Using a Wide-Angle Lens: Two Evidence-Based Approaches that Focus on Youth at Risk and Their Families

COLORADO
Department of Health Care Policy & Financing

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Agenda

- Core concepts of Functional Family Therapy and Multisystemic Family Therapy
- Indicators for populations with optimal benefit
- Adaptations for Populations of Focus
- Staff and Training Requirements and Approximate Costs
- Resources for Training

What You Will Learn today

After the training, participants will be able to:

1. Explain the core concepts anchoring Functional Family Therapy and Multisystemic Therapy.
2. Identify indicators for the target populations Functional Family Therapy and Multisystemic Therapy are developed to optimally serve.
3. Explain the similarities and differences between Functional Family Therapy and Multisystemic Therapy.
4. Identify agency and staff training requirements for extending Functional Family Therapy and/or Multisystemic Therapy

Functional Family Therapy (FFT) & Multisystemic Therapy (MST)

Overarching Concepts and Components

Both Programs are Grounded in an Ecosystemic Framework…

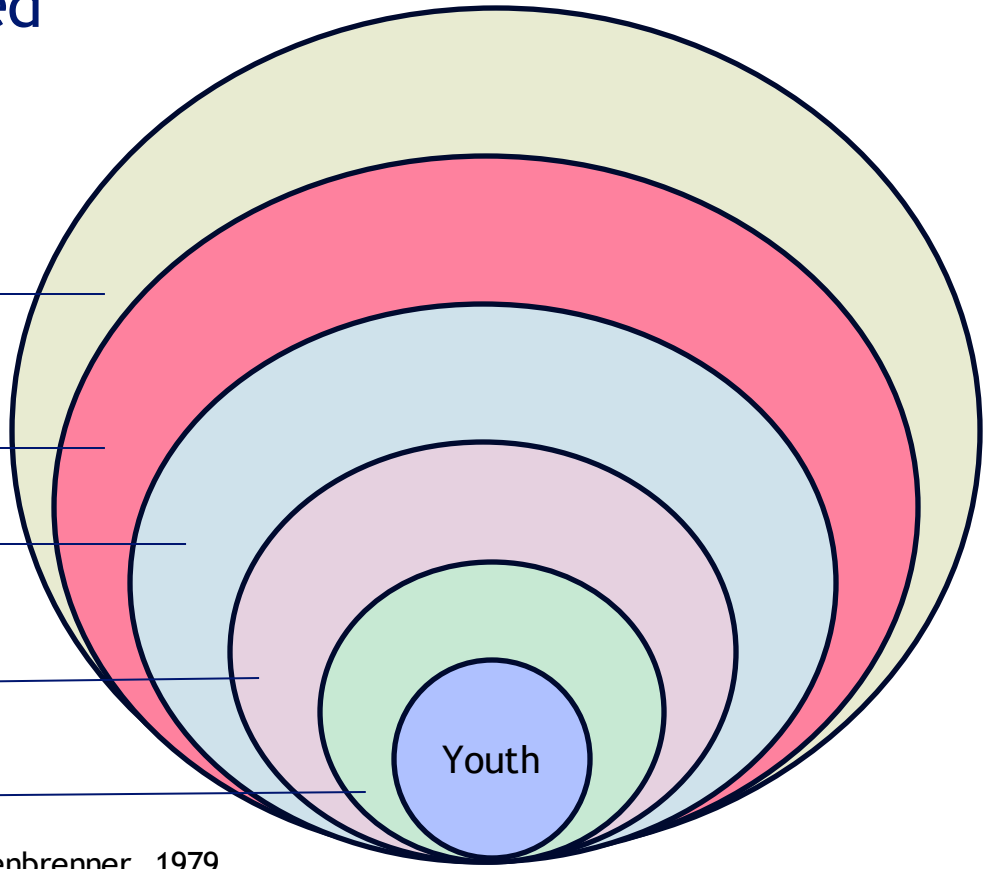
Chronosystem: Changes over Time: Historical Events, Biological Changes, & Physiological Changes

Macrosystem: Social Values, Cultural Values, Customs, & Beliefs

Exosystem: Economic, Gov't, & Educational Systems

Mesosystem: Connections Between Family, Neighborhood, & School

Microsystem: Family, Neighborhood, School



Bronfenbrenner, 1979

….and in Family Systems Theory

“The whole is more than the sum of its parts”- Aristotle

- **Patterns of interaction between family members lead to, maintain, and exacerbate problematic and non-problematic behaviors**
- **Person(s) with symptoms are drawing needed support to the system**
- **A person’s behavior cannot fully be understood without considering the context of the family system**
- **Ultimately, we are products of the systems that surround us and the dynamics we grow up with revolve around.**

