Manchester City Council
Report for Information

Report to: Children and Young People Scrutiny Committee – 21 June 2016

Subject: An update relating to Multi-systemic Therapy (MST) and Treatment Foster Care – Oregon (TFC-O)

Report of: Strategic Lead Commissioner for Children

Summary

This paper updates members on the progress of the use, by Manchester City Council, of the following evidenced based interventions.

• Multi-systemic Therapy (MST) Standard
• Treatment Foster Care Oregon–Adolescents (TFCO–UK- A) [formerly called Multi dimensional Treatment Foster Care - Adolescents (MTFC-A)]

Recommendations

Members are asked to note the information provided and invited to request clarification and ask supplementary questions.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of any background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

1. Introduction

1.1. This report is an update to previous reports to the Young People and Children Scrutiny Committee, most recently 15 December 2015. As part of the City Council's approach to working with families and young people, amongst other programmes, two specific interventions are offered which continue to be available as tools in supporting the work of key workers and social workers. Of the two programmes, the first is aimed at those children and young people on the edge of care (MST Standard) and the second is aimed at looked after children and young people in residential settings (TFCO-A). The programmes are described in more detail below.

1.2. As described in previous papers to Scrutiny, part of the Council's strategy for Children's Services is to provide social workers with a range of interventions which will assist them in supporting struggling families based on their specific needs. The approach is to ensure that the basket of interventions do not compete for the same cohorts, complement social work practice, enable Social Workers to manage their caseload effectively and provide value for money. The aim is for all interventions to be evidence based and continue to monitor their performance in detail.

2. Multi-systemic Therapy

2.1. MST is an established, evidenced based programme, which has been running in Manchester since April 2014. There are a number of variants of MST, the programme offered in Manchester is the 'Standard' programme.

2.2. The aim of this intervention is to break the cycle of anti-social behaviour by keeping young people safely at home, in school, and out of trouble. MST works to increase the skills and resources of the parents and carers to manage their child's behaviour more effectively.

2.3. MST therapists go to where the young person lives and attends school. This is because there is overwhelming evidence that all the components in a young person's life - family, friends, school and neighbourhood – can contribute to serious anti-social behaviour.

2.4. MST therapists work intensively with families, meeting with the family and other people in the young person's life several times a week. They are there when needed, and since problems don't have office hours from 9-5pm, therapists on the team are on call 24 hours a day, seven days a week. Such an intensive service is possible because therapists work with a limited number of families (4-6) at any given time.

2.5. Visiting the family in their home and community increases the likelihood that they will successfully engage with MST because appointments are arranged at convenient times and locations making it easier for them to attend.

3. Evaluation of the programme

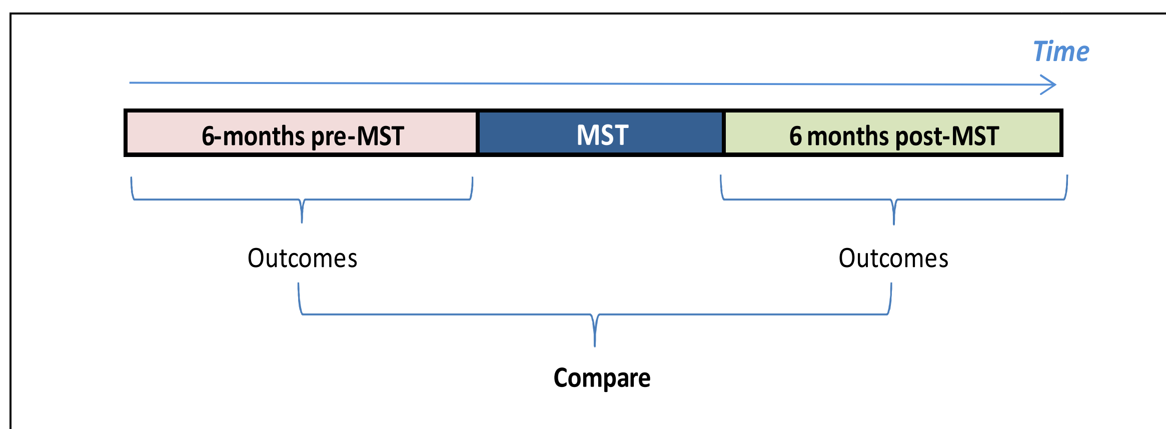
3.1. As part of its LAC reduction strategy, the Council commissioned Action for Children, a national charity, to deliver Multi-systemic Therapy (MST) to the city's eligible children and young people. MST is an intensive family and community based intervention for children and young people aged 11-17 who are at risk of out of home placement either in care or custody due to their offending or severe behaviour problems. The service works primarily with children who are living in a home environment with a primary care-giver. While children in a long-term out of home placement are not eligible for the programme, the service does work with children in care if an imminent return home is planned. In these cases, the role of MST is to support a successful return home. The duration of each intervention is usually around four to five months.

