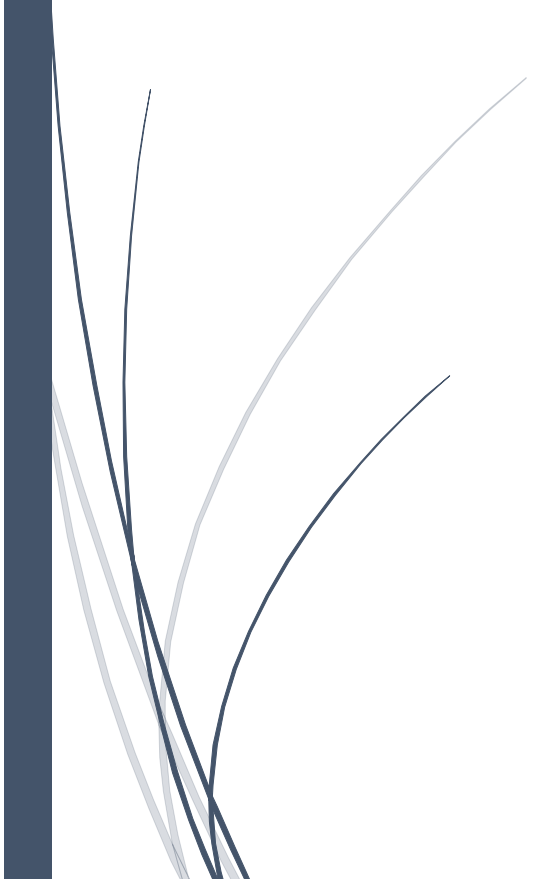
July 2019

# MULTI-SYSTEMIC THERAPY

## PRACTICE GUIDE



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**Multi-Systemic Therapy**
**(MST)**

## MISSION STATEMENT

Our mission is to provide quality intensive in-home clinical services for families and adolescents with complex behavioral health, social, and educational problems by using the Multi-Systemic Therapy evidence based model.

## CORE VALUES

MST shall be:

- in-home and community based;
- adolescent and family centered;
- grounded in research; and
- of superior quality.

## GUIDING PRINCIPLES

Adolescents should have access to treatment that

- fully assesses and integrates medical, psychological, educational, and treatment histories;
- offers evidence based treatment in a timely manner while maintaining the adolescent in their community;
- is inclusive of the adolescent and family as a full participant and partner;
- offers a range of interventions that utilizes strengths to address the needs of the adolescent and family; and
- is sensitive and responsive to cultural differences and special needs.

## TARGET POPULATION

The target population for this program are adolescents between the ages of 12-18 years, who meet the following admission criteria:

- present with significant behavioral health needs (mental health and substance use) impacting the family, school/work, community domains, and
- reside in a family setting.

Exclusionary criteria include:

- Currently suicidal, homicidal or psychotic. Adolescents in need of immediate crisis psychiatric hospitalization or stabilization (a history of psychiatric hospitalization does not exclude adolescents);
- Likely to be placed or incarcerated;

- Adolescents living independently or in long term residential treatment settings. (Treatment can begin 30 days prior to discharge from a residential setting back into family home). Must have an identified caregiver;
- Primary behavior is a sexual offense;
- Diagnosis of Autism, PDD, Mild/Moderate/Severe MR (Pervasive Developmental Delay (PDD) (Adolescent may be of below average intelligence but if IQ score is below 70 with adaptive scores limitations in two or more domains, consultant approval is required)

## SERVICE DESCRIPTION AND TREATMENT APPROACH

MST is a family and community based treatment for adolescents with complex clinical, social and educational problems. MST is delivered in homes, neighborhoods, schools, and communities. A crucial aspect of MST is its emphasis on promoting behavioral change in the natural environment. Interventions with families seek to promote the caregiver's capacity to monitor and intervene positively with each adolescent.

### Evaluation

All adolescents referred to MST will receive a comprehensive evaluation, which will result in the formulation of a *DSM 5* diagnosis and an individualized treatment plan. The evaluation will be completed by a licensed clinical staff.

