

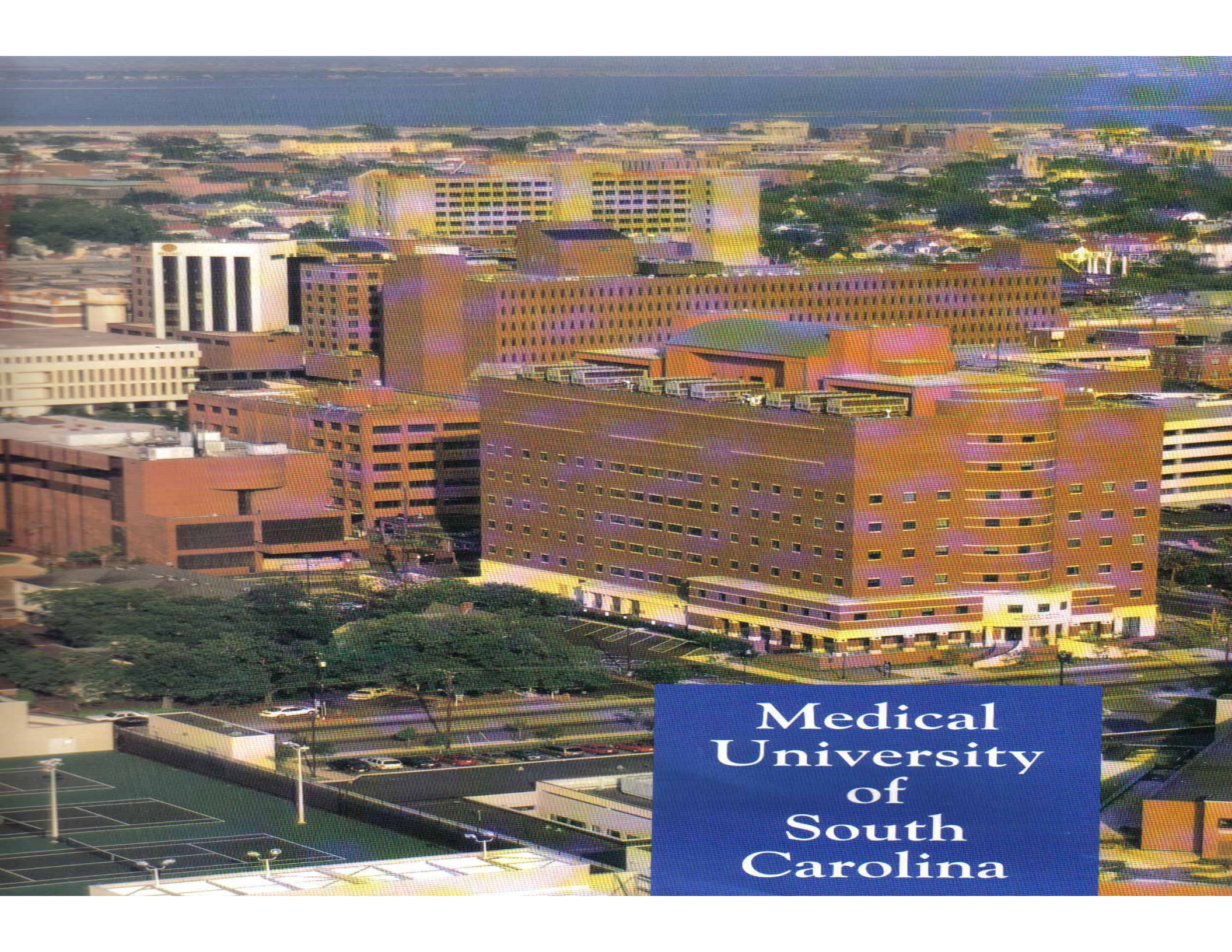
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# **Treatment for Families Experiencing Child Physical Abuse**

Cynthia Cupit Swenson, Ph.D.  
Medical University of South Carolina  
Charleston, South Carolina

