Multisystemic Therapy: Theory, Principles and Practice with Young People and Families

THE TALKING THERAPIES UK PRACTITIONER SERIES

Multisystemic Therapy: Theory, Principles and Practice with Young People and Families

A premium, in-depth programme on the ecological, family-centred approach to serious antisocial behaviour in adolescence, its evidence, adaptations and implementation in UK services

Advanced level · 30 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Multisystemic Therapy: Theory, Principles and Practice with Young People and Families course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 2. This printing was set on 1 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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Contents

How to use this manual 1

Part 1 Foundations: theory, evidence and the licensed model 5

1. What MST is and is not: origins, purpose and the licensed model . 6
2. Social ecology and the determinants of antisocial behaviour 15

How to use this manual

This premium programme is a comprehensive, practice-focused course on Multisystemic Therapy for family therapists, social workers, youth justice practitioners, psychologists, counsellors, child and adolescent mental health practitioners, school staff, supervisors and commissioners who work with young people whose serious antisocial behaviour places them at risk of care or custody. It explains what the model is, why it was developed, how it works in practice, what the evidence shows and how its ideas can be used honestly in other services.

The course is a programme of continuing professional development. It does not license or certify anyone to deliver Multisystemic Therapy, which is a licensed model delivered by teams that are trained, supervised and quality assured within a licensed network. Practitioners who want to practise the model should apply to work in a licensed team. Multisystemic Therapy and MST are registered trademarks of MST Services, LLC in the United States. This course is independent of, and not endorsed by, MST Services, and it does not reproduce any manuals, forms or adherence measure items; it describes principles and processes in its own words, as the published literature does.

The course is current to October 2026. It teaches the evidence with balance, including the early trials in the United States, the meta-analyses and Cochrane review that reached different conclusions, the London trial with young offenders, and the START trial in nine English sites, which found no advantage for MST over management as usual on out-of-home placement or offending, together with its five-year follow-up. Safeguarding content reflects Working Together to Safeguard Children 2026 and the information sharing duty in force from 30 September 2026.

Across six modules and thirty lessons you will study the origins of the model, social ecology, the evidence, fidelity and referral criteria; the nine treatment principles and the analytic process; engagement, assessment across systems, case conceptualisation with testable hypotheses, supervision and consultation, and safety and safeguarding in home-based work; interventions

with parenting and monitoring, family relationships, peers, school, and individual and caregiver difficulties; adaptations for substance misuse, child abuse and neglect, problem sexual behaviour, psychiatric crisis, health care, transitions and emerging adults, together with culture, diversity and equity; and implementation in UK services, outcome measurement, discharge and relapse prevention, ethical borrowing in non-MST practice, and supervision-level ethics and wellbeing.

Every lesson contains a worked clinical example, the common pitfalls in practice and a reflective question, together with key points, a practice task for the week, study activities and further reading. The course includes an extended case study, a glossary and a 25-question assessment with a pass mark of 80 per cent. Every reference has been checked against its publisher, its digital object identifier, legislation.gov.uk or the issuing body.

Throughout, the course treats caregivers as the people best placed to change a young person’s world, treats engagement and progress as the practitioner’s responsibility, and asks you to face the evidence honestly, including where it is disappointing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 30 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the origins, purpose and social ecological foundations of Multisystemic Therapy and its status as a licensed programme.
- Summarise the evidence for MST with balance, including US trials, meta-analyses, the London trial and the START trial and its five-year follow-up.
- Describe the nine treatment principles and the analytic process, and apply them to the formulation of a young person's behaviour.
- Engage caregivers and families, assess strengths and needs across systems, and combine the desired outcomes of key participants into measurable overarching goals.
- Develop specific, testable hypotheses about the drivers of behaviour, prioritise them and link them to intermediary goals while guarding against confirmation bias.
- Describe interventions with parenting and monitoring, family relationships, peers, school, and individual and caregiver difficulties, integrated within the principles.
- Explain in general terms how MST has been adapted for substance misuse, child abuse and neglect, problem sexual behaviour, psychiatric crisis, health care, transitions and emerging adults.
- Apply safety planning and safeguarding duties in home-based work, including responses to exploitation, domestic abuse and risk to the practitioner.
- Practise in a culturally responsive way that recognises disparities, uses interpreters properly and avoids deficit framing.
- Evaluate outcomes honestly, plan for discharge and sustainability, borrow ideas from MST ethically and identify the route to training in a licensed team.

PART 1

Foundations: theory, evidence and the licensed model

What MST is, the social ecological theory beneath it, the research record including UK trials, why fidelity matters, and who MST is for.

