Haringey Council

Report for:	**Joint CPAC & CSPPAC and CSPAC. November 5th 2013**	**Item Number:**	

Title:	**DELIVERING EVIDENCE-BASED SPECIALIST SERVICES FOR YOUNG PEOPLE ON THE EDGE OF CARE OR CUSTODY AND THEIR FAMILIES.**

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Lead Officer:	**Geoffrey Baruch – Director, The Brandon Centre**

Ward(s) affected:	**Report for Non Key Decisions:**

1. Background information

1.1 Introduction:

In 2011 the Department for Education (DfE) launched a programme for local authorities and partners to submit bids for implementing intensive, evidence based interventions as an alternative to the young person going into care or custody. A partnership comprising Haringey, Waltham Forest and the Brandon Centre successfully bid to implement Multisystemic Therapy (MST).

Financial support from DfE meets part of the cost and is as follows:

- 2011/12: £29,117 for start up costs and needs analysis.
- 2012/13: £200,000 (MST team cost is £270,564 (three MST therapists, supervisor and co-ordinator)). DfE also pays MST licence fee approx £27,000.
- 2013/14: £200,000 (MST team estimated cost is £335,500 (four MST therapists, supervisor and co-ordinator)) DfE also pays MST licence fee approx £27,000.
- 2014/15: £170,000 (MST team estimated cost is £375,50 (four MST therapists, supervisor and co-ordinator)).
- 2015/16: Mainstream.

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1.2 What is MST?

MST is an evidence based intervention that aims:

- To prevent the young person being placed out of home.
- To prevent or reduce the young person's antisocial behaviour, including violent and aggressive behaviour and other problem behaviours such as substance abuse.
- To re-engage the young person in education or training.
- To reduce the family's reliance on services in the long term.

The focus is on the family and 'empowering' parents or carers to tackle current and future problems, improving family relationships and helping the young person into being 'prosocial'. All the work takes place in the family home or in the wider community, for example school, and may involve extended family members, neighbours, friends and peers.

MST is intensive (2-3 visits per week plus telephone contact between sessions), is organised around the needs of the family, and is time limited (up to five months). The team is available 24 hours per day and seven days per week. Although MST takes the lead and responsibility for delivering the required interventions there is strong liaison with agencies that are involved with the family, particularly social services and the youth offending service. The MST therapist carries a case load of four cases at any one time. Clinical supervision is highly structured. There is a stringent quality assurance process that has quantified standards since therapist adherence to the model predicts good outcomes. A team of four therapists would see between 30 and 40 cases per annum.

1.3 The Brandon Centre:

The Centre was the third MST site in the UK and ran the first UK clinical trial between 2003 and 2009. Partner organisations were Haringey YOT, Camden YOT and UCL who were responsible for the evaluation. The findings have been published in three top peer reviewed journals. They show significant decline in non-violent crime at 18 months follow up post treatment with a similar trend for violent crime and custody although not statistically significant. Compared with the control interventions MST showed significant cost savings. The Centre has two MST teams that see commissioned cases in Camden, Ealing, Enfield, Islington as well as Haringey and Waltham Forest. A third team is involved in the first UK trial testing the effectiveness of an adapted version of MST for problem sexual behaviour in young people. There are 40 MST sites currently in the UK.

1.4 Referral criteria and family presentation for Haringey/Waltham Forest pilot:

All young people must be on the edge of care or custody due to their antisocial behaviour. Some young people may have been accommodated prior to MST.

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Young people present with high levels of violence, substance misuse, poor or no school attendance and are in some instances gang affiliated. There are also high levels of family dysfunction and parental mental health and substance misuse issues in some cases.

2. Progress thus far in Haringey:

A referral process has been successfully established, with all Haringey referrals to date coming via Safeguarding (although eight are known to the YOS). All referrals are on a voluntary basis. There is a referral and operational group that meets monthly, alternating between Haringey and Waltham Forest. Representatives from Safeguarding, the Youth Offending Services and the Brandon Centre are present. The MST team supervisor provides updates on cases, shares outcomes and feedback from parents, referrers and young people. At the meeting any challenges facing MST therapists with local agencies are discussed and problem solved.

2.1 Outputs:

15 Haringey cases have been accepted, two cases terminated due to lack of engagement, one young person remained in care with the agreement of social services and the parent. Five are currently in treatment.

Outcomes

	At home	Achieving in school	Arrests
At start of treatment (12 cases)	11	0	6
At end of treatment (12 cases)	12	9	3
At 6 month follow up (6 cases)	6	5	0

3. Future:

A key objective of the DfE programme is for MST to be mainstreamed following the end of DfE support. (It should be noted that the addition of the fourth therapist has already been funded by Haringey and only Haringey cases are being seen by this therapist). Key to any decision about mainstreaming is whether outcomes are being achieved, in particular the prevention of out of home placement (see above) since there are substantial savings in the short term if the young remains living in the family home. An

MST case costs about £10,000. There should also be savings due to reduced use of other services although how much will vary from case to case. A final key consideration is feedback from families and stakeholders, particularly social work staff about their experience of the service. Overall this has been very positive. Many parents would like the intervention to go on longer than it does, although in a number of cases we have actually exceeded the time limit of five months. At present, we address the need for ongoing support with a robust step down procedure that includes sustainability plans that the MST therapist works on with the family and the referrer. We also respond actively after a case is closed with time limited support from the MST therapist if needed for parents that have got 'off track'. In due course the entire Centre's MST teams will be piloting a new post intervention strategy that hopefully will strengthen the step down process.

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October 2013