What is MST?

Multisystemic Therapy (MST) is a family and community-based approach to treating youths who have serious clinical problems. Based on an extensive body of controlled clinical research, MST has been identified as an effective treatment of youth antisocial behavior and substance abuse (National Institute on Drug Abuse, 1999; President’s New Freedom Commission on Mental Health, 2003). The intervention targets youths with serious clinical problems who are at imminent risk for out-of-home placement. Descriptions of the MST model are provided in comprehensive clinical volumes pertaining to the treatment of antisocial behavior (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) and serious emotional disturbance (Henggeler, Schoenwald, Rowland, & Cunningham, 2002) in adolescents and their families.

History and Origins

The clinical procedures that define MST were first used by Scott Henggeler, PhD, in the late 1970s. Collaborating with doctoral students, most notably Charles Borduin, PhD (now at the University of Missouri) and Molly Brunk, PhD (now a vice president at MST Services, Inc.), Henggeler developed a treatment program for juvenile offenders diverted from the juvenile justice system. In a quasi-experimental design, the project was conducted for several years resulting in the first MST outcome study published in 1986.

The design of the early MST treatment protocols were based largely on the integration of innovative theory and intervention models that were being developed in the early 1970s. Particularly influential were works of Jay Haley, Salvador Minuchin, Gerald Patterson, and James Alexander. Both Haley and Minuchin had developed
pragmatic family therapy approaches that were well suited to the types of problems experienced by juvenile offenders and their families. Patterson was developing and testing an intervention based on social learning theory that aimed to change behavioral interaction patterns between parents and their young children presenting behavior problems. Alexander recently published a well-designed, randomized trial using Functional Family Therapy, a blend of family systems and behavioral approaches, with juvenile status offenders.

Conceptually, the MST theoretical model was based largely on general systems theory, which had a major influence on the field of family therapy, and Bronfenbrenner's theory of social ecology, which has become the preeminent model of behavioral development. Briefly, systems theorists view phenomena as interrelated (e.g., parental monitoring affects youth behavior but youth behavior could, in turn, affect monitoring), and emphasize the bi-directional nature of interactions. Further, systems theorists would regard youth behavior as being part of a larger system of interrelated phenomena such as other family, peer, and community relationships.

Similarly, the social-ecological theory of Bronfenbrenner also conceptualizes human behavior within a contextual framework. Specifically, Bronfenbrenner describes a set of concentric circles in which the individual's behavior is the innermost circle, and outer circles represent contexts as they are proximally related to the individual, such as the family, peer, school, community, and culture in which the individual is embedded. Like systems theorists, ecological theorists also hypothesize dynamic relationships, with contexts having reciprocal effects upon one another. For example, youth behavior would be perceived by the social ecological theorist as simultaneously being affected by, and having an effect upon, a wide variety of characteristics within the individual context (such as biological factors and cognitive deficits), family context (like marital discord or parenting practices), peer context (antisocial peers, poor socialization skills), and neighborhood context, such as few “pro social” activities and criminal activity.

Given the ecological foundation of MST, as well as the systems intervention framework, it followed that the field of community psychology also had a strong influence on the development of the treatment model. Community psychology emphasizes the influences of factors outside of the individual in the development of behavior. Such conceptualization is particularly well suited for interventions targeting serious youth conduct problems. For example, subsequent research demonstrated that association with deviant peers is the single most significant correlate of antisocial behavior in adolescents. Similarly, researchers have

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demonstrated the significance of extrafamilial systems such as the school, family support network, and social service agencies in the functioning of children and their families.

In 1992, Henggeler moved to the Medical University of South Carolina (MUSC) where he founded the Family Services Research Center (FSRC). Since
Based on research findings from the Norway, New Zealand, and Sweden), nine countries (Australia, Canada, operating in 34 states across the U.S. and of July 2005, licensed MST programs are technology and intellectual property. As through MUSC for the transport of MST programs for serious juvenile offenders. The MST's explicit mission is: “address family members' needs across multiple systemic contexts. For a complete list of faculty, ongoing research projects, and publications, please refer to http://www.musc.edu/fsrq/.