The assessment should provide a clinical integration of medical, psychosocial, educational, and treatment histories that is comprehensive enough to address the needs of the adolescent within the context of the family and social community. If necessary, the Provider will assist the family and/or the referral source when referral to a specialized service is indicated.

As part of the initial assessment of adolescents 12 years and older, the Provider will use the Global Appraisal of Individual Needs - Q3 (GAIN-Q3) for each adolescent at the start of services, submit the data to the web-based system, and use the resulting reports to inform treatment planning. The Contractor will use the GAIN-Q3 at the time of discharge, submit the data to the web-based system, and use the resulting reports to inform discharge planning. The GAIN-Q3 must be conducted by a staff member who is trained in GAIN-Q3 administration following a DCF-approved process.

### GAIN Rules

Below are GAIN specific instructions. The following rules apply:

1) The GAIN Q3 will be administered in English and Spanish only. For adolescents whose preferred/dominant language is not English, the GAIN Q3 will not be administered. This will be noted in the adolescent's chart.
2) Assessments can be done at 90-day (13 week) intervals to measure change over time.
3) GAIN protocol allows for follow-up assessments to be completed up to 2 weeks prior to their due date (e.g., at 11 week intervals from baseline) or up to two weeks after the due date.
4) If the adolescent is unavailable for a follow-up assessment as scheduled, and it will be late, it should be completed at the earliest opportunity. It is better to collect data outside the established timeframes than not to collect any data at all.
5) If the adolescent came with a recent Q3 (within 45 days), the provider should get a release of information to have the GAIN Q3 transferred within GAIN ABS from the original provider. GAIN ABS provides HIPAA

and HITECH secure transfer of electronic case information. The GAIN Q3 from the original provider will become the baseline for the service.

### MST Model

MST uses a combination of interventions and treatment options designed to meet the individual needs of adolescents and their families, consonant with the goal of maintaining the adolescent safely in the home and community. The provided services will include but are not limited to:

a. ***Clinical Services*** including screening and assessments, individual and family treatment, consultation, linkage to parental/caregiver substance use screening or other services, family sessions, and age appropriate therapy.
b. ***Access to Psychiatric Consultation****:* adolescents receiving MST services should be referred and have timely access to a Child and Adolescent psychiatrist, or an APRN working under the direction of a Child and Adolescent Psychiatrist, to provide consultation, assessment and evaluation when indicated.
c. ***Empowerment and Family Support Services*** including: caregiver guidance; empowerment and support; inclusion in transition/discharge planning; linkage to other community services and supports; caregiver education; and instructional modeling.
d. ***Medication Management*** including: consultation and assessment from a psychiatrist or an APRN under the direction of a psychiatrist

Providers follow all of the prescribed interventions and client goals, as outlined in the MST manual.

## DRUG TESTING

Drug tests are completed during the evaluation and randomly throughout treatment, at least monthly. The sample collection process should be safe and as comfortable as possible for the adolescent, while ensuring sample integrity. Screens are individualized to the specific needs of the adolescent and are used for treatment purposes only. Results will be incorporated in the overall treatment and are not specifically shared with others outside of the treatment team.

Drug testing is a treatment tool used to assess and engage the youth and caregiver in conversation about substance use, which is incorporated in the different interventions. Since results are used for treatment purposes, they are not shared as a stand-alone measure.

Each Provider will have policies and procedures in place that ensure that all sample collection processes are conducted safely, facilitated with sensitivity to adolescent, and ensure sample integrity. Universal precautions will be utilized. These policies and practices must include the following:

* Staff training
* Verification of client identity
* Type of test used
* Secure storage of test kits and equipment
* Documentation and sharing of results
* Sample collection procedures
* Sample chain of custody
* Practices to reduce sample adulteration or substitution
* Disposal of samples after testing is concluded
* Universal precautions

## NALAXONE[1] (**Narcan®**)

If during the evaluation or at any point during treatment the therapist becomes aware the adolescent is at risk of an opioid overdose[2], the therapist shall provide education to the adolescent and parent/caregiver on opioid overdose prevention, Narcan®, how to obtain a Narcan® kit, and emphasize the need for continued monitoring and treatment. The availability and use of Narcan® will be incorporated in the treatment and discharge plans. All discussions will be documented in the adolescent's record.