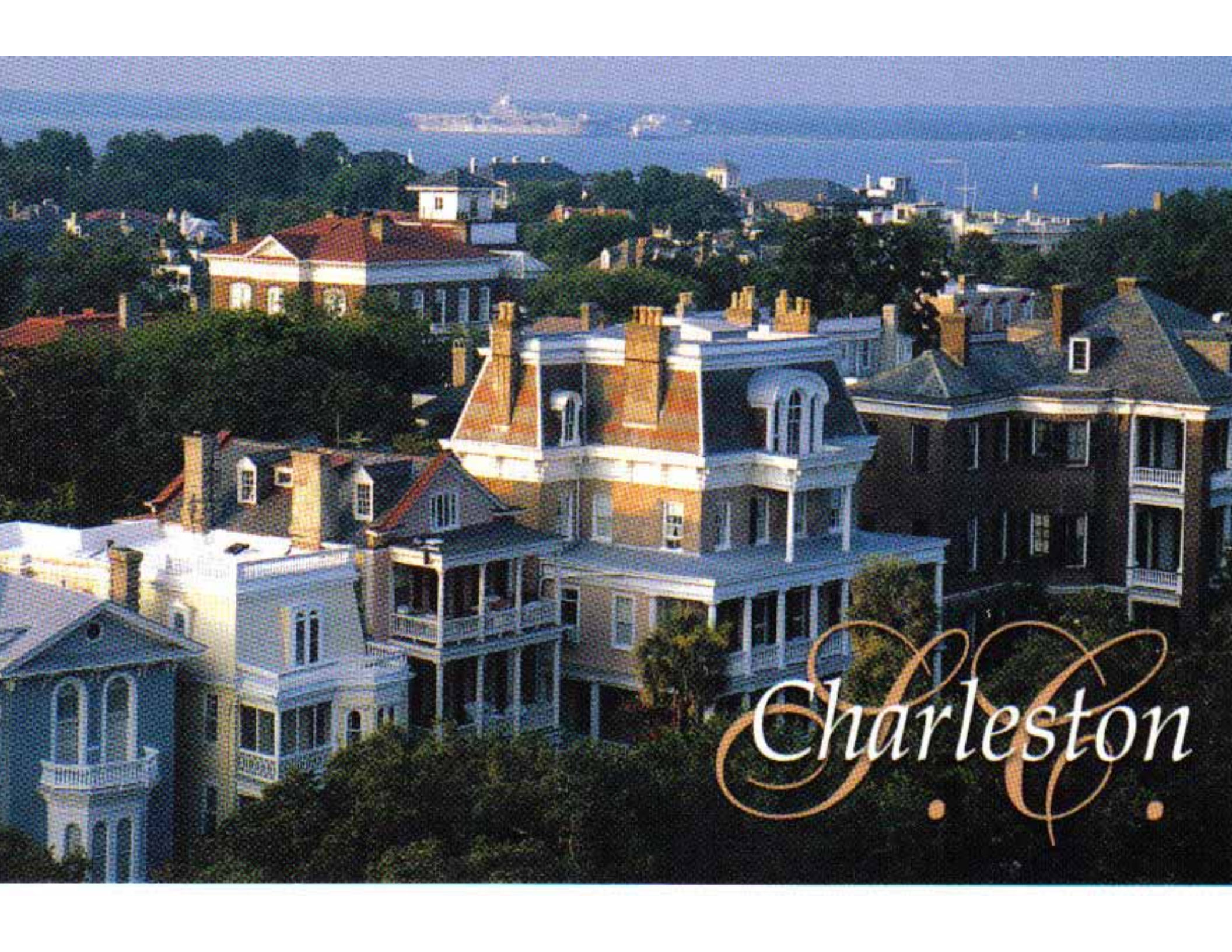
FCAP Seminar  
April 21, 2005





Medical  
University  
of  
South  
Carolina

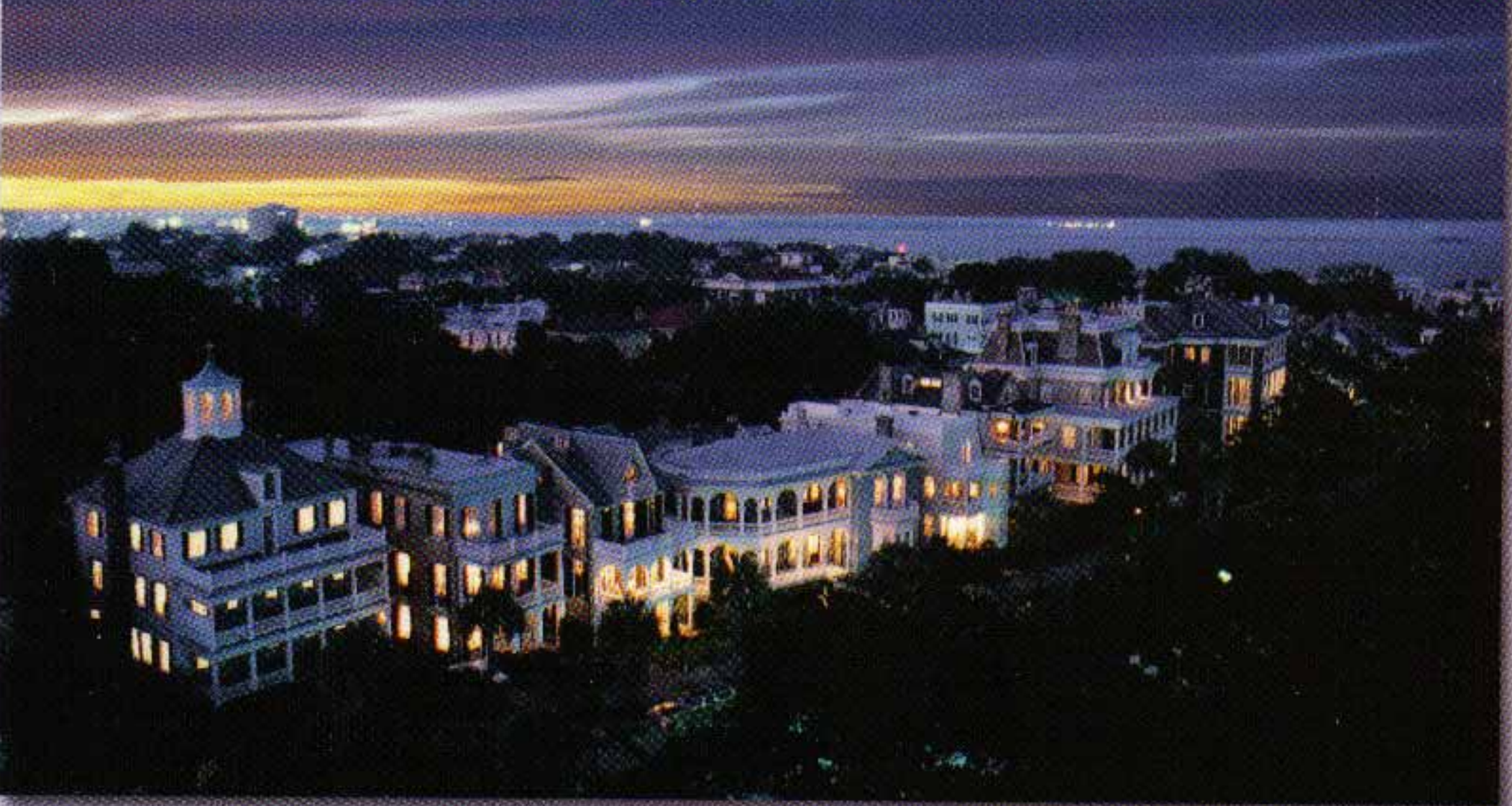




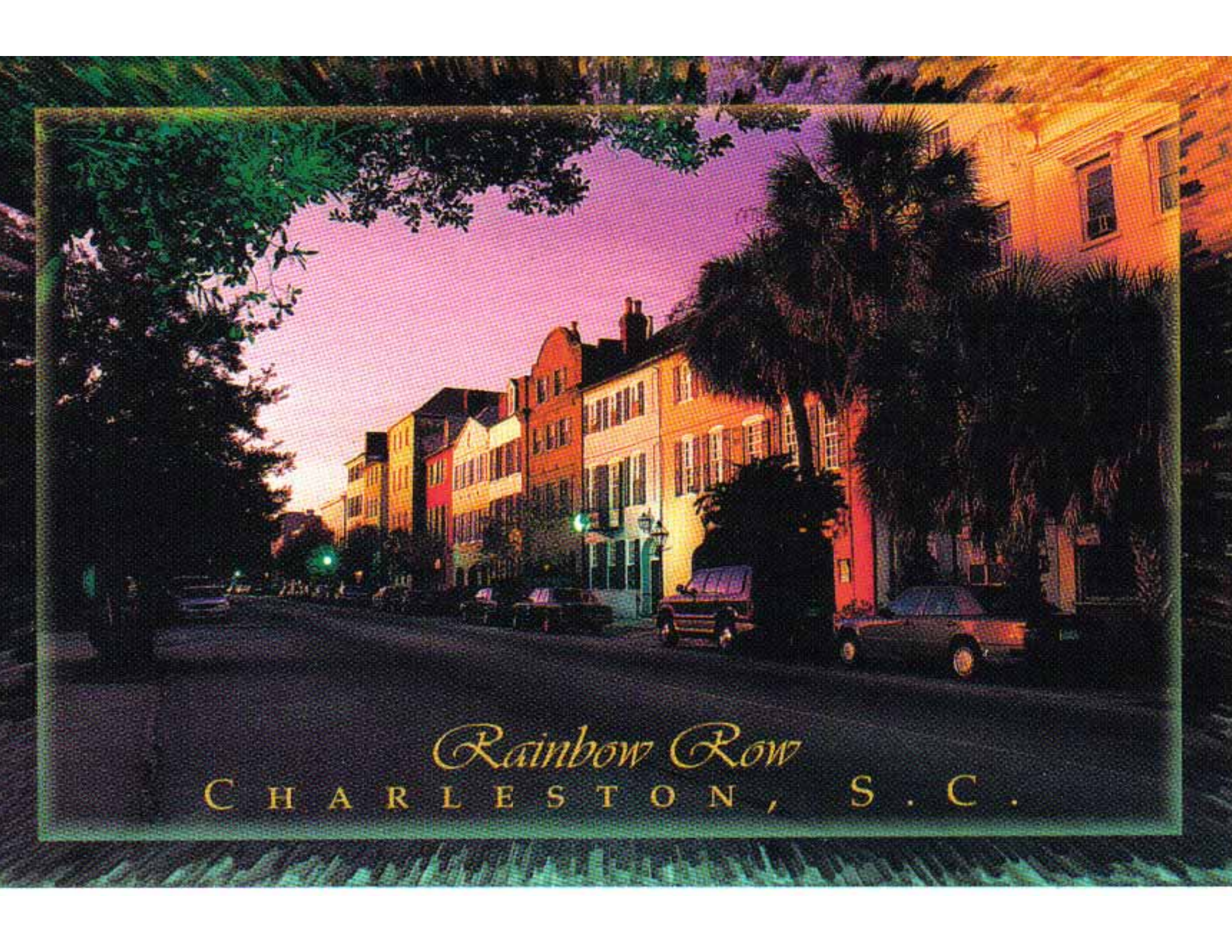
*Charleston*



# *Charleston, South Carolina*







*Rainbow Row*  
C H A R L E S T O N , S . C .





SIXTY-EIGHT SOUTH BATTERY GARDEN  
Photo © Bryan Biggs







CHARLESTON, SOUTH CAROLINA

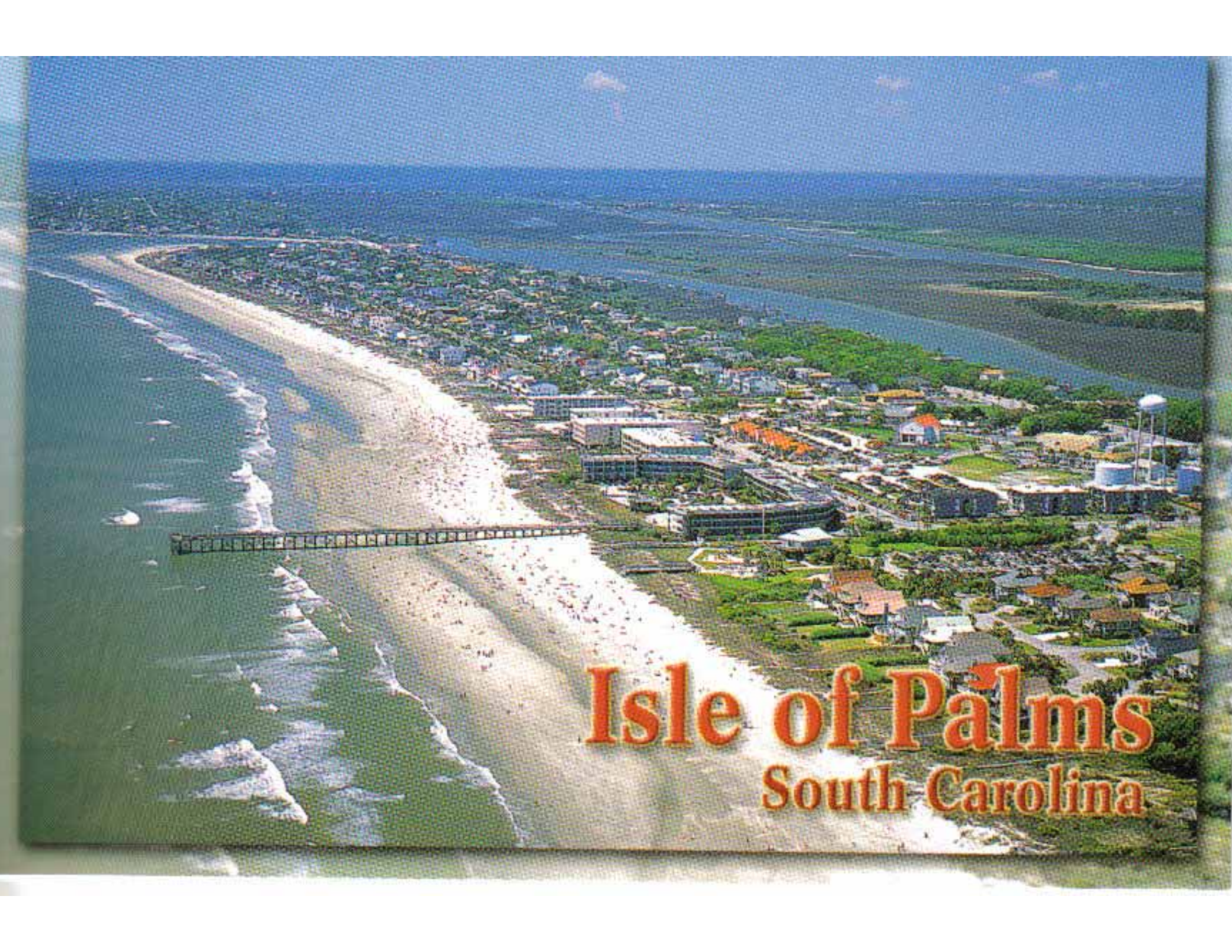
# *She-Crab Soup*

- 2 Tbsp. butter
- 1 Tbsp. flour
- 1 qt. milk
- 2 cups white crab meat  
with roe
- 5 drops onion juice
- ¼ tsp. pepper
- ¼ tsp. mace
- ½ tsp. salt
- ¼ pint heavy cream, whipped
- 4-5 Tbsp. dry Sherry
- Grated rind of one lemon

In the top of a double boiler, melt butter and blend with flour until smooth. While stirring constantly, add the milk slowly. Then add the crab meat and roe plus all the seasonings except the Sherry. Cook over low heat for 20 minutes. Serve in warm cups with one teaspoon of Sherry, and a topping of whipped cream.





