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How does the delivery of multisystemic therapy to adolescents and their families challenge practice in traditional services in the Criminal Justice System?

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ABSTRACT
Multisystemic therapy (MST) is described and contrasted with practice in traditional services for young people who have committed crime, behaved anti-socially, abused substances or suffered family conflict. The challenges to traditional services posed by MST are examined, including consideration of the process of engagement in therapy, the intensive individualised therapy delivered in the young person's own home or local community, and the quality assurance systems.

KEY WORDS
multisystemic therapy; young people; forensic treatment; family therapy; practice issues

Background
Multisystemic therapy (MST) is an intensive, evidence-based, licensed, family and community treatment for adolescents and their parents. It addresses anti-social behaviour, crime and family conflict in order to enable the young person safely to remain at home, avoiding placement in the care of the local authority or custody. It is aimed at those adolescents at risk of an 'out of home' placement. MST was originally developed in the United States in the late 1970s by Scott Henggeler and his colleagues to address the limitations of traditional services for this group of young people (Henggeler *et al*, 2009). It is currently widely used in the USA, Canada and several other countries across the world.

This paper describes the practice of MST and how it is currently operating in England. It

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overviews the MST model, compares MST with traditional services for this group of young people, and examines its effectiveness and the challenges it poses. Specific aspects of MST are contrasted, including the engagement process, the intensive, individualised therapy delivered in the family home or community setting, and the quality assurance systems.

English pilot

The systematic introduction of MST across England began in 2008 in ten sites: Hackney, Greenwich, Merton & Kingston, Peterborough, Reading, Barnsley, Sheffield, Plymouth, Leeds and Trafford. These sites were in addition to three already well-established sites in Cambridge, Northern Ireland and London. The ten national pilot sites are sponsored by the Department for Education in partnership with the Department of Health and the Youth Justice Board, on a reducing financial contribution over four years. Nine of these sites are part of a randomised control trial that began in 2010 and is looking at the transportability of the intervention to the UK. Further sites have subsequently been set up in other parts of England and in Scotland but will not be part of the national research pilot.

The theory and model of MST

MST theory is drawn from Bronfenbrenner's (1979) theory of social ecology, which focuses on the multiple systems such as family, school and the peer group which have an impact on the young person's life. The behaviours of the young person are seen as multiply determined and influenced by the systems and the interaction between these systems. The MST process identifies factors across the systems which are driving the problem behaviours, and develops interventions to reduce their impact.

There is an emphasis in social ecological theory on ecological validity, in that a complete understanding of behaviour must be gained from first-hand sources and observations, and changes made in the real-world setting such as at home, in school or in the community (Henggeler *et al*, 2009). MST does this by delivering services at home, or wherever the problems occur, rather than in clinics or consulting rooms.

MST is an intensive, relatively short-term and goal-orientated intervention. It uses a combination of evidenced-based models including cognitive behavioural therapy, family therapy and behavioural approaches, as well as parent management training, all adapted for delivery within the MST model. MST therapists work closely on empowering the parent(s) of the young person and draw on the systems in the ecology.

The model defines the process to follow in therapy to address referral behaviours, and this is referred to as the 'do loop'. It begins with identifying a problematic behaviour and then identifying the drivers (or causes) which are sustaining the behaviour, and the main drivers are prioritised for intervention. A range of evidence-based interventions can be drawn on and individually tailored to the young person's needs and situation. Throughout the treatment process the ultimate goals are evaluated each week, and advances and barriers to intervention effectiveness are identified. The differences between MST and traditional services are summarised in ***Table 1***, opposite.

The engagement process

The MST team consists of a supervisor and three or four therapists. Each therapist has a small caseload of between four and six families. At the start of treatment, the onus is on the team to engage the family and the young person in therapy, rather than on the young person to engage with the service being offered. Lack of engagement of the young person in the process of MST would not prevent MST from being delivered; the parents need to consent to have MST, but the young person does not. This is in contrast with most other models, where the agreement of the young person to participate (for example in offending behaviour programmes) is an essential prerequisite of treatment. In many forensic settings, especially secure facilities, only the young person is involved in their own treatment and the family are not included in any meaningful or ongoing way. In community treatments, confidentiality between the professional and the young person may mean that the parent is unaware of the content of sessions. In MST, the therapy is delivered mainly to the parents, who make the necessary changes with the young person. In essence, this means that MST can work without the agreement of the young person who is the target of the treatment.