3.2. This interim evaluation examines the extent to which the aims of the programme are being achieved. The council is especially concerned to understand the effectiveness of the programme in preventing the need for admitting Manchester children into residential care. The contract ran initially for two years, from April 2014 to March 2016, and has been extended for the 2015/16 financial year. The analysis covers the two year period, from April 2014 to March 2016.

3.3. Method

3.3.1. The purpose of this analysis is to estimate the extent to which the aims of the MST programme are being met, focussing particularly on those behaviours that put clients at risk of an out-of-home placement. A 'before and after' method is used to compare clients' outcomes during a period immediately before their MST intervention with an equivalent period of the same length, post-intervention period. An example of this is illustrated in figure 1.

Figure 1:



3.3.2. This method has a number of limitations. First, ethical and logistical issues prevent accurate identification of a control group, which means that it is not possible to say with any degree of certainty what clients' outcomes would have been had they not participated in the intervention. This analysis, therefore, cannot address the issue of causality – i.e., whether observed changes in clients' behaviour occur as a result of the MST intervention or whether they are due to other factors. The more limited aim of this analysis,

therefore, is to evaluate the extent to which the aims of the MST programme are being met, without attempting to attribute causality.

3.3.3. However, in order to offer some insight into the potential financial impact of the programme, the financial analysis creates a number of scenarios based on assumptions about the proportionate impact of MST on clients' behaviour and demand for reactive public services.

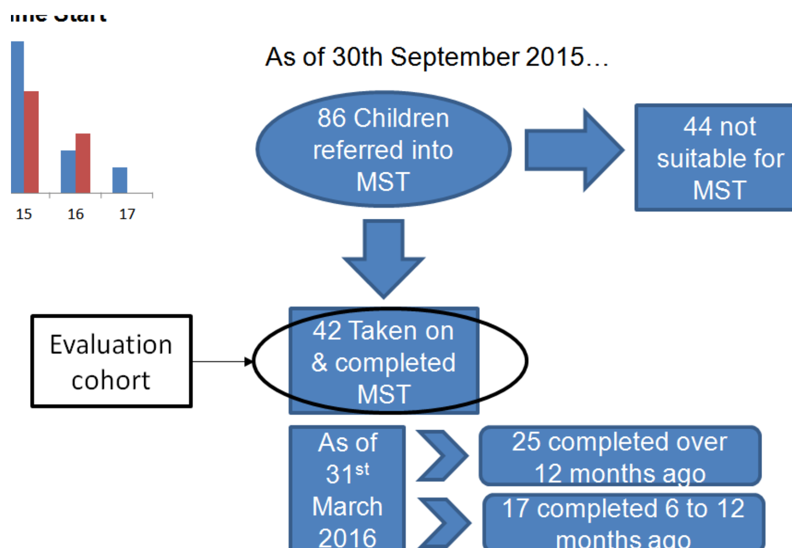
3.3.4. Also, the time periods available to assess children's outcomes are relatively short as improvements may not have become fully manifest during this time, making it difficult to identify new behaviour patterns that emerge. One randomised control trial, for example, indicates that MST's greatest impacts are not measured until 18 months post-treatment[1].

