

State of Hawaii  
Department of Health  
Child and Adolescent Mental Health Division

## **Request for Proposals**

### **RFP HTH 460-09-01 Multisystemic Therapy**

## **ADDENDUM**

Issued January 28, 2009

Note: If this RFP ADDENDUM was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, you may download the [RFP Interest form](#), complete and e-mail or mail to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

The following are amendments to RFP Number HTH 460-09-01, Multisystemic Therapy Services, originally posted January 22, 2009:

1. Section 1, VIII. Submission of Proposals, F. Hawaii Compliance Express, is amended as follows on page 1-6:

Delete "Refer to this section's part II."

Add "Website Reference for HCE's website address is <http://www.spo.hawaii.gov/spoh/hawaii-compliance-express-hce>."

2. Section 1, VIII. Submission of Proposals, I. Proposal Submittal, is amended as follows on page 1-6:

Delete "CD" to read as follows:

"Faxed proposals and/or submission of proposals on diskette or transmission by e-mail, website or other electronic means ARE NOT PERMITTED for this RFP."

Add:

"Proposals will require submission by CD along with the required number of hard copies as stated on the Proposal Mail-in and Delivery Information Sheet."

3. Section 2, II General Requirements, E. Single or multi-term contracts to be awarded, is amended as follows on page 2-6:

Single term (2 years or less)                       Multi-term (more than 2 years)

(single term unchecked, multi-term checked)

4. Section 2, III Scope of Work, A. Service Activities, 2. MST Program, is amended as follows on page 2-9:

"Each MST Therapist serves 4 to 6 youth at any given point..."

"s" is deleted at end of "Therapists"

5. Section 2, III Scope of Work, B. Management Requirements, 7. Reporting requirements for program and fiscal data is amended as follows on page 2-21:

Delete "No claims will be accepted after the 90-day period."

Amend "90-day period" to read "ninety (90) days," with other changes as follows:  
"Should a provider need to bill beyond the ninety (90) days, documented contact must be made with CAMHD Provider Relations before the end of the ninety (90)

days. However, no payment will be made for claims submitted more than twelve (12) months after the last day on which services were rendered or more than six (6) months following the end of the contract period, whichever period is shorter.”

6. Section 5, Attachments, is amended as follows:

The following Attachments are amended in this RFP and included in the subsequent pages of this Addendum:

- A. Proposal Applicant Checklist
- H. CAMHD Credentialing and Recredentialing Policies & Procedures
- M. TAM-R Data Collection Contract *SAMPLE with Attachment A*
- N. MST Services Position Statement Memos
- O. Required & Recommended Program Practices and Characteristics: Program Review Form & Rationale Statements

## Proposal Application Checklist

Applicant: \_\_\_\_\_

RFP No.: HTH 460-09-01

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website Reference.\*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
<b>General:</b>				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	<b>X</b>	
Proposal Application Checklist	Section 1, RFP	Section 5, Attachment A	<b>X</b>	
Table of Contents	Section 5, RFP	Section 5, Attachment B	<b>X</b>	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	<b>X</b>	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*	<b>X</b>	
Cost Proposal (Budget)			<b>X</b>	
SPO-H-205	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	<b>X</b>	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5	<b>X</b>	
SPO-H-206A	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206B	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206C	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206F	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206G	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206H	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206I	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206J	Section 3, RFP	SPO Website*		
<b>Certifications:</b>				
<i>Federal Certifications</i>		Section 5, RFP	<b>X</b>	
Debarment & Suspension		Section 5, RFP	<b>X</b>	
Drug Free Workplace		Section 5, RFP	<b>X</b>	
Lobbying		Section 5, RFP	<b>X</b>	
Program Fraud Civil Remedies Act		Section 5, RFP	<b>X</b>	
Environmental Tobacco Smoke		Section 5, RFP	<b>X</b>	

\_\_\_\_\_

Authorized Signature

\_\_\_\_\_

Date

## Attachment H

### CAMHD Credentialing and Recredentialing Policy & Procedures

This document can be found on the State Procurement Office website, under Health and Human Services, Request for Proposals section, in documents for RFP HTH 460-09-01:  
<http://hawaii.gov/spo2/health/rfp103f/>

Attachment M

TAM-R Data Collection Contract

*SAMPLE*  
*With Attachment A*

**TAM-R DATA COLLECTION CONTRACT BETWEEN**

**MST INSTITUTE**

**And**

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**THE CONTRACT** by and between \_\_\_\_\_, hereinafter referred to as the Client, and MST Institute, referred to as MSTI:

**WITNESS:** In consideration of the mutual promises herein contained, the parties have agreed and do hereby enter into this contract according to the provisions set out herein:

A. MSTI agrees to perform the following services:

MSTI will provide telephone contact services to collect the Therapist Adherence Measure (TAM-R) data required of the Client's Families enrolled in the MST program. This service consists of:

1. Pre-implementation assessment and consultation regarding the development and implementation of the MST TAM-R data collection process.
2. Monthly MSTI telephone contact with Client's Families enrolled in the MST Program to complete the TAM-R Questionnaire.
3. Store and maintain all Client's Family TAM-R data collected in the MSTI database.
4. Provide access to standard reports related to Client's Supervisors and Therapists on the MSTI Website ([www.mstinstitute.org](http://www.mstinstitute.org)).
5. Introduce strict procedures to protect the confidentiality of the information required to implement the MSTI data collection project.
  - MSTI and its subcontractors agree to keep all information identifying Client's Families confidential and to not disclose such identifying information to a third party, except as required to be disclosed by state or federal law.
  - The information interface for this project will be a secured data-driven website controlled by MSTI. Access to the website will be strictly controlled by a user-id and password, and all communication between the web server and Clients will be encrypted. Once a user is authenticated, the user will only have access to the forms and data needed to perform their role in the system. This system will maintain compliance with applicable HIPPA standards and guidelines.

B. The Client agrees that:

1. Compensation shall be \$20 per month per Client's Family enrolled for the service. Invoices shall be paid monthly in arrears.
2. Special report support can be obtained by requesting a quotation and will be subject to separate reimbursement.
3. The Client will follow all aspects of the data collection protocol, including informing Families that personal information will be shared with MSTI for the purposes of monitoring the quality of the services provided. A sample statement for Families is attached.
4. The Client will maintain up to date and accurate contact information of the MST staff employed by the Client on the MSTI website ([www.mstinstitute.org](http://www.mstinstitute.org)).
5. Client will provide necessary Client Family telephone contact and enrollment information to MSTI within five working days of the Client's Family first face-to-face visit with the MST Program. This information shall be entered on the MSTI website ([www.mstinstitute.org](http://www.mstinstitute.org)) and updated if contact information changes while Family is enrolled in services
6. Client will complete discharge form within one week of discharge.

