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specialist in persoonlijkheid, gedrag en gezin

MST-CAN
Kick Off Conferentie

9 augustus 2016

Rotterdam

Programma

09.00 : Welkom door Marc Verweij,
Zorgmanager locatie Rotterdam
09.15 : Presentatie Melanie Duncan, MST Services
10.30 : Pauze
10.45 : Presentatie Rob Coolen, supervisor MST CAN Den Bosch
12.00 : Lunch
13.00 : Workshops voor verwijzers
door Melanie Duncan en Marije Eijgendaal, supervisor MST-CAN Rotterdam
14.30 : Pauze
14.45 : Workshops voor verwijzers Deel II
door Melanie Duncan en Marije Eijgendaal

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Multisystemic Therapy for Child Abuse and Neglect

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MST-CAN

- A treatment model applied to families who experience physical abuse and/or neglect

- A treatment for serious, complex cases

Swenson, C.C., Schaeffer, C.M., Henggeler, S.W., Faldowski, R., & Mayhew, A. (2010). Multisystemic Therapy for Child Abuse and Neglect: A Randomized Effectiveness Trial. Journal of Family Psychology, 24, 497-507.

MST-CAN

RATED AS AN EVIDENCE-BASED TREATMENT:

California Evidence-Based Clearinghouse
for Child Welfare

RATED AS A PROMISING TREATMENT:

Office of Justice Programs

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Why Apply MST to Serious and Complex Child Maltreatment Cases

- Associated with severe short-term and long-term mental health difficulties
- Children lose their family, school, community when placed out of the home and placement changes lead to institutional care.
- Failure to treat the complex risk factors increases the risk of reabuse and a revolving door of government intervention for families

Why Apply MST to Serious and Complex Child Maltreatment Cases

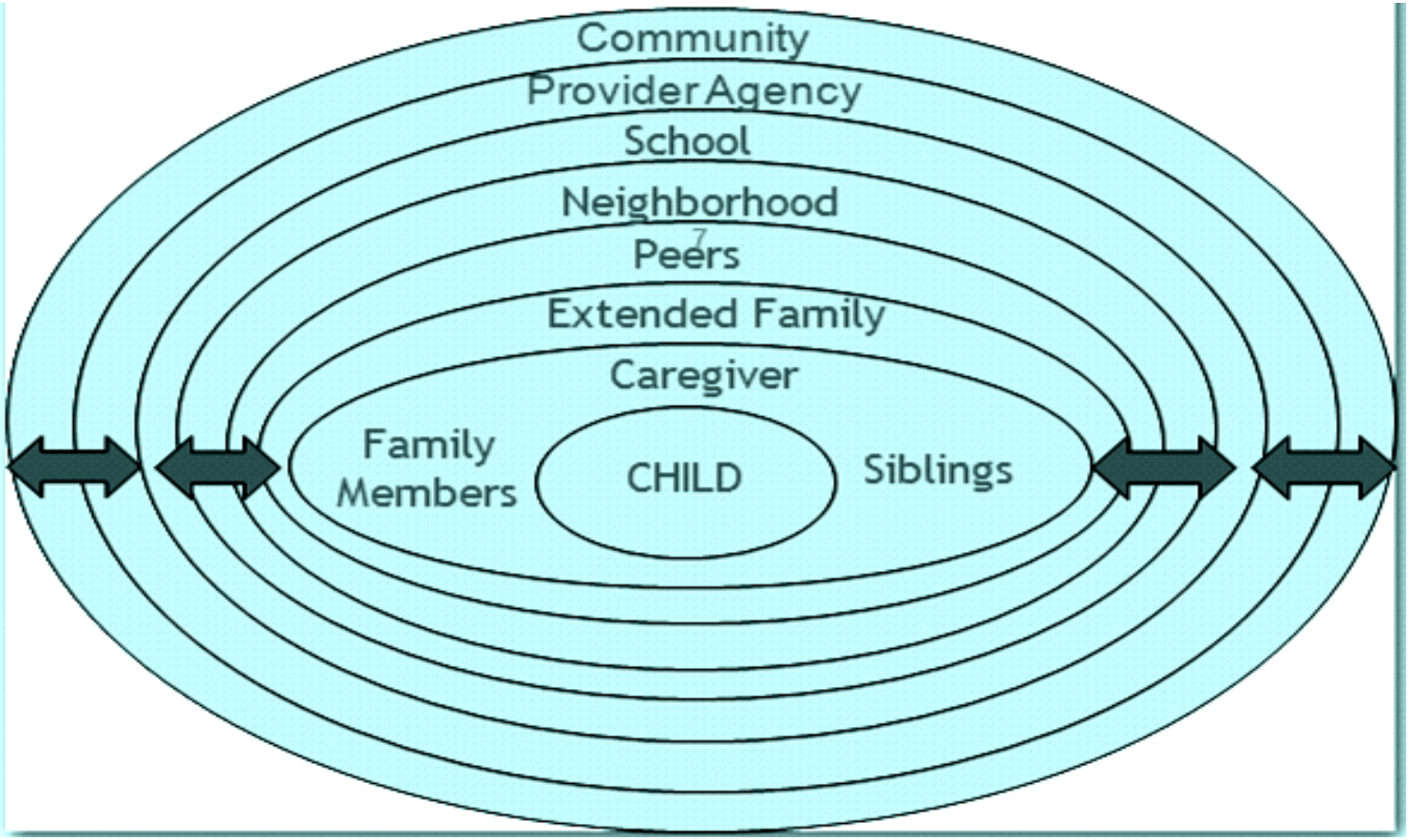
- Common treatments are fragmented, often not evidence-based and most often involve multiple providers in uncoordinated services resulting in an iatrogenic process

