



## MST Goals and Guidelines:

PROGRAM GOALS, CASE-SPECIFIC TREATMENT GOALS, CASE DISCHARGE  
CRITERIA, AND OUTCOMES

DJJ Virginia Project  
Evidenced Based Associates  
Family Preservation Services  
Waynesboro/ Staunton  
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# MST Goals and Guidelines

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# Program-level information

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## Target population to receive MST services:

Youth, 12 to 17 years old, at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system.

## Priority Criteria:

- Court status/ DJJ involvement (e.g. parole or probation); *taking into account the parole status youth and the location of commitment served, i.e. youth located in Bon Air may need MST more, rather than a youth placed in the local CPP.*
- Risk assessment score/ YASI (high or moderate level of care);
- Seriousness of offending (e.g., status vs. criminal);
- Frequency of offending (multiple separate offences);
- Duration of offending (e.g., time from first arrest);
- Multiple court involved youth in the home;
- Immediate placement risk or numerous failed services.

## 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. See [Attachment A](#) for additional information regarding referrals of youth with co-morbid psychiatric problems.
- Youth with Sexualized Behaviors/Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior). See [Attachment B](#) for additional information regarding this referral criterion.
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism. See [Attachment C](#) for additional information regarding this referral criterion.
- Low YASI score (low in both Overall and Dynamic)

## Geographic service delivery area:

*(90 minutes travel time from 246 Rolla Mill Rd. Verona, VA 24482)*

*Serving the cities of Waynesboro, Staunton, Lexington, Charlottesville, Harrisonburg; and the counties of Rockbridge, Albemarle, Nelson, Fluvanna, Greene, Goochland, Louisa and Augusta.*

## Program Capacity:

Number of Therapists	4
Caseload slots range	4-6 clients per therapist
Caseload slots average	5 clients per therapist
Supervisor Caseload (if appropriate – maximum 2 client slots)	2
Targeted average length of treatment	Target 120 days or 4 months
Treatment slots available ( <i>average caseloads x number of therapists + supervisor capacity</i> ):	22
Estimated annual program capacity ( <i>avg. total treatment slots available x 3</i> )	66

## Program goals for target population

### Required Process Goals *(tracked via the MSTI web-based data collection system)*:

PROCESS	TARGET
Length of treatment	90 – 150 days or 3 - 5 months
Target average	120 days or 4 months
Percent of youth completing treatment -	85%
Percent of youth discharged due to lack of engagement	< 5%
Percent of youth discharged due to placement	< 10%
Average caseloads range within	4 – 6 per therapist.
Therapist Adherence Measure (TAM-R) collection rate	> 70%
Overall average adherence score	0.61
Percent of youth reporting adherence above threshold (>.61)	80%
Percent of youth with at least one TAM-R interview	100%

### Required Outcome Goals *(tracked via the MSTI web-based data collection system)*

#### *Youth at home*

**MSTI Definition:** Youth is living at home. Home is defined as a private residence that is approved by the youth’s guardian. This could include a parent’s home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of “home”. Youth who are on runaway status would not be at home.

Frequency of data collection:                     discharge (required)

Post-treatment follow-up (highly recommended):    6-months                     12-months                     18-months

Person identified to collect follow-up data:                    N/A – will revisit at 6 month PIR.

#### *Educational/vocational involvement*

**MSTI Definition:** Youth is attending school (is not truant) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (at least half time).

For additional information about the tracking of Educational/Vocational Involvement please see the “Evaluating case status review at discharge” section of this document.

Frequency of data collection:  discharge (required)

Post-treatment follow-up (highly recommended):  6-months  12-months  18-months

Person identified to collect follow-up data: N/A – will revisit at 6 month PIR.

### *Out of trouble with the law*

**MSTI Definition:** Youth has not been arrested since the beginning of MST treatment, for an offense committed during MST treatment. (Many MST programs have defined arrests as involvement with police that results in a charge for a new criminal behavior (i.e., not a violation of probation)).

Frequency of data collection:  discharge (required)

Post-treatment follow-up (highly recommended):  6-months  12-months  18-months

Person identified to collect follow-up data: N/A – will revisit at 6 month PIR.