CHAPTER 1

What MST is and is not: origins, purpose and the licensed model

Practitioners in youth justice, children's social care and child and adolescent mental health services hear the letters MST used loosely. A commissioner asks for an MST-type service; a family support team describes its home visits as MST-informed; a parent arrives at a meeting having been told that her son will be getting MST. Only the last of these may refer to the programme that the research literature has tested, and then only if a licensed team is involved. This lesson sets out what Multisystemic Therapy is, where it came from, how it is delivered and governed, and what it is not, so that you can describe it accurately to families, colleagues and commissioners and can tell whether a service that uses the name is offering the model or something else.

Begin with the status of this course, because it shapes everything that follows. This is continuing professional development about MST. It does not license or certify anyone to deliver MST, and completing it does not entitle anyone to call themselves an MST therapist or to describe their work as MST. MST is a licensed model. Programmes are licensed through MST Services, which is itself licensed by the Medical University of South Carolina, and many are supported by network partner organisations. Therapists are trained and quality-assured within a licensed team, and that is the only route into practice: a practitioner who wants to practise MST should apply for a post in a licensed team. Multisystemic Therapy and MST are registered trademarks of MST Services. This course is independent of MST Services and is not endorsed by it. It describes the model's principles and processes in its own words, as the published literature does, and it does not reproduce MST manuals, forms or the content of any adherence measure.

MST was developed from the late 1970s, and refined through the 1980s and 1990s, by Scott Henggeler and colleagues in the United States, among them Charles Borduin. It was designed for adolescents with serious antisocial behaviour, many with repeated arrests, for whom the main options were often removal from home or custody. The developers argued that the

services then available tended to address one part of a young person's world at a time. A young person might see a counsellor in a clinic for an hour a week, attend a group with other young people in trouble, or be placed away from home altogether, and none of these options changed the family, peer and school conditions to which the young person would return. Their alternative rested on the observation that serious antisocial behaviour is maintained by many factors across the young person's social world, so an effective intervention must be able to reach all of them (Henggeler et al., 2009). That argument draws on social ecological theory (Bronfenbrenner, 1979), which lesson 1.2 examines. One of the early randomised trials described MST in its title as family preservation and as an alternative to incarcerating serious juvenile offenders, which states the original purpose plainly (Henggeler, Melton and Smith, 1992).

The purpose follows from that history. MST aims to reduce serious antisocial behaviour while the young person continues to live at home, attends school or works, and avoids further arrest. Those aims are built into the three ultimate outcomes that programmes report at discharge: whether the young person is living at home, whether they are in school or working, and whether they have been free of new arrests during treatment. The model pursues them mainly through the adults who care for the young person. The caregiver, whether a parent, step-parent, grandparent or other long-term carer, is treated as the key agent of change. Caregivers are present before, during and long after treatment, and they have more influence than any visiting professional over where a young person goes, whom they spend time with and what follows when they break the rules. The therapist's task is to help caregivers develop the skills, resources and support to use that influence, and to remove the barriers that prevent them. Engagement is the responsibility of the therapist and the team, not of the family: if a caregiver is not taking part, the team treats that as a problem for it to solve rather than as evidence that the family does not want help.

Delivery is designed around the same logic. MST is home and community based: the therapist works in the family home, at school and in the neighbourhood, at times that suit the family, which often means early mornings, evenings and weekends. It is intensive, with several contacts a week when needed and a level of contact that varies with need over the course of treatment. It is time limited, typically lasting three to five months, because the aim is to leave caregivers able to sustain change without the

team rather than to provide long-term support. The team also provides on-call availability 24 hours a day, seven days a week, so that a caregiver can reach an MST clinician when a crisis happens rather than at the next appointment. The reasoning is practical. A violent argument at eleven o'clock on a Saturday night is the moment at which a caregiver may decide that the young person cannot stay, and it is also the moment at which a newly agreed response can be tried with support. A service available only in office hours has no contact with the family at either moment.

Small teams and small caseloads make this intensity possible. A team typically has two to four therapists, often with master's-level qualifications, and a dedicated supervisor. Each therapist works with around four to six families at a time. A team of three therapists, each holding five families, is therefore working with about fifteen families at any one time; with treatment lasting three to five months, the same team would work with somewhere between about 35 and 60 families in a year if every place were filled. Therapists begin with an initial five-day orientation and receive regular booster training. The team meets on site every week for group supervision with its supervisor, and every week it has consultation with an MST expert or consultant, who reviews cases and the team's use of the model. Lesson 1.4 explains how these elements, together with caregiver-reported adherence measures and the tracking of outcomes, form a quality assurance system.