C. The parties agree that the following shall be essential terms and conditions of this contract.

1. **LIABILITY:** Within the limits of its professional and general policies of insurance, MSTI agrees to hold the Client, its officers, employees, and agents (indemnified persons) harmless from any liability for damages or claims for damages of whatever nature arising from the negligent acts and omissions occurring during the conduct of this contract. MSTI does not agree to hold the indemnified persons harmless for the negligence of the Client, its officers, employees, or agents, or the actions of a third party over which MSTI has no supervision, control, or jurisdiction.

Insofar as is authorized under the Constitution and laws of the State of South Carolina the Client agrees to hold MSTI harmless for any liability for damages or claims for damages of whatever nature arising from the negligent acts and omissions occurring during the conduct of this contract. The Client does not agree to hold MSTI harmless for the negligence of MSTI, its officers, employees, or agents, or the actions of a third party over which the Client has no supervision, control, or jurisdiction.

2. The term of this contract shall begin \_\_\_\_\_, 200\_\_ and will continue through \_\_\_\_\_, 200\_\_. This Agreement shall automatically renew for successive one-year terms until terminated by either party by notice at least sixty days prior to the end of any one-year term.
3. The contract may be terminated by either party for any reason by giving written notice to the other, at least 30 days before the effective date of the termination.

In the event, the MSTI shall be entitled to receive just and equitable compensation for any satisfactory authorized services rendered prior to termination date.

4. If the MSTI fails to fulfill in a timely and proper manner its obligations under the contract, or if the MSTI shall violate any of the terms of this contract, the Client shall have the right to immediately terminate this contract. Notwithstanding the above, the MSTI shall not be relieved of liability to the Client for damages sustained by virtue of any breach of the contract by the MSTI.
5. This Contract may be modified only by written amendment executed by all parties hereto.
6. All correspondence with MSTI regarding this contract, including billing questions and payments, should be directed to the following:  
MST Institute  
Attn: Shirley Claytor  
710 Johnnie Dodds Blvd., Suite 200  
Mt. Pleasant, SC 29464  
Phone: (843) 856-8226  
Fax: (843) 856-8227

7. All correspondence with Client regarding this contract, including billing questions and payments, should be directed to the following:  
Organization: \_\_\_\_\_  
Attn: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

EXECUTED this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

For:	MST INSTITUTE	CLIENT
	_____	_____
NAME:	_____	_____
TITLE:	_____	_____
DATE:	_____	_____

**Attachment A**

**MST/TAM-B Data Collection Client Family Privacy Notice**

Our MST program is committed to providing you and your family the best possible services. Therefore, someone will call you periodically to ask you questions about the services you are getting and whether you feel things are getting better. Your opinions are extremely important to our efforts to improve services to families like yours.

We are working with telephone interviewers at Pioneer Marketing Research (PMR) to collect this information. Therefore, we will share your name and telephone number with them so they can call to ask you some questions about the services you are receiving. This information will not be shared with anyone else in a way in which you can be identified. The staffs at PMR, MSTI and MST are trained in the importance of maintaining confidentiality and your privacy. Your personal information will be protected with safeguards that comply with the highest standards.

You do not need to consent to the use of your personal information in this way in order to receive MST services. However, participating in the telephone interviews does ensure that you will receive the best possible service.

If you have any questions about this notice or if we can help you in any way, please call:

MST supervisor: \_\_\_\_\_

MST Provider Organization: \_\_\_\_\_

Phone number: \_\_\_\_\_

## Attachment N

### MST Services Position Statement Memos

# MST Services

## Position Statement Memo

Author(s): Naamith Heiblum and Keller Strother

Date: 9/25/2006

Topic: **Coverage Area for MST Teams**

Issue: How large an area can an MST team cover?

### **Guidelines for Coverage Area questions**

This document is intended to provide MST programs with guidelines for determining the appropriate coverage area (i.e., establishing a 'catchment area') that is appropriate for one MST team.

Historically, there have been few guidelines about the maximum distance that is allowed between the geographical bases of each therapist within a team. A lack of clarification regarding this issue, however, has led to compromised functioning of several teams. Situations where therapists are too geographically dispersed have presented problems in the team's ability to: (1) have an on-call system that realistically allows therapists to provide adequate coverage for one another and have immediate access to families during times of unanticipated crises; (2) convene regularly for group supervision, consultation, and for individual supervision with the supervisor when indicated; (3) have easy access to other members of the team for the purpose of team trainings and in-service opportunities, providing support to each other, and, when necessary, engaging in joint interventions with families.

Accordingly, the following guidelines are strongly advised regarding "drive time" distance between therapists within a team, and between each therapist and his/her caseload of families:

- 1) Referrals for families should be restricted to a geographical area no larger than what would be normally considered to constitute 90 minutes travel time under normal daytime or evening conditions.
- 2) That each therapist should not travel more than 90 minutes (each way) to visit any family on their caseload under normal daytime or evening conditions.
- 3) That within any MST team, therapists should also not be based more than 90 minutes from each other's "work location". This is to ensure that therapist coverage, group meetings, and other clinically necessary activities can proceed on a regular basis.

There are two additional situations that merit comment since they are often associated with situations where there are concerns about the impact of the coverage area of an MST team as it relates to therapists' ability to deliver MST services as required to achieve the best possible outcomes.

#### Providing MST services in rural areas

In some rural areas, low population densities create huge barriers to delivering MST effectively. Low referral rates and excessive drive times to families are serious challenges for MST programs operating in very rural areas. The only strategy identified to date to counteract the increased drive times in these rural implementations is reduced caseloads. While this significantly increases the cost per case, it is the only way we know of to ensure that therapists retain adequate time to deliver MST when drive times exceed the guidelines outlined above.

#### "Out posting" a single therapist for program expansion

Occasionally MST programs seek to grow their programs by “expanding” their existing operations to near-by communities in ways that require drive times for the MST staff to exceed the above guidelines. While many programs justify this by assuming that the situation will exist for only a short period of time, we strongly advise against this practice because it compromises the most important people involved in the process – the MST staff and the families receiving MST. MST Services will work diligently to support programs in their program development efforts so that the near-by communities in question can start with a fully-staffed and operational team rather than starting piecemeal with a single therapist.