## Referral Procedures

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The purpose of this section is to detail the referral process so that all MST staff and key stakeholders and referral agents understand how the process should work. Such understanding will assist staff to better serve the referring agencies.

### *Primary MST Referral Contact Person:*

Name: Megan Hall, Director of Program Development

Telephone: (540) 850-8172 (Cell)

Email Address: [mhall@fpscorp.com](mailto:mhall@fpscorp.com)

Name: Andrea Kendall, MST Supervisor

Telephone: 540-248-5510

Email Address: [akendall@fpscorp.com](mailto:akendall@fpscorp.com)

Name: Erin Haase, FPS Regional Director

Telephone: 540-248-5510

Email Address: [ehaase@fpscorp.com](mailto:ehaase@fpscorp.com)

### *Eligible Referral Sources*

Agency: VA DJJ via Evidence Based Associates

Primary Contact Person: Kara Brooks, VA Project Director

Telephone: (804) 433-7554

Email Address: [kbrooks@ebanetwork.com](mailto:kbrooks@ebanetwork.com)

Estimated annual number of referrals: 70-85

## Referral Process

- 1. Notification of Openings:** Family Preservation Services MST Supervisor will maintain a current census/capacity report. EBA will send census report/ availability for referrals via EBA Newsletter/E-mail list to supervisors, local CSU and CPP staff.
- 2. Inquiries:** Any (DJJ staff) person interested in making a referral may call the EBA RSC (or Family Preservation Services MST Supervisor) to informally discuss whether a potential referral would be appropriate for MST.

3. **Determine appropriateness: Referral made by CSU (per normal Referral Procedures)/ RSC Acknowledge Referral:** When the CUS sends the referral, they will write *YOUTHS INITIALS\_MST REFERRAL* in the subject line to help expedite the process. When a referral is received for review by EBA RSC, the RSC will relay the referral to Family Preservation Services. The Family Preservation Services MST Supervisor will respond via email to the RSC and a phone call to the referring DJJ Staff acknowledging the receipt of the referral and review process the same day, or within one business day.  
**Referrals made by the CPP will be made 7-10 days prior to service initiation, which could be 30 days prior to the release; referral made 45 days prior to expected release date. Subject line will state *CPP MST REFERRAL*.**
3. **Determine program availability:** Family Preservation Services' MST Supervisor will notify EBA RSC and the referring DJJ Staff if the MST program has immediate availability or, if the youth will be placed on a Waiting List, the supervisor will project the time of program availability. If MST is not immediately available, EBA RSC will offer assistance in finding other resources for the youth and family referred IF the youth cannot be placed on a Waiting List or if the delay is significant.
4. **Determine appropriateness:** After a referral is received by Family Preservation Services, case information will be reviewed by the MST supervisor to ensure that the youth meets the inclusion criteria and that there are no known reasons for exclusion. For any youth determined not eligible for MST (for any reason) the EBA RSC will offer the referral source assistance in finding other resources.
5. The DJJ Staff will contact the family first to assure that the planned referral is acceptable to the youth's caretaker (prior to the referral). If so, Family Preservation Services will coordinate the first contact with the family with MST. The MST worker will make first contact with the family within 24 hours / one business day and see the family within 72 hours of the acceptance of the referral, or, otherwise, the EBA RSC and referring DJJ Staff will be notified of the delay.
6. **Consent for Treatment:** Upon initial contact, the MST worker will explain the program and seek consent for treatment from the primary caretaker(s). If a family is reluctant to consent for treatment, the MST worker will collaborate with the referring DJJ Staff to engage the caretaker(s). Only when all efforts by the MST worker to engage the caretaker(s) have been exhausted and the caregiver still refuses treatment, will the case not be opened for treatment.
7. **Treatment Initiation:** Upon completion of the consent for treatment, the youth and family will be assigned an MST therapist, and treatment will be initiated. Family Preservation Services will notify the EBA and the DJJ Staff that treatment has been initiated. The MST Therapist will enter the family into the MSTI database within 7 days so that the quality assurance process is initiated.

