

Multisystemic Therapy as an Intervention for Young People on the Edge of Care

Simone Fox^{1,*} and Zoë Ashmore²

¹ *Royal Holloway, University of London, Egham, TW20 0EX and South West London and St George's Mental Health NHS Trust, UK*

² *Cambridgeshire and Peterborough NHS Foundation Trust, on secondment to South London and Maudsley (SLAM) NHS Foundation Trust to work with MST Network Partnership in the United Kingdom (UK), PO Box 51, Kings College London, 16, De Crespigny Park, London, SE5 8AF, UK*

*Correspondence to Simone Fox, Department of Psychology, Royal Holloway, University of London, Egham, Surrey, TW20 0EX, UK. E-mail: simone.fox@rhul.ac.uk

Abstract

There are almost 90,000 young people in care in the UK. Many over the age of eleven years enter care due to anti-social behaviour, acute stress and family dysfunction. The short-term and long-term costs at an individual, family and societal level of going into care are high. There are a number of preventative interventions available for this vulnerable group in common use but not all have a strong evidence base. Multisystemic therapy (MST) is a community intervention which targets the systems around the young person including the family, school, peer and community. Some barriers of the intervention are that it does not target every young person at risk of care, nor is it available in every local authority and there is a low annual capacity. Some of the strengths of MST include the robust evidence base, the cost savings and the strong emphasis on implementation fidelity. It is argued that all young people at risk of care or entering custody need to have access to evidence-based treatments which aim to enable them to remain safely at home. The implications for commissioners and social care practitioners in changing current practice are discussed.

Keywords: Multisystemic therapy, family therapy, edge of care, young people, evidence-based, implementation fidelity

Accepted: March 2014

Introduction

In 2011, there were over 89,000 children under the age of eighteen years in care in the UK (NSPCC, 2012). In England, the biggest single group of the looked after population are between the ages of ten and fifteen years (39 per cent) and 56 per cent are boys (Harker, 2012) and the peak age for entry into the care system is fifteen years (Department for Education (DfE), 2012a). It is well documented that the outcomes for this group of young people are much worse when compared to children living at home and they are much less likely to be in full-time education (Harker, 2012). They are also more likely to suffer from mental health problems (such as anxiety and depression), as well as serious behavioural problems, misuse alcohol and illicit substances, and be involved with the criminal justice system (Meltzer *et al.*, 2003; Jones *et al.*, 2011). In the USA, young people first placed in care when they are between the ages of twelve and fifteen, children who have more than one placement and period in care, and those who are supervised by youth offending after involvement with the care system were at higher risk of youth custody for a serious or violent offence (Jonson-Reif and Barth, 2000). The financial costs of care are extremely high: a child looked after in foster-care can cost around £33,000 per annum and this increases to £156,000 per annum for a child looked after in a local authority children's home (Curtis, 2012).

Young people may end up in the care system for a range of reasons, including neglect and abuse from the parent to factors located within the young person that have an impact on the parent's capacity to cope (Jones *et al.*, 2011). Family dysfunction and acute stress account for around 15,000 young people entering the care system in England each year (DfE, 2012a). In order to reduce the costs both to the families, the young people and society, it is essential that appropriate evidence-based interventions are available for this high-risk group (DfE, 2012b). The interventions need to target risk factors related to the onset of anti-social behaviour such as conflicted relationships between a young person and their parent(s) and low monitoring and supervision. One such intervention which targets multiple systems around the young person is multisystemic therapy (MST) (Ofsted, 2011).

It is essential that social work practitioners understand from the available evidence when it is best to introduce MST. It is not suitable for all adolescents on the edge of care. Anti-social behaviour of the young person needs to be significant. Young people who are suicidal should be excluded and there is no evidence that MST is effective with those with severe developmental delays. Social work practitioners also need to be clear about their statutory duties before, during and after MST. The focus of the current paper is to review MST as an intervention for working with young people and their families where there is a high risk of care, with the aim of providing a balanced overview for commissioners and social work practitioners as well as practitioners who may be considering working in MST teams. Currently, social

work professionals are present in UK MST teams as therapists, supervisors and experts.

