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Multisystemic Therapy for Problem Sexual Behaviour

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.

Multisystemic Therapy for Problem Sexual Behaviour (MST-PSB) is a targeted-indicated programme for families with a young person aged between 10-17.5 years who has committed a sexual offence or demonstrated problematic sexual behaviour.

MST-PSB therapists work closely with the family and others (such as members of the community and the young person's school), using a variety of intervention strategies, to prevent further sexual abuse and improve the family's functioning.

Evidence rating: **4**

Cost rating: **5**

EIF Programme Assessment

Multisystemic Therapy for Problem Sexual Behaviour has **evidence of a long-term positive impact** on child outcomes through multiple rigorous evaluations.

Evidence rating: **4**

What does the evidence rating mean?

Level 4 indicates **evidence of effectiveness**. This means the programme can be described as evidence-based: it has evidence from at least two rigorously conducted evaluations (RCT/QED) demonstrating positive impacts across populations and environments lasting a year or longer.

This evidence rating is based on two robust studies where MST-PSB outperforms usual community services and treatment-as-usual in the context of the US system. Readers interpreting this evidence should carefully consider the generalisability of these results to the delivery context in the UK, including what treatment-as-usual services are typically offered in the UK to this group.

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.

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

Improved emotional bonding with peers

Based on study 1

4.24-point improvement on the Missouri Peer Relations Inventory (parent report)

Improvement index: **+42**

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 92% and worse outcomes than 8% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 1

1.78-point improvement on the Missouri Peer Relations Inventory (child 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.

Immediately after the intervention

Improved social maturity with peers

Based on study 1

2.70-point improvement on the Missouri Peer Relations Inventory (parent report)

Improvement index: **+38**

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 88% and worse outcomes than 12% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 1

2.49-point improvement on the Missouri Peer Relations Inventory (child report)

Improvement index: **+39**

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 89% and worse outcomes than 11% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced psychiatric symptoms

Based on study 1

0.42-point improvement on the Global Severity Index of the Brief Symptom Inventory

Improvement index: **+32**

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 82% and worse outcomes than 18% of their peers, if they had received the intervention.

Immediately after the intervention

Preventing risky sexual behaviour & teen pregnancy

Reduced deviant sexual interests

Based on study 2b

0.86-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Deviant Sexual Interests Scale - youth self report)

Improvement index: **+20**

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 70% and worse outcomes than 30% of their peers, if they had received the intervention.

Long-term 2 years later

Based on study 2b

0.68-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Deviant Sexual Interests Scale - parent report)

Improvement index: **+16**

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 66% and worse outcomes than 34% of their peers, if they had received the intervention.

Long-term 2 years later

Based on study 2a

0.51-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Deviant Sexual Interests Scale - youth self report)

Improvement index: **+12**

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 62% and worse outcomes than 38% of their peers, if they had received the intervention.

Long-term A year later

Based on study 2a

0.65-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Deviant Sexual Interests Scale - parent report)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term A year later

Reduced sexual risk/misuse

Based on study 2b

0.65-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Sexual Risk/Misuse Scale - youth self report)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term 2 years later

Based on study 2a

0.65-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Sexual Risk/Misuse Scale - youth self report)

Improvement index: **+15**

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 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term A year later

Based on study 2a

1.02-point improvement on the Adolescent Clinical Sexual Behaviour Inventory (Sexual Risk/Misuse Scale - parent report)

Improvement index: **+23**

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 73% and worse outcomes than 27% of their peers, if they had received the intervention.

Long-term A year later

Preventing child maltreatment

Reduced out-of-home placements

Based on study 2a

0.07-point improvement on the Services Utilization Tracking Form

Improvement index: **+2**

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 52% and worse outcomes than 48% of their peers, if they had received the intervention.

Long-term A year later

Based on study 2b

0.85-point improvement on the Services Utilization Tracking Form

Improvement index: **+19**

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 69% and worse outcomes than 31% of their peers, if they had received the intervention.

Long-term 2 years later

Enhancing school achievement & employment

Improved school grades

Based on study 1

1.27-point improvement on parent and teacher rated grade achievement

Improvement index: **+39**

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 89% and worse outcomes than 11% of their peers, if they had received the intervention.

Immediately after the intervention

Preventing crime, violence and antisocial behaviour

Reduced externalising symptoms

Based on study 2a

2.49-point improvement on the Youth Self Report

Improvement index: **+16**

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 66% and worse outcomes than 34% of their peers, if they had received the intervention.

Long-term A year later

Reduced delinquent behaviour

Based on study 2b

0.90-point improvement on the Self-Report Delinquency Scale

Improvement index: **+20**

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 70% and worse outcomes than 30% of their peers, if they had received the intervention.