# MST Services

## Position Statement Memo

Author(s): Dan Edwards

Date: May 25, 2005

Topic: **Personal Time Off for MST Supervisors**

Issue: MST supervisors have asked for clarification of the MST policy regarding back-up coverage during personal time off (PTO), including both planned (e.g., vacation, parental leave) and unplanned situations (e.g., unexpected emergency or family illness).

### **Position Statement:**

To support the MST supervisor and the MST team, the local MST Program must train and support a “back-up” MST supervisor within the agency or organization who can provide supervision and support to the team when a supervisor takes PTO. If the program does not have two MST supervisors who can provide coverage for each other, the MST program must designate a “back-up” supervisor for each team. **Bottom line: Clinical staff who are working with families should never be without access to a trained and qualified supervisor who is familiar with the details of their case.**

This back-up supervisor may either be:

Option 1: a senior therapist (i.e., at least one year experience as a MST therapist with positive adherence and outcomes, as well as the approval of the MST Services consultant or the Network Partner system supervisor); or

Option 2: a supervisor associated with a separate clinical program in the same organization. It is expected that, before providing supervisory coverage, this back-up supervisor will:

- a) have attended the MST 5-day orientation training
- b) attend MST quarterly boosters at least twice per year to stay current with MST concepts, research, and practices
- c) have attended the weekly MST consultation for at least one week in advance of planned time off (i.e., in order to be familiar with developments in current cases)

Option 3: MST Program identifies a qualified supervisor at a “partner” agency to provide back-up coverage. If this option is chosen, arrangements should be made to ensure that the following are in place:

- a) quid pro quo coverage agreements

- b) strategies to ensure that up-to-date materials are available to the partner in advance of any planned time off
- c) confidentiality of clinical material being shared.

In addition, it is essential that each MST program develop a policy for ensuring coverage for supervision of staff especially during unplanned situations. Part of this policy should delineate:

1. how MST supervisors are expected to contact the program manager (or designee) when an emergency necessitates back-up supervision;
2. the plan for communicating essential case information to that second supervisor; and
3. how MST therapists are informed that this has occurred.

## Attachment N

### Required & Recommended Program Practices and Characteristics: Program Review Form & Rationale Statements

## Required & Recommended Program Practices and Characteristics: Program Review Form & Rationale Statements

Met	Not Met	Required Program Practices and Characteristics:
<input type="checkbox"/>	<input type="checkbox"/>	1. MST Therapists are full-time employees assigned solely to the MST program.
<input type="checkbox"/>	<input type="checkbox"/>	2. MST Therapists do not have <u>any</u> non-MST program responsibilities in the agency, do not carry <u>any</u> additional non-MST cases, and do not have other part-time jobs outside of the agency.
<input type="checkbox"/>	<input type="checkbox"/>	3. MST staff are allowed to work a flexible schedule as needed to meet the needs of the families they are serving.
<input type="checkbox"/>	<input type="checkbox"/>	4. MST staff are allowed to use their personal vehicles to transport clients.
<input type="checkbox"/>	<input type="checkbox"/>	5. MST staff have use of either cellular phones or pagers so that clients can contact them quickly and conveniently.
<input type="checkbox"/>	<input type="checkbox"/>	6. MST Therapists operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor) and use a home-based model of service delivery.
<input type="checkbox"/>	<input type="checkbox"/>	7. MST Clinical Supervisor is assigned to the MST program a minimum of 50% time per MST Team.
<input type="checkbox"/>	<input type="checkbox"/>	8. MST Clinical Supervisor conducts weekly team clinical supervision, facilitates the weekly MST telephone consultation and is available for individual clinical supervision for crisis cases.
<input type="checkbox"/>	<input type="checkbox"/>	9. MST caseloads do not exceed 6 families per therapist and the normal range is 4 to 6 families per therapist.
<input type="checkbox"/>	<input type="checkbox"/>	10. Overall average duration of treatment is 3 to 5 months.
<input type="checkbox"/>	<input type="checkbox"/>	11. Each MST Therapist tracks progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly.
<input type="checkbox"/>	<input type="checkbox"/>	12. The MST program has a 24 hour/day, 7-day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. This system is staffed by members of the MST team.
<input type="checkbox"/>	<input type="checkbox"/>	13. With the buy-in of other organizations and agencies, MST is able to “take the lead” for clinical decision-making on each case. Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations and agencies while MST staff sustain them through ongoing, case-specific collaboration.
<input type="checkbox"/>	<input type="checkbox"/>	14. The MST program excludes youth living independently, youth referred primarily for psychiatric service needs (i.e., suicidal ideation and behavior, actively homicidal, actively psychotic), youth referred primarily for sex offenses (in the absence of other antisocial/delinquent behaviors) and youth with pervasive developmental delays.
<input type="checkbox"/>	<input type="checkbox"/>	15. Referrals to non-MST compatible programs (e.g., any form of mandated group treatment, day treatment programs, etc.) are not made while youth are in MST, especially on a “standard” or routine basis.
<input type="checkbox"/>	<input type="checkbox"/>	16. MST program discharge criteria are outcome-based rather than duration-focused.
<input type="checkbox"/>	<input type="checkbox"/>	17. Referrals for additional services after clients are discharged from the MST program are carefully planned and limited to those that can accomplish specific, well-defined goals. The assumption is that most MST cases should need minimal “formal” after-care services.
<input type="checkbox"/>	<input type="checkbox"/>	18. All MST staff, who have been working for more than 2 months, participate in a 5-day orientation training.

Met	Not Met	Additional Recommended Program Practices and Characteristics:
<input type="checkbox"/>	<input type="checkbox"/>	19. MST Therapists are Masters-prepared (clinical-degreed) professionals.
<input type="checkbox"/>	<input type="checkbox"/>	20. MST Clinical Supervisors are, at minimum, highly skilled Masters-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy).
<input type="checkbox"/>	<input type="checkbox"/>	21. MST Clinical Supervisors have both clinical authority and administrative authority over the MST Therapists they supervise.
<input type="checkbox"/>	<input type="checkbox"/>	22. A “Goals and Guidelines” document is in place. If multiple referral or funding sources exist, separate “Goals and Guidelines” documents are recommended for each.
<input type="checkbox"/>	<input type="checkbox"/>	23. Funding for MST cases is in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, “productivity”, etc.
<input type="checkbox"/>	<input type="checkbox"/>	24. The MST program has formal outcome-tracking systems in place.
<input type="checkbox"/>	<input type="checkbox"/>	25. Adequate flex funds are allocated per family (recommended \$100/family) to allow therapists to use funds for purposes such as engagement building and one-time help for families with pressing practical needs.
<input type="checkbox"/>	<input type="checkbox"/>	26. The MST program uses outcome-focused personnel evaluation methods.