Several services resemble MST in one or two respects and are regularly mistaken for it. Many local authorities run edge-of-care or intensive family support teams that visit at home, work with whole families and aim to prevent entry to care. Some are well designed, but home-based delivery does not make a service MST. Without the licence, the treatment principles and analytic process, the caseload limits, the on-call rota and the quality assurance system, a service is something else and should be described by what it does. MST is also not individual therapy for the young person with occasional family sessions, not a parenting group, not mentoring, and not case management that coordinates other agencies' work. It draws on evidence-based techniques, including behavioural parent training, structural and strategic family therapy techniques, cognitive behavioural methods, and interventions with peers and schools, but it is not defined by any one of them. It is defined by the way techniques are selected and applied within its nine treatment principles and its analytic process, which module 2 teaches. Nor is standard MST intended for every young person in difficulty: it is

designed for a specific population, and lesson 1.5 sets out who that is and when another service is the better choice.

The licensing arrangement distinguishes MST from most psychological therapies used in the United Kingdom. A counsellor who trains in an approach can usually go on to practise it independently. An MST therapist cannot, because the model exists in practice only as a licensed programme. An organisation that wants to provide MST, such as a local authority or a provider commissioned by one, makes an agreement through MST Services or a network partner, recruits a team that meets the model's requirements, and in return receives training, consultation and access to the quality assurance system. The licence ties the right to use the name to delivery under defined conditions, designed to reproduce those in which MST achieved its strongest results. Henggeler (2011) traces MST's development from efficacy trials to large-scale transport into community agencies, a process in which the developers concluded that outcomes depended on whether the model was delivered as intended; the licensing and quality assurance arrangements are the result. Henggeler and Schaeffer (2016) give a fuller account of the implementation system from the developers' perspective.

The licensed model deserves appraisal rather than either reverence or suspicion. Its strongest justification is the evidence, examined in lesson 1.4, that therapists' adherence to MST predicts outcomes, which makes a system for monitoring adherence a rational response. It also produces something uncommon in children's services: routine, comparable data on what a team does and what happens to the families it serves. Its weaknesses are equally real. Licensing and quality assurance add cost and fixed requirements, which can make a team hard to sustain in small or rural areas and leave families in neighbouring areas without access. The developers and the licensing body have a legitimate interest in the model's success, and the finding that effects were larger in developer-led efficacy studies than in effectiveness studies (Curtis, Ronan and Borduin, 2004) is a reason to give independent trials at least equal weight. Most importantly, a licence specifies how a service is organised and monitored; it does not determine the outcomes that families achieve. Independent trials in which MST was delivered by teams working within the licensed model, including the English START trial (Fonagy et al., 2018), have not always found an advantage over the services that families would otherwise have received,

and lesson 1.3 considers why. The defensible position is that licensing protects the conditions under which MST can work without settling whether it will work better than good local alternatives.

Within those limits, this course can do a good deal. It can give you an accurate understanding of the theory beneath MST, the evidence for and against it, its principles and analytic process, and the intervention strategies used across family, peer, school and community systems. It can help you make better referrals, work alongside an MST team as a referrer, social worker or school professional, explain the model honestly to families, and borrow ecological and caregiver-focused thinking for your own practice without misdescribing it, which module 6 addresses. It cannot prepare you to deliver MST. Competence in the model is built through orientation and booster training, weekly supervision and consultation, and adherence monitoring with real families over months, and none of these can be replaced by reading or provided by a course of this kind.

Worked clinical example. Aisha Rahman is a case manager in a youth justice service in a Midlands city. Reece Clarke, aged 15, is subject to a youth rehabilitation order after an assault and a robbery committed with two older boys. In the past four months he has been arrested twice more, suspended from school four times and reported missing overnight on three occasions. His mother, Donna, works rotating shifts as a care assistant and has told Reece's social worker, Tom Lewis, that she can no longer keep him safe and wants the local authority to look after him. The multi-agency panel that allocates places with the local MST team has asked Aisha to discuss a referral with the family before one is made. Aisha begins by checking her own understanding. She confirms with the MST supervisor, Gareth Pryce, that Reece's age, the seriousness of his behaviour and the risk of a care placement fit the team's criteria, that Donna is a caregiver the team could work with, and that a place is likely within about three weeks. She decides not to promise a date.

