Accessing Evidence-Based Program: Multi-Systemic Therapy (MST)

For Virginia Children's Services Act (CSA)

Created by AMIkids (AMI) and Evidence-Based Associates (EBA)
through DJJ's Regional Service Coordination (RSC) Project,
in Partnership with the VA Department of Juvenile Justice (DJJ).

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I. Introduction

The purpose of this document is to provide guidance to local CSA programs including CSA Coordinators, CPMTs and FAPTs, and to orient the CSA Programs to a community-based, evidence-based program known as "Multisystemic Therapy" (MST). After review of these documents, CSAs will have the information needed to decide if they will adopt MST locally and understand the process for making appropriate referrals to MST.

At present, MST is available in most localities across the state. The current MST teams, which were developed by AMIkids (AMI) and Evidence-Based Associates (EBA) as part of the Virginia Department of Juvenile Justice's Regional Service Coordination Project, align geographically with DJJ's administrative regions (see regional map here). See Appendix A for a list of all MST locations in Virginia and their catchments areas.

To learn more about MST please refer to the following:

- MST Services http://www.mstservices.com/
- VA Commission on Youth: *Collection of Evidence-Based Treatment Models*http://vcoy.virginia.gov/collection.asp
- Blueprints For Healthy Youth Development https://www.blueprintsprograms.org/
- Evidence-Based Prevention & Intervention Support Center (EPIS Center): *Comparison Between MST and FFT* http://www.episcenter.psu.edu/sites/default/files/FFT%20and%20MST%20May%205%202018%20Final%20%281%29.pdf

II. What is MST (and why all the fuss about 'fidelity')?

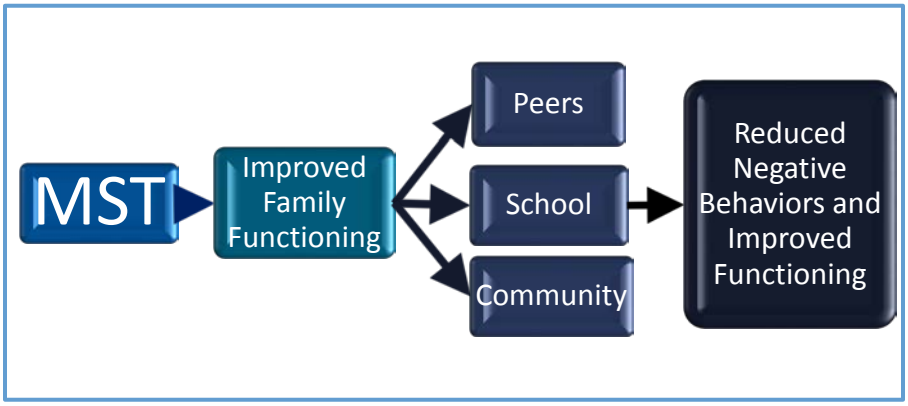
Multi-systemic Therapy (MST) is an evidence-based, intensive, community-based, family-focused treatment program which has been demonstrated through more than 30 years of research to be highly-effective for youth whose behavior puts them at risk of out of home placement (including court involved, CHINS and foster care prevention youth). Clinically, MST focuses on empowering caregivers to address challenges that are presented by the youth's behavior and to make sustainable changes in the multiple systems in which the youth operates – family, school, peer and community. ***In multiple studies, adherence to MST principles (aka fidelity to the treatment model) has predicted long-term positive outcomes for youth and families.***

MST in Brief	
Target Population	MST is an evidence-based program that empowers youth (aged 12 – 17) and their families to function responsibly over the long term. MST reduces delinquent and antisocial behavior by addressing the core causes of such conduct – and views the client as a network of systems including family, peers, school, and neighborhood. This includes truancy, substance abuse/ use, vandalism, shoplifting, physical aggression, and runaway behaviors to include Children in Need of Services (CHINS), youth served through foster care-prevention, and youth at risk of or returning from out of home placement.
CANS	CANS score (e.g. priority to include actionable needs (i.e. rated 2 or 3) in the following possible domains: school, child behavioral/ emotional needs, and child risk behaviors; may also include subcategories of substance abuse needs (SUN), violence needs (VN), runaway and juvenile justice needs (JJN) modules.
YASI (DJJ)	Risk factors or lack of protective factors in the following areas: Legal History, Family, School, Community/Peers, Alcohol/Drugs, Mental Health, Violence/Aggression, Cognitive Skills, Attitudes/ Values/ Beliefs and Employment/ Use of Free Time
Ages	12-17.5 (MST services will begin services only if there is enough time to complete a full course of treatment)
Duration	Average 120 days of services. MST is a time-limited service, per model requirements. While treatment may extend past 120 days, the model has strong guidelines about cases nearing 150 days and strongly discourages cases extending past 5-6 months.
Exclusionary Criteria	☐ Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers; ☐ Youth who are actively suicidal, homicidal, or psychotic (youth who are appropriately assessed and treated to ameliorate active ideation may be later referred to MST); ☐ Youths whose psychiatric problems are the primary reason leading to referral, or who have severe psychiatric problems; ☐ Youth where sexual offending occurs in the absence of other delinquent behavior; and ☐ Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism
EBP Directory Endorsements	Blueprints: Model Plus www.blueprintsprograms.org California Evidence-Based Clearinghouse (CEBC): Well-Supported www.cebc4cw.org Virginia Commission on Youth http://vcoy.virginia.gov/collection.asp
Certification	MST is **only** implemented in teams; individual clinicians may not practice MST to model fidelity. Teams consist of 3-4 master's level therapists (and a supervisor) with caseloads of 4-6 families. Supervisors may carry a caseload up to 2 families. Teams must be licensed by MST Services with ongoing training and weekly supervision by an MST system partner.