**The following factors have been identified as potential indicators of future or ongoing challenges to program adherence and successful implementation.**

Present	Indicator
Y <input type="checkbox"/> N <input type="checkbox"/>	27. There has been more than 30% attrition among the MST staff in the past 6 months.
Y <input type="checkbox"/> N <input type="checkbox"/>	28. MST staff compensation is equal to or less than that of staff in office-based positions or other in-home programs that hold staff to a lower level of accountability in their work.
Y <input type="checkbox"/> N <input type="checkbox"/>	29. On average, MST Therapists are seeing families fewer than two times per week.
Y <input type="checkbox"/> N <input type="checkbox"/>	30. The funding source for the next 12 months of operation has not been secured.
Y <input type="checkbox"/> N <input type="checkbox"/>	31. The MST program has lost a “champion” in one or more of the following areas: agency administration, program funding source, program referral source.
Y <input type="checkbox"/> N <input type="checkbox"/>	32. A noticeable lack of support/buy-in among one or more of the program’s stakeholders (i.e., within the agency, funding sources, referral sources, probation, child welfare, mental health, etc.) has been identified in the past 6 months.
Y <input type="checkbox"/> N <input type="checkbox"/>	33. Disincentives to use MST have been identified (e.g., referral source must pay for MST but not to place a youth).
Y <input type="checkbox"/> N <input type="checkbox"/>	34. Broader system or agency priorities appear to be shifting in ways that may not be consistent with maintaining or supporting the MST program. For example, funding is shifting so that only Medicaid reimbursement can be used to support the MST program..
Y <input type="checkbox"/> N <input type="checkbox"/>	35. Stakeholders are questioning the quality of the MST program’s outcomes (e.g., judge comments/complaints, high number of placements or violations of placement, etc.).
Y <input type="checkbox"/> N <input type="checkbox"/>	36. The number of “inappropriate” referrals (as defined in the program’s “Goals and Guidelines” document) to the MST program has increased significantly in the past 6 months.
Y <input type="checkbox"/> N <input type="checkbox"/>	37. The ability of MST staff to “take the lead” in clinical decision-making is being questioned or is becoming weaker.
Y <input type="checkbox"/> N <input type="checkbox"/>	38. The MST program is not covering program expenses (is losing money) on a regular basis.
Y <input type="checkbox"/> N <input type="checkbox"/>	39. The Supervisor position has been vacant for more than two months.
Y <input type="checkbox"/> N <input type="checkbox"/>	40. The consultant has not had direct contact with key administrative stakeholders within the organization within a twelve-month period.
Y <input type="checkbox"/> N <input type="checkbox"/>	41. The supervisor or other key stakeholder(s) has voiced dissatisfaction with the consultant or with MST Services that has gone unresolved for >= 3 months.

<b>Rationale for Required Program Practices and Characteristics:</b>	
1.	<p><b>MST Therapists are full-time employees assigned to the MST program solely.</b></p> <ul style="list-style-type: none"> <li>➤ MST Therapists must be full-time employees of the agency to enhance the therapist’s ability to effectively implement the MST model.</li> <li>➤ It is recommended that that MST Supervisors be full-time employees of the agency, even if they are only assigned to the MST program on a part-time Basis.</li> <li>➤ “Full-time” in the US is understood to be 40 hours per week or 2080 hours per year.</li> <li>➤ The expectation is that MST therapists and supervisors are salaried.</li> <li>➤ MST Therapists must participate in an on-call schedule to permit 24/7 client access to assistance by a person trained in MST and familiar with the client’s family’s situation.</li> <li>➤ It is the agency’s responsibility to ensure the program has sufficient referrals to keep therapists’ caseloads full so that each therapist can work at maximum productivity.</li> </ul>
2.	<p><b>MST Therapists do not have <u>any</u> non-MST program responsibilities in the agency, do not carry <u>any</u> additional non-MST cases, and do not have other part-time jobs outside of the agency.</b></p> <ul style="list-style-type: none"> <li>➤ MST Therapists must perform most of their MST activities away from the agency workplace, so participation in other agency activities may significantly inhibit the therapist from making contact with MST clients a first priority.</li> <li>➤ MST agencies should commit to a pay scale that will both attract and retain talented clinical staff and eliminate the necessity of holding multiple jobs.</li> <li>➤ Part-time job responsibilities outside the agency may interfere with the therapist’s ability to meet client needs in a timely manner and “as needed” fashion. (Also see rationale for item #3 below.)</li> </ul>
3.	<p><b>MST staff are allowed to work a flexible schedule as needed to meet the needs of the families they are serving.</b></p> <ul style="list-style-type: none"> <li>➤ MST Therapists must work flexible schedules to be available at times that are most convenient to their clients as a strategy to remove access as a barrier to engagement in treatment.</li> <li>➤ Flexible schedules remove the barrier of demanding that families fit their needs into an agency time schedule.</li> <li>➤ A flexible schedule allows staff to adjust their work schedules to work with families in the evening or on weekends.</li> <li>➤ Often family members work during normal and atypical work hours, making full family participation difficult without a flexible schedule.</li> <li>➤ Staff susceptibility to burnout may be reduced when the flexible schedule permits them to participate in other life activities during typical business hours and prevents overwork on the part of staff.</li> </ul>
4.	<p><b>MST staff are allowed to use their personal vehicles to transport clients.</b></p> <ul style="list-style-type: none"> <li>➤ Transporting clients can provide opportunities for engagement.</li> <li>➤ Transporting clients can remove short-term barriers to achieving weekly intermediary goals.</li> <li>➤ As the therapist becomes more aware of a client’s transportation needs and the associated barriers, he\she can develop and implement interventions to help the family resolve these problems as a long-term solution.</li> </ul>
5.	<p><b>MST staff have use of either cellular phones or pagers so that clients can contact them quickly and conveniently.</b></p> <ul style="list-style-type: none"> <li>➤ Cell phones and/or pagers allow the therapist to be more available and responsive to families, and to respond quickly to various crises that may arise with client families.</li> <li>➤ Where there are considerable drive times, or where telephone access is otherwise restricted, cell phones can improve the therapist’s and the supervisor’s efficient use of time. MST Services does not recommend the use of cell phones during driving unless a hands-free option is available.</li> <li>➤ Cell phones add an element of safety when the therapist is working in high-crime areas.</li> </ul>
6.	<p><b>MST Therapists operate in teams of no fewer than 2 and no more than 4 therapists (plus the Clinical Supervisor) and use a home-based model of service delivery.</b></p> <ul style="list-style-type: none"> <li>➤ The minimum of 2 therapists provides the opportunity for client coverage when one therapist takes personal time off.</li> <li>➤ The functioning of MST Therapists in a group context provides multiple benefits, including the efficiency of group learning, therapists bringing complementary knowledge and skill to the team, as well as providing emotional support for each other in the context of a demanding work situation.</li> <li>➤ The maximum of 4 therapists provides a limit on the number of therapists for whom a supervisor is expected to provide clinical training and support. This includes limits on the time required to conduct</li> </ul>

