Strengthening the Spirit:

Adapting Multisystemic Therapy (MST) for Native American Youth and Communities

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Abstract

Multisystemic Therapy [MST] is an evidence-based treatment for youth with severe psychosocial and behavioral problems. Discussed are the personal experiences of a Native American student in social work who is engaged in pursuing information on MST for Native youth and communities. Although there is still promise of its efficacy, there are questions on MST's effectiveness, replicability, and ease of implementation as a program. There is little quantitative and qualitative information to date to support its generalizability across race – no outcome results for Native participants have been disseminated. With goals of strengthening Native families and communities, discussion includes how MST can be adapted for use and programs concerns that should be considered.

Introduction

This article researches and qualitatively discusses the adaptability and applicability of Multisystemic Therapy (MST) as a family preservation intervention focused on Native[1] youth and communities, with interest in outcomes and program evaluation. While MST is supported by some evidence on effectiveness, there are questions on its replicability to other locations, generalizability across race, and ease of implementation as a program. There is still some promise for the use of MST with Native youth and communities. However, there is little quantitative and qualitative information to date to support this. This article may be of interest to those who work with youth and families, the juvenile justice system, child welfare, mental health, public policy; as well as those involved or have interest in outcome-based program evaluation, cultural and minority affairs, social work graduate programs, and Native issues and perspectives.

Experiences of a Native Student in Social Work

As a graduate student in social work, the first thing we learn is history: "Industrialization [italics added] was the social crisis which occurred in Western Europe and North America in the eighteenth and nineteenth centuries which led to the creation of social work as an institution and a profession" (University of Edinburgh, 2005). Early in this introduction to social work history, I began to wonder where Natives exist within the collective consciousness of my chosen profession. Having lived in Miami within a refugee community and having one parent who is an Indigenous person, I had seen the effects of colonization, racism and poverty on mental health and well-being. I was interested in broadening the knowledge I had acquired from life and work experiences. However, due to the lack of Native and other minority viewpoints and content, I felt called upon to address indifference within the research literature and clinical practice. It was necessary at times to teach instead of learn about the perspective of communities of color. As a graduate student of color, I always felt the need to probe further into discussions and research findings to get at the minority perspective and to ensure the representation of people of color in research that would affect the implementation of practices that would eventually impact them.

Over the two years of study, I attended classes and presentations on promising, evidence-based practices; participated in panels on racial disparities; and conducted literature reviews for research papers and other graduate school work with a focus on minority populations – to find that "there is a paucity of evidence based prevention and intervention practices specifically addressing [Native children's] needs" (Yellow Horse & Brave Heart, 2003). One family-focused intervention that had generated a lot of interest was Multisystemic Therapy (MST). MST is very highly regarded in evidence-based discussions, and I became interested in how Native youth fared with this intervention. In Washington State, it has been court-mandated for adolescents involved in the justice system, and there are discussions of its implementation in the DCFS child welfare system. Knowing that, as a court mandated treatment, MST will affect Natives and that MST claims to be "culturally appropriate" and culturally competent based on its practice methodology (MST Services Inc., 2005; Stewart, 2005), I became interested in further investigation on MST in the Native community. I felt I should more critically analyze emerging best practices because, as Yellow Horse and Brave Heart point out, there are "a number of evidence-based practices assumed effective for [American Indian / Alaska Native (AI/AN)] children because they were utilized with diverse ethnic groups"; and to follow the suggestion that "evidence based and promising practices, with potential to be effective with AI/AN population, should be adapted and evaluated" (2003).

From an academic perspective and with no affiliation with MST Services Inc. (the company which disseminates and licenses

MST as a practice), I probed further into MST, wanting to learn if it would be applicable and adaptable to Native families and to find out its outcomes, if any, for Native youth. I believe strongly in finding intervention efforts that can follow ICWA's mandate to make "proactive efforts to prevent out-of-home placements of Indian children by providing preventative services and supports to Indian families" (Jones, Gillette, Painte, Paulson, 2000). Thus, MST (as a family-centered, "best practice" being considered by state legislatures, departments of corrections, child welfare authorities, and state mental health agencies as the way to handle adolescents with mental health and juvenile delinquency problems) was a practice that was of interest to me as a preventative service for Native youth.