Each provider will determine if a Narcan® kit will be available on site or if it will be carried by the therapist during home or community visits. If the provider choses to have Narcan® on site and/or carried by the therapist, the provider shall establish a policy that includes training to therapists and proper storage.

## EMERGENCY AND CRISIS INTERVENTION

Providers will provide 24-hour emergency and crisis intervention services to adolescents and their families by phone or pager. Local emergency mobile psychiatric services should not be used as common practice by this program.

## REFERRAL PROCESS

Referrals will be accepted from any source such as: a parent/caregiver, DCF, school, probation/court, police, or community provider. The Providers may accept referrals via a centralized phone intake system or a DCF approved uniform referral form.

## LENGTH OF SERVICE

Length of service will be for an **average of 4 months** per adolescent/family. Services may be extended beyond this period in consultation with the MST Consultation and Evaluation provider.

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[1] Naloxone: (also known as Narcan®) is an "opioid antagonist" medication used to counter the effects of opioid overdose.

[2] People at higher risk of opioid overdose include:

- people with opioid dependence, in particular following reduced tolerance (following detoxification, release from incarceration, cessation of treatment);
- people who inject opioids;
- people who use prescription opioids, in particular those taking higher doses;
- people who use opioids in combination with other sedating substances;
- people who use opioids and have medical conditions such as HIV, liver or lung disease or suffer from depression;
- household members, especially children, of people in possession of opioids (including prescription opioids).

## TREATMENT PLAN

Following the initial evaluation and assessment a written treatment plan that is individualized, comprehensive, and adolescent focused will be developed with the adolescent and the parent/caregiver through a collaborative process. The plan is designed to meet the substance use and behavioral health treatment needs. The treatment plan includes:

- strengths, needs, and preferences of the adolescent and family that will guide the interventions;
- focus of treatment;
- goals and objectives that are measurable and include target dates for completion;
- defined treatment outcomes and criteria for discharge;
- anticipated discharge date and identified supports/resources required for discharge; and
- outline of responsible person for coordinating and implementing the plan with accompanying signatures.

The treatment plan will be reviewed and amended as needed, but not less than quarterly.

## FATHER ENGAGEMENT

Throughout the entire service, the providers will engage fathers in hopes to get them involved in the treatment process. Strategies that have been successful in working with fathers and male caregivers include but are not limited to:

- Ensuring that fathers have access, voice, and choice in the development, implementation, and revision of treatment plans;
- Making a conscious effort to recognize and understand the cultural implications of being a male caregiver;
- Being in the habit of asking caregivers, "Will Dad be a part of the meeting?" When setting appointments, ask the mother, "Can Dad be sent an invitation if he is not part of the household?"
- Making efforts to understand fathers' work schedules, and try to schedule meetings at times that are convenient for fathers;
- Ensuring that professionals speak with and to fathers (eye-to-eye contact)—not about or over them in ways that can serve to exclude and eventually alienate them;
- Engaging Dad by asking for his opinion/insight if he is not saying anything during a meeting;
- Seeking fathers' input/ideas/concerns in advance of meetings they are unable to attend;
- Following up with fathers when they must be absent from meetings (e.g. due to work, immigration, military service, incarceration status, etc.) to ensure they understand what has been discussed; to elicit their input, feedback, and suggestions; and to incorporate their ideas into their children's plans;
- Working with the custodial mother or legal guardian to include the father even when he is not the custodial parent or legal guardian, within the parameters the court sets forth during the process of divorce and after the divorce is final;
- Ensuring that treatment plans are culturally and linguistically competent. They should meet the diverse needs of fathers by ensuring that cultural preferences, practices, and mores are learned, understood, and honored; and
- Making every effort to discover fathers' strengths, needs, and key cultural considerations that are relevant to addressing the needs of their children in order to develop truly effective individualized plans.

