

**Improving the lives of Children & Young People**



**MST Goals and Guidelines:**

**Programme Goals, Case-Specific Treatment Goals,**

**Case Discharge Criteria, and Outcomes**

***MST E Team (Youth Endowment Fund)***

***Sandwell Children’s Trust***

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***Review 6 months from start, then annually***

**MST Goals and Guidelines:**

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**Case Discharge Criteria and Outcomes**

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# Programme- and Community-level information

## Target population to receive MST services:

*Young people, 10 to 15 years old, at risk of out-of-home placement due to antisocial or offending behaviors, including young people involved with the youth justice system, who are at risk of exploitation either through criminal or sexual exploitation by adults or older peers or young people already identified as being exploited.*

**Priority Criteria:**

YP exhibiting 2 or more of the following:

(a) criminal behaviour (conviction, final warning, reprimand within the last year),

(b) frequently missing/absconding,

(c) substance misuse,

(d) school exclusion/attendance concerns,

(e) association with negative peers or unknown/criminal adults,

(f) aggressive behaviour outside of the home,

**Exclusionary criteria**

* Young people 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.
* Young people who are actively suicidal, homicidal, or psychotic
* Young people whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems. See Attachment A for additional information regarding referrals of Young people **with** co-morbid psychiatric problems.
* Young sex offenders (sex offending in the absence of other delinquent or antisocial behavior). See Attachment B for additional information regarding this referral criterion.
* Young people with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism. See Attachment C for additional information regarding this referral criterion.
* Young people with learning or intellectual disabilities are often referred to MST teams. These young people are appropriate for MST teams when they meet inclusionary criteria for MST, and when the factors contributing to the Young person’s ’s behaviour problems are driven by the same factors identified via research as driving Young people’s conduct problems (e.g. the peer, family, school, community and individual drivers). MST interventions are designed to address common risk factors in these ecological domains, including individual risk factors that arise due to intellectual disabilities. If, however, the young person’s ’s intellectual disability is the only influence, or is the most powerful, direct contributor to their referral behaviors, MST is not an appropriate intervention for this young person and family. This would include situations in which the young person is severely or profoundly intellectually impaired according to the DSM.

## Communities to be served

### Geographic service delivery area:

The project will serve the Sandwell Local Authority area.

### Key community stakeholders: Partners with MST Programme

|  |  |
| --- | --- |
|  |  |
| Funder | Youth Endowment Fund |
| Those with power to place young people, or to initiate out of home placement | Frances Craven, Chief Executive  Pauline Turner, Director of Operations |
| Other key community stakeholders (e.g. school, health, police, etc.) | Sandwell Children’s Trust Executive Management Team:  Sandwell Children’s Trust Operations Directorate Heads of Service.  In addition:  Mandip Chahal, Resources Manager,  Procurement, Commissioning & Placements  ‘Horizons’ Exploitation Team, Team Manager - Andy Turvey  Police – Sergeant David Rogers  Education/Inclusion Support – Melanie Barnett  Housing – need to identify a contact  Health – need to identify a contact  Youth Offending – Claire Martin as Deputy YOS manager  Executive Director of Children’s Services in SMBC – Lesley Hagger  Chris Ward – Director of education  Errol Blackwood – Connexions |
| Other key community stakeholders (e.g. voluntary and community organisations) | Identified Lead from VCSO – contact Marc Davies/John Grant  Community Safety Manager – Tessa Mitchell  Youth Service – Dawn Maleki/Taria Karim.  Connexions – Sybil Mackenzie  **Community Links needs to be strengthened.** |

## 

## Programme Staffing and Capacity

37 of hours in a standard work week for this agency:

Name of MST Supervisor: Andrea Underhill. This role is not case holding unless by exception due to specific complexities of a family or unforeseen capacity issues in the team.

Programme Management function is led by Michael Botham, in partnership with the MST Supervisor.

Name and title of back-up supervisor: Lloyd McDonald.

Name of key support person for MST Programme from organisational leadership: Michael Botham

Name of person who will administer TAM-Rs: Jenna Rock, Business Support.

Person identified to collect follow-up data: Jenna Rock in conjunction with Andrea Underhill and the Children’s Trust data team led by Chris Yates.

* For additional guidance, please see  [Follow-up Data Collection](https://www.msti.org/userauth/PS%20Follow-up%20Data%20Collection.docx?web=1) Position Statement

Number of Therapists: 4

Caseload slots range: 4-6 clients per therapist

Caseload slots average: 4.75 clients per therapist

Targeted average length of treatment: Target 120 days (4 months)

Treatment slots available: 20

Estimated annual programme capacity : 48

# Programme goals for target population

## Required Process Goals (tracked via the MSTI web-based data collection system):

* Length of treatment - Target range: 90 – 150 days (3-5 months); Target average: 120 days (4 months)
* Percent of Young people completing treatment - Target: 85%
* Percent of Young people discharged due to lack of engagement – Target: <5%
* Percent of Young people discharged due to placement - Target: <10%
* Average caseloads range within 4 – 6 per therapist.
* Therapist Adherence Measure (TAM-R) collection rate – Target: > 70%
* Overall average adherence score - Target: .61
* Percent of Young people reporting adherence above threshold (>.61) – Target: 80%
* Percent of Young people with at least one TAM-R interview – Target = 100%

## Outcome Goals (tracked via the MSTI web-based data collection system):

Indicate in the table below which data will be collected.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Discharge | 6 mo post D/C | 12 mo post D/C | 18 mo post D/C |
| Young people at home | X | X | X | X |
| Young people in school/ working | X | X | X | X |
| Young people not arrested | X | X | X | X |

# Referral Procedures –

MST Programme staff shall clearly define and strive for a target average caseload of 4.75 for each therapist, which requires a usual caseload of 5 families and some short periods during which each therapist will carry 6 cases, typically when a family are close to discharge.

