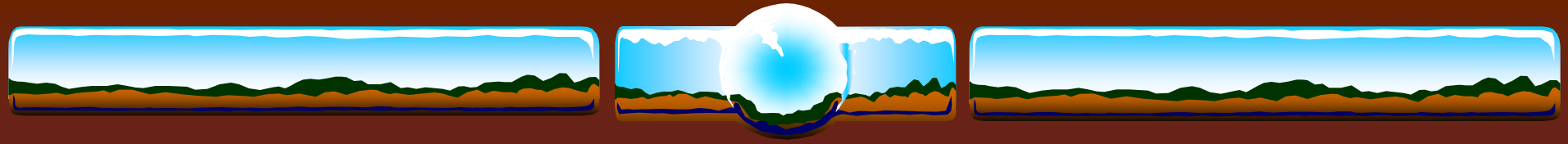
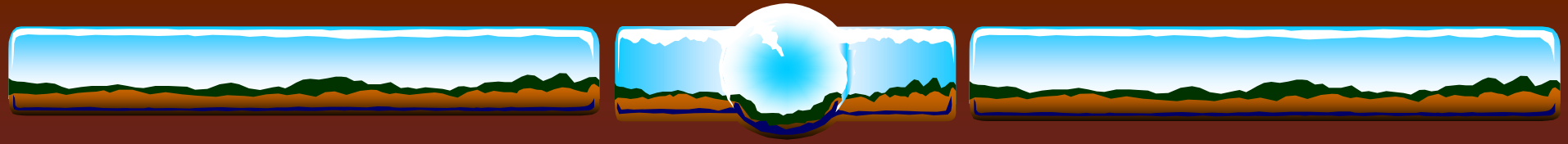


IMPLEMENTING AND EVALUATING MST IN NORWAY

Terje Ogden
”The Behavior Center – Unirand”
Center for Studies of Conduct Problems
and Innovative Practice,
University of Oslo, Norway