The hope is that in making and documenting the same efforts on including fathers as we do mothers, outcomes for the youth will improve.[3]

## SERVICE LINKAGES AND DISCHARGE PLANNING

Discharge planning begins at the time of admission and continues throughout the course of treatment. Discharge planning involves the adolescent, parents/caregivers, and other identified resources. Providers participate in case specific team meetings, as invited, and will collaborate to develop and implement a coordinated plan of care. Regular discussions with the parent/caregivers and other resources focus on discharge needs and shape the discharge plan. Adolescents may be discharged when treatment goals are met and linkages have been secured, or a different level of care is indicated.

The Provider will operationalize a service model that is specifically designed to be available to the family and child/youth in varying levels of intensity. Critical to the continued success of this model will be the appropriate matching to and arrangement for step-down and aftercare including both traditional services and non-traditional supports. Adolescents are to be discharged or stepped down from MST services when treatment goals and objectives have been met and the adolescent no longer requires the intensive level of individual and family intervention initially identified.

The Provider will develop and set in motion a step-down or aftercare plan that is understood and supported by the family. The Provider will ensure that appropriate linkage with alternative and/or transition services are in place prior to discharge from MST. Caregivers, as well as DCF, will be full partners in all discharge planning.

## EARLY DISCHARGE

Providers are expected to make efforts to keep the adolescent and families engaged and avoid early discharges. Prior to finalizing an early discharge, the Provider will make every effort to meet with the adolescent, the parent/caregiver, and other identified supports to discuss the circumstances leading to an early discharge. The discussions will include:

- reasons for the early discharge;
- steps made by the Provider to avoid the early discharge;
- impact of the decision;
- compromise or changes needed to continue with treatment; and
- identification and linkages of alternative treatment options, if the decision is to discharge early.

## STAFFING AND TRAINING

Each MST team will consist of the following staffing:

- One (1) half-time **Clinical Supervisor**

[3] Information gathered from, A Guide for Father Involvement in Systems of Care TECHNICAL ASSISTANCE PARTNERSHIP for Child and Family Teaming.

- The Clinical Supervisor is licensed with at least a master's degree in a behavioral health field and no less than three (3) years experience in delivery of clinical services. The supervisor directs and supervises professional and administrative activities of the Therapists according to the model. He/she is responsible for collecting and maintaining client and program information to meet both the model's and DCF's reporting and evaluation requirements. He/she is responsible for managing referrals, intake, case assignment, and maintaining staff schedules. The Clinical Supervisor will provide emergency or direct service coverage for the Therapists as needed.

- Three (3) **Therapists**
  - Therapists are licensed with at least a Master's degree in a behavioral health field. Exceptions to the education or licensure requirements need prior approval from DCF and the MST Consultation and Evaluation provider.
  - Therapists provide community/home-based treatment services to adolescent and families. Therapists also assume responsibility for coordinating the provision of services by other community professionals. Therapists work a flexible schedule in order to accommodate individual family needs and in order to respond to a crisis situation, as is required by the model.
  - Each Therapist will have a caseload of 5 adolescents/families.

The Providers will use the protocol in the MST model that makes recommendations for the qualifications, skills/knowledge, personal qualities, and other conditions of potential candidates for the team. Each agency will develop and will make accessible additional training beneficial to the staff in delivering MST. Trainings and/or conferences may include topics such as: substance use, juvenile justice, cultural competence, adolescent development, and engagement strategies.

## SUPERVISON

MST supervision takes place in a small group format (2-4 therapists) each week for one hour. This meeting is a priority and is typically considered a mandatory meeting unless excused by the supervisor for clinical emergencies. Group supervision takes place in a small group for several reasons: so other team members can learn from one another (successes and challenges), to role play in a safe setting, brainstorm as a group, develop a cohesive bond, and for team mates can fully "know" a client when providing vacation or sick coverage. Group supervision should be long enough to review every case as a team but should end as soon as all cases are reviewed.

Individual Supervision is not required by the MST model, but recommended when a therapist is having personal problems that interfere with job performance and when clinicians need specific support with implementing MST effectively. Individual supervision typically takes place every other week but can be reduced to monthly for clinicians who are demonstrating a high level of competency. Supervisors should utilize monthly field supervision or tape review as a tool to ensure therapist fidelity and positive treatment progress.

