

Henggeler, S. W., Rowland, M.D., Randall, J. et al. 1999. Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(11), 1331-1339.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. D. 2000. Multisystemic therapy versus hospitalization for crisis stabilization of youth: Placement outcomes 4 months postreferral. *Mental Health Services Research*, 2(1), 3-12.

Two recent articles by Scott Henggeler and his colleagues present the results of a study in which multisystemic therapy was compared to hospitalization for youth in psychiatric crisis. These are important articles both because of the significance of the topic and the encouraging results that have been obtained so far by Henggeler using multisystemic therapy (MST).

Most of the research done prior to this study by Henggeler focused on children with delinquency and/or substance abuse problems. This study therefore represents a major change in the population of concern. Participants were 116 children aged 10 through 17 in Charleston County, South Carolina who were Medicaid-funded or without health insurance, and who were judged to be in need of psychiatric hospitalization because of the presence of systems of suicidal ideation, homicidal ideation, psychosis, or threat of harm to self or others due to mental illness. Families with children who met eligibility criteria for participation and who agreed to participate (116 families out of 134 agreed to participate) were randomly assigned either to psychiatric hospitalization or to multisystemic therapy.

It is important to note that MST underwent considerable modification for purposes of serving this population of concern. For example, at the time of intake a comprehensive plan to safely resolve the crisis was developed. The basic MST treatment team was enhanced by a child and adolescent psychiatrist, psychiatric residents, and crisis caseworkers, and supervision was initially increased from weekly to daily. Also, caseloads of therapists were reduced from five families per clinician to three families, thereby enhancing the intensity of the intervention. Also, a therapeutic foster care capability was added to MST.

It is also noteworthy that participants in the MST condition were hospitalized when the MST team felt it was needed. In fact, 44% of the youths in the MST condition were hospitalized at some point. During the hospitalization, the MST treatment rather than the hospital staff maintained clinical responsibility for the youth, and extensive efforts were made to insulate the MST youth from other activities on the inpatient unit.

The first of the two articles (Henggeler et al., 1999) presents the clinical outcomes. The results are favorable for the MST condition although in a relatively modest way. For example, of nine measures of youth functioning, two were significant in favor of MST, one was significant in favor of hospitalization, and for six there were no significant differences. The two significant differences in favor of MST were the externalizing scale of the CBCL as completed by the teacher, and the externalizing scale of the CBCL as completed by the caregiver. The one difference in favor of hospitalization was on self-esteem. Of five outcome measures on family functioning, there were two that were statistically significant in favor of MST (adaptability as reported by youth on the FACES-III, and cohesion as reported by caregivers on FACES-III), and three for which there were no significant differences. Out of five measures of youth social functioning, the only significant difference between conditions

was on days out of school, which was in favor of MST. Both measures of consumer satisfaction (one from the youth and one from a caregiver) showed greater satisfaction by recipients of MST.

Overall, therefore, out of 19 measures of youth, family, or youth social functioning, there were five differences between conditions in favor of MST, one in favor of hospitalization, and 13 for which there was so significant difference between groups. On both measures of consumer satisfaction, the MST group was rated more positively than the hospitalization group. No data on effect sizes are given, although only three of the seven measures that favored MST were at the .01 level or greater.

The second article (Schoenwald, Ward, Henggeler, & Rowland, 2000) presents the findings on placement and cost. On overall number of days hospitalized, there is a clear and large difference in favor of MST, which reduced the number of hospital days used by 72% in comparison to the hospitalization group. Most of this difference was immediately after entry into the study.

The authors indicate that a "preliminary" accounting of the costs of MST with this population of concern indicated a cost of \$5,954 per youth for a four month period. The estimated daily cost of MST was \$47, which the authors report to be 52% higher than those incurred when MST is used with serious juvenile offender populations. This is important information for the children's mental health field. The average cost in the hospitalization condition was \$6,174, just about the same as for the MST condition.

Overall, it is first of all very encouraging that Henggeler et al. modified and adjusted their MST model to better meet the needs of a population of children with severe psychiatric needs. The authors indicate, in fact, that "even with the extensive track record of MST in successfully treating adolescents with serious clinical difficulties, the complexity and severity of the problems presented by the youths in psychiatric crisis and their families was significantly greater than expected" (Henggeler et al., 1999, p. 1337). Second, it is also encouraging that on measures of clinical outcome the differences were primarily in favor of MST, and both on measures of consumer satisfaction and use of hospital days the differences were clearly in favor of MST. Third, however, it should be noted that the differences in clinical outcomes appear to be relatively modest (it would be easier to judge the importance of the differences in clinical outcomes if effect sizes had been presented by the authors), and that the costs for the two interventions were virtually the same. Therefore while the results are largely positive, indicating the potential value of this expanded MST model for youth in psychiatric crisis, there is still a need for further study and perhaps program development to enhance the effect sizes.

Also, at this point the results that are presented are only for the first four months after entry into the study. The authors indicate that they are gathering more long-term data, and that these data will be forthcoming soon.

Finally, it is noteworthy that perhaps no other group of program developers/researchers devote as much time and care to trying to develop and evaluate interventions for children with special challenges and their families as Henggeler and his colleagues. The children's mental health field clearly needs to identify mechanisms to encourage and support many others in doing the type of systematic program development and evaluation work that has been the trademark of Henggeler et al. Without such encouragement and support, progress at the clinical level is likely to be very slow.