An aerial photograph of the Isle of Palms, South Carolina. The image shows a long, narrow island with a wide, white sandy beach on the left side, where waves are breaking. A long pier extends from the beach into the ocean. The interior of the island is densely packed with buildings, mostly residential houses with colorful roofs, and some larger commercial or institutional buildings. The island is surrounded by water, and the sky is a clear, pale blue.

# Isle of Palms

## South Carolina





DJOLE DANCE COMPANY



# **MST Research and Dissemination**

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**MUSC Family Services Research Center**

**MST Services**

**MST Institute**

**Licensed and affiliated organizations:**

**MST Network Partner Organizations**

**Local MST Provider Organizations**



# Family Services Research Center

## THE MISSION

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**To Increase the Effectiveness of The State  
and Nations Mental Health and  
Substance Abuse Services for Children,  
Adolescents, and Their Families**



# Where is MST Being Used?

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- Over 30 states in the U.S.
- State-wide programs in Connecticut, Colorado, Hawaii, and Ohio
- Nation-wide program in Norway (25+ teams)
- Other international replications: Canada, Denmark, Ireland, England, Sweden, Netherlands, Australia and New Zealand.



# What is “MST”?

---

- Community-based, family-driven treatment for antisocial/delinquent behavior
- Focus is on “Empowering” caregivers (parents) to solve current and future problems
- MST “client” is the entire ecology of the youth  
- family, peers, school, neighborhood
- Highly structured supervision and quality assurance processes are employed



# MST: Assumptions & Beliefs

---

- Children's behavior is strongly influenced by their families, friends and communities (and vice versa)
- Families are key to success
- Families can live successfully without formal, mandated services
- Change can occur quickly
- Professional treatment providers should be accountable for achieving outcomes
- Science/research can provide guidance



# Families as the Solution

---

- MST focuses on families as the solution
- Families are full collaborators in treatment planning and delivery with a focus on family members as the long-term change agents
- Giving up on families, or labeling them as “resistant” or “unmotivated” is not an option
- MST has a strong track record of client engagement, retention, and satisfaction



# How Does MST Work?

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- MST Theoretical Assumptions
- Ecological Models
- Causal Models of Delinquency and Drug Use
- How does MST “work”



# MST Theoretical Assumptions

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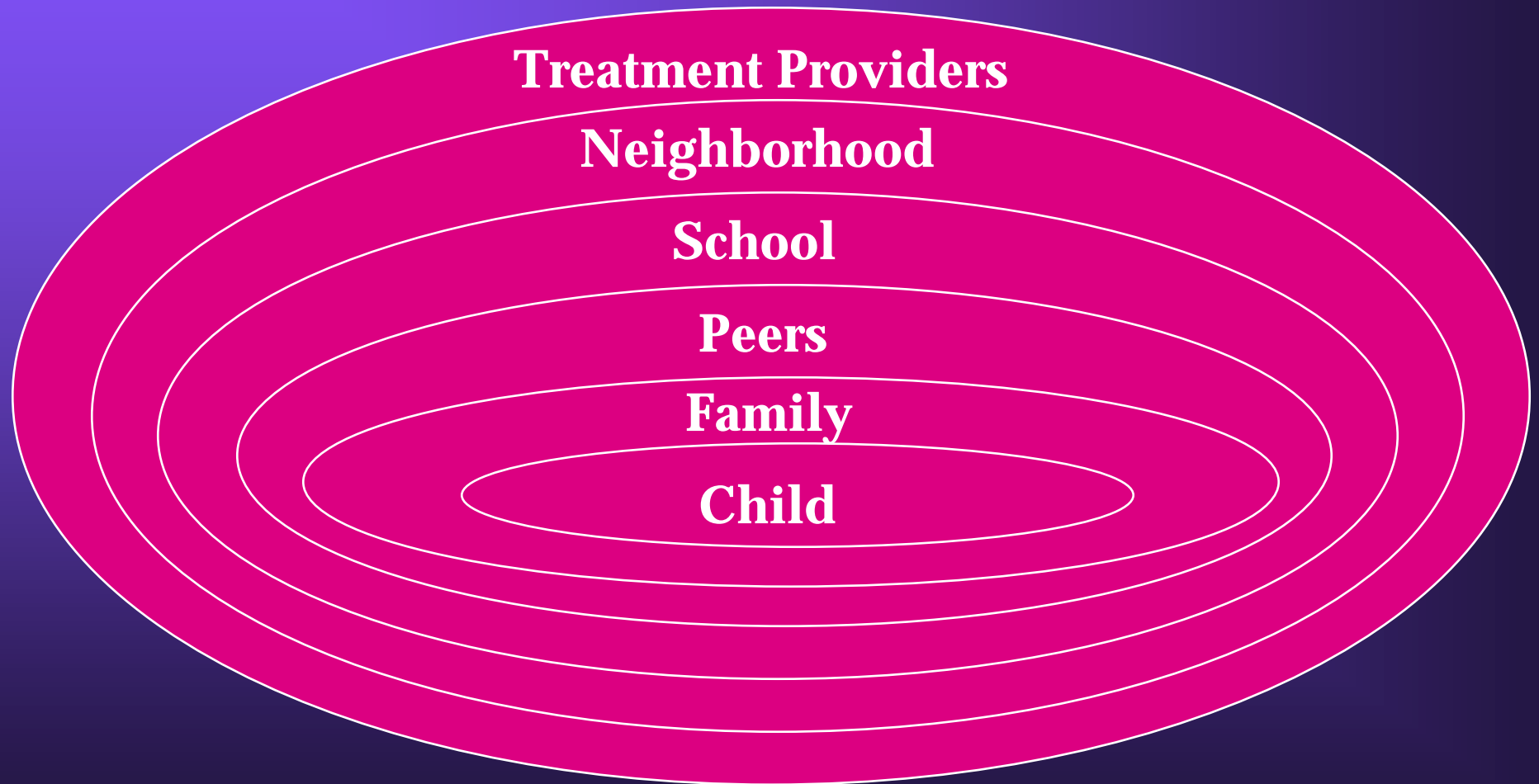
**Based on Bronfenbrenner, Haley , and Minuchin**

- Children and adolescents are live in “ecologies” or systems that impact their behaviors in direct and indirect ways
- These influences act in both each directions (they are reciprocal and bi-directional)



# Ecological Model

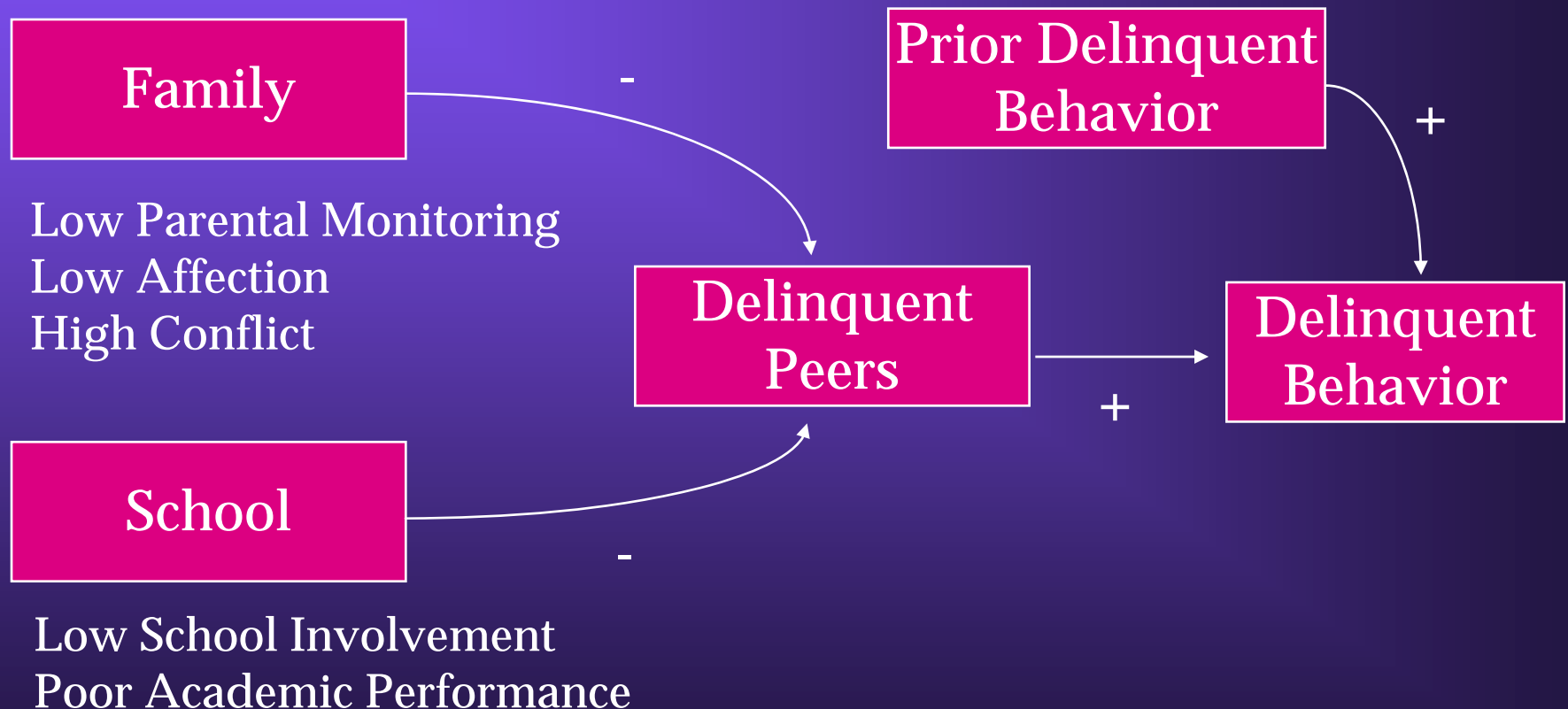
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# Causal Models of Delinquency & Drug Use

## Condensed Longitudinal Model



*Elliott, Huizinga & Ageton (1985)*



# Delinquency is a Complex Behavior

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- Common findings of 50+ years of research: delinquency & drug use is determined by multiple risk factors:
  - Family (low monitoring, high conflict, etc.)
  - Peer group (law-breaking peers, etc.)
  - School (dropout, low achievement, etc.)
  - Community (↓ supports, ↑ mobility, etc.)
  - Individual (low verbal & social skills, etc.)

