Multisystemic Therapy Consultation Manual

SONJA K. SCHOENWALD

Multisystemic Therapy Consultation Manual

Sonja K. Schoenwald, Ph.D.

August, 1998

Table of Contents

Acknowledgments

I greatly appreciate the support of Shay Bilichik and the Office of Juvenile Justice and Delinquency Prevention (Grant Number 97-JN-FX-0016) who provided the resources needed to develop this manual. In addition, I owe special thanks to the following MST supervisors and consultants whose constructive feedback helped to shape the form and content of this manual: Phillippe B. Cunningham, Dan L. Edwards, Christine C. Hamel, Scott W. Henggeler, and Melisa D. Rowland.

Introduction

This document is the third of four written works that specify multisystemic therapy (MST) and the quality assurance mechanisms needed to support successful implementation of the MST model. The clinical foundation of MST is detailed in a volume, *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). A supervisory manual, *The Multisystemic Therapy Supervisory Manual: Promoting Quality Assurance at the Clinical Level* (Henggeler & Schoenwald, 1998), describes the structure, process, and content of MST supervision. Such supervision is designed to promote therapists' acquisition and implementation of the conceptual and behavioral skills required to achieve adherence to the MST treatment model. This document describes the role that an MST expert plays as a consultant who teaches clinicians and supervisors how to implement MST effectively and how to identify and address organizational and systemic barriers to program success. The fourth document (Strother, Swenson, & Schoenwald, 1998) describes organizational conditions and procedures conducive to the establishment of a sustainable MST program.

Weekly consultation with an MST expert is a central component of a comprehensive training and quality assurance package developed for use with providers who wish to establish MST programs. The components of this package are:

- A site assessment process designed to identify organizational and community conditions conducive to the development of a sustainable MST program (see Strother et al., 1998).
- A 5-day Orientation Training for clinicians and supervisors, the first day of which generally involves representatives of community agencies that interface with the MST program.
- Quarterly booster sessions tailored to the clinical competencies and needs of each team and supervisor and to the specific challenges of populations served by the team.
- On-site, weekly clinical supervision of the MST team provided by a doctoral-level or advanced master's-level professional who works closely with the MST consultant.
- Ongoing telephone consultation from an MST consultant for the team and supervisor.

This document focuses on telephone consultation by an MST expert, because this function is designed to support ongoing therapist and supervisory fidelity to the MST treatment model. Section I describes the expertise of MST consultants. Section II describes consultation as a teaching process and identifies consultation skills that facilitate learning. Section III lays out the structure and process of weekly telephone consultation, and Section IV describes strategies to facilitate supervisor implementation of MST supervision practices.

The Evolution of MST Consultation

In early clinical trials demonstrating the effectiveness of MST, the original developers of the model, Drs. Scott W. Henggeler and Charles M. Borduin, directly supervised the therapists, who were doctoral students in clinical psychology. In the first study that used community-based practitioners, Dr. Henggeler was geographically removed from the study site, so he provided weekly supervision to the clinicians by telephone. The supervision was case-specific and focused on designing interventions in accordance with MST principles and solving problems that prevented intervention success. When providers around the country began to request training in MST, Family Services Research Center (FSRC) faculty conducting

research on MST began to provide the 5-day orientation training, quarterly booster sessions, and weekly telephone contact to clinicians. In addition, they provided ad hoc consultation to individuals serving as clinical supervisors for MST teams. At that time, the formalization of procedures for MST supervision and telephone consultation began. As more programs sought to implement MST, it became clear to FSRC faculty that more attention to supervisory training was needed to facilitate clinician learning and application of MST between consultation sessions. This need gave rise to the specification of the MST supervision protocol (Henggeler & Schoenwald, 1998). Within a year after the first training to remote sites was offered, the FSRC research faculty realized that the extensive demands associated with providing ongoing MST consultation and training for multiple providers simultaneously would require full-time attention. As a result, MST Services, an organization dedicated to the quality-controlled dissemination of MST, was established. It began recruiting and training a cadre of doctoral-level professionals to provide this consultation and training.

Because clinical trials of MST have not measured supervisor or consultant behavior, the aspects of each that are critical to achieving therapist adherence to MST are just now being identified. On the basis of experiences with more than 40 supervisors employed by a variety of organizations, a measure of MST supervisory practices has been developed and is currently being piloted. In contrast, fewer than 10 people–all of whom work for either FSRC or MST Services–have served as MST expert consultants. A multi-year study of MST dissemination scheduled to begin in fall of 1998 proposes to promote individuals from MST therapist to supervisor to consultant on the basis of demonstrated adherence to MST, outcomes achieved, and the ability to teach others to adhere to the model. In addition, empirical investigations of the relationships among consultation, MST supervision, clinician adherence to MST, and child outcomes are in the planning stages. At this time, however, the number of individuals serving as consultants is small, and specification of the critical elements of consultation (i.e., those having the most influence on supervisory practices, clinician adherence, and outcomes) is still in the descriptive stage. Consultation and supervisor training guidelines described in this document draw from the experiences of the original FSRC and MST Services consultants.

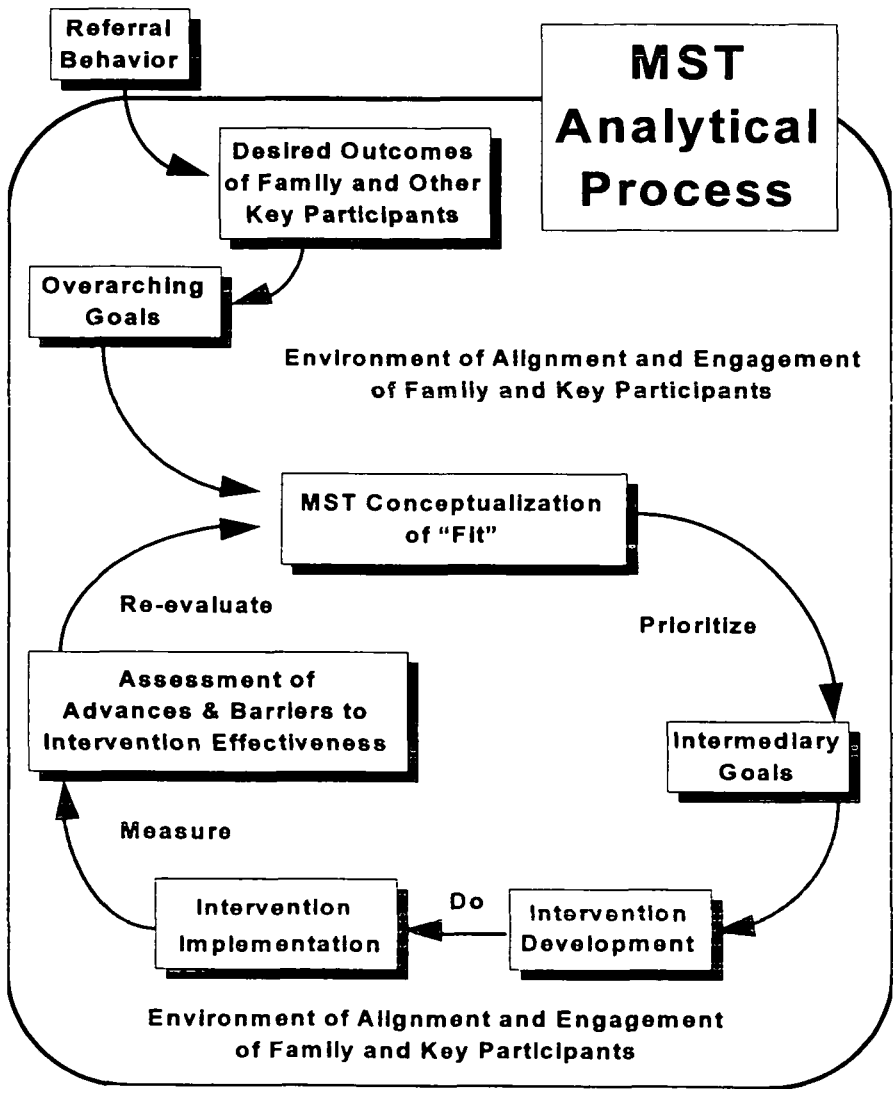
The Objectives of MST Consultation

The broad objectives of expert MST consultation are:

- To facilitate clinician learning and the application of MST principles to cases when both the clinicians and the on-site supervisor are new to MST.
- To facilitate logical and critical thinking throughout the ongoing assessment and intervention process, as depicted in the MST Analytical Process (AKA, Do-Loop; see Figure 1).
- To monitor and support clinician and supervisor adherence to the MST treatment principles as teams become more experienced with MST.
- To coach supervisors how to use the MST supervision protocol effectively (Henggeler & Schoenwald, 1998) and monitor the consistency of their supervisory practices with it.
- To provide guidelines to clinicians and supervisors to incorporate specific treatment modalities into MST intervention plans.
- To provide updated information, as needed, about research related to MST, empirically supported treatments subsumed within MST, and the etiology of problems experienced by target populations served by MST programs.
- To identify organizational and service system barriers to the effective implementation of MST and to assist the team and organizational leadership, as needed, to address those barriers (Strother et al., 1998).

Figure 1

MST Assessment and Intervention Process (AKA, MST Do-Loop)



The MST Consultant As Expert

Experts, regardless of their domain of expertise, possess several characteristics. Experts (Glaser & Chi, 1988):

- Excel primarily in their own field, but not necessarily in other domains (e.g., being an expert in child treatment does not make one an expert in economics).
- Perceive large meaningful patterns in their domain.
- See and represent a problem in their field at a deeper, more principled level than novices, who tend to represent a problem at a superficial level.
- Are faster at performing skills in their domain and can solve problems with little error.
- Have superior short-term and long-term memory for material in their domain.
- Spend more time analyzing problems in their domain qualitatively.
- Have strong self-monitoring skills.

All of these characteristics describe individuals who serve as MST consultants. The expertise of the MST consultant lies in two general categories–expertise in MST itself and in teaching clinicians to think and act in accordance with MST principles at every step of the way in every case. The MST consultant must teach clinicians and supervisors to assess complex clinical problems by focusing on interactions within and between systems in the youth's natural ecology, to design interventions consistent with the nine MST treatment principles, and to use the MST Analytical Process (AKA, Do-Loop, Figure 1) automatically.

The consultant must be able to teach clinicians to execute these tasks with each case during relatively brief consultant-clinician interactions. Clinicians have direct contact with client families and the systems in which they are embedded, and they are directly responsible for all assessment and intervention activities. Thus, their interactions with client families are both intensive and extensive. Similarly, the supervisor's knowledge of and experience with client families is more indirect than direct, but also quite extensive. Supervisors enure that assessments are sufficiently comprehensive (i.e., include all relevant information regarding all relevant systems), treatment goals and interventions are logically linked, interventions are consistent with MST principles, and clinicians have the skills required to implement interventions effectively. Supervisors directly observe and interact with clinicians about each case on an ongoing basis, occasionally observing clinician interaction with family members using field or audiotaped supervision.

In contrast, the consultant has no direct contact with client families and relatively limited contact with clinicians and supervisors. From the limited information available in weekly case summaries and telephone narratives, the consultant must be able to detect the critical points needed to help clinicians and supervisors move cases forward. Thus, MST consultants must be able to grasp problems at a deeper, more principled level; see deep patterns; analyze and solve problems quickly in terms of the MST principles; develop excellent short- and long-term memory; provide recommendations with a low margin of error; and engage in ongoing self monitoring (Glaser & Chi, 1988). Extensive knowledge and experience is needed to develop these characteristics.

The Consultant's Knowledge and Experience Base

MST presents a significant departure from the treatments and services for children and families available in most communities in the United States. When an MST program is introduced to a community, numerous questions arise about the treatment model and the similarities and differences between MST and existing services. If these questions are not answered, clinicians, supervisors, and program administrators may be slow to adopt MST, which could erode the support needed from entities that refer and pay for the MST program. Consequently, consultants must have substantive expertise in a variety of treatment, service, and service system topics that arise when MST programs are introduced to a community. Consultants also must be able to convey this expertise in ways that are acceptable to the diverse audiences (families, clinicians, program administrators, advocates, and policymakers) who raise critical questions.

Theoretical and Empirical Underpinnings of MST

MST consultants must have a thorough working knowledge of the theoretical and empirical underpinnings of MST. As a result, consultants must thoroughly understand the social-ecological models developed by Urie Bronfenbrenner (1979), and the family systems theories of Patricia Minuchin (1985), Salvador Minuchin (1974), and Jay Haley (1976). The expert should be able to integrate them into MST. Systemic and ecological ways of thinking do not typify most clinical practice and agency mandated services for youth, which are generally individually oriented. Thus, consultants must grasp the tenets of ecological and systems theories and be able to explain them to audiences (clinicians, program administrators, agency heads, payers) who typically have supported the status quo of individual treatment.

The consultant must maintain up-to-date information about the empirical literature on the correlates and causes of serious clinical problems in youth, empirically supported treatment modalities, and the extent to which findings on those modalities relate to youth experiencing serious clinical problems and to their families. This knowledge base includes:

- Past and newly emerging findings from clinical trials of MST (including methods, participants, and outcomes of all studies)
- Empirically supported interventions incorporated into MST
- Findings from rigorous multivariate and longitudinal (as opposed to narrowly focused, cross-sectional, and poorly designed) studies on the causes and correlates of specific problems encountered by MST clinicians
- Developments in children's mental health services research that are relevant to the models of service delivery (e.g. home-based, therapeutic foster care, wrap-around services, intensive case management)
- Service system issues encountered by clinicians using MST. A list of pertinent studies appears in Appendix A of this document.