MST: Overview

MST was originally developed in the U.S. in the late 1970s by Scott Henggeler at the Family Services Research Center (FSRC), Medical University of South Carolina (MUSC) (more detailed information about MST can be found at MST Services Inc., 2005). The intervention was to address, very specifically, problems with juvenile delinquents. MST evolved to address youth with severe psychosocial and behavioral problems -- youth with multiple delinquency offenses, who are at risk for out-of-home placements; often with co-occurring disorders such as substance and alcohol abuse (Stewart, 2005). In response to increased interest, MST Services Inc. (a private organization affiliated with FSRC) was created to handle dissemination of MST intervention services, while FSRC continued with research. Research and development in the U.S. and internationally continues; and to date, MST is offered in 25 U.S. states, as well as internationally in Australia, Canada, Denmark, Norway, Northern Ireland, England, New Zealand and Sweden, serving more than 8,000 families annually (MST Services Inc., 2005).

MST is based on a family preservation model, while viewing the youth in a complex social ecology (social-ecological model, see Figure 1). The approach views "individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems" (MST Services Inc., 2005). This is congruent with a Native worldview that sees interconnected spheres of influence, rather than discrete individuals or family groups. MST therapists work with youth, their families, along with other people who can affect positive change in the youth's life. For Natives, this could include parents, extended family, elders and spiritual advisors, tribal community, peer, and social groups (a Native ecological model is also discussed in Red Horse, Lewis, Feit, Decker, 1978). Thus, MST intervention services are delivered to the family and community as a whole.

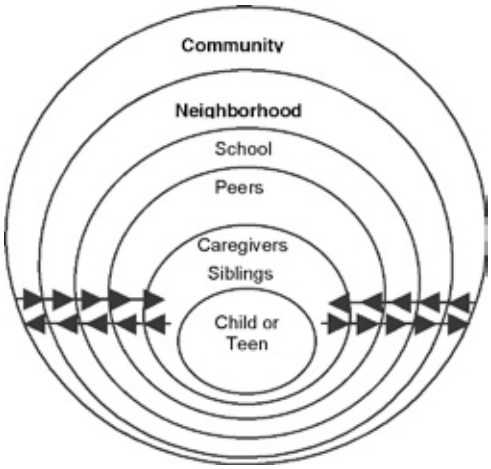

Figure 1. Social-Ecological Model of MST

Ecology model of social support shows caregivers, siblings, peers, school, neighborhood, and other community members as key figures in the lives of children and adolescents. From D.G. Stewart, 2005, Principles and practices of Multisystemic Therapy (MST), PowerPoint presentation, Seattle, WA: Prime Time, University of Washington School of Medicine. Adapted with permission.

As an alternative (sometimes, court-mandated) to out-of-home placement, youth and their families are referred to the MST program. If they qualify, they are assigned to a MST therapist. In a case management approach, therapists handle a small caseload (4-6 families) in order to effectively deliver intensive services. The intervention is

designed to be short-term and time-limited (generally, 4-6 months). Service delivery is home-based, with therapy done at the home, often with several home visits and approximately 15 contact hours during a week. MST therapists are available 24 hours / 7 days a week, on-call through a pager system. Therapists are mental health professionals with masters or doctoral degrees, and MST Teams include therapists, crisis caseworkers, and a supervisor who is a clinical psychologist or psychiatrist. Teams are specially trained and certified, their agencies are approved and licensed, and on-going consultation and training is provided by MST Services Inc. Treatment modality is manualized, available "off the shelf", and there is emphasis on quality assurance and adherence to the model.

MST as a clinical intervention differs from other approaches in its "multi-system" approach. Conceptualization of the problem is comprehensive, but specific interventions practices are not limited -- a variety of strategies can be employed to address specific problems (in other words, through MST, a variety of interventions can be employed). In addition, it offers a pragmatic approach to the families. Therapists develop, in collaboration with the family, well-defined treatment goals. Daily assigned tasks focus on addressing specific problems, and achievements draw from family's strengths (strengths-based). Services are provided in the context of the family's needs, values, beliefs, and culture.

Is MST Good Medicine?