At the home visit Aisha explains the model in plain terms. A therapist from the MST team, not Aisha, would work with the family at home, at school and in the neighbourhood, several times a week when needed, at times arranged around Donna's shifts, for typically three to five months. Donna would have a number answered by an MST clinician at any hour, every day. Most of the therapist's time would be spent with Donna and with Reece's grandmother,

who looks after him two evenings a week, because they have the most influence over where he goes, who he is with and what happens when he breaks the rules. Donna asks whether this means the professionals think she is the problem. Aisha answers that the focus on caregivers reflects their influence, not blame, and that if the work stalls the team treats that as its own problem to solve. Reece asks whether he has to take part. Aisha explains that the youth justice service remains responsible for his order, that MST would sit alongside it, that the therapist would want to hear what he wants to change, and that the team cannot start without Donna's agreement. She explains which agencies would share information and why, and that any concern about a child's safety would be shared under local safeguarding procedures, consistent with the expectation in Working Together to Safeguard Children (UK Government, 2026) that information sharing is clear, lawful, proactive and timely. She does not say that MST will keep Reece at home; she says that it is a well-researched approach with mixed results in English services and that the team will ask for Donna's views on its work during treatment. Donna's request for Reece to be looked after remains a matter for Tom and children's social care, and Aisha tells her so. Aisha records the explanation given, the leaflet left with the family, each person's questions and views, Donna's consent to the referral and to information sharing with named agencies, the screening against the criteria, that no start date was promised, and her agreement with Tom about who will tell the family the panel's decision.

Common pitfalls. The first is describing a service as MST, MST-based or MST-informed in a way that leads families or commissioners to believe they are receiving the licensed model. The name is a registered trademark, and the honest description of an unlicensed service is an account of what it actually does. The second is presenting MST to a family as therapy for the young person. Caregivers who expect weekly sessions between their son and a therapist are unprepared for a service that asks them to change routines, supervision and consequences, and some disengage when they discover the difference; explain from the first conversation that the work is mainly with caregivers. The third is overstating availability or outcomes. On-call availability means that a family can reach an MST clinician at any hour, not that a therapist will arrive within minutes, and no referrer can promise that MST will prevent a placement; precise descriptions protect trust when the work becomes difficult. The fourth is assuming that

knowledge amounts to competence. Reading the clinical texts or completing CPD such as this course can improve your referrals and your own systemic practice, but it does not equip you to deliver the model; if you want to practise MST, the route is a post in a licensed team, with its orientation training, supervision and consultation.

Reflective question. Think of a family you have worked with whose difficulties occurred mainly in the evenings, at weekends, at school or on the street rather than in your appointments. Which features of your own service, such as its hours, its location, the people it routinely sees and the length of its involvement, limited what you could change for that family, and which of those features are within your authority to alter?

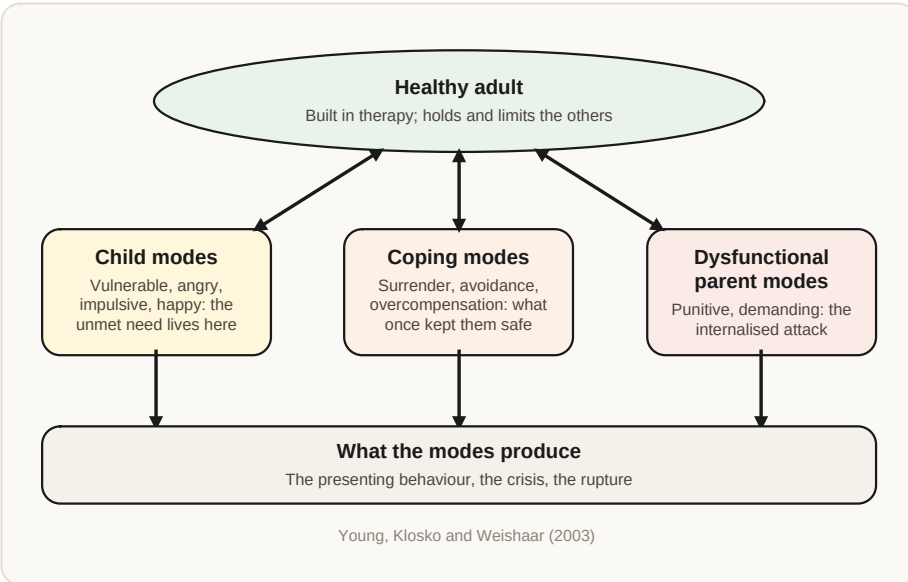


FIGURE 1.1 Schema modes

Schema therapy describes a mode as the emotional state and coping response active at a given moment. Grouping the modes makes the work in the room legible: the child modes carry the unmet need, the coping modes are what once kept the person safe, the internalised parent modes carry the attack, and the healthy adult, built over the course of therapy, is the part that eventually holds and limits the other three. What presents in the consulting room is the product of the three mode classes, which is why the crisis is read as a mode and not as a diagnosis.