<b>Rationale for Required Program Practices and Characteristics:</b>	
	weekly group supervision where all cases must be reviewed weekly.
7.	<p><b>MST Clinical Supervisor is assigned to the MST program a minimum of 50% time per MST team.</b></p> <ul style="list-style-type: none"> <li>➤ The role of the supervisor extends well beyond conducting weekly group supervision, and at least 50% time is needed for a supervisor to fulfill the full range of responsibilities. (Refer to the job description for MST Supervisor to better understand the scope of the supervisor's responsibilities.)</li> <li>➤ In some programs, such as those in which the supervisor also fills the tasks associated with the role of Program Manager, more than 50% time should be allocated for the supervisor.</li> </ul>
8.	<p><b>MST Clinical Supervisor conducts weekly team clinical supervision, facilitates the weekly MST telephone consultation and is available for individual clinical supervision for crisis cases.</b></p> <ul style="list-style-type: none"> <li>➤ Group supervision is required to provide opportunity for all therapists to become familiar with all cases in order for them to provide quality crisis coverage. This must occur at least weekly to keep staff informed of recent progress and challenges.</li> <li>➤ Individual supervision on cases is not recommended in MST, because it tends to replicate activity in the group process and because other team members may not learn about decisions made in individual supervision.</li> <li>➤ Individual supervision may be provided in addition to the group supervision sessions in certain circumstances, primarily to address crisis situations, when the therapist's training needs vary greatly from the training needs of the remainder of the team, and occasionally when required for licensure of a new therapist. In addition, often clinician development planning happens in an individual context with the supervisor.</li> <li>➤ Weekly attendance at both supervision and consultation is required for both supervisor and therapists.</li> </ul>
9.	<p><b>MST caseloads do not exceed 6 families per therapist and the normal range is 4 to 6 families per therapist.</b></p> <ul style="list-style-type: none"> <li>➤ Caseloads must be sufficiently large (i.e., at least 4 cases) to assure good, well-managed use of the therapist's clinical skills and to facilitate focused, efficient use of time by the therapist and supervisor. Often when therapists carry a small caseload, therapist tasks expand to fill the extra time and the focus of treatment is not as sharp.</li> <li>➤ Caseloads must be sufficiently small (i.e., averaging 5 cases and a periodic maximum of 6 cases) to assure time for the intensity of treatment and the families' needed access to the therapist.</li> <li>➤ Intensity is generally much higher at the beginning of treatment, so if all cases are new, a caseload of 4 may be considered full for a limited time.</li> <li>➤ If one or more families are nearing termination, their treatment may become very low in intensity, allowing for additional new family referrals up to a maximum of 6 total cases.</li> </ul>
10.	<p><b>Overall average duration of treatment is 3 to 5 months.</b></p> <ul style="list-style-type: none"> <li>➤ The aim of MST is to implement sustainable ecological changes that will guide positive youth behavior change long after treatment is terminated. The youth may still test the limits of the system from time to time, but in MST research trials 3-5 months were sufficient to implement the change and test the ecology's new responses.</li> <li>➤ MST studies also indicate that clients generally receive diminished benefit with longer lengths of service, but the provider's daily expense of providing the service remains constant over time resulting in increased cost per client served.</li> </ul>
11.	<p><b>Each MST Therapist tracks progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly.</b></p> <ul style="list-style-type: none"> <li>➤ MST paperwork takes a planning focus and plays a central role in the ongoing MST analytical process that assures that new information from intervention outcomes or from new information sources can be incorporated into the treatment quickly.</li> <li>➤ MST paperwork communicates needed information to the team therapists, supervisor and the MST Expert in a way that allows for constructive feedback to assure ongoing adherence to MST principles as well as the best intervention strategies for client families.</li> <li>➤ Review of paperwork by the supervisor and MST Expert prior to group supervision and consultation, respectively, allows the group contexts of each to be used more efficiently and constructively, with much of the group time spent on concrete intervention planning.</li> </ul>
12.	<p><b>The MST program has a 24 hour/day, 7-day/week on-call system to provide coverage when MST Therapists are on vacation or taking personal time. This system is staffed by members of the MST team.</b></p> <ul style="list-style-type: none"> <li>➤ 24-hour access to care removes a common barrier to engagement in services. Families are encouraged</li> </ul>