# Implications for Effective Intervention

---

- Address multiple risk factors present
- Comprehensive services providing “total care”
- Individualize services that are family & child centered
- Collaborate with family and be family-focused
- Intervene in the naturally occurring systems, all efforts must be “ecologically valid”
- Services must be delivered with skill, persistence, and a strong sense of accountability



# How does MST “work”

---

Intervention strategies: MST draws from research-based treatment options:

- Behavior therapy
- Cognitive behavior therapy
- Pragmatic family therapies
  - Structural Family Therapy
  - Strategic Family Therapy
- Pharmacological interventions (e.g., for ADHD)

# How does MST “work” (continued)

---

## Context for use of evidence-based intervention strategies

- Services are comprehensive, individualized and address all identified drivers of the problem behaviors
- MST program philosophy emphasizes that service providers are accountable for outcomes
- Families and communities are central and essential partners in MST “treatment” and
- Caregivers/parents are key to long-term success
- Program structure removes barriers to service access



# How is MST implemented?

---

- Single Therapist working intensively with 4 to 6 families at a time
- 4 months is the typical treatment time
- MST staff deliver all treatment - there is no “case management” function or brokering of other services for the family
- Work is done in the community: home, school neighborhood, etc.

# MST Quality Assurance System

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Elements of the MST Quality Assurance system:

- Structured training (orientation and booster)
- On-the-job training
- Weekly supervision
- Weekly consultation
- Research-validated adherence technologies



# MST Treatment Principles

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- Nine principles of MST intervention design and implementation
- Treatment fidelity and adherence is measured with relation to these nine principles

# Principles of MST

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## **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.



# Principles of MST

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## **3. Increasing Responsibility**

Interventions should be designed to promote responsibility and decrease irresponsible behavior among family members.

## **4. Present-focused, Action-oriented & Well-defined**

Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.

# Principles of MST

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## **5. Targeting Sequences**

Interventions should target sequences of behavior within and between multiple systems that maintain identified problems.

## **6. Developmentally Appropriate**

Interventions should be developmentally appropriate and fit the developmental needs of the youth.



# Principles of MST

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## **7. Continuous Effort**

Interventions should be designed to require daily or weekly effort by family members.

## **8. Evaluation and Accountability**

Interventions efficacy is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.

# Principles of MST

---

## 9. Generalization

Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering care givers to address family members' needs across multiple systemic contexts.



Referral  
Behavior

# MST Analytical Process

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 & Barriers to  
Intervention Effectiveness

Prioritize

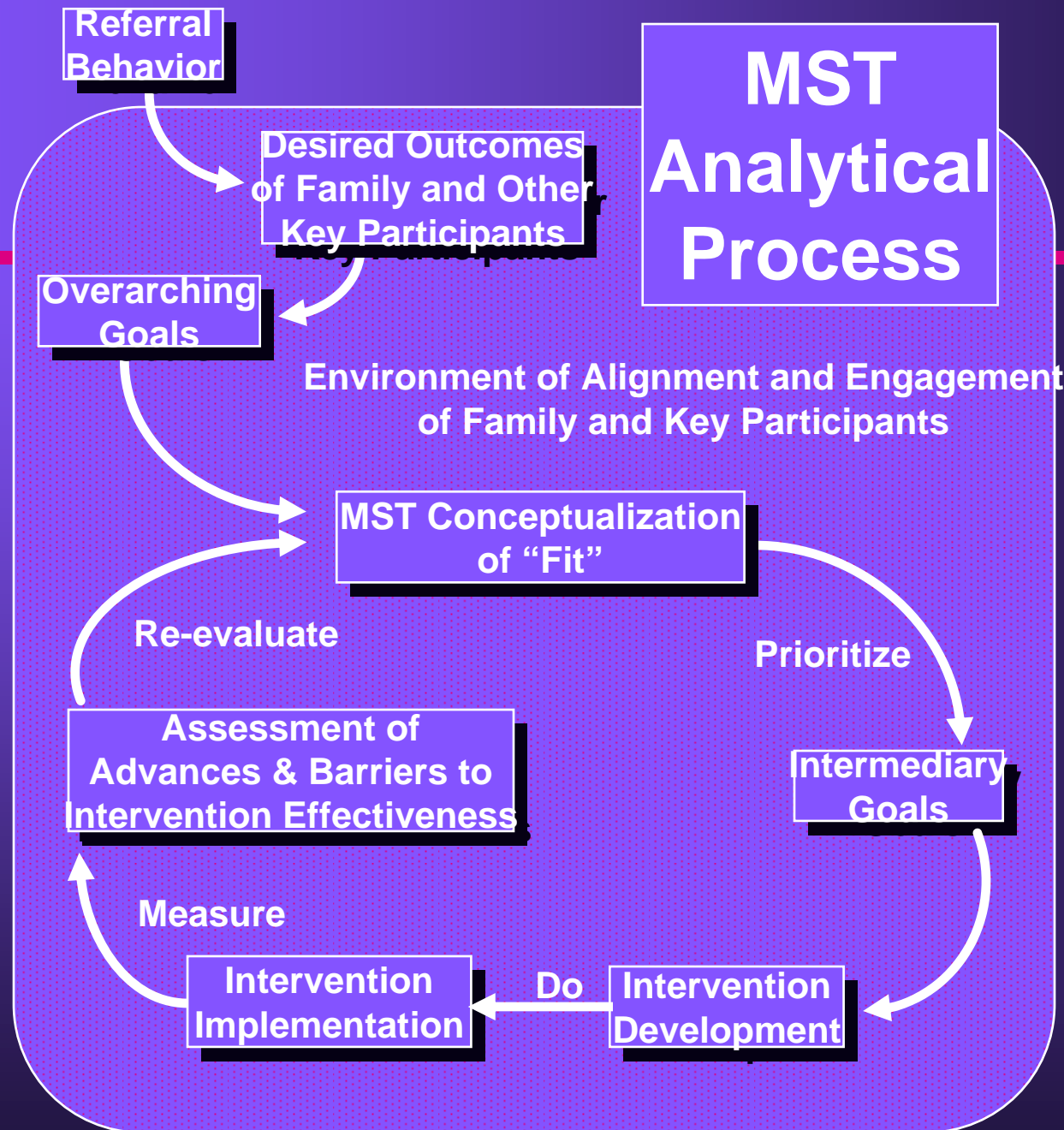
Intermediary  
Goals

Measure

Intervention  
Implementation

Do

Intervention  
Development



# MST's Research Heritage

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- 25+ years of Science
- Consistent Outcomes
- Current Research Trials

# 25+ years of Science

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Published Randomized Trials: 11 trials to date

- 4 with violent and chronic juvenile offenders
- 2 with juvenile sexual offenders
- 1 with serious antisocial youth in Norway
- 1 with substance-dependent juvenile offenders
- 1 with youths presenting psychiatric emergencies
- 1 with maltreating families
- 1 with inner-city delinquents



# Consistent Outcomes

---

In Comparison with Control Groups, MST:

- Higher consumer satisfaction
- Decreased long-term rates of rearrest 25% to 70%
- 47% to 64% decreases in long-term rates of days in out-of-home placements
- Improved family relations and functioning
- Increased mainstream school attendance
- Decreased adolescent psychiatric symptoms
- Decreased adolescent substance use

# Current Research trials (in progress)

---

- Vanderbilt University (Weiss) - antisocial middle schoolers
- Charleston, SC (Henggeler) - drug court
- New York City (NY OCFS, Satin) - serious offenders
- Stark County, Ohio (Timmons-Mitchell) - juvenile offenders
- Charleston, SC (Swenson) - physically abused children
- Detroit (Ellis) - youths with poorly controlled IDDM
- International (Schoenwald) - 27 site transportability study of the dissemination of MST

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# **Why Apply MST to Child Abuse and Neglect?**



# Research and Policy

## Reasons for New Directions

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- **Costs of Violence Against Children (\$460 Million in Foster Care/Administration [10 years ago]; >\$164 Billion Annually)**
- **Serious Short-Term Mental Health Consequences**
- **Serious Long-Term Mental Health Consequences**

# Short-Term Consequences/Correlates

---

- **Aggression/Behavioral Difficulties**
  - Most Consistent Finding
  - Persists Into Latency/Adolescence
  - Towards Adults and Peers
- **Poor Social Competence**
  - General Social Skills Deficits
  - Problems in Peer Interactions
  - Poor Social Problem Solving