Child and Adolescent Treatment Research

Consultants are familiar with empirically supported treatment models for youth who have disruptive behavior problems and with the limitations of these treatments and the research demonstrating their efficacy. Current reviews of this research (e.g., Chambless & Hollon, 1998; Hibbs & Jensen, 1996; Kazdin, 1994; Liddle & Dakof, 1995; Lipsey, 1992; Quay & Hogan, in press; Thornberry, Huizinga, & Loeber, 1995) are listed in Appendix A. Consultants know the original studies cited in these reviews well enough to understand the types of populations and procedures used to test the treatments and the implications of the findings for the treatment of youth and families with multiple problems (i.e., populations served by MST). Because MST represents a distinct departure from the clinical practices typically provided in

communities, clinicians usually have numerous questions about why they should abandon their usual practices for MST. Consultants must be able to answer these questions on the basis of empirical knowledge rather than opinion or faith.

Consultants must have a working knowledge of empirically validated treatment modalities and the studies testing their efficacy because they are the primary source of information and training experiences for clinicians who lack the requisite experience to implement empirically based techniques within the context of the MST framework. During quarterly booster sessions and through phone consultation and resource materials, consultants provide clinicians with training in pragmatic family therapies, parent-child behavior management, cognitive-behavioral treatments for adults and youth, marital interventions, substance abuse interventions, and peer interventions. Consultants also help supervisors tailor on-site training experiences for clinicians who need practice with a particular modality (e.g., cognitive-behavioral techniques for depression, social problem solving skills training for adults and youth, marital interventions). Thus, consultants must know about treatment protocols and array of techniques associated with the efficacy of the treatment. As described subsequently, the consultant's clinical experience with empirically validated practices is valuable to the teaching process.

Mental Health Services Research

Consultants are familiar with the nature and outcomes of children's mental health services research. Youth and families seeking treatment in the community receive services in a variety of settings, including community health and mental health clinics, public or private hospitals, schools, and facilities operated through public mental health, juvenile justice, or child welfare agencies. "Thus, services research for children and adolescents is characterized by investigations of the interrelated conditions within which services to children, adolescents, and their families are provided [in community settings]" (Hoagwood & Hohman, 1994, p. 260). Two genres of inquiry are subsumed within child and adolescent mental health services research. One focuses on service systems; the other, on the use and effectiveness of various services delivered within those systems. For the past decade, service systems research has focused primarily on organizational aspects of service systems (Oswald & Singh, 1996), that is, on the ways that agencies and systems coordinate services, on reducing barriers to coordination through the integration (administrative and fiscal) of services across service sectors (e.g., mental health, education, juvenile justice, child welfare), and on the impact of systems integration on mental health outcomes (e.g., Attkisson, Dresser, & Rosenblatt, 1995; Glisson, 1994; Glisson & Hemmelgarn, in press).

Because many communities where MST programs are introduced will have invested considerable financial, political, and philosophical capital in developing such systems of care for children and families, consultants are familiar with the nature and outcomes of research on these systems. MST programs often operate in the context of a system of care that can both facilitate and hamper the ability of clinicians to take the clinical lead with youth and families referred for MST. Consultants must be familiar enough with the tenets of the system of care and how they have been put into effect within a particular community so that they can help MST therapists and program administrators make the MST program successful.

A second major thrust of mental health services research focuses on service utilization and effectiveness. Utilization research includes epidemiological studies that examine the nature of the population in need of services (i.e., number and demographic characteristics of youth and families, nature of their mental health needs, types of services available and utilized) and the factors (geographic location, cost, reimbursement methodologies) that affect the use of those services. Effectiveness research focuses on which services work in real world conditions, for whom, in which service settings and service sectors, and at what cost. Consultants must be familiar with the variety of family preservation services, therapeutic foster care, individualized or "wrap around" services, respite care, crisis care, family support services, and intensive case management provided to children and families. (Appendix A lists relevant reviews by Burns,

Hoagwood, & Maultsby, 1998; Kutash & Rivera, 1996; Reddy & Pfeiffer, 1997; Schoenwald & Henggeler, 1997). Although these new community-based models of service delivery (e.g., respite, wrap-around, etc.) have proliferated rapidly, research on their effectiveness is sparse, and controlled studies of these services are rare (Jensen, Hoagwood, & Petti, 1996).

In addition, the consultant should have working knowledge of the nature of the differences between treatment efficacy research and mental health service effectiveness research and the gap between research and practice that developed as a result of these differences. Critical discussions of this topic have been written by Kimberly Hoagwood and her colleagues at the National Institute of Mental Health (Hoagwood, Hibbs, Brent, & Jensen, 1995; Jenson et al., 1996), Barbara Burns and colleagues at Duke University (Burns, Hoagwood, & Maultsby, 1998; Burns, 1996), Scott Henggeler and colleagues at Medical University of South Carolina (Henggeler, Schoenwald, & Pickrel, 1995; Schoenwald & Henggeler, in press), and John Weisz and colleagues at the University of California-Los Angeles (Weisz, Donenberg, Han, & Kauneckis, 1995; Weisz, Donenberg, Han, & Weiss, 1995; Weisz, Han, & Valeri, 1997).

Clinical Expertise

To date, MST consultants have had a broad array of clinical experience conducting systemic and ecological interventions with children and families in community based settings such as homes, schools, and community-based clinics. Among the treatment modalities in which clinical experience is helpful are: strategic (Haley, 1975) and structural (Minuchin, 1974) family therapies; behavioral family system therapies (Alexander & Parsons, 1982; Robin & Foster, 1989); parent-child behavior management techniques; marital therapies; cognitive-behavioral interventions for adolescent social problem solving, social skills deficits, and depression; and cognitive-behavioral interventions for depression in adults (Beck, 1995). Experience providing training and structured supervision to clinicians in one or more of these modalities also is highly desirable.

To gain clinical experience with the MST model of treatment, most people who are MST expert consultants have been supervisors in ongoing clinical trials of MST or have carried MST cases of their own under the supervision of Dr. Henggeler or a supervisor trained by him. Field experience conducting MST and providing MST supervision is recommended highly for anyone who eventually will serve as an MST consultant.

Expertise in the Consultation Process

Demonstrated competency at implementing MST does not necessarily guarantee the ability to teach others effectively to develop and execute that competency. MST consultants receive training in the consultation process itself. The training is largely experiential. It involves live observation of consultation, role-played practice of telephone consultation, and expert review of consultation tapes when the novice consultant begins working with teams. The live observation is structured incrementally. The consultant trainee begins by observing seasoned consultants during telephone consultation. Structured pre-consultation briefings are held to orient the trainee to the team members, cases, and objectives that the consultant has for each clinician on the team and for the consultation hour.

Debriefing occurs after each observed consultation, and the consultant trainee has time to ask questions and make observations. Next, the consultant trainee prepares to meet with a seasoned consultant as if it were his/her own consultation and compares his/her assessment of the proposed objectives and possible techniques to meet them with those developed and executed by the seasoned consultant during the consultation hour. As the trainee's assessment of the consultation objectives for a particular team begins to converge with that of the seasoned consultant, role-played practice of the consultation hour begins. The seasoned consultant takes the role of one or more of the clinicians the trainee has heard and the trainee

takes the consultant role. Some trainees need relatively few practice opportunities before in vivo consultation begins, but others require more frequent role-played practice (several times per week) for a more extended time (up to a month).

If the trainee will be inheriting a team previously served by a seasoned consultant, the latter takes the lead in preparing the supervisor, team, and managers of the organization (if needed) for the transition. Similarly, the senior consultant ensures that the trainee is well-versed on how well individual clinicians and the supervisor adhere to the MST treatment principles, use the Do-Loop, and engage in the consultation process. The senior consultant should provide well-organized records of the team's case summaries and consultation recommendations to the consultant taking over the team. Typically, the transition is made by having the seasoned and trainee consultant conduct one or two consultation sessions conjointly before the new consultant takes over the team entirely. When the trainee is the first consultant for a novice team, he/she prepares the team for the consultation process during the orientation training week.

Once in vivo consultation begins, a seasoned consultant reviews the trainee's audiotaped consultation sessions with all teams on a weekly basis. Within two or three months, the seasoned consultant generally reviews just those segments of each tape that the trainee feels were particularly challenging or successful. This process requires that the consultant trainees should be able to review their own tapes and identify the strengths and weaknesses in their performance (self-monitoring expertise). The goal of this targeted review is for assessments done by the consultant trainees and the seasoned consultant to match with respect to the strengths and weaknesses in each taped segment of the trainee's consultation. When convergence is reached consistently (usually, this has occurred within about 6 months), the expert reduces his review of the audiotapes to once a month and the trainee's peers begin to review the audiotapes monthly. During peer-reviewed audiotape sessions, consultants listen to segments of each other's tapes for evidence of consistency of consultation practices across consultants. In addition, the peer consultants identify patterns of consultant behavior that contribute to the success of a particular clinician, supervisor, or team or to the challenges faced by that team.

Teaching MST Through Clinical Consultation

To ensure that consultation is effective, consultants must be able to do several things quickly and with a relatively limited amount of clinical information (hence the relevance of the characteristics of experts enumerated at the beginning of the previous section). Most of the clinical information is derived from clinicians' case summaries and telephone narratives. On the basis of this information and using their expertise, consultants must accomplish the following:

- Identify which tasks on the Do-Loop (Figure 1) clinicians are executing, and evaluate whether the tasks are appropriate and whether the clinician is aware of where she/he should be with respect to the tasks on the Do-Loop.
- Evaluate how well MST principles are being followed and the extent to which the clinician thinks they are being followed.
- Communicate feedback clearly and effectively to clinicians and supervisors.
- Ensure that team members understand and can use consultation feedback.
- Ensure that the supervisor understands and can reinforce consultation recommendations
- Follow up weekly to determine whether recommendations were implemented and the outcomes of those recommendations.
- Detect and label for the team patterns in cases that may be relevant to making progress but that clinicians and supervisors may overlook when they are bogged down in details of the week.
- Evaluate how clinicians are developing with respect to implementing the MST principles and Do-Loop.
- Evaluate how supervisors are developing with respect to implementing the MST supervisory process.
- Identify organizational and systems barriers to the implementation of MST, as needed, and address these with organizational leadership.

In effect, these tasks constitute the consultant's assessment and intervention process, a process directed more toward the behavior of clinicians and supervisors than toward the behavior of youth and families referred to MST programs. Clearly, however, an adequate understanding of the latter is required to help the clinician implement effective interventions and achieve positive outcomes. As with the working relationship between families and clinicians and between clinicians and supervisors, the consultant's assessment and intervention tasks are executed in the context of ongoing engagement.

Engagement of the Team

The consultant begins to develop working relationships with clinicians and supervisors during the initial 5-day orientation training. In most cases, the consultant already has developed a telephone relationship with the organization's supervisor and key management and leadership staff before the orientation train-

ing. This occurs naturally because the consultant coordinates the training arrangements with the organization once the site assessment process is completed. During the orientation week, the consultant begins to form preliminary impressions of the professional experiences and personal strengths of individual clinicians and of their initial receptivity to the theory and principles of MST. The consultant may even begin to develop hypotheses about how the clinicians' experiences may help or hinder the adoption of MST. The variety of didactic, role-play, and group exercise activities provided during the training week provide opportunities to observe clinicians' ways of thinking about the causes of serious problems in youth, (including theoretical orientation), clinical skills, support of other clinicians, and openness to recommendations from peers and the consultant.

Similarly, clinicians form preliminary impressions of MST and of the consultant(s) who provide training. At the very least, the consultant should demonstrate mastery of the materials presented during each module of the orientation week. In addition, the consultant should begin to demonstrate his/her potential value to clinicians in several ways during that week. The formation of this perception is critical because most clinicians are professionals who have not previously been required to participate in continuous supervision, much less in consultation with an "expert" who is not a member of the organization. Thus, the consultant must demonstrate to the clinician the value not only of MST, but also of him/her self. Clinicians begin to perceive the value of the consultant when they receive quick responses to questions about their examples and see how the consultant incorporates such examples in the didactic portions of training. The consultant also should be able to address questions about similarities and differences between MST and the theories, clinical practices, and models of service delivery familiar to the clinicians. The consultant should build upon the similarities between extant practices and MST wherever possible. Consultants should reinforce questions or comments and behaviors (e.g., in role-plays, group exercises) that are consistent with MST and provide clear rationale when they disagree with an audience member's comment or question.

Finally, the consultant's abilities as an effective teacher contributes to how the audience perceives his/her value. Consultants should provide clear structure and expectations for the training week and for each module presented. They should identify objectives for each learning experience, provide a variety of medium for learning (didactic, role-plays, group exercises involving clinician cases), and be open to feedback about the effectiveness of presentation or other learning exercise (e.g., role-play, group exercise). In addition, consultants must manage group interactions and dynamics effectively, show genuine interest and enthusiasm for MST, and display a high level of interest and enthusiasm toward teaching seasoned professionals to implement the treatment model effectively.