3.3.5. Given these limitations, the main purpose of this study is limited to providing some initial insights into how clients' outcomes have changed over the two year period, for some this will be (approximately) a 16 month period (six months pre-intervention, four months intervention and six months post intervention), others is will be 28 months. The outcomes for the cohort of children who have completed MST will continue to be tracked to judge whether improvements are seen after a longer time period and/or sustained over a longer period of time than currently available.

3.3.6. The Cohort

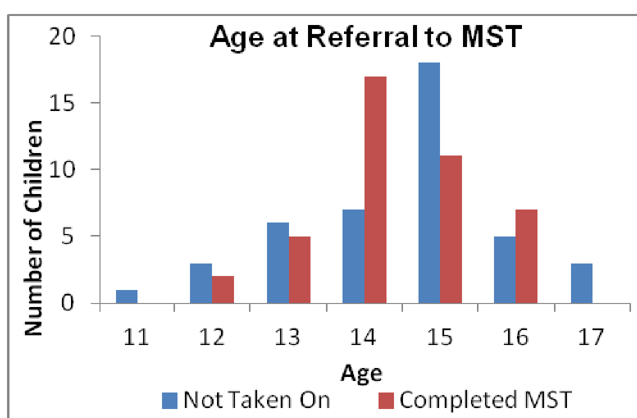
3.3.7. A total of 42 children are included in the cohort as shown in figure 1. The cohort has been spilt into those that completed MST over 6 months ago and those that completed over 12 months ago as of 31st March 2016. The 17 children who completed MST at least 12 months prior to 31st March 2016 allow for outcomes to be tracked over a longer time period to see to what extent outcomes have been sustained.

[1] Butler, S. *Et al.* A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders , J Am Acad Child Adolesc Psychiatry. 2012 Mar;51(3):337.



3.3.8. In order to overcome the limitations of the evaluation the 44 children who have been referred to MST but were not deemed to be suitable and therefore not taken on have, wherever possible, been used as a comparison group. These children should have a similar level of need given that they have been judged to be at risk of care by social workers. Whilst this group is not a control group they can provide a useful comparison with the assumption that they have a similar level of need albeit with different types of needs and behaviours than those taken on by MST.

3.3.9. Of the children referred to MST the majority were between 14 and 16, with small numbers of younger and older children (graph 1). The proportions of male and females are similar with 47% being female and 53% male.



3.3.10. For those that were taken on and completed MST, the average length of involvement was 122 days ranging from 42 to 161 days.

3.3.11. The key measureable outcomes sought from MST fall in to the three broad areas of:

- Social Care – reducing level of need and cost;
- Education – improving attendance and behaviour and
- Police – reducing crime and missing from home incidents.

3.3.12. The outcomes and cost benefit analyses will therefore focus on these areas.

3.4. Outcome analysis

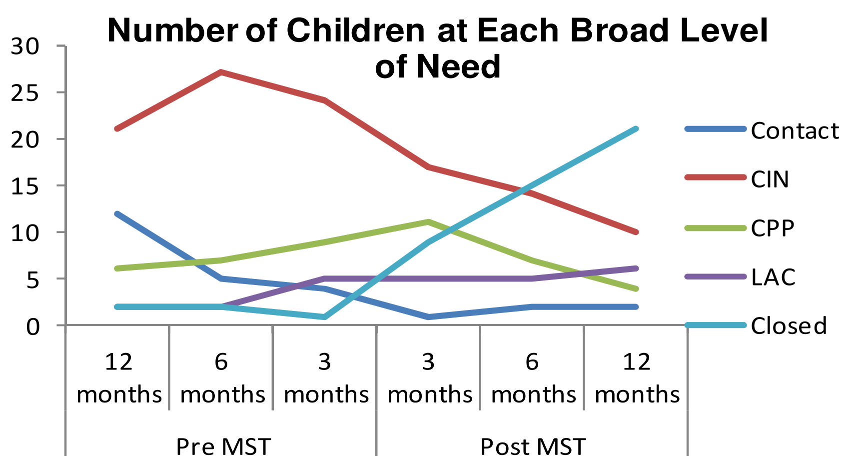
3.4.1. Social Care

3.4.2. Avoiding care, reducing demand and reducing costs have been the focus of outcomes for social care. Improvements in these three broad areas will demonstrate a benefit to social care of commissioning MST over business as usual social work.