<b>Rationale for Required Program Practices and Characteristics:</b>	
	<p>to call when they need help and not to wait until traditional (i.e., 8 am to 5 pm) office hours.</p> <ul style="list-style-type: none"> <li>➤ The on-call system must be staffed by the team’s therapists or supervisor, who participate in the weekly supervision and consultation, to assure that the person providing the on-call services will be familiar with the family’s needs and strengths.</li> <li>➤ Teams may choose the method for implementing the 24-hour on-call system as long as it meets the criteria for client access to a team member.</li> </ul>
13.	<p><b>With the buy-in of other organizations and agencies, MST is able to “take the lead” for clinical decision-making on each case. Stakeholders in the overall MST program have responsibility for initiating these collaborative relationships with other organizations and agencies, while MST staff sustain them through ongoing, case-specific collaboration.</b></p> <ul style="list-style-type: none"> <li>➤ Taking the lead on clinical decision making is consistent with the MST emphasis of accountability for family engagement and outcomes.</li> <li>➤ Multiple case managers may bring different, sometimes conflicting, perspectives to the case and may engage families in either overlapping services or services that conflict with MST and confuse the client family (e.g., group therapy for the youth).</li> <li>➤ In situations where the primary case manager is mandated for other reasons (e.g., probation officer, social service protective caseworker), MST will assure there is communication and collaboration among the systems to prevent case management problems. MST does request that mandated case managers include MST in all clinical decision-making activities related to the client family.</li> </ul>
14.	<p><b>The MST program excludes youth living independently, youth referred primarily for psychiatric service needs (i.e., suicidal ideation and behavior, actively homicidal, actively psychotic), youth referred primarily for sex offenses (in the absence of other antisocial/delinquent behaviors) and youth with pervasive developmental delays.</b></p> <ul style="list-style-type: none"> <li>➤ MST Services limits use of the MST treatment model to populations where there is proven evidence of positive outcomes.</li> <li>➤ Accepting client families outside the normal population parameters may result in therapist burnout and poorer client outcomes.</li> <li>➤ MST research focusing on other populations has revealed that MST must be significantly adapted to meet the needs of other populations. Adaptations generally result in additional resource requirements (e.g., specialized staff training, changes in caseload size and average length of treatment, different supervision protocols).</li> </ul>
15.	<p><b>Referrals to non-MST compatible programs (e.g., any form of mandated group treatment, day treatment programs, etc.) are not made while youth are in MST, especially on a “standard” or routine basis.</b></p> <ul style="list-style-type: none"> <li>➤ Research on treatments that group delinquent youth together indicate that these types of programs often lead to more crime and other undesirable outcomes.</li> <li>➤ Youth who spend time in these other programs have less time available for other types of activities encouraged through MST treatment, such as involvement in prosocial activities.</li> </ul>
16.	<p><b>MST program discharge criteria are outcome-based rather than duration-focused.</b></p> <ul style="list-style-type: none"> <li>➤ The determination to discharge a youth from MST is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g., youth, parent, school, probation officer) indicating that: <ul style="list-style-type: none"> <li>○ a majority of the overarching goals for the case have been met and sustained;</li> <li>○ the youth has few significant behavioral problems and the family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 4 weeks;</li> <li>○ the youth is making reasonable educational/vocational efforts;</li> <li>○ the youth is involved with prosocial peers and is not involved with, or is minimally involved with, problem peers; and</li> <li>○ the therapist and supervisor feel the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.</li> </ul> </li> <li>➤ Discharge from MST may also occur when few of the overarching goals have been met and when, despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested.</li> </ul>
17.	<p><b>Referrals for additional services after clients are discharged from the MST program are carefully</b></p>

<b>Rationale for Required Program Practices and Characteristics:</b>	
	<p><b>planned and limited to those that can accomplish specific, well-defined goals. The assumption is that most MST cases should need minimal “formal” after-care services.</b></p> <ul style="list-style-type: none"> <li>➤ MST aims to identify all supports needed by the youth and family to sustain positive outcomes. First priority is given to informal supports such as immediate or extended family, the youth’s and the family’s friendship network, and any other support that naturally exists within the family’s ecology (e.g., public recreation, the family’s church). Informal supports: <ul style="list-style-type: none"> <li>○ do not require application, qualification or special funding</li> <li>○ tend to be stable over time (i.e., no staff turnover)</li> <li>○ may be sensitive to the youth’s and the family’s needs because of long-standing relationships</li> <li>○ have no stigma attached to them</li> <li>○ may require some form of reciprocation</li> </ul> </li> <li>➤ Informal supports typically are managed and/or influenced by the youth’s caregivers, empowering the caregivers to take a lead in decision-making regarding the youth. Such empowerment often is not built into formal services.</li> <li>➤ MST treatment providers strive to help families limit the number and scope of formal services with which the family is involved, with a primary goal of empowering the family to make the primary decisions about their involvement with formal supports, to use their natural supports wherever possible, and to develop their own resources and problem-solving skills.</li> <li>➤ Additional formal services provided after MST may not support the gains achieved during MST, if they employ significantly different strategies than MST.</li> </ul>
18.	<p><b>All MST staff, who have been working for more than 2 months, participate in a 5-day orientation training.</b></p> <ul style="list-style-type: none"> <li>➤ MST 5-day Orientation is designed to equip the therapist and supervisor with the basic knowledge and skills needed to gain maximum benefit from supervision, consultation and clinical development activities.</li> <li>➤ MST provider organizations must provide budget support for new staff to receive training as soon as possible. Organizational efforts to recruit competent staff and provide incentives for staff retention will likely minimize the impact of turnover.</li> </ul>

<b>Additional Recommended Program Practices and Characteristics:</b>	
19.	<p><b>MST Therapists are Masters-prepared (clinical-degreed) professionals.</b></p> <ul style="list-style-type: none"> <li>➤ MST employs multiple clinical strategies such as Cognitive-Behavioral Therapy, Structural Family Therapy, Strategic Family Therapy, and other approved methods that are often taught in advanced clinical training courses. Knowledge of these strategies greatly accelerates a new therapist’s ability to implement MST with fidelity.</li> <li>➤ The MST Supervisor is required to provide training to any therapist lacking in one or more of the necessary clinical skill areas. Therefore, hiring inexperienced or untrained staff may reduce the amount of supervisor time spent on required duties and/or contribute to supervisor burnout.</li> <li>➤ In countries where clinical training differs from that in the United States, alternative applicant qualifications will need to be developed.</li> </ul>
20.	<p><b>MST Clinical Supervisors are, at minimum, highly skilled Masters-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy).</b></p> <ul style="list-style-type: none"> <li>➤ The MST Clinical Supervisor is the most important person on the team. A clinically strong supervisor with good leadership skills can transform a team with average capability into a highly effective team. A weak supervisor may find difficulty in retaining strong therapists and may be unable to improve the skills of less experienced therapists.</li> <li>➤ Strong skills in the component parts of MST provide the supervisor with the depth of knowledge needed to incorporate the skills into MST implementation.</li> </ul>
21.	<p><b>MST Clinical Supervisors have both clinical authority and administrative authority over the MST Therapists they supervise.</b></p> <ul style="list-style-type: none"> <li>➤ MST Services does not support the use of therapists from multiple agencies to comprise a single team.</li> <li>➤ MST Services does not support the use of therapists who are not full-time employees of the MST</li> </ul>