MST starts from the current ecology and identifies the strengths. This strengths focus is maintained throughout MST and in all supervision and consultation sessions about the family. The focus of treatment is then about what is working well, rather than what is wrong. This process is underpinned by the model, where the changes in the ecology which are supporting the improvements are identified and charted on diagrams called

Table 1: The difference between traditional models for young people exhibiting anti-social and/or offending behaviour and MST

Traditional models	MST
Individual – focus on young person (YP)	Systemic – includes whole family, school, peers, community, etc
Onus is on YP to engage	Onus is on MST to engage YP & family
Clinic-based – prison, secure setting, YOT office	Home/community based
Fixed times – limited working hours	Flexible – 24/7
High caseloads	Low caseloads
Less intensive	Highly intensive
Treatment is non-contextual	Treatment is ecologically valid
Needs-focused	Strengths-focused
Many professionals involved	Therapist is multi-skilled – main treatment provider
Supervision of professional behaviour	Quality assurance – outcome-assessed
Programmes/intervention generalised to the population	Interventions individualised to needs of YP
Group work – association with negative peers	Focus on YP remaining with pro-social peers
Treatment provider from one discipline	Treatment provider from range of disciplines
Model is managerial – meeting performance targets and programmes are accredited	More professional governance and quality assurance based

'positive fits', which are built into plans to sustain and generalise the changes. Traditional models, for example accredited group work programmes, start by selecting participants on the basis that they have identified needs which can be met by that particular programme, for example cognitive deficits, poor problem-solving abilities, anger/violence management difficulties or sexual offending behaviours. Often this can involve a lengthy assessment period. There are minimal barriers to assessing suitability for MST, enabling engagement and treatment to begin as soon as possible and capitalising on the current situation which has brought the family to seek treatment. Young people at risk of care or custody are excluded only if there is a lack of evidence that MST would be an effective intervention for them due to the presence of identified exclusion criteria such as pervasive developmental disorders (such as autism), current risk of suicide or psychosis.

Intensive individualised therapy

MST lasts for between three and five months and amounts to approximately 60 hours of contact time or more in total. Typically there are at least three visits a week at the beginning of treatment, decreasing to two or one a week towards the end of the intervention. The duration of MST is briefer than in many traditional services, although it is more intensive than most. MST is kept deliberately

short but intensive to avoid families becoming dependent on the therapist, but long enough to learn for themselves how to implement changes and sustain them. The final months of treatment focus more on enabling parents to generalise and sustain the changes achieved in the earlier months. The families are encouraged to increase responsible behaviour and the parents are empowered to make the necessary changes themselves, with encouragement and appropriate support from the MST therapist. In essence, the parents are doing the work with their son or daughter, rather than the therapist.

This contrasts with many traditional services, where the focus is on the professional working directly with the young person. Once the young person is engaged in individual treatment, there is a risk that the parent might minimise their responsibility or not attend to their role in maintaining their child's negative behaviours as they become more excluded from the target of their son or daughter's treatment.

MST challenges current practice and policy in its operational delivery. It operates 24 hours a day, seven days a week, all the treatment taking place in the family home, the school or the local community rather than in a Youth Offending Service, a clinic or a secure setting. It is also delivered at a time that is most convenient for the families involved. The model of delivery aims to minimise barriers for families to access treatment, and makes the service more responsive to any barriers to successful outcomes, as it addresses the range of risk factors across multiple systems specific to the young person and their family. It is ecologically valid (Boer, 2009) because MST occurs where the problems are actually happening in order to promote treatment generalisation and sustainability.

It is an individualised treatment programme which means that, rather than following a pre-set scripted format, as is done in accredited groupwork programmes for example, it is individually designed for the family using the MST model and following the 'do loop' process (Henggeler *et al*, 2009). The systemic approach targets a range of risk factors in the ecology; usually the focus is on the family, the individual young person, the peer group or the school or work setting, or some or all of these areas. The young person can therefore undertake just one individualised MST programme rather than having to undergo a succession of different, separate treatment programmes in order to meet all their needs.

Peer interactions, especially association with deviant peers, or rejection or neglect by peers, are well known to have a powerful effect on anti-social behaviour in adolescents (Lahey *et al*, 2003). Most young people commit criminal offences in the context of peer activities (Howell, 2003). The negative influence of an anti-social peer group is targeted in MST, and the young person is encouraged to engage in mainstream activities with pro-social peers rather than attend group work programmes with others who have offended.

Quality assurance systems

MST demands high standards of adherence to the model and the nine principles of MST. Every week, paperwork detailing the therapy is completed, and group supervision is undertaken so that each therapist reviews all their families with their peers and the MST supervisor. The process is repeated again with the MST consultant, who also advises on cases, usually by telephone. Written paperwork can be supplemented by recordings of therapy sessions which are available to the supervisor and the consultant, or by observational visits with the supervisor. These arrangements support delivery of MST which is true to the model and nine principles, but individualised to the family. The supervision of professional behaviour and adherence to professional standards by a similarly qualified professional, crucial in many traditional models, is then less critical in MST because the detailed quality assurance process, with its emphasis on outcomes, takes precedence. This also means that therapists can be drawn from a range of disciplines, typically qualified and experienced practitioners in psychology, social work, youth offending, family therapy or child and adolescent mental health, and still be supervised by a MST supervisor from a different professional background.

The therapists' and supervisor's adherence to the MST model is evaluated throughout the treatment period by the families, using the Treatment Adherence Measure – Revised (TAM-R; Henggeler & Borduin, 1992). Higher scores are associated with improved outcomes (Schoenwald, 2008). Therapists also complete a Supervisor Adherence Measure (SAM; Schoenwald *et al*, 1998) every two months, which identifies strengths and needs for the supervisor.