Points worth keeping

- This course is continuing professional development about MST and does not license or certify anyone to deliver MST or to describe their work as MST.
- MST programmes are licensed through MST Services, itself licensed by the Medical University of South Carolina, and many are supported by network partner organisations.
- Multisystemic Therapy and MST are registered trademarks of MST Services, and this course is independent of, and not endorsed by, MST Services.
- Scott Henggeler and colleagues, including Charles Borduin, developed MST in the United States from the late 1970s for adolescents with serious antisocial behaviour and their families.
- MST is home and community based and intensive, typically lasts three to five months, and gives families on-call access to a clinician 24 hours a day, seven days a week.
- Teams typically have two to four therapists and a dedicated supervisor, and each therapist works with around four to six families at a time.
- The caregiver is treated as the key agent of change, and engagement is the responsibility of the therapist and team rather than of the family.
- A licence specifies how an MST service is organised and monitored but does not guarantee that it will outperform good local services.

PRACTICE TASK

This week: Write a plain-English description of MST, of no more than 300 words, that you could give to a family considering a referral. Cover who would visit, where and how often, how long treatment typically lasts, the on-call service, the central role of caregivers, how information would be shared, and the fact that outcomes cannot be promised. Then find out whether a licensed MST team serves the area where you work. If one does, compare your description with the team's own information for families and correct any differences. If none does, note which services families in your area receive instead and whether any of them is described in a way that could be confused with MST.

Study activities: The reflective-practice activity (20 minutes) helps you notice how the design of your own service shapes what you can change. Choose one closed case involving an adolescent, write a short account of where and when the problem behaviour occurred and where and when your contact took place, and then write a paragraph on the gap between the two and what it meant for the outcome. The skills-practice activity (30 minutes) builds your ability to explain MST accurately under pressure. With a colleague playing a sceptical caregiver, spend ten minutes explaining a possible MST referral, including your answers to two questions: whether the referral means the caregiver is to blame, and whether MST will stop the young person going into care. Swap roles for a further ten minutes, then spend ten minutes together checking both explanations against this lesson and noting any statement that overstated availability, outcomes or the young person's role in treatment.

Further reading:

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D. and Cunningham, P.B. (2009) Multisystemic Therapy for Antisocial Behavior in Children and Adolescents. 2nd edn. New York: Guilford Press.

Henggeler, S.W. and Schaeffer, C.M. (2016) 'Multisystemic Therapy®: clinical overview, outcomes, and implementation research', Family Process, 55(3), pp. 514 to 528.

Henggeler, S.W. (2011) 'Efficacy studies to large-scale transport: the development and validation of multisystemic therapy programs', Annual Review of Clinical Psychology, 7, pp. 351 to 381.

CHAPTER 2

Social ecology and the determinants of antisocial behaviour

A 14-year-old is referred for anger management after his third assault in a year. The referral assumes that the problem sits inside him and that a course of individual sessions will reduce it. Several decades of developmental research point in a different direction. Serious antisocial behaviour in adolescence is associated with factors in the young person, the family, the peer group, the school and the neighbourhood, and those factors influence one another. This lesson sets out the theory and research on which MST's design rests, so that you can read a referral ecologically, explain to colleagues why an intervention aimed at one system is unlikely to be enough, and avoid interventions that the evidence suggests can make matters worse.

The theoretical frame comes from Bronfenbrenner (1979), who argued that development cannot be understood by studying a child in isolation, or in artificial laboratory situations, because it takes place within a set of nested systems, each contained within the next. The innermost are microsystems: the settings in which the young person takes part directly, each with its own patterns of activity, roles and relationships, such as the home, the classroom and the peer group. The mesosystem is the set of links between those settings, for example whether parents and teachers communicate, or whether a young person's friends are known to their parents. The exosystem contains settings in which the young person does not take part but which affect them, such as a parent's workplace or the decisions of a local authority. The macrosystem is the wider pattern of culture, belief, economic conditions and policy within which the other systems sit. Bronfenbrenner insisted that influence runs in both directions: the developing person shapes their settings as well as being shaped by them. For example, a defiant child may elicit harsher parenting, which in turn shapes the child. He also described ecological transitions, such as starting secondary school or moving into care, as changes in a person's role or setting that are both consequences and instigators of development.

MST turns this framework into a working assumption about every referral:

the young person's behaviour makes sense in the light of its connections with the systems around them, and assessment should identify which connections are maintaining it (Henggeler et al., 2009). In MST these systems are usually described as the individual, the family, peers, school, and the neighbourhood and community. The developers also drew on causal modelling studies of delinquency. In their reading of that research, association with antisocial peers is almost always a direct predictor of antisocial behaviour; family relationships predict it either directly or through their influence on which peers a young person spends time with; and school difficulties predict affiliation with antisocial peers. The practical message is that the peer group is often where antisocial behaviour is enacted, while the family and the school are often where it can most readily be influenced. Module 2 shows how MST assesses the fit between a problem and these systems for an individual young person.