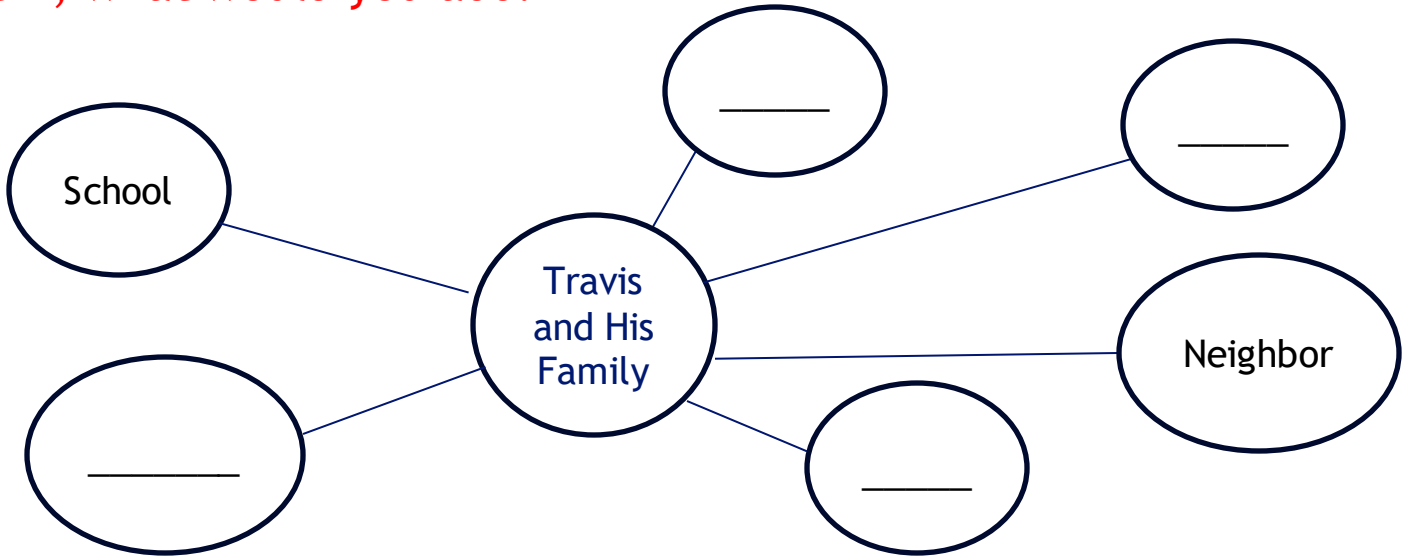
Our Case for Today

Travis is 13 years old and lives with his paternal grandmother and his 11-year old sister. Their parents died from a fatal drug overdose 5 years ago. Their grandmother is unable to work due to severe complications related to diabetes and comorbidities. She is going to various doctors to help manage her health. Her neighbor frequently takes care of the kids when she is unable to due to her health or feelings of ineffectiveness. While very bright, Travis is often truant from school and has been caught several times breaking and entering into cars and stealing loose change or things he can sell. When asked why he does it, he says that he is trying to buy things that he needs and that his grandmother cannot afford. He vapes regularly and sells the vapes to the other kids in the neighborhood. He loves playing baseball, video games, and is pretty good at cooking meals for he and his family when they have supplies. His sister is quiet and loves painting and dancing. She is slightly behind her grade level in reading but is receiving support from an afterschool tutor.

What is an Ecomap?

Ecomaps show all the systems involved in an individual's life

If you were to finish drawing an ecomap of Travis' family and the networks surrounding them, what would you add?



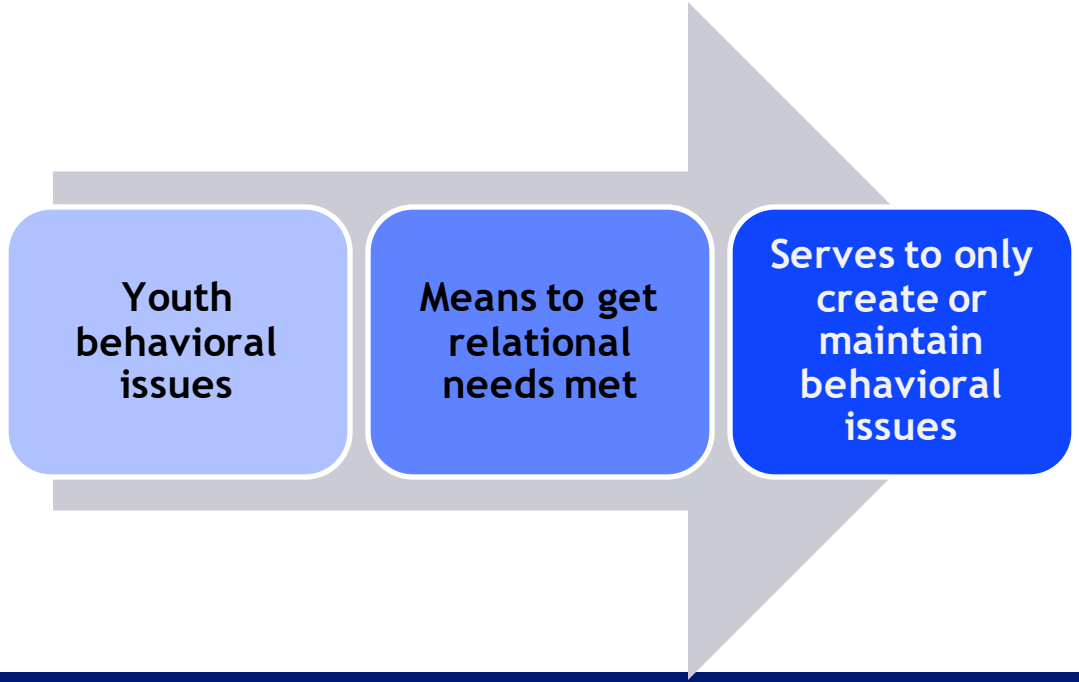
First, Let's Take A Closer Look at…

What is FFT?

- Developed by Jim Alexander in the 1970s
- A short-term systematic, evidenced-based, manual driven, family-based treatment program prevention program
- Aims to address risk and protective factors that impact the adaptive development of 11- to 18-year-old at-risk youth who have been referred for behavioral or emotional problems, and their families

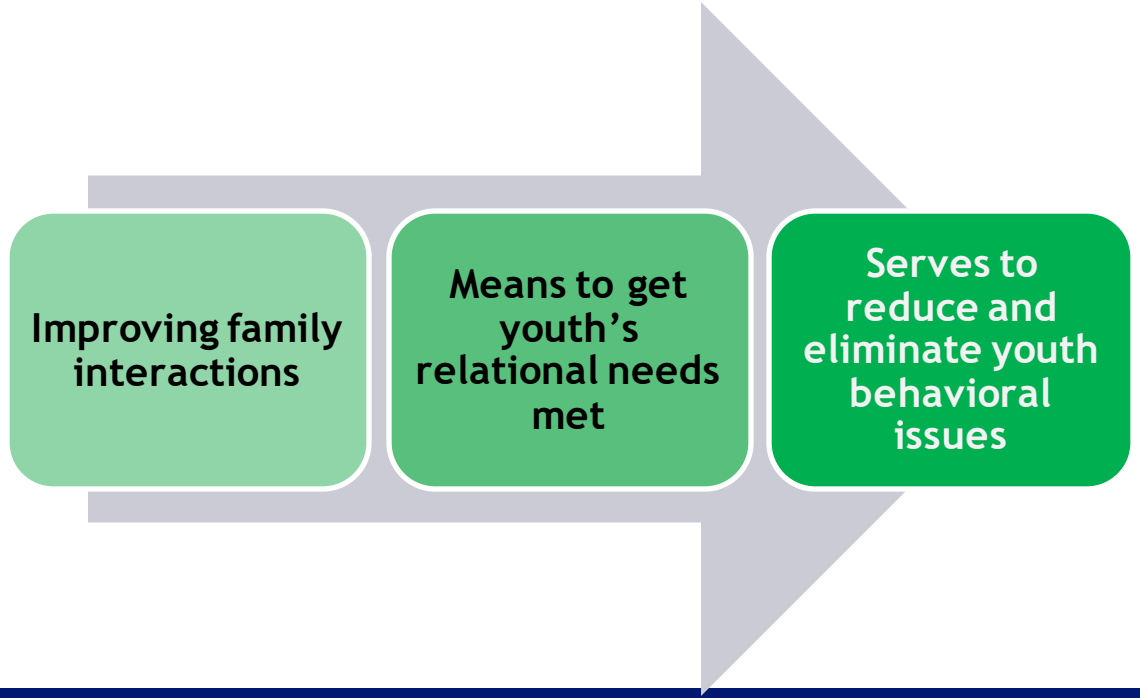
Theoretical Basis of FFT

Designed to address the following pattern common to some youth behavioral issues.