The Orientation Training week introduces the structure and process of clinical supervision and the protocol for weekly telephone consultation. Consultants generally establish the regular consultation time with each team by the end of that week. In addition, the consultant reviews the structure and process of MST supervision and of weekly consultation with supervisors during the orientation training week. From the first telephone consultation, the consultant strives to maximize the value of the consultation hour for the team. Ultimately, the value of consultation lies in its ability to enable clinicians and supervisors to achieve positive outcomes. On a weekly basis, however, clinicians generally feel that consultation is valuable when the consultant quickly identifies dilemmas they are trying to resolve, articulates these dilemmas in a way that rings true for them, and provides feedback that moves case conceptualization and intervention plans ahead. The consultant may note, for example, that the clinician seems to be frustrated with a grandfather's lack of follow-through when, in fact, there is some evidence that the grandfather is not yet "on board" with the notion of treatment. Similarly, clinicians find it helpful when a consultant verifies that their conceptualizations of a problem and the interventions that they have attempted are consistent with the principles of MST. Thus, the consultant is quick to praise and reinforce the clinician who can articulate the "fit" of the grandfather's lack of follow-through in terms of several observable barriers, including engagement. Value is increased when the consultant helps clinicians and supervisors develop the compe-

tencies necessary to implement MST throughout the week between consultation calls. Consultation strategies for addressing case-specific, clinician-specific, and supervisory issues are presented in the following sections.

As noted earlier, expertise in the substance of MST alone does not necessarily make for effective consultation. To find a consultant's expertise valuable, clinicians need to feel that MST is helpful to them and the clients they serve. Clinicians also need to believe that the consultant respects and values their previous experience and understands the context in which they work. Thus, MST consultants should learn something about each clinicians background before and during the orientation training, throughout the first quarters of MST consultation, and during booster training sessions. In addition, consultants use a variety of Socratic and didactic methods during consultation, thus balancing the provision of direct recommendations and short (2-5 minute) teaching points with opportunities for clinicians to come to their own MST-like answers to questions. Consultants behave as professionals and engage others as professionals. Such a stance does not preclude the use of liberal doses of humor, encouragement, and even judicious admonishment that is tailored to the preferences of individuals and teams.

Barriers to Team Engagement and Strategies to Overcome Them

Occasionally, despite the consultant's persistent and creative efforts of a consultant to engage a team in the process of learning and implementing MST, some clinicians show low responsivity to consultant recommendations and requests, little evidence of change in their behavior, and slow progress with their cases. Possible reasons for a team's failure to engage with the consultant include organizational factors, supervisory factors, clinician factors, and consultant factors. At the level of the organization, concrete resources necessary to make effective use of consultation include the availability of a fax machine, and time for preparing case summaries and attending weekly telephone consultation. In addition, as described in the organizational manual (Strother et al., 1998), personnel policies and procedures pertaining to flexible working hours, compensation, and personal time must be configured to support the 24-hour, 7-day availability of MST clinicians. Also, caseload, criteria for referral and termination, and the ability of the clinicians and supervisor to take the clinical lead on cases must be negotiated with referral and reimbursement agencies before establishing the MST program. If a consultant perceives that the provider organization or inter-agency practices are interfering with the clinician's efforts to implement MST, then he/she should speak with the clinical supervisor and other key players in the organization about this perception. The consultant also should be ready to develop strategies that help the supervisor and organizational leadership address these barriers. Generally speaking, such strategies are discussed by telephone, documented for the provider organization in a summary prepared by the consultant, and re-evaluated by the consultant, supervisor, and organization administrator at a mutually agreed upon date.

The behavior of the team's supervisor may influence how clinicians engage in consultation. New supervisors sometimes do not model MST practices or reinforce consultant recommendations simply because they lack the knowledge and experience to do so. A supervisor who is new to an ecological and multi-determined approach to case conceptualization may continue to talk about the causes of referral problems in terms of a single factor or historic terms. A supervisor with significant case management experience may suggest that a therapist refer a depressed parent for individual treatment, whereas the consultant would recommend that the MST therapist implement cognitive-behavioral interventions and collaborate with the parent and a psychiatrist to determine whether medication is necessary or desired. When the consultant suspects that a supervisor simply lacks the knowledge or skill to model MST practices, the consultant should establish regularly scheduled telephone appointments with the supervisor to provide coaching in accordance with the supervisory manual. In addition, consultants may offer to review audio tapes of group supervision to gain firsthand knowledge of the supervisor's strengths and struggles and provide corrective feedback accordingly. Some supervisors fail to help clinicians use consultation effectively because they are wedded to theories of intervention that are inconsistent with MST. Other supervi-

sors have begun to adopt MST themselves, but have not yet learned to provide the type of leadership and management that encourages clinicians to do so. Alternatively, lack of supervisor engagement in consultation may reflect problems in the supervisory process itself. Common barriers to effective supervision and strategies to overcome them are described in the supervisory manual (see in particular Sections I and VI).

When consultants suspect that a supervisor is not engaged in the consultation process, they should contact the supervisor. The objective of the contact is to describe the consultant's perceptions of the lack of engagement and evidence supporting them, obtain the supervisor's perspective, identify the "fit" of lack of engagement, and conjointly design solutions to increase engagement. For example, the consultant may note, "I asked for this time to talk because your comments during the consultation seem to suggest that you don't agree with the recommendations I'm making." The consultant should be prepared to provide evidence to support this statement, citing specific examples from telephone consultations. The consultant then invites discussion regarding possible factors explaining the "fit" of the disagreements. A supervisor may be having difficulty reconciling his/her previously held theoretical orientations with MST, or he/she may not understand the rationale underlying consultation recommendations (see subsequent section on effective communication of consultant feedback). On the other hand, the supervisor may be struggling to master the management and leadership aspects of her/his position, and having difficulty attending to the substance of MST. Strategies to help supervisors with these difficulties appear in the MST supervision manual (Henggeler & Schoenwald, 1998). Similarly, clinician factors that hamper the effectiveness of supervision (e.g., theoretical orientation, failure to see role in team, lack of skills, etc.; see Henggeler & Schoenwald, 1998) also may result in poor use of consultation. Consultants should obtain the supervisor's understanding of the "fit" of a clinician's lack of engagement in consultation and work with the supervisor to design supervisory and consultation strategies to enhance active engagement in consultation.

Finally, the consultant's behavior may contribute to a team's lack of engagement in consultation. First, consultants must possess adequate expertise in MST to help the team adhere to MST principles and improve progress toward positive case outcomes. And, as noted earlier, the consultant should convey respect and collegiality, make consultation enjoyable, and be able to balance Socratic and didactic methods to create teachable moments whose impact can be generalized across cases and clinicians. Our experience to date suggests that consultants who lack one or more of the following are perceived as unhelpful by teams and may not be effective:

- Adequate knowledge base and experience related to MST
- Management skills needed to make most productive use of the consultation hour
- Ability to balance assertive leadership with openness to team suggestions
- Flexibility to tailor teaching techniques to a particular clinician's strengths and weaknesses

The development of the knowledge base and clinical experience relevant to MST was described previously. The following sections describe three broad competencies that seem to help consultants apply their substantive expertise in MST in ways that facilitate clinician and supervisor implementation of MST. These broad competencies are: pattern detection, effective communication of feedback, and assuring that clinicians understand and can implement the feedback.

Skills Central to the Consultation Process

Pattern Detection

Consultants must be familiar enough with the details of cases to be able to detect the patterns of behavior among key players in the youth's ecology that are most salient to MST case conceptualization and intervention. For the consultant, this information is embedded in the weekly narrative and written accounts

that clinicians and supervisors provide. As well, the consultants' extensive experience with MST cases (consultants are responsible for 100-140 cases at a time) and expertise in the etiology and treatment of complex problems in youth enable them to make hypotheses about what may be relevant to a particular case. Importantly, consultants must be able to detect patterns of behavior in therapists and supervisors that support or detract from MST adherence and from progress toward outcomes. Consultants must be able to develop recommendations to support adherence at the case, clinician, supervisor, and team level, and to detect organizational and systemic factors that may detract from the successful implementation of MST.

At the case level, the consultant begins with a conceptualization of the "fit" of referral problems and the strengths and needs in each system in the youth's ecology that the clinician describes on consultation forms and during telephone sessions. On the basis of experience with MST cases, however, consultants often can extend a team's case conceptualization beyond the information that becomes apparent to clinicians on a piecemeal basis (i.e., after each contact with family, teachers, peers, etc.). When clinicians report interactions as if they were discrete and unrelated events, consultants, by virtue of their expertise with MST, can help clinicians to see patterns of interaction relevant to an engagement problem, referral problem, or barrier to intervention's success. For any given case, the consultant is able to build, from the pieces of information provided by the clinician and team, a puzzle that incorporates important details about the youth's ecology from information that the team and clinician provide. In contrast with the clinicians, however, the consultant often is able to build the puzzle more quickly because she/he can compare almost automatically the details with similar cases, MST principles, and their knowledge of research on the problem. Although each case is unique in some ways, the consultant's "deeper understanding" (Glaser & Chi, 1988) of MST and of youth and families with complex problems enables her/him to conceptualize the fit of treatment advances and barriers rapidly and comprehensively. In addition, consultants track intervention success, failure, and partial success and help teams to identify patterns in their approaches to intervention that are more or less effective with particular families. Such a perspective is sometimes difficult for clinicians to retain when they are focused on implementing interventions and managing the sequel of unsuccessful interventions.

At the level of the clinician, the consultant assesses the clinician's strengths and weaknesses with respect to the application of all nine MST treatment principles and with respect to his/her ability to "think through" the treatment process depicted on the Do-Loop. The consultant also teaches the new MST supervisor how to assess whether a clinician has mastered the MST assessment and intervention process (Do-Loop) and whether the clinician's interventions conform to MST treatment principles. Such coaching generally occurs in the context of separate telephone contacts, and it may include the development of written materials to assist a particular supervisor in tracking clinician progress with respect to adherence to the treatment principles and implementation of the steps in the Do-Loop. This topic is discussed further in Section IV of this document. Also described in that section are supervisor training strategies implemented by MST consultants.

During the consultation hour, the consultant also listens to see if the questions and recommendations that the **supervisor** raises are consistent with MST. Does the supervisor suggest that clinicians re-examine the "fit" of presenting problems when only one fit factor is identified? Can the supervisor provide concrete tips for increasing engagement when the consultant observes that engagement seems to be a problem in a given case? To what extent does the supervisor agree or disagree when a consultant provides evidence that a clinician continues to try various interventions without assessing the barriers to intervention success? During periodic, scheduled telephone contact with the supervisor, the consultant discusses how group supervision is progressing and whether any challenges to the implementation of MST supervision practices (see Henggeler & Schoenwald, 1998) exist. In addition, the consultant may suspect, on the basis of the case summaries provided by clinician and team interaction on the phone, that the supervisor is having difficulty implementing MST. The consultant collaborates with the supervisor to develop a plan to change

and monitor supervision. This plan may include periodic review of audiotaped group supervision sessions by the consultant, development of specific supervisory objectives to be met within a certain time frame, and more frequent individual consultation with the supervisor.

Effective Communication of Feedback

The consultant's ability to communicate clearly and effectively with clinical teams can be facilitated using several strategies. One general strategy used throughout the telephone hour is that of verbally labeling consultant behavior. The consultant's ability to label what she/he is doing in the context of a particular interaction is important for several reasons. First, labeling helps prepare clinicians to listen for a particular line of inquiry or recommendation, thereby increasing the likelihood that the inquiry will be productive or that the recommendation will be heard and understood. Second, labeling can serve as a proxy for the types of nonverbal behavior and visual cues that might otherwise signal that the consultant is about to speak to a particular point on a clinician's case. That is, if the consultant and team could see each other, the consultant could point to a fit circle on the case summary, signal that she/he is about to speak, and so on. Without this visual contact, the consultant verbalizes the intent to address a particular point. Third, given the complexity of cases referred for MST and the number of cases discussed in a given consultation hour, team members often perceive each detail of a case as equally important. The consultant, on the other hand, often has identified key patterns in family or clinician behavior as salient to developing an adequate case conceptualization or prioritizing intervention strategies. The onus is on the consultant to "make room" in the clinician's telephone narrative to address the more critical points. When the consultant does not label his/her intention to do so, clinicians often fail to understand why the consultant is focusing on a particular point, experience the consultant's focus as arbitrary and therefore disregard it, or understand the point but disagree that it is of particular importance. Fourth, labeling may enhance clinician and supervisor learning and generalization of the MST principles and analytical process. By announcing why the consultant is focusing on a particular point, she/he is modeling the process of moving from diffuse or marginally organized thinking about case events to more focused case conceptualization or intervention. Thus, a consultant should routinely:

- Identify the specific aspects of team members' telephone narrative or case summaries that prompt a particular recommendation
- Explain briefly the rationale for focusing on a particular point, using MST principles, the analytic process (Do-Loop), and relevant information from this and other cases
- Ascertain whether the team can see the value of the point and use it

For example, when a clinician describes a variety of encounters with a stepfather and is unaware that the description could signal an engagement problem, the consultant may say, "I'd like to stop you for a minute to discuss these meetings with the stepdad because it sounds like there may be problems with engagement." Or, after hearing a few minutes of narrative about a parent-child intervention that was designed to decrease conflict but appears to be failing, the consultant may say, "From your description of the interactions between Dad and Keith, I think we need to revisit the fit of the conflict." With new teams in particular, clinicians tend to describe all details about cases as if they are equally important and often do so in ways that reflect numerous violations of MST principles. Thus, it is often necessary to actively manage clinicians and periodically interrupt them. To do so respectfully, it is helpful to label the consultant-clinician interaction rather than simply jumping in with recommendations. In our experience, recommendations provided in the absence of a ready listener are rarely implemented. Thus, the consultant may say to a clinician, "Terry, I'd like to interrupt your description of last night's family fight because I think it is just another example of a pattern of family conflict we had previously identified, and we need to get to intervention strategies to reduce that conflict quickly. Can you shift gears with me for a minute?"