## Initiation of Referrals from Community Stakeholders

1. ***FROM SOCIAL CARE VIA EXISTING TRIAGE OF MST MANAGERS AND FAMILY SOLUTIONS TEAM MANAGER***
2. ***VIA EXPLOITATION HUB MEETINGS /AND OR THE HORIZON TEAM***

If more than one team or panel exists, duplicate this table as needed.

|  |  |
| --- | --- |
| Is there an assessment or referral team or panel in the community that will send referrals? | No |

* **External Assessments or Authorisations**

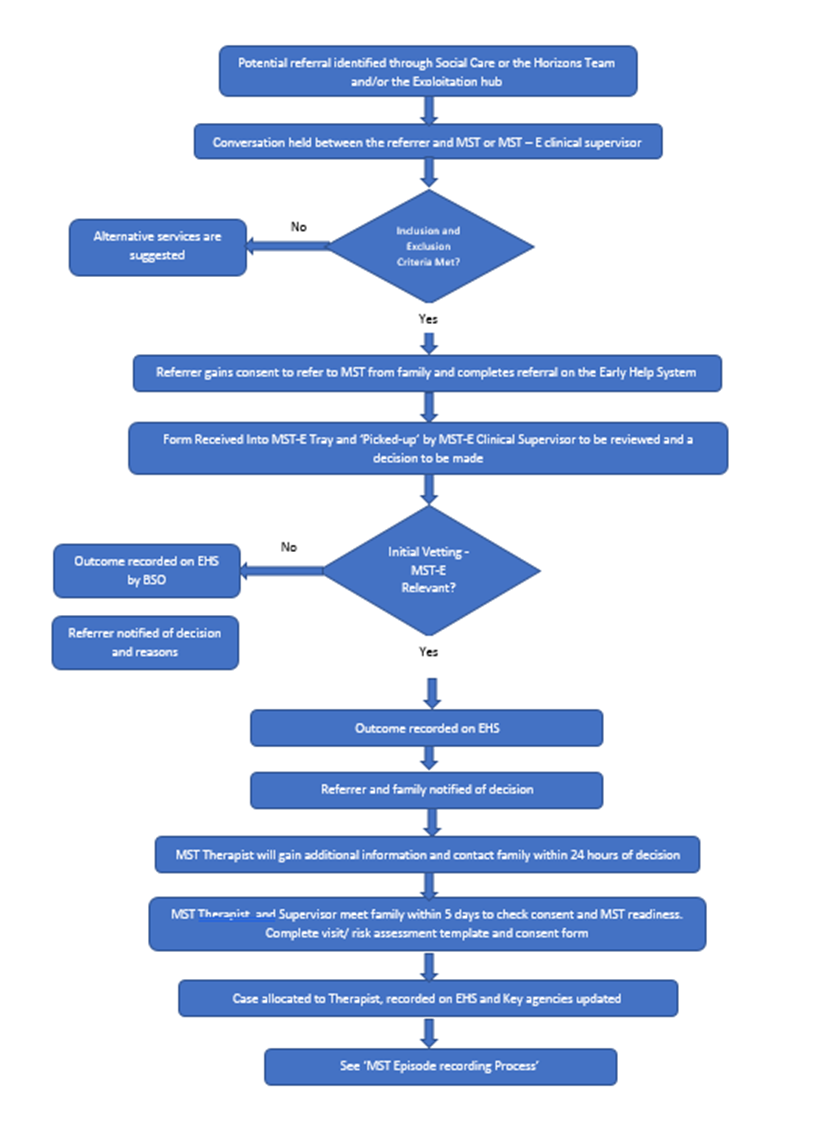
If more than one team or panel exists, duplicate this table as needed.

|  |  |
| --- | --- |
| Are any external assessments or authorisations required **prior to** MST Programme being referred the case? | No |

* **Referrer questions about appropriates of referrals should be addressed to the following person in the MST Programme**; Andrea Underhill
* **Referrals should be sent electronically via the Early Help System to the MST inbox.**
* **Will an MST Referral Form be used?** X Yes No

Please see Appendix E

* **Referral Flowchart:**



## Steps Taken Once Referral is Received by MST Programme

* **Agency intake process**

|  |  |
| --- | --- |
| Is there some sort of intake team or panel in the provider agency that screens referrals that will come to the MST Programme? | Yes, triage conversation between MST Supervisors (x2) and Family Solutions. |
| If Yes, | |
| How frequently do they meet? | Virtually as referrals are received. |
| Will the MST Supervisor sit on the team or committee? | Yes |
| Is anyone else in the MST Programme agency involved in managing referrals? | Programme manager in the event of escalation. |
| If Yes, |
| Please list names here | Mike Botham  Jo Burgess (FST) |

* **Case Acceptance Decision**

|  |  |  |
| --- | --- | --- |
|  | **Responsibility** | **Timeline** |
| Who will request additional information if needed? | MST Supervisor | At time of initial referral |
| Who will determine if Programme has current capacity to accept referral? (Consider both therapist and supervisor capacity.) | MST Supervisor | At time of initial referral |
| Who will assure permission is secured with referred family for first MST contact? | Referring agency | At time of initial referral |
| Who will enter Young people ’s info on MSTI website? | Business support staff | At time referral is accepted |

* **Authorisation and Assessment AFTER Referral**

|  |
| --- |
| Does authorisation need to be obtained from funder after referral is approved?  No |
| Is a formal assessment required by funder after referral is approved?  No |

* **Treatment Initiation**

|  |  |  |
| --- | --- | --- |
| Who will make first contact with family to secure consent to treat and agreement to participate in MST? | MST Supervisor | Within 72 hours of referral |
| Who will contact referral source with outcome of family consent and agreement to participate in MST, and do the following?   * Document reasons for family refusal if needed * Seek assistance from referral source in recruiting reluctant family if needed | MST Therapist | Within 72 hours of first family contact |

* **Disposition of Referrals Not Accepted**

|  |  |  |
| --- | --- | --- |
| Who will inform referral source when a referral is not accepted and why? | MST Supervisor | As indicated – within 1 week of receipt of referral |
| Who will assist the referral source in locating another MST Programme or alternative services or resources for family? | MST Supervisor | As required |
| Who will provide information to referral source to improve future referrals if inappropriate referrals are being sent? | MST Supervisor | As required |

# MST Programme guidelines

## Primary goals of MST treatment:

* Eliminate or significantly reduce the frequency and severity of the young person’s’ referral behavior(s);
* Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower young people to cope with family, peer, school, and neighbourhood problems.