MST is a relatively new evidenced-based clinical intervention for this population in the UK (Fox and Ashmore, 2011). The theory underlying the model will be described briefly and some of the other models of practice used will be summarised. The paper will conclude by drawing together the barriers and strengths of the model that are thought to make MST an effective intervention for reducing the likelihood of care.

MST theory of change

The theory and development of MST are based on Bronfenbrenner's (1979) ecology of human development theory, a broader systems model where the immediate situation extends beyond a dyad. Bronfenbrenner described a series of interconnected systems in the ecology around the child which affect his/her development. The model is bi-directional, which means that each system has an impact on the systems around it; for example, the behaviour of the child will influence how the parent reacts to them and vice versa.

The MST Theory of Change is based on Bronfenbrenner's model and sees the young person embedded in multiple systems, mainly the family, the peer group, the school and the community (Henggeler *et al.*, 2009b). Their offending and anti-social behaviour are thought to result from a range of risk factors linked to the systems around them which interact. The MST therapist levers on the family strengths or protective factors, and works with the family to improve family functioning and implement interventions.

One of the main assumptions of MST is that the care-giver is the primary catalyst for change. The interventions are thus focused on empowering the care-givers through the acquisition of skills to effectively manage their child's behaviour (Henggeler *et al.*, 2009a). According to the MST theory of change, the MST therapist works with the family to overcome barriers which prevent effective parenting and management of child behaviour (e.g. the introduction of consistent boundaries). As the parents' effectiveness increases, so will their impact on the peer, school and community systems which will reduce anti-social behaviour in the young person. The aim is to generate contexts which facilitate more pro-social behaviours, building and utilising social support networks (e.g. friends, community, extended family) to help maintain treatment gains. The changes are then sustained and generalised by supporting the drivers which are maintaining the changed pro-social context. There may be limited direct contact between the therapist and some of the other systems, such as the anti-social peers.

Huey and colleagues (2000) and Henggeler and colleagues (2009a) suggest that a decrease in involvement with negative peers is mediated by an improvement in family relations and an increase in care-giver consistency and discipline. The therapist can work with the care-giver even if the young person is

not involved, unlike more traditional approaches to tackling anti-social behaviour (Ashmore and Fox, 2011). In essence, this means that MST can be implemented even if the young person does not consent to treatment. Furthermore, parents reported that the MST strategy of targeting the intervention at them was a productive way of improving engagement (Tighe *et al.*, 2012).

Current models of practice

Reclaiming Social Work was a new model initially introduced into Hackney in 2007 in an attempt to completely change the culture of social work and achieve improved outcomes for vulnerable children and young people (Goodman and Trowler, 2011). The model, which has now been recognised nationally, introduced small social work teams led by a consultant social worker and comprising a social worker, a child practitioner, a clinical therapist and a unit administrator who worked systemically, using evidence-based interventions and responding holistically to families' needs. More emphasis was put on direct intervention and the reorganisation of services allowed better services to be delivered earlier and more quickly. The independent evaluation (Cross *et al.*, 2010) carried out over two years found the new model produced significantly better outcomes than the traditional social work model with the units supporting better skill development and learning, and having a clear focus of social work on the family. The numbers of looked after children fell by over 30 per cent over the course of the implementation of Reclaiming Social Work and there was a reduction of nearly 5 per cent in costs and a 55 per cent drop in staff sickness days. Service users were also positive about the model. The review concluded that Reclaiming Social Work has had a positive impact and the authors of the evaluation endorsed the value of this approach.