# Short-Term Consequences/Correlates

---

- **Trauma-Related Emotional Symptoms**
  - Anxiety, Hypervigilance, Depression, Low Self-Esteem
  - PTSD rates vary from 0-50%
  - Sub-Clinical PTSD
- **Developmental Deficits in Relationship Skills**
  - More Anxious Attachment Than Non-Abused
  - Less Enthusiasm, Less Positive Affect
  - Low Frustration Tolerance
  - Less Secure Readiness To Learn/Outer Directedness



# Short-Term Consequences/Correlates

---

- **Cognitive/Neuropsychological Deficits**
  - Receptive/Expressive Language
  - Reading Ability and Comprehension/Abstraction
  - Use of motoric expression in absence of language skills
  - Limited solving of interpersonal conflicts through language

# Long-Term Consequences/Correlates

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- Long-Term Effects

- Related to Interpersonal Aggression, Violent Crime, Self-Injurious Behavior, Relationship Problems
- Major Risk Factor For PTSD and Depression
- Substance Abuse

# Top 10 Real World Reasons for New Directions

---

- **Number 10:** All the Child Protection Service Workers and Police in the town greet the therapist by his first name
- **Number 9:** The school's secretary has the therapist's business card taped to her computer in duplicate
- **Number 8:** The therapist is invited to more school meetings about behavior problems than parties with friends



# Top 10 Real World Reasons for New Directions

---

- **Number 7:** The child is taking her clonidine PRN, the school is ready to put her out and the mom is slurring her words when the therapist calls her to set an appointment
- **Number 6:** The child client feels anxious after a therapy session because of a shooting in the neighborhood
- **Number 5:** The 13-year-old child client is angry because he has a 2 am curfew & this problem doesn't get addressed in the CBT exposure protocol

# Top 10 Real World Reasons for New Directions

---

- **Number 4: Parents of the therapist's child client feel disempowered because the therapist gets to have all the nice talks with their child and has more power than the parent**
- **Number 3: The parents never follow the therapist's suggestions because grandma says people in the system are not to be trusted**
- **Number 2: The parent expresses the belief that the therapist will take the child, fix her, and return her a new person who will not "make them hit her"**

# Top 10 Real World Reasons for New Directions

---

- **Number 1:** The child has been a patient at the mental health clinic and has been receiving individual therapy for 1 year due to the abuse. Although he's no longer anxious about the abuse, the parent, school principal, and peers complain he's still fighting, argumentative, and smoking pot. Child Protective Services wonders if they should recommend out-of-home care.

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# Context Influences Type, Severity, and Chronicity of Maltreatment and Resilience



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Contextual Factors ARE The  
Work of Therapy  
Individual Factors may be the  
Least Concern

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Child Maltreatment Does Not  
Occur in a Vacuum  
It Occurs within Contexts

# Management of Complex Maltreatment Cases

---

- May require that we extend our thinking beyond traditional office-based psychotherapy practice
- CBT delivered by a professional therapist may remain the most popular psychotherapy, but it is important to extend our thinking beyond psychotherapy and think ecologically
- To focus heavily on the strengths & protective factors

# Management of Complex Maltreatment Cases

---

- What challenges do we *really* face in dealing with complex cases? Often, the biggest questions are not matters of CBT therapy technique, but rather include things like:
  - “They’ve quit coming.....again”
  - “He is truant from school, so he’s home by himself with nothing to do but play video games or watch TV or hang out with this group of older kids in the town center.....”
  - “I think she’s having unprotected sex all the time, but she won’t talk to me about it.....”
  - “Mom has a drug problem. Grandma is afraid she’ll return to heroin and steal from the family and doesn’t know what to do.....”



# Management of Complex Maltreatment Cases

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- One traditional solution to complex multi-problem maltreatment cases has been long-term residential care. However, this has numerous disadvantages:
  - Institutionalization and deterioration
  - Aggregation with delinquent peers
  - Loss of family, school and community ties
  - High cost
  - Poor maintenance of gains
  - Stigmatization
- Intensive ecological approaches offer an alternative to residential care placements

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# MST-CAN

## How is it Different?

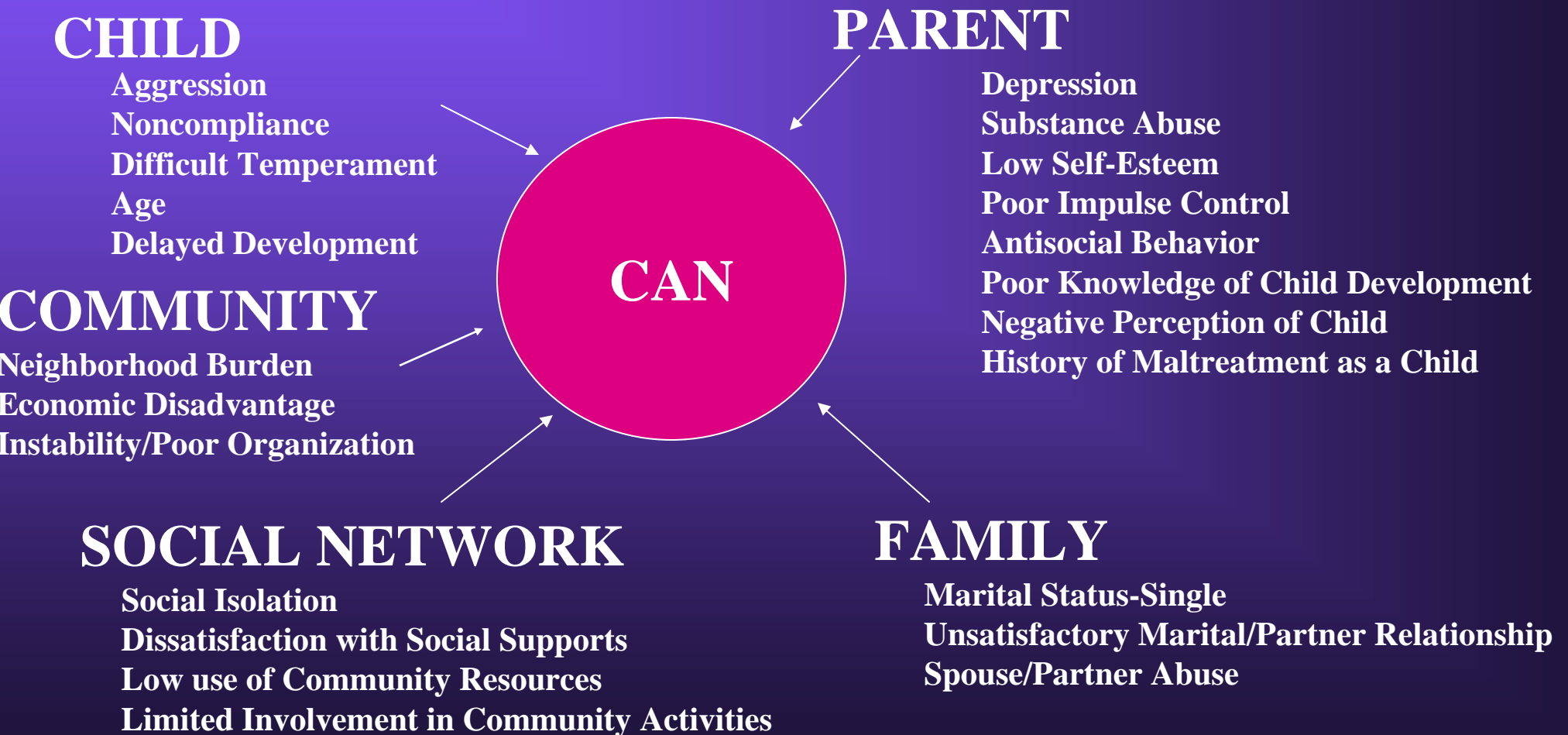
# Risk and Protection An Ecological View

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- Risk - Factors that correlate with the occurrence or recurrence of abuse
- Protective - Factors that correlate with healthy parent, child, and family functioning or reduce the risk of abuse

# RISK FACTORS

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# Protective Factors Play a Critical Role

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- A relationship with at least one significant adult who is invested in the youngster's wellbeing, educational achievement and future, and who is “good enough” at providing:
  - Calm and stability
  - Affection
  - Supervision
  - Support and encouragement
  - Correction and discipline
  - A good role model

# ADAPTATIONS

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- Family Safety Plan
- Functional Analysis of the Use of Force or Physical Discipline
- Treatment for Anger Management
- Treatment for PTSD
- Treatment for Substance Abuse
- Family Communication Training
- Clarification of the Abuse
- Inclusion of a Psychiatrist
- Involving CPS in Treatment

# Family Safety Plan

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- First strategy with a family
- Determining what individuals from each system will do
- Determining who the parent, youth, or other family will call
- Therapist contact number
- Who will monitor children if parent needs to leave
- Agreed upon and signed by all parties
- Reviewed at subsequent sessions

# Risk and Safety

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- **Intake Safety Checklist at Intake**
  - Drug and Alcohol Use
  - Medications
  - Dangerous Acts
  - The environment
  - Guns
- **Follow-up Safety Checklist – Weekly**
- **Ecological Safety Assessment- By 2<sup>nd</sup> Week**
- **Ecological Safety Plan**



# Functional Analysis of Physical Discipline

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- Determining what happened that led to a Child Protection report
- Helps determine the sequence of events and where to intervene
- Helps determine the fit of the behavior
- May need to complete individually with child and parent
- Use to develop a self-management plan

# Treatment for Problems With Anger Management

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- Difficulty managing anger is associated with a history of physical abuse
- Discussion of the role anger plays in the individual's parenting
- All parents experience anger and frustration
- Anger management training is to help parent manage children in a more self-controlled manner
- No intent to diminish parental authority

# Treatment for Problems With Anger Management

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- Identify persons and situations that trigger anger
- Identify physiological cues early in the escalation process (signal that escalation is beginning)
- Identify cognitive cues early in the escalation process (signal that escalation is beginning)
- Rank order cues in the escalation process

# Treatment for Problems With Anger Management

---

## De-Escalation Skills

- Physiological
  - Controlled breathing
  - Relaxation training
- Cognitive
  - Cognitive restructuring (changing appraisal of a situation, an alternate view)
  - Self-Instruction
  - Think ahead of consequences

# Treatment for Post Traumatic Stress Disorder

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- The impact of past victimization or other traumatic events can be a barrier to managing daily stress and parenting
- Involvement with Child Protection may remind parent of childhood abuse history
- PTSD symptoms can increase abuse risk
- Treatment of these symptoms may be individual or include another adult in the ecology



# Treatment for Post Traumatic Stress Disorder

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## Components

- 9-12 Sessions, 90 Minutes each
- SIT
- Prolonged Exposure
- Cognitive Restructuring

# Treatment for PTSD-What is Recommended for Whom

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PE Alone – uncomplicated PTSD-anxiety and avoidance

PE plus Cognitive Restructuring – PTSD anxiety plus guilt, shame, or anger that feels debilitating

PE plus SIT - high levels of arousal and feel out of control, initially hesitant to engage in exposure.

