s quality management includes monitoring and improving the efficiency of the use of these resources in addition to the clinical quality management.

SERVICE PROVIDER ORGANIZATIONS

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In general, public mental health settings or private provider organizations that deliver mental health services provide the home for most MST programs. The culture of such settings are more likely to include an emphasis on providing rehabilitative services for disadvantaged families vs. being punishment oriented. In addition, the infrastructure of these agencies routinely include processes such as case record keeping system, staff knowledgeable about issues such as confidentiality, relations with formal community resources, that supports the provision of community-based mental health services. A caveat, however, is that a percentage of such organizations may also support other programs with philosophies (e.g., children are best treated in out-of-home placements) or theoretical frameworks (e.g., psychodynamic) that may conflict with those of MST. The goals of MST

programs include providing clinically effective, family-based services with high levels of provider accountability for outcome. Thus, the functional mission and current service array of the MST host agency must be examined for compatibility with the MST treatment approach. MST Services, Inc. extends considerable efforts toward examining such compatibility during initial site development work. The ideal organizational context is one in which the provider administers a range of family- and community-based services that vary in restrictiveness from outpatient, to home-based, to therapeutic foster care, with even a small short-term residential component in some cases.

MST Network Partner Organizations

A key element of the dissemination strategy employed by MST Services is the development of a network of “partner” organizations that are committed to disseminating the MST model with full integrity and fidelity. Typically, larger MST provider organizations with the aim of large-scale growth are targeted for this level of development. These MST Network Partner organizations employ staff fully trained in MST program development as well as clinical staff training and development. MST Services maintains an on-going working relationship with each MST Network Partner organization focused on staff development, quality improvement and quality assurance activities. In effect, MST Services trains and supports MST Network Partner organizations with a level of intensity that allows MST Services to retain accountability for quality assurance.

Provider Agency Staffing and Supervision

MST is conducted by master's-level therapists, (or, in some cases highly competent bachelor's-level professionals) who receive on-site supervision from doctoral- or masters-level mental health professionals. Therapists are selected on the basis of their motivation, flexibility, common sense, and "street smarts," the master's degree being viewed more as a sign of motivation than as evidence of a particular type or level of clinical expertise. Each MST treatment team consists of three to four therapists, with each therapist carrying a caseload of four to six families.

Weekly supervision is provided during scheduled times and as needed. Like MST interventions, supervision is pragmatic and goal-oriented. Therapists are expected to conceptualize cases in multisystemic terms, and supervision is directed toward articulating treatment priorities, obstacles to success, and designing interventions to successfully navigate those obstacles. As members of therapist teams, therapists consult one another informally and during formal supervision. In addition

and as described next, MST integrity is further supported and reinforced through weekly consultation with an MST expert. Thus, a high level of clinical support is provided to therapists from team members, supervisors, and MST consultants.

PROGRAM PRACTICES AND CHARACTERISTICS



The Success of MST depends on the provision and proper management of necessary resources. The costs of this intervention must be compared with the relative costs (including outcomes) of other alternatives. The MST Provider organization with full support of all community stakeholders, must commit to provide the following resources:

- MST Therapists must be full-time employees assigned to the MST program solely.
- MST Therapists must be accessible at times that are convenient to their clients and in times of crisis, very quickly. Issues to be addressed in the area include the dedicated nature of the MST Therapist role, the use of flex-time/comp-time, policies regarding the use of personal vehicles, and the use of pagers and cellular phones.
- MST Therapists must operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor) and use a home based model of service delivery.
- MST Clinical Supervisors must be assigned to the MST program a minimum of 50% time per MST Team to conduct weekly team clinical supervision, facilitate the weekly MST telephone consultation, and be available for individual clinical supervision for crisis cases.
- MST case loads must not exceed 6 families per therapists with a normal range being 4 to 6 families per therapist. The expected duration of treatment is 3 to 5 months.
- In order to achieve outcomes through consistent adherence to the MST model, MST Therapists must track progress and outcomes on each case weekly by completing case paperwork, and participating in team clinical supervision and MST consultation.
- The MST program must have a 24 hour/day, 7 day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. This system must be staffed by professionals who know the details of each MST case and understand MST.
- With the buy-in of other organizations and agencies, MST Therapists must be able to "take the lead" for clinical decision making on each case. The organization sponsoring the MST program has responsibility for initiating collaborative relationships with these organizations and agencies. Each MST Therapist sustains these relationships through ongoing, case-specific collaboration.
- Inappropriate referrals to the MST program include youth referred for primarily psychiatric behaviors

(i.e. actively suicidal, actively homicidal, actively psychotic), and youth referred for sex offenses.