Current models of practice in local authorities and partner agencies in England and Wales to divert young people away from care include Family Intervention Projects (FIPs), Family Group Conferencing (FGC) and MST. A study by Ofsted examined how these services successfully prevented young people entering care (Ofsted, 2011). However, the study did not define the differences in practice delivery in the models collectively termed FIPs. More importantly in this review, Ofsted failed to mention the lack of an evidence base for FIPs and FGC. A further review of FIPs concluded that reductions in anti-social behaviour were based on small samples and qualitative measures, and that the FIPs had not delivered sustained reductions in anti-social behaviour in the wider community (Gregg, 2010). FGC is a well-respected and frequently used in social work and youth justice in the UK and yet there has been 'limited empirical evidence undertaken to evaluate FGC particularly where focused on vulnerable young people and especially where there are child welfare or youth justice concerns' (Fox, 2008, p. 157). Fox made recommendations regarding learning from the experience of service users and further investigation of longer-term outcomes.

In its review of eleven local authorities, [Ofsted \(2011\)](#) drew on the experience of forty-three families to identify successful interventions aimed at keeping children out of care. One major limitation of this review was that the models looked at were not compared to a control group so it was not possible to draw comparisons either between interventions or what specifically about the intervention impacted on outcomes. The conclusion that ‘no evidence was found that one intervention was more effective than another’ was more to do with the limitations of the methodology employed as opposed to any one particular model. The report does nothing to help hard-pressed local authorities, who might turn to Ofsted as a trusted source to help them identify where they should be spending their money to achieve the best outcomes for this vulnerable group of young people.

[Henggeler \(2003, p. 53\)](#) noted that, in the USA, ‘implementation of the evidence based treatments of adolescent criminal behaviour requires considerable change in prevailing clinical and administrative practices’ and estimated that only about 4 per cent of this population received evidence-based treatment. The challenge to the criminal justice service set by evidence-based approaches such as MST has yet to be grasped by many local authorities and partner agencies with now much reduced budgets yet still failing to seize the opportunity to eliminate services where there is limited, if any, evidence that they will achieve the outcomes this vulnerable population deserve ([Ashmore and Fox, 2011](#); [Butler *et al.*, 2011](#)).

Overview of MST

In 2008, the Department of Health, in partnership with the DfE (formerly the Department of Children, Schools and Families) and the Youth Justice Board, funded a number of MST pilot sites (see [Fox and Ashmore, 2011](#)). These sites were part of a large-scale randomised control trial (RCT) that aimed to expand on the findings from a smaller RCT that found that MST had better outcomes at eighteen-month follow-up when compared to a statutory youth justice intervention ([Butler *et al.*, 2011](#)). In 2011, there were twelve standard MST sites in England (nine of which were part of the RCT) working with eleven-to-seventeen-year-olds.

That year, further funding was made available by the DfE to develop MST services more widely across England, and several of the current sites are expanding their services to cover wider geographical locations so that there are now over forty teams. Further sites were also developed in Scotland and Northern Ireland. There are a number of new sites using adaptations of the standard MST intervention for specific populations, such as for child abuse and neglect (MST-CAN), which target younger children, substance misuse (MST-SM) and problem sexual behaviour (MST-PSB).

Referrals to MST teams are received from a number of different sources including children’s social care, youth justice, education, child and adolescent

mental health services (CAMHS), other charitable organisations and the police. Of the nine pilot sites included in the RCT, children’s social care was the main referral agency, over an approximate eighteen-month time frame per site, with 42 per cent of the total number of referrals (Fonagy *et al.*, 2013). Some of the MST teams are directly employed by the local authority, some sit within the Mental Health Trust or voluntary sector organisations, and others are more closely linked with the Youth Offending Team.

Barriers and strengths of the MST model

Although there are a number of interventions for children on the edge of care, this section will focus on the barriers and strengths of MST. Table 1 provides a summary of the different areas that will be covered.

Barriers of MST

Does not target everyone at risk of care

The standard MST intervention does not target everyone who is at risk of going into care. Where there is not an evidence base that MST is effective, then it would not be offered, such as with young people with severe pervasive developmental delays or referred primarily for psychiatric service needs. Also, young people who are at risk of care but not showing anti-social behaviour would not be suitable for standard MST. In some cases, it is the parents’ behaviours which are the main concern. MST child abuse and neglect (MST-CAN), which is an adaptation to standard MST, would be suitable for these families but it is not yet widely available in the UK. MST cannot replace social work practice in statutory work, requiring both agencies to work together to ensure safeguarding of children and young people (DfE, 2013).