III. MST Logic Model and Fidelity Tracking System

A. The Goal of MST Implementation:

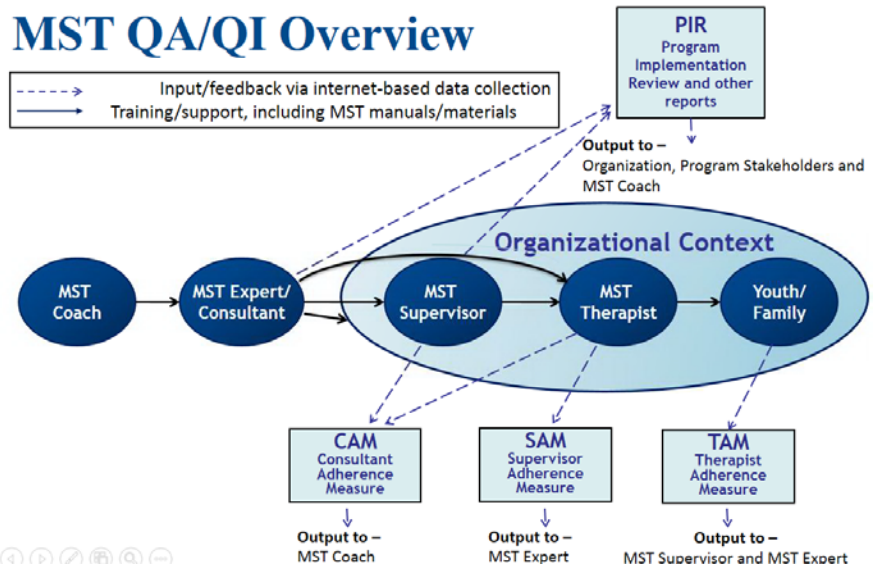
Obtain positive outcomes for MST youth and their families.



The caregivers' efforts are the key avenue through which change occurs. MST clinicians work with caregivers to leverage the strengths of the caregivers, youth, and their ecology to improve discipline and monitoring of the youth, improve family relationships, increase collaboration with the school, and improve the caregivers' linkage to peers and other supports.

B. Quality Assurance/ Continuous Quality Improvement (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



The in-depth and ongoing QA/QI process is central to the nature of evidence-based models such as MST.

Accountability for the outcomes for youth and families in MST are shared by all members of the team – Family, MST Therapist, MST Supervisor, MST Expert and Organization. The QA/QI processes outlined above demonstrate the different components of the MST model that are designed to set therapists and families up for success and to obtain the best possible outcomes (i.e. decreasing antisocial behavior, improving family functioning, etc.). The QA/QA process is ongoing, and feedback is received at all levels within MST. Monitoring implementation of the model is an ongoing process in MST.

IV. Getting started: How to build program readiness for MST

CSAs located within the service areas covered by DJJ's current MST teams, and interested in exploring the use of MST for their localities should contact AMIkids or EBA to initiate the Site Readiness and Implementation Process. As the RSCs, AMI and EBA, partner with the MST Teams to deliver quality services and provides ongoing oversight in implementation and utilization management.