## Guidelines for the initiation of new referrals:

To give the referral process adequate advance notice, the MST Supervisor will look at the following indicators on a weekly basis to plan for new referrals:

- Cases where the majority of overarching goals are met.
- Cases with chronic engagement challenges or are reaching a point of diminishing returns.
- Cases that have been open for 90 days.
- Cases that have been open for 120 days will initiate an immediate request for referral.

# MST program guidelines

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## The primary goals of MST treatment:

- Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s);
- Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighborhood problems.

## *Overarching case-specific goals for treatment:*

MST defines the primary case-specific treatment goals as "Overarching Goals."

### *An overarching goal:*

- refers directly to the referral/target behavior;
- incorporates the desired outcomes of caregivers and other key participants; and
- is written objectively, so an outside observer can easily determine whether or not the goal has been met.

Assuring that case-specific overarching goals are always consistent with program goals

is the responsibility of each MST therapist and supervisor. To accomplish this objective, each therapist must be aware of both the goals and the referral criteria for the MST program. Therapists should fully engage the referral staff to ensure that the goals of their agency or department are reflected in the overarching goals of each case.

## Length of treatment

Typical duration of treatment is three to five months. From the first meeting the therapist is planning for discharge by establishing overarching goal with clear criteria for success and by facilitating interventions that are carried out, as much as possible, by family members and other key participants.

The therapist needs to gauge decisions about discharge based upon achievement of overarching goals. The therapist needs to end treatment when:

- there is evidence **at any point in the treatment** that overarching goals have been sustained over a period of 3-4 weeks, or
- overarching goals have not been met and treatment has reached a point of diminishing returns.

## Extending MST treatment

Factors affecting the decision to extend treatment beyond 5 months

- What are the identified needs of this specific youth and family, and how do these needs weigh against the needs of youth yet to be served (input from the referral agency will be required)?
- To what extent has the family been engaged and what other specific strategies can be used to improve engagement?
- What additional investment of time/energy will be needed by therapist to move the case forward?
- What are the projected outcomes of extended treatment time?
- What are the funding-related requirements?

## Discharge criteria

The determination to discharge a youth from MST is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g. youth, parent, school, probation officer) indicating that:

- a majority of the overarching goals for the case have been met and sustained;
- the youth has few significant behavioral problems;
- the family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 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; and
- the therapist and supervisor feel the caregivers have the knowledge, skills, resources, and support needed to handle subsequent problems.

Discharge from MST may also occur when few of the overarching goals have been met, but 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.

## Evaluating case status review at discharge

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When it has been determined that a case will be discharged, the MST team will review the status of the case in three areas:

- the current status of case progress,
- the status of key instrumental outcomes, and
- the status of the case relative to three areas of “ultimate,” or real-world, outcomes.

See [Attachment D](#) for additional information regarding the impact of Runaway Status on the evaluation of case status at discharge.

The information is collected in these three areas, reviewed with the MST expert, then entered into the MSTI database for program quality assurance and improvement as follows:

## Case Progress Review Item

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*At discharge, the following guidelines are followed to input data for case closure into the MSTI Website.*

### Reason for case closure: *(One reason only is selected)*

- Completion:** The youth was discharged based upon the mutual agreement of the primary caregiver(s) and the MST team.
  - The reason for case closure does not meet any of the other categories AND
  - team and family agree that there is evidence that overarching goals have been sustained over a period of 3-4 weeks, OR



- team and family agree that overarching goals have not been met and treatment has reached a point of diminishing returns for the additional time invested.

*Selection of this category does not assume that the case closed with all goals met, only that primary caregiver(s) and team agreed that no further progress on overarching goals is likely.*

- **Lack of engagement:** The decision to discharge the youth was made because the MST team was not able to engage the family in treatment, despite persistence on the therapist’s part to engage and align with the family.
  - Despite persistent efforts by the therapist, the family has not EVER been seen face-to-face for two consecutive weeks OR
  - Family has formally declined MST services OR
  - Family states they do not want to continue (a statement to this effect should be included in note section) AND
  - The consultant and team have identified and addressed barriers to inadequate engagement and agree that all engagement strategies have been exhausted.