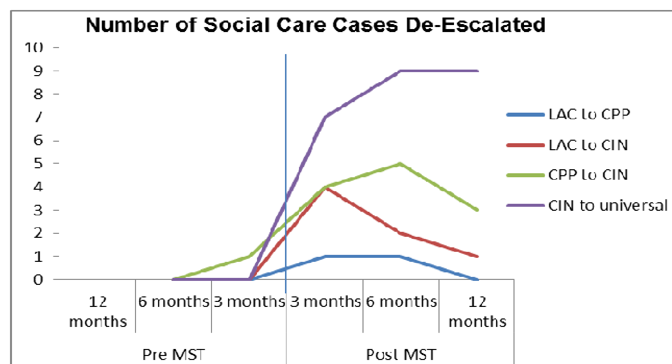
3.4.3. There is evidence of cases being de-escalated or stepped down by social care following completion of MST. Graphs 3 and 4 show the number of children at each level of need in the time periods either side of MST involvement. The categories have been determined by the greatest amount of time a child has spent in the category in the time period. For example if a child was at Child in Need (CiN) for 1 month and on a Child Protection Plan (CPP) for 2 months in the 3 months prior to MST they will be shown as CPP on graphs 3 and 4 as they spent the majority of their time at this level in that period.

3.4.4. Graph 3 shows the number of cases at each broad level of need in the period before and after MST. The graph shows that in the period after completion of MST there is a clear trend in decreasing number of children who are CPP and CIN and a sharp increase in the number of children whose case has been closed to social care.

Graph 3 Social Care Level of Need

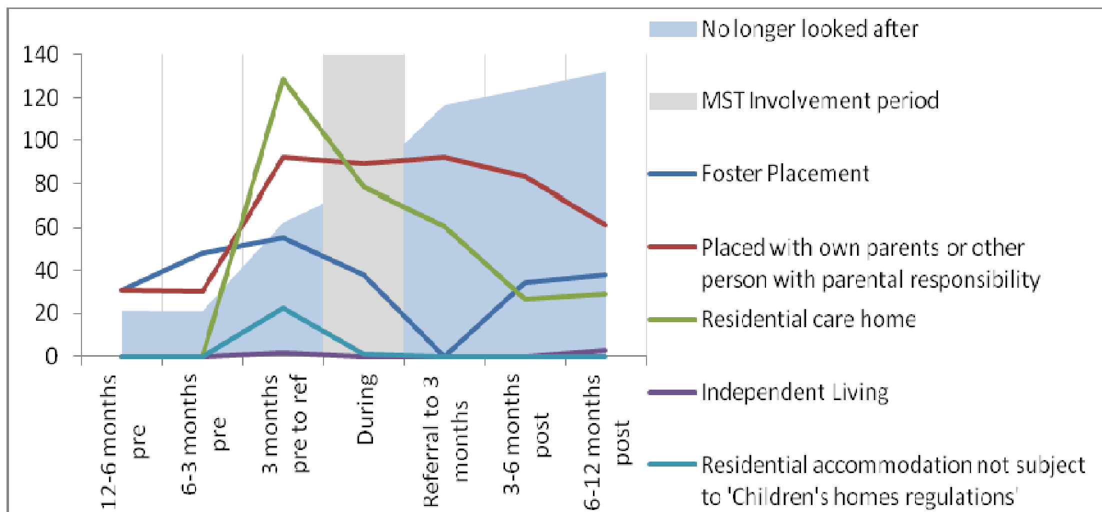


Graph 4 Social Care cases de-escalated



3.4.5. Graph 4 shows that in the period prior to MST there were very few cases de-escalated indicating that children are staying at the same or increasing their level of need. In the period following completion of MST there is an increase in the number of cases that have been de-escalated within social care. These graphs provide evidence therefore, that following MST demand on social care services has been reduced as social workers have seen improvements that have allowed them to close or de-escalate cases to a lower level of need.