**Overarching case-specific goals for treatment:**

MST defines the primary case-specific treatment goals as “Overarching Goals.”

**An overarching goal**

* refers directly to the referral/target behavior
* incorporates desired outcomes of caregivers and other key participants
* is written objectively, so an outside observer can easily determine whether or not the goal has been met.

Assuring that case-specific overarching goals are always consistent with programme goals is the responsibility of each MST therapist and supervisor. To accomplish this objective, each therapist must be aware of both the goals and the referral criteria for the MST Programme. Therapists should fully engage the referral staff to ensure that the goals of their agency or department are reflected in the overarching goals of each case.

## Length of treatment

Typical duration of treatment is three to five months. From the first meeting the therapist is planning for discharge by establishing overarching goal with clear criteria for success and by facilitating interventions that are carried out, as much as possible, by family members and other key participants.

The therapist needs to gauge decisions about discharge based upon achievement of overarching goals. The therapist needs to end treatment when:

* there is evidence ***at any point in the treatment***that overarching goals have been sustained over a period of 3-4 weeks, or
* overarching goals have not been met and treatment has reached a point of diminishing returns

**Extending MST treatment**

Factors affecting the decision to extend treatment beyond 5 months

* What are the identified needs of this specific young person and family, and how do these needs weigh against the needs of young people yet to be served (input from the referral agency will be required)?
* To what extent has the family been engaged and what other specific strategies can be used to improve engagement?
* What additional investment of time/energy will be needed by therapist to move the case forward?
* What are the projected outcomes of extended treatment time?
* What are the funding-related requirements?

**Discharge criteria**

The determination to discharge a young person from MST is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g. Young person, parent, school, social worker) indicating that:

* a majority of the overarching goals for the case have been met and sustained;
* the Young person has few significant behavioral problems;
* the family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 4 weeks;
* the Young person is making reasonable educational/vocational efforts;
* the Young person is involved with prosocial peers and is not involved with, or is minimally involved with problem peers; and
* the therapist and supervisor feel the caregivers have the knowledge, skills, resources, and support needed to handle subsequent problems.

Discharge from MST may also occur when few of the overarching goals have been met, but despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested.

# Evaluating case status at discharge

When it has been determined that a case will be discharged, the MST team will review the status of the case in three areas:

* the current status of case progress,
* the status of key instrumental outcomes, and
* the status of the case relative to three areas of “ultimate,” or real-world, outcomes.

See Attachment D for additional information regarding the impact of the young person being missing or on ‘Runaway Status’ on the evaluation of case status at discharge.

The information is collected in these three areas, reviewed with the MST expert, then entered into the MSTI database for programme quality assurance and improvement as follows:

**CASE PROGRESS REVIEW ITEM**

At discharge, the following guidelines are followed to input data for case closure into the MSTI Website.

**Reason for case closure:** (One reason only is selected)

* **Completion**: The Young person was discharged based upon the mutual agreement of the primary caregiver(s) and the MST team.
* The reason for case closure does not meet any of the other categories AND
* team and family agree that there is evidence that overarching goals have been sustained over a period of 3-4 weeks, OR
* team and family agree that overarching goals have not been met and treatment has reached a point of diminishing returns for the additional time invested.

*Selection of this category does not assume that the case closed with all goals met, only that primary caregiver(s) and team agreed that no further progress on overarching goals is likely.*

* **Lack of engagement**: The decision to discharge the young person was made because the MST team was not able to engage the family in treatment, despite persistence on the therapist’s part to engage and align with the family.
* Despite persistent efforts by the therapist, the family has not EVER been seen face-to-face for two consecutive weeks OR
* Family has formally declined MST services OR
* Family states they do not want to continue (a statement to this effect should be included in note section) AND
* The consultant and team have identified and addressed barriers to inadequate engagement and agree that all engagement strategies have been exhausted.

*Selection of this category indicates that the family has chosen to not participate in MST Services. In other words, this category documents that the team never had engagement. As long as the family was actively involved in working on at least one goal for some part of treatment, this category is NOT checked. This latter case would be counted as “completed” with lack of progress reflected in instrumental goals.*

* **Placement**: The young person was placed in a restrictive setting (Youth Offending Institution, residential placement), or foster care for a duration of time that precluded further MST involvement.
* **Placement, prior event**: The young person was placed in a restrictive setting, or foster care due to an event or offence that occurred prior to the beginning of MST treatment.
* **MST Programme administrative removal/withdrawal**: Young person was removed from the programme by the MST Programme administration due to administrative issues or decisions unrelated to the progress of the case.
* **Funding/referral source administrative removal/withdrawal**: Young person was removed from the Programme by the funding or referral source due to administrative issues or decisions unrelated to the progress of the case.
* **Moved**: The family moved out of the programme’s service area.

**Instrumental Outcomes**. The Instrumental Outcomes are documented in the MST Goals and Guidelines as the criteria for determining whether a case was closed successfully or not. While some guidance in defining these items is provided, it is critical for each Programme to define these in terms of objectives for the case. For example, if the case had an overarching goal of increasing involvement in pro-social activities as evidenced by attending one approved recreational activity a week, then the related instrumental outcome would be rated as met if the Overarching Goal is met. Therefore, responses to these items are not completely standardized across Programmes. The following items are scored as “yes” or “no” at the point of a case discharge:

* The therapist and supervisor have evidence that the primary caregiver(s) has improved the parenting skills necessary for handling subsequent problems.
* There is evidence of improved family relations specific to the instrumental and affective domains in that family’s subsystems that were drivers of the young person’s referral behaviour.
* The family has improved their network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (informal to formal) as needed.
* The young person is showing evidence of success in an educational or vocational setting.
* The young person is involved with prosocial peers and activities and is minimally involved with problem peers.
* Changes in behaviour of the young person and in the systems contributing to the referral problems have been sustained for 3-4 weeks.

