Submission No. 48
(youth violence)
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LIFE WITHOUT BARRIERS

Committee Secretary
Standing Committee on Family, Community, Housing and Youth
PO Box 6021
House Of Representatives
Parliament House
CANBERRA ACT 2600
AUSTRALIA

To the Committee Secretary of Family, Community Housing and Youth

Please find attached a submission addressing the current inquiry into the impact of violence on young Australians.

I am currently the National Manager of Life Without Barriers MST operations for Australia and New Zealand. I have worked in the field of criminal offending, substance abuse and juvenile justice for the last 15 years developing and running a range of programs both in the community and in residential settings. Part of my current role is to provide Quality Assurance, consultation and training to a number of multisystemic therapy teams that aim to reduce youth violence and substance use.

If you require more information please do not hesitate to get in touch.

Regards

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This letter is in response to the request for submission on the impact of violence on young Australians and I intend to focus specifically on strategies to reduce violence.

Effectively addressing youth violence and substance use can seem overwhelming however, in the past decade there have been significant advances in treatment that provides hope for communities and families. Three programmes are showing promising international results with reducing violence in young people: Functional Family Therapy, (FFT; Alexander & Sexton, 2002); Multisystemic therapy (MST; Curtis, Ronan, Heiblum, Reid & Harris, 2002) and Multidimensional Treatment Foster Care (MTFC; Chamberlain, 1998). Of these treatments, MST is the only approach that is available in Australia.

What is MST?

Multisystemic Therapy (MST) is a family and community based treatment approach that has achieved long-term positive outcomes with antisocial youth (aged 10 to 17) by addressing the multiple determinants of serious antisocial behaviour. Positive outcomes include reducing offending, increasing school or vocational attendance and reducing the need for out-of-home placements. The approach provides cost savings in comparison with usual mental health and juvenile justice services. Although essentially a combination of "best practice" treatment models, MST is distinguished by three key features.

Firstly, MST is provided within the context of the family, and is focused on empowering parents and others to develop the necessary skills and competences to help the youth reduce problematic behaviour and function more effectively. Therapists are available 24 hours, seven days a week to families in order to be helpful at times that are most convenient to families. Therapists work alongside families to develop interventions that fit with their unique values and cultural needs and that build on existing strengths. MST views the caregivers as key players in achieving long-term sustainable change. Treatment is time limited with an emphasis on the family taking ongoing responsibility for the management of the young person with the direction and guidance of the MST therapist – usually five months.

Secondly, MST has a 20 year history of rigorous scientific evaluation to show its long term effectiveness. International empirical findings indicate that MST has long-term efficacy in treating serious antisocial behaviour in adolescents (e.g., Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Henggeler, Schoenwald, Pickrel, Rowland, & Santos, 1994), as well as a variety of co-occurring problems such as substance abuse, sexual offending, and severe emotional disturbance (Henggeler, et al., 1994).

Thirdly, an intensive quality assurance process has been developed to help MST programmes maintain strict adherence to the treatment model. MST outcome studies clearly demonstrate that treatment adherence is predictive of positive treatment outcomes (e.g., reduced rates of

offending and out of home placements, improved school attendance). Indeed, failure to maintain adherence has been found to compromise treatment outcomes across numerous research trials (Henggeler, Rowland et al., 1997). In response to this emphasis on adherence LWB MST was established to train providers and ensure agencies maintain strong fidelity to the treatment model. This is done through assistance with all aspects of programme development, clinical consultation, staff training and implementation. Whilst small caseloads, 24/7 coverage, and extensive quality assurance adds to the costs of this programme, it is considered value for money when the favourable results are taken into account.

The first controlled study of MST with juvenile offenders in the USA was published in 1986, and since then, three randomised clinical trials with violent and chronic juvenile offenders have been conducted. In these trials, MST has demonstrated long-term reductions in criminal activity, drug-related arrests, violent offences, and incarceration. This success has led to several randomised trials and quasi-experimental studies aimed at extending the effectiveness of MST to other populations of youth presenting serious clinical problems. The first study of MST in the southern hemisphere in New Zealand was conducted by Nici Curtis (2003) and replicated several of the findings of the American studies.

Current situation in Australia

There are currently 9 MST teams in Australia. This number is made up of two mental health teams and five Juvenile Justice teams in Western Australia that begun in 2003 and two Juvenile Justice teams in NSW that were created in 2008.

MST within Life Without Barriers: MST Australia

The core activities provided by MST Australia, the national organisation licensed to provide consultation and training, consisting of an initial training, ongoing MST clinical support, quarterly booster training, ongoing organizational assistance and quality assurance support through the monitoring of treatment fidelity/adherence.

The MST dissemination process and protocols developed by the models founders replicate the characteristics of training, clinical supervision, consultation, and monitoring provided in the successful clinical trials of MST. This programme implementation protocol has been refined through extensive experience with communities and providers in numerous sites within the USA and with other countries including Norway, Sweden, United Kingdom and New Zealand (The programme has also proved easily adaptable to national and local cultural needs). After start-up, training continues through weekly telephone MST consultation for each team of MST clinicians. The weekly consultation is aimed at monitoring treatment fidelity and adherence to the MST treatment model. Further training and monitoring also takes place at face-to-face quarterly on-site booster trainings. The MST consultant teaches each MST team supervisor to implement a manualised MST supervisory protocol to promote the ongoing clinical development of all team

members. The MST consultants also assists at the organizational level, providing support for teams with funding issues and recruitment and also helps organisations address ongoing barriers to MST treatment delivery. This attention to rigorous adherence is designed to ensure that young people achieve the result of reducing violence, increasing prosocial involvement and remain at home with their families.