- Costs are in the billions each year

Follows The Standard MST Model

- Theoretical basis is social ecological and family systems
- Follows nine principles
- Views the family as the major agent for changing youth behavior and views the ecology as the client
- Clinically follows an analytic process

Social Ecological Model



Follows The Standard MST Model

- Assessment focuses on factors that drive the target behavior rather than diagnoses
- Interventions are research supported
- Treatment is tailored to the needs and context of the family – is not one size fits all
- Clinician availability 24/7; Sessions at times convenient to families; Treatment is home-based
- Evidence-based intervention and model drift is prevented by use of a strong Quality Assurance process

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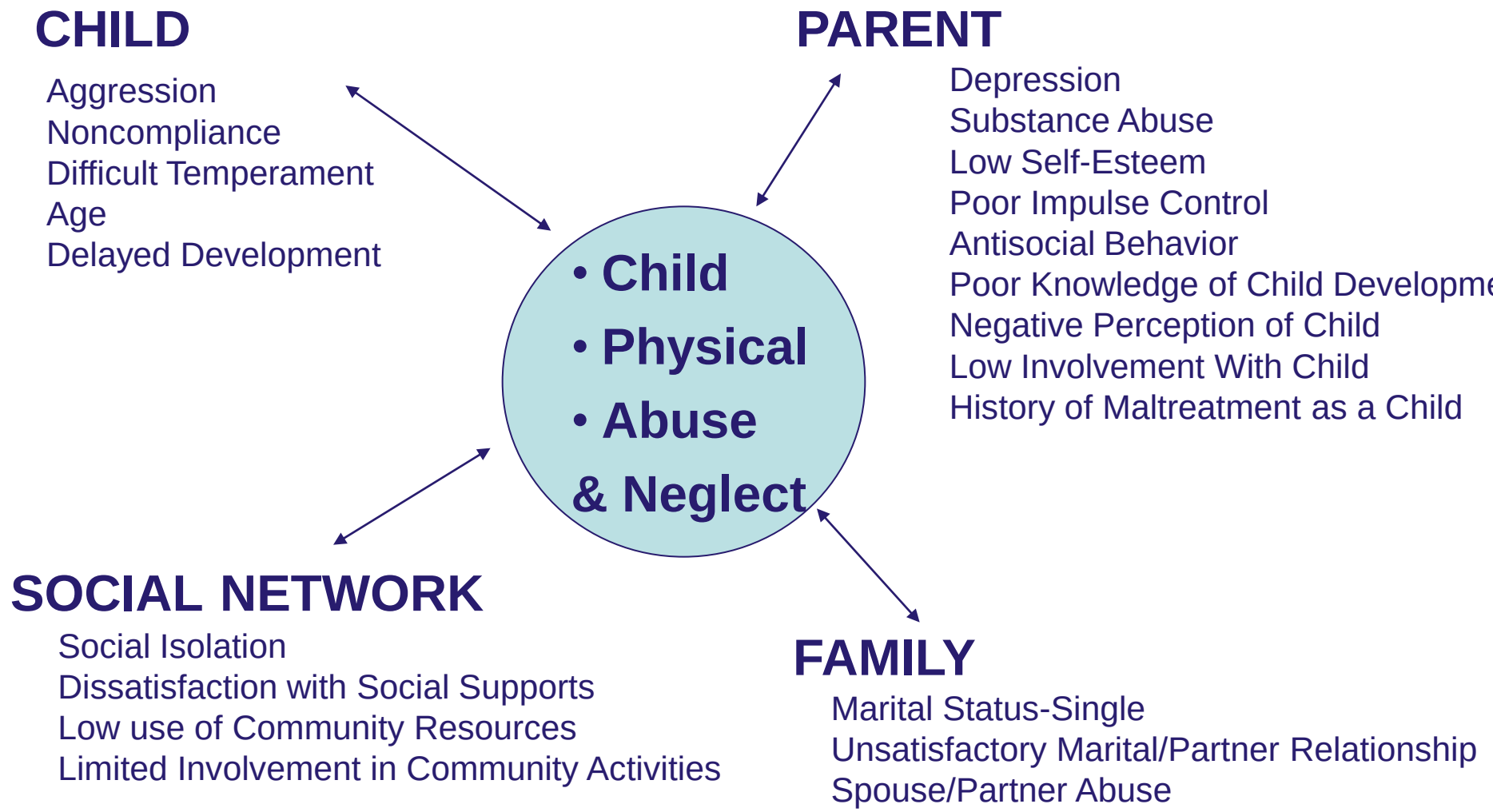
Physical Abuse and Neglect Is Multidetermined