1. Upon being contacted by an interested CSA, the Provider Program Manager or the Regional Service Coordination Agency will meet with the CSA Coordinator (via meeting or phone call) to determine a clear understanding and expectation of the Model. As part of the conversation, the Provider Supervisor will share informational material with the CSA Coordinator or CPMT (i.e. existing MST Goals and Guidelines Document, brochures, etc.).
    a. The Goals and Guidelines document is a standard document template that is part of the MST quality assurance process, ensuring that (among other things) there are clear inclusionary and exclusionary criteria to guide each referral to the program. Copies are available upon request from the MST Provider or the RSC.
    b. The existing guidelines have been developed by the MST Provider Agency (e.g., FPS or NCG) in partnership with the RSC and the MST Program Development experts.
2. Next, the RSC Program Director and/or the MST Team Supervisor will schedule with the CSA Coordinator, CPMT, and/or FAPT an on-location stakeholder meeting to discuss the program specifics (i.e. MST will review and revise the Goals and Guidelines Document).
    a. The Site Visit/Stakeholder meeting is open to anyone interested in supporting MST adoption but shall include at a minimum, representatives from the FAPT and/or CPMT (depending on the locality these could occur simultaneously).
    b. The Site Visit shall be jointly hosted by the CSA Coordinator, the MST Provider agency, and the RSC.
    c. The stakeholder meeting, also known as the site visit, will typically include discussion of the following specific topics/ agenda items:

Stakeholder Meeting Agenda: Overview of MST Treatment Model*

- Primary goals of MST
- Theoretical underpinnings of MST (i.e., the social-ecological model)
- Causal models of delinquency and drug use
- Research overview and examples of the effectiveness studies of MST
- How MST is "specified" and practiced
    - The Nine MST Treatment Principles
- Outcomes, Quality Control, and Adherence Monitoring
- Review of target population
- Definition of the referral process
- Definition of the program goals and outcome measures
    - Discussion of resources required for success
    - Discussion of community and MST Provider Agency collaboration
    - Identification of potential barriers to successful Implementation

*Agenda may be abbreviated as needed

V. Referral Procedures

The purpose of this section is to detail the referral process so that all MST team members, key stakeholders and referral agents understand the process. Such understanding will assist MST staff to better serve the referring agency. Referrals may be accepted if the youth/ family resides in the identified catchment area for the MST Team.

Following the stakeholder meeting, the Goals and Guidelines Document will be revised and updated. Once it is completed, the Goals and Guidelines Documents will outline the detailed referral process and should be reviewed by each stakeholder. A Referral Form will be provided to the CSA Coordinator.

Where do I send a referral?

The MST Referral Form is located on the EBA or AMIkids website. The form can also be electronically sent to the CSA office, following a stakeholder meeting, for distribution to case managers. A completed referral form and attachments are required to complete the MST referral packet.

- Referrals for EBA's region should be sent to: VACSAreferral@ebanetwork.com.
- Referrals for AMIkids region should be sent to: VAServices-Referrals@amikids.org

Inclusionary Criteria

- ☐ 12 to 17 years old
- ☐ In community or ready to return to the community within 30 days.
- ☐ Family available and willing to participate.
- ☐ Inclusionary referral behaviors include externalizing behaviors, internalizing symptoms, and/or substance abuse.
- ☐ Referral issues can be from one domain (externalizing alone) or in combination (co-morbidity of substance abuse and externalizing behaviors).

Exclusionary Criteria

- ☐ Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
- ☐ Youth who are actively suicidal, homicidal, or psychotic
- ☐ Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- ☐ Youth with Sexualized Behaviors/Juvenile Sex Offenders (sex offending in the absence of other delinquent or antisocial behavior).
- ☐ Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.
- ☐ Youth involved in other family therapy service

Priority Criteria for Waitlist

If the MST Provider is at capacity and the client is placed on a wait list; referrals will be prioritized based upon the considerations listed below and then triaged. Referrals are not prioritized solely on the date of referral or the convenience of a provider. The RSC and MST Provider may also staff any high priority/ high risk cases with the MST Expert to see if appropriate for services or to determine triage order.

- Court status/ DJJ involvement (e.g. parole or probation);
- YASI risk assessment score (prioritizing high and moderate risk levels);
- Seriousness, duration, and frequency of offending (e.g., status vs. criminal, person vs. property);
- Multiple court / system involved youth in the home;
- Immediate placement risk or numerous failed services and/or history of out of home placements.
- Availability or access to services
- CANS score

VI. Looking ahead

Who to contact for support?

The Project Directors for the each of DJJ's contracted Regional Service Coordination companies are available to answer questions about the MST referral process. For questions about the MST model, the team-specific Goals and Guidelines Document, which should answer most questions. The RSC, in collaboration with local CSU Directors, the MST Expert and MST Provider, previously facilitated a robust conversation with stakeholders in developing the Goals and Guidelines document. This living document serves as the resource guide for how referrals will be communicated and processed. The Goals and Guidelines Document serves as the "How To" document for MST, providing information and tips to referral sources in making referrals and knowing the specific steps.