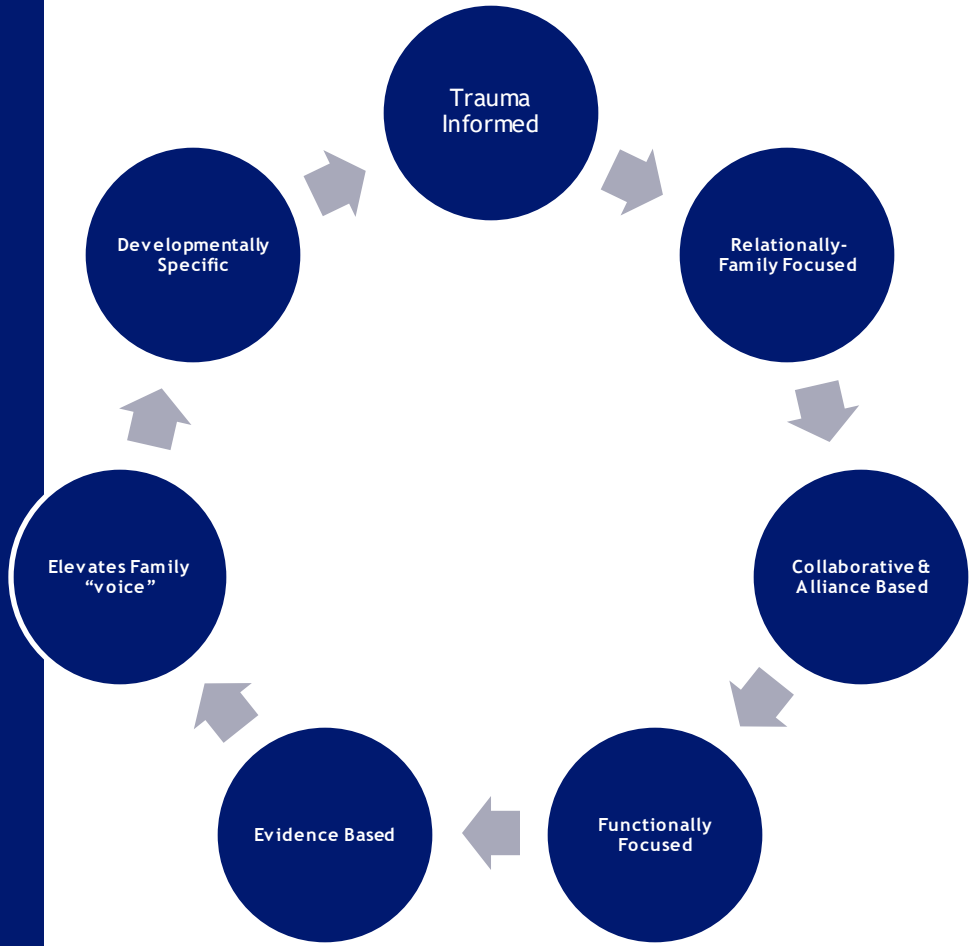


FFT's Transformation Effect

When treating the family as a unit with FFT outcomes include:



Core Guiding Principles of FFT



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Five Phases of FFT (#1)

Phases	Goals	Focus	Activities
1. Engagement	Enhancing perceptions of therapist responsiveness and credibility	Immediate responsiveness; maintaining a strength-based relational focus	High availability, telephone outreach, contact with as many family members as possible, "matching," and a respectful attitude
2. Motivation	Creating a positive motivational context by decreasing family hostility, conflict, and blame while increasing hope and building balanced alliances with family members	A respect- and strength-based process focused on highlighting dignity and hope for positive change in relationships	Interruption of negative interaction patterns, pointing process, sequencing, and reframing of the themes by validating the negative impact of behavior while introducing possible benign/ noble (but misguided) motives for behavior

FFT | Evidence-based Family Counseling Service (fftllc.com)

Five Phases of FFT (#2)

Phases	Goals	Focus	Activities
3. Relational Assessment	Analyzing patterns of family interaction to understand relational "functions"—or interpersonal motives behind individual's behaviors	Intrafamilial and extrafamilial contexts and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, resources, and limitations)	Observation, questioning, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective
4. Behavior Change	Reducing or eliminate adverse behaviors by improving family functioning and individual skill development	Addressing specific referral problems, risk, and protective factors at individual and family system levels	Modeling and promoting positive behavior, providing directives and information, and developing creative programs to change behavior

FFT | Evidence-based Family Counseling Service (fftllc.com)

Five Phases of FFT (#3)

Phases	Goals	Focus	Activities
5. Generalization	Extending improvements made during the Behavior Change phase into multiple areas; planning for future challenges	Building sustainable relationships between family members and multiple community systems	Collaborating with the community, developing and maintaining contacts, initiating clinical linkages, creating relapse prevention plans, and helping the family develop independence

FFT | Evidence-based Family Counseling Service (fftllc.com)

Let's Apply the Phases of FFT to Working with Travis' Family

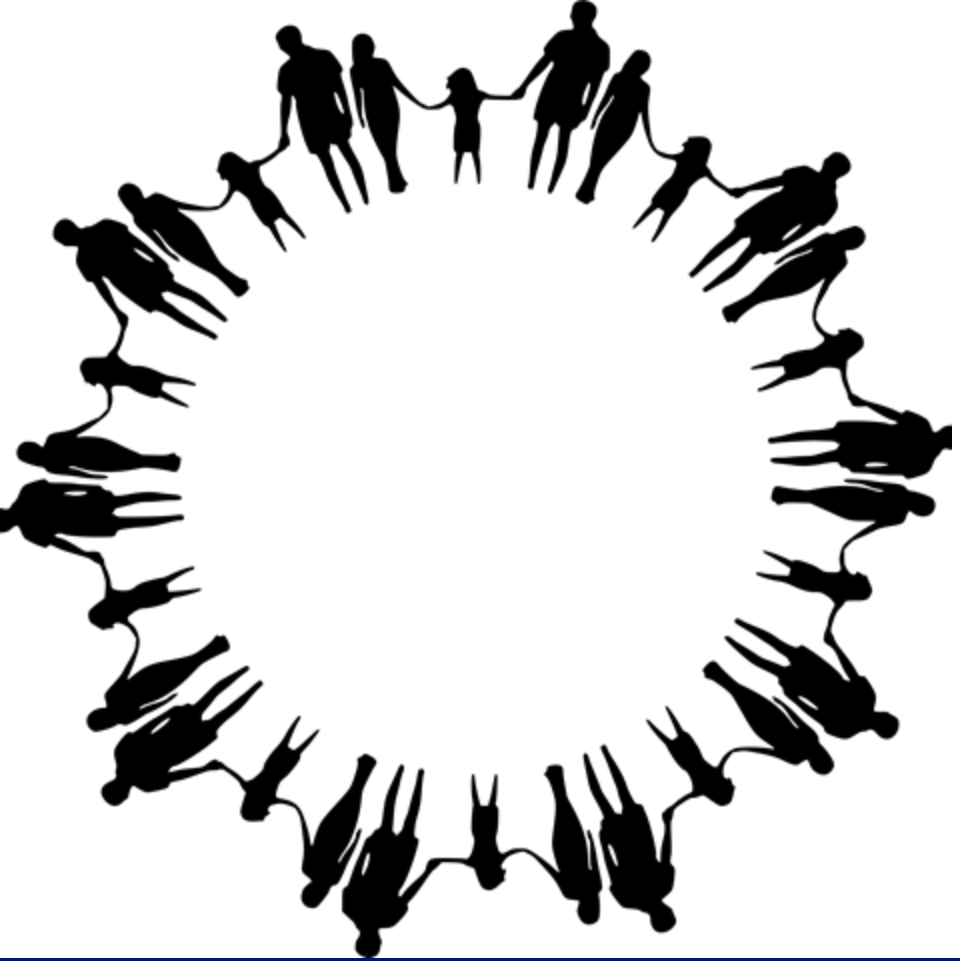
Phase	Application
Engagement	What would you do to try and engage with Travis and his family?
Motivation	How could you reframe some of the behaviors and their impact?
Relational Assessment	What types of questions would you ask the family to switch from an individual problem focus to a relational perspective?
Behavior Change	How would you model the positive behaviors you would want to see?
Generalization	What types of community partnerships and programs would you consider for this family?