# Treatment for Post Traumatic Stress Disorder

---

## Components

### ■ Prolonged Exposure

- Longer exposure more effective than shorter
- Research supports use as superior to other techniques with combat veterans and rape victims
  - Rationale
  - Education about common reactions to trauma
  - Breathing retraining
  - Repeated *in vivo* exposure to a situation the client is avoiding because of assault-related fear
  - Prolonged imaginal exposure

# Treatment for Post Traumatic Stress Disorder

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## ■ Cognitive Restructuring

- Assumes that interpretation of the event determines an individual's emotional state and dysfunctional thoughts lead to dysfunctional emotional states
- 3 steps
  - Identification of dysfunctional thoughts
  - Evaluation of the validity of the thoughts and challenging those that are erroneous
  - Replacement of the dysfunctional thoughts with more helpful ones

# Treatment for Post Traumatic Stress Disorder

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## ■ Stress Innoculation Training

- Education
- Skills Training
  - Physiological
  - Cognitive
  - Behavioral
- Trauma Processing
- Role Play/Covert Modeling



# Treatment for Substance Abuse

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- Targeted when substance use increases risk for reabuse and interferes with parenting
- Gather information on use from all in ecology
- Current evidence does not indicate that residential programs or hospitals are more effective than outpatient
- Among outpatient treatments, behavioral therapies most successful
- Contingency Management approach effective for serious drug use and dependence

# Treatment for Substance Abuse

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## COMPONENTS

- Point and Level System
- Functional Analysis
- Weekly Urine Drug Screens/Breath Scans
- Coping with Cravings
- Self-Management Planning
- Drug Refusal Skills
- Jobs, Housing, Recreation

# Treatment for Family Communication Problems

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## Family Communication/Problem Solving

### ■ Problem Solving Training

- Define the Problem
- Generate alternative solutions (paraphrase/listen)
- Evaluate/Decide upon the best idea
- Plan to implement the selected solution

### ■ Communication Training

- Family to evaluate negative communication habits
- How negative communication impacts family
- Suggest, model, rehearse constructive positive comm.
- Intense correction of negative communication habits via a problem solving discussion

# Parental Clarification of the Physical Abuse

---

## ■ Why Conduct a Parental Abuse Clarification

- Parental attribution of blame --> increased risk for PA
- Sexual abuse self-blame--> depression, reduced self-esteem, PTSD
- Clarification process is a therapeutic intervention designed as a way to openly discuss the abuse that occurred, have the parent take responsibility for the behavior and assure that the child is clear physical force is not appropriate discipline.
- Involves the construction of a letter, read by the maltreating parent to the child and other family members

# Abuse Clarification

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## Purpose

- Alter maladaptive parent, child, and family member attributions regarding blame for the abuse
- Focus responsibility for the abuse on the maltreating caregiver
- Absolve children of responsibility for parent's inappropriate behavior
- Focus the family toward safety and away from violence as punishment



# Abuse Clarification

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- General Structure of Clarification
  - Child Preparation for Clarification Session
  - Maltreating Parent Letter
  - Letter Evaluation by team and other adults in ecology
  - Clarification Session

# Abuse Clarification

---

## ■ Content of the Letter

- Purpose
- Describe Abusive Behaviors
- Take Full Responsibility for the Abuse, Effects on Family, & Legal Consequences if any
- Absolve Child of Blame
- Apologize for All Behaviors
- Tell Child what Parent has Learned in Treatment and What will do Differently
- Talk About the Child's Positive Attributes

# Abuse Clarification

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## The Clarification Meeting

- Rules
  - Developed by Child/Family
  - Touching, Expressing Feelings
- The Letter
- Hearing from Child
- Hearing from Family Members

# Inclusion of Caseworker and Psychiatrist

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## Caseworker

MST Training

Attend Supervision

Attend Key Family Sessions

Partnership Role

Safety Planning

Court

Case Management

# Inclusion of Caseworker and Psychiatrist

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Psychiatrist

MST Training

20%

Parent and Children

Support Supervisor on Adherence



# Other Differences

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- Caseload size – no more than 4
- Length of treatment longer
- Treat all children in family
- Increased individual adult strategies

# **Community-Based Treatment for Child Physical Abuse: Costs and Outcomes**

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**NIMH-Funded Project (2000-2005)**

**Principal Investigator: Cynthia Cupit Swenson, Ph.D.**

**Co-Investigators: Scott W. Henggeler, Ph.D.**

**Richard Faldowski, Ph.D.**

**David Ward, Ph.D.**

**Project Coordinator: Lisa Saldana, Ph.D.**

# **Community-Based Treatment for Child Physical Abuse: Costs and Outcomes**

---

**PEACE, Betta Fuh Fambly**  
(Project Empowering Adults, Children, & Their Ecology)

- **Funded by National Institute on Mental Health**
- **5 Year Project**
- **Adolescents 10-17**
- **Physical Abuse Referrals from Charleston County Child Protective Services**

# **PEACE, Betta Fuh Fambly**

(Project Empowering Adults, Children, & Their Ecology)

---

- **Effectiveness Study**
- **Site-Charleston/Dorchester Mental Health Services For Children, Adolescents, and Their Families**
- **N = 86 Families**
- **Random Assignment**
- **2 groups-MST versus Parent Training Group Plus Standard Community Services**

# **PEACE, Betta Fuh Fambly**

(Project Empowering Adults, Children, & Their Ecology)

---

- **5 Assessments -Intake, 2 month, 4 month, 10 month, 16 month**
- **Outcomes**
  - **Child Level**
  - **Parent Level**
  - **Family Level**
  - **Service Utilization (Monthly Interview)**
  - **Cost**

# Implementation of MST Within CPS: Project Initiation

---

- Discuss with Agency Director
- Agency Director discusses with Program Director
- Letter to Agency State Director
- Meeting between DSS management and MST project staff
- Letter of Support
- Memorandum of Agreement



# Implementation of MST Within CPS: Gaining Staff Support

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- Program Director develops buy-in of program
- Program Director meets with supervisors and staff
- Develop a notification process
- Establish communication process
- MST and DSS teams establish a starting date with discrete guidelines

# What We Know At This Point

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## Client Demographics

Age: M = 13.9

Female = 56%

Race: Minority – 78%

Youth EPC at Referral: 19%

Parents with Abuse History: 42%

# What We Know At This Point

---

## Recruitment & Retention

**Study Recruitment Rate: 97%**

### **Retention Rates:**

**16 Month Research: 95%**

**Treatment-MST: 98%**

**Treatment-Group: 86%**

# Short-Term Outcomes

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Both Groups Showed  
Dramatic Reductions in:  
Physical Violence  
Psychological Aggression