Implications of Multidetermined Risk

- Treatment should address risk factors across all systems
- Treatment should be tailored to the unique risk factors within a given family
- Treatment must be comprehensive
- Historical risk or fit factors are important to understand BUT alterable risk factors are the focus of treatment

MST-CAN - The Families

- **Families**
  - Physical abuse and/or neglect
  - Children and Youth ages 6-17
  - Children and Youth may be in placement with expectation of rapid return
  - Family may be long-term client of Child Protection
  - New report in last 180 days
- **Exclusion Criteria**
  - Active sexual abuse cases
  - Active partner violence cases
  - Children with autism – pervasive developmental disorders

MST-CAN - The Team

- 1 full-time Supervisor
- 3 Therapists
- 1 full-time Crisis Caseworker
- 20% dedicated time from Psychiatrist
- Close working relationship with Child Protection

MST-CAN - Services

- Caseload
  - Maximum caseload of 4 Families
  - All family members treated (average = 5)
  - Special emphasis on adult treatment

- Treatment Length
  - 6-9 months

MST-CAN - Services

- Treatment Delivery

- Services in the home or places convenient to families
- Services delivered at times that meet the needs of the family
- Availability of 24-hours a day, 7 days a week
- Crisis on call services
- Supporting families in court processes
- Services in foster home if indicated

MST-CAN - Quality Assurance

- Training

- Completion of the 5-Day MST Orientation Training
- Completion of 4 Days of MST-CAN specific training
- Completion of the 4-Day booster on trauma treatment
- Quarterly boosters

MST-CAN - Quality Assurance

- Supervision and Consultation

- MST Services consultant weekly supervisor development teleconference
- MST Services consultant weekly phone consultation with team
- Weekly team group supervision
- Monthly telephone interviews with families to assess adherence to the model

MST-CAN - Research Supported Treatments to Address Risk Factors Across Multiple Systems

- All Families Receive:

  - Family Safety Planning
  - Clarification of the Abuse

- Treatments used on an as indicated basis that are common across families:

  - Functional Analysis of the Use of Force or Physical Discipline
  - Cognitive Behavioral Therapy for Anger Management
  - Cognitive Behavioral Therapies for Child and Adult Trauma
  - Reinforcement-Based Treatment for Adult Substance Abuse
  - Family Communication and Problem Solving raining