MST therapists and supervisors undergo a one-week additional training in MST and quarterly booster training on an aspect of MST which is delivered by the consultant. Therapists are responsible for the delivery of all the individualised interventions to the family, direct work typically focusing on the main care giver. Thus, instead of

the lead professional co-ordinating the treatment to the young person or family from a range of professionals, which is the norm in traditional services in the Criminal Justice System (CJS), the MST therapist will deliver all the required treatment to the family member to the extent required to achieve the positive outcome for the young person who is the target of the MST.

Effectiveness of MST

Since the beginning of MST, there has been a strong emphasis by its developers on its being empirically supported (Henggeler *et al*, 2009). MST has been shown to be effective in decreasing 'out of home' placements, anti-social behaviour and offending, improving family relationships, increasing attendance at mainstream school and decreasing adolescent substance abuse (Borduin, 1999; Fonagy *et al*, 2002; Farrington & Welsh, 2002; Henggeler *et al*, 2009).

Two major randomised control studies completed in the USA showed favourable outcomes for MST compared with 'usual services' (Henggeler *et al*, 1992; Schaeffer & Borduin, 2005). However, their design methodology has been criticised, including the variation in 'usual services', and one of the trials included cases where there was infrequent monitoring by probation services (Littell, 2005, 2006). The Brandon Centre in Camden, London was the first site to begin a randomised control trial in England which compared MST to usual services (Butler & Baruch, 2007). It has just been completed, but there are no published studies yet. Further research on the effectiveness of MST is currently under way with a large-scale randomised control trial of MST in the pilot sites in England led by Peter Fonagy and his colleagues at UCL, Leeds and University of Cambridge.

Challenges to traditional services in CJS

Clearly there are a range of differences in the operational delivery and practice of MST, as described above, but does this pose any challenge to traditional models?

Service users who are hard to engage have shown they prefer aspects of MST such as delivery of the service in their own home, the 24-hour, seven days a week support and contact, and access to services from one point. This leads to much lower rates of non-attendance for families who are very hard to engage in community treatments. The individualised intensive treatment offered means that a lengthy assessment process can be avoided, and work can begin immediately on areas of concern to families.

There is a requirement to design services around the needs of service users and not around the needs of staff and individual services. The challenge to current services is how they can be transformed to meet these needs. MST provides a model for services on how it can be achieved by meeting a range of identified needs through one MST therapist.

Many forensic services are provided in secure settings. The cost of a place per year in a secure children's home is £215,000, in a secure training centre it is £160,000, and in a Young Offender Institution it is £60,000 (Hansard, 2009, as cited in Prison Reform Trust, 2010). Adopting MST can lead to significant savings against the high cost of placement in care or custody, and even deferring young people from custody may have significant long-term benefits. Reducing or eliminating the amount of time spent in care or custody as a child will limit the psychological impact of an 'out of home' placement at this stage of a young person's development. The outcomes for young people in custody or care are poor: 74% released from custody re-offended within one year (Ministry of Justice, 2010).

Separating young people from their families and placing them in the company of other young people also convicted of crimes can reduce parental involvement and allow the negative influence of an anti-social peer group to increase and attitudes to delinquent behaviour to deteriorate. These factors have been found to increase the risk that young people will become involved in criminal or anti-social behaviour (McCarthy *et al*, 2004).

Coleman and Hagell (2007) found that anti-social friends continue to reinforce disruptive behaviour. Mixing with delinquent peers may not be the initial cause of difficulties, but a delinquent peer group may make it more likely that delinquent behaviours will actually occur. Adolescents take more risks, focus more on the benefits than the costs of risky behaviour, and make riskier decisions when in peer groups than alone (Gardner & Steinberg, 2005). The authors conclude that the findings support the idea that adolescents are more inclined towards risky behaviour and risky decision making than adults, and that peer influence plays an important role in explaining risky behaviour during adolescence.

The individualised MST programme tailored to the young person and their family minimises the need for them to mix with anti-social peers, again challenging the way in which services are currently

organised, which tends to bring young people together with others who are behaving anti-socially. Young people who are out of school or mainstream schooling are educated together with others who are also excluded from mainstream school services. Delivery of traditional services to young people and their families in the CJS has typically meant services to individual young people in groups with others in custody or in the community who have offended or are behaving anti-socially. The challenge posed by MST is to do much more to engage with young people and their families, where often traditional services have failed, and to deliver high-quality, evidence-based, intensive individualised therapy in the young person's own home or local community.

The high financial cost and the poor outcomes achieved by sending young people into custody or placing them in the care of the local authority pose a challenge to professionals and families. In order to access many of the current services, this group of young people often have to be in secure settings a long way from home or join groups or community services where they will meet others who are there because they too are behaving anti-socially. This practice poses risks that young people will commit further crime or anti-social behaviour.

The challenge MST poses to practice in these traditional services is to find effective and acceptable community alternatives such as MST has provided, so that young people can safely remain with their families while receiving services aimed at reducing the risk of further anti-social or offending behaviour or family conflict.

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