*Selection of this category indicates that the family has chosen to not participate in MST Services. In other words, this category documents that the team never had engagement. As long as the family was actively involved in working on at least one goal for some part of treatment, this category is NOT checked. This latter case would be counted as “completed” with lack of progress reflected in instrumental goals.*

- **Placement:** The youth was placed in a restrictive setting (detention center, residential placement *for more than 30 days*), or foster care for a duration of time that precluded further MST involvement.
- **Placement, prior event:** The youth was placed in a restrictive setting (detention center, residential placement *for more than 30 days*), or foster care due to an event or offense that occurred prior to the beginning of MST treatment.
- **MST Program administrative removal/withdrawal:** Youth was removed from the program by the MST program administration due to administrative issues or decisions unrelated to the progress of the case.
- **Funding/referral source administrative removal/withdrawal:** Youth was removed from the program by the funding or referral source due to administrative issues or decisions unrelated to the progress of the case.
- **Moved:** The family moved out of the program’s service area.

## Instrumental Outcomes

The Instrumental Outcomes are documented in the MST Goals and Guidelines as the criteria for determining whether a case was closed successfully or not. While some guidance in defining these items is provided, it is critical for each program to define these in terms of objectives for the case. For example, if the case had an overarching goal of increasing involvement in pro-social activities as evidenced by attending one approved recreational activity a week, then the related instrumental outcome would be rated as met if the Overarching Goal is met. Therefore, responses to these items are not completely standardized across programs. The following items are scored as “yes” or “no” at the point of a case discharge:

- The therapist and supervisor have evidence that the primary caregiver(s) has improved the parenting skills necessary for handling subsequent problems.
- There is evidence of improved family relations specific to the instrumental and affective domains in that family’s subsystems that were drivers of the youth referral behavior.

- The family has improved their network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (informal to formal) as needed.
- The youth is showing evidence of success in an educational or vocational setting.
- The youth is involved with prosocial peers and activities and is minimally involved with problem peers.
- Changes in behavior of the youth and in the systems contributing to the referral problems have been sustained for 3-4 weeks.

**Ultimate Outcomes.** These items provide some basic information about how the youth is functioning at the time of discharge. The meaning of the terms (e.g., ‘arrests’) may vary from county to county, state to state, and country to country; therefore, it is difficult for the MST Institute to establish a “one-size-fits-all” definition. The operational definition of each of the following should be made clear for each MST program and documented in the Goals and Guidelines document. The following definitions are offered as guidance based on common performance measures used in the United States. [The following items are scored as “yes” or “no” at the point of a case discharge:](#)

- Youth is living at home.** Home is defined as a private residence that is approved by the youth’s guardian. This could include a parent’s home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of “home”. Youth who are on runaway status would not be at home.
- Youth is attending school** (is not truant) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (at least half time).
  - Youth is attending school, a high school equivalency program (GED program,) or a vocational program in the youth's natural ecology, or working. The primary objective of the program is educational or vocational. A youth in a correctional facility or treatment setting in which educational or vocational activities are provided, where the primary objective is treatment or correction, will NOT count as a "yes" for this item.
  - If the youth is in school, youth is attending frequently enough to meet expectations placed on youth by school system or court. If the discharge occurs during the summer when school is not in session, it is recommended that the response “yes” be selected if the youth was attending school at the end of the last school year, or is working.

*This item should be answered for all youth, in addition to the choice of “yes” or “no” above. Please select one item from the list that BEST describes the youth’s current setting.*

- traditional school
- traditional school that includes a vocational component
- solely vocational training program
- GED or other secondary school equivalency program
- alternative educational program or setting due solely to academic need
- alternative program or setting due to anti-social, offending or disruptive behavior
- in a correctional facility or treatment setting where the primary objective is treatment or correction (choose this even if educational or vocational activities are provided in the facility)
- not in any educational or vocational program, and working at least half-time
- not in any educational or vocational program, and not working at least half-time
- other- please specify

- **Youth has not been arrested since the beginning of MST treatment, for an offense committed during MST treatment.** Many MST programs have defined arrests as involvement with police that results in a charge for a new criminal behavior (i.e., not a violation of probation).