FFT is Widely Recognized Evidence-Based Program

FFT is a Blueprints Model program (http://www.blueprintsprograms.com/).

Special endorsements from the Office of Juvenile Justice and Delinquency Prevention, the Center for Disease Control and Prevention, the American Youth Policy Forum, and the US Department of Justice.

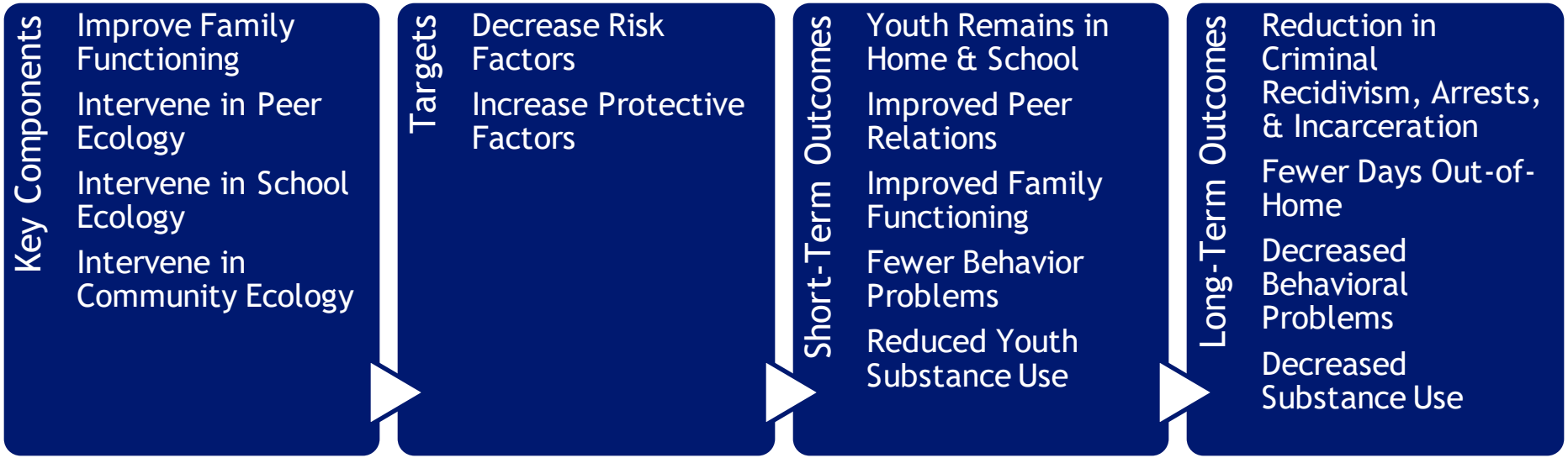
Next, A Closer Look At….



What is MST?

- Developed by Dr. Scott Henggeler in in the 1970s
- Community-based, family-driven treatment approach for at-risk youth
- Client is the entire ecology around and inclusive of the youth
- Involves a highly structured supervision system and quality assurance processes

MST Logic Model



Henggeler et al., (2009)

Focuses on Risk and Protective Factors Impact on Youth Outcomes

Risk Factors

- Aggressive or withdrawn behavior
- Negative peer influence
- Poor school performance
- Lack of pro-social goals
- Poor relationship with parents

Protective Factors

- Positive future orientation
- Peer pressure resistance skills
- Pro-social peer relationships
- Positive management of emotions
- Empathy with parents

9 Core Principles of MST (#1)

Principle	Description
1. Finding the Fit	Assess to understand the "fit" between identified problems and successes; how to make sense in the entire context of the young person's environment; helps guide the treatment process
2. Focusing on Positives and Strengths	Focusing on strengths has numerous advantages, such as building on strategies the family and youth already know how to use, building feelings of hope, identifying protective factors, decreasing frustration by emphasizing problem solving and enhancing parents or carers' confidence
3. Increasing Responsibility	Interventions designed to promote responsible and decrease irresponsible actions by family members and youth.

Nine Principles | MST (mstuk.org)

9 Core Principles of MST (#2)

Principle	Description
4. Present-focused, Action-oriented, & Well-defined	Therapists look for action that can be taken immediately, targeting specific and well-defined problems; Enables participants to track the progress of the treatment and provide clear criteria to measure success; Family works actively toward goals by focusing on present-oriented solutions, versus gaining insight or focusing on the past. When the clear goals are met, the treatment can end
5. Targeting Sequences	Interventions target sequences of behavior within and between the various interacting elements of the adolescent's life—family, teachers, friends, home, school and community—that sustain the identified problems.
6. Developmentally Appropriate	Interventions are appropriate to the young person's age and fit developmental needs. Emphasize building the young person's ability to get along well with peers and acquire academic and vocational for a successful transition to adulthood.