**Ultimate Outcomes**. These items provide some basic information about how the young person is functioning at the time of discharge. The meaning of the terms (e.g., ‘arrests’) may vary from county to county, state to state, and country to country; therefore, it is difficult for the MST Institute to establish a “one-size-fits-all” definition. The operational definition of each of the following should be made clear for each MST Programme and documented in the Goals and Guidelines document. The following definitions are offered as guidance based on common performance measures used but can be adapted to each community as needed. The following items are scored as “yes” or “no” at the point of a case discharge:

* **Young person is living at home.** Home is defined as a private residence that is approved by the Young people ’s guardian. This could include a parent’s home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of “home” if agreed by the project funders. Young people who are missing from home would not be classified as at home.
* **Young person is attending school** the required numbers of hours and level of attendance or vocational training or, if of the legally appropriate age to not attend school, has a paying job (at least half time).
* Young person is attending school, a high school equivalency programme (GED Programme,) or a vocational programme in the young person 's natural ecology or working. The primary objective of the programme is educational or vocational. A young person in a secure setting (correctional facility) or treatment setting in which educational or vocational activities are provided, where the primary objective is treatment or correction, will NOT count as a "yes" for this item.
* If the young person is in school, young person is attending frequently enough to meet expectations placed on them by school system or court. If the discharge occurs during the summer when school is not in session, it is recommended that the response “yes” be selected if the young person was attending school at the end of the last school term, or is working.

*This item should be answered for all young people, in addition to the choice of “yes” or “no” above. Please select one item from the list that BEST describes the young person ’s current setting.*

* traditional school
* traditional school that includes a vocational component
* solely vocational training Programme
* GED or other secondary school equivalency Programme
* alternative educational Programme or setting due solely to academic need
* alternative Programme or setting due to anti-social, offending or disruptive behavior
* in a correctional facility/secure setting or treatment setting where the primary objective is treatment or correction (choose this even if educational or vocational activities are provided in the facility)
* not in any educational or vocational Programme, and working at least half-time
* not in any educational or vocational Programme, and not working at least half-time
* other- please specify
* **Young person has not been arrested** **since the beginning of MST treatment, for an offence committed during MST treatment.** This is defined this as involvement with police that results in a charge for a new criminal behaviour, rather than just being arrested.

# Communicating Outcomes to Stakeholders

Every six months the MST Programme will be reviewed for purposes of identifying status of adherence, Programme-level goals, strengths, identified barriers to Programme success, and interventions for ongoing Programme improvement. The **Programme Implementation Review (PIR)** is completed in collaboration between the MST supervisor, potentially other provider agency staff, and the assigned MST Expert. Programme Implementation Reviews will be sent to members of the steering group.

The PIR is not necessarily easily interpreted by wider stakeholders. Sandwell will aim to translate outcomes into simple and meaningful feedback to referrers where it is appropriate to do so. Communications to stakeholders and the wider partnership on general outcomes and successes of the programme will be completed via the Steering Group (for steering group members) as a matter of routine, and at organized celebration events or public facing communication releases.

Sandwell will adhere to any specific terms of the Youth Endowment fund when considering communications and evaluation.

# Attachment A: MST Referral Guidelines Regarding Young People with Co-Morbid Psychiatric Problems

The decision to implement the MST treatment model with a given population should be informed by empirical data concerning the effectiveness of MST with the target population. While substantial data from numerous randomized clinical trials involving more than 1000 families supports the use of MST with young people in the juvenile justice system exhibiting serious criminal behavior, the development of MST to serve young people at risk of out-of-home placement due to serious psychiatric impairment is a work in progress. To date, only one large randomized trial and one small pilot randomized study support the use of an enhanced version of MST, MST-Psychiatric, for young people presenting primarily psychiatric problems. Both data and clinical experience obtained in these trials have led to substantial modifications of the MST treatment model when it is to be used with these young people and their families. These modifications include the incorporation of psychiatrists and crisis caseworkers into the team, additional respite placement resources, and substantial additions to the training, supervision and quality assurance protocols. Findings from these studies suggest that standard MST teams are not equipped with the adequate resources and training required to treat young people presenting primarily with serious psychiatric difficulties. Information about the MST-Psychiatric is available from MST Services.

Thus, while MST is appropriate for young people presenting primarily with behavioral problems that may have mild to moderate co-morbid psychiatric problems, young people whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems, should be excluded from standard MST teams.

Examples of young people’s characteristics that may indicate a referral is inappropriate for a standard MST team include:

* Actively psychotic (unless temporary and due to drug use)
* Diagnosed with schizophrenia
* Actively suicidal or recent attempt
* Actively homicidal

In some cases, it is possible that a young person will be inappropriate for referral due to psychiatric problems that are not as obvious or clear as the above characteristics, such as young people accurately diagnosed with bipolar disorder or young people taking antipsychotic medications. Determination of whether these young people are appropriate for MST requires a thorough evaluation of the relevant factors by the MST team, often in collaboration with their MST expert and in some cases with local Child Mental Health Services. In particular, the team should assess the degree to which psychiatric, biologically-based factors are the primary reasons for the young people ’s behavior problems, as opposed to “willful misconduct,” the degree to which active management of the psychiatric condition and/or medications is needed, and the degree to which extensive safety interventions are likely to be needed. The team should also do their best to ensure that the psychiatric diagnosis is well documented and based on a thorough assessment.

These criteria have been selected as “red flags,” or potential “red flags,” because they signal the need for MST teams to have access to increased clinical resources to safely and adequately treat young people with serious mental health problems. These resources include access to a psychiatrist, who is trained in the MST model and integrated into the clinical team, as well as additional trainings in safety interventions and increased supervisory and clinical support. Based on the clinical trials of MST with young people experiencing serious psychiatric symptoms, substantial amounts of ongoing supplemental trainings and services are needed before MST teams can adequately serve such young people. Thus, standard MST teams should not accept young people presenting primarily with psychiatric (rather than behavioral) problems or young people with serious psychiatric problems as outlined above. While many young people with externalizing symptoms and antisocial behavior may also occasionally present with psychiatric problems, the bulk of the behaviors for which the young people are being referred should be antisocial or externalizing in nature, placing them at risk of a juvenile justice placement. Two examples are given to clarify this point.

