Multisystemic Therapy (MST)

Key Continuous Quality Improvement (CQI) Considerations

CQI BRIEF FOR CALIFORNIA COUNTIES AND EBP PROVIDERS

INTRODUCTION

As California continues to strive for excellence in child welfare, the implementation of evidence-based programs (EBPs) is a fundamental component of the Family First Prevention Services (FFPS) prevention plan. **This policy brief is designed to provide counties and providers with a comprehensive framework for implementing Multi-Systemic Therapy (MST)**, a well-supported evidence-based program approved by the Family First Prevention Services Clearinghouse to meet the diverse needs of at-risk youth and their families.

As you review this information, consider how you will measure the success of MST within your county and how you can develop or refine your implementation to ensure eligibility for IV-E reimbursement, as well as improved outcomes for children and families.

Counties and providers can utilize this Brief to facilitate discussions at the county, agency, and community levels, aimed at identifying best practices for tracking and sharing data. These discussions should also focus on reviewing the CQI prompts to assess program delivery and implementation, making necessary adjustments as needed. Additionally, counties and providers should use these Briefs to establish feedback loops for sharing qualitative data on family-specific needs, ensuring that future efforts to serve and support families are informed and responsive.

The information presented in this resource, including service descriptions, target populations, program or service delivery, and implementation details, is informed by several key sources. These include meetings with the MST developer/purveyor and California's Family First Prevention Services CQI Subcommittee, Family First Prevention Services Advisory Committee, Community Pathway Advisory Committee, and IV-E Advisory Committee.

Key Terms

Developer/Purveyor: The entity responsible for creating and supporting the implementation of the EBP. They provide training, resources, and guidance to ensure fidelity and effective implementation.

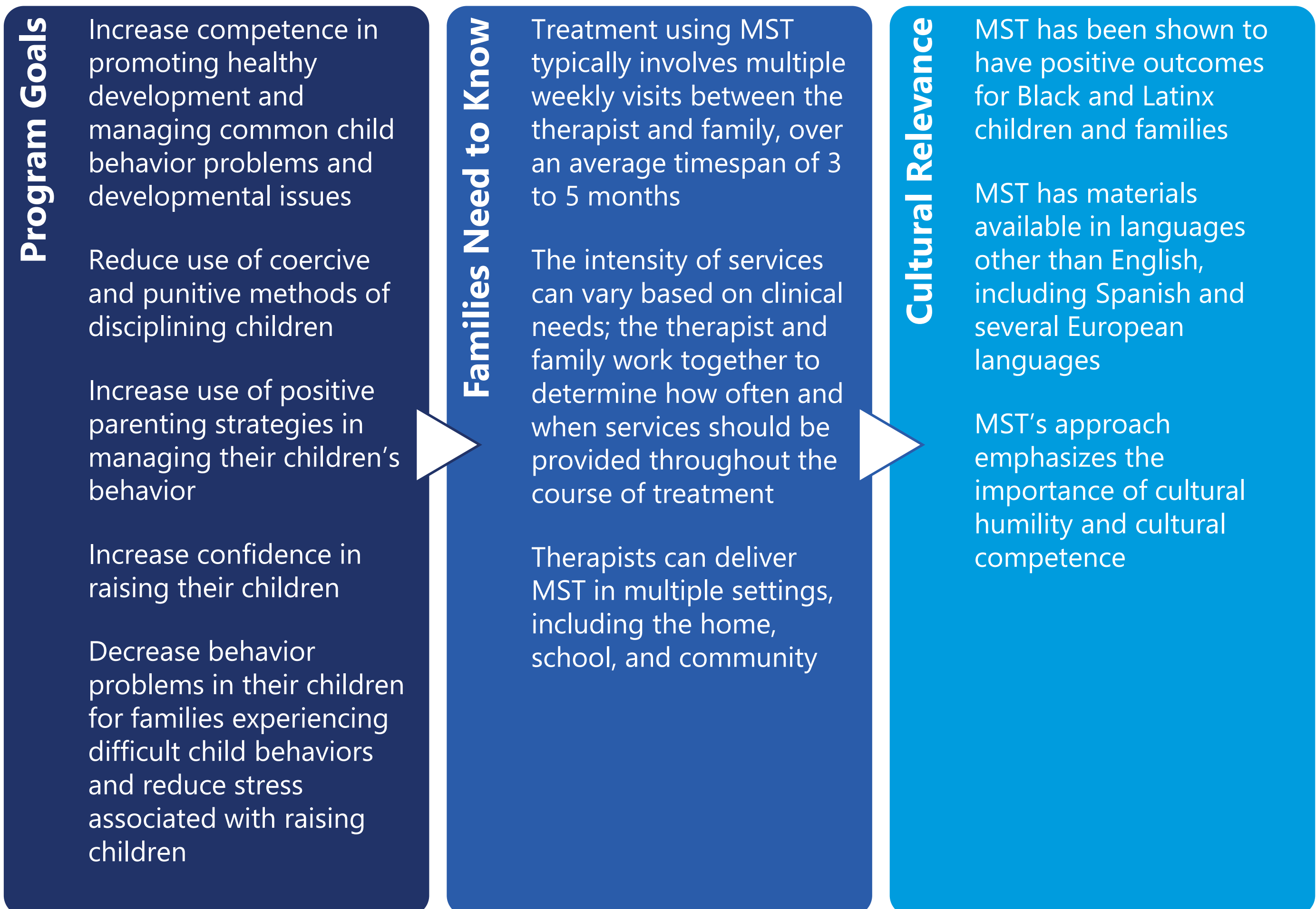
Provider: The individual or organization delivering the EBP services directly to children and families.

