Center disseminates MST, other best practices to reduce mental illness, substance abuse, delinquency among youth

—by Paul M. Kubek

There are many circumstances that might negatively impact the course of development for children and adolescents, including neglect and assault in homes, violence in schools and neighborhoods, mental illness, and addiction to alcohol and other drugs.

Patrick J. Kanary, MEd, knows first-hand the prevalence and impact of such circumstances. He is Director of the Center for Innovative Practices (CIP), a technical-assistance organization within the Begun Center for Violence Prevention Research and Education at the Mandel School of Applied Social Sciences. He cites some alarming statistics to illustrate the serious conditions affecting today’s youth.

For instance, the American Academy of Child and Adolescent Psychiatry reports that approximately 20 percent of youth experience some type of mental health disorder during childhood. In addition, five to eight percent of youth experience a severe mental illness such as depression, anxiety, and conduct and behavioral disorders. Also, the Substance Abuse and Mental Health Services Administration reports that the prevalence of co-occurring mental illness and substance use disorders is at least 43 percent among adolescents.

“Our goal at the Center,” Kanary says, “is to assist communities in identifying, selecting, and implementing evidence-based practices and other promising services that address these complex needs.”

A FOCUS ON FAMILIES

The models disseminated by the Center are predominantly home-based, which means that behavioral healthcare professionals such as therapists and case managers work with youth and their families to change and enhance their relationships in ways that will help them manage emotional impulses, thoughts, and behaviors. The interventions are also community-based, which means the professionals work with youth and their peers and with teachers, school administrators, and other adults, such as those at community centers. A key goal is to identify and strengthen the natural supports available to youth and their families.

The emphasis on family and community is imperative, Kanary explains, because this approach helps reduce out-of-home placements of youth, helps with transitions back to their families, and helps stop the revolving door of recidivism. Kanary notes that 85 percent of youth who have been placed outside of their homes return to their homes, schools, and neighborhoods.

“An investment in evidence-based behavioral healthcare improves quality of life and other outcomes for youth and their families,” Kanary says, “but it also saves money for systems like juvenile justice and child welfare, because it helps families stay intact. An investment in behavioral health is a smart cost-avoidance strategy.”

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Kanary explains that in Ohio, the cost of incarceration by the Department of Youth Services (juvenile justice) is approximately $168 thousand per youth per year. In contrast, the average cost of an intensive home-based intervention is about $8 to $10 thousand per youth for a course of treatment, which is typically three to five months. Medicaid is a primary source of support for family-based interventions like Multisystemic Therapy (MST).

**MULTISYSTEMIC THERAPY (MST)**
MST was developed by researchers at the Family Research Center of the Medical University of South Carolina and is disseminated through MST Services, Inc. The Center for Innovative Practices is the only certified MST technical-assistance organization in the State of Ohio. It is a member of the national MST network of partner organizations. The Center is currently providing consultation and training to 15 MST teams in nine Ohio counties.

MST is an intensive family-based and community-based treatment model that addresses serious antisocial behavior. Clinicians in behavioral healthcare organizations use MST with youth 12- to 17-years old who have a history of disruptive behavior at home, school, or in the community, including involvement in the juvenile justice system. MST teams maintain fidelity to some core components. For instance, they have small caseloads: One therapist works intensively with four to six families. They have focused clinical supervision: Each team has one clinical supervisor for two to four therapists. They provide on-call services: Clinicians are available 24 hours per day, seven days per week. And they provide intensive services: Treatment occurs several times a week over three to five months.

**Clinical Approach**
MST teaches clinicians to view each youth as being nested within a complex network (or ecology) of interconnected social systems that includes their homes, schools, neighborhoods, and peer groups. MST therapists recognize that each system plays a critical role in a youth’s life and each system requires attention when effective change is needed. Together, therapists and caregivers keep adolescents focused on staying in school and developing job skills. They also introduce youth to positive peer activities, such as sports and other recreational activities, as an alternative to just “hanging out” with peers.

A major goal of MST is to empower parents with skills and resources they need to address the difficulties of raising teenagers and to empower youth with skills to cope with family, peer, school, and neighborhood problems. Intervention strategies include cognitive behavior therapies, behavioral management training, and family therapies.

**Outcomes**
According to the MST website, this model has undergone 30 years of research. In 18 studies, it has been shown to achieve the following:
- Keep youth in their homes, reducing out-of-home placements up to 50 percent
- Keep youth in school
- Keep youth out of trouble, reducing re-arrest rates up to 70 percent
- Improve family relations and functioning
- Decrease adolescent psychiatric symptoms
- Decrease adolescent drug and alcohol use

Kanary concludes that the results in Ohio have been impressive. An analysis of data for over 500 youth served in Ohio in 2012 shows the following:
- 87 percent completed treatment
- 87 percent living at home
- 84 percent in school/working
- 76 percent with no new arrests

The Center is in the process of analyzing 10 years of outcomes data that it has collected on nearly 5,000 youth served by Ohio’s MST programs.
Infants, toddlers experience delayed reactions to domestic violence

—by Paul M. Kabek

While some children are victims of violence in their homes, others are witnesses. Do not be misled by this distinction though. Being a witness does not make children less vulnerable to the consequences. Acts of violence and the emotions they produce—intense fear, anger, grief, a constant anticipation of the next terrifying incident—get imprinted in the child’s mind and expressed, sometimes not right away but eventually. In fact, the consequences might take a few years to show up.