**Example of an appropriate referral** of a young person with co-morbid psychiatric problems: *TL is a 16-year-old female with a history of depression, past suicidal ideation and past suicide attempt, who was hospitalized for an overdose 2 years prior to the current referral. She was referred by the youth court or Youth Offending Service for shoplifting, truancy and runaway behaviour. She is not currently suicidal and has had no suicide attempts since the hospitalisation.*

**Example of an inappropriate referral** of a young person with co-morbid psychiatric problems: *JM is a 15-year-old male referred by the youth courts for domestic violence. He is currently trying to harm his mother and himself. He has ongoing suicidal ideation and has been diagnosed with bipolar affective disorder. He is intermittently homicidal toward family members. He has experienced these problems periodically for the past 2 years.*

# Attachment B: MST Referral Guidelines Regarding Sex Offending Behavior

**(a.k.a. Problem Sexual Behavior)**

The decision to implement the MST model with a given population should be formed by empirical data about the effectiveness of the model with the target population. Treatments for juvenile sex offenders are rapidly proliferating in the absence of data supporting their effectiveness. The only randomized trials of juvenile sex offender treatment in the research literature are the studies of MST-PSB (MST for Problem Sexual Behavior). More information about this adaptation of MST can be found at the MST Associates Website, <http://mstpsb.com> or from MST Services.

Standard MST Programmes may not accept referrals for primarily sex offending behaviours. Programmes that wish to serve young people referred for primarily sex offending behaviours must have their staff trained in MST-PSB by MST Associates (see <http://mstpsb.com> for additional information).

However, young people who have previously engaged in sexualized behavior can be accepted into an MST Programme, as long as the sex offending behavior is not the primary reason for referral. Below are two examples that serve to clarify appropriate versus inappropriate referrals into an MST Programme.

**Example of an appropriate referral** of young person with sex offending behaviors: *A 16-year-old male has a history of criminal charges for shoplifting and breaking and entering. He is chronically truant from school, and there is a strong suspicion that he abuses marijuana and alcohol. There are also two reported incidents of inappropriate sexual behavior by this young people, including touching the breasts of a classmate and attempting to force sexual relations with the younger sister of a neighbourhood peer. These two incidents occurred in close proximity to one another and there have* been no further allegations for the past year.

**Example of an inappropriate referral** of a young person with sex offending behaviours: *A 15-year-old male has just been charged with a third sexual offence, molesting a 4-year-old neighbour. This young person has a history of two similar offences with other children in the past year. The young person has no other reported behaviour problems. He attends school regularly, and functions well there, and has only been involved with the courts for allegations of sexual misconduct. The referral indicates there are reports of verbal conflict between parents and the young person and within the marital dyad.*

# Attachment C: MST Referral Guidelines Regarding Young People with Moderate to Severe Difficulties with Social Communication, Social Interaction, and Repetitive Behaviours

Young people with moderate to severe difficulties with social communication, social interaction, and repetitive behaviours, should be excluded from MST teams due to the fact that they may respond poorly or in adverse ways to some of the routine behavioural and parenting interventions employed by MST teams. These difficulties may be diagnosed as Autism Spectrum Disorder (ASD) at Levels 2 or 3, or as Childhood Autism (CA.). Importantly, the expertise to treat this problem, which is biological in nature and differs substantially from “willful misconduct,” does not exist within the resources currently available to MST teams. Young people who present with mildly delayed communication and social interaction difficulties, (e.g. diagnosed with ASD with social communication and repetitive behaviours at Level 1, or diagnosed with Childhood Autism based on mild difficulties,) may qualify for referral assuming that the focus of treatment concerns young people conduct disorder symptoms. Such young people should be considered on a case-by-case basis.

The decision to implement the MST treatment model with a given population should be informed by empirical data about the effectiveness of MST with the target population. Currently, the MST treatment model has not been empirically evaluated for young people diagnosed with Autism Spectrum Disorder or Childhood Autism. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) defines ASD as follows:

“The essential features of Autism Spectrum Disorder are persistent impairment in reciprocal social communication and social interaction, and restricted, repetitive patterns of behaviour, interests or activities. These symptoms are present from early childhood and limit or impair everyday functioning.”

The DSM-V includes severity levels for ASD, as follows:

* Level 3, “requiring very substantial support” and including “severe deficits… severe impairments in functioning… behaviours markedly interfere with functioning in all spheres.”
* Level 2, “requiring substantial support” and including “marked deficits…behaviours interfere with functioning in a variety of contexts.”
* Level 1, “requiring support” and including “without supports in place, deficits…cause noticeable impairments… significant interference with functioning in one or more contexts.”

The ICD-10 defines Childhood Autism as follows:

“A pervasive developmental disorder defined by the presence of abnormal and/or impaired development that is manifest before the age of 3 years, and by the characteristic type of abnormal functioning in all three areas of social interaction, communication, and restricted, repetitive behaviour.”

Young people diagnosed with what were previously referred to in the DSM as Pervasive Developmental Disorders have not been included in clinical trials of MST for young people in the juvenile justice system and have been actively excluded from studies of MST for young people with severe emotional disturbances and mental health problems. Young people with PDD have been excluded from MST clinical trials due both to the biological nature of their problems and to the different treatment approaches required to address their symptoms. While substantial clinical expertise and evidence-based practices are currently being developed to address the needs of young people with Autism Spectrum Disorder or Childhood Autism, this expertise does not reside within the resources available to MST Services. Early findings from research pioneers in the field would suggest that the techniques and strategies required to modify the behaviours and treat the symptoms of young people with ASD or CA may actually differ significantly from the types of evidence-based strategies employed by MST teams to effect behavioural changes in young people with conduct and behavioural problems.