Table 1 The barriers and strengths of MST as an intervention for children on the edge of care

Barriers	Strengths
Does not target everyone at risk of care	Strong evidence base
MST sites need to be licensed and teams trained in the model	Strong emphasis on implementation fidelity
Intervention is limited to three to five months even if family have not met outcomes	Cost savings
Case needs to close if young person has gone into care for over four weeks	Engagement and alignment process
Does not work with respite care	Families do not feel judged or blamed
Demanding role for MST professionals	Present-focused
Each team has low annual capacity due to low caseloads	Provides information for comprehensive assessment
	Different professions can provide the intervention
	Maintenance/sustainability plans pre discharge

MST sites need to be licensed and teams trained in the model

MST needs to be delivered in the way which the research has shown has been effective in achieving the best outcomes. This means that MST strictly adheres to the model, known as the ‘Do Loop’ and follows nine treatment principles. It therefore cannot be provided by general social care or CAMHS services and sites need to be licensed. Set-up is complex and all new services are provided with organisational support with this and ongoing service development.

Intervention is limited to three to five months

One of the underlying assumptions of MST is that change can occur quickly (Henggeler *et al.*, 2009b). Intervention is limited to three to five months and cannot be extended even if families have not achieved the goals that were set at the outset. There is often pressure on the MST team to extend the intervention, but no research has been done to suggest that extending the intervention would improve outcomes. This can cause concern for referrers, as MST may have been viewed as the ‘last option’ before initiating care proceedings and other local interventions available may not be as intensive as MST. Other interventions may have also previously been tried and not been successful.

Case needs to close if young person has gone into care for over four weeks

If a young person is not living at home with their primary care-giver(s) for a period of four weeks or more, the intervention needs to be ceased. This is because the aim of the intervention is to empower the care-giver to take responsibility for managing their child’s behaviour. If the young person is not living at home, then this cannot be tested. As the main referral criterion is for young people at risk of entering care (or custody), there is a strong possibility that agencies not directly involved may recommend removal from the home, such as through either civil or criminal courts. The therapist may need to do some work with these systems to try and delay any decisions about care until the MST intervention has been completed. If outcomes have been achieved, then this would provide a stronger argument to support recommendations to keep the young person at home. In such cases where the young person is no longer living at home, it may be possible to re-refer to MST when there is a clear plan for them to return home.

Demanding role for MST professionals and families

Respite care can be offered to families in order to give them time away from the pressure of caring for a young person whose behaviour is challenging. In

MST, this type of intervention is not compatible with the model which seeks to equip parents and carers with the skills to manage rather than to use other services. The emphasis is on building up informal social and family supports, and decreasing the involvement of statutory agencies and formal inputs such as respite care.

On-call and out-of-hours

The requirements for MST staff to be able to offer services flexibly every day of the week and to periodically also cover the twenty-four-hour on-call is not suitable for all professionals. It can be particularly difficult for those with other responsibilities. The requirement to be able to respond to on-call restricts what staff can do and where they can go when they are required to be able to give advice over the phone in the first instance at any time they are on-call. The need to keep families in mind means professionals can feel they have less time away from the daily pressures of the job. This way of working is viewed as a strength for both families and stakeholders.

Each team has low annual capacity due to low caseloads

MST teams are small, with three to four therapists, and caseloads for each therapist range from four to six young people. This means that, at any one time, full team capacity will be twelve to twenty-four young people. As intervention is on average four months, at most, the annual capacity of a fully staffed team ranges from thirty-six to seventy-two young people. This may mean that, within any particular local authority, not all families who meet the criteria can be offered the intervention if they were to be referred, and families would need to be prioritised according to risk of immediate care or custody and level of offending/aggressive behaviour. It may be necessary to look at alternative less intensive interventions prior to referring to MST.

