



Los Angeles County Department of Mental Health Multisystemic Therapy (MST) Referral Form

MST is an intensive, family-based intervention for youth (ages 12-17 years) at risk of severe consequences within their family, school, or community due to serious externalizing, anti-social, and/or challenging behaviors. MST may be appropriate for youth who are involved in the juvenile justice system and/or who are at risk of out-of-home placement due to a history of criminogenic behavior.

Referral Date		
Date:		
Client Information		
Client Name:	DOB:	IBHIS #:
Address:	City:	Zip code:
Phone:	Preferred Language:	Medi-Cal #:
School:		
Referring Provider Information		
Provider Name & Provider #:		Referring Practitioner/Title:
Phone:		Email:
Parent/Guardian/Caregiver		
Name:	Phone:	Preferred Language:
Check if Applicable		
☐ DCFS ☐ Probation Involvement		☐ Services are court ordered ☐ Other: _____
Youth Behavioral Characteristics (check all that apply)		
☐ Violent/physically aggressive behavior ☐ Verbally aggressive or threatening behavior ☐ Robbery, theft ☐ Vandalism ☐ Drug related criminal offending		☐ Substance Use ☐ Running Away ☐ Non-compliance with probation of court order ☐ Non-compliance with family rules and expectations ☐ Other: _____



Youth School Characteristics (check all that apply)	
☐ Expelled or dropped out of formal education ☐ Attending alternative school setting – not mainstream ☐ Multiple suspensions for problem behavior ☐ High association with antisocial school peers ☐ Academic problems – risk of failure	☐ Low affiliation with prosocial school peers ☐ Poor relationships with school staff ☐ Attendance problems ☐ Other: _____
Youth-Peer Characteristics (check all that apply)	
☐ Gang membership or strong affiliation ☐ High affiliation with mostly antisocial peers	☐ Mixed antisocial and prosocial peers ☐ Low affiliation with prosocial peers
Desired Outcomes for referral to MST Services (check all that apply) Please place an “H” next to the areas you see as having highest priority	
☐ Prevent out of home placement ☐ Reduce aggressive and/or criminal behaviors ☐ Retain in school/vocational efforts and/or improve school attendance ☐ Improve academic functioning ☐ Reduce substance use	☐ Improve family problem solving skills ☐ Improve family communication and cohesiveness ☐ Improve youth pro-social involvement and peer relationships ☐ Improve family behavioral management skills ☐ Other: _____
Additional Referral Information (i.e. special accommodations/accessibility needs, etc.)	
If referring from a contracted provider, please submit the following attachments with your referral:	
☐ Most recent clinical assessment/addendum ☐ Needs Evaluation ☐ Diagnosis ☐ Progress notes (last 3 clinical notes)	☐ CANS-IP ☐ Problem List ☐ Treatment Plan (if applicable) ☐ Other: _____

Exclusion Criteria:

- Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers
- Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors.
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
- Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism.

For general questions, please contact BHSAEI@dmh.lacounty.gov