Multisystemic Therapy (MST) is an evidence-based intervention for youth that has grown in popularity in Pennsylvania. This therapy is targeted for youth and families when the youth are between 12 and 17 years of age and are in trouble with the law. There are currently 13 providers in Pennsylvania with 45-50 functioning MST teams, covering almost all of the counties in the Commonwealth. In 2010 about 2,300 youth were served by this service. These programs are monitored by the Department of Public Welfare (Office of Mental Health and Substance Abuse Services [OMHSAS] as well as Office of Children, Youth and Families) and are paid for by a combination of state and federal dollars. One of the recent concerns in Pennsylvania is the perceived (and inaccurate) belief held by some prescribers that a youth must have a conduct disorder diagnosis to be eligible for this service. It is the intent of this article to encourage psychological evaluators to focus on the identification of the chronic and serious externalizing behaviors that need intensive remediation within a range of possible DSM diagnoses in determining a youth’s appropriateness and “fit” for MST services.

MST is an intensive, 24-hour, 7-day per week, in-home service. This approach uses the research identifying the risk and protective factors associated with the development of antisocial behavior to inform both the assessment and treatment. MST therapists work with the youth and family to clearly identify externalizing behavioral problems for the youth in the family, peer, school, and community settings in which they live. The therapists focus on what specifically drives each behavioral problem for an individual youth by assessing the context in which it is manifested and then empowering family members to strengthen their parenting skills and use natural supports to rectify the problem. Specific goals for youth in this program include decreasing the behavioral problems while increasing pro-social behaviors, decreasing time spent with problematic peers while increasing time with positive peers and activities, improving the ability of parents to set limits, make decisions in managing their child’s mental health issues, improve the family relationship, improve performance in school or work settings, and develop supports within the community that will continue to aid both the youth and family after the therapy is concluded.

The therapeutic model is primarily aimed at vigorously improving behavior, and the focus is on the here and now. Caretakers must be actively involved on a daily to weekly basis. Engagement of the youth and family are specific tasks for the therapist. Therapy typically lasts between 3 and 5 months. The model involves specific training and intense supervision of staff and measurement of fidelity to the model.
One of the unique facets of this model is that it has had multiple research studies, including those with randomized assignment of participants and control groups. Improvements demonstrated in these studies include decreases in re-arrests, out-of-home placement, and drug arrests. The Prevention Research Center at Penn State did a cost analysis in 2008 and estimated that for every dollar invested in this therapy the return to the community (in Pennsylvania) in future cost savings is estimated at $3.60. That is potentially a statewide benefit of $30 million.

Youth are eligible for this service primarily because of negative, externalizing behaviors that bring them to repeated/chronic contact with the justice system. They do not need to have a DSM diagnosis, but meeting the full criteria for conduct disorder is not the only way for a youth to qualify. There could be an oppositional and defiant disorder, attention deficit disorder, or a disruptive behavior disorder. There could also be a depressive disorder if the externalizing symptoms require behavioral treatment of this intensive nature (rather than medication and/or psychotherapy as given in an outpatient setting) and if this behavior impacts multiple systems (i.e., home, school, community). Another concept in determining appropriateness of the use of this intervention is that the associated externalizing behaviors are such that the youth is at risk for out-of-home placement. In addition, the youth might have a co-occurring substance use problem and still be eligible unless the D&A problem is the primary diagnosis and takes precedence in terms of what needs to be addressed for the youth. In such an instance the D&A treatment should occur before participation in MST. MST Services expects to provide concentrated interventions and as a result strongly discourages involvement with multiple therapeutic services simultaneously.

A psychological or psychiatric evaluation is required before service can begin, as well as an interagency service planning team meeting. It is hoped that this article has clarified for the prescriber criteria to use in determining if MST is a good treatment option for an individual youth. Further questions can be addressed to the author at the Children’s Behavioral Health Services Bureau, OMHSAS, at c-alitzelm@state.pa.us.