The empirical case for multiple determinants is brought together in Loeber and Farrington (1998), a synthesis of longitudinal research on serious and violent juvenile offenders. Its contributors identified risk factors across several domains. Individual factors included early aggression, impulsivity and attention problems. Family factors included poor supervision, harsh or inconsistent discipline, conflict between parents and parental antisocial behaviour. School factors included low attainment, weak attachment to school and truancy. Peer factors centred on association with delinquent peers, and neighbourhood factors included concentrated disadvantage and the availability of drugs and weapons. The synthesis supports conclusions that matter for practice. Risk is cumulative, so the probability of serious offending rises with the number of risk factors across domains rather than with any single factor. Serious and violent offending usually follows a developmental progression from less serious problem behaviour that began earlier. Interventions can be worthwhile at any age, including adolescence, which answers the fatalism that sometimes surrounds older young people with long histories.

Within the family, the most precise account of how antisocial behaviour is learned is coercion theory, set out in Patterson (1982). Patterson and colleagues observed families at home and described sequences in which aversive behaviour is reinforced. A parent tells a child to do something; the child protests, shouts or becomes aggressive; the parent drops the demand to end the unpleasantness. The child learns that escalation removes

demands, and the parent learns that giving in ends the conflict, so both behaviours are strengthened by negative reinforcement. Over many repetitions the exchanges become more frequent and more intense, parents alternate between giving in and occasional explosive punishment, and warmth and positive attention decline. Monitoring often weakens at the same time, because supervising a child who reacts with hostility is exhausting. Later research in the same tradition linked these patterns learned at home to rejection by prosocial peers and difficulties at school in middle childhood, which in turn make drift towards antisocial peers more likely. Coercion theory matters for MST because it locates a maintaining process in an interaction that caregivers can change. Calm, consistent and predictable consequences, positive attention for wanted behaviour and active monitoring interrupt the cycle. Behavioural parent training is built on this logic, and module 4 shows how MST applies it with adolescents.

Peers are the system in which adolescent antisocial behaviour is most often carried out. Dishion, McCord and Poulin (1999) drew together evidence that bringing high-risk young people together can increase the very behaviour an intervention is meant to reduce. They described a prevention trial in which young adolescents who took part in peer-group sessions showed more smoking and more problem behaviour reported by teachers at follow-up than those who did not, and a reanalysis of a long-running study of boys at risk in which those sent to summer camps more than once had worse outcomes in adulthood. They proposed a mechanism that they called deviancy training: in conversations among antisocial friends, talk about rule-breaking is rewarded with laughter and attention, and the amount of such talk predicts later escalation. The implication is direct. Group programmes made up mainly of antisocial adolescents, and settings that concentrate them, carry a risk of harm that individual and family-based work does not. MST therefore avoids group treatment of antisocial young people and works on peer relationships largely through caregivers, who can monitor, limit contact with antisocial peers and help the young person into prosocial activities.

Developmental pathways add a further qualification. Moffitt (1993) distinguished two broad groups. A small minority show life-course-persistent antisocial behaviour, which begins in early childhood, is associated with neuropsychological difficulties such as problems with language and self-control interacting with adverse environments, and continues into adulthood. A much larger group show adolescence-limited antisocial

behaviour, which starts in adolescence, reflects in part the gap between biological maturity and access to adult roles, often involves imitating more persistent peers, and usually stops in early adulthood. Moffitt argued that adolescence-limited offenders can nonetheless become trapped by what she called snares, such as a criminal record, custody, school failure or substance dependence, which close off routes back to conventional life. Two implications follow. Onset history matters for formulation and prognosis, because a young person who has been aggressive since primary school needs a different level and length of support from one whose offending began at 14 with a new peer group. And services should take care not to create snares themselves: removing a young person to custody or a residential setting can sever ties with school and prosocial supports and bring them into daily contact with more persistent peers.

Two features of the current UK context extend this picture. The first is criminal exploitation. A young person who carries drugs or money for older people may appear on a police record as an offender influenced by antisocial peers, but the peer system in that case includes adults who are exploiting the young person, and the behaviour has to be understood as harm done to the young person as well as harm done by them. The second is the online world, which is now part of the peer system: contact with antisocial peers, arrangements to meet and pressure to offend often run through phones and social media. Working Together to Safeguard Children (UK Government, 2026) gives particular attention to children experiencing multiple or simultaneous harms and to the link between online and in-person harm, and an ecological assessment that ignores either will miss part of what maintains the behaviour. Where exploitation is suspected, safeguarding procedures apply alongside any therapeutic plan.