The Goals and Guidelines Documents are available upon request and may be located on the RSCs' website.

Ongoing Reporting Requirements (with referring case manager)

The MST Provider will send a weekly e-mail or call the referring staff to provide a brief outline of the interaction with the youth and family and progression through MST. An individual monthly report will provide an overview of the youth's progress on short-term objectives, successes, challenges, and dates of sessions. Monthly reports will be sent to the RSC and/or the referring agency, by the 5th of every month (this may vary based on local CSA contracts).

Appendix A: Where is MST currently available in Virginia?

On behalf of the Virginia Department of Juvenile Justice (DJJ), AMIkids (AMI) and Evidence-Based Associates (EBA) contracted with providers to begin the development of MST Teams in the following regions.

Provider	Launch Date	CSUs Served	Office Location	RSC	Service Area
Family Preservation Services (FPS)	10/1/2017	26, 20W	Winchester	EBA	Winchester, Woodstock, Harrisonburg, Warren, Frederick, Clarke, Shenandoah, Rockingham, Page, Fauquier, and Rappahannock
Family Preservation Services (FPS)	10/1/2017	21, 22, 23A	Martinsville	EBA	Danville, Franklin, Pittsylvania, Martinsville, Henry, Patrick, Roanoke City
Family Preservation Services (FPS)	10/1/2017	23, 23A, Parts of 27, Parts of 29	Montgomery Co.	EBA	Montgomery, Pulaski, Floyd, Radford, Roanoke City, Roanoke County, Salem, Smyth, Giles, Bland, Wythe, Carroll
Family Preservation Services (FPS)	10/1/2017	Parts of 16, Parts of 25	Staunton	EBA	Staunton, Augusta, Waynesboro, Rockbridge County, Lexington, Buena Vista, Charlottesville, Albemarle, Highland, Culpeper, Madison, Greene, Nelson, Bath, Rockingham, Harrisonburg, Covington, and Alleghany
Horizon Behavioral Health	6/20/2018	24 and one area in 10	Lynchburg	EBA AMI	Lynchburg, Bedford, Campbell, Amherst, Appomattox
National Counseling Group (NCG)	10/18/2017	1, 2, 3, 4	Virginia Beach, Norfolk	AMI	Virginia Beach, Norfolk, Chesapeake, Portsmouth
National Counseling Group (NCG)	10/18/2017	7, 8	Hampton	AMI EBA	Hampton, Newport News, Williamsburg, York, Gloucester, James City, Poquoson
Henrico Mental Health (CSB)*	continuation	14 (EBA CSU 9)	Henrico	AMI EBA	Henrico, which is a continuation of an existing program. New Kent and Charles City
Richmond Behavioral Health	continuation	13	Richmond	AMI	Richmond City and Chesterfield County

Appendix B: Making Referrals

Referral Packet

The referral packet is completed by the CSA/ Lead Agency Case Manager. A complete packet shall include:

- ☐ MST Referral Form
- ☐ Consent / Release of Information
- ☐ CSA Face Sheet (with youth demographics and family contact information)
- ☐ Funding Approval
- ☐ FAPT approved IFSP and meeting notes
- ☐ CHINS Approval (as needed)
- ☐ Recent CANS Assessment
- ☐ Recent assessments or evaluations that provide details of recent behaviors, if applicable

Failure to submit a complete referral packet, may cause a delay in service provision.

Where to send Referrals?

Referral packets shall be sent via e-mail to:

- EBA at VACSAReferral@ebanetwork.com
- AMIkids at VAServices-Referrals@amikids.org

Referrals sent directly to the MST Provider may cause a delay in services.

What to expect after I make a referral?

The RSC will promptly (i.e., within 48 hours) reply acknowledging receipt of the referral will review the packet for completeness and will ensure adequate information is available to determine appropriateness.

If additional information is needed, the RSC will send the referral packet to the MST Supervisor and copy the referral source.

NOTE: If the Provider/ MST team receives the referral packet directly from the CSA, the provider will forward the referral packet to the RSC and MST Supervisor for review and copy the referring staff, which may cause a delay in the referral process and service initiation.

Disposition of Inappropriate Referrals

- If it is necessary to deny a referral, the RSC will email an explanation to the referring agency and follow with a phone call to provide information to the referral source to improve future referrals.
- The RSC will include the MST Supervisor (copied via e-mail) of the inappropriate referral, in the event the MST Provider agency can support the referral through another service.

Once the RSC has submitted the referral to the MST Provider and the referral has been received and reviewed by the MST Team Supervisor, it is expected that the case will be assigned to a therapist and that the therapist will initiate contact with the family within 48 hours.