

Multisystemic Therapy for Problem Sexual Behaviour

Review: September 2017

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

Reduced psychiatric symptoms - based on **study 1**

Reduced externalising symptoms - based on **study 2a**

Enhancing school achievement & employment

Improved school grades - based on **study 1**

Preventing crime, violence and antisocial behaviour

Improved emotional bonding with peers - based on **study 1**

Improved social maturity with peers - based on **study 1**

Reduced aggression towards peers - based on **study 1**

Reduced number of person and property crimes - based on **study 1**

Reduced number of arrests for sexual and nonsexual crimes - based on **study 1**

Reduced number of days spent in detention facilities - based on **study 1**

Reduced deviant sexual interests - based on **study 2a, study 2b**

Reduced sexual risk/misuse - based on **study 2a, study 2b**

Reduced delinquent behaviours - based on **study 2a, study 2b**

Reduced out-of-home placements - based on **study 2a, study 2b**

Preventing substance abuse

Reduced substance use - based on **study 2a**

Preventing risky sexual behaviour & teen pregnancy

Reduced deviant sexual interests - based on **study 2a, study 2b**

Reduced sexual risk/misuse - based on **study 2a, study 2b**

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

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.

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 QCF-7/8 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 QCF-7/8 level), with 82 total hours of programme training.
- One programme developer supervisor (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-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

Contact details

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<http://www.mstpsb.com/Pages/default.aspx>

<http://mstservices.com/>

<http://mstuk.org>

<http://www.blueprintsprograms.com/factsheet/multisystemic-therapy-problem-sexual-behavior-mst-psb>

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

<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=46>

<http://www.cebc4cw.org/program/multisystemictherapy-for-youth-with-problem-sexualbehaviors/>

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 | **Study rating:** 3

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 social maturity with peers
- Reduced aggression towards peers
- Improved school grades
- Reduced number of person and property crimes
- Reduced psychiatric symptoms
- Reduced number of arrests for sexual and nonsexual crimes
- Reduced number of days spent in detention facilities

Other outcomes:

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

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 | **Study rating:** 3

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 sexual risk/misuse

Reduced deviant sexual interests

Reduced sexual risk/misuse

Reduced delinquent behaviours

Reduced substance use

Reduced externalising symptoms

Reduced out-of-home placements

Other outcomes:

None measured

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 | **Study rating:** 3

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 sexual risk/misuse

Reduced deviant sexual interests

Reduced sexual risk/misuse

Reduced delinquent behaviours

Reduced out-of-home placements

Other outcomes:

None measured

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.

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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