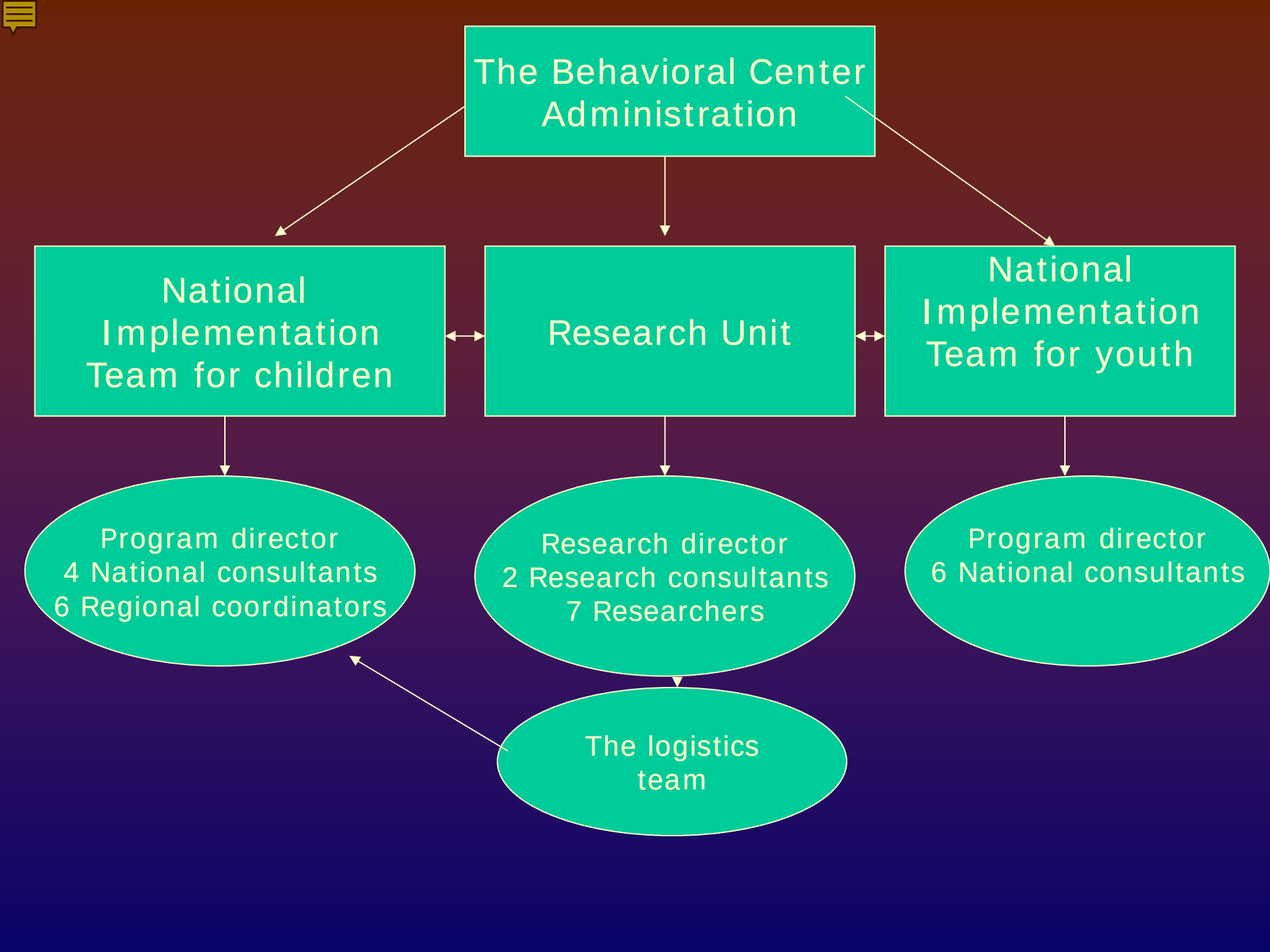


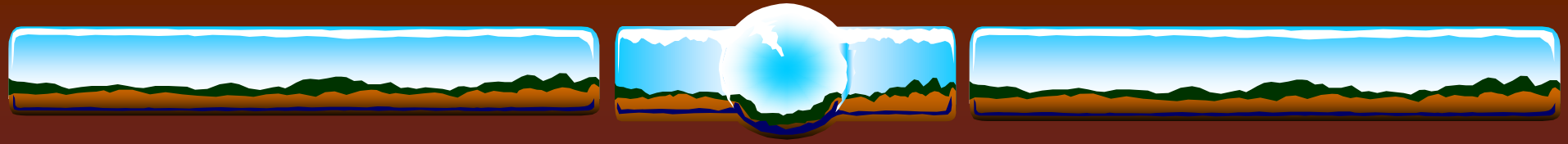
Background

- 1997: Lack of services and comptence: An international expert conference hosted by the Norwegian Research Council
- 1998: ”The program kitchen”: An expert panel report recommending the implementation and controlled evaluation of selected evidence based programs
- 1999: Towards ”evidence based practice”: the ’Behavior Project’ with nationwide implementation of PMTO and MST
- 2000: PMTO/MST clinical outcome studies – new standards for clinical outcome research
- 2003: ’Norwegian Center for Studies of Conduct Problems and Innovative Practice’ (Atferdssenteret – Unirand)

Overall strategy

- Establishing a national implementation and research center
  - National implementation teams for children and youth
  - Research group
- Plans for regional and local implementation at the county and municipal level
- Therapist recruitment strategy – in-service recruitment
- Establishing comprehensive therapist, training and maintenance programs
- Creating professional networks for collaboration, supervision and quality control
- Conducting research on clinical outcomes, the implementation process and on the development of serious behavior problems in children and youth