Strengths of MST

Strong evidence base

One major consideration in the commissioning of a new service is the evidence base around whether that intervention will work with a particular population. [Haynes and colleagues \(2012\)](#) and [Henderson \(2012\)](#) highlight the importance of developing evidence-based treatments from well-run RCTs in order to influence policy.

One of the main strengths of MST is that there is a strong body of evidence, especially from the USA, but increasingly across other countries, that it is effective in both the short and the long term in reducing 'out-of-home'

placements and anti-social behaviour and improving family relationships (Borduin, 1999; Henggeler *et al.*, 2009b; Fonagy *et al.*, 2002). Positive outcomes have also been achieved when comparing MST to ‘usual interventions’ in the USA, Norway and the UK (Schaeffer and Borduin, 2005; Ogden and Hagen, 2006; Butler *et al.*, 2011). However, Littell and colleagues (2005) drew less favourable conclusions about the effectiveness of MST. Their review of eight MST RCTs found that results were inconsistent across studies and there was a variation in quality and context. The MST research was also criticised in that it was carried out by the programme developers and they questioned the transportability of the intervention. One study in Canada (Leschied and Cunningham, 2002) and one in Sweden (Sundell *et al.*, 2008) found that MST failed to reduce anti-social behaviour more than usual services. Since the Littell review, there have been independent RCTs which have demonstrated good outcomes for MST (e.g. Butler *et al.*, 2011; Ogden and Hagen, 2006). National Institute of Clinical Excellence (NICE, 2013) guidelines now recommend multimodal interventions such as MST for treatment of conduct disorder in eleven-to-seventeen-year-olds.

In the literature on effectiveness of interventions, long-term outcome studies which follow up families for more than a year are scarce. However, the long-term effects of MST have been investigated. In one early RCT, MST was compared with individual counselling after four years (Borduin *et al.*, 1995). Improved family relations and a 69 per cent decrease in recidivism were found. The same families were followed up at 13.7 years (Schaeffer and Borduin, 2005) and 21.9 years (Sawyer and Borduin, 2011). Rates of reoffending were significantly lower and time spent in custody significantly less for those who had MST compared to individual counselling. In the later follow-up when the young people who had MST were now 37.3 years old on average, family-related civil suits for those who had MST almost twenty-two years previously were also significantly lower.

Strong emphasis on implementation fidelity

Implementation fidelity is defined as how well a proposed programme is put into practice. It can vary across settings and this influences outcomes (Duriak, 1998). Fidelity is critical in the delivery of evidence-based programmes and interventions need to be delivered in the way intended by the programme developers (Mihalic, 2002). This cannot just be assumed to happen but needs to be closely managed and monitored (Flay *et al.*, 2005). The monitoring systems set up around MST give additional weight to the evidence base. The MST model is highly structured and the intervention provided to the family is constantly evaluated. The goals and outcomes set are reviewed weekly and families play a key role in monitoring whether therapists are adhering to the treatment model by providing monthly feedback using an adherence questionnaire.

MST still has a close, regular association with the developers and uses treatment adherence measures along with an array of treatment and operational manuals, booster training and expert weekly support through consultation. A transportability study has shown that both therapist and supervisor adherence to the model predicts reduction in anti-social behaviour (Schoenwald, 2008).

Cost savings

MST has been estimated to cost around £8,000–£12,000 per family, which can be seen as expensive when compared to other types of treatment such as parenting interventions or individual therapy provided by CAMHS (Hughes *et al.*, 2012). However, the young people and families seen within MST present with highly complex and multiple needs. The ultimate aim of the intervention is to prevent family breakdown and the need for expensive care placements. If MST is successful in keeping the young person safely at home and out of a foster-care placement or a children's home, then significant savings will be made. Local authorities are able to benefit from the cost savings if a young person avoids care and this saving accrues over the following years where care is averted.