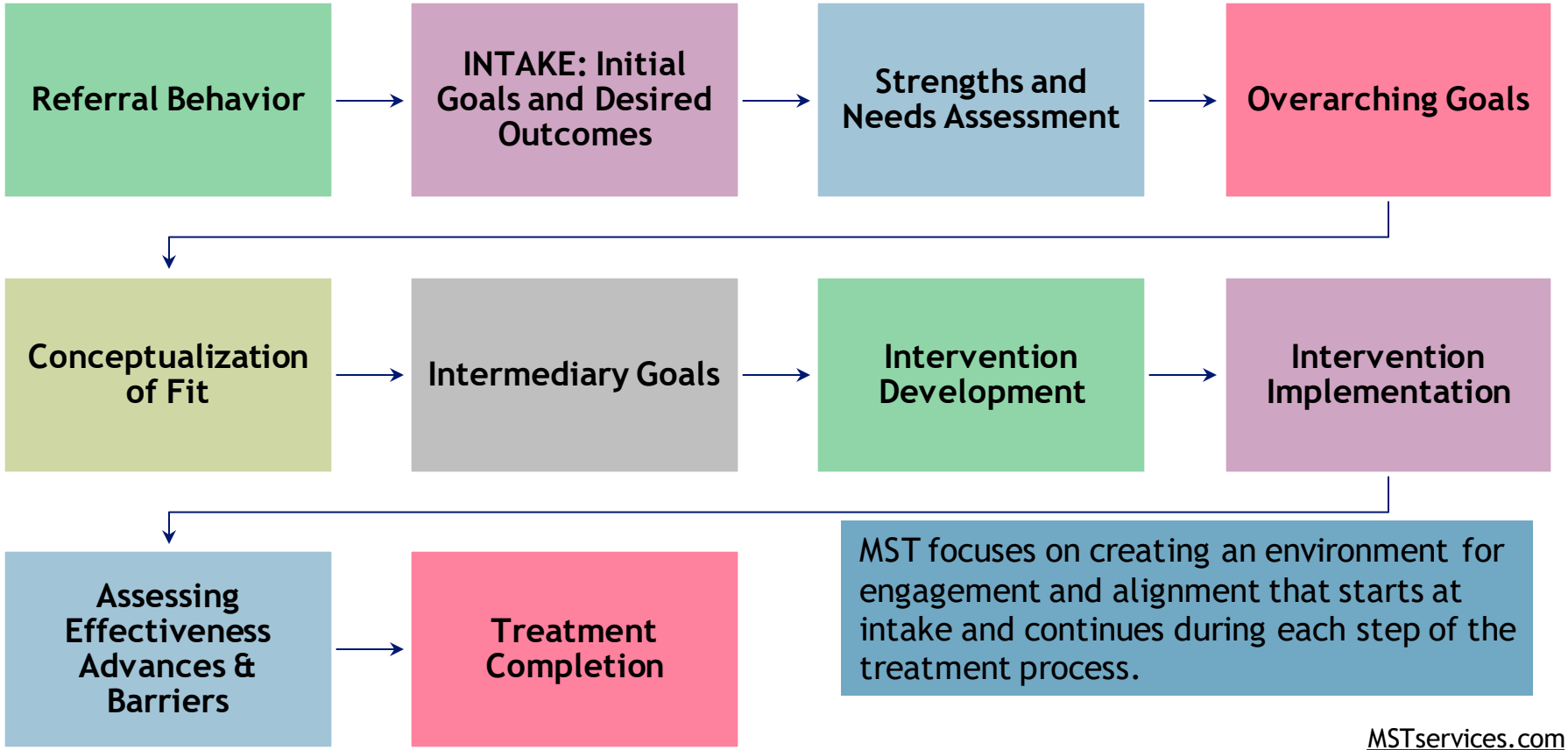
Nine Principles | MST (mstuk.org)

9 Core Principles of MST (#3)

Principle	Description
7. Continuous Effort	Interventions require daily or weekly effort by family members so that the young person and family have frequent opportunities to demonstrate their commitment. Allows for more rapid problem resolution, earlier identification of when interventions need fine-tuning, continuous evaluation of outcomes, more frequent corrective interventions, more opportunities for family members to experience success and giving the family power to orchestrate their own changes.
8. Evaluation and Accountability	Intervention effectiveness is evaluated continuously from multiple perspectives with MST team members being held accountable for overcoming barriers to successful outcomes. MST does not label families as "resistant, not ready for change or unmotivated." This approach avoids blaming the family and places the responsibility for positive treatment outcomes on the MST team
9. Generalization	Interventions are designed to invest the parents or carers with the ability to address the family's needs after the intervention is over. The parent or carer is viewed as the key to long-term success. Family members drive change process in collaboration with the MST therapist.

Nine Principles | MST (mstuk.org)

MST Process Overview



MST focuses on creating an environment for engagement and alignment that starts at intake and continues during each step of the treatment process.

MSTservices.com

Let's Apply one of the Core Principles of MST to Working with Travis' Family

Principle 2: Focusing on Positives and Strengths

- What are some of the ways you could envision focusing on the positives and strengths found in Travis and his family?
- What strengths would you see this family already knows how to use?
- How would you help them to build on feelings of hope?
- What are some of the protective factors that you would want to build on?
- How could you support this family in decreasing frustration by emphasizing problem solving and enhancing the grandmother's confidence in parenting?

MST is also a Widely Recognized Evidence-Based Program

MST is a Blueprints Model PLUS program

In 2016, noted as one of only two programs, and the only youth intervention in the world, that meet this highest standard of evidence-based models, including independent replication of research findings. http://www.blueprintsprograms.com/.

MST is also endorsed by United Nations on Drugs and Crime, Center for Medicare and Medicaid Services, U.S. Department of Justice Office of Justice Program, the National Institute of Health, National Institute of Drug Abuse, and Substance Abuse and Mental Health Administration.

Populations of Focus for FFT and MST

Let's Think about Our Own Communities First

Write down 5 youth and/or family-related stressors present in your communities and corresponding barriers to their improvement

Stressors	Barriers
E.g., Financial	Lack of safe job opportunities for youth

FFT Criteria for Treatment Inclusion

- Youth ages 11-18
- Low, moderate, and high-risk juveniles with behavioral and substance misuse problems; multiple serious offenses (e.g., felonies and transition from incarceration; and/or co-occurring internalizing symptoms, such as anxiety and depression (acting out behaviors, must be present to the degree that functioning is impaired)
- Families where there is a lot of blame and negativity between the youth and parents/other members (therapist works to build an alliance to help the family move beyond activating thoughts and statements).
- At least one adult caregiver must be available to provide support and willing to be involved in treatment.

FFT Exclusion Criteria

- Youth living independently
- Families currently engaged in family therapy
- Sex offending behavior in the absence of other anti-social behavior
- Youth with moderate to severe autism (difficulties with social communication, social interaction, and repetitive behaviors)
- Youth whose psychiatric problems are the primary reasons leading to referral or have severe and serious psychiatric problems

FFT Adaptations for Treatment Focus and Inclusion

Adaptation	Child Age Range	Program Description
FFT through Child Welfare (FFT-CW)	0-18 years	Family preservation program designed to provide services to youth (0-18 years old) and families in a child welfare setting
FFT Gang (FFT-G)	11-18 years	Gang prevention/intervention program designed to impact youth who are gang-involved or at risk of involvement. Focuses on the family and directly addresses criminogenic risk factors that are often more prominent in a gang population than in a more general delinquent population
FFT Probation and Parole (FFP)	11-18 years	Juvenile probation and parole program for youth who are on supervision in the community

MST Inclusion Criteria

- Youth between the ages of 12-17 who are demonstrating antisocial or delinquent behaviors and meet any of the following criteria:
  - Imminent risk of out of home placement
  - Physically aggressive at home, school, or in the community
  - Verbally aggressive threatening to harm others
  - Substance abuse along with any of the above

- Ideal for youth who are resistant to treatment and disengaged

MST Exclusion Criteria

- Youth living independently, or for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers
- Youth who are actively suicidal, homicidal, or psychotic
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.