# Child Report of Discipline

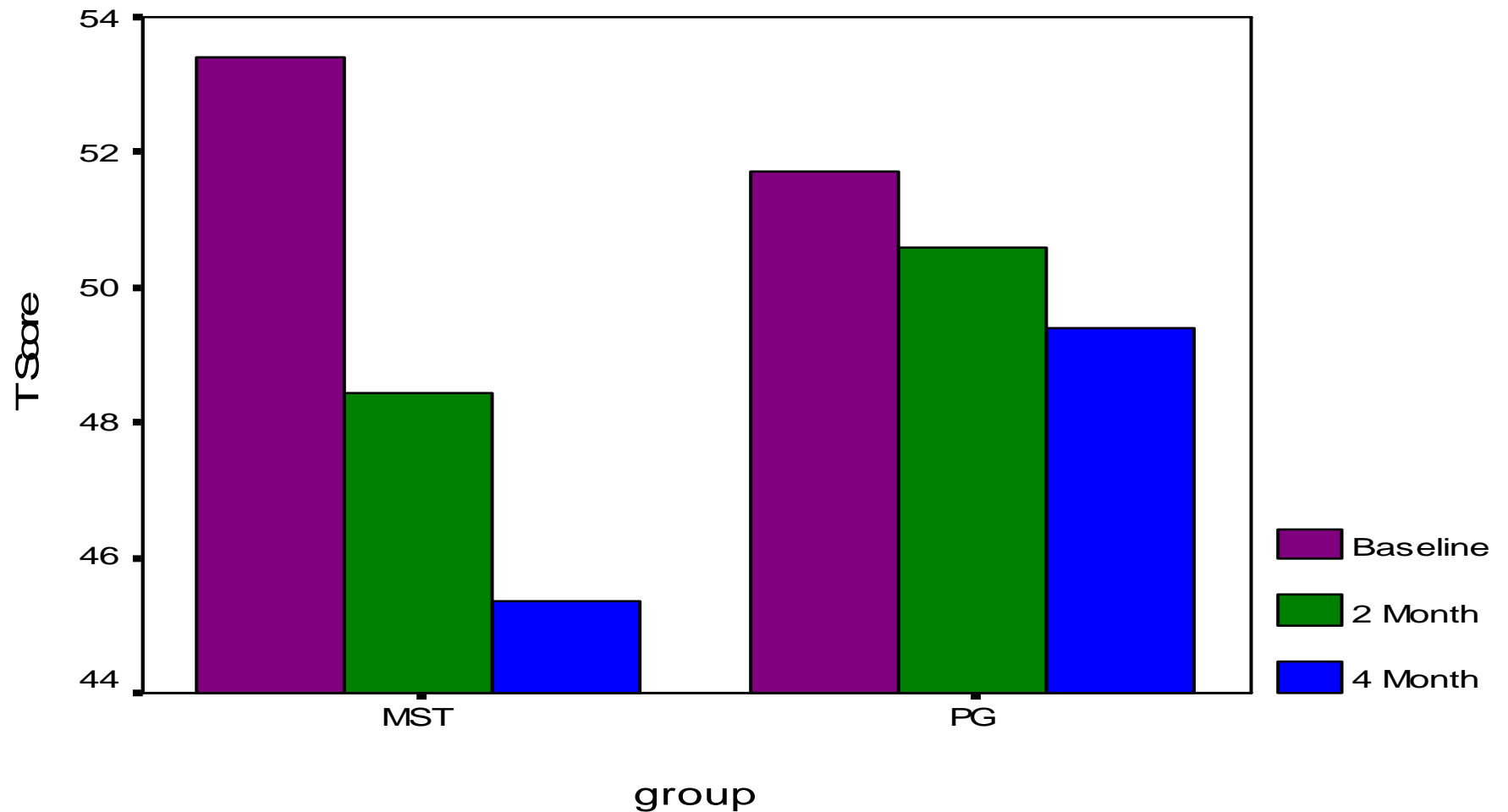
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Use of Non-Physical Discipline

MST > PG,  $p < .01$

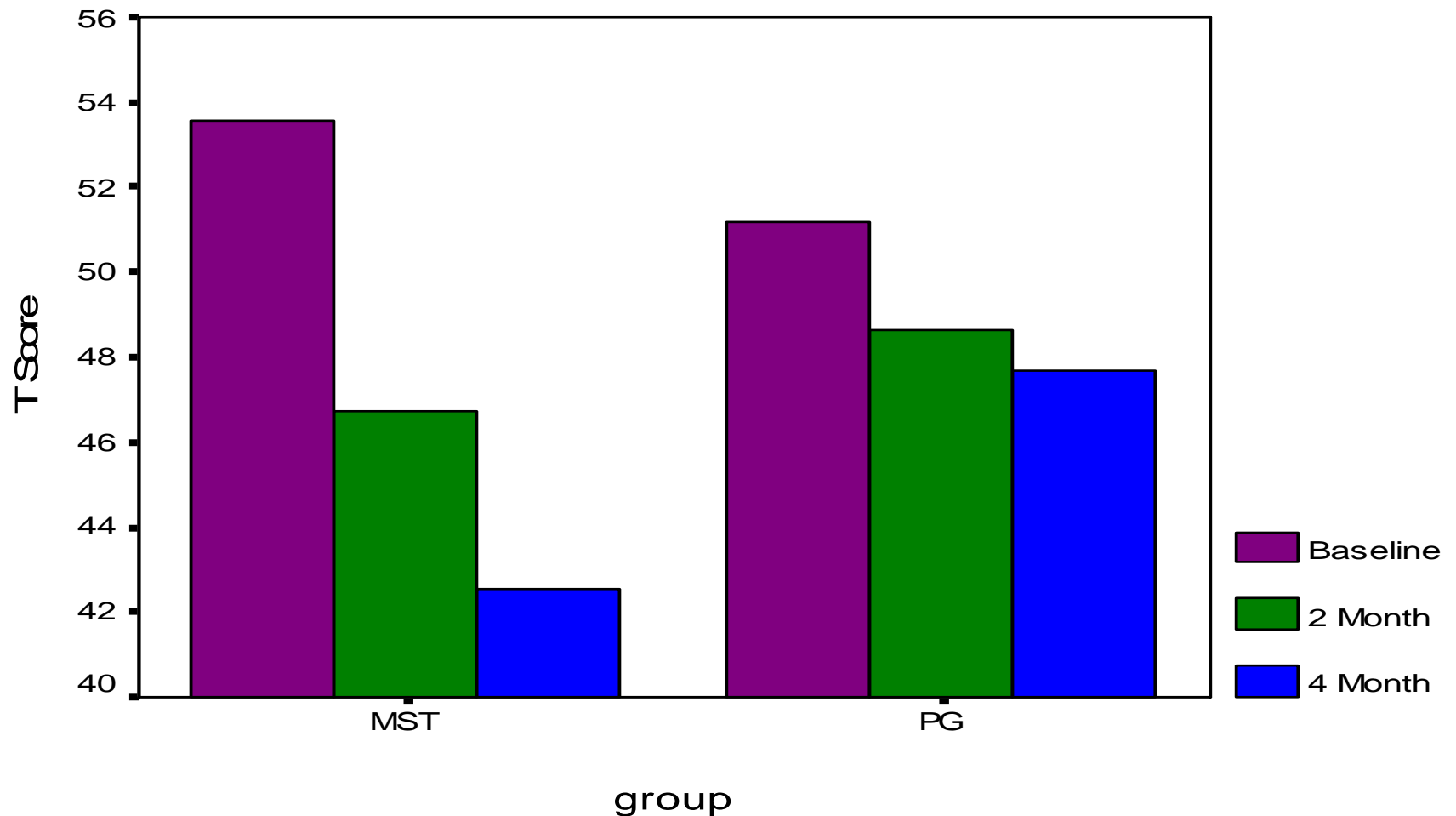
# TSCC: Sexual Concerns

( $p = .05$ )