Clinical Supervisors will receive regular supervision in accordance to agency standards.

## CULTURAL COMPETENCE

In accordance with the core values and guiding principles, services will be developed and delivered in a culturally competent manner. The Provider must assure that their policies, practices, staff, and service delivery are

sensitive and responsive to all adolescents and families regardless of their race, ancestry, color, age, gender, religion, marital status, disability, national origin, behavioral health disorder, sexual orientation, gender confirming, and ability to pay. The Provider will strive to hire staff and establish community linkages which are representative of and support the cultural, racial, linguistic characteristics of the adolescents and families served.

It is preferable to provide treatment in the adolescent/family's primary language. Each provider will establish a plan on how to provide services to youth/families who are not fluent in English or a language not spoken by the Therapist. The use of agency staff or interpreters may be used if it is in the adolescent/family's best interest. Adolescents will not translate for parents or family members.

## ETHICAL STANDARDS

Providers will follow the ethical standards of their respective agencies and staff will adhere to the ethical standards of their respective professions. Minimal standards include:

- ensure dignity and worth of all adolescents and families by acting with integrity and respect;
- serve the identified needs of adolescents and their families to the best of staff abilities by providing treatment that is safe, effective, and the adolescent's best interest;
- provide uniform standards of treatment and conduct regardless of any adolescents' or families' race, ancestry, color, age, gender, religion, marital status, disability, national origin, behavioral health disorder, sexual orientation, gender confirming, or ability to pay; and
- ensure confidentiality.

## TRANSFER PROCESS

There may be times where a Provider is not able to provide the service or provide it in a timely manner. Situations may include but are not limited to: waitlist, the family moving out of the catchment area, language barriers, or conflicts of interest between the Provider and family. Every case will be handled individually. If a transfer is needed, the following steps will take place:

1. The Provider will contact the Program Development and Oversight Coordinator (PDOC) to request a transfer.
2. The PDOC will contact another DCF funded MST provider or request permission from Court Support Services Division (CSSD), who funds the other MST teams, to consider the transfer.
3. The Provider will let the referral source know of the status of the referral.

## HIGHER LEVEL OF CARE

Some youth may require a higher level of care to address legal, medical, mental health, or substance use needs. For youth who will return to the community within 30 days, the provider will maintain the case open and will continue to provide services to the adolescent and/or caregiver, as appropriate. If within 30 days the adolescent is recommended to a longer term higher level of care or a different substance use program, the provider will meet (or contact as appropriate) the adolescent and caregiver and prepare the case for closure. Should the adolescent be discharged later with a recommendation to MST, the referral and treatment will be re-assessed.

## COMMUNICATION AND NOTIFICATION PROCESS

The Provider will obtain releases of information to communicate with other community partners in order to collaborate and share information pertinent to each partner's involvement. Releases will be obtained for school, previous providers, DCF, probation, etc., as applicable. Specifically, the Provider will notify the adolescent's pediatrician and mental health Provider (if applicable) of the admission to the program and will provide a brief description of the treatment. At the end of treatment, the Provider will inform the pediatrician and mental health Provider (if applicable) of the discharge outcome including any progress made and known barriers to continued recovery.

It is anticipated that there will be times when the adolescent and/or family present with hesitation or unavailability. To maintain the lines of communication open, the Provider will maintain regular contact with the referral source. An individual formal written plan (FIT Circles) on how to further engage the adolescent/family will be developed and reviewed during the weekly supervision of the treatment plan. Steps to engage the adolescent and/or family will include but are not limited to:

- Increase phone, mail, text, and/or email contact
- Increased home or community visit
- School or other site visit with parental/guardian pre-approval
- Participation in a team meeting (DCF facilitated meeting- as appropriate)
- Contact resources already identified by the youth or caregiver
- Joint home visit with the referral source or other supports
- Rescheduling sessions to better accommodate the adolescent/family's schedule
- Incentives

## ADOLESCENT AND FAMILY RIGHTS

The Providers shall have written policy that outlines the adolescents' and families' rights and responsibilities. Parents/guardians will be notified of this policy. The policy includes the following:

