Data Trends
Summaries of research on mental health services for children and adolescents and their families
July, 2003
No. 114

Rowland, M. D., Halliday-Boykins, C. A., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J., et al. (2005). A randomized trial of Multisystemic Therapy with Hawaii's Felix Class youths. *Journal of Emotional and Behavioral Disorders, 13*(1), 13-23.

keywords: Multisystemic Therapy, Asian multiethnic, Hawaii, continuum of care

This randomized trial compared the effects of Multisystemic Therapy on a group of youth receiving services through Hawaii's Continuum of Care (COC)[1] with youth receiving usual services also through Hawaii's COC. Although the project ended prematurely due to implementation issues, results showed improvement among MST youth on measures of mental health symptomology, criminal behavior, and family social support when compared to youth receiving usual COC services.

The results reported below are for all youth (N = 31) who received six-month follow up assessments before the termination of the study. These youth lived on the island of Oahu with family or a caregiver, were at risk of out-of-home placement, and met the qualifications of the Felix Youth Degree (i.e., for "youths attending a public school and qualified to receive mental health services via a structured Individualized Education Plan process applying IDEA or Section 504 criteria," p. 14). Youth and their families were randomly assigned to one of two groups: (a) MST treatment within the context of Hawaii's COC, (n = 15); and (b) usual services provided by the COC (n = 16). There were no significant differences between groups, except that MST youth had higher rates for self-reported delinquency. All youth were an average age of 14.5 years (range: 9-17). Most of the youth were boys (58%), and 84% of both groups were multiracial Asian (i.e., primarily Asian, Pacific Islander and Caucasian). Ten percent were Caucasian, and 7% were Asian American and Pacific Islander. On average, all youth had been hospitalized twice for psychiatric or substance abuse problems and had been arrested 7.5 times before entering the study. Almost all youth (94%) met criteria for one or more clinical diagnoses at intake, with conduct disorder (39%) and bipolar disorder (32%) the two most common diagnoses. A battery of measures was administered at intake and at six-months follow up, including measures for: mental health, substance use, criminal activity, school placement/attendance, family relations and family social support.

Results showed significantly greater improvement by MST youth on the youth version of the Child Behavior Checklist for internalizing and externalizing symptoms when compared to usual services youth. MST youth also reported significantly fewer instances of criminal behavior when compared to their counterparts. MST was also more effective at maintaining youth in the community, with an average of 3.75 days in out-of-home placement compared to 11.83 days for usual services youth. Marginally significant, MST youth also spent 42% more days in school per month when compared to usual services youth. Additionally, although the researchers expected to find an improvement in family functioning for MST youth, they did find near-significant improvements for social support among caregivers when compared to caregivers of usual services youth.

Enrollment into the study began in July 2000, but by August 2001 the program had been discontinued, for five reasons: (a) there were difficulties with recruiting an adequate number of participants who were at risk of out of home placement; (b) there was a limited number of therapists familiar with this evidence-based practice; (c) consultations between MST consultants and providers were inhibited by the time zone difference between Hawaii and the mainland; (d) there were difficulties getting providers (e.g., hospitals, residential services, and child welfare) to buy-in to the MST model, and; (e) there were political factors that affected the "perceived fiscal stability" (p. 20) of the project.

Continued...

Prepared by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd. Tampa, FL 33612, (813) 974-4661
For more information, contact kutash@fmhi.usf.edu; Website: http://rtckids.fmhi.usf.edu
The Center is jointly funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

Although the project was terminated early, the authors write that the core MST home-based and crisis intervention components were "operational throughout the project" (p. 14). Overall, "these findings show, in spite of generally low treatment fidelity, that the intensive MST program developed by [Hawaii] to serve the mental health needs of its most challenging youths achieved a portion of the desired goals (decreased symptoms, improved functioning, decreased use of restrictive placements)" (p. 21). Finally, while the authors did not provide an analysis of the effects of MST on culture, this is the first study of MST on a primarily Asian multicultural population.

[1]For more about Hawaii's COC, see *Data Trends* #57.

Prepared by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd. Tampa, FL 33612, (813) 974-4661
For more information, contact kutash@fmhi.usf.edu; Website: http://rtckids.fmhi.usf.edu
The Center is jointly funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.