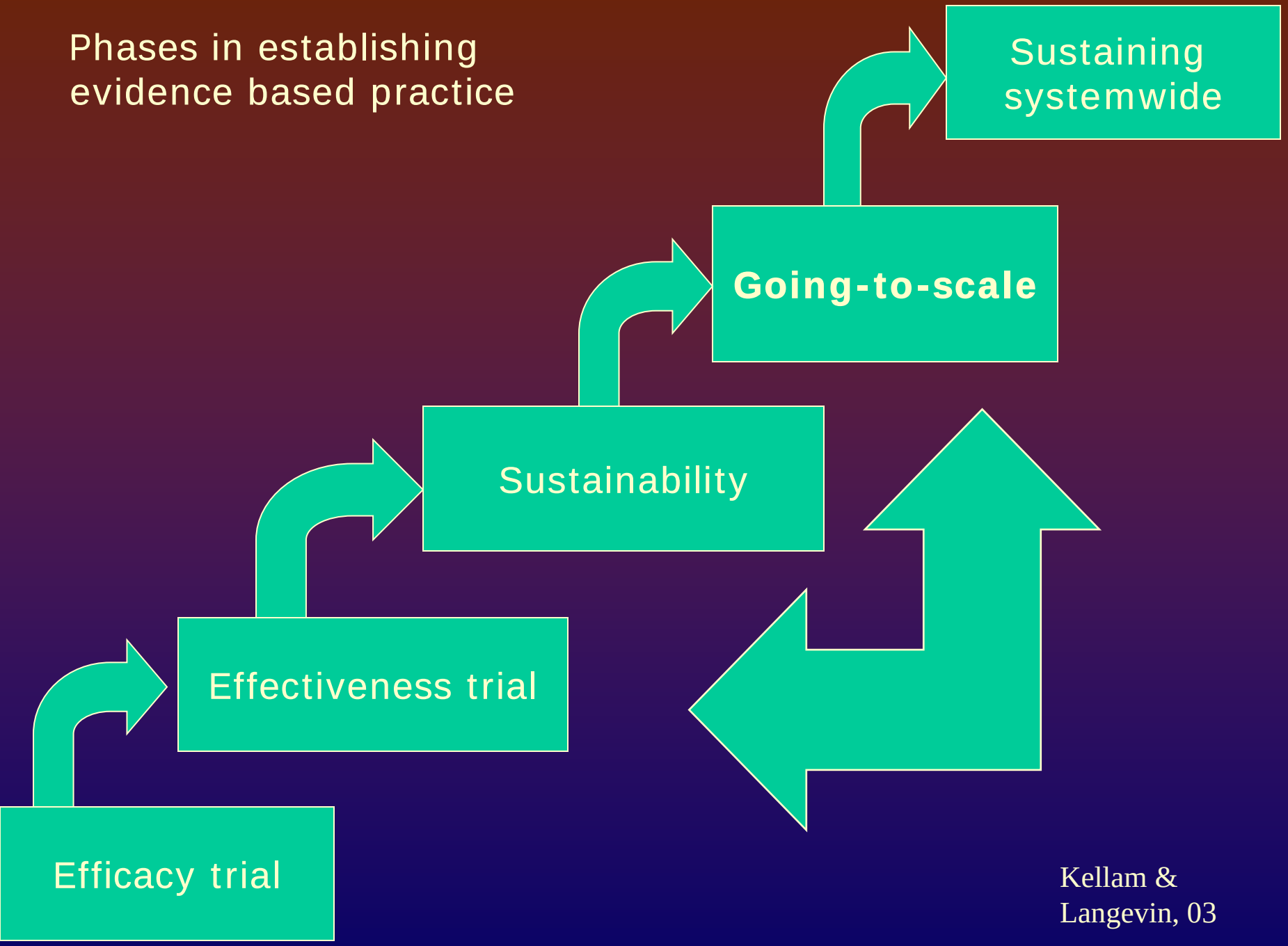

The Behavioral Center Administration
National Implementation Team for children
Research Unit
National Implementation Team for youth
Program director
4 National consultants
6 Regional coordinators
Research director
2 Research consultants
7 Researchers
Program director
6 National consultants
The logistics team



Support from the national center

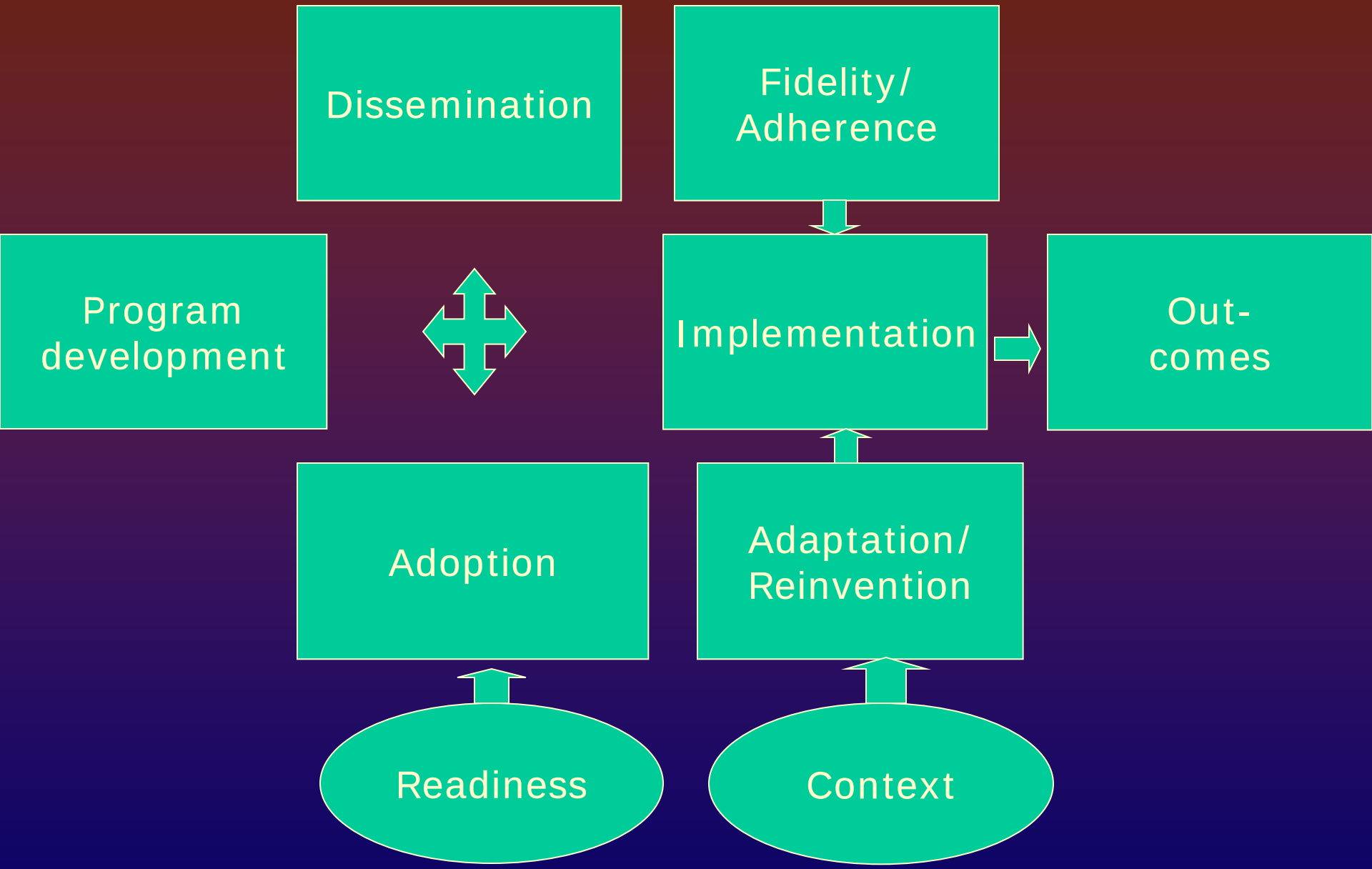
- Site assessments
- Introductory training programs
  - 5 days introductory training (MST)
  - 1.5 years initial training and certification (PMTO)
- Training manuals, treatment protocols
  - MST organizational manual and practitioner manual
  - PMTO handbook
  - Online support
- Ongoing supervision and quality control
  - MST therapist and supervisor adherence (TAM, SAM)
  - MST weekly telephone consultations
  - FIMP – Fidelity of Implementation Code (PMTO)
  - FPPC – Family Peer Process Code & Coders Impression (PMTO)
  - Regional supervision groups (PMTO)