In Washington State, MST has the support of some key "agency stakeholders", including juvenile justice and child welfare systems. Washington State Institute for Public Policy (WSIPP), a Washington State legislature funded research group, has recognized MST as a "Blueprint Program"(based on The University of Colorado's Center for the Study and Prevention of Violence Criteria, 2005;

Barnoski, 2004) and as a research-proven "Blue Chip" program, which WSIPP recommends investing public money in (Aos, Lieb, Mayfield, Miller, Pennucci, 2004). From a Euro-Western viewpoint, it was found to be a cost-efficient alternative to juvenile corrections, $9,316 U.S. dollars per youth, or a return-on-investment of $2.64 benefit-per-cost in U.S. dollars (ibid).

MST is generally regarded as a tested treatment theory with effective program outcomes. It is cited as "an effective, evidence-based treatment model" by many U.S. groups including U.S. National Institute on Drug Abuse, National Institute on Mental Health, Surgeon General's Office, Center for Substance Abuse Prevention, Office of the Juvenile Justice and Delinquency Prevention, Annie E. Casey Foundation, and The Substance Abuse and Mental Health Services (Littell, 2005, p. 450).

U.S. research studies on effectiveness have found that it prevents further delinquency (long-term recidivism reduced by 25-75%) (MST Services Inc., 2005, referencing studies by Henggeler, Borduin, Brunk, Becker, etc.). In addition, MST also reduced out-of-home placement by roughly about half (47-64%) (ibid) and improved family functioning – outcomes which are aligned with what Native communities most value. MST also resulted in decreased mental health symptoms and problems. The intervention kept youth in their communities, out of custody with less public expense, without putting the community at risk.

Recent research, however, has begun to question the "evidence" behind MST. Interim results discussed in annual program reports in Ontario, Canada ["Ontario study"], conducted independently by Leschied and Cunningham, found no statistically significant differences between MST groups and control groups (2002). Researchers found mixed results – with positive family functioning and psychosocial measures, yet less impact on re-incarceration than expected (Leschied & Cunningham, 2001, 2002; Cunningham 2002; Henggeler 2005).

From a perspective of the science and practice of research synthesis, Littell recently published a systematic review

including a meta-analysis of intervention effects described in prior MST research, following the standards and guidelines of the Cochrane Collaboration and the Campbell Collaboration on conducting and disseminating unbiased research syntheses (2005, p. 447). Littell's systematic review of MST "points to inconsistent and incomplete reports on primary outcome studies, important variations in the implementation and integrity of randomized experiments, errors of omission and interpretation in previous reviews, and findings that differ from those of prior, published reviews" (p. 445). The review also points out that a 2001 WSIPP cost/benefit report may have included MST studies without full samples, and it comments that several MST studies underestimated or did not provide information on attrition in published reports (p. 450).

Cultural Appropriateness

Are effective practices replicable and generalizable to all races and ethnicities, or is cultural adaptation and consideration required? MST in U.S. studies appears to work for a variety of groups – for African Americans, for ethnically Hispanic, for all ages, and for inner-city urban as well as rural youth. When screened for race / ethnicity, outcome results of randomized trials showed no difference. MST Services Inc. concludes that these "outcomes constitute empirical evidence of the cultural and developmental appropriateness of MST" (2005). However, research so far in the U.S. has been limited to focus on African Americans and Hispanics. Can off-the-shelf, one-size-fits-all programs without adaptation to the uniqueness of communities be "culturally appropriate"? Or is MST truly flexible enough and in what areas? By its limitations so far to randomized trials with serious juvenile offenders of only one racial minority and one ethnic minority, can you even evaluate whether MST is truly applicable and generalizable to all minorities?

Without further information to supplement outcome results -- such as correlated cultural measures of study participants; documented cultural considerations; specifics on the "social-ecology", key participants; and the racial/ethnic makeup and cultural measures of the MST team -- is it even ethical to extrapolate to all minorities? How can MST be sure that cultural appropriateness did not impact engagement, and therefore, outcome results? Although the correlated effect of cultural affiliation and identification is a weak link, it is believed to indirectly affect Native youth. In a survey, Native youth who identified with "Indian culture" were less likely to be involved in alcohol use, and a strong sense of group identification was linked to well being (Sanchez-Way & Johnson, 2000). Thus, it is very important that MST research on Native participants includes correlated measures of culture and group identity in order to identify marginalization and reconciliation with Native communities.