Megan R. Holmes, PhD, Assistant Professor of Social Work at the Mandel School of Applied Social Sciences, studies domestic violence, also called intimate partner violence (IPV). She explains that each year nearly five million children are exposed to IPV. They witness the acts of violence or the after-effects. They hear fights. They see bruises, lacerations, and broken bones. They navigate homes in disarray—shattered glass, overturned furniture. She adds that more than half of these children are exposed to severe forms of IPV. They witness a parent or other important caregiver being burned, choked, or threatened with a knife or gun.

Holmes explains that many research studies link exposure to IPV with a number of difficulties for children, including emotional problems such as depression and anxiety; academic problems such as lower intellectual ability and struggles with memory and concentration; social problems like loneliness and less competence with establishing peer relationships; and behavioral problems such as aggression and delinquency. In other words, children might internalize the effects of violence and suffer privately, or they might externalize the havoc and suffer publicly. Sometimes it’s both.

INFANTS AND TODDLERS
In her most recently completed research project, Holmes examined the long-term effects of IPV on children who were exposed between birth and age three (n=107) and compared the data with children of the same age who were not exposed (n=339). She chose this age group because little is known about the long-term consequences of IPV exposure for the youngest witnesses.

“The earliest childhood experiences provide the foundation for later development,” she says, “and for success in school and in relationships with other children and adults.”

In her study, Holmes conducted a secondary analysis of data collected as part of the National Survey of Child and Adolescent Well-Being, which is a longitudinal study designed to assess the outcomes of children who have been reported to Child Protective Services as being victims of abuse or neglect. The study was funded by the National Quality Improvement Center on Early Childhood (www.qic-ec.org). Some of the results from this study are being published in the Journal of Child Psychology and Psychiatry, which is in press.

Results: A Sleeper Effect
Holmes studied the long-term effects of IPV upon children’s prosocial skills, which include cooperation, responsibility, assertiveness, and respect. She also examined the long-term effects on aggressive behaviors, which include yelling, shouting, and hitting. Her analyses included five years of data and revealed that negative effects do not show up immediately. Rather, children gradually become more aggressive, especially between the ages of five and six. In addition, children exposed to severe forms of IPV (e.g., burns, choking, threats with a knife or gun) demonstrate prosocial deficits a year after the incident. Holmes refers to this as the sleeper effect. Many of these symptomatic

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behaviors arise as children enter preschool and grade school, when they start to socialize more formally with their peers.

ASSESSMENT & INTERVENTION
These findings have important implications for social work practice. When social workers learn that a child has been or may have been exposed to IPV, it is important for them to assess for the negative effects not only now but also over time, especially as the child begins to enter school. Likewise, when a problematic behavior shows up, it is important not only to assess for current exposure to IPV but also for previous exposure—one, two, three, or more years earlier. Holmes adds that assessments need to include the age or developmental period when IPV exposure began as well as the nature of exposure, including duration and level of severity. Interventions should be targeted towards those children who are exposed when they are three years or younger and toward those who have experienced longer durations to or more severe forms of IPV.

“Early assessment and intervention is necessary for supporting and promoting a future with more positive outcomes,” she concludes.

2012-2013 Research Colloquia & Workshops
PowerPoint slides from the presenters may be obtained online: http://msass.case.edu/research/workshops.html

Friday May 10, 2013
Research for Action: The Influence of Research on Public Policy
Presenter: Jack Habib, PhD, Director, Myers-JDC Brookdale Institute, Israel.

Wednesday March 27, 2013
From Practice Innovation to Evidence-Based Model Dissemination: Issues and Challenges in Social Work Intervention Research Workshop
Presenter: Daniel B. Herman, Professor and Associate Dean for Scholarship and Research, Silberman School of Social Work at Hunter College, City University of New York.

Wednesday November 14, 2012
Constructing and Testing a Screening Instrument for Children’s Exposure to Violence to be Used by the Defending Childhood Initiative
Presenters: Jeffrey M. Kretschmar, PhD, Research Assistant Professor, Mandel School of Applied Social Sciences & Mark L. Singer, PhD, Leonard W. Mayo Professor in Family and Child Welfare, Mandel School of Applied Social Sciences.

Wednesday January 30, 2013
Managing Spoiled Identities in Life Story Interviews
Presenter: Mary P. Erdmans, Associate Professor, Department of Sociology, Case Western Reserve University.

Wednesday October 10, 2012
Evaluation and Learning in Community Change: Insights from a Mixed-Methods Study of a Mixed-Income Community in Akron
Presenters: Robert L. Fischer, PhD, Research Associate Professor, Mandel School of Applied Social Sciences & Mark L. Joseph, PhD, Associate Professor, Mandel School of Applied Social Sciences.

Tuesday October 2, 2012
Structural Equation Modeling (SEM) in Social Work Research Workshop
Presenter: Natasha Bowen, PhD, Associate Professor, School of Social Work, University of North Carolina at Chapel Hill.

For more information about the Research and Training activities at the Mandel School, please contact David E. Biegel, Ph.D., Associate Dean for Research & Training (david.biegel@case.edu).

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