When labeling the rationale for specific recommendations, consultants should be able to refer to one or more of the MST principles and/or to a task on the Do-Loop. Thus, a consultant may say, "I hear that you're implementing parent-child behavior management interventions without having really engaged mom or understanding clearly the multiple factors that contribute to her lax parenting, so I think we should spend a few minutes right now going back to engagement and fit." The consultant also frames feedback in terms of a specific MST principle:

> It sounds like you've done a good job engaging grandmother because she now pages you to ask for help, but as long as she needs you at the house when she's getting ready to enforce a consequence, we haven't done what it takes to change the ecology to support change after you're gone. So the next step is to figure out what it will take to enable her to effectively enforce the consequence when you aren't there. Remember, Principle 9–interventions should be designed to generalize and maintain treatment gains over time.

A second strategy that enhances the effectiveness of consultant communication is to understand the "fit" of clinician behavior before recommending alternative courses of action. The shorthand for this strategy is "ask, then tell." A consultant may ask, for example, "What prompted you to focus on the relationship with Monica's boyfriend?" before suggesting that the focus be redirected. Consultant inquiry about the rationale for a clinician's behavior accomplishes several purposes. First, the inquiry conveys respect for the clinician's efforts. Mutual respect between the clinician and consultant is needed for clinicians to remain open to the consultant's feedback. Second, from the responses the consultant learns the extent to which clinician case conceptualization and intervention skills are developing along MST. In particular, responses suggest specific tasks on the Do-Loop, specific MST principles, or present particular challenges for the clinician. Third, the consultant reduces the risk that the clinician is complying without understanding. Such compliance not only hampers the consultant-clinician working relationship, but also impedes the clinician's deeper understanding of MST principles and practices. Finally, upon hearing a clinician's rationale for taking a particular course of action, the consultant may withhold a previously developed recommendation. Although different in detail from the consultant's recommendation, the clinician's decision may be worth pursuing, as long as it is consistent with MST principles and current case priorities. Moreover, as with clinician interventions with families, if a strategy is designed by the person who must implement it (in this case, the clinician), generalization is more likely to occur.

A corollary of the "ask, then tell" strategy is, "Tell why you're asking." The consultant should ensure that the team understands the rationale for his/her pursuit of a line of questioning. Cues that the team may not be following the logic of consultant questions include: other team members guessing at answers; the supervisor repeatedly restating the question for the clinician; and, most obviously, the clinician indicating that she/her does not understand the question. For example, in one case a clinician seemed to link a mother's new relationship with a boyfriend to the recent school suspension of the referred youth. Initially, the consultant began to ask questions about the new relationship, then switched to asking about the sequence of events leading up to the suspension. The clinician answered, but with little indication that she understood how these answers would help her move forward. Instead of asking about the details of a mother's relationship with her boyfriend or the events that led up to the son's school suspension, the consultant might have said, "I'm unclear about the connection between the mother's relationship with the boyfriend and Stan's school suspensions. Can you describe the connection for me?" If the clinician is unable to do so, the consultant may indicate that she/he is going to ask some clarifying questions to help the team better understand what, if any connection, exists between the new relationship and the referral behavior.

A third strategy to enhance consultant communication is the balancing of Socratic methods of consultation with more directive or didactic teaching. Socratic methods involve asking clinicians questions that enable them to come to their own conclusions. Such questioning requires that the consultant already has identified: (a) a particular point he/she thinks the clinician should be aware and has good rationale for

focusing on this point; and, (b) evidence that the clinician has been able to successfully engage in such a guided discovery process on the phone. This type of questioning is distinguished from questions the consultant asks simply to gain information that he/she needs to help a team think about assessment or intervention strategies (i.e., "How often do these blow-ups occur?"; or, "Which problem was the mother-daughter mall trip supposed to address?"). Socratic methods are valuable because teachers are more likely to internalize the teaching points when they have gone through the process of deriving their own answers. The potential problem with relying primarily on Socratic methods is that learners must possess a certain level of awareness and competency in the subject matter to make effective use of the questioning process. A novice to physics, for example, cannot rely on Socratic methods to learn that subject because he/she has no knowledge or experience from which to draw possible answers. Similarly, when clinicians are accustomed to thinking about youth behavior problems in terms of theoretical orientations inconsistent with MST (e.g., psychodynamic, Bowenian family therapy, 12-step programs for substance abuse), they are likely to generate answers to consultant questions that reflect their past experience, rather than the principles of MST. Consultants should balance the use of Socratic and didactic methods during the consultation hour on the basis of each clinician's demonstrated ability with MST.

To maximize the efficiency and value of the consultation hour to the team (and the families it serves), the consultant should judiciously monitor the time and effort required (on behalf of both consultant and clinician) to lead a clinician to his or her own answers through questioning. Sometimes, consultants try a variety of questions with the intention of leading the clinician to an MST-like answer about some aspect of a case. Feedback from clinicians suggests that this type of questioning process can be seen as a hunting expedition: The clinicians sense that the consultant is hunting for a particular answer, but they don't know what the answer is, even after several interchanges. Such hunting expeditions often are frustrating to the team. If a clinician has been unable to respond to the consultant's efforts to uncover answers consistent with MST for him/herself after two or three interchanges, the consultant tells the clinician the point that he/she is trying to make, assures that the clinician understands it, and moves on.

Ensuring Reception of Feedback

Ensuring that clinicians and supervisors have understood and can apply the recommendations of the consultant is a third obligation of MST consultants. To this end, consultants often ask clinicians to summarize briefly the major points they think the consultant has made. In addition, consultants ask what clinicians will do with a case as a result of a particular recommendation, sometimes including the steps they will take in the next week. Consultants also elicit supervisor support for specific recommendations during the consultation hour. The consultant may suggest that the supervisor and clinician get together after consultation to map out the details of an intervention strategy broadly outlined by the consultant: After recommending for the second week that a clinician named Terry should expand her focus beyond parent-child interactions to include marital issues, a consultant suggested, "Sarah, could you get together with Terry to go over the approach to the first marital session?" The consultant would then check with Sarah (the supervisor) about Terry's progress with implementing marital interventions. This follow up would be done during regularly scheduled (generally bi-monthly or monthly once supervisors are experienced in MST) supervisory consultation.

In addition, consultants monitor the extent to which their own preparation, in-session behavior, and follow-up strategies incorporate techniques to ensure that they and supervisors understand their recommendations. This process is described in further detail in the next section. To monitor their own abilities at pattern detection, effective communication, and ensuring reception of feedback, consultants record weekly recommendations made for each case and the extent to which the recommendations were followed by team members during the subsequent week (as described below). Consultation with a senior consultant (using audiotapes of consultation sessions, described earlier) provides opportunities to receive corrective

feedback regarding the consultation process. Finally, clinicians and supervisors provide consultants with feedback regarding the extent to which consultation is perceived as helpful in the achievement of case outcomes. Such feedback typically occurs informally, during or after a particularly helpful or difficult consultation hour. Supervisors also inform consultants of the team's perceptions of the strengths and weaknesses of consultation during regularly scheduled consultant-supervisor telephone meetings.

The Structure And Process Of Weekly MST Consultation

Preparing for Consultation

Review of Case Summaries

As mentioned earlier, the consultant describes the purpose and structure of weekly telephone consultation to clinicians and supervisors during the initial Orientation Training. Following the instructions given during that week, the consultant should receive weekly summaries for each case 24 to 48 hours prior to consultation. For new cases, consultants receive the Initial Contact Sheet (see Figure 2), which contains information about the reasons for referral, a genogram, and the desired outcomes of the family, referral agency, and other key stakeholders. The clinician assessment of strengths and needs in each system of the youth's ecology is part of this summary. As clinicians gain new information about strengths and weaknesses in each system, the consultant updates her/his copy of the Strengths/Needs Form. During each subsequent week, the consultant receives weekly case summaries (see Figure 3). The consultant reviews each summary, noting case-specific questions and recommendations prior to the consultation hour. In addition, clinician-specific objectives (see below) may be noted on these summaries. The consultant files summaries for each active case separately. When clinician progress with a particular case seems slow or intermittent, the consultant should review all or most of the accumulated summaries for that case (including consultation recommendations and outcomes of those recommendations) to help detect trends that might account for the unsatisfactory progress.

In addition, consultants often recommend that clinicians develop and fax "fit circles" to track their assessment of factors sustaining one or more referral problems or barriers to change. The center of the circle contains the identified target behavior (e.g., marital conflict, maternal inconsistency with rules and consequences, youth aggression with peers), and all factors thought (on the basis of evidence observed by and/or reported to the clinician) to contribute to that behavior are depicted on arrows pointing to the circle. Often, several circles identifying related but not identical problems are drawn on a single page so that clinicians can see whether a particular factor (e.g., parent's long work hours, contentious teacher-parent link) contribute to several problems. Consultants often draw such circles while reviewing case summaries in preparation for the consultation hour or listening to clinicians describe case events on the phone. The resulting diagrams are described or faxed, depending upon the team's preference.

Developing Consultation Objectives

Armed with previous weeks' case summary forms, notes about additional information presented by clinicians on the phone, and her/his log of recommendations made for each case, the consultant develops objectives for each consultation hour. Some of these objectives are specific to perceived problems with the fit assessment (i.e., incomplete, focused on individual rather than systemic factors, past rather than present-focused, etc.), intermediary goals (e.g., lack of logical connection with overarching goals, focused on factors that are not primary drivers of a particular problem), intervention strategies (e.g., inconsistent with MST principles, consistent with principles but targeting low-priority problems, incompletely developed or implemented), or barriers to treatment success in a particular case. Generally speaking,

Figure 2

Initial Contact Sheet

Summary of Mental Health, Juvenile Justice, and Placement History

Participant

Youth

Parent Figures

Others

Initial Goals/Desired Outcomes

Participant	Goals
Primary Caregiver	
Secondary Caregiver	
Youth	
Referral Agencies	

Overarching MST Goals

1.

2.

3.

4.

5.

Therapist	Date	Supervisor	Date

Figure 2
Initial Contact Sheet
(Page 2)

Date of Intake: _____ Referral Agency: _____

Reasons for Referral: 1. _____ 2. _____ 3. _____ 4. _____

STRENGTHS	NEEDS/BARRIERS
Family	
School	
Peers	
Individual	
Neighborhood/Community	

Genogram

Figure 3

MST Weekly Case Summary Form

Family: _____ Therapist: _____ Date: _____

Weekly Review

I. Overarching\Primary MST Goals

II. Previous Intermediary Goals Met Partially Not

III. Barriers to Intermediary Goals

IV. Advances in Treatment

V. How has your assessment of the fit changed with new information/interventions?

VI. Goals/Next Steps for the Week

detailed discussion of fit assessments and the many steps required to implement effective intervention strategies for each case occur in the context of on-site group supervision rather than during telephone consultation. Consultation is used to ensure that the assessment and intervention process is occurring as it should and that the supervisor is taking action to assist clinicians to adhere to the principles in case-specific discussions and problem-solving efforts. When the clinicians and supervisor are new to MST, however, consultants often make numerous specific recommendations for each case to ensure that engagement and progress can be achieved quickly. As the supervisor develops the skills to detect case- and clinician-specific problems and to remedy them in accordance with MST principles, consultant recommendations for each case diminish in number and specificity. Case-specific recommendations, however, can be made even with seasoned MST teams. Nevertheless, consultants should not focus in detail on aspects of cases that are being well-managed through the team's supervision process.

The objectives that a consultant develops for each team's hour also are derived from his/her observations of consistencies in clinician performance across cases. Within the first 3 months of consultation, differences in clinician development with respect to applying the MST principles and using the analytical process become apparent. Thus, consultation objectives often address patterns of clinician behavior that appear in several cases. When such patterns are apparent, the consultant:

- Describes the behavior that she/he sees in those cases to the clinician
- Gets the clinician's perspective on the evidence of the pattern of behavior presented by the consultant
- Makes recommendations about what the clinician should do differently and why
- Applies the recommendation to one or two cases on the phone
- Asks the clinician to apply the recommendation to the remaining cases before the next consultation session

In addition, the consultant may suggest that the clinician consult with the team and/or supervisor in applying the recommendations from week to week. During subsequent weeks, the consultant follows up to ensure that the recommendations are being implemented.

Take, for example, a team of four clinicians and a half-time supervisor that has participated in consultation for 4 months. Like many teams, two of the clinicians seem to be progressing well in their understanding of MST, one (James) has problems applying one or more MST principles, and one (Sara) has made little progress with her cases. The consultant notices that James continues to understand the "fit" of referral problems and treatment barriers in characterological (i.e., "the mother is dependent," "the youth has anger built up inside") or historical ("he was abused as a child") terms. In previous consultation sessions, the consultant has noted, "James, you've listed 'dependent' as the only fit factor for Ms. Smith's permissive parenting style. Let's take a minute right now to identify all the factors that might contribute to Ms. Smith's inability to follow through with consequences." However, this "single factor explanation" pattern continued to appear across several of James' cases over time. Thus, the consultant developed an objective for consultation with James that read, "Expand conceptualization of fit across all cases." Given such an objective, a typical consultant-clinician interaction would sound something like this:

> "James, this is the third week your case summary indicates that the only barrier to dad's contacting the school is his pride. Given everything else we know about this case, I suspect there are at least two or three other factors, including dad's work schedule, the conflicts he's had with the principal before, and the fact that Toby (his son) is actually attending school for the first time in months, so meeting with the school may not seem urgent. There may be others. I've also noticed you've listed single factors as barriers to change in your other cases pretty consistently (consultant gives examples). Do you understand what I'm saying? (Consultant gets clinician's feedback).