- MST program discharge criteria must be outcome-based and ameliorate the referral problem/behavior.

Additional recommended program practices and characteristics:

- MST Therapists should be Masters level professionals.
- MST Clinical Supervisors should be Ph.D. level professionals.
- MST Clinical Supervisors should have both clinical authority and administrative authority over the MST Therapists they supervise.
- Funding for MST cases should be in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, "productivity", etc.
- MST programs should have formal outcome tracking systems in place.
- MST programs should use outcome-focused personnel evaluation methods.
- Planning for cases after they are discharged from the MST program should be carefully managed and limited to after-care referrals that target specific, well-defined problems. The assumption is that most MST cases should need minimal "formal" after-care services.

For expanded definitions and descriptions of Program Practices And Characteristics click on this link: [MST Program Practices And Characteristics](#) (Word document).

MST (MULTISYSTEMIC THERAPY) SERVICES

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MST Services is at the center of efforts to disseminate Multisystemic Therapy within the United States and internationally. MST Services provides assistance with all aspects of program development and staff training through licensing agreements with the Medical University of South Carolina and the Family Services Research Center.

The mission of MST Services is to provide high quality, highly responsive training and consultation services to organizations seeking to deliver home-based services using Multisystemic Therapy to target populations with which MST has been shown to be effective. The personnel delivering the training and consultation services are doctoral and masters level experts in MST.

The MST program start-up, support, and training program has been developed to replicate the

characteristics of clinicians, training, clinical supervision, consultation, monitoring and program support provided in the successful clinical trials of MST. The core MST clinical training package consists of pre-training program start-up services, initial 5-day training, weekly MST clinical consultation for each team of MST clinicians, quarterly booster training, and monitoring of fidelity and adherence to the MST treatment model. The MST program start-up, support, and training program has been refined through extensive experience with MST program replications in Canada, Norway, and throughout the United States.

PROGRAM START-UP SERVICES



The program start-up services include technical assistance and materials designed to produce a program description, projected budget, and implementation timeline. Key critical elements include review of RFP documents and/or responses, clear articulation of the target population definition and prioritization process, referral and discharge criteria and processes, recommendations regarding clinical record keeping practices and initial program evaluation planning.

Prior to MST training, an MST Program Developer provides on-site and/or telephone consultation regarding the development and implementation of a successful MST program. The development of a new MST program is a process that requires significant community collaboration and often takes up to 12 months to complete. The objectives of the pre-training assessment are to identify the mission, policies, and practices of the customer organization and of the community context in which it operates, and to specify the clinical, organizational, fiscal, and community resources needed to successfully implement MST. These assessment activities include: on-site meetings with the organization's leadership and clinical staff; meetings with staff from agencies that influence patterns of referral, reimbursement, and/or policy affecting the customer organization's capacity to implement MST; designing clinical record-keeping to document MST treatment goals and progress; assistance in developing systems to measure outcomes; review of evaluation proposals; and, consultation regarding Requests for Proposals (RFPs) relevant to the development and funding of the MST program.

The MST Program Developer will visit your community to provide an overview presentation and meet with your community stakeholders to assure the buy-in needed for program success after start-up. Next, staff recruitment assistance includes sample job descriptions, review of hiring

advertisements, interviewing and selecting staff most qualified to implement MST successfully. Finally, all selected initial staff will complete the 5-day MST Orientation Training.

TRAINING AND RELATED SERVICES



The core of MST services provided consists of an initial 5-day training, ongoing MST clinical support, quarterly booster training, ongoing organizational assistance and quality assurance support through the monitoring of treatment fidelity/adherence.

The ongoing MST clinical support we provide has been developed to replicate the characteristics of training, clinical supervision, consultation, and monitoring provided in the successful clinical trials of MST. This program implementation protocol has been refined through extensive experience with communities and providers in numerous sites in the US and internationally. After start-up, training continues through weekly telephone MST consultation for each team of MST clinicians aimed at monitoring treatment fidelity and adherence to the MST treatment model, and through quarterly on-site booster trainings (1 1/2 days each). Our trained MST experts will teach your MST supervisor to implement a manualized MST supervisory protocol and collaborate with the supervisor to promote the ongoing clinical development of all team members. The MST expert will also assist at the organizational level as well.