Taken together, these strands explain the main features of MST's design. If antisocial behaviour has multiple, interacting determinants, an intervention must be able to work across systems and in the places where the behaviour occurs. If caregivers' monitoring and discipline are central maintaining processes, and if caregivers are the adults best placed to influence peers and school, then caregivers are the most efficient route to change. If grouping antisocial adolescents can cause harm, peer work should operate through caregivers and prosocial activities rather than through groups. And if removal from home can create snares while leaving the ecology the young person will return to unchanged, then supporting the young person to remain

at home is consistent with the evidence, provided that the home can be made safe.

The theory has limits that practitioners should keep in view. Most of the risk factor evidence is correlational. A factor that predicts offending may be a marker of another process rather than a cause, and showing that a factor predicts behaviour does not show that changing it will change behaviour; the stronger test is an intervention trial in which the targeted process changes and the behaviour follows. MST's own process research offers some evidence of this kind, discussed in lesson 1.4, but much of it comes from the developers' studies. Risk factors also cluster with poverty, poor housing, racism and exclusionary school practices, and a framework that locates risk in families and neighbourhoods can slide into describing those families in deficit terms while leaving structural causes unexamined. Bronfenbrenner's framework organises enquiry rather than specifying which links matter for a particular young person, so it cannot by itself tell a practitioner where to intervene. Moffitt's two-group taxonomy has been qualified by later research that identified more than two developmental trajectories, and it describes groups rather than predicting the course of any individual. Coercion theory was developed largely from observations of families with younger children, and applying it to adolescents requires attention to the young person's growing autonomy and to the greater influence of peers.

Worked clinical example. Hannah Okafor is a therapist in a licensed MST team in a market town in the East Midlands. Kacper Nowak, aged 14, was referred after police recorded five thefts from cars and an assault on a younger boy over four months; he has had three fixed-term suspensions this year and is on a part-time timetable. He lives with his mother, Agnieszka, who works night shifts at a distribution warehouse four nights a week, and his sister, aged nine. Hannah's first task is not to find a single cause but to map connections. Over two evening visits with Agnieszka, and using police, school and youth justice information, she draws an ecological map with Kacper at the centre, recording for each system the factors linked to his offending and the strengths available. Individually, Kacper has reading difficulties noted at primary school but never assessed, and he becomes impulsive when frustrated; he is also a capable footballer and protective of his sister. On shift nights his sister stays with Agnieszka's sister, Marta, but Kacper refuses to go and is unsupervised from about eight in the evening. When Agnieszka tries to stop him going out he shouts and once broke a

door, and she now avoids the confrontation, a coercive sequence of the kind Patterson (1982) described. On those nights Kacper joins older boys at a skate park, two of whom are known to the police; he had prosocial friends at a football club until the fees rose in the spring. The school's only contact with home has been suspension letters, which Agnieszka, whose first language is Polish, reads with difficulty, although a PE teacher is an adult Kacper respects. The youth club closed two years ago, and cannabis is sold near the skate park.

Hannah then tests the links against evidence. Police records place four of the five thefts between nine in the evening and midnight on shift nights. Agnieszka's rota changed in the spring, when the football fees also rose, and the offending began soon afterwards, which places part of the explanation in the exosystem. School records describe disruptive behaviour since Year 3, suggesting earlier onset and a need for sustained support; Hannah records this as information for planning, not as a prediction. When the youth justice service proposes a group programme for young people convicted of vehicle crime, she raises with the case manager the risk of placing Kacper with other offending adolescents (Dishion, McCord and Poulin, 1999). Kacper agrees that the skate park is where things happen but denies that the older boys are a problem, and both views are recorded. Hannah files the map with the source of each item, discusses the unsupervised nights with Agnieszka as an immediate safety issue, and takes the map to group supervision, where the team turns it into hypotheses about evening supervision, peer contact and communication between home and school, to be tested rather than assumed.

Common pitfalls. The first is producing an ecological map that is a list of deficits. A map that records only risks omits the strengths that interventions will depend on, such as an aunt who can supervise or a teacher the young person respects, and it confirms the family's experience of being judged; record strengths in every system, and the links between systems as well as their contents. The second is referring an antisocial adolescent to a group made up mainly of other antisocial adolescents without weighing the risk of harm that Dishion, McCord and Poulin (1999) identified; consider individual and family-based options first, and raise the risk with whoever is proposing the group. The third is treating Moffitt's taxonomy as a label for an individual. Describing a young person in a report as life-course persistent can follow them for years and lower everyone's expectations; describe the onset

history and what it implies for the level and length of support instead. The fourth is mistaking a correlate for a cause. A report that attributes offending to a single-parent household or a deprived estate names a circumstance the family cannot change; identify the specific, changeable process through which that circumstance operates, such as unsupervised evenings or the absence of contact between home and school.