> My objective is to help you to expand your conceptualization of barriers so that they are more consistent with MST no matter which case we're talking about. For starters, let's try the Smith case for a few minutes. Then, please work with the team on the Jones and Williams case before the next consultation session."

Sara, on the other hand, seems to be experiencing more pervasive difficulties with implementing MST. She has made little progress toward outcomes in any of her cases and attributes this lack of progress to a variety of "crises" in each case that require her attention. Such crises include family conflicts that end in verbal threats of violence, as well as more concrete circumstances such as the death of a relative in another town, changes in the employment of a parent figure or the delivery of an eviction notice. In periodic telephone discussions with the supervisor, the consultant confirmed that Sara seems to have an inordinate number of "crises" on her hands and that a disproportionate amount of group supervision time is spent problem-solving these crises. In addition, Sara seeks individual supervision far more frequently than other team members. The supervisor acknowledged that the situations seem important at the time and that he hadn't noticed the pattern identified by the consultant. With the supervisor's agreement, the consultant developed a consultation objective that read: "Keep Sara focused on treatment goals and reduce effort expended on 'crises.'" During telephone consultation, the consultant interrupted when Sally began to describe the latest "crisis" in a family, and said:

> "Sara, I've been noticing how frequently unexpected events sidetrack you and this family from the intermediary goals you've established together, and that we are no closer to the ultimate outcomes for this case even though we've worked with the family for 9 weeks. As I looked through the case summaries for your other families, I'm noticing the same pattern–for one or two weeks, some incremental progress toward one or more goals is made, and then an unexpected event takes the attention of you and the family away from these goals. Does this perception of mine seem accurate to you?"

If the clinician understands the point, (it might take one or two additional case examples from the consultant) the consultant may ask. "Let's take a minute now to discuss how this sidetracking pattern makes sense to you. If it takes more than a few minutes, please work with the team this week to identify fit factors. I'll check back with you next week about this."

Effective Use of the Consultation Hour

Effective use of the consultation hour is a responsibility shared by the supervisor and the consultant, although the consultant has the responsibility of managing the time properly. Team members are asked to prioritize their cases prior to the consultation hour, and it is the supervisor's responsibility to ensure that this occurs. When teams have difficulty doing so, the consultant describes the criteria for prioritization (i.e., cases going well need not be discussed, cases with imminent crises take priority, cases experiencing some mix of progress and difficulty are discussed next), and may help the team to prioritize during the consultation hour. If this help is still needed after several weeks, the consultant should contact the supervisor to coach her/him in helping the team prioritize their cases before the consultation. Failure to do so may indicate that prioritization is not occurring during group supervision either. If this is the case, strategies to monitor the team's supervision sessions are established by the consultant. These strategies are described in the next section.

The consultant should be able to meet the limited number of objectives that she/he had developed for each consultation, alter them if needed, and manage clinician narrative effectively. The strategies for effective communication described earlier (e.g., labeling purpose of interruption, asking then telling, labeling one's own behavior, providing rationale for recommendations, etc.) are all useful interaction management tools. When clinicians persist in providing unnecessary details (i.e., information not needed by the consultant to

help the clinician understand "fit" or develop effective intervention strategies), the consultant respectfully conveys this message. The particular style of message delivery varies in accordance with the consultant and quality of consultant-clinician relationship. One consultant may be able to effectively interrupt by asking, "Why are you telling me this?" Another may ask permission to interrupt and then point out that the new information being conveyed is not germane to case conceptualization or intervention development. If the tendency to describe details persists over time, thus limiting the productivity of the consultation hour for other members of the team, the consultant contacts the supervisor. The consultant obtains information about the pervasiveness of the excessive narrative in team and supervision interactions and the extent to which the clinician's narrative seems to help her/him understand and respond to case developments. The consultant also ascertains what, if any, strategies the supervisor has implemented to change the pattern and develops strategies to manage narrative that the supervisor and consultant can mutually reinforce.

Follow-Up

Consultants track clinician attendance at supervision, cases discussed, and recommendations made during each consultation. All consultants make case-specific recommendations on the case summary form. Although a formal notation system has not been required to date, such a system is being developed. Because consultants serve a dozen or more teams simultaneously, they keep a 1-to-2 page chart of all active cases on a team, grouped by clinician. Such a chart provides information quickly about consultation dates, progress or barriers discussed, and the theme of consultant recommendations. Consultants use a combination of summary charts and recommendations listed on previous case summaries to follow up on clinician response to previous recommendations. The consultant lists the outcomes of recommendations if clinicians have not been done so on subsequent case summary forms. When recommendations are not followed, the consultant ascertains why and either concurs, reissues, or revises the recommendation, depending upon the evidence regarding progress in the case.

Duration and Frequency of Consultation

As with group supervision, the purpose of the small group format for consultation is to create opportunities for team members to learn from one another's cases and from the recommendations made by the consultant regarding those cases, increase the resources available (more individuals present) for problem solving, and provide support for one another that is consistent with both supervisory and consultation recommendations. Each team of 3 or 4 clinicians and the on-site supervisor receive consultation on a weekly basis. Consultation is scheduled for an hour for teams of this size. All team members should attend each consultation session; barring illness or scheduled vacation. On occasion, a mandatory case-related appointment, such as a court appearance, may interfere with clinician or supervisor attendance for the consultation. However, clinicians should not schedule meetings with probation officers, social service staff, teachers, and families during consultation time. The supervisor and team are responsible for calling the consultant on schedule and remaining available for the full consultation hour. If one or more team members frequently is late, leaves early, or is absent, the consultant initiates contact with the supervisor to discuss the source of the problem and develops strategies to ensure regular and punctual attendance.

As described in the next section, consultants talk with supervisors regularly outside of the group consultation hour. If particularly challenging developments arise with a case, a supervisor may request a brief consultation for one or more team members between regularly scheduled consultations. Such ad hoc consultation tends to occur more frequently when a team is new to MST. If requests for such consultation continue as the team becomes more seasoned, the consultant should examine the "fit" of the requests. Do the requests indicate that the regularly scheduled consultation hour is not meeting the needs of the team? Does the supervisor lack the knowledge, expertise, or management skills to handle the issues requiring ad

hoc consultation? Assessment of the factors leading to requests for additional consultation is a collaborative process that involves consultant, supervisor, and clinicians.

When MST programs first open, clinicians typically have a caseload of one or two families for several weeks, until referrals to the new program begin to increase. Consultants can spend more time talking through engagement, assessment, and intervention strategies during these early weeks of program operation. As a clinician's caseload increases, the consultant restructures how much detail is covered in consultation so that team members can address the major areas of concern in each case. Increasingly, the responsibility for managing the consultation hour is shared with the supervisor and clinicians as the team gains more experience with MST cases, MST on-site supervision, and the role of consultation.

Training Of MST Supervisors

Establishing Consultant-Supervisor Collaboration

Supervisor Orientation

As mentioned previously, the training of MST supervisors begins during the Orientation Training, when consultants meet for at least one evening with supervisors. In some instances, consultants are invited to assist program administrators in hiring therapists and supervisors for the MST team, and thus they may have some preliminary knowledge about the clinical, conceptual, and management skills of the supervisor before the orientation training. In the future, consultants will be promoted (in accordance with performance- and outcomes- based criteria) from the position of MST supervisor within an organization. Under such circumstances, the consultant may be quite familiar with the strengths and needs of fellow supervisors and therapists. The internal promotion process also presents challenges to the newly appointed consultant and remaining supervisors. Among the challenges to the consultant are retaining collegial relationships while evolving into a hierarchically unequal position, decreasing case-specific involvement from the level required of supervisors to that required by consultants, and filling in any gaps in the knowledge and experience base needed to serve as the primary training resource for the team. Internally promoted consultants are paired with a senior, seasoned consultant to help them manage the transition from supervisor to consultant. Supervisors and therapists who were formerly equals with the newly promoted consultant also need to adapt to their colleague's new role. Some individuals may experience negative feelings about the person who was promoted or about the organization, for example. Program managers, consultants, and supervisors must manage the intricacies of such circumstances collaboratively in a way that facilitates a continued sense of camaraderie and common purpose (outcomes for youth and families).

The consultant is intimately familiar with the content of each section of the supervisory manual (Henggeler & Schoenwald, 1998), which lays out the procedural and substantive aspects of MST supervision, barriers to effective supervision, and strategies for overcoming those barriers. This manual is provided to supervisors before the orientation training. The supervisor orientation meeting led by the consultant that has several objectives relevant to the consultation process. These are to:

- Establish the groundwork for a close collaborative working relationship with the supervisors.
- Gain familiarity with the supervisors' professional experiences related to clinical supervision.
- Assess the similarities and differences between these experiences and MST supervisory practices, and begin a dialogue about these similarities and differences.
- Begin to identify potential strengths and weaknesses with respect to each individual's knowledge base, clinical experience, and leadership capacity as they relate to the role of MST supervisor.
- Assess level of "buy in" to the MST model or other ecological orientations to clinical work.

- Discuss and clarify the objectives of MST supervision (Henggeler et al., 1998, Henggeler & Schoenwald, 1998).
- Discuss the assumptions underlying MST supervision (Henggeler et al., 1998, Henggeler & Schoenwald, 1998).
- Identify the similarities and differences between MST supervision and consultation and clarify the role of the supervisor has in preparing the team for consultation.
- Answer questions about the MST supervisory manual (Henggeler & Schoenwald, 1998).
- Orient supervisors to the forms used in supervision and consultation (e.g., Initial Contact Sheet, Weekly Case Summaries) and their relationship to the ongoing assessment and intervention process (Do Loop).
- Provide concrete tips for time management, engagement of clinicians in the group supervision process, etc.
- Help supervisors prioritize the many concerns they often have when new to MST, the supervisory role, or both.
- Establish a regularly scheduled time to talk with each supervisor by telephone (generally monthly during the first year of training, though more frequent contact occurs in response as needed).

Delineation of Clinician, Supervision, and Consultation Responsibilities

Clinicians are the direct link with client families and key players in the ecologies of these families. Together, the therapist and caregivers are the primary change agents in the youth's ecology. The therapist and caregiver(s) conduct all assessment, intervention, and inter-agency linkage activities required for each case. Supervisors ensure that all activities are consistent with MST principles and that they follow the MST Analytic Process (Do-Loop). With assistance from the MST consultant, the supervisor also provides on-site training in intervention strategies unfamiliar to clinicians. Supervisors provide the ongoing technical support that clinicians need to be effective change agents that adhere to the MST treatment principles. When teams are new to MST, consultants teach both clinicians and supervisors the competencies needed to implement MST through a combination of training (orientation, boosters) and ongoing telephone consultation. As teams become more experienced and start achieving positive outcomes, consultants provide the technical support that clinicians and supervisors need to ensure that the processes between clinician and client and between supervisor and clinician are consistent with MST principles and efficient. The consultant helps the supervisor, team, and organization to handle any internal or external factors that might threaten the sustainability of an effective MST program.

The details of the supervisor's job are described in the MST supervisory manual. Aspects of that position that compliment the consultation role are listed below.

- Ensure that clinician assessments are truly multisystemic (includes all applicable systems).
- Ensure that the ultimate or overarching goals of treatment ameliorate or greatly reduce referral problems and are measurable.
- Ensure that weekly goals are directly linked with overarching goals.
- Ensure therapist adherence to MST treatment principles in all aspects of assessment and intervention.
- Assist therapists in thinking critically (e.g., gathering evidence to support or refute hypotheses, linking interventions logically to the assessment of fit, etc.).

- Assess and address strengths and weaknesses that clinicians have adhering to the MST principles and executing the steps of the Analytic Process (Do-Loop).
- Ensure documentation meets functional and applicable standards.
- Represent the needs of the team to the MST consultant.
- Represent the needs and resources of the team to the organization and vice versa.

When teams are new to MST, consultants engage in all of these activities except the last one. As teams demonstrate success with families and supervisors improve their supervisory skills, the consultant begins to balance supervisory tasks with consultative ones. Thus, consultants generally:

- Review interventions for consistency with MST principles.
- Facilitate and reinforce MST case conceptualization.
- Review clinician and supervisor activity for clarity of focus and efficiency of effort.
- Assist team to address barriers to engagement and treatment progress.
- Facilitate critical thinking on behalf of clinicians and supervisor: Can the therapist articulate whether and why interventions are or are not working? Can they cite evidence to support hypotheses about the causes of problems and of treatment successes?
- Encourage and reinforce efforts that are consistent with MST and evidence of progress toward outcomes.
- Assess the development of clinicians and supervisors with respect to competence in MST techniques and MST supervision, and assist the supervisor with the development of strategies to enhance such development.
- Help identify systemic (intra- and inter-organizational) factors that may compromise implementation of MST with a particular case, or across cases, and consult with the team and administrative leadership regarding strategies to address these factors.

Ongoing Supervisor Training

Monthly Supervisor Check-in

Supervisors should master the material in the MST treatment manual (Henggeler et al., 1998) and supervisory manual (Henggeler & Schoenwald, 1998), and consultants should be available (on a scheduled basis and during training), to answer any questions about the material presented in these volumes for supervisors. In addition, consultants provide an hour of monthly telephone consultation to supervisors until evidence clearly indicates that such calls are minimally helpful (i.e., all members of the team are getting positive outcomes, supervisor and team behavior during consultation indicates adherence to MST principles, no systems barriers to program sustainability are arising). If things are going smoothly, the monthly call can be brief (10 to 15 minutes) or decreased in frequency. The primary purpose of the monthly consultation is to assist and monitor supervisor development with respect to the substance, structure, and process of supervision. This time also may be used to develop strategies to help a particular clinician to "get on board" with MST or to develop particular competencies. Programmatic or systems barriers to MST implementation also may be discussed during the monthly consultant-supervisor telephone call. During this call, the consultant does several substantive tasks that include facilitating clinician adherence to principles, solving problems to engagement and treatment success, and assessing and enhancing clinician development with respect to implementation of the MST principles and Do-Loop. Structural and procedural questions may arise about issues such as time management, collegiality, and supervi-

sor leadership (Henggeler & Schoenwald, 1998). A variety of strategies have been developed to assist supervisors with these tasks.