Lack of Recognizing Natives In Research

A question needs to be consistently raised -- are the results also true for Natives? To my knowledge, there are no U.S. MST studies or reports, published or in progress, where Native Americans are a significant treatment population. I asked key MST representatives (who are involved in MST practice and research[2]), "Why are there no Native Americans?" in their frequently cited research studies and would there be any research to address that question? One response[3] was:

- There are few American Indians in South Carolina and Missouri [early MST research sites].
- The Native population is small, and in research, statistically insignificant.
- It's a good idea. It would be interesting to know.

Nonetheless without sufficient research findings, MST Services Inc. and affiliates continue to disseminate and offer MST as a solution for all racial and ethnic minorities. Independently, through literature review with a specific focus on Native Americans, I came across the Ontario study directly from the Ontario researcher's website.

Later, I would find brief mentions of this study on the MST Services Inc. website, (although as of this writing, external hyperlinks to the Ontario group's website were incorrect) (MST Services Inc., 2005).

The Ontario study is invaluable to those interested in MST as an emerging "best practice" for Native Americans, as it appears to be the only MST study that mentions Natives in its demographic information. As self-identified, Aboriginal youth were 13% of the study participants overall (Leschied & Cunningham, 2002), which is roughly representative of Aboriginal youth in custody in the Ontario province (15%, Latimer & Foss, 2004). Although results are yet to be published, interim program reports are available. Unfortunately, initial outcomes are not reported by race. However, Ontario researchers recognize this need, pointing out that "[s]till outstanding" is "secondary analysis of the data presented here, for example, … the relative outcomes of sub-groups such as Aboriginals…" (Leschied & Cunningham, 2002, p.7). The researchers also point out "it would have been informative to survey the members of both [study] groups to determine their opinions" (Cunningham, 2002, p. 27).

In public discussion, I pointed out that given the over-representation of Native youth in juvenile corrections and child welfare, Native youth were key target populations for MST… yet there is no information as to whether or not MST is being applied to them and what the outcomes were for them. In response, the MST representative agreed that the population exists, but offered no solutions as to future research or directions[4]. In addition, when I brought up the Ontario study's mixed findings, the MST representative theorized that perhaps "[the Ontario study] is a bad study" and later commented that "many organizations faced challenges with programs"[5]. I was surprised the issue was so quickly and efficiently dismissed, especially given that many audience members seemed interested given their own client demographics.

I find that dismissing the Ontario study is irresponsible given the scope of the study and its participant demographics. Ontario is invaluable to those interested in MST, both as a research study on the effectiveness of MST intervention and as a case study on implementation of an MST services program. It is important to recognize that:

(1) Ontario has worked in collaboration with FSRC to participate in a National Institute for Mental Health study on "Transportability Study" of MST, linking adherence to the treatment model and outcomes / intervention effects (study results are pending);

(2) Ontario sites are MST Services Inc.-approved and licensed providers, and thusly, under some level of supervision by MST Service Inc. so fidelity to the treatment modality can be assured to some degree;

(3) The Ontario study was independently evaluated ("the first replication of MST outside the [FSRC]", Leschied & Cunningham, 2002, p. 11);

(4) Using study quality criteria, Littell's systematic review points out "higher confidence in the Ontario study" (2005, p. 457);

(5) The Ontario study was a randomized, controlled trial;

(6) The study "was the largest MST trial to date (n=409)" (Littell, 2005, p. 457);

(7) It was a large-scale, multi-site, four-year study; and

(8) A large amount of Canadian public funds and effort was used to implement and study the project.

In the systematic review of MST studies, Littell (2005, p.446, p.458-459) offers several possible explanations for sources of bias in dissemination and previous reports, including:

· "**Publication Bias**" -- publishing was more likely when findings were statistically significant;

· "**Authority and Tradition**" -- with reports appearing in "very prestigious journals and several MST reviews were authored by highly respected scholars and government officials", thus leading

Table 1. U.S. States, By Representation of Native Juvenile Offenders

	NATIVE			
STATE	Percent Representation, General Juvenile Population (2001)	Percent Representation, Juveniles Offenders (2001)	Number of Juvenile Offenders (2001)	Number of MST- Licensed Agencies (2005)
South Dakota	12.1%	41.7%	207	0
Alaska	21.4%	42.1%	147	0
North Dakota	6.8%	35.0%	63	0
Montana	9.3%	22.6%	60	0

Note. The data in column 2 is from Easy Access to Juvenile Populations, by C. Puzzanchera, T. Finnegan, and W. Kang, 2005, Office of the Juvenile Justice and Delinquency Prevention, available online at http://www.ojjdp.ncjrs.org/ojstatbb/ ezapop/. The data in columns 3 and 4 are from Census of Juveniles in Residential Placement Databook, by M. Sickmund, T.J. Sladky, and W. Kang, 2004, Office of the Juvenile Justice and Delinquency Prevention, available online at http://www.ojjdp. ncjrs.org/ojstatbb/cjrp/. Columns 2 and 3 are calculated. Data for column 5 is from "MST Targeted Risk and Protective Factor", by MST Services Inc., 2005, retrieved from http://www.mstservices.com.

