Commentary on Ellis et al.: Adapting Multisystemic Therapy for Challenging Clinical Problems of Children and Adolescents

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The purpose of this commentary is to place the important adaptation of the multisystemic therapy (MST) model being developed by Ellis et al. within a broader research and services framework, one that encourages the consideration of other well-conceived adaptations of this evidence-based approach.

The Traditional Focus of MST: Serious Antisocial Behavior in Adolescents

MST (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) is an intensive family-based treatment that has extensive support in the treatment of violent juvenile offending (U.S. Public Health Service, 2001) and adolescent substance abuse (National Institute on Drug Abuse, 1999). MST clinical research has been conducted with youths presenting serious antisocial behavior and their families for the past 25 years, with several randomized trials published and numerous others in progress. Moreover, favorable outcomes from this research in combination with significant community need for effective juvenile services has led to the transport of MST programs to provider organizations in 30 states and 8 nations.

MST Adaptations: For Whom?

The success of MST in treating serious antisocial behavior has led to adaptations to treat other serious and costly clinical problems. For example, considerable work has been devoted to adapting the model for youths presenting psychiatric crises (Henggeler, Schoenwald, Rowland, & Cunningham, 2002), and studies of MST adaptations for treating child maltreatment and juvenile sexual offenders are currently in progress. Ellis's adaptation for treating adolescents with type 1 diabetes that is under poor metabolic control, however, is the first adaptation to move beyond the mental health/juvenile justice/substance abuse arena. This begs the question, How is an intensive treatment of youth violence and emotional disturbance applicable to a pediatric population?

Adapting What?

Adaptations for other challenging and costly clinical populations are possible because MST, fundamentally, is not a psychosocial intervention per se. Rather, MST is an intervention program that includes several critical and interrelated components that are potentially applicable to a range of serious problems.

Multidetermined Problems. MST fits best for problems that have an array of known risk factors consistent with a social ecological model of behavior (Bronfenbrenner, 1979). The social ecological nature of antisocial behavior in children is well established, and MST explicitly targets key risk factors while building protective factors. Likewise, Ellis et al. briefly described the contextual determinants of adherence problems among adolescents with type 1 diabetes, and the case examples attended to a relatively broad range of these risk factors.

Commitment to Service Access. Multiproblem, disadvantaged families, usually the focus of MST programs, can experience many legitimate and significant barriers to bringing their children to clinic visits. Throughout the development of MST, the use of a home-based model of service delivery has proven effective at overcoming barriers to service access. Moreover, this model provides more reliable and valid clinical assessment and outcome data from which to base clinical decisions. The intensity of the home-based model (e.g., low caseloads), however, requires a focus, for reasons of cost-effectiveness, on populations at high risk of expensive services (e.g., incarceration, hospitalization). Thus, Ellis et al. have focused their ongoing randomized trial on adolescents with very poor metabolic control.
Integration of Evidence-Based Intervention Techniques.
Taking advantage of advances made by many other investigators, MST integrates existing evidence-based intervention techniques. Thus, for example, protocols from the community reinforcement/contingency management approaches to substance abuse treatment are integrated with standard MST protocols (which, themselves, integrate behavioral, family, and cognitive behavioral intervention techniques) in treating substance abuse; and established medication algorithms are used for treating youths with attention-deficit hyperactivity disorder. In type 1 diabetes, established adherence procedures for improving metabolic control received considerable clinical attention from Ellis et al.

Caregivers Are Key to Achieving Outcomes. The integration of evidence-based interventions, however, occurs within a context in which caregivers are viewed as critical to achieving long-term outcomes. Thus, most clinical resources are devoted to empowering caregivers to serve as change agents for their children. Barriers to such efforts (e.g., caregiver depression) are also the focus of MST interventions. For example, the first MST intervention for Case 2 was to assist the mother in improving her own health and enhancing her social support system. These changes are viewed as critical steps in developing capacity for sustained change in child health.

Quality Assurance Protocols. These critical features (i.e., identifying and addressing risk factors, integrating evidence-based intervention techniques, removing barriers to services access, empowering caregivers) are implemented within the context of an intensive quality assurance system. The quality assurance system includes numerous components (e.g., training, booster training, fidelity monitoring, outcome monitoring, and layered consultation) that promote favorable youth outcomes by enhancing treatment fidelity, holding providers accountable for outcomes, and building the skills of the practitioners. Thus, in addition to the considerable clinical expertise provided by the MST-trained supervisor at the type 1 diabetes project site, weekly case consultation is being provided by a seasoned MST expert consultant, and the development of practitioner competence is ongoing.

Testing the Viability of Adaptations
Although feasibility studies play critical and relatively low-cost roles in deciding whether a particular adaptation to a treatment model is worth pursuing, such studies must be followed by well-designed (e.g., randomized) and well-implemented (e.g., minimal research attrition, high treatment fidelity) evaluations. As noted toward the end of their article, Ellis et al. are currently conducting a randomized trial of their adaptation of MST for youths with poorly controlled type 1 diabetes funded by the National Institute of Diabetes and Digestive and Kidney Diseases. This study will eventually include 100 adolescents, as well as a follow-up that continues 18 months past the end of the MST intervention. Results from this trial will inform the possible transport of the model to other pertinent pediatric sites. As the field is learning (e.g., Schoenwald & Henggeler, in press), however, the transport of evidence-based practices is considerably more challenging and complex than the conduct of a successful clinical trial. If their present project is successful, Ellis et al. should be prepared to provide the same careful planning and reasoned implementation to any transportability efforts that they have on their clinical trial.

Future Implications for Pediatric Psychology
Although much of my early work was in pediatric psychology, I have had little contact with that network of researchers for more than a decade. So it would be presumptuous to make authoritative suggestions for the possible utility of an MST approach to various problems in behavioral pediatrics. Nevertheless, in light of Ellis’s promising preliminary findings, it seems that some applicability might exist. For example, organ transplant rejection in pediatric populations is extremely costly from both personal and financial perspectives. Yet the probability of rejection can be attenuated with better adherence to medication protocols. From anecdotal information, poorly adhering youths seem to be embedded in challenging family contexts. Such contexts are the bread and butter of MST intervention protocols. Thus, with insights gleaned from the work of Ellis et al. as well as from the broader field of pediatric psychology, it seems possible that the MST model could improve outcomes of other serious pediatric problems.

Received October 31, 2001; accepted November 4, 2002

References
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