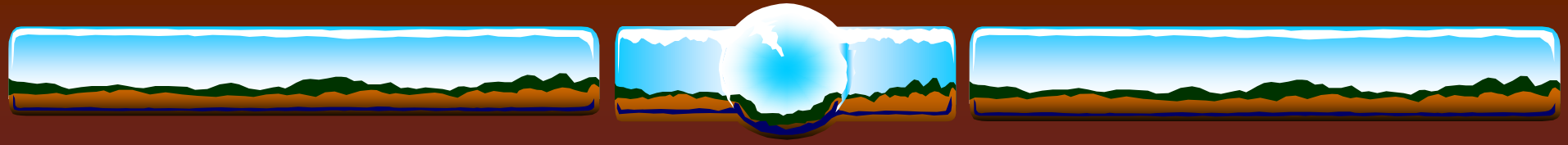
Phases in establishing evidence based practice



Kellam & Langevin, 03

Stages of program implementation





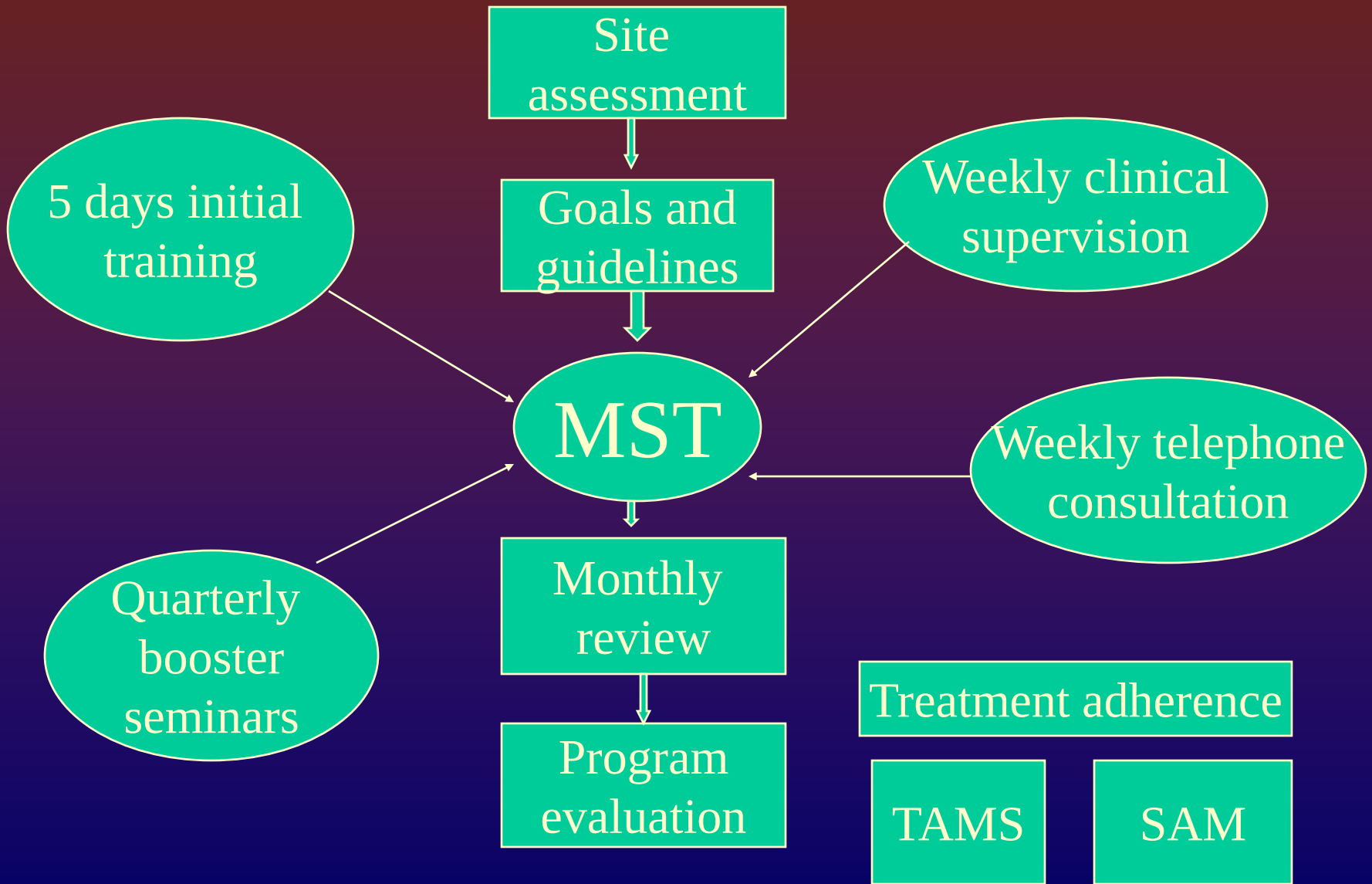
MST – as implemented in Norway

- Treatment site: Home, school, neighbourhood and community
- Duration: 3-5 months or earlier if goals are reached
- Provider: 25 MST-teams with 3-4 therapists, a team leader (clinical supervisor) and project manager (optional)
- Caseload: minimum 3 and maximum 6 families for each therapist
- Team availability: 24 hours – 7 days a week
- Total care: Intensive, individualized and comprehensive services
- Treatment adherence measured on a regular basis
- Accountability: Progress and productivity reported on a regular basis: monthly reviews, local program evaluation

MST in Norway

- By 2003, 25 MST-teams are established in all regions of Norway on a regular basis and as part of the national Child Welfare Services
- Training and consultation of the teams by the National Implementation Team for youth (NIT) in collaboration with MST-services, Charleston
- In 2003, 520 cases was initiated and 500 cases were completed
- The national drop out rate is 5% and 10% of the cases are terminated because of placement out of home or lack of therapeutic change

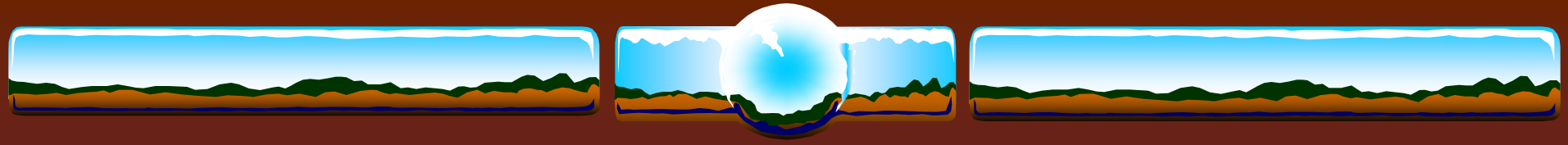
MST MODEL


Site assessment
5 days initial training
Goals and guidelines
Weekly clinical supervision
MST
Weekly telephone consultation
Quarterly booster seminars
Monthly review
Program evaluation
Treatment adherence
TAMS
SAM

MST clinical outcome study

Ogden,T. & Halliday-Boykins,C.A. (2004). Multisystemic Treatment of Antisocial Adolescents in Norway. Replication of Clinical Outcomes Outside of the U.S. *Child and Adolescent Mental Health, 9, 77-83.*

Ogden,T. & Hagen,K.A. (2005). Multisystemic Therapy of Serious Behaviour Problems in Youth: Sustainability of Treatment Effectiveness Two Years After Intake. *Child and Adolescent Mental Health, in print.*



The aims of the study

- To determine the degree to which favourable outcomes obtained in the U.S. would be replicated in Norway for youths with serious behaviour problems