*Each MST program should view the lack of a clear definition of the above as an 'opportunity' to revise, clarify, and improve their existing Goals & Guidelines document. This will likely entail drafting a working definition and then seeking input from key stakeholders in order to establish a clear, specific, objective, and measurable definition to guide future entries on the website.*

## Communicating Outcomes to Stakeholders

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Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the burden of the MST providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier.

### Outcome reporting requirements

**Reporting case outcomes to the referral source:** FPS will send a weekly e-mail (or phone call, as needed) to the referring CSU staff providing a brief outline of the interaction with the youth and family, short-term objectives, successes and challenges. Overarching treatment plans and monthly reports will be sent to EBA and the referring CSU, by the 5<sup>th</sup> of every month.

**Sharing Program-level Reviews with Key Stakeholders:** Every six months the MST program will be reviewed for purposes of identifying status of adherence, program-level goals, strengths, identified barriers to program success, and interventions for ongoing program improvement. The **Program Implementation Review (PIR)** is completed in collaboration between the MST supervisor, potentially other provider agency staff, and the assigned MST Expert. The format of this document may be difficult for non-program stakeholders to interpret, so often a summary report is developed for the purpose of stakeholder information and engagement.

Program Implementation Reviews should be reported as follows: *The PIR will be sent every six (6) months to the identified CSU, DJJ and EBA staff.*

Program Implementation Reviews will be sent to the following individuals/agencies:

Local CSU Directors:

CSU 16 Director: Martha Carroll [Martha.Carroll@djj.virginia.gov](mailto:Martha.Carroll@djj.virginia.gov)

CSU 25 Director: Sandra Crawford [Sandra.Crawford@djj.virginia.gov](mailto:Sandra.Crawford@djj.virginia.gov)

CSU 26 Director: Peter Rouso [peter.roussos@winchestercounty.gov](mailto:peter.roussos@winchestercounty.gov);

CC: Beth Stinnett, Statewide Program Manager [Beth.Stinnett@djj.virginia.gov](mailto:Beth.Stinnett@djj.virginia.gov)

Stephanie Garrison DJJ Central Region Program Manager [Stephanie.Garrison@djj.virginia.gov](mailto:Stephanie.Garrison@djj.virginia.gov)

Lesley Hull, DJJ Central Performance Improvement Coach [Lesley.hull@djj.virginia.gov](mailto:Lesley.hull@djj.virginia.gov)

Dan Edwards, EBA President: [dedwards@ebanetwork.com](mailto:dedwards@ebanetwork.com)

Kara Brooks, EBA Project Director [kbrooks@ebanetwork.com](mailto:kbrooks@ebanetwork.com)

# Attachment A: MST Referral Guidelines Regarding Youths with Co-Morbid Psychiatric Problems

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The decision to implement the MST treatment model with a given population should be informed by empirical data concerning the effectiveness of MST with the target population. While substantial data from numerous randomized clinical trials involving more than 1000 families supports the use of MST with youth in the juvenile justice system exhibiting serious criminal behavior, the development of MST to serve youth at risk of out-of-home placement due to serious psychiatric impairment is a work in progress. To date, only one large randomized trial and one small pilot randomized study support the use of an enhanced version of MST, MST-Psychiatric, for youth presenting primarily psychiatric problems. Both data and clinical experience obtained in these trials have led to substantial modifications of the MST treatment model when it is to be used with these youth and their families. These modifications include the incorporation of psychiatrists and crisis caseworkers into the team, additional respite placement resources, and substantial additions to the training, supervision and quality assurance protocols. Findings from these studies suggest that standard MST teams are not equipped with the adequate resources and training required to treat youth presenting primarily with serious psychiatric difficulties. Information about the MST-Psychiatric adaptation of MST is available on the MST Website, <http://www.mstservices.com/index.php/target-populations/psychiatric>.