Initial 5-day training

Five days of initial training is provided for all clinical staff in the customer organization who will engage in treatment and/or clinical supervision of MST cases, and for individuals who could influence MST treatment plans (e.g., psychiatrists, psychologists, counselors with whom the customer organization contracts for services). The objectives of the 5-day training are:

- to familiarize participants with the scope, correlates, and causes of the serious behavior problems addressed with MST;
- to describe the theoretical and empirical underpinnings of the treatment model;
- to describe the family, peer, school, and individual intervention strategies used;

- to train participants to conceptualize cases and interventions in terms of the principles of MST; and,
- to provide participants with practice in designing Multisystemic interventions.

Training procedures include slide presentations, structured discussion, role-play, and interactive formats. The training is attended by all agency staff who will have clinical or supervisory responsibility in the MST program. In addition, administrators and stakeholders from collaborating agencies often attend the first day of training to become oriented to program rationale goals, procedures, and so forth.

When there is staff turnover, new staff need to receive the 5-day initial training in MST prior to joining the MST team and accepting cases. After they receive the 5-day initial training, new staff will join the rest of the existing team in weekly MST consultation and 1.5 day booster training. With regard to the initial 5-day training, organizations can access the training in one of two ways. New staff can come to Charleston, SC and participate in one of the quarterly open-enrollment training provided by MST Services Inc. Alternatively, providers can elect to have MST Services Inc. conduct an additional 5-day initial training at their site.

Quarterly booster training with the MST Consultant

As therapists gain field experience with MST, quarterly booster sessions are conducted on site. The purpose of these 1 1/2 day boosters is to provide additional training in areas identified by therapists (e.g., marital interventions, treatment of parental depression in the context of MST) and to facilitate in-depth examination, enactment, and problem-solving of particularly difficult cases. Again, during the first and most of the second phase of a large scale project, MST Services' MST Consultants will be responsible for designing and delivering the booster training. During the second phase, these responsibilities will be transferred to the customer's personnel who are being trained to be MST Consultants (dependent upon their development with regard to providing the weekly telephone consultations).

Weekly phone consultation with the MST Consultant

Weekly phone consultation is provided for each treatment team (therapists and supervisor) by the MST consultant. Consultation sessions focus on promoting adherence to MST treatment principles, developing solutions to difficult clinical problems, and designing plans to overcome any barriers to obtaining strong treatment adherence and favorable outcomes for youths and families. As noted earlier, high treatment adherence is critical to obtaining favorable long-term outcomes for serious

juvenile offenders, and, as such, the central goal of the training and consultation process is to maximize adherence to the MST principles. Further information regarding training, including cost estimates, can be obtained from MST Services.

Ongoing organizational assistance

Ongoing organizational assistance aims to overcome barriers to achieving successful clinical outcomes through services that may include a comprehensive business planning process, promotion of the MST program within the broader service community, and developing program-level interventions designed to increase referrals, reduce staff attrition, or restructure program funding mechanisms to increase sustainability.