**Example of an appropriate referral**: *MA is a 16 year-old-male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviors both Level 1). MA was recently referred to MST because of charges of burglary and shoplifting. He has also been observed smoking marijuana. Due to significant difficulty relating to young people his age, MA has been hanging out with a group of 13- year-old males who seem to be the instigators of the recent burglary and shoplifting and of the marijuana use. MA told his mother* *that he went along with the shoplifting plans because he wants to have friends. His mother states that following ongoing interventions he has recently shown some success in being able to interact with other young people but is more comfortable with younger children. MA has been unsupervised after school and some evenings because his mother works late.*

**Example of an inappropriate referral**: *AM is a 13-year-old male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviours both Level 1). He has shown significant difficulty in relating to other young people at school. His teacher reports that he does not seem to understand how to play with others, avoids contact with classmates, and becomes disruptive or aggressive when in unavoidable proximity to other young people or when having to wait. His classmates view AM as odd, and he is frequently teased and bullied. As a result, he has been refusing to attend school. His mother has been trying to force AM to attend school, which has increased his anxiety and resulted in AM using physical aggression to resist his mother’s efforts. Consequences for this behaviour have not been effective and seem to increase his aggression. During a recent morning when his mother tried to get AM to go to school, he became extremely aggressive and assaulted his mother. He was subsequently arrested for domestic violence.*

# Attachment D: Guidelines for When Young People are Missing from Home (on Runaway Status)

**Assumptions**

1. Being missing from home is considered an antisocial behaviour, just like any other antisocial behavior (e.g. Being absent from school). From an MST perspective, it should be addressed like any other behaviour, and a case should not be discharged based on this behaviour alone.
2. Different systems vary in how they respond to young people going missing. This can present significant challenges to the team in being able to continue to provide MST, e.g. some systems have time limits for how long the case can remain open if the young person is missing
3. Despite the legal parameters the MST team works within, if the family has had an opportunity for a full course of treatment, the case should be closed using one of the “clinical” reasons, e.g., “closed by mutual agreement”, “lack of engagement” or “placed”.
4. The case closure categories, “MST Programme administrative removal/withdrawal” or “Funding/referral source administrative removal/withdrawal”, are limited to situations where the case is closed for reasons that are “unrelated to the progress of the case”. Therefore, careful consideration must be used when closing a case for this reason.

**The following guidelines are provided to assist in deciding how to code the case progress review item when the team closes a case while the young person is still on runaway status or missing from home.**

1. **Determine if the family has had an opportunity for a full course of treatment.** An example of not having this opportunity might be if the young person was missing at the time of referral, or shortly thereafter and the funder requests closure (preventing the therapist and family from having more than a couple of sessions). This case could be closed using the category “MST Programme administrative removal/withdrawal” or “Funding/referral source administrative removal/withdrawal”.
2. **Determine if therapist has ever had engagement with the family.** As long as the family was actively involved in working on at least one goal for some part of treatment, the category of “lack of engagement” should not be used.
3. **Determine if the case should be closed as “placed”.** This category is used only if the team is quite certain that once found, the young person will be placed out of home, e.g., the young person will be placed automatically without returning to court.
4. **Determine if the case should be closed as “completion” (due to diminishing returns).** This closing category does not assume that the case closed with all goals met, only that stakeholder/funder, primary caregiver(s) and team agreed that no further progress on overarching goals is likely due to young people not being in the home. The actual case progress on goals would then be documented using the ratings for instrumental and ultimate outcomes.

**The following guidelines are provided to assist in deciding how to code Ultimate Outcomes when the team closes a case while the young person is still missing (on runaway status).**

1. **Coding Ultimate Outcomes:**
   1. “At home”: if a Young person is missing from home (on runaway status) at the time of closure, this would be marked “no”.
   2. “In school/working”: there are young people that may be missing but are still attending school (or working); therefore, the team would need to verify whether the young person is attending school (or work) in order to determine how to mark the ultimate outcome of “in school/working.”
   3. “Arrest”: this is completed based on stakeholder’s definition of arrest. Many MST Programmes have defined arrests as involvement with police that results in a charge for a new criminal behaviour

Appendix E

**Sandwell MST Referral and Risk Assessment Form**

**The following section must be completed when making a referral to MST**

|  |  |  |
| --- | --- | --- |
| **INCLUSION CRITERIA:** Young person must meet criteria **1 AND 2** or **1 AND 3** below to be suitable for a referral to MST | | |
| Is the young person aged between 10 – 17 years of age? | ☐Yes | ☐No |
| Is the young person at risk of coming into care or custody? | ☐Yes | ☐No |
| Does the young person exhibit anti-social behaviour in more than one setting? (i.e. home, at school, in the community) | ☐Yes | ☐No |
| **EXCLUSION CRITERIA:** Any young person meeting any of the criteria below would not be suitable for a referral to MST | | |
| Is the young person living independently? (This includes a young person placed in a residential school) | ☐Yes | ☐No |
| Is the young person actively psychotic, homicidal or suicidal? | ☐Yes | ☐No |
| Are the concerns primarily around sexual offending in the absence of other antisocial behaviour? | ☐Yes | ☐No |
| Does the young person have ongoing developmental disorder (for example, Autism or Asperger’s: Young person with moderate to severe difficulties with social communication, social interaction, and repetitive behaviours) | ☐Yes | ☐No |
| Young people who are subject to a care order (section 31, C.A. 1989), interim care order (section 38, C.A. 1989) or emergency protection order (section 44, C.A. 1989) and who are looked after regardless of where they live. | ☐Yes | ☐No |

**SECTION 1 - PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Childs full name: |  | | |
| Child’s date of birth: |  | Child’s age: |  |
| Childs ethnicity: | ☐ White British | ☐ White Irish | ☐ Any other White background |
| ☐ White and Black Caribbean | ☐ White and Black African | ☐ White and Asian | ☐ Any other Mixed background |
| ☐ Indian | ☐ Pakistani | ☐ Bangladeshi | ☐Chinese |
| ☐ Any other Asian background | ☐Caribbean | ☐African | ☐ Any other Black background |
| ☐ Any other ethnic group - Please specify: |  | | |
| Full address (inc. post code): | |  | |
| Name and address of child’s school: | |  | |
| Parents /carers full name: | |  | |
| Parents /carers date of birth: | |  | |
| Relationship to child: | |  | |
| Telephone number for parent: | |  | |
| Telephone number for child: | |  | |
| Family religion: | |  | |
| Details of extended family or friend. Please also detail telephone number: | |  | |
| Details of any siblings and date of birth: | |  | |
| Please detail all previous services that the child and / or family has used in the last 3 years: | | Contact telephone number and named contact of previous service: | |
|  | |  | |

