

# Multisystemic Therapy for Child Abuse and Neglect

Review: September 2017

**Note on provider involvement:** This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

**Multi-systemic Therapy for Child Abuse and Neglect (MST-CAN) is an intensive treatment for families who have recently been reported to Child Protection Services for physically abusing and/or neglecting a child between the ages of 6 and 17.**

MST-CAN therapists provide the family with tailored individual and family support and therapy over a six- to nine-month period with the aim of helping parents learn how to parent their child in a way that is not abusive or neglectful. MST-CAN has initial evidence of reducing parents' maltreating behaviour and out-of-home placements.

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Evidence  
rating: 3

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Cost rating: 5

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## EIF Programme Assessment

Multisystemic Therapy for Child Abuse and Neglect has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

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Evidence  
rating: **3**

### What does the evidence rating mean?

**Level 3** indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

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## Cost rating

A rating of 5 indicates that a programme has a high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of more than £2,000.

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Cost rating: **5**

# Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

## Supporting children's mental health and wellbeing

### Reduced symptoms of child PTSD

#### Based on study 1

1.43 point improvement on the Administrative data from the Child Protective Services

Improvement index: **+21**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 71% and worse outcomes than 29% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

0.25 point improvement on the Trauma Symptom Checklist for Children

Improvement index: **+25**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 75% and worse outcomes than 25% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

### Reduced child dissociative symptoms

#### Based on study 1

0.94 point improvement on the Trauma Symptom Checklist for Children

Improvement index: **+27**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 77% and worse outcomes than 23% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Reduced internalising symptoms

**Based on study 1**

2.13 point improvement on The Child Behaviour Checklist (parent report)

Improvement index: **+26**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 76% and worse outcomes than 24% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Preventing child maltreatment

### Reduced neglect

**Based on study 1**

0.18 point improvement on the Conflict Tactic Scale (child report)

Improvement index: **+31**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 81% and worse outcomes than 19% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

0.04 point improvement on the Conflict Tactic Scale (parent report)

Improvement index: **+11**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 61% and worse outcomes than 39% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Reduced psychological aggression

**Based on study 1**

0.03 point improvement on the Conflict Tactic Scale (child report)

Improvement index: **+8**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 58% and worse outcomes than 42% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Reduced minor assault

**Based on study 1**

0.02 point improvement on the Conflict Tactic Scale (child report)

Improvement index: **+6**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 56% and worse outcomes than 44% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Reduced severe assault

### Based on study 1

0.34 point improvement on the Conflict Tactic Scale (child report)

Improvement index: **+21**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 71% and worse outcomes than 29% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

0.15 point improvement on the Conflict Tactic Scale (parent report)

Improvement index: **+22**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 72% and worse outcomes than 28% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Reduced non-violent discipline

### Based on study 1

0.02 point improvement on the Conflict Tactic Scale (child report)

Improvement index: **+8**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 58% and worse outcomes than 42% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

0.04 point improvement on the Conflict Tactic Scale (parent report)

Improvement index: **+22**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 72% and worse outcomes than 28% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Increased placement stability

### Based on study 1

0.18 point improvement on the administrative data from the Child Protective Services

Improvement index: **+8**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 58% and worse outcomes than 42% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

## Preventing crime, violence and antisocial behaviour

### Reduced total problem behaviours

#### Based on study 1

3.50 point improvement on The Child Behaviour Checklist (parent report)

Improvement index: **+30**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 80% and worse outcomes than 20% of their peers, if they had received the intervention.

Between the end of the intervention and 10 months later

This programme also has evidence of supporting positive outcomes for couples, parents or families that may be relevant to a commissioning decision. Please see the 'About the evidence' section for more detail.

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# Key programme characteristics

## Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Primary school
- Preadolescents
- Adolescents

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## How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

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## Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Out-patient health setting

The programme may also be delivered in these settings:

- Out-patient health setting

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## How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated
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## Where has it been implemented?

Australia, Netherlands, Norway, United Kingdom, United States

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## UK provision

This programme has been implemented in the UK.

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## UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

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## Spotlight sets

EIF does not currently include this programme within any Spotlight set.

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## About the programme

### What happens during delivery?

#### How is it delivered?

- MST-CAN is delivered by a therapist individually to families in their homes.
- Therapists are available 24/7 to the family and carry a caseload of three to four families at a time.
- Therapy sessions typically last between 50 minutes and two hours.
- The frequency of the sessions vary depending on the needs of the family and the stage of the treatment, typically ranging from three days a week to daily.
- Therapists work with individual families for an average of six to nine months.

### What happens during the intervention?

- The MST-CAN therapist works closely with his or her MST-CAN expert, supervisor and family to find a good 'fit' between the family's issues and tailored strategies. This includes identifying barriers to the success of the programme (eg parental substance misuse or mental health problems) and developing methods for removing these barriers.
- A key aim of the intervention is to help families assume greater responsibility for their behaviours and actively work to resolve serious family issues.

### What are the implementation requirements?

#### Who can deliver it?

- The practitioner who delivers this programme is an MST-CAN therapist with QCF-6 level qualifications.

## **What are the training requirements?**

- Practitioners have 104 total hours of programme training. Booster training of practitioners is recommended.

## **How are the practitioners supervised?**

- It is recommended that practitioners are supervised by one host-agency supervisors (qualified to QCF-7/8 level), with 120 hours of programme training.
- It is recommended that practitioners are supervised by one programme developer supervisors (qualified to QCF-7/8 level).

## **What are the systems for maintaining fidelity?**

Programme fidelity is maintained through the following processes:

- Training manual
- Other printed material
- Other online material
- Video or DVD training
- Face-to-face training
- Fidelity monitoring.