Table 2. Canadian Provinces / Territories, By Representation of Native Juvenile Offenders

	ABORIGINAL		
PROVINCE / TERRITORY	Percent Representation, Juveniles Offenders (2001)	Number of Juvenile Offenders (2001)	Number of MST- Licensed Agencies (2005)
Saskatchewan	87.9%	203	0
Ontario	15.0%	166	5*
Manitoba	79.8%	138	0
Alberta	35.6%	90	0
British Columbia	41.4%	60	0

Note. The data in columns 2 and 3 are from A one-day snapshot of Aboriginal youth in custody across Canada: Phase II, by J. Latimer and L.C. Foss, 2004, Department of Justice Canada, available online at http://canada.justice.gc.ca/en/ps/rs/rep/snap2/ snapshot2.pdf. Column 2 is calculated. Data for column 4 is from "MST Targeted Risk and Protective Factor", by MST Services Inc., 2005, retrieved from http://www.mstservices.com. * *Includes Ontario study sites.*

to reports being "very influential and are frequently cited"; and

- "**Conflicts of Interest**", also described as "allegiance effects" -- where program developers are involved in the study of their own programs, were authors or co-authors of reports, and were less likely to be critical than independent reviewers.

The fact is -- Ontario's program implementation concerns and challenges are of interest to all other agencies that are considering MST implementation. Ontario's interim results bring up questions that MST needs to address, and the question of how effective MST is for Native youth and communities is still unanswered. Given MST's emphasis on outcomes and measures, it is interesting that there is no information on MST's effectiveness with specifically Native Americans; that agencies that may have a high Native treatment population have no information for MST Services and affiliates to disseminate (e.g., Apache Behavioral Health, Whiteriver, AZ; the San Diego Unified School District, San Diego, CA; Children's Psychiatric Hospital, Albuquerque, NM). Why don't we know more about their outcomes? If evaluation is not in place, there should be target funding to do outcomes reporting in these agencies.

Target treatment population. Are Native juvenile delinquents really a small population for MST studies? In the U.S. Federal Bureau of Prisons, Native youth represent 60-70% of the confined youth (Scalia, 1997, reports 61%; Andrews, 2000, reports 70%), and most juvenile Federal cases[6] involve violent offenses (Greenfeld & Smith, 1999). The numbers have increased 50% since 1994 (Andrews, 2000).

In some U.S. states, Native youth are a large proportion of the juvenile offenders in state, local and tribal prisons, representing as high as 42% of the youth in custody (i.e., held in residential placement) (Sickmund, Sladky, & Kang, 2004). Several states (including South Dakota, North Dakota, Montana, and Alaska) with a high representation of Native youth in custody have no available MST licensed agencies for services (see Table 1). MST program developers should not ignore the population of Native juvenile delinquents. There is a need to develop and test programs to address the unique needs of Native youth and communities.

A similar analysis can be done for Canada (however, MST services are more limited, due to a much shorter history of dissemination and implementation). Representation of Aboriginal youth in custody can be as high as 100% in Canadian provinces and territories (see Table 2).

Can MST Work for Natives?

MST still shows some promise as an intervention for Native youth, families, and communities. It should be kept in mind, however, that there are questions on its general effectiveness, transportability to other sites, and that generalizability to Native families has yet to be documented. There are some areas in which MST could or should be adapted to work with Native communities.

Historical context. MST therapists and clinical supervisors need to know about Native history and our attempts to reconcile families and communities. Awareness could be achieved by incorporating these topics in training curricula, as discussion during an overview of the community to which they are serving, or as part of the process when determining overarching community outcomes.