CEBC » Multisystemic Therapy › Program › Detailed (cebc4cw.org)

MST Adaptations for Treatment Focus and Inclusion (#1)

Adaptation	Child Age Range	Program Overview
MST	12-17	Foundational model for youth with serious behavioral issues including substance abuse
MST for Youth with Problem Sexual Behaviors (MST-PSB)	10-17	For youth with externalizing, delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses.
MST Psychiatric Care (MST-Psych)	9-17	For youth at risk for out- of home placement due to serious behavioral problems AND co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety and impulsivity. It includes the addition of a child psychiatrist (part-time) to the MST team. May be used to stabilize home placement after acute hospitalization or to avert residential placement.
MST Substance Use (MST-SA)	12-17	For youth with substance-abuse issues; includes drug and alcohol testing.

MST Adaptations for Treatment Focus and Inclusion (#2)

Adaptation	Child Age Range	Program Description
MST Child Abuse and Neglect (MST-CAN)	6-17	For youth and their families with child protective services (CPS) involvement due to physical abuse and/or neglect; and maltreatment report filed within the last six months
MST Emerging Adults (MST-EA)	17-26	For transition age youth and young adults with justice system involvement and mental health and/or substance use disorders; emerging adults old enough to emancipate from their families and may be living independently or exiting foster care.
MST Building Stronger Families (MST-BSF)	6-17	For families involved with CPS due to co-occurring parental subs abuse and physical abuse and/or neglect of a child aged 6 - 17 in the family; Combines two evidence-based treatment approaches: (1) MST-CAN and (2) Reinforcement Based Therapy (RBT) for parental substance abuse
MST Juvenile Drug Courts (MST-JDC)	12-17	Implemented in collaboration with JDC; serves youth who currently participate in a drug court program and who have stable community-based placement with an adult caregiver who is willing to participate in treatment. Most JDCs target one year of participation per youth.

MST Adaptations for Treatment Focus and Inclusion (#3)

Adaptation	Child Age Range	Program Description
MST Family Integrated Transition (MST-FIT)	12-17	For youth transitioning back to the community from being incarcerated in facilities that are implementing the Integrated Treatment Model (ITM). ITM directly targets emotion dysregulation as a primary driver of problematic behaviors and substance use relapse.
MST Health Care (MST-HC)	12-17	For youth failing to adhere to medical health care recommendations in a number of domains such as treating poorly controlled type 1 diabetes, obesity, asthma and HIV in youths.
MST Prevention (MST-PRV)	12-17	For teenage youth with child welfare system involvement due to delinquent/incorrigible behaviors. The primary goal is to decrease the risk that these youth will become more deeply involved in the child welfare or juvenile justice systems. Largely based upon standard MST but includes enhanced safety planning and is highly responsive to the reporting and administrative needs of the specific child welfare system.

MST Adaptations for Treatment Focus and Inclusion (#4)

Adaptation	Child Age Range	Program Description
MST Autism Spectrum Disorder (MST-ASD)	10-17	Aimed at the broad range of factors associated with disruptive behaviors among youth with ASD.
MST Intellectual Disabilities (MST-ID)	10-19	For youth and/or caregiver(s) with an intellectual disability (known or suspected presence of an ID, or as having impaired functioning indicative of an ID); Based on standard MST, with additional training and resources developed for the MST-ID teams to have increased skills and responsivity for serving this population and its stakeholders
MST Interpersonal Violence (MST-IPV)	0-17	Treatment of families who have come to the attention of CPS due to a report of physical abuse and/ or neglect and violence between the adult partners/parents in the home in the last 6 months; for families whose clinical challenges are severe (e.g., likely have prior reports or investigations; parents or partners experiencing significant mental health difficulties) with at least one credible report of violence between the adult partners/parents and are at risk of further escalation; children may be at risk of out-of-home placement or in out-of-home placement when CPS has a plan to reunite the family.

True or False: Similarities between FFT and MST

T/F Draw from family systems theory and integrate behavioral approaches.
T/F Designed to be used with culturally sensitive interventions
T/F Engage youth and parents/caregivers as essential participants
T/F Strength-based
T/F Aim to improve family functioning
T/F Provide care in the field (MST also in office setting) and at times convenient to the family
T/F Tailor treatment to each family's unique needs
T/F Foster natural supports for the family
T/F Therapists receive group supervision on a weekly basis and spend intersession time planning interventions.
T/F Teams receive ongoing consultation from model experts to ensure fidelity (MST requires consultation weekly via phone from an MST model expert)
T/F Have a single therapist supported by a generalist team of 2-4 therapists and one supervisor (FFT); 3-8 therapists including the supervisor (MST)

True or False: Main Differences Between FFT and MST

T/F MST treats youth who are repeat clients and having committed several serious crimes. Many can be characterized as hard core and will very likely end up incarcerated or in an out of home placement; FFT works with high-risk juveniles who have committed lesser serious crimes.

T/F MST is intensive, 3-5 months with session frequency determined by clinical need, with therapists on call 24 hours a day, seven days a week, ready to go to the offender's home whenever needed. Treatment on average lasts 60 hours over four months; FFT is an intervention which works with less contract time with families, average 8-12 one-hour sessions, but up to 30 sessions for those with more severe conditions.

T/F MST has a defined course of treatment based on top clinical concerns presenting for treatment; FFT has flexibility for the therapist to treat based on themes presenting in therapy

T/F FFT excludes families currently engaged in family therapy; whereas MST invites the family to decide what co-occurring treatments they want to pursue concurrently sessions

True or False: Similarities between FFT and MST (answers)

True	Draw from family systems theory and integrate behavioral approaches.
True	Designed to be used with culturally sensitive interventions
True	Engage youth and parents/caregivers as essential participants
True	Strength-based
True	Aim to improve family functioning
True	Provide care in the field (MST also in office setting) and at times convenient to the family
True	Tailor treatment to each family's unique needs
True	Foster natural supports for the family
True	Therapists receive group supervision on a weekly basis and spend intersession time planning interventions.
True	Teams receive ongoing consultation from model experts to ensure fidelity (MST requires consultation weekly via phone from an MST model expert)
True	Have a single therapist supported by a generalist team of 2-4 therapists and one supervisor (FFT); 3-8 therapists including the supervisor (MST)

True or False: Main Differences Between FFT and MST (answers)

True MST treats youth who are repeat clients and having committed several serious crimes. Many can be characterized as hard core and will very likely end up incarcerated or in an out of home placement; FFT works with high-risk juveniles who have committed lesser serious crimes.