Thus, while MST is appropriate for youth presenting primarily with behavioral problems that may have mild to moderate co-morbid psychiatric problems, youth whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems, should be excluded from standard MST teams.

Examples of youth characteristics that may indicate a referral is inappropriate for a standard MST team include:

- Actively psychotic (unless temporary and due to drug use)
- Diagnosed with schizophrenia
- Actively suicidal or recent attempt
- Actively homicidal

In some cases, it is possible that a youth will be inappropriate for referral due to psychiatric problems that are not as obvious or clear as the above characteristics, such as youth accurately diagnosed with bipolar disorder or youth taking antipsychotic medications. Determination of whether these youth are appropriate for MST requires a thorough evaluation of the relevant factors by the MST team, often in collaboration with their MST expert. In particular, the team should assess the degree to which psychiatric, biologically-based factors are the primary reasons for the youth's behavior problems, as opposed to "willful misconduct," the degree to which active management of the psychiatric condition and/or medications is needed, and the degree to which extensive safety interventions are likely to be needed. The team should also do their best to ensure that the psychiatric diagnosis is well documented and based on a thorough assessment.

These criteria have been selected as "red flags," or potential "red flags," because they signal the need for MST teams to have access to increased clinical resources to safely and adequately treat youth with serious mental health problems. These resources include access to a psychiatrist, who is trained in the MST model and integrated into the clinical team, as well as additional trainings in safety interventions and increased supervisory and clinical support. Based on the clinical trials of MST with youth experiencing serious psychiatric symptoms, substantial amounts of ongoing supplemental trainings and services are needed before MST teams can adequately serve such youth. Thus, standard MST teams should not accept youth presenting primarily with psychiatric (rather than behavioral) problems

or youth with serious psychiatric problems as outlined above. While many youth with externalizing symptoms and antisocial behavior may also occasionally present with psychiatric problems, the bulk of the behaviors for which the youth are being referred should be antisocial or externalizing in nature, placing them at risk of a juvenile justice placement. Two examples are given to clarify this point.

### *Example*

**Example of an appropriate referral** of a youth with co-morbid psychiatric problems: *TL is a 16-year-old female with a history of depression, past suicidal ideation and past suicide attempt, who was hospitalized for an overdose 2 years prior to the current referral. She was referred by the juvenile courts for shoplifting, truancy and runaway behavior. She is not currently suicidal and has had no suicide attempts since the hospitalization.*

**Example of an inappropriate referral** of a youth with co-morbid psychiatric problems: *JM is a 15-year-old male referred by the juvenile courts for domestic violence. He is currently trying to harm his mother and himself. He has ongoing suicidal ideation and has been diagnosed with bipolar affective disorder. He is intermittently homicidal toward family members. He has experienced these problems periodically for the past 2 years.*

## Attachment B: MST Referral Guidelines Regarding Sex Offending Behavior (a.k.a. Youth with Sexualized Behavior)

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The decision to implement the MST model with a given population should be formed by empirical data about the effectiveness of the model with the target population. Treatments for juvenile sex offenders are rapidly proliferating in the absence of data supporting their effectiveness. The only randomized trials of juvenile sex offender treatment in the research literature are the studies of MST-PSB (MST for Problem Sexual Behavior). More information about this adaptation of MST can be found on the MST Website, <http://www.mstservices.com/index.php/target-populations/problem-sexual-behavior>, and at the MST Associates Website, <http://mstpsb.com>.

Standard MST programs may not accept referrals for primarily sex offending behaviors. Programs that wish to serve youth referred for primarily sex offending behaviors must have their staff trained in MST-PSB by MST Associates (see <http://mstpsb.com> for additional information).

However, youth who have previously engaged in sexualized behavior can be accepted into an MST program, as long as the sex offending behavior is not the primary reason for referral. Below are two examples that serve to clarify appropriate versus inappropriate referrals into an MST program.