## **Is there a licensing requirement?**

Yes, there is a licence required to run this programme.

## How does it work? (Theory of Change)

### How does it work?

- MST-CAN is informed by ecological theory that suggests that child maltreatment is multiply determined by risks occurring at the level of the child, family, school and community.
- MST-CAN therapists help families identify strengths within each ecological level that will help them overcome the risks contributing to the maltreating behaviours.
- Parents also learn strategies that are specific to their identified strengths to overcome the risks they are experiencing.
- In the short term, parent and child behaviours improve; families experience greater cohesion and improved relationships with their child's schools and wider support systems.
- In the long term, the risk of child maltreatment decreases, children are at less risk of behavioural problems, and there is less likelihood that the child will need to go into care.

### Intended outcomes

Preventing child maltreatment

### Contact details

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[www.mstcan.com](http://www.mstcan.com)[www.mstservices.com](http://www.mstservices.com)[www.mstuk.org](http://www.mstuk.org)[www.mstinstitute.org](http://www.mstinstitute.org)

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## About the evidence

The most rigorous evidence for MST-CAN comes from an RCT, which was conducted in the USA. This is a rigorously conducted (level 3) study, which has identified a statistically significant positive impact on a number of child and parent outcomes. A programme receives the same rating as its most robust study, and so MST-CAN receives a level 3 rating overall.

## Study 1

**Citation:** Swenson et al., 2010

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**Design:** RCT

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**Country:** United States

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**Sample:** 90 parent-child dyads in families with a child between the ages of 6-17

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**Timing:** Baseline; 2 months post-baseline; 4 months post-baseline; 10 months post-baseline; 16 months post-baseline

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**Child outcomes:**

- Reduced symptoms of child PTSD
  - Reduced child dissociative symptoms
  - Reduced internalising symptoms
  - Reduced neglect
  - Reduced psychological aggression
  - Reduced minor assault
  - Reduced severe assault
  - Reduced non-violent discipline
  - Increased placement stability
  - Reduced total problem behaviours
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**Other outcomes:**

- Reduced psychological distress Improved social support Reduced violent parenting behaviours
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**Study rating:** 3

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Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic Therapy for Child Abuse and Neglect: a randomized effectiveness trial. *Journal of Family Psychology*, 24(4), 497.

Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928578/>

### **Study Design and Sample**

The first study is a rigorously conducted RCT.

This study involved random assignment of 90 children to a MST-CAN group (n=45), or Enhanced outpatient treatment (n=45).

This study was conducted in the USA (Charleston, South Carolina), with a sample of families who were known to child protection services. Families were eligible if there was a reported incident of abuse or neglect in the past 90 days and they had a child between the ages of 10 and 17 years.

### **Measures**

Participants completed a battery of validated parent and child measures at baseline (pre-treatment) and then 2, 4, 10, and 16 months post-baseline:

- Youth behavioural and emotional functioning was measured using The Child Behaviour Checklist (CBCL) (parent report), the Trauma Symptom Checklist for Children (TSCC) (child self-report), and the Social Skills Rating System (child self-report).
- Psychiatric distress in parents was measured using the Global Severity Index (GSI) of the Brief Symptom Inventory (parent-report).
- The number of psychiatric symptoms was measured using the BSI Positive Symptom Total Scale (PST) (parent report).
- Parenting behaviour was measured using the Conflict Tactics Scale (CTS) (parent and child report).
- Social Support for the parents was measured using the 40-item Interpersonal Support Evaluation List (ISEL).
- Maltreatment (re-abuse) and youth out-of-home placement was measured using data obtained from CPS records. Re-abuse was defined as a new report of abuse of the target child, abuse of any child by the target parent. With regards to out-of-home placements; this referred to whether children were placed, for how many days they were placed, and whether there were any placement changes.

### **Findings**

This study identified statistically significant positive impact on a number of child and parent outcomes. This includes:

- Reduced internalising behaviour (CBCL),
- Reduced total behaviours (CBCL),
- Reduced PTSD (CBCL, TSCC),
- Reduced dissociative symptoms (TSCC).
- Reduced neglect (parent and child report),
- Reduced psychological aggression (child report),
- Reduced minor assault (child report),
- Reduced severe assault (parent and child report),
- Reduced non-violent discipline (parent and child report).
- Improved parental psychiatric distress (GSI),
- Improved social support.

## Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

Brunk, M. A., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology*, 55(2), 171-178. <http://dx.doi.org/10.1037/0022-006X.55.2.171> - **This reference refers to a randomised control trial, conducted in the USA.**

Schaeffer, C.M., Swenson, C.C., Tuerk, E.H., & Henggeler, S.W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families programme. *Child abuse & neglect*, 37(8), 596-607 - **This reference refers to a pre-post study, conducted in the USA.**

Swenson, C.C., Schaeffer, C.M., Tuerk, E.H., Henggeler, S.W., Tuten, M., Panzarella, P., Lau, C., Remmele, L., Foley, T., Cannata, E., & Albert Guillorn, A. 2009. Adapting Multisystemic Therapy for Co-Occurring Child Maltreatment and Parental Substance Abuse: The Building Stronger Families Project.

Stallman, H.M., Walmsley, K.E., Bor, W., Collerson, M.E., Swenson, C.C., McDermott, B. 2010. New directions in treatment of child physical abuse and neglect in Australia: MST CAN: A case study - **This reference refers to a case study design, conducted in Australia.**



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## Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

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[How to read the Guidebook](#)

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[EIF evidence standards](#)

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[About the EIF Guidebook](#)

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## EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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[www.EIF.org.uk](http://www.EIF.org.uk) | [@TheEIFoundation](https://twitter.com/TheEIFoundation)

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