In light of the success of several MST clinical trials with serious juvenile offenders published in the 1990s, stakeholders in communities across the United States began to request the development of MST programs to decrease youth antisocial behavior and out-of-home placement. A new organization, MST Services (www.mstservices.com), was formed in 1996 with the mission of supporting the effective transport and dissemination of MST programs for serious juvenile offenders. MST Services has the exclusive license through MUSC for the transport of MST technology and intellectual property. As of July 2005, licensed MST programs are operating in 34 states across the U.S. and nine countries (Australia, Canada, Denmark, England, Ireland, Netherlands, Norway, New Zealand, and Sweden). Based on research findings from the FSRC, MST Services provides ongoing quality assurance to licensed provider agencies in order to promote treatment fidelity. Indeed, findings from several studies indicate that high therapist adherence to the MST treatment protocol has been associated with favorable short and long-term outcomes whereas poor treatment adherence has not. Thus, one of the paramount components of the MST model is an emphasis on fidelity of treatment implementation.

**Treatment Description**

MST is provided within a family-focused, home-based model of service delivery. Home-based service delivery reduces many of the practical barriers to accessing services, and thereby increases the likelihood that families will remain in treatment. Moreover, engagement strategies used within the MST model increase the likelihood that multiple therapist-family contacts will occur each week and that treatment gains will be achieved consistently and quickly. The average length of MST is relatively short (approximately four months), with the intensity of treatment decreasing from inception to termination.

Use of a therapeutic team approach further the opportunity for individualized and comprehensive service delivery. MST therapists operate in teams of no fewer than two and no more than four therapists, the clinical supervisor, and an MST expert (through MST Services or a Network Partner Organization), thereby creating a cohesive therapeutic team. Each therapist’s caseload ranges between four to six families, so that therapists are able to provide sufficiently intensive and frequent contact with their families. A member of the team also is available 24-hours-a-day to ensure therapeutic support is available to families during times of crisis. For example, if a substance abusing youth does not come home on a Friday night as planned, an MST therapist is available to work with the parents during non-typical working hours to provide support and develop a plan of finding the youth and creating a safe environment when the youth returns.

Following the nine principles of MST, therapists rely on specific intervention techniques integrated from treatment approaches that have substantial empirical support, including cognitive-behavioral, behavioral, and pragmatic family therapies (structural and strategic). Treatment goals are individualized to meet the needs of each youth and family, with targeted goals existing across multiple systems, such as school and peers. Thus, if a youth is having difficulty with school, for example, teachers and school officials are viewed as integral members of the treatment. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family to behave responsibly and to be accountable for the youth’s behavior. Therapists emphasize the positive and use strengths across multiple systems—individual, family, peer, and community—to achieve treatment goals. Moreover, the effectiveness of these therapeutic efforts is evaluated continuously from multiple perspectives, such as caregivers, teachers, or extended family members, and interventions are modified until the desired therapeutic changes are achieved. Table 1 shows the nine treatment principles that build the foundation for conceptualization and treatment planning.

**Empirical Support for MST**

MST has been identified by several federal entities (National Institute on Drug

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### NINE MST PRINCIPLES

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions are present focused and action oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspective with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members’ needs across multiple systemic contexts.
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The model have been and continue to be developed for treating a range of serious clinical problems for youth and their families (for a list of ongoing grants please visit http://www.musc.edu/fsrc). Adaptations include protocols to treat: (1) youths with serious emotional disturbance; (2) youths referred for juvenile sexual offenses; (3) families referred for child physical abuse; (4) youths with poorly controlled Type I diabetes; (5) youth referred to outpatient treatment with comorbid substance use and internalizing disorders; (6) young children with serious behavior problems; (7) youths involved with juvenile drug court; (8) maltreating parents with comorbid substance abuse; (9) parents with substance abuse disorders; and (10) youth with HIV. Within each of these ongoing clinical research ventures, there is a strong commitment to monitoring treatment fidelity and following the quality assurance manuals. In addition, efforts have emphasized the need for the evaluation of cost effectiveness of treatments. It is hoped that maintenance of these procedures will help promote the use of this evidence-based practice in a manner that will be most effective for the families of youths with these serious clinical and medical problems.