MULTISYSTEMIC THERAPY PROGRAM OVERVIEW

Multisystemic Therapy (MST) is an intensive treatment for youth delivered in multiple settings. MST aims to promote prosocial behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers.

Who is Eligible?

Youth ages 12 to 17 with serious emotional or behavioral needs, along with their families, are eligible for the MST program. However, the program excludes youth living independently, those referred primarily for psychiatric behaviors or severe psychiatric issues such as being actively suicidal, homicidal, or psychotic, those referred solely for sex offenses without other antisocial or delinquent behaviors, and youth with moderate to severe autism.



MEASURING PROGRAM SUCCESS

Research has shown that family outcomes improve significantly when therapists, supervisors, and experts adhere closely to the MST treatment model. Regular quality assurance monitoring, required for licensure, ensures this adherence. The MST developer/purveyor collects data to provide feedback, helping improve both adherence to the treatment model and program outcomes. This data is stored in an online database managed by the MST Institute (MSTI).

Data Collection for Federal IV-E Reimbursement

Under the Family First Prevention Services Act (FFPSA), federal IV-E reimbursement for evidence-based programs (EBPs) is contingent upon several requirements described on pages 27, 39, and 52 of the federally approved California Prevention Plan. To meet these requirements and ensure accurate cost tracking:

- **MST providers will enter reach and capacity data into the CARES provider portal on a monthly basis.**
- Tracking both outcome and fidelity data is required for IV-E reimbursement. MST providers have access to outcome and fidelity reports generated by the MST developer/purveyor.
- **Outcome data will be reported by the developer/purveyor and submitted to CARES using the designated developer/purveyor template provided in Appendix B.**
- Fidelity data reporting is split between MST providers and the developer/purveyor. **The developer/purveyor will submit fidelity data using the template in Appendix B, while MST providers will use the template in Appendix A to report additional fidelity data.**
- CDSS is in the process of contracting with the MST developer/purveyor to receive outcome and fidelity reports on a consistent basis.

The **CDSS FFPS Program** will:

- **Upload outcome and fidelity data** into the backend of CARES.
- **Translate the reach, capacity, outcome and fidelity data into Tableau reports for use in state- and county-level FFPS CQI processes.**

Key Metrics for Continuous Quality Improvement (CQI)

To measure the success of MST, it's important to regularly review data in four key areas:

1. ***Capacity –*** *staff requirements*
2. ***Reach –*** *the extent to which children and families are being served*
3. ***Fidelity –*** *adherence to model implementation requirements*
4. ***Outcomes –*** *impact of services on children and families*

These metrics provide a comprehensive view of program effectiveness. More information on this framework can be found here: Measurement Framework for Implementing and Evaluation Preventive Services.

MST MEASUREMENT FRAMEWORK

The **MST Measurement Framework** provides standardized metrics for California counties and EBP providers to evaluate **capacity**, **reach**, **fidelity**, and **outcomes**, supporting continuous quality improvement (CQI) and compliance with the Family First Prevention Services Act (FFPSA) for federal IV-E reimbursement. The following data tables outline these measures and expectations for tracking critical program components. **It is recommended that all stakeholders review and familiarize themselves with this information to clearly understand the expectations for tracking and assessing critical components of program implementation.** CQI prompts are included to guide discussions, identify successes, address barriers, and support effective program implementation and oversight.

Capacity

Capacity refers to the resources dedicated by the agency or program to effectively deliver services to children and families, including staffing, infrastructure, and service availability. Adequate capacity is essential for successful implementation of MST and influences the program's ability to meet community needs.

Table 1 outlines key capacity measures required to monitor program implementation. **MST providers will submit capacity data for each provider site monthly through the CARES provider portal.** Counties should review capacity data and conduct CQI activities monthly.