Aos and colleagues compared the effectiveness and cost of interventions for this group of young people and concluded that MST is one of the most cost-effective of a range of interventions aimed at reducing serious crime by young people (Aos *et al.*, 2006). In the UK, Cary and colleagues (2013) also found that MST plus an intervention from the Youth Offending Team (YOT) cost less in terms of criminal activity than YOT services alone. MST aims to empower the parent in increasing responsibility and improving parenting skills, which can be generalised to other children in the family (not just the target child) and thus reduce the need for future care placements. Additional costs to society, in both the short and the long term, include costs of being involved in the criminal justice process (as well as costs to victims) and not being in education, employment or training (NEET). There is a strong emphasis throughout the intervention on improving outcomes in both of these domains.

The engagement and alignment process

The mode of delivery of an intervention plays an important role in the levels of engagement and alignment of the recipient of that service. Engagement is closely attended to by therapists and their supervisors, and individually tailored interventions designed to overcome any barriers to treatment access are implemented. A key strength of MST is that it is flexible to the time constraints of the family and sessions are arranged around work and school

commitments. There is a twenty-four-hour, seven-days-a-week, on-call system available for families to access support in times of need. The family are not required to attend a clinic and sessions are delivered in the home, school or community. These factors are believed to play an important role in engaging families who have previously had poor relationships with services (Tighe *et al.*, 2012). Unlike other services, MST places a strong emphasis on building on strengths (as opposed to focusing on risks or needs). The focus on treatment is on what is working well (Henggeler *et al.*, 2009b) and this helps the family to feel that goals are achievable and that they can make changes. Parents and young people are continually reinforced for increasing responsibility in their behaviour. This positive way of working and building feelings of hope and expecting positive results is linked to favourable outcomes (Greenberg and Pinsof, 1986).

Families do not feel judged or blamed

There is some evidence to suggest that neither care-givers nor young people feel judged by the therapist and this helps to improve the therapeutic alliance (Tighe *et al.*, 2012). MST programmes demand the use of non-pejorative, non-judgemental and non-blaming communication when discussing families (Cunningham and Henggeler, 1999).

Present-focused

The intervention does not dwell on historical events and there is a clear present focus to the work. As caseloads are low, therapists are able to see families several times a week and so are able to build relationships and get on top of difficulties as and when they arise. Clear goals are agreed at the beginning of treatment and these are reviewed frequently throughout treatment. Families are able to see things change more quickly, thus empowering them and helping them to generalise their skills.

Provides information for comprehensive assessment

As the intervention is intensive and the therapist does the work mostly within the family home, a lot of information is gathered within a short space of time. Families often act out arguments and typical sequences in front of the MST therapist, providing a rich source of data that helps with intervention development. Even when treatment has not been successful, or partially met, the nature of the intervention means that the MST service will be able to provide comprehensive recommendations to stakeholders about the family. This means that the required interventions can be based on a full assessment.

Can co-work alongside social work

Social workers value the engagement success which MST emphasises especially with families who are unable to access other services. For families who are struggling to look after their teenage children yet have managed to care for them throughout their childhood, MST is an intervention which can be deployed. It has the specific aim of working with families so that the young person can remain safely at home in education or training and out of trouble. While younger children are not the target of the intervention, improvements in managing the older sibling can generalise to younger children.

Many of the young people and families referred to MST are subject to child in need (CIN) or child protection (CP) plans. It is therefore important that a professional's meeting (which may include a CORE group meeting) is scheduled at the beginning of the intervention in order to set goals for the family and work out which professionals will be responsible for providing which services to the family and monitoring outcomes. The MST therapist will collect 'desired outcomes' from the family and key professionals, which are recorded in their own words and are amalgamated into three or four overarching goals for MST treatment.