Native values. MST Teams can have an understanding and incorporate Native values, such as cooperation, group harmony, respect, and respect for elders (Daisy, Brown, Behrens, 2001). It would be interesting to determine, by using qualitative analysis such as interviews and surveys, what the direct experiences are (or were) of Native youth, families, and communities through the program. The Ontario researchers, in retrospect, would have liked to have implemented qualitative work. I have yet to find case studies or descriptive information that can bring the perspective of Native program participants.

Native circles: An adapted social-ecological model. MST's social-ecological model should be adapted, as needed, for a Native view. Natives should engage to have a voice in these discussions, as there are other "circles" within Native communities that may not be apparent to MST professionals. Community stakeholders, such as elders and council members, should be involved in discussing the involvement of the community in program efforts. Native communities value inter-relationships, and MST helps identify those relationships and reinforces those connections.

Program implementation and deployment concerns. Ontario researchers consistently reported "lessons learned", outlining challenges experienced in program implementation and of potential research pitfalls (Cunningham, 2002; Leschied and Cunningham, 2002). This should be reviewed by any agency considering MST implementation. There are some major concerns that are very applicable to Native communities and agencies:

- There is a need to have "fidelity" to the treatment model, a desire and ability to continue with quality assurance efforts, and willingness for agencies to engage in ongoing, paid consultation by MST Services Inc.
- Programs will need to sustain funding and momentum over time (especially when involved in research and determining long-range outcomes over several years).
- Logistics and operational changes must take place for effective program implementation. This includes setting up a 24/7, on-call system. In addition, unionized staff regulations or prior employment agreements may pose some difficulties with professional staff.
- Therapists must be specifically trained for one week, plus quarterly boosters (currently, training is offered in South Carolina; thus, incurring travel fees, as well as training fees). Therapists must be open to supervision, including weekly phone consultations, and criticism. Because there is a lot of fieldwork involved, therapists may feel isolated in their work, especially those traveling to remote areas. Importantly, there is therapist attrition and high turn-over, which adds to training costs and affects MST Team make-up and performance. Masters and doctoral-level staff are required, and this may be a significant barrier to many Native community agencies. It is unclear if paraprofessional can participate as therapists as well.
- A good referral system must be developed, including support through community service networks. Low referrals will affect assumptions in cost/benefit ratios, leading to lower than expected program benefits and return on investment.
- Community engagement is critical for referrals and participation towards pragmatic goals. Communities must not only be at the table in an advisory capacity but also as a resource for youth.
- Funding is a significant concern – MST is expensive therapy and an expensive program. These costs impact the cost/benefit expected. Agencies must devote ongoing funding for training, travel, supervision, licensing, and importantly, to complete outcomes evaluation.

In Ontario's case (Leschied & Cunningham, 2002):

- Projected cost per case was $6,000-$7,000 CDN (however, because of low referrals, actual cost is likely over $25,000 per case) (p. 124).
- Funding over time was a challenge. First-year, start-up cost was approximately $22,500 CDN per site (4 sites, for a total of $91,000 CDN). This included MST consultant site visits and travel, staff training, and annual license fee ($6,000 US). Second-year cost included the annual fee, plus unexpected costs and exchange rate increases. The Ontario program was initially designed with only one year of MST Services Inc. supervision. However, due to results of treatment fidelity (TAM) studies, MST Services Inc. supervision was recommended into

the next year. Second year costs were much higher than expected: $115,000 CDN, or roughly $28,750 CDN per site. Concern over the budget for MST consultation and supervision and an interest in independence, Ontario built supervisory capacity within its program, thus thereafter only paid the annual licensing fee. Program funding to year four was a challenge.

Funding for various research studies and MST programs vary. MST has been funded by Medicaid and other Federal funds, such as Substance Abuse and Mental Health Services Administration (SAMHSA), and block grants; allocation of funds through State and local programs allocated for juvenile justice, mental health, residential treatment programs, foster care, and education systems; managed care organization for the provision of continuum of care; foundations (e.g., Annie E. Casey Foundation); and so on – which indicates that the economics of MST must be further researched.