Table 1. Description of MST Capacity Data Elements

Measure	Indicator
Staffing	Total # of provider agency sites
	Total # of full-time model-trained or certified practitioners
	Total # of supervisors
Supervisor / Practitioner Ratio	1:4
Full-time Caseload *(Part-time practitioners are not permitted)*	4-6 families
Service Duration	16 weeks

Capacity CQI Prompts:

- **Analyze Waitlist and Capacity Data: Combine waitlist information, reach data, and staffing levels to identify if more clinicians or service slots are needed in specific communities.**
- **Address Staffing Challenges: If Supervisor/Clinician ratios, caseloads, or service duration are not meeting standards, collaborate with providers to identify barriers and develop solutions.**
- **Evaluate Capacity Trends: Regularly review capacity data to detect patterns of increased demand and adjust staffing or resources accordingly.**

Reach

Reach refers to the extent to which the program engages its target population by ensuring eligible children and families are identified, referred, and actively enrolled in services. It measures how well MST is serving those it is intended to reach and whether the service is accessible to those in need.

Table 2 lists the reach data elements to be tracked for effective outreach and engagement. **MST providers will submit reach data monthly through the CARES provider portal.** Counties should review reach data and conduct CQI activities monthly.

Table 2. Description of Standardized Reach Data Elements

Measure	Indicator
Eligible Child Welfare & Probation Candidates *(This data will come from the Title IV-E agency)*	Total # of FM/VFM/602 youth who come to the attention of the agency*
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition**
	Total # identified as a Family First pregnant or parenting youth in care (PPY)
	Total # not identified as a candidate
Eligible Community Pathway Candidates *(This data will come from the Title IV-E agency)*	Total # of community pathway children granted IV-E agency candidacy approval
	Total # of community pathway children denied IV-E agency candidacy approval • Reason for denial ○ MH, SA, or PS imminent risk/need not identified ○ Child outside of age range of the recommended EBP
EBP Referrals to Providers	Total # candidates referred to an EBP provider
EBP Service Uptake	Total # candidates who started the EBP
	Total # candidates who did not start the EBP • Reason did not start the EBP ○ No action taken; referral still in process ○ Placed on waitlist; median days on waitlist ○ Provider rejected referral ○ Provider unable to contact or engage with the family ○ Family did not consent, etc. ○ Other
EBP Service Completion	Total # candidates who completed the full EBP
	Total # candidates who did not complete the full EBP • Reason did not complete the full EBP ○ Provider unable to contact or engage with family ○ Family withdrew ○ Family no longer eligible ○ Provider capacity issues ○ Other

**Total number of referrals to Probation (inclusive of citations and arrests)*

***Youth referred to Probation by a Law Enforcement Agency for alleged involvement in delinquent behavior that could result in a WIC 602 petition*

Reach CQI Prompts:

Look at eligible child welfare and probation candidates and compare with the number referred to MST, started MST, and completed MST. Discuss strategies to address:

- **Service Flow: Compare eligible candidates to those referred, enrolled, and completed.**
- **Waitlists: Identify causes and reduce delays.**
- **Referral Rejections: Address common reasons for declined referrals.**
- **Family Contact: Improve provider outcome and engagement.**
- **Consent Issues: Increase family consent rates.**
- **Withdrawals: Identify strategies to reduce early terminations.**
- **Eligibility Changes: Minimize service disruptions.**
- **Provider Capacity: Align staffing and resources to demand.**

Outcomes

Outcomes refer to the measurable impacts of the program on children and families, demonstrating whether MST is achieving its intended goals. These metrics help assess program effectiveness and inform continuous quality improvement efforts.

Table 3 outlines the key outcome measures needed to monitor and evaluate program success. **The MST developer/purveyor will use a standardized template to submit outcome data to CDSS biannually. The CDSS FFPS team will upload developer/purveyor outcome data into the CARES backend for county CQI activities.** Counties should review outcome data and conduct CQI activities quarterly.

Table 3. Description of MST Outcome Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Maintain Family Stability	At discharge, % of youth still at home.	90%	Case Discharge Form	Collected at discharge	Program Implementation Review (PIR) and MST Dashboard Report
Maintain Educational & Vocational Involvement	At discharge, % of youth in school or working.	90%			
Reduce Arrests	At discharge, % of youth not arrested during treatment.	90%			

Outcomes CQI Prompts:

- **Review Discharge Data: Analyze youth discharge reports biannually to identify outcome trends and challenges. Share successful strategies among providers.**
- **Assess Population Impact: Compare reach data to identify which candidacy groups (e.g. probation vs. child welfare, FM vs. VFM) are benefitting most, considering factors like race, ethnicity, gender, and age.**

Fidelity

Fidelity refers to how closely the program follows the prescribed MST model to ensure services are delivered as intended. Maintaining high fidelity is crucial for achieving positive outcomes and ensuring program integrity.