Audiotaped Supervision Review

Currently, most supervisors tape one or two supervision sessions each month for the MST consultant to review, although some have provided such a tape for review on a weekly basis. The consultant reviews the tape before a scheduled telephone call with the supervisor. The consultant and supervisor discuss the strengths and weaknesses of the supervisory session, and the consultant makes specific recommendations to be implemented in the next supervisory session. Although the topic of this review is focused more on supervisor-clinician (and team) interaction than on case-specific details, the consultant's behavior during the telephone consultation parallels that reflected in team consultation. The consultant develops objectives for the supervision consultation, obtains the supervisor's perspective on the "fit" of a particular problem in supervision, tries to understand the rationale for a supervisory recommendation or lack of activity that contributed to an unproductive session, and provides a rationale for the recommendations. If it becomes apparent from the monthly audiotaped review and from the behavior of the clinician during weekly phone consultation that the supervisor is having significant difficulties, then weekly audiotaped review and discussion with the consultant is initiated for a time-limited period. When evidence of improved supervisory performance is obtained, the frequency of audiotaped review is reduced.

Booster Training

Booster sessions also are used to support adherence to MST supervisory practices. Typically, several supervisors come together to spend a day with the consultant and focus on audio and/or video-taped supervisory sessions. Each supervisor is required to bring two or three such tapes to the booster. Supervisors are instructed to identify beforehand "brags and drags"–tape segments that illustrate productive and effective supervision process (brags) and particularly challenging aspects of supervision (drags). Feedback about the strengths and weaknesses is provided, and alternative courses of action are role-played. Supervision-related topics of particular interest to the group are identified before the supervision booster, and supervisors are asked to bring some tapes that are relevant to these particular topics. For example, many supervisors struggle to clarify either case- or clinician-specific objectives for each supervision session. To illustrate the struggle and help supervisors develop and meet appropriate objectives, segments of tape are played in which the group must try to identify the supervisor's objectives. The supervisor whose tape is being played does not identify what his/her objectives were. Opinions about the objectives are compared against the supervisor's stated objectives, and additional tape is played so that the group can determine the extent to which the objectives were: (a) important to the supervision session, and (b) met. Then, role-playing exercises are conducted to illustrate effective strategies to meet an agreed-upon objective. Similar exercises are done with respect to other aspects of supervision that many supervisors find challenging, such as managing unproductive storytelling, prioritizing the needs of particular cases and clinicians, or helping a clinician who inconsistently adheres to MST principles.

Finally, a supervisory measure currently under development (Schoenwald, Henggeler, & Edwards, 1998) should facilitate identification of aspects of supervision that are more or less problematic for a particular individual.

Tracking Clinician Development

To help supervisors assess a clinician's development of MST competencies, a variety of tools have been developed. For example, a therapist assessment checklist for supervisors developed by one consultant (Swenson, 1997) appears in Table 1. Several supervisors have reported that the checklist helps them to track therapist development along the key dimensions of adherence to MST principles and facility with

the Do-Loop. Consultants also track clinician strengths and weaknesses over time, and thus can support supervisor assessments of clinician development and collaborate in the development of strategies to enhance competencies in a particular area. As MST programs implement the MST Therapist Adherence Measure (Henggeler & Borduin, 1992), programs will receive periodic feedback regarding clinician adherence to MST principles. Taken together with the outcome data collected by provider organizations, the adherence data will enable supervisors and consultants to identify effective MST therapists.

Table 1

Therapist Assessment

I. Referral Behavior

- Does the therapist gain a clear understanding of all significant referral behaviors, including frequency, intensity, or seriousness, duration (per episode over time), and systems affected? Is this understanding sufficient to set reasonable termination criteria?
- At the point of referral, does the therapist identify all of the key participants of the various systems affected by the referral behaviors?

II. Key Participants & Desired Outcomes

- Does the therapist interview all key participants soon after the referral, as part of the initial assessment process?
- Does the therapist gain an understanding from all key participants of:
  - Behavior described from the participant's perspective?
  - Understanding of how that participant understands or makes sense of the problem behavior (fit)? This would include a listing of potential strengths in each of the child's major systems (individual, family, school, peer, community) that might serve as levers for changing the problem behaviors, and the factors in each of the systems that might support or sustain the problem behaviors (needs or weaknesses)–again, from the perspective of that participant.
  - What that participant thinks needs changing for the behavior to no longer be sustained or supported in the child's ecology?
  - What the participant would have to see early on to know that the treatment is on the right track?
- Does the therapist use these interviews for the purpose of initially engaging of all key participants, explaining the MST treatment process and obtaining initial buy-in?
- Does the therapist effectively overcome barriers to the engagement of key participants?

III. Overarching Goals

- Does the therapist assemble the information from the initial interviews of the key participants and develop overarching goals which include:

A clear statement of the expected change in the problem behavior?

A general statement of measurement methodology (i.e., "as evidenced by ..")?

A statement by which key participants would measure the change and would agree that the goal has been completed? Sometimes this may take the form of two or more key participants agreeing that the behavior is now manageable in the natural ecology, no longer requiring intensive MST intervention (e.g., agreement between parent and teacher that disruptive behavior is no longer preventing school success).

- Does the therapist review all overarching goals with the key participants in order to assure that each participant agrees with and is willing to commit to these goals?

IV. MST Conceptualization of "Fit"

- Does the therapist assemble all systematic strengths and needs/weaknesses gained from records, direct knowledge, and input from key participants into a comprehensive list with emphasis placed on identification of strengths?
- Does the therapist consider all "fit" information obtained from records, direct knowledge, and input from key participants and then use that information to develop a comprehensive fit assessment of each problem behavior?
- Are each of the fit factors supported by reliable, observable, and measurable evidence?

- Are the fit factors stated in such a way that the therapist, team, and supervisor can hypothesize about the relative influence of each factor on the problem behavior and thus prioritize the factors for intermediary goal setting and intervention development?

V. Intermediary Goals

- Does the therapist select one or more factors deemed to have major influence and write intermediary goals focusing on selected factors?
- Are the intermediary goals written in a manner similar to and clearly linked to one or more of the Overarching Goals including:
  - A clear statement of the expected change in the problem behavior?
  - A general statement of measurement methodology (i.e., "as evidenced by ..")?
  - A statement by which key participants would measure the change, and would agree that the goal has been completed?

VI. Intervention Development

- Does the therapist, with input from the team and supervisor (and, where possible, the parents), list all of the steps of interventions that will likely be required to achieve the intermediary goal?
- Does the therapist prioritize the steps of interventions in a sequential manner, noting the steps or interventions that may be accompanied simultaneously?
- Following the prioritized list for the targeted intermediary goal, does the therapist develop logical interventions that meet the criteria of the nine MST Principles?
- Are the interventions clearly specified?
- Does the therapist ensure that all intervention participants are informed and agree to their role in the intervention implementation?
- Does the therapist develop interventions which challenge the status quo, but which employ sufficient systematic strengths that the intervention has a high likelihood of success?

VII. Intervention Implementation

- Does the therapist have the requisite clinical skills, based on training and experience to effectively implement the specified intervention?
- Did the therapist implement all necessary steps to complete the intervention?
- Did the therapist adequately monitor the implementation to assure success?
- In cases where therapist clinical experience may not be sufficient to promote successful interventions (e.g., marital therapy experience) does the therapist request, and does the supervisor and agency have resources to supply, needed expertise in the form of training and/or consultation?

VIII. Assessment of Advances & Barriers to Intervention Effectiveness

- Does the therapist record the achievement of completed steps and interventions toward completion of an intermediary goal weekly in the "Advances" section of the weekly review sheet used for supervision and consultation?
- Does the therapist identify specific barriers that prevented the completion of a step or intervention and list these on the "barriers" section of the weekly review sheet used for supervision and consultation?
- When barriers are identified, does the therapist conduct a thorough assessment of the fit of these barriers, including a self- assessment of the therapist's intervention development?

IX. Reconceptualization of Fit–Updating the Treatment Plan

- Does the therapist update, as needed, the initial "strengths and needs/weaknesses" sheet as new information is obtained?
- Does the therapist compare intervention results with the fit assessment for each problem behavior to ensure that new information supports the current understanding of the fit?

- When new information conflicts with the current understanding of the fit, does the therapist, team and supervisor, revise the fit assessment to incorporate the new information (e.g., parent has relapsed, marital problems more serious than previously thought)?
- Does the therapist review the overall treatment strategy and make adjustments when indicated?

General Assessment

- Can the therapist articulate the treatment plan and strategy clearly and concisely, from a clear MST perspective?
- Does the therapist demonstrate a clear commitment to implementing MST with treatment mode integrity?
- When the therapist questions the appropriateness of using MST interventions (e.g., with a population or problem not validated by MST clinical trails), does the therapist bring these questions to supervision and consultation?
- Does the therapist come to group supervision prepared to review all current MST cases?
- Does the therapist follow through with MST interventions recommended by the team and/or supervisor?
- Does the therapist demonstrate interest in and contribute to the cases presented by other therapists during group supervision?
- Is the therapist knowledgeable enough about the cases of other therapists that he/she would be able to provide coverage without threat to treatment continuity and integrity?

References

Alexander, J. F., & Parsons, B.V. (1982). Functional family therapy: Principles and procedures. Carmel, CA: Brooks/Cole.

Attkisson, C. C., Dresser, K., & Rosenblatt, A. (1995). Service systems for youth with severe emotional disorders: System of care research in California. In L. Bickman & D. Rog (Eds.), Children's mental health services: Research, policy and innovation (pp. 236-280). Beverly Hills, CA: Sage.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Burns, B. J. (1996). What drives outcomes for emotional and behavioral disorders in children and adolescents. In D. M. Steinwachs, L. M. Flynn, G. S. Norquist, & E. A.Skinner (Eds.), Using client outcomes information to improve mental health and substance abuse treatment (pp. 89-102). San Francisco: Jossey-Bass.

Burns, B. J., Hoagwood, K., & Maultsby, L.T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In M. H. Epstein, K. Kutash, & A. J. Duchnowksi, (Eds.), Outcomes for children and youth with emotional and behavioral disorders and their families. Programs and evaluation best practices (pp. 685-708). Austin, TX: Pro-ed.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66, 7-18.

Glaser, R., & Chi, M. T (1988). Overview. In M. T. H. Chi, R. Glaser, & M. J. Farr (Eds.), The nature of expertise (pp. xv-xxix). Hillsdale, NJ: Lawrence Erlbaum Associates.

Glisson, C. & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. Child Abuse and Neglect, 22, 401-421.

Haley, J. (1976). Problem solving therapy. San Francisco: Jossey-Bass.

Henggeler, S. W., & Schoenwald, S. K. (1998). The MST supervisory manual: Promoting quality assurance at the clinical level. Charleston, SC: The MST Institute.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). Multisystemic treatment for antisocial behavior in children and adolescents. New York: Guilford Press.

Henggeler, S. W., Schoenwald, S. K., & Munger, R. L. (1996). Families and therapists achieve clinical outcomes, systems of care mediate the process. Journal of Child and Family Studies, 5, 177-183.

Henggeler, S. W., Schoenwald, S. K., & Pickrel, S. G. (1995). Multisystemic therapy: Bridging the gap between university- and community-based treatment. Journal of Consulting and Clinical Psychology, 63, 709-717.

Hibbs, E. D, & Jensen, P. S. (Eds). (1996). Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice. Washington, DC: American Psychological Association.

Hoagwood, K., Hibbs, E., Brent, D., & Jensen, P. (1995). Introduction to the special section: Efficacy and effectiveness in studies of child and adolescent psychotherapy. Journal of Consulting and Clinical Psychology, 63, 683-687.

Hoagwood, K., & Hohman, A. A. (1994). Child and adolescent services research at the National Institute of Mental Health: Research opportunities in an emerging field. Journal of Child and Family Studies, 2, 259-268.

Jensen, P. S., Hoagwood, K., & Petti, T. (1996). Outcomes of mental health care for children and adolescents: II. Literature review and application of a comprehensive model. Journal of the American Academy of Child and Adolescent Psychiatry, 35, 1064-1077.

Kazdin, A. E. (1994). Psychotherapy for children and adolescents. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (pp. 543-594). New York: John Wiley & Sons, Inc.

Kutash, K., & Rivera, V. R. (1996). What works in children's mental health services? Uncovering answers to critical questions. Baltimore: Brooks.

Liddle, H. A., & Dakof, G. A. (1995). Efficacy of family therapy for drug abuse: Promising but not definitive. Journal of Marital and Family Therapy, 21, 511-543.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Mulvey, E. P., Arthur, M. W., & Reppucci, N. D. (1993). The prevention and treatment of juvenile delinquency: A review of the research. Clinical Psychology Review 13, 133-167.

Oswald, D. P., & Singh, N. N. (1996). Emerging trends in child and adolescent mental health services. In T. H Ollendick & R. J Prinz (Eds.), Advances in Clinical Child Psychology, Vol. 18 (pp. 331-365). New York: Plenum Press.