Reflective question. Recall a young person whose antisocial behaviour you formulated mainly in individual terms, such as anger, trauma or impulsivity. If you redrew that formulation as an ecological map, which links between family, peers, school and neighbourhood would you need information about, who holds that information, and how might the plan you agreed have differed if those links had been part of it?

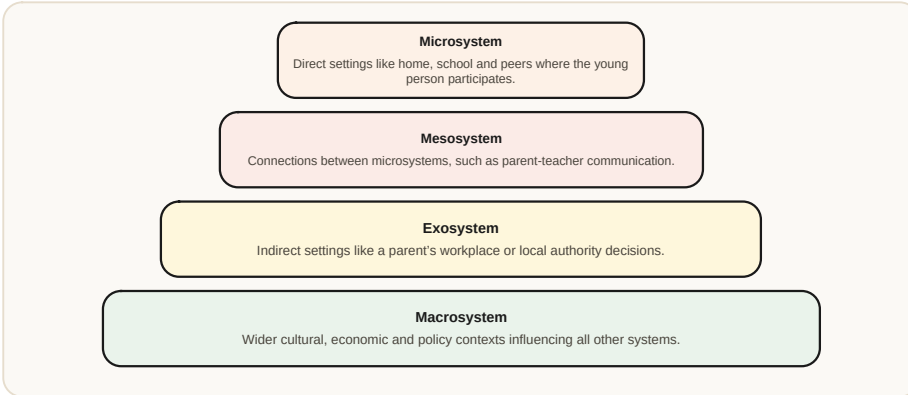


FIGURE 2.1 Nested Systems of Development

This figure illustrates Bronfenbrenner's ecological model, showing how a young person is embedded within concentric systems. Each layer represents a distinct level of influence, from direct settings to the wider cultural context.

Points worth keeping

- Bronfenbrenner described development as taking place within nested, reciprocally influencing systems: microsystems, the mesosystem linking them, the exosystem and the wider macrosystem.
- Loeber and Farrington brought together evidence that serious youth offending has risk factors across individual, family, school, peer and neighbourhood domains, and that risk accumulates.
- Patterson's coercion theory shows how parent and child reinforce each other's escalation, and why calm consistent consequences, positive

attention and monitoring interrupt the cycle.

- Dishion, McCord and Poulin found that grouping high-risk young people can increase problem behaviour, so MST avoids group treatment of antisocial adolescents.
- Moffitt distinguished life-course-persistent from adolescence-limited antisocial behaviour and argued that snares such as custody and school failure can prolong offending.
- MST works mainly through caregivers because they can influence monitoring, discipline, peer contact and school in ways that a visiting professional cannot.
- Criminal exploitation and online contact are part of a young person's ecology, and suspected exploitation requires safeguarding procedures alongside any therapeutic plan.
- Risk factor research is largely correlational, so an ecological map should generate hypotheses about changeable processes to be tested rather than conclusions about causes.

PRACTICE TASK

This week: Choose one young person you work with, or have worked with recently, whose difficulties include serious conflict or offending. Using anonymised information only, draw an ecological map with the young person at the centre and the family, peers, school and neighbourhood around them. For each system record at least one factor linked to the behaviour and at least one strength, and mark any links between systems, such as contact between home and school. Note the source of each item and whether it has been checked with the family. Finally, write two sentences naming one changeable process that the map suggests is maintaining the behaviour and how you could test that idea.

Study activities: The reflective-practice activity (20 minutes) examines the language you use about families. Take two recent reports or case notes you have written, mark every phrase that attributes behaviour to a family's circumstances or character, and rewrite each one so that it describes a specific, changeable process and at least one strength. Then write a few lines on what the rewriting changed in your view of the family and whether you would have been comfortable for the family to read the original. The skills-practice activity (30 minutes) builds skill in identifying coercive sequences. Write a short composite account of an argument between a caregiver and an adolescent about going out at night. Divide it into steps showing what each person did and what happened next, and mark the point at which each person's behaviour was reinforced. Draft two alternative caregiver responses that could interrupt the sequence without increasing risk, and write a short paragraph explaining your reasoning and the support the caregiver would need to keep using the new response.

Further reading:

Bronfenbrenner, U. (1979) The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press.

Patterson, G.R. (1982) Coercive Family Process. Eugene, OR: Castalia.

Dishion, T.J., McCord, J. and Poulin, F. (1999) 'When interventions harm: peer groups and problem behavior', American Psychologist, 54(9), pp. 755 to 764.

Moffitt, T.E. (1993) 'Adolescence-limited and life-course-persistent antisocial behavior: a developmental taxonomy', Psychological Review, 100(4), pp. 674 to 701.