**SECTION 2 – DETAILS OF REFERRAL**

|  |  |  |
| --- | --- | --- |
| Reason for referral to MST: | | Comments |
| Avoid escalation into children’s social care: | ☐ |  |
| Avoid out of home into secure setting: | ☐ |  |
| What outcomes do you want from MST? | | |
|  | | |

**SECTION 3 – SUMMARY OF RELEVANT BACKGROUND**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AGGRESSION (please tick relevant box if applicable)** | | | | | | | | | |
|  | | Young person | | Family member | | Details | | | |
| Physical Violence: | | ☐ | | ☐ | |  | | | |
| Threats Of Violence Towards Others: | | ☐ | | ☐ | |  | | | |
| Known To Carry Weapons: | | ☐ | | ☐ | |  | | | |
| Use Of Weapons: | | ☐ | | ☐ | |  | | | |
| Verbally Abusive Behaviour: | | ☐ | | ☐ | |  | | | |
| Property Damage: | | ☐ | | ☐ | |  | | | |
| **SUBSTANCE MISUSE (please tick relevant box if applicable)** | | | | | | | | | |
|  | | Young person | | Family member | | Details | | | |
| Drugs: | | ☐ | | ☐ | |  | | | |
| Alcohol: | | ☐ | | ☐ | |  | | | |
| Legal Highs: | | ☐ | | ☐ | |  | | | |
| **OFFENDING BEHAVIOUR (please tick relevant box if applicable)** | | | | | | | | | |
|  | | Young person | | Family member | | Details: | | | |
| Antisocial Behaviour: | | ☐ | | ☐ | |  | | | |
| Violent Offending: | | ☐ | | ☐ | |  | | | |
| Sexually Offending: | | ☐ | | ☐ | |  | | | |
| Racist and / or Homophobic Abuse / Hate Crime: | | ☐ | | ☐ | |  | | | |
| Stealing/Theft: | | ☐ | | ☐ | |  | | | |
| Gang Involvement: | | ☐ | | ☐ | |  | | | |
| **ACADEMIC DIFFICULTIES (please tick relevant box if applicable)** | | | | | | | | | |
|  | | Young person | | Details | | | | | |
| Poor Attendance / Truancy: | | ☐ | |  | | | | | |
| Behavioural Difficulties: | | ☐ | |  | | | | | |
| Exclusions: | | ☐ | |  | | | | | |
| Alternative Provisions: | | ☐ | |  | | | | | |
| Education Health Care Plan (EHC Plan): | | ☐ | |  | | | | | |
| **MENTAL HEALTH (please tick relevant box if applicable)**  Is there evidence that anyone in the family (including young person) has a history of the following? | | | | | | | | | |
|  | | | Young person | | Family member | | | Details | |
| Mental Health Condition: | | | ☐ | | ☐ | | |  | |
| Self-Harm: | | | ☐ | | ☐ | | |  | |
| Attempted Suicide: | | | ☐ | | ☐ | | |  | |
| Witness Of Domestic Abuse: | | | ☐ | | ☐ | | |  | |
| Sexual Exploitation: | | | ☐ | | ☐ | | |  | |
| **Parental motivation and willingness to engage** | | | | | | | | | |
| Are the family MST ready? Do they understand the level of commitment involved? Are they clear about their involvement? Are they able to recognise that they require help to assist with their family difficulties? | | | | | | | | | |
| **Please specify any previous Family Support interventions** e.g. Triple P, Systemic Family Therapy and Scaling, Family Group Conferencing: | | | | | | | | | |
| Please identify any parental vulnerabilities: | | | | | | | | | |
| Print Name : |  | | | | | | Telephone No: | |  |
| Date: |  | | | | | | | | |
| Team: |  | | | | | | Manager: | |  |

**Consent for information storage and information sharing**

I understand the information that is recorded on this form and that it will be stored and used for the purpose of providing services to me and the young person for who I am parent / carer. (Delete as appropriate)

I agree to the information recorded on this form being shared with the other people / services listed below who may be able to help provide services to me and the young person for whom I am parent/carer. (Delete as appropriate).

|  |  |
| --- | --- |
| Consent to seek feedback: It is important that feedback is obtained wherever possible to help improve service delivery. Please ascertain whether the Parent and young person is willing to be contacted at a later date to give feedback on their experience of this process. | |
| Parent / Carer consent to contact for feedback:  ☐ | Young Persons consent to contact for feedback:  ☐ |

|  |  |  |
| --- | --- | --- |
| The information may be shared with the following people / services: | | |
| **Signed:** | **Name:** | **Date:** |

Appendix 6

**MST Risk Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date to be reviewed: |  |
| Date Completed: |  | Key Worker: |  |

|  |
| --- |
| Please indicate in the chart below the likelihood of each risk/behaviour occurring by ticking the relevant box.  Please provide further information in the comment box if there is a risk or has been in the past. |

|  | **Not Attempted** | **Evident In Past History** | **Some Attempts** | **Regularly Attempted** | **A High Risk** | **Risk Currently Evident** | **Comments/Details** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Suicidal Behaviour |  |  |  |  |  |  |  |
| Physical Harm To Others |  |  |  |  |  |  |  |
| May Cause Significant Damage To The Property |  |  |  |  |  |  |  |
| Threatening Behaviour |  |  |  |  |  |  |  |
| Fire Setting |  |  |  |  |  |  |  |
| No Sense Of Danger |  |  |  |  |  |  |  |
|  | **Not Attempted** | **Evident In Past History** | **Some Attempts** | **Regularly Attempted** | **A High Risk** | **Risk Currently Evident** | **Comments/Details** |
| Will Cause Harm To Themselves |  |  |  |  |  |  |  |
| Substance/Drug Abuse |  |  |  |  |  |  |  |
| Inappropriate Sexualised Behaviour |  |  |  |  |  |  |  |
| Risk Of Absconding Whilst Out |  |  |  |  |  |  |  |
| May Become Agitated In Small Spaces |  |  |  |  |  |  |  |
| Associated To A Gang |  |  |  |  |  |  |  |
| Vicious Animal |  |  |  |  |  |  |  |
| Family Violence |  |  |  |  |  |  |  |

Appendix 7

**Management of Risk**

|  |  |  |  |
| --- | --- | --- | --- |
| **Identified Risks** | **Triggers For This Risk** | **Key Worker’s Action –**  **Minimise Risk** | **Management Action** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Key Worker:…………………………….. Date:……………………………

Service User:……………………………. Date:……………………………

Line Manager:…………………………... Date:……………………………

Review Date:…………………………….

