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Multisystemic Therapy for Emerging Adults With Serious Mental Illness and Justice Involvement

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Most serious mental illnesses (SMI) have onset by emerging adulthood and SMI can impair adolescents' transitions into healthy, productive adults. Emerging adults (EAs) with SMI are at high risk for justice involvement, and rates of recidivism are greater for offenders with SMI than without. These EAs are frequently multi-system involved (e.g., aging out of foster care; both juvenile and adult arrests; prison reentry). Few interventions, however, have focused specifically on EAs, and no interventions have focused on reducing recidivism in EAs with or without SMI. Multisystemic Therapy for Emerging Adults (MST-EA) is an adaptation of standard MST (for adolescent antisocial behavior) that was specifically designed for EAs with SMI and justice involvement. This paper provides the first description of MST-EA, including clinical outcome data on pilot cases and an extensive case example. To date, 57 cases have been treated with MST-EA. Success at discharge was demonstrated on main outcomes (rearrest and mental health) and other functional outcomes. Clinical data on pilot cases is promising and supports further research to assess long-term outcomes and effectiveness.

Emerging adulthood marks a unique developmental stage beginning as early as 14 years of age and continuing to 25 or 26 years of age (Arnett, 2000; Davis & Vander Stoep, 1997). Emerging adults (EAs), also known as transition-age youth, are at heightened risk for an array of problems that can have a lifetime of impact. The onset of mental illness occurs primarily during this age range, with three quarters of all serious mental illnesses (SMIs; e.g., schizophrenia, major depressive disorder, posttraumatic stress disorder) having onset before the age of 25 (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012; Kessler et al., 2007). Prevalence rates of SMIs (excluding substance abuse disorders) are nearly 10% among EAs and are higher during this time than at any other developmental period (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

The transition to adulthood can be tremendously compromised by mental health needs in functional realms, with 42% unemployment, 45% high school dropout, and 30% homeless rates among EAs with SMI (Davis & Koroloff, 2006; Davis & Vander Stoep, 1997; Embry, Vander Stoep, Evens, Ryan, & Pollock, 2000; Newman, Wagner, Cameto, & Knokey, 2009). Further, SMIs acutely impact EAs' struggle to stay out of trouble with the law. Young adulthood marks the peak age of criminal activity (Farrington, 2005), but adolescents transitioning to adulthood with an SMI are two to three times more likely to become justice involved than adolescents without SMIs (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007; Vander Stoep et al., 2000). Notably, 1-year rearrest rates among EAs with SMI are 49% in males and 28% in females (Davis et al., 2007). This denotes an astoundingly high-risk subpopulation (i.e., one half of young men and one third of young women with an SMI who get arrested will be rearrested within a year), yet little research and no clinical interventions have targeted this population.

Multisystemic Therapy for Emerging Adults (MST-EA) is an intervention specifically designed to reduce recidivism in young adults (ages 17 to 21 years) who have SMIs. As described subsequently, it was adapted from MST for juvenile delinquents (age 12 to 17 years; Henggeler, Schoenwald, Rowland, & Cunningham, 2002), an intensive, home-based family and ecological treatment targeting adolescent antisocial behavior (i.e., it is not used for young adults or for SMIs) and preservation of community-based living (i.e., avoiding out-of-home placements). With more randomized controlled trials than any other youth treatment for conduct problems, including numerous replications by independent investigators, and striking positive outcomes (e.g., 47% to 64% reduction in out-of-home placements; over 50% reduction in arrests and incarceration; over 40% reduced justice involvement; less than one-fifth the cost of typical

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institutional placement) in both the short- and long-term (e.g., 25 year posttreatment outcomes demonstrated), MST is one of the few well-established evidence-based practices for juvenile delinquency (see McCart & Sheidow, in press).