3.4.6. With the cost of placements in residential care homes being high, reducing these placements represents a key area for financial savings to be made. The number of days spent in a residential placement by children who were looked after at some point in the pre and post MST periods show that there has been a decrease in the number of days of residential care home placements and the numbers of children in residential care placements. In the three months pre-MST, children in the evaluation cohort who had been Looked After, spent a total of 129 days in residential care placements, this more than halved to 60 days in the three months post-MST period. This further reduced in the 3-6 month post MST period to 27 days. This is shown in graph 5, along with the other main placement types for this cohort. The graph also shows an increase in home placements being sustained post MST. The reduction in days spent in residential placements relates to a reduction in children from 8 to 4 spending at least 1 day in residential care placements in the 3 months pre compared to 3 months post MST periods. There is also an increase in the number of children who are discharged from being Looked After further increasing the number of children at home and also reducing social care intervention.

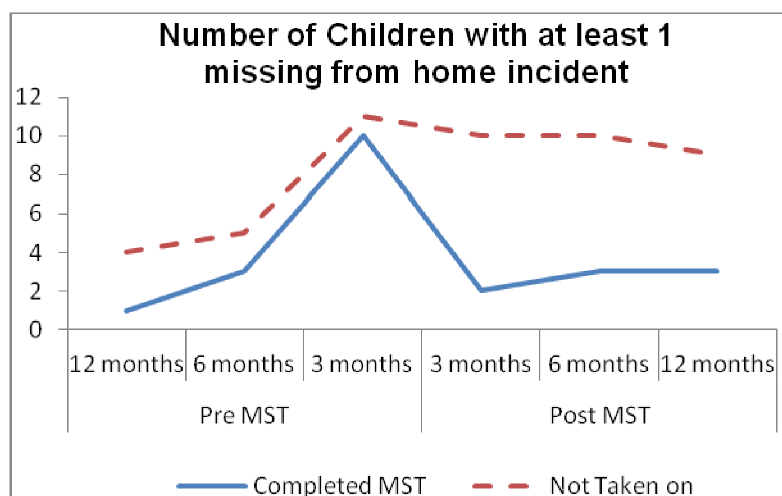


3.4.7. Police

3.4.8. Two of the main demands on police resources that these cohorts will place on the service are through arrests for criminal behaviour and going missing from home.

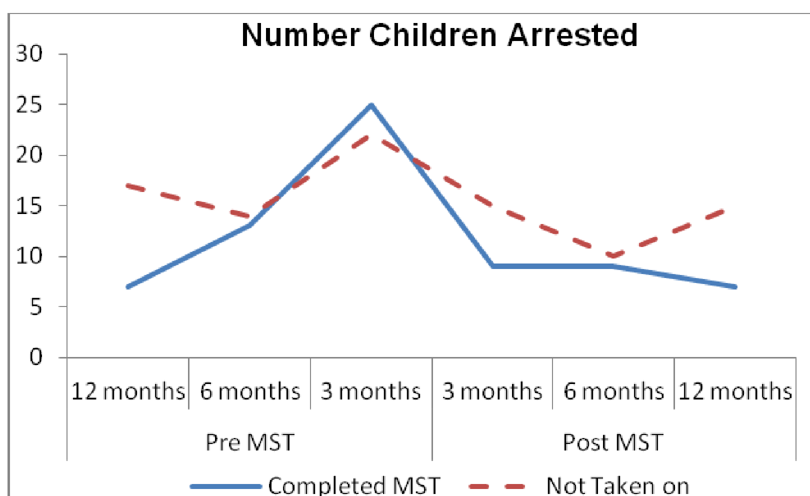
3.4.9. The outcomes relating to police time and activity show a peak in the numbers of children with at least one incidence of missing from home in the three months before MST and a sharp drop in the three months post MST. The dashed line in graph 6 represents the children who were referred to MST but were deemed unsuitable for the intervention. Taking the assumption that these children had a similar level of need and being at risk of care as valid, the comparison shows a similar pattern of increasing missing from home incidents pre referral to MST but less of a decline in incidents post referral compared to those that completed MST. This could be because of the different needs of this cohort or could be that MST is more effective in bringing stability to families than other interventions so children are less likely to go missing from home.