(Management of risk forms should be reviewed after an incident and every 3 months)

Appendix 8

**MST Treatment - Programme Agreement Form**

I have had the MST treatment model explained to me and have been given written information explaining the model.

I have been provided with information on how to access MST team members and understand that while working with the programme I can have access to a team member 24 hours a day seven days a week.

I understand that in order to provide continuity of treatment I may be introduced to another MST Therapist who I will have contact with if my allocated MST Therapist is not available.

I understand that the first 3-4 weeks of the programme is the assessment phase where the worker is gaining information about my family and ensuring the MST programme is the best treatment model for my family.

I understand that as part of the MST programme my family and I will be expected to meet with the worker a minimum of two/three times a week and each session will last a minimum of one hour. This is likely to reduce as the family work progresses. In addition to these sessions, my family and I will be able to have phone support from the therapist. I understand that if I need to cancel a session I will let my therapist know in good time and will reschedule an appointment for within that week. I understand that the MST Therapist will in turn inform me, should they need to reschedule appointments for any reason.

I will ensure that I create a safe environment with no distractions or risks e.g. visitors or pets and a suitable space in which the work can be completed during my sessions with the MST Therapist.

I understand that MST is an intensive service and my family's active participation is needed to achieve our goals. It has been explained to me that the MST treatment model is based on the principal that parents / carers are expected to give continuous effort.

I understand that my family will work with the MST Therapist to develop our overarching goals and the intermediary goals that are part of the treatment plan.

I understand that as part of the work with the MST Therapist, my family may receive aspects of family or individual therapy, behavioural planning, safety planning, substance abuse therapy / support and collaboration with other services working with my family.

Confidentiality and information sharing has been explained to me and I have signed an information sharing agreement form.

I understand that as part of the programme I will be asked to complete a short standard monthly questionnaire about how the sessions are going and that this will be conducted by the Business Support Officer by telephone.

It has been explained to me that these questionnaires are completely confidential and the MST Therapist will not have sight of the responses I have given. I understand that the anonymous scores will ensure that the treatment follows MST guidelines.

I will ensure that if I am not available to complete the monthly questionnaire, I will notify my therapist, who will inform the Business Support Officer.

I understand that I will be asked to complete a variety of questionnaires in order for the MST team to monitor and evaluate the effectiveness of the service that is being provided.

It has been explained to me that if at any point there are difficulties in making these commitments that there will be a review meeting to discuss the concerns with the MST Supervisor and MST Therapist if appropriate.

|  |  |  |
| --- | --- | --- |
| Signature: (parent/carer) |  | |
| Client name: (print name) |  | |
| Signature: (MST Therapist) |  | |
| Therapist: (print name) |  | Date: |
| Therapist contact number: | Office: | Mobile: |

Appendix 9

**Audio / Video / Photographic Recording Consent Form.**

The Sandwell and Dudley MST Team may from time to time, during sessions, wish to audio record or video record sessions with the young person and their family for the purposes of staff supervision, training or consultation only.

The form below gives details on what is intended before requesting consent.

|  |  |
| --- | --- |
| **Young person details** | |
| Surname: |  |
| First names: |  |
| Date of birth: |  |

|  |
| --- |
| Details and purpose of recording: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Statement of person with parental responsibility for the young person**  I agreeto the recording described above. | | | |
| Signature: | Print name: | | Date: |
| Relationship to young person: | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Confirmation of consent** *(to be completed by the MST Therapist)*  I have explained the intended uses of the recording to the child/young person/parent/carer. I have confirmed that they have no further questions regarding the use of any recordings. | | | |
| Signature: | | Print name: | Date: |
| Job Title: |  | | |

**Copy to be given to child / young person / parent / carer**

Appendix 10

**Parental consent form to work with MST**

|  |  |
| --- | --- |
| Name of young person: |  |

I hereby give my written consent to work with MST. I also give consent for information collated through the sessions with my MST Therapist to be shared verbally and electronically with the following:

* MST Supervisor, MST Therapists, MST Consultant and MST services to enable guidance and advice in relation to the treatment model and plan for future work to be undertaken with myself and family members.
* The relevant professional that referred my family and any other agencies working with me or my children.
* I also give permission to track my views on the progress of the work being completed via the collection of an anonymous Therapist Adherence Measure (TAM-R) collected monthly from me.

I understand that the MST team will also advise the family G.P (doctor) of the involvement of the MST team with my family. It has been explained to me that the purpose of this is to ensure that information is shared should any serious health or safety concerns arise.

|  |  |
| --- | --- |
| GP Name: |  |
| Surgery Address: |  |
| Tel number: |  |

I understand that the MST team will not share any information without my consent; **unless** there are any risks to myself or any other persons, i.e.

* If there is a risk of harm to self or others
* If urgent medical assistance is require

I consent to work with MST:

|  |  |
| --- | --- |
| Name: |  |
| Signed: |  |
| Date: |  |

**Privacy statement**

The information you have provided us with will be used to inform the MST work. Once we have gathered your information, we might need to share it with other agencies working with your family.

You have a right to access any personal information we may hold about you. If you wish to exercise this right, please put your request in writing and address it to [contact@sandwell.gov.uk](mailto:contact@sandwell.gov.uk).

If you require further information regarding how we handle your personal data or have any query, please contact Lloyd McDonald, MST Clinical Supervisor on 0121 569 8121.