Quay, H. C., & Hogan, A. (Eds.) (In press). Handbook of disruptive behavior disorders. New York: Plenum Press.

Reddy, L. A., & Pfeiffer, S. I. (1997). Effectiveness of treatment foster care with children and adolescents: A review of outcome studies. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 581-588.

Robin, A. L., & Foster, S. (1989). Negotiating parent-adolescent conflict: A behavioral family systems approach. New York: Guilford Press.

Schoenwald, S. K., & Henggeler, S. W. (1997). Combining effective treatment strategies with family preservation models of service delivery: A challenge for mental health. In R .J. Illback, H. Joseph, Jr., & C. Cobb (Eds.), Integrated services for children and families: Opportunities for psychological practice (pp. 121-136). Washington, DC: American Psychological Association.

Schoenwald, S. K., Henggeler, S. W., & Edwards., D. (1998). MST supervisory measure. Charleston, SC: MST Institute.

Strother, K. B., Swenson, M. E., & Schoenwald, S. K. (1998). MST organizational manual. Charleston, SC: MST Institute.

Swenson, M. E. (1998). Supervisor training outline: Therapist assessment. Charleston, SC: Author.

Thornberry, T. P., Huizinga, D., & Loeber, R. (1995). The prevention of serious delinquency and violence: Implications from the program of research on the causes and correlates of delinquency. In J. C. Howell, B. Krisberg, J. D. Hawkins, & J. J. Wilson (Eds.), A sourcebook: Serious, violent, & chronic juvenile offenders (pp. 213-237). Newbury Park, CA: Sage.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Kauneckis, D. (1995). Child and adolescent psychotherapy outcomes in experiments versus clinics: Why the disparity? Journal of Abnormal Child Psychology, 23, 83-106.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. Journal of Consulting and Clinical Psychology, 63, 688-701.

Weisz, J. R., Han, S. S., & Valeri, S. M. (1997). More of what? Issues raised by the Fort Bragg study. American Psychologist, 52, 541-545.

Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. American Psychologist, 47, 1578-1585.

Weisz, J. R., & Weiss, B. (1993). Effects of psychotherapy with children and adolescents. New York: Sage.

Appendix

Required Reading for MST Consultants

Clinical and Theoretical Foundations of MST–Representative Texts

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Haley, J. (1976). *Problem solving therapy*. San Francisco: Jossey-Bass

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York and London: Guilford Press.

Henggeler, S. W., Schoenwald, S. K., Pickrel, S. G., Brondino, M. J., & Hall, J. A. (1994). *Treatment manual for family preservation using multisystemic therapy*. Columbia, SC: South Carolina Health and Human Services Finance Commission.

Henggeler, S. W. & Borduin, C. M. (1990). *Family therapy and beyond: A multisystemic approach to treating the behavior problems of children and adolescents*. Pacific Grove, CA: Brooks/Cole.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard UniversityPress.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

Munger, R. L. (1993). *Changing children's behavior quickly*. Lanham, MD: Madison Books.

Patterson, G. R. (1979). *Living with children*. Champaign, IL: Research Press.

Patterson, G. R., (1982). *Coercive family process*. Eugene, OR: Castalia Press.

Seaburn, D., Landau-Stanton, J., & Horwitz, S. (1996). *Core techniques in family therapy*. In R. H. Mikesell, D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 5-26). Washington, DC: American Psychological Association.

Development and Validation of MST as an Effective Treatment

Early Clinical Trials

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 34, 105-113.

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, 55, 171-178.

Henggeler, S. W., Rodick, J. D, Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J.R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. *Developmental Psychology*, 22, 132-141.

Recent Clinical Trials

Borduin, C. M., Mann, B. J., Cone, L., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63, 569-578.

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., Cone, L., & Fucci, B. R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly*, 1, 40-51.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using multisystemic treatment: Long-term follow-up with serious juvenile offenders. *Journal of Child & Family Studies*, 2, 283-293.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65, 821-833.

Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Miller, S. L., Cunningham, P. B. Santos, A. B., Schoenwald, S. K., Randall, J., & Edwards, J. E. (1997). Investigating family-based alternatives to institution-based mental health services. *Journal of Clinical Child Psychology*, 26, 226-233.

Schoenwald, S. K., Ward, D. M., Henggeler, S. W., Pickrel, S. G., & Patel, H. (1996). MST treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. *Journal of Child and Family Studies*, 4, 431-444.

MST in the Context of Mental Health Services Research

Henggeler, S. W., Schoenwald, S. K., & Pickrel, S. G. (1995). Multisystemic therapy: Bridging the gap between university- and community-based treatment. *Journal of Consulting and Clinical Psychology*, 63, 709-717.

Henggeler, S. W., Schoenwald, S. K., Pickrel, S. G., Rowland, M. D., & Santos, A. B. (1993). The contribution of treatment outcome research to the reform of children's mental health services: Multisystemic therapy as an example. *Journal of Mental Health Administration*, 21, 227-237.

Schoenwald, S. K. & Henggeler, S. W. (1997). Combining effective treatment approaches with family preservation models of service delivery: A challenge for mental health. In R. J. Illback, H. Joseph, Jr. & C. Cobb (Eds.), *Integrated services for children and families: Opportunities for psychological practice* (pp. 121-136). Washington, DC: American Psychological Association.

Schoenwald, S. K. & Henggeler, S. W. (in press). Services research and family based treatment. In H. Liddle, G. Diamond, R. Levant, J. Bray, & D. Santisteban (Eds.), *Family psychology intervention science*. Washington, DC: American Psychological Association.

Schoenwald, S. K., Thomas, C. R., & Henggeler, S. W. (1996). Treatment of serious antisocial behavior. *Advances in Learning and Behavioral Disabilities*, 10B, 1-21.

Sondheimer, D. L., Schoenwald, S. K., & Rowland, M. D. (1994). Alternatives for the hospitalization of youth with a serious emotional disturbance. *Journal of Clinical Child Psychology*, 23, 7-12.

Research on Child Psychotherapies

General Reviews

Hibbs, E. D., & Jensen, P. S. (Eds.). *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice*. Washington, DC: American Psychological Association.

Kazdin, A. E. (1991). Effectiveness of psychotherapy with children and adolescents. *Journal of Counseling and Clinical Psychology*, 49, 785-798.

Kazdin, A. E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology*, 26, 114-129.

Kazdin, A. E., & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, 19-36.

Ollendick, T. H., & Prinz, R. J. (Eds.). (1996). *Advances in clinical child psychology*, Vol. 18 (pp. 1-63). New York & London: Plenum Press.

Weisz, J. R. (1997). Effects of interventions for child and adolescent psychological dysfunction: Relevance of context, developmental factors, and individual differences. In S. S. Luthar, J. A. Burack, D. Cicchetti, & J. R. Weisz (Eds.), *Developmental psychopathology: Perspectives on adjustment, risk, and disorder* (pp. 3-22). New York: Cambridge University Press.

Weisz, J. R., Donenberg, G. R., Han, S. S. & Kauneckis, D. (1995). Child and adolescent psychotherapy outcomes in experiments versus clinics: Why the disparity? Special Issue: Psychosocial treatment research. *Journal of Abnormal Child Psychology*, 23, 83-106.

Weisz, J. R., Donenberg, G. R., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology*, 63, 688-701.

Weisz, J. R., & Weiss, B. (1993). *Effects of psychotherapy with children and adolescents*. Newbury Park, CA: Sage.

Empirically Validated Family Therapies

Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. (1994). The process and outcome of marital and family therapy: Research review and evaluation. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 595-630). New York: John Wiley & Sons, Inc.

Gordon, D. A., Graves, K., & Arbuthnot, J. (1995). The effect of functional family therapy for delinquents on adult criminal behavior. *Criminal Justice and Behavior*, 22, 60-73.

Henggeler, S. W., Borduin, C. M. & Mann, B. J. (1993). Advances in family therapy, empirical foundations. *Advances in Clinical Child Psychology*, 15, 207-241.

Kurtines, W. M., & Szapocznik, J. (1996). Family interaction patterns: Structural family therapy within contexts of cultural diversity. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 671-697). Washington, DC: American Psychological Association.

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystemic engagement strategy in family-based adolescent treatment. *Psychotherapy*, 32, 39-58.

Liddle, H. A. (1996). Family-based treatment for adolescent problem behaviors: Overview of contemporary developments and introduction to the special section. *Journal of Family Psychology*, 10, 3-11.

Liddle, H. A., & Dakof, G. A. (1995). Efficacy of family therapy for drug abuse: Promising but not definitive. *Journal of Marital and Family Therapy*, 21, 511-543.

Empirically Validated Treatments for Conduct, Oppositional, and Disruptive Behavior Problems

See reviews by Kazdin, Weisz and Weiss (1993) listed under "General Reviews" above.

Dodge, K. A. (1993). The future of research on the treatment of conduct disorder.

Development and Psychopathology, 5, 311-319.

Forehand, R. & Kotchick, B. A. (1996). Cultural diversity: A wake-up call for parent training. *Behavior Therapy*, 27, 187-206.

Quay, H. C., & Hogan, A. E. (in press). *Handbook of disruptive behaviors*. New York: Plenum Publishing Corp.

Schoenwald, S. K., & Henggeler, S. W. (in press). Treatment of oppositional defiant disorder and conduct disorder in home and community settings. In H. C. Quay & A. E. Hogan (Eds.), *Handbook of disruptive behaviors*. New York: Plenum Publishing Corp.

Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy*, 27, 171-186.

Wierson, M., & Forehand, R. (1994). Parent behavioral training for child noncompliance: Rationale, concepts, and effectiveness. *Current Directions in Psychological Science*, 3, 146-150.

Cognitive-Behavioral Treatments

Beck, A. T., Cognitive therapy: Past, present, and future. *Journal of Consulting and Clinical Psychology*, 61, 194-198.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press.

Hollon, S. D., Shelton, R. C. & Davis, D. D. (1993). Cognitive therapy for depression: Conceptual issues and clinical efficacy. *Journal of Consulting and Clinical Psychology*, 61, 270-275.

Kendall, P. C. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology*, 61, 235-247.

Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 62, 100-110.

Mahoney, J. J. (1993). Introduction to special section: Theoretical developments in the cognitive psychotherapies. *Journal of Consulting and Clinical Psychology*, 61, 187-193.

Meichenbaum, D. (1993). Changing conceptions of cognitive behavior modification: Retrospect and prospect. *Journal of Consulting and Clinical Psychology*, 61, 202-204.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. *Journal of Consulting and Clinical Psychology*, 61, 248-260.

Wilson, G. T. & Fairburn, C. G. (1993). Cognitive therapy of anxiety disorders. *Journal of Consulting and Clinical Psychology*, 61, 248-260.

Children's Mental Health Services Research

General Reviews

Burns, B. J., & Friedman, R. M. (1990). Examining the research base for child mental health services and policy. *Journal of Mental Health Administration*, 17, 87-97.

Burns, B., Hoagwood, K. H., & Maultsby, L. T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In M.H. Epstein, K. Kutash & A. J. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 685-707). Austin, TX: Pro-ED.

Day, C., & Roberts, M. C. (1991). Activities of the child and adolescent service system program for improving mental health services for children and families. *Journal of Clinical Child Psychology*, 20, 340-350.

Friesen, B. J., & Koroloff, N. M. (1990). Family-centered services: Implications for mental health administration and research. *Journal of Mental Health Administration*, 17, 13-25.

Henggeler, S. W., Borduin, C. M., Culbertson, J. L., Duchnowski, A. J., Eyebrow, S. M., Friedman, R. M., Hanley, J. H., Melton, G. B., Meyers, J. C., Nelson, K. E., Rodrigue, J. R., Sondheimer, D. L., Rowland, M. D., & Schoenwald, S. K. (1994). Task force report on innovative models of mental health services for children, adolescents, and their families. *Journal of Clinical Child Psychology*, 23 (Suppl.), 3-58.

Jensen, P. S., Hoagwood, K., & Petti, T. (1996). Outcomes of mental health care for children and adolescents: II. Literature review and application of a comprehensive model. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1064-1077.

Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Journal of Emotional and Behavioral Disorders*, 1, 8-16.

Kutash, K., & Rivera, V. R. (1996). *What works in children's mental health services? Uncovering answers to critical questions*. Baltimore: Brooks.

Stroul, B. A., & Friedman,. R. M. (1994). A system of care for children and youth with severe emotional disturbances. (Rev. Ed.). Washington, D.C.: Georgetown University Child Development Center. National Technical Center for Children's Mental Health, Center for Child Health and Mental Health Policy.

System-of-Care Studies

Bickman, L. (1996). A continuum of care: More is not always better. *American Psychologist*, 51, 689-701.

Bickman, L., Heflinger, C. A., Summerfelt, W. T., Bryant, D., Lambert E. W., Guthrie, P. R., Sonnichsen, S. E., Brannan, A. M., Foster E. M., Saunders, R. C., Behar, L., Paris, M. L., Lane, T. W., Friedman, R. M., & Burns, B. J. (1996) The Fort Bragg experiment. *Journal of Mental Health Administration*, 23 (Suppl.), 6-147.

Bickman, L., Summerfelt, W.T., Firth, J., & Douglas, S. (1997). The Stark County Evaluation Project: Baseline results of a randomized experiment. In D. Northrup & C. Nixon (Eds.), *Evaluating mental health services: How do programs for children "work" in the real world?* Newbury Park, CA: Sage.

Glisson, C., & Hemmelgarn, A. (in press). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect.*

Weisz, J. R., Han, S. S., & Valeri, S. M. (1997). More of what? Issues raised by the Fort Bragg study. *American Psychologist*, 52, 541-545.