Table 4 outlines the fidelity measures required to assess program adherence. Reporting on fidelity data will be divided between the provider and the developer/purveyor. **The MST developer/purveyor will submit their fidelity data to CDSS using a standardized template biannually, while MST providers will use a separate template to report additional fidelity data biannually. The CDSS FFPS team will upload both developer/purveyor and provider fidelity data into the CARES backend for county CQI activities.** Counties should review fidelity data and conduct CQI activities quarterly.

Table 4. Description of MST Fidelity Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of therapists who have been working more than 2 months who complete the 5-day orientation training and obtain certification in MST.	100%	Collected by provider agencies	Collected once initial therapist training is completed	Program Implementation Review (PIR)
	% of supervisors who complete supervisor orientation training.	100%		Collected once initial supervisor training is completed	Reported by provider agencies
	% of therapists who participate in quarterly booster training.	100%		Collected quarterly	
Provider Meets Staffing Qualification Requirements	% of therapists that have a master's degree in social work or counseling.	66%	Collected by provider agencies	Collected at program start-up and every six months during the Program Implementation Review	Reported by provider agencies
	% of clinicians who are part of a licensed MST program.	100%			
Completion of the Therapist Adherence Measure Revised (TAM-R)	% of TAM-R due that are completed.	70%	Therapist Adherence Measure Revised (TAM-R)	Completed by caregivers during the second week of therapy and approximately every 4 weeks thereafter	MST Dashboard Report
	% of youth with at least one TAM-R interview.	100%			
	Overall average TAM-R adherence score.	0.61			
	% of youth reporting adherence above the threshold of 0.61.	80%			

Fidelity CQI Prompts:

- **Verify Training and Qualifications: Review MSTI reports biannually to ensure adherence to training requirements, staff qualifications, and TAM-R completion rates.**
- **Address Implementation Challenges: If issues are identified, collaborate with providers and the model developer to develop solutions.**

RESOURCES

To ensure the successful implementation of MST, it is crucial to establish a strong relationship between the MST provider, the MST developer/purveyor, and the county. Here are the steps to initiate this process:

Providers Contact MST Services: Reach out to MST Services, the official developer/purveyor of Multisystemic Therapy. Contact information can be found on their website: www.mstservices.com. Initiate a conversation to discuss your interest in implementing MST and to seek guidance on the next steps.

Providers and County Leaders Contact Your Local CPP Lead: Providers or counties looking to implement MST for IV-E reimbursement should contact their local Comprehensive Prevention Planning Lead to ensure their implementation plans align with state and federal requirements, including IV-E reimbursement guidelines. Follow this link to determine your point of contact: https://cdss.ca.gov/Portals/9/CCR/FFPSA/ffps-title-iv-eagency-county-contact-list.pdf

You can also submit additional questions to the FFPS Inbox at FFPSAPreventionServices@dss.ca.gov

STAY TUNED!

In the coming months, the CQI Subcommittee and statewide advisory committees (see Page 1) will be drafting a comprehensive California Continuous Quality Improvement Plan. The content will include governance structure recommendations, CQI focused resources/policies, data analysis, and feedback loops. Stay tuned for these updates as we enhance our statewide CQI practices for Family First Prevention Services.

REFERENCES

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APPENDIX A: PROVIDER FIDELITY TEMPLATE

Multisystemic Therapy (MST)				
Provider submits percentage for each location via data file				
Measure	**Provider received and maintained required training**		**Meets staffing qualification requirements**	
Indicator	*% of supervisors who complete supervisor orientation training.*	*% of therapists who participate in quarterly booster training.*	*% of therapists that have a master's degree in social work or counseling.*	*% of clinicians who are part of a licensed MST program.*
Target Level	100%	100%	100%	100%
Site 1				
Site 2				

APPENDIX B: DEVELOPER/PURVEYOR OUTCOME & FIDELITY TEMPLATE

MST Outcome Measures

Multisystemic Therapy (MST)			
Purveyor will send the percentage for every location via a data file.			
Measure	**Maintain family stability**	**Maintain educational and vocational involvement**	**Reduce arrests**
Indicator	*At discharge, % of youth still at home.*	*At discharge, % of youth in school or working.*	*At discharge, % of youth not arrested during treatment.*
Target Level	90%	90%	90%
Site 1			
Site 2			
Site 3			

MST Fidelity Measures

Multisystemic Therapy (MST)					
Purveyor will send the percentage or average score for every location via a data file.					
Measure	**Provider received and maintained required training**	**Completion of the Therapist Adherence Measure Revised (TAM-R)**			
Indicator	*% of therapists who have been working for more than 2 months who completed the 5-day orientation training and obtain certification in MST.*	*% of TAM-R due that are completed.*	*% of youth with at least one TAM-R interview.*	*Overall average TAM-R adherence score.*	*% of youth reporting adherence above threshold (>.61).*
Target Level	100%	70%	100%	0.61	80%
Site 1					
Site 2					