Quality assurance support

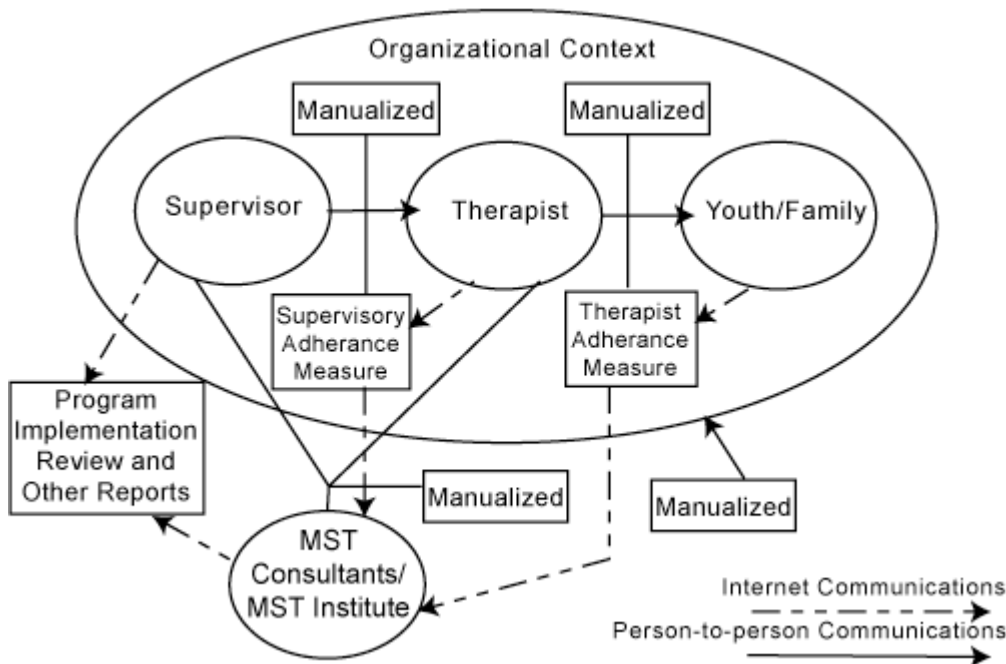
Considerable resources have been devoted to the development of quality assurance mechanisms aimed at enhancing MST treatment fidelity, and this has taken place for two primary reasons. First, considerable research consistently supports the link between therapist adherence to MST treatment principles and youth outcomes (i.e., reduced rates of recidivism and incarceration). Hence, the development and testing of a strong quality assurance is critical toward the goal of optimizing youth and family outcomes. Second, with the transport of MST programs to community settings procedures to support the effective implementation of MST in distal sites became critical.

Quality assurance support activities focus on monitoring and enhancing program outcomes through increasing therapist adherence to the MST treatment model. The MST Therapist Adherence Measure and the MST Supervisor Adherence Measure have been validated in the research on MST with antisocial and delinquent youth and are now being implemented by all licensed MST programs. Additionally, new measures of supervisor practices, organizational, and broader systems-level influences on client outcomes are under development and are available to interested MST sites. Also, A brief measure of ongoing youth outcomes is in development.

MST consultants orient clinical supervisors to the process of periodic reviews of clinician adherence to MST. Such reviews entail supervisor review of clinicians' audio-taped treatment sessions and rating of adherence with measures developed in clinical trials of MST. Review of audio-taped sessions may also be recommended to identify aspects of therapist-family interactions and interventions that facilitate and/or complicate advancement toward therapeutic goals.

Figure 1 provides a representation of the MST quality assurance system (Henggeler & Schoenwald, 1999). As described extensively by Henggeler, Schoenwald et al. (2002), the therapist's interactions with the family are viewed as primary because of their critical role in achieving outcomes. Several structures and processes are used to support therapist adherence to MST when interacting with families. These include manualization of key components of the MST program, ongoing training of clinical and supervisory staff, ongoing feedback to the therapist from the supervisor and MST expert consultant, objective feedback from caregivers on a standardized adherence questionnaire, and organizational consultation. By providing multiple layers of clinical and programmatic support and ongoing feedback from several sources, the system aims to optimize favorable clinical outcomes through therapist support and adherence.

Figure 1: MST Quality Assurance System.



Manualization of program components

All components of the quality assurance system are manualized. The treatment manuals for antisocial behavior (Henggeler et al., 1998) and serious emotional disturbance (Henggeler, Schoenwald et al., 2002) are available from Guilford Press. The other manuals are provided to MST sites. Sites are licensed through MST Services, Inc. (www.mstservices.com), which has the exclusive license for the transport of MST technology and intellectual property through the Medical

University of South Carolina.

- Treatment: (Henggeler et al., 1998) – specifying MST clinical protocols based on the nine core treatment principles.
- Supervision: (Henggeler & Schoenwald, 1998) – specifying the structure and processes of the weekly onsite supervisory sessions and ongoing development of therapist competences.
- Expert consultation: (Schoenwald, 1998) – specifying the role of the MST consultant in helping teams achieve youth outcomes and in building the competencies of team therapists and supervisors.
- Organizational support: (Strother, Swenson, & Schoenwald, 1998) – addressing administrative issues in developing and sustaining a MST program.

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