In such cases, the social worker continues to hold statutory responsibility for the family but the MST worker takes the clinical lead and is the single point of therapeutic contact for the family. The MST therapist will be working more intensively with the family and implementing direct interventions but the social worker will hold responsibility for monitoring levels of risk and whether the goals set out in any plan are being met. The MST therapist who is assigned to the family needs to work closely with the allocated social worker to update on progress and share care plans to ensure they are aligned. The therapist will develop sustainability plans with the family as treatment reaches a conclusion. These plans should be shared with professionals involved with the family, including social work. As MST is time-limited (three to five months), the social worker may need to hold responsibility for managing any CP plans and monitoring whether improvements have been sustained upon closure of MST. The aim is to reduce statutory involvement, if it is safe to do so, and to build up informal social and wider family support to help the family sustain and generalise the treatment goals.

Different professions can provide the intervention

In the UK, a MST team constitutes a MST supervisor (and a back-up supervisor who will cover leave), three to four MST therapists and a team administrator. The backgrounds of the supervisors and therapists vary both within and across teams. They include professionals from applied psychology (clinical, forensic and counselling), social work, youth justice, family therapy and nursing. It is

important that the skills mix of the team is diverse, as each professional will bring their own strengths to the team. As supervision is done within a group format, each therapist can share their area of expertise with the team. The therapist recruitment toolkit recommends key characteristics for a therapist that fit with the MST model including: effort and accountability such as being flexible with working hours; having a strong work ethic; being open to peer supervision and feedback; and being resilient in order to manage the emotional intensity of the work. Other qualities also recommended include: good conceptualisation and thinking skills; having a strength focus with an ability to be empathic; strong interpersonal skills and knowledge; and experience of clinical modalities used in MST such as cognitive behavioural, family therapy and behavioural treatment (MST Services, 2010).

Maintenance/sustainability plans pre discharge

There is a strong emphasis on maintenance of the improved behaviours and sustainability in MST throughout treatment. MST therapists design interventions which encourage all family members to take more responsibility and to make use of informal and family support networks. The quality-assurance process attends to sustainability planning to enable therapists to take advantage of opportunities to help family members decrease irresponsible behaviour and learn new skills. Therapists are encouraged not to undertake tasks for the family but instead to coach them and practise the behaviours and then support them to carry them out by themselves. There is considerable evidence that MST is successful in achieving long-term sustainable changes and, in RCTs where MST has been compared to other services, it has been shown that these changes have been sustained for eighteen months in the UK (Butler *et al.*, 2011), two years in a Norwegian study (Ogden and Hagen, 2006) and 13.7 years (Schaeffer and Borduin, 2005) and 21.9 years (Sawyer and Borduin, 2011) in the USA.

Implications and conclusion

In summary, there are a large number of young people in care in the UK and it is well known that outcomes for this vulnerable group are poor. In order to reduce the costs at both an individual and a societal level, clinical interventions need to be evidence-based. A recent review by Ofsted has also acknowledged the role of FIPs and FGC as alternative models of practice. However, the methodological limitations of this review question the conclusions that can be made around their effectiveness. This paper has reviewed the MST model for families where there is a high risk of breakdown. The barriers of the model include: that it is not suitable for every young person where there is a risk of care; it is limited to three to five months even if outcomes

have not been met; and there is a low annual capacity. A number of strengths of the model have been highlighted which include the robust evidence base at both a national and an international level, high levels of quality control, the cost savings and the strong emphasis on treatment adherence, amongst others.

In terms of the implications for social work, although MST is not available in every local authority, it is essential that what is available is reviewed. The importance of developing evidence-based treatments from well-run RCTs and providing evidenced-based clinical interventions which are implemented with fidelity has been described. In general, evidence-based interventions are not systematically used or available for eleven-to-seventeen-year-olds on the edge of care. Often, interventions are employed on an ad hoc basis and the evidence for effectiveness is not taken into consideration in commissioning. Social workers have a vital role in identifying the right services for families. It is important to understand how to evaluate the effectiveness of treatment options and be able to target the right young people at the right time. The challenge to commissioners is about reallocating resources in favour of robust evidence-based practice which has been shown to have an impact on reducing care costs.

Acknowledgements

The authors would like to thank Helen Jones, from the Department for Education, and Cathy James, from NHS England, and Tom Bowerman, SLAM NHS Foundation Trust, for their input into drafts of this article.

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