True MST is intensive, 3-5 months with session frequency determined by clinical need, with therapists on call 24 hours a day, seven days a week, ready to go to the offender's home whenever needed. Treatment on average lasts 60 hours over four months; FFT is an intervention which works with less contract time with families, average 8-12 one-hour sessions, but up to 30 sessions for those with more severe conditions.

True MST has a defined course of treatment based on top clinical concerns presenting for treatment; FFT has flexibility for the therapist to treat based on themes presenting in therapy

True FFT excludes families currently engaged in family therapy; whereas MST invites the family to decide what co-occurring treatments they want to pursue concurrently sessions

FFT Outcome Studies and Ratings

- Blueprints Registry
- **Rating:** Model
- **Link:** Blueprints Programs – Blueprints for Healthy Youth Development

- Crime Solutions from National Institute of Justice Registry
- **Rating:** Effective
- **Link:** Program Profile: Functional Family Therapy (FFT) | CrimeSolutions, National Institute of Justice (ojp.gov)

- Washington State Institute for Public Policy Registry
- **Rating:** Research-based
- **Link:** Wsipp_Washington-States-Functional-Family-Therapy-Program-Outcome-Evaluation_Report.pdf

- Title IV-E Prevention Services Clearinghouse
- **Rating:** Well-supported
- **Link:** Functional Family Therapy (hhs.gov)

MST Outcome Studies and Ratings

- Blueprints Registry
- **Rating:** Model+
- **Link:** https://www.blueprintsprograms.o...

- Crime Solutions from National Institute of Justice Registry
- **Rating:** Effective
- **Link:** https://crimesolutions.ojp.gov/r...

- Washington State Institute for Public Policy Registry
- **Rating:** Research-based
- **Link:** http://www.wsipp.wa.gov/BenefitC...

- Title IV-E Prevention Services Clearinghouse
- **Rating:** Well-supported
- **Link:** Title IV-E Clearinghouse: Multisystemic Therapy (MST) (hhs.gov)

Stock Photo. Posed by Models

FFT and MST Agency and Staff Training Requirements

FFT Agency Requirements

- FFT certifies agencies, not individual therapists. To promote and support model fidelity, FFT LLC strongly believes in the need for ongoing administrative support and clinical work groups.

- Funding plan for your organization's FFT program. The key to financing an FFT program is to identify funding that will cover both start-up costs and ongoing costs. Start-up costs include fees for initial licensure, staff recruitment assistance, training/ certification, etc. Ongoing costs include staff salaries, overhead, and fees for continuous FFT program support.

- FFT LLC's Business and Program Development team will send the agency an FFT application for site training and site certification.

FFT | Evidence-Based Interventions and Family Counseling (fftllc.com)

FFT Therapist and Supervisor Requirements

- FFT should be implemented with a team of 3-8 master's level therapists
- Each therapist must have a caseload of at least 5-6 cases at any given time (20 hours/week) and up to 10-12 cases at any given time (40 hours/ week)
- Therapists can expect to complete a case in approximately 3-5 months. So, a full-time FFT therapist can expect to complete 25-30 cases during the course of a year.
- The site supervisor is also required to carry a caseload.
- Site supervisors may reduce their caseloads to meet the requirements of the position; however, this caseload must be a minimum of five active cases at all times.

FFT | Evidence-Based Interventions and Family Counseling (fftllc.com)

FFT- 3 Phasic Training Process

Clinical Training

Train clinical externs in 12-18 months

Supervision Training

Train a site's extern to become the onsite supervisor in a year long process

Maintenance Phase

Annual training activities

FFT | Evidence-Based Interventions and Family Counseling (fftllc.com)

FFT Costs (not exhaustive)

Start-up costs are incorporated in phase one of program development.

- Training is team based with an optimal team size of 5-6 therapists.
- The cost of phase one training and technical assistance is $40,000, plus an estimated $10,000 for travel for a total of $50,000; year 2 cost is $22,000 (plus $4,000 for travel), and the cost for year 3 and beyond is $9,750 (plus $1,000 for travel) per year
  - Some costs will be incurred after the program staff are trained and seeing clients.
  - With therapist caseloads of 10-12 (average of 11) and supervisors seeing 5 families and an average service length of 4 months, the program could serve approximately 246 youth/families. Average youth/family cost in this example would be $3,130

Other start-up costs include:

- Staff salaries during the training period and the cost of developing office space (more space will be needed if implementation is to be office-based).
- A one-time license fee will be incurred for the assessments that will be needed from Quality Outcome Measures (based on team size and is usually around $2,000)

Blueprints Programs – Blueprints for Healthy Youth Development

MST Agency Requirements

- Must have community support for sustainability.
- With the buy-in of other organizations and agencies, MST is able to "take the lead" for clinical decision-making on each case.
- Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations and agencies while MST staff sustain them through ongoing, case-specific collaboration.
- Agencies collect data as specified by MST Services, and all data are sent to the MST Institute (MSTI) which is charged with keeping the national and international database system.
- MSTI data reports are used to assess and guide program implementation.
- Agencies use MST Institute (MSTI) MSTI reports to monitor and assure fidelity to the MST model.

https://www.mstservices.com

MST Therapists and Supervisors

- MST clinical "teams" are defined to consist of a Ph.D. or master's level supervisor and two to four master's level counselors operating together to provide MST services in a specific area or region.

- Clinical supervisors must be at least 50% part-time and may supervise 1-2 teams only.

- Clinical supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (e.g., Structural Family Therapy and Strategic Family Therapy).

- Clinical supervisor conducts on-site weekly team clinical supervision, facilitates the weekly MST telephone consultation, and is available for individual clinical supervision for crises.

** Caseloads may differ depending on the MST adaptation being delivered and the level of severity of the family system's issues

https://www.mstservices.com

MST- License and Start Up Costs (not exhaustive)

MST Group LLC (doing business as MST Services) offers comprehensive assistance with the full development of MST programs by providing program start-up assistance, initial and on-going clinical training and program quality assurance support services

- Master License: $4,750 per year per agency
- Team License: $2,950 per team per agency

Program start-up costs including initial staff training ($14,500 plus travel)

- Includes one on-site 5-day Orientation training for up to three teams.
- 3+ teams, or teams starting on a staggered schedule will need to purchase additional on-site 5-day Orientation trainings ($2,000 per additional team plus travel)

https://www.mstservices.com

MST Intervention Implementation Costs (not exhaustive)

The following fee structure applies to each team or group of teams for on-going Booster training (costs below are exclusive of Program Dev't and Start-up or 5-day Orientation training fees).