### *Example*

**Example of an appropriate referral** of youth with sex offending behaviors: *A 16-year-old male has a history of criminal charges for shoplifting and breaking and entering. He is chronically truant from school, and there is a strong suspicion that he abuses marijuana and alcohol. There are also two reported incidents of inappropriate sexual behavior by this youth, including touching the breasts of a classmate and attempting to force sexual relations with the younger sister of a neighborhood peer. These two incidents occurred in close proximity to one another and there have been no further allegations for the past year.*

**Example of an inappropriate referral** of a youth with sex offending behaviors: *A 15-year-old male has just been charged with a third sexual offense, molesting a 4-year-old neighbor. This youth has a history of two similar offenses with other children in the past year. The youth has no other reported behavior problems. He attends school regularly, functions at grade level, and has only been involved with the courts for allegations of sexual misconduct. The referral indicates there are reports of verbal conflict between parents and the youth and within the marital dyad.*

## Attachment C: MST Referral Guidelines Regarding Youth with Moderate to Severe Difficulties with Social Communication, Social Interaction, and Repetitive Behaviors

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Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, should be excluded from MST teams due to the fact that they may respond poorly or in adverse ways to some of the routine behavioral and parenting interventions employed by MST teams. These difficulties may be diagnosed as Autism Spectrum Disorder (ASD) at Levels 2 or 3, or as Childhood Autism (CA.). Importantly, the expertise to treat this problem, which is biological in nature and differs substantially from “willful misconduct,” does not exist within the resources currently available to MST teams. Youth who present with mildly delayed communication and social interaction difficulties, (e.g. diagnosed with ASD with social communication and repetitive behaviors at Level 1, or diagnosed with Childhood Autism based on mild difficulties,) may qualify for referral assuming that the focus of treatment concerns youth conduct disorder symptoms. Such youth should be considered on a case-by-case basis.

The decision to implement the MST treatment model with a given population should be informed by empirical data about the effectiveness of MST with the target population. Currently, the MST treatment model has not been empirically evaluated for youth diagnosed with Autism Spectrum Disorder or Childhood Autism. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) defines ASD as follows:

“The essential features of Autism Spectrum Disorder are persistent impairment in reciprocal social communication and social interaction, and restricted, repetitive patterns of behavior, interests or activities. These symptoms are present from early childhood and limit or impair everyday functioning.”

The DSM-V includes severity levels for ASD, as follows:

- Level 3, “requiring very substantial support” and including “severe deficits... severe impairments in functioning... behaviors markedly interfere with functioning in all spheres.”
- Level 2, “requiring substantial support” and including “marked deficits...behaviors interfere with functioning in a variety of contexts.”
- Level 1, “requiring support” and including “without supports in place, deficits...cause noticeable impairments... significant interference with functioning in one or more contexts.”

The ICD-10 defines Childhood Autism as follows:

“A pervasive developmental disorder defined by the presence of abnormal and/or impaired development that is manifest before the age of 3 years, and by the characteristic type of abnormal functioning in all three areas of social interaction, communication, and restricted, repetitive behavior.”

Youth diagnosed with what were previously referred to in the DSM as Pervasive Developmental Disorders have not been included in clinical trials of MST for youth in the juvenile justice system and have been actively excluded from studies of MST for youth with severe emotional disturbances and mental health problems. Youth with PDD have been excluded from MST clinical trials due both to the biological nature of their problems and to the different treatment approaches required to address their symptoms. While substantial clinical expertise and evidence-based practices are currently being developed to address the needs of youth with Autism Spectrum Disorder or Childhood Autism, this expertise does not reside within the resources available to MST Services or the Family Services Research Center. Early findings from research pioneers in the field would suggest that the techniques and strategies required to modify the

behaviors and treat the symptoms of youth with ASD or CA may actually differ significantly from the types of evidence-based strategies employed by MST teams to effect behavioral changes in youth with conduct and behavioral problems.