Graph 6 Missing from home incidents



3.4.10. There is also a decline in the number of children being arrested in the post MST period. Again, there is a peak in activity in the three months before MST and a sharp decline in the three months afterwards. The numbers of children being arrested peaks during the 3 months prior to starting/being referred to MST and then drops in subsequent months. The low numbers being arrested post MST has been sustained up to the 12 months post MST that the time period allows. In this case the comparison group shows a similar pattern although there is a less steep decline following referral and evidence of numbers starting to increase again after 6 months. The number of children who completed MST being arrested more than halves from the three months pre to three months post MST.

Graph 7 Children being arrested



3.4.11. The difference between the two groups of children in the numbers of arrests is less stark than missing from home incidents which could indicate that other interventions are just as effective as MST at reducing criminal behaviour but not for sustaining a change in behaviour. This data suggests an increase in disruptive and challenging behaviour in the period prior to referral for all children that were referred to MST which provides some validation to the assumption that the two cohorts of children (those taken on and those not taken on by MST) have similar levels of need.

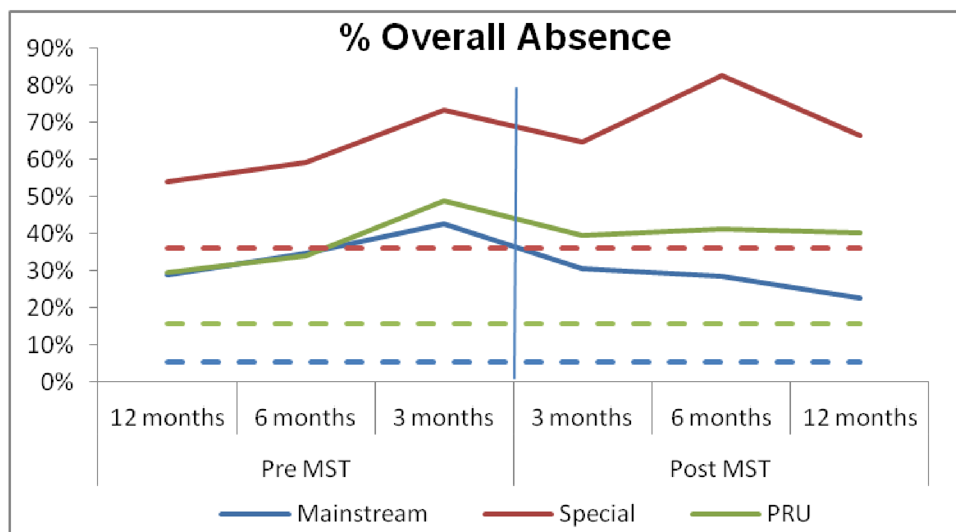
3.4.12. Education

3.4.13. For schools, high absence and exclusions from school indicated higher demand on their resources and potentially disruptive behaviour.

3.4.14. There have been improvements in absence rates for children who have completed MST despite absence rates for these children generally being higher than the average for all children. Graph 8 shows the change in absence rates before and after completion of MST. The solid lines show the absence rates of children who completed MST in each period before and after MST for the three main types of school. The dashed lines show the averages for all pupils in Manchester schools for the same three main types of school. The graph shows that the absence rates are generally high for