Long-term 2 years later

Based on study 2a

0.92-point improvement on the Self-Report Delinquency Scale

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.

Long-term A year later

Reduced aggression towards peers

Based on study 1

5.09-point improvement on the Missouri Peer Relations Inventory (parent report)

Improvement index: **+43**

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 93% and worse outcomes than 7% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced number of arrests for nonsexual crimes

Based on study 1

3.42 reduction in the number of arrests for non-sexual crimes (measured using juvenile and adults arrest records)

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.

Long-term 8.9 years later

Reduced number of person related crimes (e.g. assault, armed robbery)

Based on study 1

6.60-point improvement on the Self-Report Delinquency Scale

Improvement index: **+34**

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 84% and worse outcomes than 16% of their peers, if they had received the intervention.

Immediately after the intervention

Reduced number of property crimes (e.g. vandalism, stealing a car)

Based on study 1

27.95-point improvement on the Self-Report Delinquency Scale

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.

Immediately after the intervention

Reduced number of arrests for sexual crimes

Based on study 1

0.66 reduction in the number of arrests for sexual crimes (measured using juvenile and adults arrest records)

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.

Long-term 8.9 years later

Reduced number of days spent in detention facilities

Based on study 1

80% reduction in days spent in detention facilities (measured using juvenile and adults arrest records)

Improvement index: **+24**

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 74% and worse outcomes than 26% of their peers, if they had received the intervention.

Long-term 8.9 years later

Preventing substance abuse

Reduced substance use

Based on study 2a

1.2-point improvement on the Personal Experiences Inventory

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.

Long-term A year 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.

Key programme characteristics

Who is it for?

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

- Preadolescents
- Adolescents

How is it delivered?

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

- Individual

Where is it delivered?

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

- Home
- Secondary school
- Community centre

The programme may also be delivered in these settings:

- Home
- Children's centre or early-years setting
- Primary school
- Secondary school
- Community centre
- In-patient health setting
- Out-patient health setting

How is it targeted?

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

- Targeted indicated

Where has it been implemented?

Netherlands, United Kingdom, United States

UK provision

This programme has been implemented in the UK.

UK evaluation

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

Spotlight sets

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

About the programme

What happens during delivery?

How is it delivered?

- MST-PSB is delivered by a therapist who works individually with the young person and family in their home, for an average of 6-9 months.
- Therapy sessions typically last between 50 minutes and 2 hours. The frequency of the sessions vary depending on the needs of the family and the stage of the treatment; however, sessions usually range from three days a week to daily.
- Therapists work in the community in teams of 3-4 therapists plus a supervisor. The therapists are available to the family 24/7, and carry a caseload of 3-4 families at a time.

What happens during the intervention?

- A variety of intervention strategies are used individually with the young person, their caregiver(s), and the wider family. Used strategies include: family discussions, role plays, structural family therapy, safety planning, and sexual education.
- The intervention follows a set of principles, so that problems are resolved in a strategic way with families. In addition, work is undertaken to strengthen the families' informal network of support and to reduce their future dependence on statutory services.
- In line with the broader MST aims, the aims of MST-PSB include: 1) eliminating sexual offending and other antisocial behaviour by the young person; 2) keeping the young person in the home and avoiding out-of-home placement; 3) helping the young person to be successful in school, work, and other community activities; and 4) providing families with problem-solving skills to tackle any future difficulties.

What are the implementation requirements?

Who can deliver it?

- The practitioner who delivers this programme is an MST-PSB therapist with NFQ-9/10 level qualifications.

What are the training requirements?

- Practitioners have 46 hours of programme training in total.
- Booster training of practitioners is recommended.

How are the practitioners supervised?

It is recommended that practitioners are supervised by:

- One host-agency supervisor (qualified to NFQ-9/10 level), with 82 total hours of programme training.
- One programme developer supervisor (qualified to NFQ 9/10 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-PSB is informed by ecological theory that assumes that the young person's problematic sexual behaviour is multi-determined by risks that occur at the level of the child, family, school, and community.
- MST-PSB also assumes that the young person's caregivers are usually the primary agent of change.
- MST-PSB therapists, therefore, work closely with the young person and his/her caregiver(s) to develop a plan that increases their parenting effectiveness, improves communication within the family, decreases any denial that may exist regarding the child's sexual behaviour, and increases the safety of others.
- Family denial decreases, parenting effectiveness increases, family communication improves, and harmful sexual behaviour decreases.
- The young person is ultimately less likely to reoffend and the need to go into care or prison is averted.