Community-Based Models of Service Delivery/Family Preservation Services

Fraser, M. W., Nelson, K. E., & Rivard, J. C. (in press). The effectiveness of family preservation services. *Social Work Research.*

Haapala, D. (1996). The Homebuilders model: An evolving service approach for families. In M.C. Roberts (Ed.), *Model programs in child and family mental health* (pp. 295-316). Mahwah, NJ: Lawrence Erlbaum Associates.

Henegan, A. M., Horwitz, S. M., & Leventhal, J. M. (1997). Evaluation of intensive family preservation programs: A methodological review. *Pediatrics*, 97, 535-542.

Schoenwald, S.-K. & Henggeler, S. W. (1997). Combining effective treatment strategies with family-preservation models of service delivery. In R. J. Illback, H. Joseph, Jr., & C. Cobb (Eds.), *Integrated services for children and families: Opportunities for psychological practice* (pp. 121-136). Washington, DC: American Psychological Association.

Schuerman, J. R., Rzepnicki, T. L., & Littell, J. H. (1994). *Putting families first: An experiment in family preservation.* New York: Aldine de Gruyter.

Therapeutic Foster Care

Chamberlain, P. (1996). Intensified foster care: Multi-level treatment for adolescents with conduct disorders in out-of-home care. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 475-490). Washington, DC: American Psychological Association.

Reddy, L. A., & Pfeiffer, S. I. (1997). Effectiveness of treatment foster care with children and adolescents: A review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 581-588.

Intensive Case Management

Burns, B. J., Farmer, E. M. Z., Angold, A., Costello, E. J., & Behar, L. (1996). A randomized trial of case management for youths with serious emotional disturbance. *Journal of Clinical Child Psychology*, 25, 476-486.

Wrap-Around Process/Services

Hyde, K. L., Burchard, J. D., & Woodworth, K. (1996). Wrapping services in an urban setting. *Journal of Child and Family Studies*, 5, 67-82.

Rosenblatt, A. (1996). Bows and ribbons, tape and twine: Wrapping the wraparound process for children with multi-system needs. *Journal of Child and Family Studies*, 5, 101-116.

VanDenBerg, J. E., & Grealish, E. M. (1996). Individualized services and supports through the wrap-around process: Philosophies and procedures. *Journal of Child and Family Studies*, 5, 7-21.

Research on Delinquency & Adolescent Substance Abuse–Correlates and Causes

Dishion, T. J., Patterson, G. R., Stoolmiller, M., & Skinner, M. L. (1991). Family, school, and behavioral antecedents to early adolescent involvement with antisocial peers. *Developmental Psychology*, 27, 172-180.

Fraser, M. W. (1996). Aggressive behavior in childhood and early adolescence: An ecological-developmental perspective on youth violence. *Social Work*, 41, 347-361.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 111, 434-454.

Henggeler, S. W. (1991). Multidimensional causal models of delinquent behavior and their implications for treatment. In R. Cohen & A. W. Siegel (Eds.), *Context and development* (pp. 211-231). Hillsdale, NJ: Lawrence Erlbaum Associates.

Henggeler, S. W. (1997). The development of effective drug abuse services for youth. In J. A. Egertson, D. M. Fox, & A. I. Leshner (Eds.), *Treating drug abusers effectively* (pp. 253-279). A copublication with the Milbank Memorial Fund. New York: Blackwell Publishers.

Loeber, R., Keenan, K., & Zhang, Q. (1997). Boys' experimentation and persistence in developmental pathways toward serious delinquency. *Journal of Child and Family Studies*, 6, 321-358.

Mulvey, E. P., Arthur, M. W., & Reppucci, N. D. (1993). The prevention and treatment of juvenile delinquency: A review of the research. *Clinical Psychology Review 13*, 133-167.

Attention Deficit Hyperactivity Disorder

Abikoff, H. B., & Hechtman, L. (1996). Multimodal therapy and stimulants in the treatment of children with Attention Deficit Hyperactivity Disorder. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice.* (pp. 341-369) Washington, DC: American Psychological Association.

Barkely, R. (1990). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment.* New York: Guilford Press.

Barkely, R. A., & Associates. The ADHD report. New York: Guilford Press.

Barkley, R. A. (1994). Impaired delayed responding: A unified theory of attention-deficit hyperactivity disorder. In D. K. Routh (Ed.), *Disruptive behavior disorders in childhood* (pp. 11-57). New York: Plenum Press.

Research on Parent-Child Relations and Parenting Typologies (including maltreatment)

Abidin, R. R., Jenkins, C. L., & McGaughey, M. C. (1992). The relationship of early family variables to children's subsequent behavioral adjustment. *Journal of Clinical Child Psychology*, 21, 60-69.

Baumrind, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child development today and tomorrow: The Jossey-Bass social and behavioral sciences series* (pp. 349-378). San Francisco: Jossey-Bass.

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. Special issue: The work of John P. Hill: I. Theoretical, instructional, and policy contributions. *Journal of Adolescence*, 11, 56-95.

Baumrind, D. (1996). Effects of authoritative parental control on child behavior. *Child Development*, 37, 887-907.

Becker, J. V., Alpert, J. L., Bigfoot, D. S., Bonner, B. L., Geddie, L. F., Henggeler, S. W., Kaufman, K. L., & Walker, C. E. (1995). Empirical research on child abuse treatment: Report by the Child Abuse and Neglect Treatment Working Group, American Psychological Association. *Journal of Clinical Child Psychology*, 24 (Suppl.), 23-46.

Belsky, J., & Vondra, J. (1989). Lessons from child abuse: The determinants of parenting. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 153-202). New York: Cambridge University Press.

Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry*, 56, 96-118.

Kendziora, K. T., & O'Leary, S. G. (1993). Dysfunctional parenting as a focus for prevention and treatment of child behavior problems. In T. H. Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (pp. 175-206), New York: Plenum Press.

Robin, A. L., & Foster, S. (1989). *Negotiating parent-adolescent conflict: A behavioral family systems approach*. New York: Guilford Press.

Steinberg, L, Lamborn, S. D., Darling, N., Mounts, N. S., & Dornbusch, S. M. (1994). Over-time changes in adjustment and competence among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development*, 65, 754-770.

Vissing, Y. M., Straus, M. A., Gelles, R. J., & Harrop, J. W. (1991). Verbal aggression by parents and psychosocial problems of children. *Child Abuse & Neglect*, 15, 223-238.

Wahler, R. G. (1980). The insular mother: Her problems in parent-child treatment. *Journal of Applied Behavior Analysis*, 13, 207-219.

Wahler, R. G., & Fox, J. J. (1981). Setting events in applied behavior analysis: Toward a conceptual and methodological expansions. *Journal of Applied Behavior Analysis*, 14, 327-338.

Wahler, R. G., & Graves, M. G. (1983). Setting events in social networks: Ally or enemy in child behavior therapy? *Behavior Therapy*, 14, 19-36.

Wahler, R. G., & Hann, D. M. (1991). The communication patterns of troubled mothers: In search of a keystone in the generalization of parenting skills. *Education and Treatment of Children*, 7, 335-350.

Wahler, R. G., & Sansbury, L. E. (1990). The monitoring skills of troubled mothers: Their problems in defining child deviance. *Journal of Abnormal Child Psychology*, 18, 577-589.

Wolfe, D. A. & McGee, R. (1994). Dimensions of child maltreatment and their relationship to adolescent adjustment. *Development and Psychopathology*, 6, 165-181.

Marital Relations and Interventions

Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. (1994). The process and outcome of marital and family therapy: Research review and evaluation. In A. E. Garfield & S. L. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp.595-630). New York: John Wiley & Sons.

Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology*, 61, 40-50.

Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology*, 66, 53-88.

Cummings, E. M. & Davies, P. (1994). *Children and marital conflict: The impact of family dispute and resolution*. New York: The Guilford Press.

Emery, R. E. (1994). *Renegotiating family relationships: Divorce, child custody, and mediation*. New York: Guilford Press.

Gottman, J. M. (1993). The roles of conflict engagement, escalation, and avoidance in marital interaction: A longitudinal view of five types of couples. *Journal of Consulting and Clinical Psychology*, 61, 6-15.

Jacobson, N. S., & Addis, M. E. (1993). Research on couples and couple therapy: What do we know? Where are we going? *Journal of Consulting and Clinical Psychology*, 61, 85-93.

Markman, H. J., Renick, J. J., Floyd, F. J., Stanley, S. M., & Clements, M. (1993). Preventing marital distress through communication and conflict management training: A 4- and 5-year follow-up. *Journal of Consulting and Clinical Psychology*, 61, 70-77.

Sternberg, K. J., Lamb, M. E., Greenbaum, C., Cicchetti, D., Dawud, S., Cortes, R. M., Krispin, O., & Lorey, F. (1993). Effects of domestic violence on children's behavior problems and depression. *Developmental Psychology*, 29, 44-52.

Snyder, D. K., Mangrum, L. F., & Wills, R. M. (1993). Predicting couples' response to marital therapy: A comparison of short- and long-term predictors. *Journal of Consulting and Clinical Psychology*, 61, 61-69.

Single Parents and Families in Transition

Barber, B. L., & Eccles, J. S. (1992). Long-term influence of divorce and single parenting on adolescent family- and work-related values, behaviors, and aspirations. *Psychological Bulletin*, 111, 108-126.

Bray, J. H., & Berger, S. H. (1993). Developmental issues in stepfamilies research project: Family relationships and parent-child interactions. *Journal of Family Psychology*, 7, 76-90.

Bray, J. H., & Hetherington, E. M. (1993). Families in transition: Introduction and overview. *Journal of Family Psychology*, 7, 3-8.

Daly, M. & Wilson, M. I. (1996). Violence against stepchildren. *Current Directions in Psychological Science*, 5(3), 77-81.

Duncan, S. W. (1994). Economic impact of divorce on children's development: Current findings and policy implications. *Journal of Clinical Child Psychology*, 23, 444-457.

Forehand, R., McCombs, A., Long, N., Brody, G., & Fauber, R. (1988). Early adolescent adjustment to recent parental divorce: The role of interparental conflict and adolescent sex as mediating variables. *Journal of Consulting and Clinical Psychology*, 56, 624-627.

Hetherington, E. M. (1993). An overview of the Virginia longitudinal study of divorce and remarriage with a focus on early adolescence. *Journal of Family Psychology*, 7, 39-56.

Hetherington, E. M., & Clingempeel, W. G. (1992). Coping with marital transitions. *Monographs of the Society for Research in Child Development*, 57, 1-229.

Maccoby, E. E., Buchanan, C. M., Mnookin, R. H., & Dornbusch, S. M. (1993). Post divorce roles of mothers and fathers in the lives of their children. *Journal of Family Psychology*, 7, 24-38.

Olson, M. R. & Haynes, J. A. (1993). Successful single parents. *Journal of Contemporary Human Services*, 5, 259-267.

Shaw, D. S., & Emery, R. E. (1987). Parental conflict and other correlates of the adjustment of school-age children whose parents have separated. *Journal of Abnormal Child Psychology*, 15, 269-281.

Peer Relations and Peer Interventions

Bukowski, W. M., Newcomb, A. F., & Hartup, W. W. (1996). *The company they keep: Friendship in childhood and adolescence*. New York: Cambridge University Press.

Cicchetti, D., & Bukowski, W. M. (1995). Developmental processs in peer relations and psychopathology. *Development and Psychopathology*, 7, 587-589.

Dodge, K. A., Pettit, G. S. & Bates, J. E. (1994). Effects of physical maltreatment on the development of peer relations. *Development and Psychopathology*, 6, 43-55.

Newcomb, A. F., & Bagwell, C. L. (1995). Children's friendship relations: A meta-analytic review. *Psychological Bulletin*, 117, 306-347.

Parke, R. D., Burks, V. M., Carson, J. L., Neville, B., & Boyum, L. A. (1994). Family-peer relationships: A tripartite model. In R. D. Parke & S. G. Kellum (Eds.), *Exploring family relationships with other social contexts. Family research consortium: Advances in family research* (pp. 115-145). Hillsdale, NJ: Erlbaum.

Prinz, R. J., Blechman, E. A., & Dumas, J. E. (1994). An evaluation of peer coping-skills training for childhood aggression. *Journal of Clinical Child Psychology*, 23, 193-203.

School Based Interventions

Duchnowski, A. J. (1994). Innovative service models: Education. *Journal of Clinical Child Psychology*, 23 (Suppl.), 13-18.

Hoagwood, K. & Erwin, H. D. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies*, 6, 435-452.

Hundert, J., Cassie, J. R. B., & Johnston, N. (1988). Characteristics of emotionally disturbed children referred to day-treatment, special-class, outpatient, and assessment services. *Journal of Child Clinical Psychology*, 17, 121-130.

Peacock Hill Working Group (1991). Problems and promises in special education and related services for children and youth with emotional or behavioral disorders. *Behavioral Disorders*, 16, 299-313.

Rodick, J. D., & Henggeler, S. W. (1980). The short-term and long-term amelioration of academic and motivational deficiencies among low-achieving inner-city adolescents. *Child Development*, 51, 1126-1132.

Steinberg, Z., & Knitzer, J. (1992). Classrooms for emotionally and behaviorally disturbed students: Facing the challenge. *Behavioral Disorders*, 17, 145-156.

THE AUTHOR CAN BE CONTACTED AT THE FOLLOWING ADDRESS:

Sonja K. Schoenwald, Ph.D.
Family Services Research Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29425-0742