MST CAN: an evidence based treatment for child abuse and neglect- a clinician’s perspective.

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MST-CAN

• An evidence-based, restorative, ecological treatment model applied to families under the guidance of CPS due to recently substantiated physical abuse and/or neglect with a target child/youth ages 6-17.

• A treatment for serious, complex cases

Development of MST-CAN

The Context

- Virtually no research on treatment for physical abuse
- The neglect of neglect
- Treatment of the day was individual child
- Multiple providers creating an iatrogenic process
- Most work not evidence-based

MST-CAN started from

- Clinical work
- Talking to people involved
- Training experiences
- Scientific literature
What We Know About Causes and Correlates of Physical Abuse and Neglect

**CHILD**
- Aggression
- Noncompliance
- Difficult Temperament
- Younger
- Delayed Development

**PARENT**
- Depression/Other Mental Health Hx
- Substance Abuse
- Blaming Child for Misbehavior
- Over reactive Disciple/Anger Reaction
- Poor Knowledge of Child Development
- Negative Perception of Child
- Low Involvement With Child
- History of Maltreatment as a Child
- Low Educational Attainment

**SOCIAL NETWORK**
- Poor Social Network Doubles Risk
- Dissatisfaction with Social Supports
- Low use of Community Resources
- Limited Involvement in Community Activities

**FAMILY**
- Marital Status-Single
- Unsatisfactory Marital/Partner Relationship
- Partner Abuse

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Multisystemic Therapy for Child Abuse and Neglect

MST-UK

Multisystemic Therapy
What the Multiple Risk Factors Tell us About Treatment

• The risk is across multiple systems
• Treating one system only does not solve the problem
• There is a need for treatment that addresses all systems and multiple risk factors individual to a family
• An ecological model may be our best hope for complex, deep-end cases
GOALS OF MST-CAN

1. Keep Families Together Safely
2. Prevent Re-abuse and Neglect
3. Reduce Mental Health Difficulties Experienced by Adults and Children
4. Increase Natural Social Supports
Principles of MST

1. **Finding the Fit**
The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context.

2. **Positive & Strength Focused**
Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.

3. **Increasing Responsibility**
Interventions should be designed to promote responsible behaviour and decrease irresponsible behaviour among family members.

4. **Present-focused, Action-oriented & Well-defined**
Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

5. **Targeting Sequences**
Interventions should target sequences of behaviour within and between multiple systems that maintain identified problems.
6. Developmentally Appropriate
Interventions should be developmentally appropriate.

7. Continuous Effort
Interventions should be designed to require daily or weekly effort by family members.
Emphasising skills training which is all about practice, practice, practice.

8. Evaluation and Accountability
Intervention efficacy is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.

9. Generalization
Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change.
Multisystemic Therapy: Principles and Process

MST Analytical Process

- Referral Behavior
- Desired Outcomes of Family and Other Key Participants
- Overarching Goals

Environment of Alignment and Engagement of Family and Key Participants

- MST Conceptualization of “Fit”
- Re-evaluate

Assessment of Advances and Barriers to Intervention Effectiveness

- Prioritize

Measure

- Intervention Implementation

Do

- Intervention Development

Intermediary Goals

<< Continued from front
Environment of Alignment and Engagement
of Family and Key Participants

Prioritize

Do

MST Conceptualization of “Fit”
Identify fit factors for critical safety barriers

Occurrence of Critical Safety Barrier

Overarching Goals
To increase safety by reducing or eliminating critical safety barriers

MST-CAN Safety Do-Loop

Evaluate & follow-up

Goal Met
Safety barrier is no longer a problem

Intermediary Goals
Increase safety by reducing or eliminating specific safety barriers

Safety barrier is still a problem

Intervention Development
Identify actions to increase safety by eliminating specific safety barriers

Intervention Implementation
Do actions to increase safety by reducing or eliminating specific safety barriers

Leeds story
MST-CAN - The Families

Inclusion

• 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

• Child out of home with no plan to reunite
• Active sexual abuse occurring in the family
• Child has autism or a pervasive developmental delay
• Youth is living independently or where a caregiver cannot be identified despite extensive efforts to locate
• Youth has been identified as having committed a sexual offense
MST-CAN — The Team

• 1 full-time Supervisor
• 3 Therapists
• 1 full-time Family Case Manager
• 20% dedicated time from a Psychiatrist
• Close working relationship with Child Protection
MST-CAN - Service Characteristics

Treatment Delivery:

- Services in the Home or Places Convenient to Families
- Services delivered at Times That Meet Needs of Family
- Availability of 24 Hour a Day, 7 Days a Week Crisis On Call Services
- Supporting Families in Court Processes
- Services in Foster Home if Indicated
Service Characteristics

• Caseload
  – Maximum caseload of 3 Families
  – All family members treated (average = 5)
  – Special emphasis on adult treatment

• Treatment Length
  – 6-9 months
MST-CAN - Clinical Work

All Families Receive:

- Ongoing Safety Assessment and Planning
- Investment Check Up (ICU)
- Clarification of the Abuse or Neglect

As Needed, Families Receive:

- Reinforcement-Based Treatment (RBT) for Substance Abuse
- PTSD treatment – parents and children/youth
- Family therapy / family communication skills and problem solving training
- Marital / partners therapy
- Anger management training
- Child behavior management
- School-based interventions
MST-CAN - Status of the Research

Randomized Clinical Trials

- **Efficacy Study** (Brunk, Henggeler, & Whelan, 1987)
- **Effectiveness Study** (NIMH; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010)
- **Cost Study** (NIMH; Dopp, Schaeffer, Swenson, & Powell, under review)

Other Studies

- Brisbane, Queensland qualitative study of interagency collaboration (Hebert, Bor, Swenson & Boyle, 2014)
- Brisbane, Queensland case study (Stallman, Walmsley, Bor, Collerson, Swenson, McDermott, 2010)
- University of Leeds doctoral dissertation qualitative study exploring collaboration in introducing an evidence-based intervention (Mayers, Cottrell, Ahmed, 2016)
Status of the Research

Quasi Experimental Studies

- Queensland, Eastern Australia Research Pilot (Bor, McDermott, complete)
- Denver, Colorado (Swenson, complete)
- Greenwich, UK (Swenson, follow-up data collection phase)
- Cambridge, UK (Swenson & Squire, follow-up data collection phase)
- Leeds, UK (Cottrell & Swenson, data collection phase)
- Leeds, UK cost study (Watmuff, Ross, 2016)
- Switzerland (Perez, Rhiner, Fux, Feurstenau, Schmid, analysis phase)
- Switzerland Cost Effectiveness (Perez, Rhiner, Fux, Feurstenau, Schmid, under review)
- Amsterdam (Brand, analysis phase)
- Norway (Christensen, start-up phase)
MST-CAN Cost Benefits
Research Under Review

- **Cost Savings**
  - **Charleston RCT** - US$2.93 return on each dollar spent
  - **Leeds UK** – £1.59 return on every £1.00 spent
  - **Switzerland** - 16-50% lower than the costs of contingency plans
The Leeds story.

2009: MST introduced to Leeds and quickly expanded to 3 teams, one in each wedge of the city.

2013: MST CAN team set up.

2015: MST FIT introduced to support the return of youths from care (rather than custody)
MST CAN Leeds Case Study.

John Smith (aged 10) and his family; half brother Mikey (5), step mum Jan and Jim (Dad) who was not allowed at the home following John’s disclosure of physical abuse.
Summary of the Referral Behaviours

The 180 day incident that prompted the referral to MST CAN:

• John disclosed being hit with a belt by Dad to a member of staff at school. A further incident of Jim assaulting Jan led to Jim having to move out the family home and escalation to pre care proceedings (PLO)

• PLO meeting took place a few days before allocation and the parents behaviour increased concerns
Areas of Work

1. Dad’s physical abuse of oldest child - Emotional regulation, including assessment of PTSD symptoms.
2. Dad’s increased alcohol abuse - Reinforcement based treatment (RBT) to abstain.
3. Aggressive outbursts from John. Including work to develop developmentally appropriate routines and limits.
4. Home and school to work together to support John’s social and emotional development and transition to high school.

Overarching Goals (OAGs) were developed with social care and the parents. Each goal was worked around the analytical process throughout treatment and became the PLO goals also. During the last 3/9 months the clarification Process and Sustainability planning.
R.B.T.

- Jim signed up for treatment on day 1 (RBT was part of the work offered as alcohol abuse impacted on his parenting).

- Initially we completed an assessment of his alcohol use, including a functional analysis and compiled a personalised feedback report.

- A FIT of alcohol use in which prioritised driver was coping strategy for stress and his family and peers were drinkers.

- We worked with him on alternative coping strategies to use in stressful situations and recreational activities to compete with drinking with his friends and drinking alone (fishing). When he was successfully abstinent following a stressful event (he was stressed a lot!) or over a weekend when he went fishing, we did a positive functional analysis of skills he used to support sobriety and/or a positive FIT so he learned from success. When he had a lapse we did an FA of the lapse to learn from that also.

- We tested Jim for alcohol and drug use x 3 per week throughout treatment. He earned a voucher for each clean test for the first 3 months of treatment. He used some of this money to buy fishing equipment, which supported the development of his recreational activities.
Referral FIT why Jim drinks.

- I enjoy drinking and the atmosphere of the pub
- Drinking culture in my family and peers
- Parenting assessment raised a lot of issues from past trauma which was a trigger that increased my drinking.
- Started drinking at home.
- My job became more stressful - when off-door and on reception.
- When feeling low, stressed or in a 'funny mood' (coping strategy)
- Continued downhill spiral of social care involvement and separation from my family (but problems started before this).
Emotional Volatility and Trauma

- PTSD Assessment: Jim reported traumas in his life relating to childhood sexual abuse of himself and his sister, his sister's disclosure and the traumatic death of his father who was also the perpetrator.