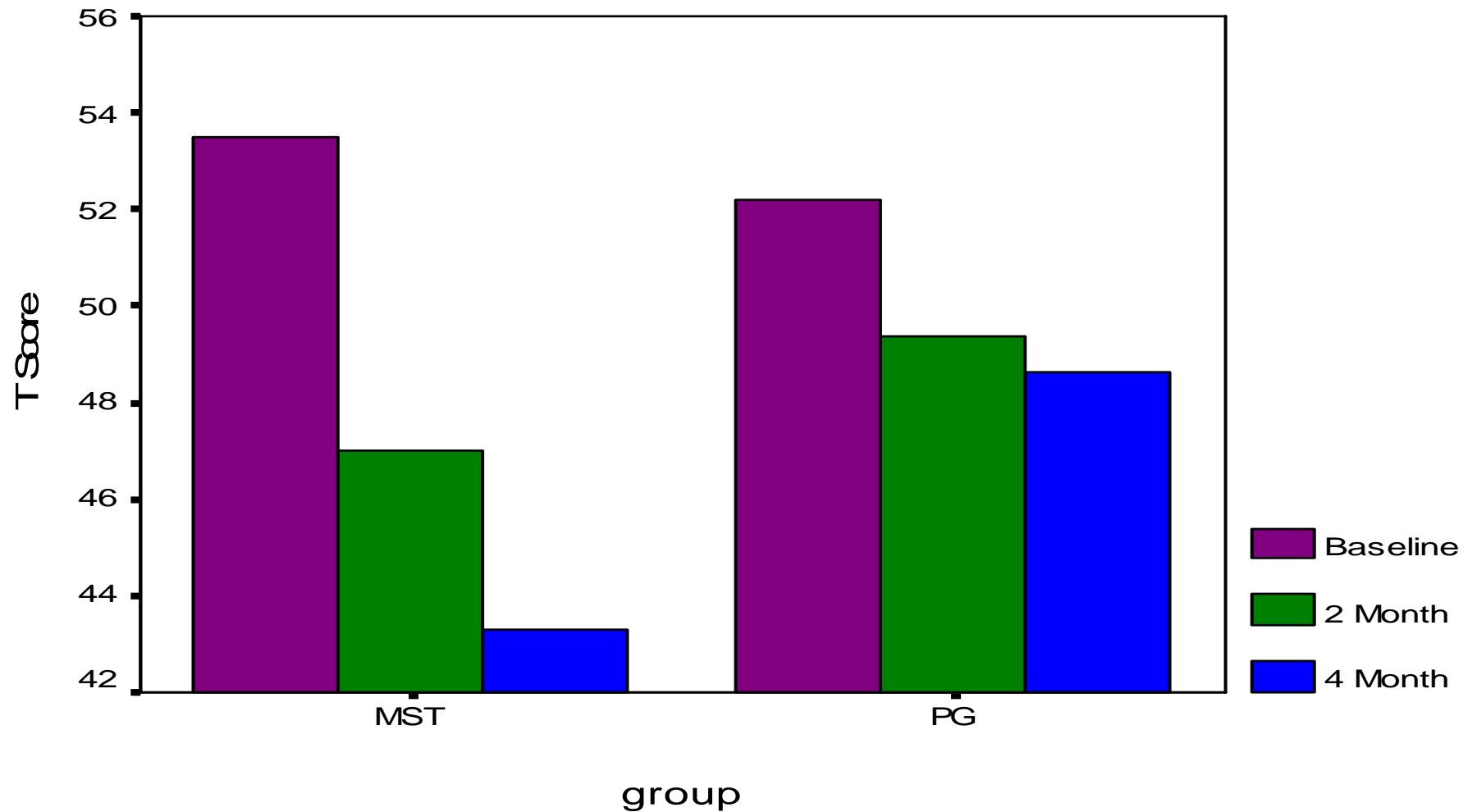


# Children's Depression Inventory: Total Score ( $p < .05$ )



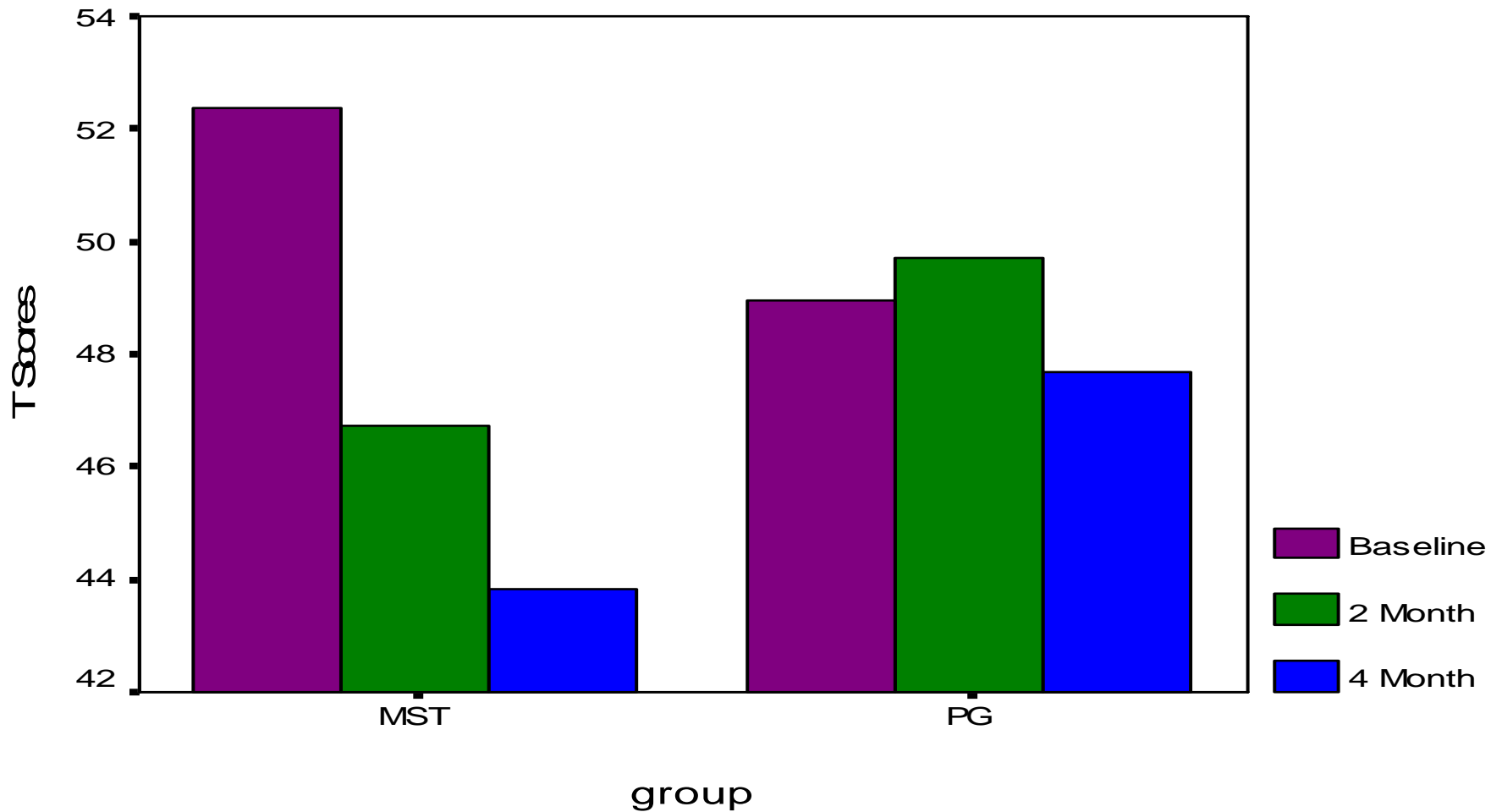
# CDI: Negative Mood

( $p < .05$ )



# CDI: Anhedonia

( $p < .01$ )



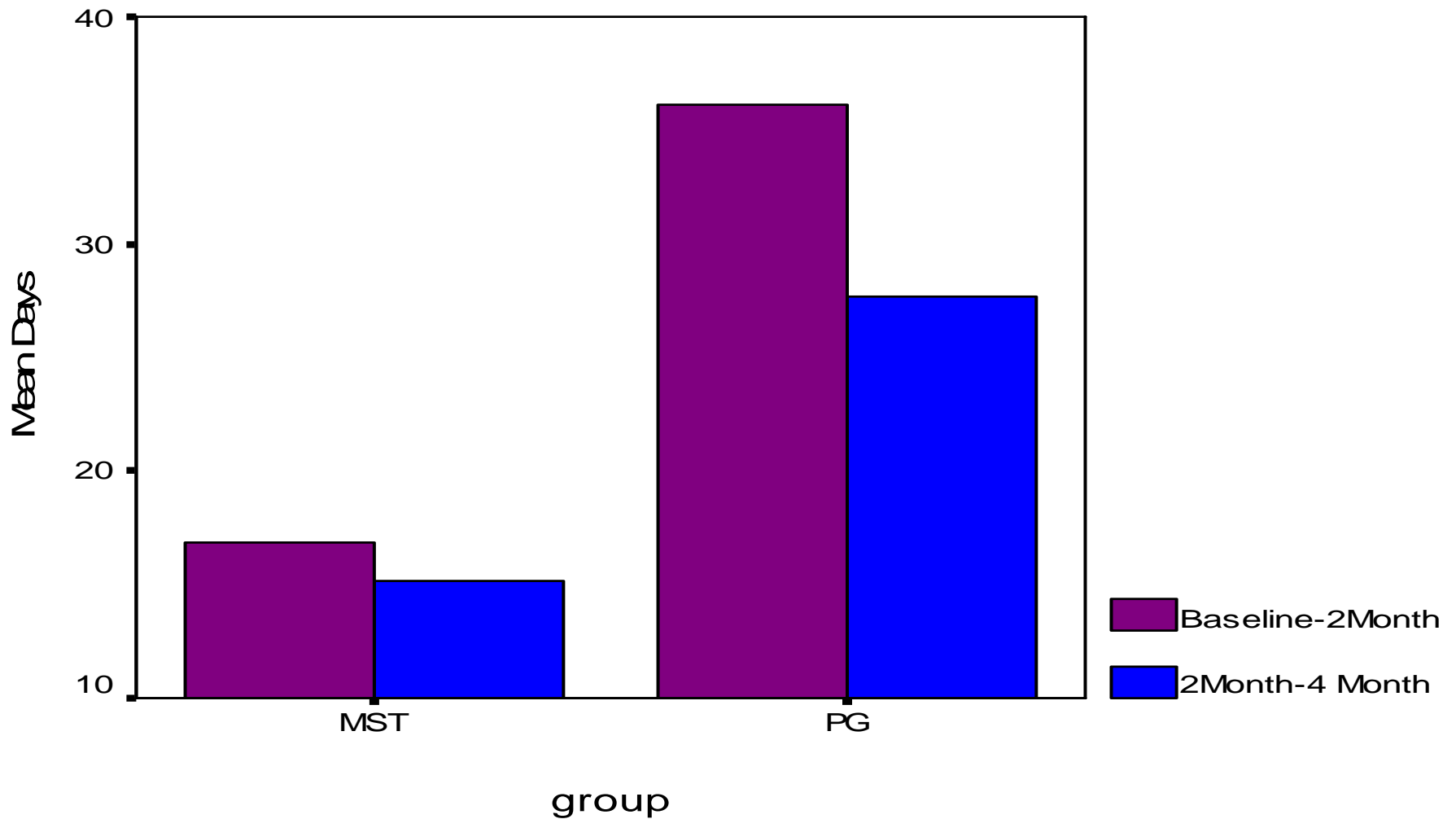
# Satisfaction with Services

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- MST Parents Reported Greater Satisfaction with Services:
- Services Were Worthwhile to the Family  $p < .01$
- Services Helped the Family  $p < .05$
- Services Changed the Way the Family Behaves  $p < .01$
- Skills Learned Became a Part of Daily Life  $p < .01$
- Treatment Matched the Individual Needs of the Family  $p < .01$

# Out-of-Home Placement-16 Months

(MST  $n = 6$ ; PG  $n = 12$ )



# Summary

---

Though Youth and Parents in Both Groups Got Better

## In the Short Term

MST Youth Were More Likely to:

- Be Home with the Family
- Feel Safe
- Experience less Depression & Anhedonia
- Report that their Parent was Using more Non Physical Discipline Strategies

MST Parents Were More Likely to:

- Have Their Child Home with the Family
- Have Their Child Report that the Parent was using more Non Physical Discipline
- Be Happy with Treatment and Feel it is Helping The Family Change and That Skills Learned are Becoming Part of Daily Life
- Report that their child's symptoms of anxiety and distractibility are reduced



# FUTURE DIRECTIONS

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From Research to Practice

**Efficacy**



**Effectiveness**



**Pilots/Replications**



**Dissemination**

# **FUTURE DIRECTIONS**

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## **PILOTS/ REPLICATIONS**

**Eastern Australia**

**MST-CAN**

**State of Connecticut**

**MST-CAN plus RBT**