MST-CAN Research Outcomes
The Efficacy Trial

- Brunk, Henggeler, & Whelan, 1987
- First Randomized Trial (N =43)
- Multisystemic Therapy vs. Parent Training
- Children were abused or neglected
- Mean age 9.8 for youth in MST Condition
  6.8 for youth in the Parent Training Condition

MST	Greater alleviation of family difficulties
	Greater control of child
	Neglectful parents more responsive
PT	Greater decrease in parent social problems

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MST-CAN Research Outcomes
The Effectiveness Trial

- 5-Year Randomized Effectiveness Trial Completed in Charleston, South Carolina and funded by the National Institute of Mental Health
- 86 Families
- MST-CAN compared to Enhanced Outpatient Treatment (Systematic Training for Effective Parenting group, special engagement strategies, any other treatment needed through the Mental Health Center)
- Outcomes measured at 5 points in time across 16 months
- For MST-CAN, average length of treatment was 7.6 months
- Hours of treatment did not significantly differ between the groups

MST-CAN Research Outcomes
The Effectiveness Trial

Participants

- 98% Recruitment Rate and Treatment Retention of 98% for MST-CAN and 83% for Enhanced Outpatient Treatment
- 78% Minority Families, primarily African American
- Youth Average Age = 13.8
- 56% Female
- 23.3% of families had a prior CPS report
- More than 80% of abuse incidents involved minor injuries

MST-CAN Research Outcomes

16 months post-baseline, MST-CAN youth showed:

- Greater reductions in parent reported internalizing symptoms, total behavior problems, PTSD symptoms
- Greater reductions in youth reported PTSD symptoms and dissociative symptoms

MST-CAN Research Outcomes

16 months post-baseline, MST-CAN parents/ caregivers showed:

- Greater reductions in global psychiatric distress
- Greater increases in total, appraisal, and belonging social support

MST-CAN Research Outcomes

16 months post-baseline, MST-CAN parents/ caregivers showed:

- Higher levels of satisfaction - helping family change, change way family behaves, skills are becoming a daily part of life, match individual needs of family, quality of treatment

MST-CAN Research Outcomes

16 Months Post-Baseline, MST-CAN parenting outcomes included:

- Greater reductions in:
  - minor assault (youth report)
  - severe assault (caregiver and youth report)
  - psychological aggression (youth report)
  - neglectful parenting (caregiver and youth report)

- More likely to use nonviolent discipline (caregiver and youth report)

MST-CAN Research Outcomes

Reabuse

- Fewer MST-CAN youth experienced an incident of reabuse (4.5% [2 children] vs 11.9% [5 children in EOT] ns.
- Fewer MST-CAN caregivers had an incident of reabuse (2.3% [1 caregiver] vs 4.8% [2 caregivers in EOT] ns.

MST-CAN Research Outcomes

Out-Of-Home Placement

- Significantly fewer MST-CAN youth in out-of-home placements (6 vs. 13)
- MST-CAN Youth who were placed experienced significantly fewer placement changes

MST-CAN - Clinical Signifi**cance**

Youth:

MST-CAN reduced percentage of youth scoring in the clinical range on self reported PTSD symptoms by half whereas EOT group increased

Parents:

MST-CAN parents who exceeded clinical thresholds for psychological distress decreased by 75%, EOT remained flat

Parenting:

MST-CAN youth reported half the number of severe assaults by their parent across 16 months

MST-CAN
Post Randomized Trial Activities

United States

- Completion of 2-year transportability pilot in Denver, Colorado that led to national dissemination

- Completion of 7-year project in Connecticut in which MST-CAN is part of a treatment (MST-Building Stronger Families) for co-occurring abuse/neglect and parental substance abuse. A randomized trial funded by the National Institute on Drug Abuse started in Connecticut in August 2010

MST-CAN
Post Randomized Trial Activities

International

- Completed 3-year project in Eastern Australia
- Currently being implemented in England, Switzerland, The Netherlands and now Norway
- Piloting internationally all programs to establish feasibility and acceptability to the country and to consider the local culture in how the research-based model is implemented prior to dissemination with no developer involvement

MST-CAN Information

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