- Single teams: $37,200 per year plus required quality assurance services: $6,000/year for Therapist Adherence Measure (TAM) data collection (required)
- Two or three teams training jointly: $28,500 per team per year**
- Replacement staff cost (due to attrition) who start after "initial" program start-up:
  - 5-day Orientation for $12,500/training delivered on site, plus travel costs, or
  - $950/participant for those who attend 5-day Orientation trainings in Atlanta, Georgia (workshop fee only, exclusive of travel, lodging and meal costs)

**Costs that vary by locality include admin support, space, travel, supplies, and communications.
**Implementation costs vary significantly across the country.
**MST Services provides an MST Program Budget Template to assist communities in estimating costs

Multisystemic Therapy® (MST®) (blueprintsprograms.org)

Let's Apply!

What changes in your current agency structure would need to happen to implement FFT or MST?

Referral Process Guidelines for FFT and MST

FFT

- Delinquent/anti-social youth
- Medium to high-risk youth
- Clients on the lower risk end
- Identify system expectations regarding planned linkage to post-care services
- Focus on the family system in the early phases of treatment and then collaborate with other systems as the family reaches the final phase of treatment.
- Engage in pre-treatment systems work to connect with referral sources at the beginning of treatment and keeps these sources informed (with appropriate consent) in a collaborative manner throughout treatment.

MST

- Delinquent/anti-social youth
- High-risk youth
- Youth needing access to 24- hour services due to youth and family needs, and to system concerns (e.g., community safety)
- Define consultation to and collaboration with other systems as a key element of the model from the beginning of treatment.
- Reach out to all key participants to gather their desired outcomes for developing treatment goals.
- Inform key participants (with appropriate consent) of treatment gains throughout the treatment process.

Summary by Comparison (#1)

	FFT	MST
Treatment Site	Field, Office (depending on family need)	Field, home, school, neighborhood, community
Provider	Single therapist as part of a team	Single full-time therapist as part of a team
Team size	3-8 therapists including the supervisor	2-4 therapists plus a supervisor
Treatment	Phase-based and systematically targeting risk and protective factors at multiple levels in the youth's ecology. Systemic and cognitive-behavioral interventions are included to change/replace maladaptive emotional, behavioral, and psychological processes within the individual, the family, and with relevant extra-family systems	Total behavioral health care (some exceptions for long-term care services such as psychiatric care, see more below under "Case Management Function") with an emphasis on addressing all systems in the youth and family's ecology that affect youth behaviors, and on empowering the family to manage challenges on their own.

2. FFT and MST May, 2019_0.pdf (unc.edu)

Summary by Comparison (#2)

	FFT	MST
Case Management Function	After youth & family have adopted positive coping patterns will link with other resources to enhance skills and provide additional resources	Service provider rather than broker of services –success of referrals to long-term care providers, such as psychiatric care, are seen as responsibility of the MST therapist
Approach to other co-occurring treatments	Exclude families currently engaged in family therapy	Family makes the decision regarding what co-occurring treatments are pursued, though MST therapists help the family minimize other services as much as possible
Treatment Duration	Approximately 3 months, up to 5 months in serious cases	3 to 5 months in most cases, an average of 4 months
Staff Credentials	MA-level is preferred, exceptions can be made for highly skilled BA-level clinical staff	MA-level is preferred, exceptions can be made for highly skilled BA-level clinical staff

2. FFT and MST May, 2019_0.pdf (unc.edu)

Summary by Comparison (#3)

	FFT	MST
Staff employment status	Preference is for full-time staff but part-time staff working with a minimum caseload of 5 families (approximately 10- 12 hours per week) can be acceptable	Full-time therapists with no other duties outside of MST. Supervisor commitment of 50% time per team as a minimum
Clients/Families per staff	10-12 cases for a full-time therapist	4-6 cases per full-time therapist
Staff Availability	Expectation that staff will work flexible schedule based upon needs of the family. No requirements for 24/7 on-call system.	Expectation that staff will work flexible schedule based upon needs of the family. 24 hr.\7 day\wk. team available
Treatment Outcomes	Responsibility of staff and agency	Responsibility of staff and agency

2. FFT and MST May, 2019_0.pdf (unc.edu)

Summary by Comparison (#4)

	FFT	MST
Expectations of Outcomes	Immediate, maximum effort by family and staff to attain goals	Immediate, maximum effort by family and staff to attain goals
Referral Process Guidelines	• Delinquent/anti-social youth • Medium to high-risk youth • Status offenders on the lower risk end • System expectations regarding planned linkage to post-care services	• Delinquent/anti-social youth • High risk youth • Youth needing access to 24-hour services due to youth and family needs, and to system concerns (e.g., community safety concerns)

2. FFT and MST May, 2019_0.pdf (unc.edu)

How to Find FFT and MST Therapists and Bring Training Opportunities to Colorado

FFT

- Functional Family Therapy Locations | FFT (fftllc.com)

MST

- https://www.mstservices.com/licensed-organizations

To better inform our future trainings and request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

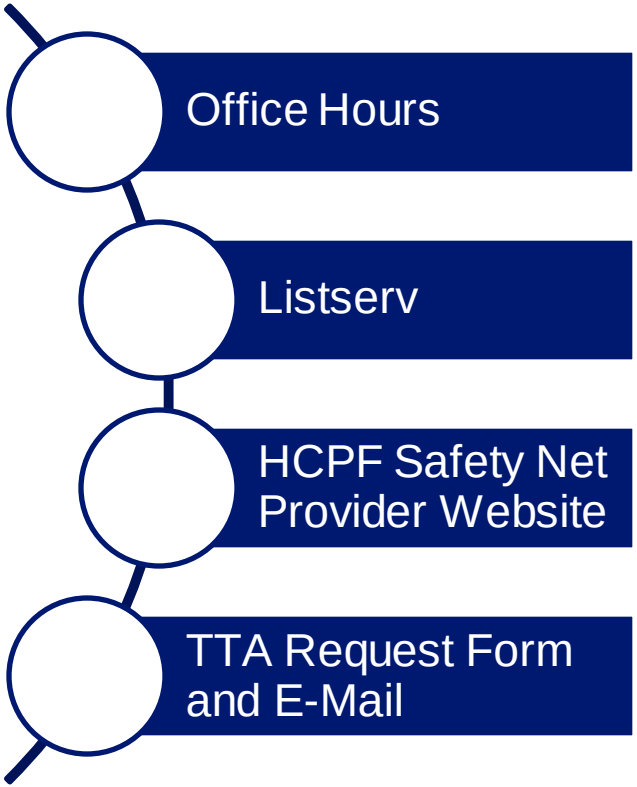
https://bit.ly/bhprovidertrainingsurvey

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

HMA
Health Management Associates

Appendix A: Additional Resources



Office Hours are offered on the last Friday of every month (through September 2024) at noon MT! Please visit the HCPF Safety Net Website for details & registration information.

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

Visit the website for details on upcoming training topics and announcements, training recordings and presentation decks, FAQs and more: https://hcpf.colorado.gov/safetynetproviders

Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press

* Rest of material referenced regarding FFT and MST is linked in the slides