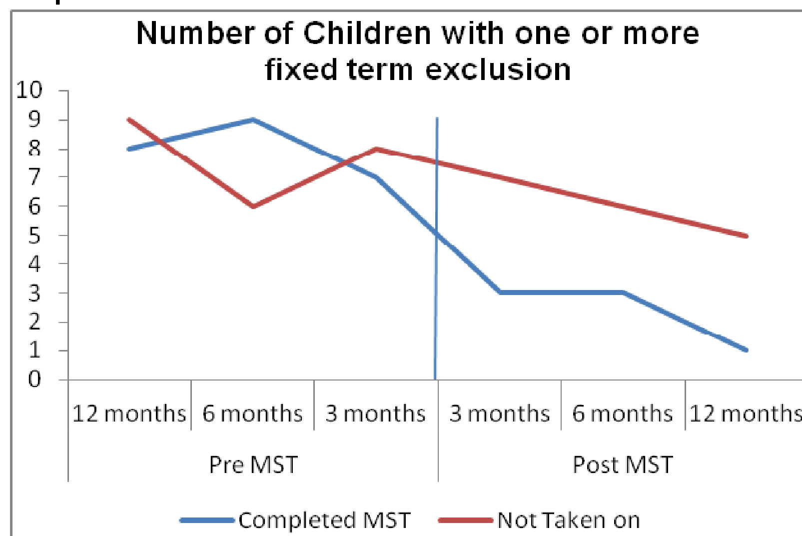
children completing MST and above the average rates for all children but there are improvements in absence rates for children in mainstream and pupil referral units (PRU) schools. As with other outcomes, there is a peak in absence just before referral to MST. The fact that for many this trend of increasing absence has been reversed for pupils in these age groups can be viewed as some degree of success especially in the context that absence generally increases in the higher year groups in all types of school both in Manchester and nationally.

Graph 8 School absence



3.4.15. The number of children being excluded from school shows an improvement post MST. The number of children with one or more fixed term exclusion drops markedly from the three month pre to the three month post MST period. This gives an indication that extreme behaviour has improved from there children following MST. The comparison to the children referred but not taken on to MST shows a more gradual improvement for these children. Additionally, none of the children who completed MST were permanently excluded following MST.

Graph9Schoolexclusions



3.4.16. A cautionary note for school based outcomes is that some of the children will have reached school leaving age in the periods post MST and could account for some of the reduced numbers being excluded. However, there are only a small number of children who had been excluded prior to MST who would reach school leaving age following MST and they generally reach leaving age after the three month post MST period.

3.4.17. Cost Benefit Analysis

3.4.18. There is a requirement for MST to provide a financial benefit to Manchester City Council as well as improving outcomes to ensure that the programme provides value for money and brings savings to The Council. This analysis does only focus on the impact of the programme on public spending; it does not include the wider social and economic benefits of the programme.

3.4.19. A cost benefit model was developed for the previous evaluation in October 2015 using the New Economy Unit Cost Database and this has been updated for the outcomes from this evaluation. As with all models certain assumptions need to be used within the model. With this model the two main assumptions that are made are the contribution of MST to the outcomes and avoidance of children being taken into Local Authority care.

3.4.20. The amount to which the improvements in outcomes that can be directly attributed to MST is difficult to accurately quantify without a control group. However, given that a requirement of MST providers is that no other intervention services work with the children at the same time supports the case for attributing much of the success seen in the changes in outcomes to MST. The assumption used in the previous evaluation that MST contributes 50% of the improvement in outcomes therefore seems as reasonable assumption to continue to use.

3.4.21. As already stated, the professional social work judgement that these children were all at risk of being taken into care supports the assumption that the children who completed MST avoided becoming Looked After. The assumption used in the model that children avoided out of home care placements for at least two months again seems reasonable given that children coming into care in their teens are more likely to be placed in out of home placements. Additionally, the reduction in residential care placements during the 3 months post MST compared to the 3 months pre MST gives more validity to this assumption.

3.4.22. Given these two assumptions and the improvement in outcomes seen, the cost-benefit analysis based on the 43 children who have completed MST since April 2014 shows Manchester City Council have realised a benefit or £1.61 for every £1 spent on MST. Basing the cost benefit analysis on the 26 children who have completed MST at least 12 months ago gives a similar result with MCC seeing a benefit of £1.64 for every £1 spent. Increasing the avoidance of an out of home LAC placement to 3 months increases the benefit to £1.91 and £2.10 respectively.