### *Example*

**Example of an appropriate referral:** *MA is a 16 year-old-male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviors both Level 1). MA was recently referred to MST because of charges of burglary and shoplifting. He has also been observed smoking marijuana. Due to significant difficulty relating to youth his age, MA has been hanging out with a group of 13- year-old males who seem to be the instigators of the recent burglary and shoplifting and of the marijuana use. MA told his mother that he went along with the shoplifting plans because he wants to have friends. His mother states that following ongoing interventions he has recently shown some success in being able to interact with other youth but is more comfortable with younger children. MA has been unsupervised after school and some evenings because his mother works late.*

**Example of an inappropriate referral:** *AM is a 13-year-old male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviors both Level 1). He has shown significant difficulty in relating to other youth at school. His teacher reports that he does not seem to understand how to play with others, avoids contact with classmates, and becomes disruptive or aggressive when in unavoidable proximity to other youth or when having to wait. His classmates view AM as odd, and he is frequently teased and bullied. As a result, he has been refusing to attend school. His mother has been trying to force AM to attend school, which has increased his anxiety and resulted in AM using physical aggression to resist his mother's efforts. Consequences for this behavior have not been effective and seem to increase his aggression. During a recent morning when his mother tried to get AM to go to school, he became extremely aggressive and assaulted his mother. He was subsequently arrested for domestic violence.*



# Attachment D: Guidelines For When Youth Is On Runaway Status

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## Assumptions

- 1) Being on runaway status is considered an antisocial behavior, just like any other antisocial behavior (e.g., being truant). From an MST perspective, it should be addressed like any other behavior, and a case should not be discharged based on this behavior alone.
- 2) Different systems vary in how they respond to runaway behavior. This can present significant challenges to the team in being able to continue to provide MST, e.g., some systems have time limits for how long the case can remain open if the youth is on runaway status.
- 3) Despite the legal parameters the MST team works within, if the family has had an opportunity for a full course of treatment, the case should be closed using one of the “clinical” reasons, e.g., “closed by mutual agreement”, “lack of engagement” or “placed”.
- 4) The case closure categories, “MST Program administrative removal/withdrawal” or “Funding/referral source administrative removal/withdrawal”, are limited to situations where the case is closed for reasons that are “unrelated to the progress of the case”. Therefore, careful consideration must be used when closing a case for this reason.

**The following guidelines are provided to assist in deciding how to code the case progress review item when the team closes a case while the youth is still on runaway status.**

- 1) **Determine if the family has had an opportunity for a full course of treatment.** An example of not having this opportunity might be if the youth was on the run at the time of referral, or shortly thereafter and the funder requests closure (preventing the therapist and family from having more than a couple of sessions). This case could be closed using the category “MST Program administrative removal/withdrawal” or “Funding/referral source administrative removal/ withdrawal”.
- 2) **Determine if therapist has ever had engagement with the family.** As long as the family was actively involved in working on at least one goal for some part of treatment, the category of “lack of engagement” should not be used.
- 3) **Determine if the case should be closed as “placed”.** This category is used only if the team is quite certain that once found, the youth will be placed, e.g., the youth is already a ward of the juvenile system and will be placed automatically without returning to court for sentencing for the runaway behavior.
- 4) **Determine if the case should be closed as “completion” (due to diminishing returns).** This closing category does not assume that the case closed with all goals met, only that stakeholder/funder, primary caregiver(s) and team agreed that no further progress on overarching goals is likely due to youth not being in the home. The actual case progress on goals would then be documented using the ratings for instrumental and ultimate outcomes.

**The following guidelines are provided to assist in deciding how to code Ultimate Outcomes when the team closes a case while the youth is still on runaway status.**

### 1) Coding Ultimate Outcomes:

- a. “At home”: if a youth is on runaway status at the time of closure, this would be marked “no”.
- b. “In school/working”: there are youth that may be on the run, but are still attending school (or working); therefore, the team would need to verify whether the youth is attending school (or work) in order to determine how to mark the ultimate outcome of “in school/working.”

- c. "Arrest": this is completed based on stakeholder's definition of arrest. Many MST programs have defined arrests as involvement with police that results in a charge for a new criminal behavior (i.e., not a violation of probation which is the typical charge for youth absconding/on the run).

**Optional:** Some major stakeholders want systems/organizations/teams to track the number of youth who are on runaway status at discharge. This is not defined by MST as an ultimate outcome; therefore, teams can consider tracking this by adding documentation of runaway status in the "notes field" of the Discharge Form or by using a research code.