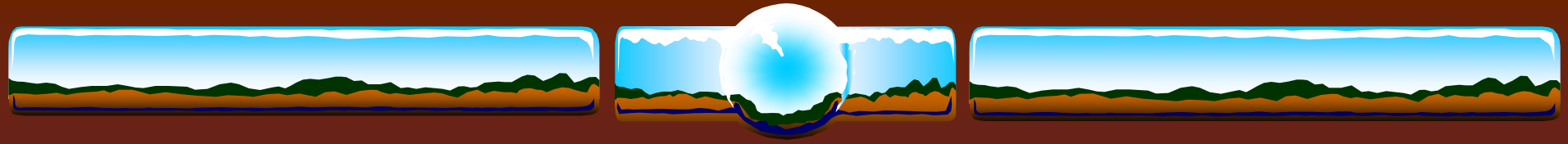
- To examine the extent to which MST can produce long term outcomes that are superior to the comprehensive and treatment-oriented services already provided to youthful offenders in Norway

Reasons for referral

- Serious behaviour problems (64%),
- Status offences (53%),
- Substance abuse (50%),

- Criminal offences (37%),
- Threat of harm to self or others (36%),
- Involvement as victim or perpetrator in domestic violence (29%),

- School expulsions (6%),
- After care from a residential treatment centre or incarceration (6%),
- Abuse or neglect (4%)
- Other reasons (28%).

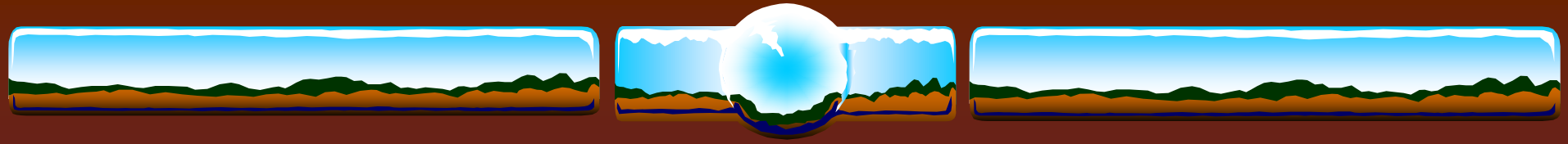


Place of living at time of referral

- With both of their parents (25%),
- With one of their parents and another adult (21%)

- With their mother only (29%),
- With their father only (9%),

- In hospitals or other institutions (9%),
- In foster homes (6%).



Interventions

- Multisystemic Therapy was implemented as detailed in the treatment manual (Henggeler et al., 1998) with no major modifications to the original intervention model
- MST treatment was delivered by 6 MST teams, each with 3-4 therapists and a clinical supervisor.
- MST-treatment was terminated when the goals were accomplished in each case, with an average treatment time of 25 weeks (range: 7 to 38 weeks)

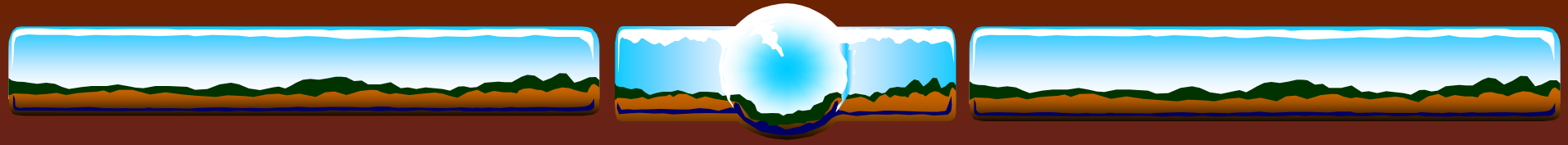
- Regular child welfare services (RS): long-term institutional placement, placement in a crisis institution for assessment and in-home follow-up, supervised by a social worker in their homes or other home-based treatment. App. 5% refused the services offered.

Participants

- The original sample consisted of 100 participants with a post assessment retention rate of 96%
- In the earlier pre-post evaluation of these families, one site was unable to establish the procedure for collecting treatment adherence information from their participants (Ogden & Halliday-Boykins, 2004)
- It was therefore questionable whether MST was being implemented at this site at all, leading us to concentrate the follow up analyses on 3 of the 4 sites
- This narrows down the number of participants to 75; 48 boys and 27 girls with a retention rate of 92%.

Out of home placement

- MST youths were maintained in the home significantly more often than RS youths
- At follow up, 80% of the MST youths and 55% of the RS youths living at home at intake, had been living at home the past 6 months
- 79% of the MST boys were living at home compared to 37% of the RS boys, but there were no significant difference between MST and RS girls.