3.4.23. Key points from the evaluation

3.4.24. The improvement in outcomes and positive cost-benefit analysis result provides evidence that the MST programme is having a positive effect on changing participants behaviour, reducing demand on public services and providing an overall saving on investment.

3.4.25. The limitations of the available data and method prevent attributing the cause of the changes wholly to MST but there is a high probabilistic likelihood that MST has a substantial effect given they are the only intervention service working with the children and the increase seen in demand and disruptive behaviour prior to MST becoming involved.

3.4.26. These outcomes coupled with the wider outcome of keeping families together and avoiding the far more disruptive process of taking children in to care provides a sound evidence base for the effectiveness of MST in being about positive change in families and young people lives

3.4.27. Further work will be done in continuing to track the outcomes and public service involvement with these children and also children who have recently completed or are currently involved with MST to further evaluate the extent to which outcomes are initially improved and sustained.

4. Treatment Foster Care Oregon – UK - Adolescent (TFCO-UK-A)

4.1.1. This social impact bond funded programme is designed to lead to better outcomes for young people aged between 11-17yrs and offers a cost effective alternative to living in a residential setting for particular young people. The model has been shown to be effective with young people who have histories of complex behavioural difficulties. Specific treatment techniques are integrated from those therapies that have been shown to be most effective including cognitive, behavioural and family therapies. The programme works with the young person, their foster carer and their birth family, with the aim that the young person will be able to return home or, more likely, move to a stable long term placement following their time in the programme (up to twelve months).

4.1.2. Working with the young person

4.1.3. The intervention focuses on supporting the young person to:

- increase positive behaviour
- make the most of relationships with friends and family
- to get on well in school
- to enjoy leisure activities

The young person is coached in developing social and relational skills and supported to practice these in community settings. Through dedicated time with a therapist the young person is supported to build a range of coping strategies and problem solving skills and given the opportunity to address areas of difficulty in their lives.

4.1.4. Supporting the foster carer as part of the team

4.1.5. The focus for foster carers looking after with young people in the A programme is to:

- provide effective supervision for the young person
- enable a close, mentoring relationship
- encourage and support young people
- to celebrate achievements

4.1.6. Working with families

4.1.7. Through the ‘adolescent’ programme both birth families and long term carers are provided with training and support to ensure that they can continue to support the young person when they leave the programme. This includes:

- training in parenting strategies that work for adolescents to enable a positive relationship with the young person
- support to enable the young person to build on the skills they have learned

4.1.8. In Manchester, the programme is aimed specifically at young people with challenging behaviour who are in a long-term residential setting or are at high risk of doing so as a result of multiple foster care placement breakdowns. A ‘team around the child’ works intensively with a small number of young people – the programme is designed for a maximum of 7 young people at any one time - who are placed with a specialist and closely supported foster carers for up to twelve months. The aim of the programme is for those young people to be supported to move into a situation where they are living with a family, either back home or within a traditional foster placement.

4.1.9. The approach will deliver much better outcomes for individual participants at the same time as saving significant cost to the council.

4.1.10. The programme is aimed at young people with very difficult behaviour patterns who will find it uncomfortable to engage with a process which requires significant investment from them as individuals. Therefore, it is not for everyone. Those young people who have chosen to engage are working extremely hard to achieve their goals.

4.1.11. Performance (to 19 May 2016)

Categories	Numbers	Comments
Graduates	**3**	Young people who have successfully progressed through the programme and are now in a follow-on mainstream foster care placement
Active Placements	**5**	Young people currently participating in the model

		(at different stages)
Disrupted Placements	**4**	Young people still on model but in the process of being reallocated to a new carer
Breakdowns	**2**	Placements where the young person has left the programme and is no longer on model
Planned moved to parents	**2**	Young people have returned home and have either left or not started the programme.
Total	**16**	
The young people engaged in the programme have a range of complex challenges to overcome in graduating from the programme and successfully making the transition from being in a residential placement to living with a family. There is significant and sustained input applied from carers, workers and the young person themselves,		

5 Recommendation

5.1 Members are asked to note the information provided and invited to request clarification and ask supplementary questions.