- Informed Consent- the right to participate in service and discharge planning, including the right to refuse or question services offered.
    - **Audio/video recordings** are used for the training of Therapists and supervisors, as well as for model fidelity. Providers will explain the purpose of the recording, including who will hear it, and how long it will be stored. Adolescents and families will be informed that treatment is not conditional on signing a recording consent. The parent/guardian should discuss this with the adolescent, help assess whether the adolescent is capable of providing voluntary consent, and assess any adverse impact. Adolescents/caregivers have the final determination on whether or not they want to be recorded. Each Provider will have a policy on audio/video recordings.
- Confidentiality- the right to confidential services. Adolescents and families should also be expected to respect the confidentiality of others in the program. Limits of confidentiality must be discussed including mandated reporting, risk of injury to self or others, or disclosure by court order. The Provider will seek the guidance from DCF prior to releasing information outside standard requests, such as: research projects, evaluations, etc.

- Grievances- the right to grieve an unfair or unjust act. The process to file a grievance will be shared with the adolescent and family.
- Access to Records- the right to access to and/or copy their records. Records and the process to access information will be available and shared with the adolescent and/or family upon request and within applicable statutory authority.

## RECORDS

Each adolescent will have his/her own electronic and/or hard copy case record. Each record will be safeguarded to protect confidentiality as required under state and federal regulations regarding protected health information. Information is entered and stored within the agency's data system, in MSTI, in Chestnut Health Systems (GAIN database), and in the Provider Information Exchange (PIE- DCF database). The Provider's record shall contain, but not be limited to, the following information as applicable and as released by the parent/guardian or the court:

* Referral form
* Confidentiality safeguards
* Client rights forms
* Drug screen results
* Releases of information
* Progress notes and reports
* Billing details
* Monthly reports
* Permission to treat
* Grievance procedures
* Substance use evaluation
* Previous evaluations and discharge summaries
* Assessments
* Treatment plan
* All correspondence
* Discharge report

The MSTI database will store model specific measures. The GAIN database will contain the required GAIN Q3, and PIE will contain demographic and program specific information.

Disposal of records will occur according to the schedule and standards required by state and federal regulations.

## QUALITY ASSURANCE

In order to continuously improve the quality of MST, an internal and external quality assurance plan shall be in place.

- **Internal**
  The agency staff will receive clinical supervision within the agency on a regular basis. The Clinical Supervisor will be responsible for the quality of services. The Provider will maintain a database and will analyze information specific to the performance measures.

- **External**
  DCF contracts with Advanced Behavioral Health, Inc. (ABH) to provide the following:
    - all training in the theory and application of MST for therapists, supervisors, and administrators; and

- fidelity checks through weekly clinical consultation, organizational and systems consultation, ongoing training, and quality management.

DCF will hold regular Provider meetings where some of these areas may be reviewed. In addition, Providers will follow all requirements to maintain their appropriate license through the Department of Public Health (DPH) and/or DCF.

- **Consumer Satisfaction Surveys**- Within a month of MST ending, the Provider will give the adolescent and the parent/caregiver a satisfaction survey to complete. The referral source will also be provided a satisfaction survey. The survey is voluntary and is standard across Providers. The Provider is responsible for aggregating the results twice a year and providing this report to the DCF PDOC.

- **Quarterly and Annual Reports-** DCF will review and analyze referral and report data quarterly through a combination of PIE and GAIN, and twice annually with the MSTI database. DCF will complete quarterly reports and report cards that will aggregate the information. The reports will include the results of the following performance measures.

1. A minimum of 45 adolescents/families will be complete the program annually
2. 85% of adolescents/families will complete the program annually
3. 95% if adolescents/families served will achieve an average length of service of 4 months
4. 100% of MST teams will achieve an overall average adherence score of at least 0.61
5. 85% of adolescents will be abstinent of show a reduction in use of substances
6. 80% of adolescents will be living at home at time of discharge
7. 85% of adolescents will show improvement in school attendance at time of discharge
8. 72% of adolescents will have no new arrests during treatment (not including probation or parole violations)
9. 80% of parent/caregivers will have the necessary parenting skills to handle future problems