How would or could MST be funded as a Native American program? The U.S. Commission on Civil Rights (2003) reviewed six different Federal departments and found that "there persists a large deficit in funding Native American programs" and that the "government's failure is systemic." The Office of Juvenile Justice and Delinquency Prevention- Tribal Youth Program (TYP), was funded $12.5 million in FY 2000, as part of the Indian Country Law Enforcement Initiative, and is involved in the Mental Health and Community Safety Initiative for American Indian/Alaska Native (AI/AN) Children, Youth, and Families (Andrews, 2000). This is one of many Indian programs that could be considered as a potential funding source. In addition, MST may also be funded under ICWA's provision to provide preventative services. It is unclear as to smaller agencies' capacity to fund MST program services.

Program outcomes. Overall outcomes should have more emphasis on other measures besides re-arrests and delinquency recidivism. Can MST be a medium for reconciliation? Towards this initiative, there should be emphasis in Native programs to look further into various family functioning measures. Focus can be on family functioning, family preservation, cultural identity, and engagement in pro-social activities. All interventions (independent variables) should be documented and evaluated to determine best-practices for Native youth, families, and communities. In addition, understanding the perspective of program participants as they engage in MST services is critical in understanding their stories. Documented case studies can be used in education, training and dissemination efforts to explain MST to Native communities and stakeholders.

In Closing

MST as an intervention is designed to effect change by empowering families and communities to address at-risk youth. In theory, the treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The goals are to keep youth out of custody and in their homes and communities, while improving family functioning and promoting their health and well-being. MST may be an intervention that helps us prevent the removal of children, address reconciliation, and promote Native communities and families. However, it needs to be skillfully and responsibly implemented with an eye towards the specific concerns and challenges of the community where it is being used. Perhaps for-profit firms like MST Services Inc. are not the appropriate partners for Native communities? It may be that only not-for-profit organizations, with a demonstrated commitment to the community instead of with a monetary stake in disseminating its methodology, are better partners? Perhaps non-Native methodologies are not the way to go at all. Nonetheless, "best practices" therapies will continue to be applied to Native youth and communities, and it is key to critically analyze their impacts.

With the tools to assess and control the placement of our children while also keeping the community safe, we can grow a new generation of whole People and

begin to address and overcome the systemic losses we have suffered. Today, we need to recreate, not a long ago utopia but Sovereign, self-regulating communities with rights and responsibilities that we all share.

MST is currently implemented nationwide in the U.S. (including court-mandated services). We do not know if it is helping or hurting Native youth. It is unknown as to how well it applies to Native communities, or if it requires mindfully adaptation to be sensitive to Native youth, families, and communities. I recommend seeking knowledge of the outcomes and experience of Native participants in MST, and justification of MST's claim of its "cultural appropriateness".

Unlike any other community, Native communities have a special history. We must encourage efforts toward reconciliation, and perhaps, MST may provide an opportunity at providing lasting, positive outcomes.

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(Endotes)

[1]. The use of the word "Native" and "Native American" is not limited and describes U.S. American Indian and Alaska Natives (AI/AN), Canadian Aboriginals (First Nations, Métis, Inuit), and North, Central, and South American indigenous peoples. Other terms may be used throughout, especially when referencing citations.

[2]. E.W. Trupin and D.G. Stewart, University of Washington School of Medicine, are program designers of the Family Integrated Transitions (FIT) pilot program, which includes MST as one of four evidence-based interventions. The Washington State Legislature directed the Juvenile Rehabilitation Administration to develop the program, which was launched in 2000 and was independently evaluated by the Washington State Institute for Public Policy (Aos, 2004). The UW School of Medicine, Division of Public Behavioral Health and Justice Policy, Prime Time Project is a licensed MST agency and affiliate.

[3]. D.G. Stewart, University of Washington School of Medicine, guest speaker -- classroom dialog during "Principles and Practices of Multisystemic Therapy (MST)" presentation to the University of Washington School of Social Work, February 24, 2005.

[4]. E. W. Trupin, University of Washington School of Medicine, speaker -- public dialog during "Evidence-Based Practices in Children's Mental Health" presentation, part of the Evidence-Based Practices in Child Welfare 2004-2005 forum series by the Northwest Institute for Children and Families, held at the University of Washington School of Social Work, March 29, 2005. Invited to attend were many key stakeholders in child welfare and juvenile justice.

[5]. Ibid.

[6]. Inmates may include those sentenced and those pending trial. In the U.S., tribal and Federal laws apply in Indian Country; however, most juvenile cases are handled by Federal courts. If certain types of crimes are committed, Federal laws take jurisdiction. Tribes can transfer to the State systems.

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