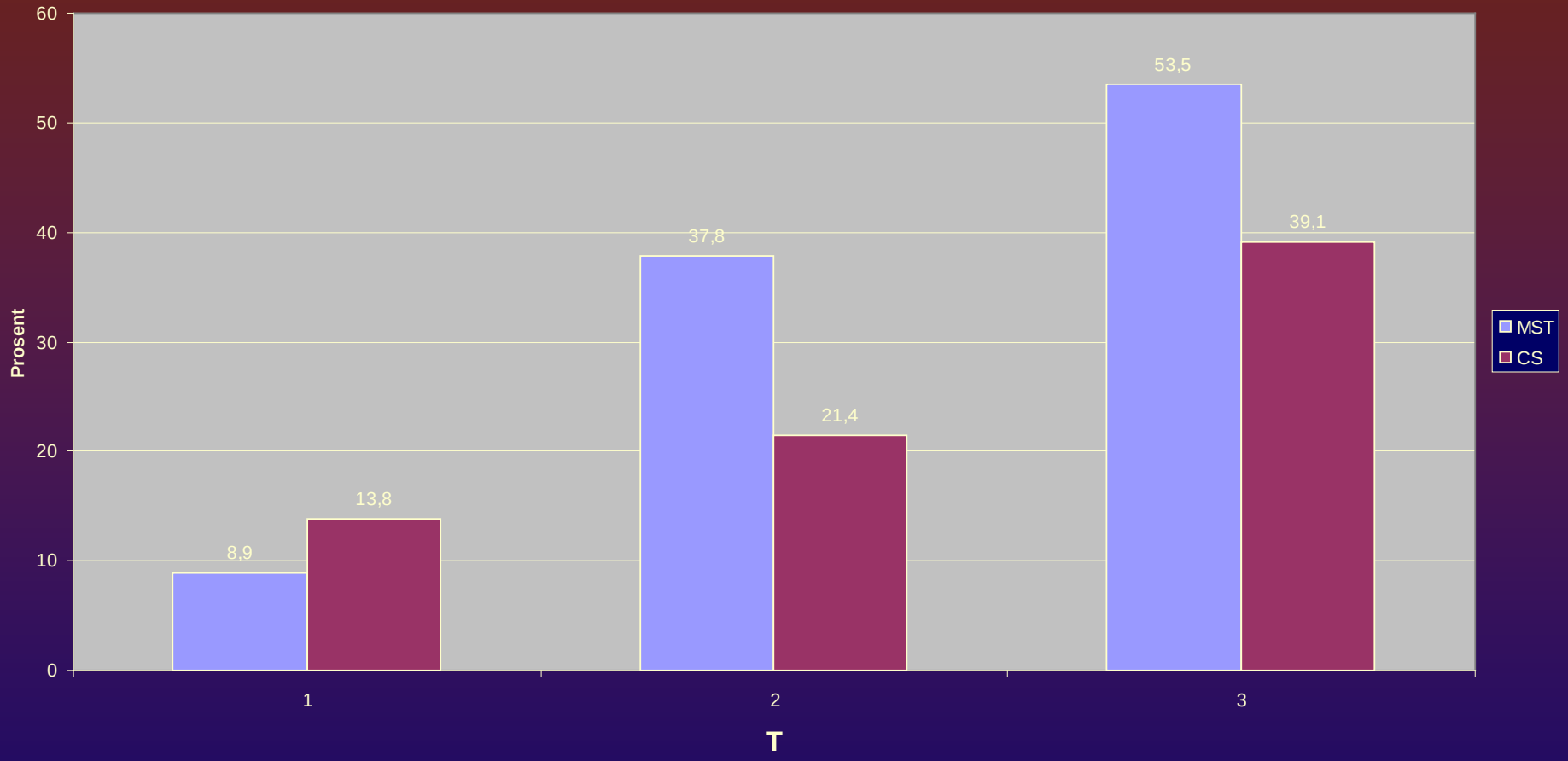
Multi-informant assessment of problem behavior

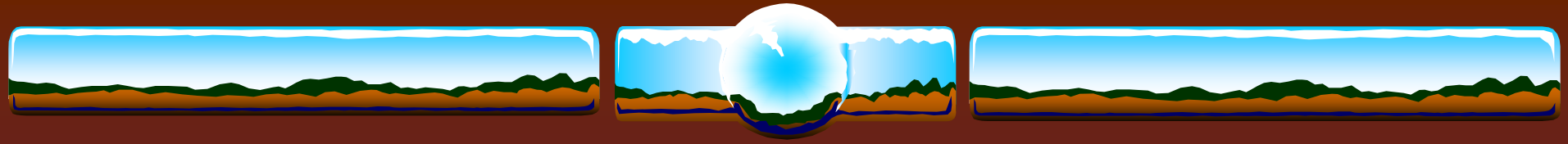
- Adolescents receiving MST scored significantly lower on the Self Report Delinquency Scale (SRD) than did adolescents receiving regular services, after controlling for their scores at intake
  - Self Report Delinquency Scale (SRD) Effect size: 0.26

- Adolescents in both the MST and RS conditions scored significantly lower at follow-up than they did at pre-assessment on the Youth Self Report (YSR) – no treatment effect was detected