<b>Additional Recommended Program Practices and Characteristics:</b>	
	<p>provider agency.</p> <ul style="list-style-type: none"> <li>➤ MST quality assurance and supervisory practices require compliance by therapists to the MST clinical model to assure fidelity in the implementation of the model. Any question about the supervisor’s authority may interfere with appropriate responses to supervisory directives .</li> </ul>
22.	<p><b>A “Goals and Guidelines” document is in place. If multiple referral or funding sources exist, separate “Goals and Guidelines” documents are recommended for each.</b></p> <ul style="list-style-type: none"> <li>➤ The “Goals &amp; Guidelines” (G&amp;G) document represents the agreement between the MST provider agency and the community stakeholders about how the program will operate and be held accountable.</li> <li>➤ The G&amp;G is used in an ongoing way as the basis for problem solving when a problem with understanding or implementing the referral process is identified, when stakeholders forget the specific terms of the agreement, or new stakeholders become involved with an existing MST program. The document is meant to be a “living” document and can be amended as the need to operate differently is established and agreed upon by the same agency-stakeholder group.</li> </ul>
23.	<p><b>Funding for MST cases is in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, “productivity”, etc.</b></p> <ul style="list-style-type: none"> <li>➤ MST aims to separate the method of cost reimbursement from clinical activity to reduce the chance that funding will influence clinical decision-making.</li> <li>➤ MST aims to eliminate staff incentives that are based only on the amount of service provided regardless of its relevance or outcome.</li> <li>➤ For traditional contact hour billing mechanisms, significant amounts of provider energy tend to be spent on documentation of contact hours and this type of administrative activity is not likely to contribute to better client outcomes.</li> <li>➤ MST therapists spend considerable time engaged in activities that typically aren’t billable (e.g., treatment planning, making repeated contacts to engage families that are hard to reach, travel time) but are critically related to obtaining positive outcomes.</li> <li>➤ Goals of MST treatment include achieving positive outcomes as quickly and efficiently as possible, ensuring that treatment gains are sustainable by the family on their own, and increasing family responsibility; therefore, the therapist often only needs to meet with families infrequently and/or for short periods of time towards the end of treatment, which conflicts with billing practices that focus on client contact hours.</li> <li>➤ In practice, case rates appear to work best to facilitate fidelity to MST, as the model dictates an intensive yet individualized treatment delivery.</li> </ul>
24.	<p><b>The MST program has formal outcome-tracking systems in place.</b></p> <ul style="list-style-type: none"> <li>➤ MST is implemented as a strategy to meet some community-level goals - typically, to reduce costs associated with out-of-home placement, to improve public safety by reducing offending behavior and to improve youth engagement in productive prosocial activities such as school or work.</li> <li>➤ Long-term stakeholder support of MST depends on evidence that the program is meeting the community’s needs in a cost-effective manner.</li> <li>➤ MST aims to increase provider accountability by focusing on client outcomes.</li> <li>➤ Tracking outcomes provides a feedback loop for ongoing program improvement through clinical development of staff and improved collaboration with other community agencies and resources.</li> </ul>
25.	<p><b>Adequate flex funds are allocated per family (recommended \$100/family) to allow therapists to use funds for purposes such as engagement building and one-time help for families with pressing practical needs.</b></p> <ul style="list-style-type: none"> <li>➤ Flex funds are only used as a last resort to overcome barriers to treatment when natural resources and supports are not immediately available to do so. The therapist works with the family during treatment to establish long-term plans for the family to address their financial and practical needs.</li> <li>➤ Therapists often find that small purchases, such as an occasional pizza for a family session, can facilitate engagement. Examples of other expenditures that can help a family and the treatment process include having a phone connected or paying enrollment fees for the youth to attend a prosocial activity.</li> <li>➤ Use of the account is managed by the MST Supervisor to assure that funds are not used to replace resources available in the family’s ecology or to create dependency on the therapist or on the program.</li> </ul>
26.	<p><b>The MST program uses outcome-focused personnel evaluation methods.</b></p> <ul style="list-style-type: none"> <li>➤ Personnel evaluations focused on program adherence and client outcomes will promote clinical improvement among staff. Also, staff with poor adherence or few positive client outcomes will likely</li> </ul>

<b>Additional Recommended Program Practices and Characteristics:</b>	
	<p>move to other positions.</p> <ul style="list-style-type: none"> <li>➤ If an agency supports the notion that positive and sustainable client outcomes are the primary aim of the service, attaching staff incentives to such outcomes ensures that the therapist's actions are outcome-focused.</li> </ul>

**The following factors have been identified as potential indicators of future or ongoing challenges to program adherence and successful implementation.**

	<b>Indicator</b>
27.	<p><b>There has been more than 30% attrition among the MST staff in the past 6 months.</b></p> <ul style="list-style-type: none"> <li>➤ Staff with more MST experience typically operate more efficiently and effectively and are able to produce better client outcomes.</li> <li>➤ Anecdotal reports from field staff implementing MST indicate that basic familiarity with MST occurs within the first 6 months of experience, but building relationships in the community that promote collaboration can take a year or more to develop because of the relatively diffused contacts made over time.</li> </ul>
28.	<p><b>MST staff compensation is equal to or less than that of staff in office-based positions or other in-home programs that hold staff to a lower level of accountability in their work.</b></p> <ul style="list-style-type: none"> <li>➤ MST requires considerable commitment on the part of therapists and supervisors to do “Whatever It Takes” to achieve client outcomes. This may sometimes mean working unusual hours and a high level of responsiveness to client family needs. Workers who observe others with less responsibility earning similar wages may feel unappreciated or under valued.</li> <li>➤ MST supports a structure where compensation is in line with responsibility and required employee commitment. MST also supports providing an opportunity for therapists and supervisors to earn incentives for positive client outcomes sustained 18 months post treatment termination.</li> <li>➤ Hiring well-qualified MST therapists is essential to the success of the program. When compensation is inadequate, programs have difficulty attracting and retaining the best qualified staff, which can lead to poorer outcomes for families.</li> </ul>
29.	<p><b>On average, MST Therapists are seeing families fewer than two times per week.</b></p> <ul style="list-style-type: none"> <li>➤ Interventions in MST require daily effort on the part of family members. Early in treatment, therapists may need to make contact with the family members daily to assure that changes are being implemented and done correctly.</li> <li>➤ As families move through treatment, client contact is reduced as family members demonstrate ability and consistency in implementing interventions.</li> <li>➤ MST does not support designating a specific number of visits per week, either as a minimum or maximum. The therapist can then develop a frequency of contact based on family needs, not based on funding requirements.</li> </ul>
30.	<p><b>The funding source for the next 12 months of operation has <u>not</u> been secured.</b></p> <ul style="list-style-type: none"> <li>➤ Funding that is not secure past 12 months may result in program staff seeking other employment that can offer more stability.</li> <li>➤ Funding instability may reflect either an unsupportive stakeholder environment or ineffective management of the MST provider agency.</li> </ul>
31.	<p><b>The MST program has lost a “champion” in one or more of the following areas: agency administration, program funding source, and/or program referral source.</b></p> <ul style="list-style-type: none"> <li>➤ MST provider agencies must maintain relationships with key stakeholders to assure productive communication and collaboration. Loss of an identified champion of MST may reduce overall community support for the program.</li> <li>➤ Loss of a stakeholder or champion should trigger a well-planned response to identify a replacement and initiate the new relationship.</li> </ul>
32.	<p><b>A noticeable lack of support/buy-in among one or more of the programs’ stakeholders (i.e., within the agency, funding sources, referral sources, probation, child welfare, mental health, etc.) has been identified in the past 6 months.</b></p> <ul style="list-style-type: none"> <li>➤ The support and buy-in of program stakeholders or champions is vital to long-term program viability. Diminished support by program stakeholders should be viewed as a high priority issue, and addressed as a quickly as possible.</li> </ul>
33.	<p><b>Disincentives to use MST have been identified (e.g., referral source must pay for MST but not to place</b></p>