The primary purposes of the MST-EA adaptation are to reduce recidivism and support positive functioning in school, work, independent living, and relationships, while ensuring treatment and management of mental illness and any co-occurring substance use disorder. Currently there are no proven effective interventions to reduce recidivism in EAs, with or without SMI, but MST-EA has been piloted over the past 4 years to target this high-risk population. Promising results from a small open trial demonstrating efficacy of MST-EA were recently published (Davis, Sheidow, & McCart, 2015). Presented here is the first description of the MST-EA model, as well as clinical data on all pilot cases to date and a case example that demonstrate important characteristics of the model.

Multisystemic Therapy for Emerging Adults (MST-EA) Description

Intended Population

Currently, MST-EA is intended for young adults at highest risk for recidivism: that is, 17- to 21-year-olds diagnosed with SMIs who have had a recent arrest or release from incarceration (i.e., jail, prison, detention) in the past 18 months. MST-EA clients must have a diagnosed mood, anxiety, psychotic, or eating disorder. Clients can also have co-occurring behavioral disorders (conduct, attention, and substance use disorders), but these are not required to qualify for MST-EA treatment. Individuals with co-occurring autism, pervasive developmental disorders, or mental retardation must be excluded due to extensive reliance on individual cognitive interventions in MST-EA treatment.

MST-EA is appropriate for individuals who can safely reside in the community (e.g., not actively suicidal, homicidal, psychotic), including those approaching release from treatment or justice facilities (e.g., re-entry populations). Individuals may or may not have involvement from family members and could be living with family or independently, as well as in group homes or supervised living situations that are community-based (i.e., facilities that are not "locked" and allow EAs to leave the facility for activities, school, jobs, and appointments). Pregnant and parenting young adults can be treated in MST-EA. The treatment is intended for individuals who have stable community residence (i.e., are not currently homeless, temporarily "bunking" with others, "couch–surfing," or in shelters), although homelessness can arise during treatment.

Treatment Delivery

As with standard MST, MST-EA treatment is provided by a team of highly trained and monitored professionals, with each team member having specific roles and responsibilities. The MST-EA treatment team includes three to four full-time MST-EA therapists who have at least a master's degree and a full-time MST-EA supervisor who has at least a master's degree and 3 years of experience in delivering clinical services. Therapists carry a low caseload limited to four clients/therapist, delivering intensive interventions to each client for between 4 and 12 months (average has been 7 months.) Contact is frequent, sometimes daily (combination of in-person and phone sessions), with a minimum of about 4 hours of direct contact each week ranging as high as necessary (e.g., 5–10 hours is not uncommon). As with all MST adaptations, the therapists and supervisor work closely together to provide 24 hours/day, 7 days/week availability, allowing for flexibility in session times and for emergency problem solving with clients and members of their ecology. Clinical services are delivered in home, work, school, and/or neighborhood settings at times convenient to the client, with extensive effort devoted to engagement and retention of clients in treatment. An off-site expert clinical consultant provides weekly quality assurance and ongoing training in MST-EA, as is the case for all MST programs.

In addition to the MST-EA therapists and supervisor, a psychiatrist (or psychiatric nurse practitioner) has worked with the team for 4–6 hours/week to focus on mental illness symptom assessment and psychopharmacological care, when needed. As the clinical program was piloted, however, the team faced barriers with transitioning clients who would need long-term psychopharmacological care to community-based professionals, so the MST-EA team no longer includes its own psychiatric support; rather, the team develops and maintains close collaborations in the communities they serve and coordinates psychopharmacological care (as well as other physical health–related care; e.g., gynecological care, dental care, prevention care) for EAs. As part of their coordination efforts, the MST-EA therapist assists the psychiatrist (or other health-care professional) in assessing medication or health regimen adherence, as well as assessing throughout the week the effectiveness of any regimen changes. Initially, the MST-EA therapist may be an active participant in working with the health care professional (e.g., transporting EAs to appointments, assisting EAs in tracking adherence and outcome of the regimen), but the therapist teaches these skills to the EA and transitions the EA into leading their own health care during treatment. To ensure that long-term health care needs are addressed, therapists will identify and