

Purpose and Target Audience: The purpose of this document is to provide guidance to Referral Sources (including CSU and CSA) and Direct Service Providers of MST or FFT.

Background: FFT and MST are home- and family-based services designed to address a multitude of family-related issues which often serve families with multiple siblings in the same home and families with other/non-traditional family structures. Both models indicate positive outcomes for the whole family, including siblings. MST reports a 40% reduction in overall sibling arrest rates, by equipping caregivers with the needed skills. Siblings of youth receiving FFT showed lower arrest rates than siblings from alternative treatment conditions 2 ½ to 3 ½ years post-treatment, specifically a sibling study that demonstrates FFT prevents younger children from penetrating the system of care. While both FFT and MST strive to include all family members in the treatment process (i.e., resulting from a single referral), there are circumstances which may justify a secondary referral which identifies an additional family member as the primary target for treatment and tracking of outcomes. While this Referral Guide won't cover every unique situation, it aims to guide the referral process and outline situations which may be appropriate for a second referral within the same family/family structure.

All initial referrals for MST and FFT must meet the following criteria:

- All youth referred must be on probation or parole to receive DJJ funding through the RSC model
- The RSC must approve funding prior to provider invoicing
- Request must be initiated by the PO or other referral source

Referral guidelines:

Referrals for siblings or other household members should be considered on case-by-case basis. Referral request should indicate rationale of how needs are not being met with current MST/ FFT services focused on a sibling.

For example:

- Siblings live in the separate homes and therapist will engage two separate ecological models
- Youth referrals are starting at different times (i.e., one youth may be placed out of the home and then s/he transitions back home in at a separate time and is not able to acclimate to the progress and pacing of the youth currently receiving the service). Note: this is not to contradict the MST position statement recommending time-limited services (see Appendix A).
- Siblings have different parents, guardians or caregivers (i.e. step parents, biological parents).
- Family dynamics are so complex and/or individual drivers for delinquent behavior are unique or separate for each referred youth which requires a separate assessment and analysis. For example, the youth are in different peer groups, social settings, and/or schools, whereby overarching goals are not aligned with one another.)

Important Notes: The goal should be for a single therapist to work with the family, even with multiple youth referrals in the same household. This maintains therapeutic congruence and partnership with the family. In some circumstances, the FFT Consultant or MST Expert may recommend that siblings have two separate therapists. These outliers would be staffed on a case by case basis with the model expert and RSC.

Funding: DJJ will fund sibling referrals at the fully contracted approved rate for cases that meet the above criteria.

Appendix A

MST Services

Position Statement Memo

Date: September 23, 2005

Topic: **The referral of more than one child or youth per family to MST**

Issue: Often, a referral source considers referring more than one child within a family to MST. When this happens, questions arise regarding the accounting of cases among MST providers and other stakeholders.

MST Official Position Statement

The MST team may open separate cases on youth within a family *as long as* each youth meets the criteria for inclusion in MST as established in the program Goals and Guidelines.

When several youth in a family present concerns but only *one* youth is actually referred to MST, then referral sources should be informed that MST will focus only on, and “can only be held accountable for,” those youth actually referred to MST. In other words, referral sources should not expect generalization to the other youth to be ‘automatic’ since youths within the same family often have different parents, different schools/teachers, different peer groups and different individual characteristics that may impact treatment success, given that the drivers of delinquent behavior are unique to each individual youth.

Related issues:

- 1) Assignment of therapists: It is often advantageous to assign the *same* therapist to all of the youth in the family in order to maximize the therapeutic efficiency when working with the parents or other overlapping key participants.
- 2) Referral practices: Referral sources should be cautioned against the practice of making ‘consecutive referrals’ to MST (i.e., send one child now, a second child in the same family at the end of the first course of MST, then a third, etc.), thereby artificially extending the length of treatment for the family (but not for any individual youth). This practice is not consistent with the short-term, intensive, ‘family empowering’ nature of MST and should not be utilized.
- 3) Quality Assurance monitoring: TAMs should be collected from the caregiver per standard protocols, i.e., one TAM per month per youth. In the situation where there is only one therapist working with multiple youth in the family, then only one TAM interview per month should be collected but the data should be entered on the website for each youth so that TAM collection “percentage of TAMs collected” is not affected.
- 4) Paperwork for supervision and consultation: Therapists and supervisors should be clear that these youth would be considered *separate* cases with separate weekly summaries to be provided each week.