Service Name	**MULTISYSTEMIC THERAPY (MST)**
Setting	Services are rendered in a professional office, clinic, home or other environment appropriate to the provision of psychotherapy services.
License	• As required by DHHS Division of Public Health. • In order to be considered a MST service, the provider will be trained and licensed in MST with MST Services and the Medical University of South Carolina. Teams will also receive regular consultation from MST Services or an MST network partnering agency.
Basic Definition	MST is an evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence an individual's involvement, or potential involvement in the juvenile justice system. The therapeutic modality uses family strengths to promote positive coping activities, works with the caregivers to reinforce positive behaviors, and reduce negative behavior, and helps the family increase accountability and problem solving. Beneficiaries accepting MST receive assessment and home based treatment that strives to change how the individuals, who are at risk of out-of-home placement, or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior. MST's therapeutic model aims to uncover and assess the functional origins of adolescent behavioral problems by altering the individual's behavior in a manner that promotes prosocial conduct while decreasing aggressive/violent, antisocial, substance using and/or delinquent behavior by keeping the individual safely at home, in school and out of trouble. Treatment is used at the onset of behaviors that could result in (or have resulted in) criminal involvement by treating the individual within the environment that has formed the basis of the problem behavior.
Service Expectations : basic expectations for more detail see Title 471 chapter 32	• An Initial Diagnostic Interview (IDI) will be completed prior to the beginning of treatment and will serve as the initial treatment plan until a comprehensive treatment plan is completed. • Assessments and treatment shall address mental health/substance abuse needs, and mental health and/or emotional issues related to medical conditions. • The treatment plan will be individualized and include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; and the responsible professional. The treatment plan is to be developed with the individual, the identified, appropriate family members, and key participants as part of the outpatient family therapy treatment planning process. • Treatment plans will be reviewed every 90 days or more often if clinically indicated. • The treating provider may consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated. • It is the provider's responsibility to coordinate with other treating professionals as needed. • Services include collateral and telephone contacts with significant others that affect the individual including, but not limited to, the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, individual welfare, health and mental health systems. • All psychiatric/therapy services for provisionally licensed psychologists, LMHP's, PLHMP's will be provided under the direction of a supervising practitioner (physicians; licensed psychologists; and/or Licensed Independent Mental Health Practitioners). Supervision is not a billable service.

	• Supervision entails: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; individual specific case discussion; periodic assessments of the individual; and diagnosis, treatment intervention or issue specific discussion. Involvement of the supervising practitioner will be reflected in the IDI, the treatment plan and the interventions provided. The Supervisor should track progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly. • After hours crisis assistance is to be available and staffed by MST team members. • Services are to be culturally sensitive, age and developmentally appropriate, and incorporate evidence based practices when appropriate.
Length of Service	Length of treatment is individualized and based on the progress of the individual and family according to their treatment goals. Duration of treatment is an average of four months with an expected range of three to five months.
Staffing	• MST treatment providers (i.e., therapists) will have a master's degree or greater and be a member of a licensed MST treatment program in order to be trained to provide the service. An active MST team requires an MST trained clinical supervisor and two to four MST trained treatment providers(i.e., therapists) working collaboratively with one another using the MST model as defined by the international MST services program. • MST therapists are assigned to the MST program solely and have no other agency responsibilities. • One part-time clinical supervisor, spending 50% of their time, is assigned to one MST team, or one full-time clinical supervisor to two MST teams. • MST supervisors carrying a partial MST caseload should be assigned to the program on a full-time basis. • Clinical supervisors will be physicians, licensed psychologists and/or Licensed Independent Mental Health Practitioners (LIMHP). All clinical supervisors will be trained in the MST model, with experience in the practice in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy). • Assessment providers may be any of the following: physician, psychiatric Advanced Practice Registered Nurse (APRN), Nurse Practitioners (NP) licensed psychologists, provisionally licensed psychologist and a LIMHP, all acting within their scope of practice. • Treatment providers (i.e., MST therapists) may be any of the following: physician, APRN, NP, licensed psychologist, provisionally licensed psychologist, LIMHP, LMHP, and a PLMHP, acting within their scope of practice. • Non-licensed master and bachelor's level providers may not provide clinical services. All non-licensed providers will be supervised by a licensed master's level practitioner for any support activities.
Staffing Ratio	All staffing shall be adequate to meet the individualized treatment needs of the individual and meet the responsibilities of each staff position as outlined in the MST model. MST caseloads do not exceed six families per therapists with an average caseload of five families per therapist over time and a normal range being four to six families per therapist.
Hours of Operation	Services include a 24/7 on-call system to provide coverage when the designated MST treatment provider is unavailable. This system will be staffed by MST treatment providers or supervisors who are familiar with the details of each MST case.
Desired Individual Outcome	The individual and the family maintain connections to his or her home or community and have an improved level of functioning in order to successfully function in the home setting.
Admission guidelines	All of the following guidelines are required to be met: • Referral / target ages of 12-17

	• Externalizing behavior symptoms such as chronic or violent juvenile offenses, resulting in a DSM (current version) diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (ODD, Behavior Disorder NOS, etc.) • Individual is at risk for out-of-home placement or is transitioning back from an out-of-home setting; • Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems; and • Less intensive treatment has been ineffective or is inappropriate. One of the following is required to be met in addition to the mandatory guidelines: • Individual with behavioral health issues that manifest in outward behaviors that negatively impact multiple systems (e.g. family, school, community); or • Individuals with substance use disorder issues may be included if they meet the mandatory criteria, and MST is deemed clinically more appropriate than focused drug and alcohol treatment. Exclusion Criteria *(Any of the following criteria are sufficient for exclusion from this level of care):* • The individual meets criteria for out-of home placement due to suicidal, homicidal, or psychotic behavior or are those individuals whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems. • Individuals living independently, or individuals for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers. • Referral problem is limited to serious sexual misbehavior. • Individuals with an autism spectrum diagnosis.
Continued stay guidelines	• Treatment does not require more intensive level of care. • The treatment plan has been developed, implemented and updated based on the individual's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated. • Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident. • The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.
Discharge Criteria	• Individual's documented treatment plan goals have been substantially met, including discharge plan. • Individual/family no longer meets admission criteria, or meets criteria for a less or more intensive level of care. • Individual and/or family have not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care despite treatment.