	<b>Indicator</b>
	<p><b>a youth).</b></p> <ul style="list-style-type: none"> <li>➤ MST providers must be aware of the larger picture of the service system and the associated roles, relationships and issues.</li> <li>➤ Disincentives to use MST may be present when there are multiple treatment options available and there is little understanding of the long-term impact of each option, or when system-level responsibilities for youth change when youth are legally placed in the custody of the service system.</li> <li>➤ Sometimes, political stakeholders must be engaged in an ongoing effort to assure that the political focus is on the best outcomes and on the most cost-effective solutions for the overall system.</li> </ul>
34.	<p><b>Broader system or agency priorities appear to be shifting in ways that may not be consistent with maintaining or supporting the MST program (e.g., funding is shifting so that only Medicaid reimbursement can be used to support program).</b></p> <ul style="list-style-type: none"> <li>➤ MST agencies must maintain awareness of the trends in program finance to be sure that an effort to support program finance (e.g., initiation of Medicaid funding support) does not result in removal of support from other sources. For instance, Medicaid funding alone is unlikely to pay for full program operation, requiring contributions from other sources.</li> <li>➤ The focus of any given system or agency often shifts over time. MST program staff must maintain an awareness of these shifts and regularly communicate with decision makers within the system or agency about the value and positive outcomes of the MST program in order to obtain support for its continued existence.</li> </ul>
35.	<p><b>Stakeholders are questioning the quality of the MST program’s outcomes (e.g., judge comments/complaints, high number of placements or violations of placement, etc.).</b></p> <ul style="list-style-type: none"> <li>➤ MST Services views stakeholders who report problems as being helpful. When complaints are made, it is up to MST program staff to assess the fit of the complaint and address the relevant drivers and issues.</li> <li>➤ Objective data on program implementation (adherence) and outcomes may provide help inform stakeholder concerns.</li> <li>➤ MST agencies should be willing to provide objective data, even when the data indicates problems or challenges. When problems are identified, engage the stakeholder by sharing quality improvement plans and inviting input from the stakeholder.</li> <li>➤ In some cases, community stakeholder barriers may contribute to program challenges. We encourage programs to renegotiate roles and relationships, assuring that all are focused on common outcome goals.</li> </ul>
36.	<p><b>The number of “inappropriate” referrals (as defined in the program’s “Goals and Guidelines” document) to the MST program have increased significantly in the past 6 months.</b></p> <ul style="list-style-type: none"> <li>➤ Inappropriate referrals can have a variety of causes including: <ul style="list-style-type: none"> <li>○ Poor understanding of MST on the part of referral sources</li> <li>○ Insufficient numbers of appropriate referrals</li> <li>○ Shift in stakeholder priorities</li> <li>○ Shift in agency administration priorities</li> <li>○ Other problems in the referral process</li> </ul> </li> <li>➤ Accepting inappropriate referrals often leads to poorer outcomes with those youth since the MST model isn’t designed to meet their needs. Poor outcomes may damage the program’s reputation and adversely affect the program’s viability.</li> <li>➤ Accepting inappropriate referrals typically has a snowball effect; once one such referral is seen as acceptable, the frequency of inappropriate referrals increases, which typically leads to reduced adherence to the model by the MST program and worse outcomes overall.</li> </ul>
37.	<p><b>The ability of MST staff to “take the lead” in clinical decision-making is being questioned or is becoming weaker.</b></p> <ul style="list-style-type: none"> <li>➤ MST clinical decision-making leadership assures consistency and continuity of services.</li> <li>➤ As time passes and stakeholders change, newer persons may not understand the need for centralized clinical decision-making.</li> </ul>
38.	<p><b>The MST program is not covering program expenses (is losing money) on a regular basis.</b></p> <ul style="list-style-type: none"> <li>➤ Most agencies cannot sustain MST programs that consistently lose money. We recommend regular reviews of budgets, cost recovery methodology ( i.e., case rates vs. hourly or sub-hourly rates), unanticipated losses or rejection of billing, staff turnover rates, average caseloads, average length of treatment and other relevant data to determine the sources of the problem.</li> </ul>
39.	<p><b>Supervisor position has been vacant for more than two months.</b></p> <ul style="list-style-type: none"> <li>➤ The MST Supervisor is the most important person on the team. Even when another supervisor is</li> </ul>

	Indicator
	providing coverage, the team collaboration and effectiveness will be damaged without a permanent supervisor in place.
40.	<p><b>The MST Expert has not had direct contact with key administrative stakeholders within the organization within a twelve-month period.</b></p> <ul style="list-style-type: none"> <li>➤ The MST Expert must take ownership of relationships with key provider agency personnel. Building and maintaining relationships with key provider agency personnel is a critical part of the larger process of maintaining strong internal support for the MST program. This link is necessary to establish the role of the expert as supporting the program to achieve outcomes which often includes the expert's participation in crafting and helping to implement agency-level and/or system-level interventions.</li> <li>➤ The MST Expert may need to work with key administrative agency personnel to solve problems within the program and team (e.g., low supervisor performance or high turnover).</li> </ul>
41.	<p><b>The supervisor or other key stakeholder(s) has voiced dissatisfaction with the MST Expert or with MST Services that has gone unresolved for &gt;= 3 months.</b></p> <ul style="list-style-type: none"> <li>➤ Indications of dissatisfaction with either an MST Expert or with MST Services should always be addressed quickly through a process of open communication and collaborative in problem-solving.</li> <li>➤ MST Services will always support a position of constant evaluation and improvement of adherence to MST and its implementation protocol and an ongoing focus on client outcomes.</li> <li>➤ MST Services may invite the top state-level stakeholders into the problem resolution process to assure that the wishes of those ultimately responsible for meeting the needs of youth and families are satisfied.</li> </ul>