- The MST youths were rated significantly more positive by parents and by teachers at follow up
  - Child Behavior Checklist (CBCL) Effect size: 0.50
  - Teacher Report Form (TRF) Effect size: 0.68

Percentage of youths scoring lower than the 90th percentile on CBCL in a normal sample



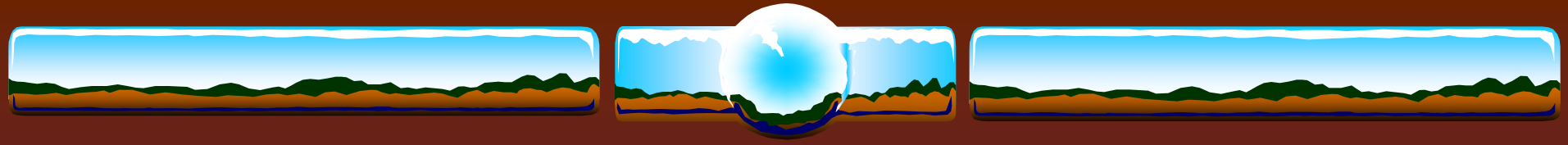


Conclusions

- The Norwegian findings support the effectiveness of MST relative to the services usually available for youths with serious behaviour problems at three out of four sites
- MST prevented placement out of home to a greater extent than regular services
- MST was associated with decreased internalising and externalising problem behavior in youths
- A marginally greater caregiver satisfaction with treatment relative to RS was reported by the MST families at post assessment
- Differential MST treatment effects across sites at post treatment and at follow up, may be due to variability in the quality of treatment implementation.

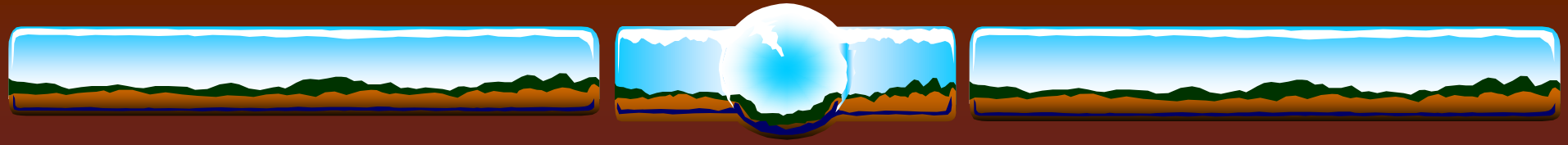
Characteristics of the Norwegian MST clinical outcome study

- The first controlled evaluation study (RCT) of MST outside North America and in a non-english speaking country
- One of the first trials not involving the developers of MST
- The trial was conducted by independent investigators who did not participate in the training and supervision of MST therapists nor in the actual treatment of families
- One of the first MST studies examining site differences in treatment effects
- Implemented as 'real world' treatment in a country without a juvenile court system (Child Welfare Services only).



Setting new standards for intervention research

- Implementing empirically or evidence based programs with pre-defined intervention components
- Quantitative, controlled group designs
- Multimethod, multi-informant measurement
- The measurement of implementation quality and treatment fidelity
- Studies that might be included in international meta-analyses and Campbell Collaboration (C2) reviews.

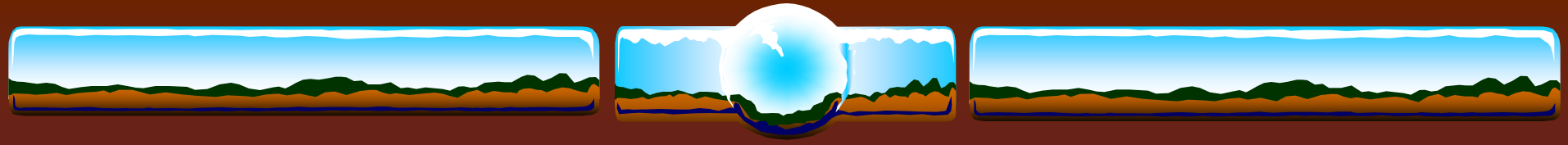


Controversies

- Characteristics of the treatment program:
  - Short term intervention with predefined core components,
  - Measuring behavioral change and monitoring treatment fidelity
  - Working through parents rather than directly with the youth

- Program myths:
  - Works only in family with resources
  - Too little flexibility
  - Superficial behavior change
  - Not taking the cultural or social context into consideration

- The post-modernistic critique: A positivistic, reductionistic and fragmented view on reality and knowledge.



Facilitators at the national level

- Increased professional demand for empirically based methods to treat and prevent behavior problems
- ‘Champion advocates’ at the national, regional and local level
- A genuine interest and commitment at the political and administrative level - consistent funding
- Establishing a national implementation and research center and a national training program
- The ability of the program developers and stakeholders to motivate and inspire Norwegian practitioners
- Positive feedback from families and from the media.