- Symptoms included negative thoughts and feelings about himself and how others viewed him, others being untrustworthy (especially anyone in authority).

- Trauma Focused CBT: The work initially focussed on his thoughts and feelings in relation to sexual abuse and preceding events, including ‘all or nothing’ thinking such as ‘My Dad doing bad things to me and to my sister makes my Dad a bad man; having some fond memories of my Dad makes me a bad person’.

- Work in the here and now to regulate emotions – his automatic thoughts ‘It’s a done deal; they have decided, there is nothing I can do’, feeling upset, angry, powerless, ‘I'm sacking them off!’ . Alternative thoughts e.g. ‘this isn’t getting me what I want’. Planning and predicting for meetings, goal setting, experimenting and reviewing ‘did I achieve my goal?’ (advances and barriers).
Behaviour Management and Parenting

Initial work with Mum regarding taking on a parenting role with both children (see FIT next slide), co parenting as work progressed, including:

• Developmentally appropriate parenting *
• Reinforcing wanted behaviour with praise, following through with immediate consequences and starting a fresh. Jim taking on a supportive and encouraging role when Jan called him. Use of on call if she struggled **
• Strengthening their relationship with special time.
Managing Behaviour without physical abuse.

John’s aggressive behaviour

- John feels angry and upset that dad not at home
- (button pushing) ‘winds us up’, e.g. Urinates on toilet seat, breaks things, when angry with Jan
- Jan’s cognitions ‘ignoring a behavior is doing nothing’, he plays up for me as I’m not his mum, he’s smirking at me. I nothing will work with him (he’s the problem), Jim is the only one who can manage him.
- Low confidence - Jan thinks she will struggle without Jim (Jim managed discipline)
- Low warmth
- Lack of developmentally appropriate parenting e.g. not allowed to make drink, bedtime same as 5 year old brother
- Jan does not know how to manage behavior - previously disciplined by Dad (low skill)
- Refusing to do as asked.
- Refusing to accept consequence
- Lots of consequences
- Seeking attention

Jan does not know how to manage behavior - previously disciplined by Dad (low skill)
Home and school

• School concerned that John struggled to make friends, lied, refused to do his work (as reported at home).

• Communication – school talked to social care and social care spoke to the parents, parents felt upset and frustrated. Parents blamed school for not meeting John’s needs (school failed Ofsted)

• Work re improving communication and collaboration and preparing for transition to high school.
Sustainability

• We had a number of professional meetings during treatment and two investment checks to agree the direction of treatment and Dad’s return to the home. This was in addition to the statutory meetings.

• Therapist joined the PLO Meetings and they worked from the ‘Overarching Goals’ developed collaboratively with parents. As these goals are behavioural they can be evidenced.
Clarification Process

John,

We are writing this letter to let you know how much we love you and explain why social care and MST got involved with our family. Social Care got involved with our family after daddy slapped you, daddy is very sorry about this; it was not your fault. We were all really stressed and daddy has having problems at work, but we know it was wrong. It was wrong that we both said it had not happened at first, we are sorry. Daddy moved out of the house and worked a lot with Jayne and stopped drinking alcohol. This really helped him and we know you have seen all the graphs and stickers. Daddy is going to keep this up.

In the past I did not have the mummy role in the house and we know this might have been confusing for you. I am now mummy to both you and Mikey and we are both in charge and gives out the rewards and treats. We now do lots of activities together like you and daddy go fishing and we all go to the park. I like to help you with homework, looking on YouTube for funny films and watching wildlife programme and Daddy likes your time fishing or when you help him with the decorating.

John you are kind and funny and cheeky all in one and we love you. We are really proud at how well you are doing in school and all the achievements and good comments you are getting. You are helpful around the house and we you try really hard with the homework.

We know that it has been really hard especially when daddy moved out. We have all worked really to make these changes and want to keep things moving forward now.

We love you lots
Mummy and Daddy
Outcomes

• The family came of PLO shortly before we closed. We closed a year ago and a month later the family closed to CSWS.

• Parents were praised as model parents in a meeting at the high school at closure. John had a successful transition and made friends in school.

• The last update, Jim says he still does not bother with drinking and continues with fishing for himself and a shared interest with his oldest son, they all go to watch the younger son play rugby and father and sons are now enjoying a new interest cycling together.
Message from the Parents

• What has changed from before treatment to now?

• How do you feel about the future?
Successful outcome

- MST clinical lead-referral behavior and goals negotiated with social care.
- Therapist available when needed (including on call).
- Time: low case load and 6-9 months treatment.
- Stakeholder alignment.
- Clear goals that can be evidenced.
- Family developing new skills (restorative practice).
- Continual review (advances/barriers, supervision, professional meetings and investment checks).
- Work with all the systems around the child - parents, school and social care and extended family.
- Package of work to meet needs of individual family.
- Planning re sustainability.
- Treatment for drug/alcohol abuse/PTSD alongside child protection concerns.
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