Intended outcomes

Supporting children's mental health and wellbeing Enhancing school achievement & employment Preventing crime, violence and antisocial behaviour Preventing substance abuse Preventing risky sexual behaviour & teen pregnancy

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https://www.crimesolutions.gov/ProgramDetails.aspx?ID=62

About the evidence

MST-PSB's most rigorous evidence comes from two RCTs which were conducted in the USA. These are rigorously conducted level 3 studies, which have identified statistically significant positive impact on a number of child and parent outcomes. Since the programme is underpinned by two level 3 studies and there is also evidence of long-term positive impact, the programme receives a level 4 rating overall.

This evidence rating is based on two robust studies where MST-PSB outperforms usual community services and treatment-as-usual in the context of the US system. Readers interpreting this evidence should carefully consider the generalisability of these results to the delivery context in the UK, including what treatment-as-usual services are typically offered in the UK to this group.

Study 1

Citation:	Borduin et al., 2009
Design:	RCT
Country:	United States
Sample:	48 families in which the youth (mean age = 14 years) has been arrested for a serious sexual offense
Timing:	Post-test 9-year follow-up

Child outcomes:

- Improved emotional bonding with peers
- Improved emotional bonding with peers
- Improved social maturity with peers
- Improved social maturity with peers
- Reduced psychiatric symptoms
- Improved school grades
- Reduced aggression towards peers
- Reduced number of arrests for nonsexual crimes
- Reduced number of person related crimes (e.g. assault, armed robbery)
- Reduced number of property crimes (e.g. vandalism, stealing a car)
- Reduced number of arrests for sexual crimes
- Reduced number of days spent in detention facilities

Other outcomes:

- Reduced mothers' and fathers' psychiatric symptoms Improved family cohesion Improved family adaptability

Study rating: 3

Borduin, C.M., Heiblum, N., Schaeffer, C.M. (2009). A Randomized Clinical Trial of Multisystemic Therapy with Juvenile Sexual Offenders: Effects on Youth Social Ecology and Criminal Activity. Journal of Consulting and Clinical Psychology, 77, 26-37.

Available at:https://www.ncbi.nlm.nih.gov/pubmed/19170451

Study design and sample

This study is a rigorously conducted RCT, which involved random assignment of youths and their families to a MST-PSB intervention group and a usual community services control group.

The study was conducted in the USA, with a sample of 48 youths (mean age = 14 years) and their families. Youths were referred to the study by juvenile court personnel, after having been arrested for a serious sexual offense. 95.8% of the sample were boys; 72.9% were White and 27.1% were Black. The primary caretaker of the youth included biological mothers (91.7%), biological fathers (6.3%), or stepmothers (2.1%), and 31.3% lived with only one parental figure (always a biological parent). Families averaged 3.3 children and 54.8% of the families were of lower socioeconomic status.

Measures

- Youth behaviour problems were assessed using the Revised Behaviour Problem Checklist (RBPC; parent report)
- Perceptions of the youth's peer relations were assessed using the Missouri Peer Relations Inventory (MPRI; child self-report, parent report, and teacher report)
- Reports of youth grades were obtained across five areas (English, Math, Social Studies, Science, and Other) using 5-point Likert scales ranging from 0 (grade F) to 4 (grade A) (parent and teacher report)
- Delinquent behaviour was assessed using the Self-Report Delinquency Scale (SRD; child self-report)
- Arrests for criminal offenses were obtained from juvenile office records (administrative data)
- Incarceration details were obtained from criminal records (administrative data)
- Psychiatric symptoms in mothers, fathers, and youths were assessed using the Global Severity Index of the Brief Symptom Inventory (GSI-BSI; parent and child self-report)
- Family cohesion and adaptability were assessed using the Family Adaptability and Cohesion Evaluation Scales II (FACES II; parent and child self-report)

Findings

At post-test, this study identified statistically significant positive impact on a number of child and parent outcomes, including:

- Emotional bonding to peers (MPRI; child self-report, parent report, and teacher report)
- Social maturity with peers (MPRI; child self-report, parent report, and teacher report)
- Aggression towards peers (MPRI; parent and teacher report)
- School grades (parent and teacher report)
- Person crimes (SRD; child self-report)
- Property crimes (SRD; child self-report)
- Mother's psychiatric symptoms (GSI-BSI; parent report)
- Father's psychiatric symptoms (GSI-BSI; parent report)
- Youth's psychiatric symptoms (GSI-BSI; child self-report)
- Family cohesion (FACES II; parent and child self-report)
- Family adaptability (FACES II; parent and child self-report)

Moreover, results from the 9-year follow-up, identified statistically significant positive impact on:

- Arrests for sexual and nonsexual crimes (administrative data)
- Time spent in detention facilities (administrative data)

Study 2a

Citation: Letourneau et al., 2009

Design: RCT

Country: United States

Sample: 127 families in which the youth (aged 11-18 years) has been charged with a sexual offense

