Multi-systemic therapy: beyond offending behaviour

Brigitte Squire describes multi-systemic therapy (MST), an intervention model that addresses the complex systemic needs of the young offender within the family.

In this article I would like to reflect about the specific contributions multi-systemic therapy has to make within the context of offending behaviour work. Having worked previously as a clinical psychologist in a tertiary out-patient specialist mental health adolescent service in North London, I was confronted with the limitations of my interventions to reach these families that were desperate for help to regain control over their out-of control offspring, who were now getting involved in criminal acts. Individual anger management was only touching the surface and often families showed difficulty in coming to regular appointments and turned up at crisis point, when they were expecting outside agencies to solve the problems for them.

In December 2001, Cambridgeshire YOS used the opportunity of a new project, ISSP (Intensive Supervision and Surveillance Programme) launched by the Youth Justice Board, to implement an evidence based treatment intervention, MST, that had shown significant positive results in the USA in reducing offending behaviour and out-of-home placements. Three years on, the team has gained a wealth of experience and insight in the lives of these young offenders, often reflected in hard statistics about characteristics and risk factors associated with offending behaviour. More recently the team has a local service level agreement with child and adolescent mental health services and social services to see young people with severe behavioural and anti-social problems and who are at risk of being placed in care and developing 'a career' in the juvenile justice system. As the average age of these young people is lower than the ISSP sample, MST has gained very promising results so far in the reduction of problems and creating positive changes.

What is multi-systemic therapy?

As defined by Scott Henggeler (Henggeler *et al.*, 1998) it is an intensive family and community based treatment that addresses the multiple determinants of serious anti-social behaviour in chronic, violent or substance abusing young offenders at high risk of out-of-home placements. Its focus is on empowering the caregivers to make changes in the direct environment of the young person to reduce the risks of re-offending by offering practical help and advice to tackle the problems faced. Strong emphasis is given on assisting the carers to bring consistency and warmth within the family relationships by setting clear and fair rules about certain unwanted behaviours while at the same time introducing positive rewards and attention for successful attempts for change. Parents are also encouraged to break the cycle of the young person's mixing with anti-social peers by putting in place monitoring systems and introducing pro-social activities. Effort is made in trying to reintegrate the young offender in education, training or employment and to make a strong link between the education or training provision and the carers.

Although the collaborative goals are very well defined at start of the intervention by all participants involved, the family and the MST worker face an overwhelming task in the profusion of problems. MST provides a clear framework on how to proceed and how to prioritise the factors that need to be addressed. It follows an analytical process that evaluates on a weekly basis the intermediary goals and steps of intervention to enable the MST worker to tackle the barriers encountered. For example, if the intermediary goal was to make sure that the young person was out of bed in time to go to school and the barrier that week was that mother was not able to wake him up in time, then the MST worker will reflect with mother what the problems are in getting up in the morning and being so exhausted. Often we are confronted with parents who have untreated mental health problems themselves, marital problems, financial problems and housing difficulties. The MST worker will assist the carer on a practical and therapeutic level to address the problems in so far as they interfere with the parental tasks. The focus remains on changing the behaviour of the young person using all the strengths in the system available.

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MST is an intensive intervention with two to three home visits a week with additional phone calls and professional meetings as required. The MST worker therefore has a low caseload of four families and works in a team of three to four other workers that provide support and back-up. The MST worker has to be flexible in her working hours to be available to

the family when most convenient and the need is highest. A 24 hour, seven days a week on-call service is available to the family for immediate advice and support. The duration of the intervention is between three and five months.

MST Services in South Carolina allocate a lot of importance to quality assurance and they have an elaborated system of securing and evaluating the adherence to the model by providing initial and quarterly training and life consultation on a weekly basis. There are also monthly questionnaires where families are asked about the quality of the MST sessions in relation to the guiding principles that need to be followed.

What is different and useful about MST?

In October 2004, Oxford University published a report (Moore *et al.*, 2004) that evaluated the first 41 ISSP programmes. In their description of the characteristics of these persistent young offenders and their environment, it became evident that a high proportion present with a very problematic background and environment, with social services currently or previously involved in two-thirds of the sample. Numerous empirical studies have highlighted the relevance of the complex systemic needs of children with severe aggressive behaviour but services providing help are often individually focused for the young person, the adult or the parent. This is even more accentuated within the youth justice system provisions where offenders will receive individual attention either alone or in a group with youngsters with similar problem behaviours or the parents will be suggested or mandated to follow parent group training.

The danger about separating different needs to different specialist services is that no integration is taking place and although there might be some insights on an individual level, the family doesn't learn how to apply these insights in practice, faced with all the barriers in their lives. Often the family finds it hard to accommodate all the appointments to different services within the chaos of their problems and it is not unusual that the professionals involved are not communicating sufficiently to work towards similar goals.

When MST becomes involved in the life of a young offender, the worker becomes the central figure in supporting the young person and his family with all their needs. They will help the family access certain specialist services such as psychiatric input for medical requirements, but overall they will help the family to apply parenting skills while providing individual coping strategies to the young person. Family sessions will be added to bring together different perspectives and allow the family members to communicate directly to resolve ongoing conflicts.

We have experienced several benefits in using the MST model in addressing offending behaviour. By involving all relevant participants in the young person's life in trying to reduce the risk factors of offending behaviour, there is more chance that changes are long lasting as family and support networks will be able to continue this work once the team is no longer involved. The holistic approach to problems addresses all relevant issues that might have precipitated and perpetuated the behaviour. Combined with an intense home based service provision, the family finally feels and hopes that change might be possible. Upcoming problems can be dealt with immediately and conflicts can be analysed on the spot, giving all members a chance to have their say. Active problem solving is modelled and coached to empower the carers to solve future problems. It is a hands-on intervention programme with ongoing reflection about the progress made.

Challenges of MST

Despite the clear treatment framework and intensive supervision, the work is still challenging and sometimes overpowering for the workers. They need a lot of dedication and tolerance to face the initial anger and disbelief projected onto them, or the hopelessness and hostility within the family. Workers face difficult working conditions as they travel long hours and see young people and their families in their homes on their own, in the evenings or even weekends. They meet on the family's own territory where they have less control over the therapeutic relationship. Being accountable for engagement and outcomes, they might become too responsible, and there is a risk of seeing setbacks and unsuccessful outcomes as a personal failure. Finding staff who are robust and skilled and willing to adopt to a specific intervention model with ongoing scrutiny is an continual task when recruiting new people. Despite all these barriers, visitors to our team have been impressed with the dedication of the staff and their belief in the model. It is rewarding to achieve changes when previously everybody in the system has given up. Many of the MST workers leaving the service have found it difficult to work in traditional ways, once having seen how a multi-systemic approach can make a difference. ■

Since the 1990s MST has been disseminated as an evidence based practice and there are now 301 licensed programmes in 30 states and eight nations. In Norway and Denmark MST is implemented nationwide and a recent research study in Norway (Ogden et al., 2004) showed a significant difference in treatment results in favour of MST. In Britain there are three MST teams, in Belfast, Cambridge and North London. For more information, see the website, mstservices.com or contact Brigitte Squire on 01223 713046.

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