Timing: 1-year follow-up

Child outcomes:

- Reduced deviant sexual interests
- Reduced deviant sexual interests
- Reduced sexual risk/misuse
- Reduced sexual risk/misuse
- Reduced out-of-home placements
- Reduced externalising symptoms
- Reduced delinquent behaviour
- Reduced substance use

Other outcomes:

- None measured

Study rating: 3

Letourneau, E.J., Henggeler, S.W., Borduin, C.M., Schewe, P.A., McCart, M.R., Chapman, J.E., Saldana, L. (2009). Multisystemic Therapy for Juvenile Sexual Offenders: 1-Year Results from a Randomized Effectiveness Trial. J Fam Psychol., 23(1), 89-102.
Available at: https://www.ncbi.nlm.nih.gov/pubmed/19203163
Study design and sample

The second study is a rigorously conducted RCT. It involved random assignment of youths and their families to a MST-PSB intervention group and a treatment as usual control group.
The study was conducted in the USA, with a sample of 127 youths (mean age = 14.6 years; range = 11-17) and their families. Youths were referred to the study by the county State's Attorney after having been charged with a sexual offense. 97.6% of the sample were boys; 54% were African-American and 44% were White, and 30% indicated Hispanic ethnicity. The youth's primary caregivers included mothers (64%), fathers (15%), other female relatives (19%), foster parents (2%), and a male relative (1%). Family economic status varied, with 33% of families earning less than $10,000/year, 38% earning $10,000 to $30,000/year, and 28.5% earning $30,000 or more, indicating that the participating families were generally socio-economically deprived.
Measures

- Inappropriate adolescent sexual behaviour was assessed using two subscales of the Adolescent Clinical Sexual Behaviour Inventory (ACSBI; parent report and child self-report)
- Youth criminal behaviour was assessed using the General Delinquency subscale of the Self-Report Delinquency Scale (SRD; child self-report)
- Youth substance use was assessed with a subscale of the Personal Experience Inventory (PEI; child self-report)
- Youth mental health symptoms were assessed with the Externalizing and Internalizing scales of the Child Behavior Checklist (CBCL; parent report and child self-report)
- Youth placement data was assessed using the Services Utilization Tracking Form (parent report)

Findings

This study identified statistically significant positive impact on a number of child outcomes at 1-year follow-up, including:

- Deviant sexual interests (ACSBI; parent report and child self-report)
- Sexual risk/misuse (ACSBI; parent report and child self-report)
- Delinquent behaviour (SRD; child self-report)
- Substance use (PEI; child self-report)
- Externalizing symptoms (CBCL; child self-report)
- Out-of-home placement (Services Utilization Tracking Form; parent report)

Study 2b

Citation:	Letourneau et al., 2013
Design:	RCT
Country:	United States
Sample:	127 families in which the youth (aged 11-18 years) has been charged with a sexual offense
Timing:	2-year follow-up

Child outcomes:

- Reduced deviant sexual interests
- Reduced deviant sexual interests
- Reduced sexual risk/misuse
- Reduced out-of-home placements
- Reduced delinquent behaviour

Other outcomes:

- None measured

Study rating: 3

Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. Journal of Family Psychology, 27, 978-985.

Available at:https://www.ncbi.nlm.nih.gov/pubmed/24188082

Study 2b describes follow-up findings from study 2a.

Follow-up assessments were at two years post-intervention.

Outcomes measured included:

- Inappropriate adolescent sexual behaviour was assessed using two subscales of the Adolescent Clinical Sexual Behaviour Inventory (ACSBI; parent report and child self-report)
- Youth criminal behaviour was assessed using the General Delinquency subscale of the Self-Report Delinquency Scale (SRD; child self-report)
- Youth substance use was assessed with a subscale of the Personal Experience Inventory (PEI; child self-report)
- Youth mental health symptoms were assessed with the Externalizing and Internalizing scales of the Child Behavior Checklist (CBCL; parent report and child self-report)
- Youth placement data was assessed using the Services Utilization Tracking Form (parent report)

The study identified statistically significant positive impact on a number of child outcomes, including:

- Deviant sexual interests (ACSBI; parent report and child self-report)
- Sexual risk/misuse (ACSBI; parent report and child self-report)
- Delinquent behaviour (SRD; child self-report)
- Externalizing symptoms (CBCL; child self-report)
- Out-of-home placement (Services Utilization Tracking Form; parent report)

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.

Borduin, C.M., Henggeler, S.W., Blaske, D.M., Stein, R.J. (1990). Multisystemic Treatment of Adolescent Sexual Offenders. International Journal of Offender Therapy and Comparative Criminology, 35, 105-114 - **This reference refers a randomised control trial.**

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.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

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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