# Multisystemic Therapy as an intervention for young people on the edge of care

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**Abstract**

There are almost 90,000 young people in care in the UK. Many over the age of 11 years enter care due to antisocial 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 engagement and alignment with the family. 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 policy in changing current practice are discussed.

**Keywords:** Multisystemic Therapy, family therapy, edge of care, young people, practice issues

**Introduction**

In 2011 there were over 89,000 children under the age of 18 years in care in the UK (NSPCC, 2012). This includes children being looked after by the local authority and subject to care orders under section 31 of the Children Act 1989 as well as those looked after on a voluntary basis through agreement with their parents. In England, the biggest single group of the looked after population are between the ages of 10 to 15 years (39%) ,and 56% are boys (Harker, 2012) and the peak age for entry into the care system is 15 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). These young people 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 12 and 15, 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 & 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 and preventative services are available for this high risk group (DfE, 2012b). These interventions need to target those factors that contribute to relationship breakdown between a young person and parent(s) and the onset of significant behavioural problems. One such intervention which targets the multiple systems around the young person is Multisystemic therapy (MST) (Ofsted, 2011).

The focus of the current paper is to review MST as an intervention for working with young people and their families where the risk of going into care has been identified as significant. MST is a relatively new intervention for this population in the UK (Fox & Ashmore, 2011). The theory underlying the model will be described and some of the other models of practice used will be briefly

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 a young person entering the care system.

**Theory of the intervention**

The theory and development of MST is 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 first part of system is the immediate environment in which the child lives, i.e. the immediate family, but this is influenced by the wider systems such as the school and community. If relationships in the immediate system break down the child may not have the tools to explore outer parts of the system effectively. The way that a caregiver interacts with other parts of the outer systems will have an impact on the child even though he/she may not be directly involved with them, such as the caregiver's place of work or the extended family. The system furthest from the child still has a great influence over the child such as the attitudes, the values, the laws and customs of the culture in which the young person functions.

Social learning theory proposes that behaviour is learned from others modelling it and so children learn through the process of observation and imitating the actions of others (Bandura, 1977). The main models for children are parents or other family members, and teachers or peers at school, and the behaviour is more likely to occur if it is seen to be reinforced. Furthermore, the development of social skills is essential for a child's capacity to grow and form lasting relationships and participate and function effectively in the community (Cacioppo, 2002). Social skills emerge gradually through childhood and adolescence and reflect a dynamic interplay between the individual and his/her environment (Beauchamp & Anderson, 2010). MST is consistent with both of these theories and

interventions focus mainly on working with the parents or carers, to help influence the behaviour of the young person, help the development of social skills and ensure that pro-social behaviour is reinforced.

*MST Theory of Change*

The MST Theory of Change, is based on Bronfenbrenner's model described above, and sees the young person embedded in multiple systems; mainly the family, the peer group, the school and the community (Henggeler et al, 2009). Their offending and antisocial behaviour is thought to result from a range of risk factors linked to the systems around them which interact. Interventions need to tackle the multiple drivers from these systems which will be identified as the risk factors which are pertinent to that individual. The MST therapist levers on the family strengths or protective factors and works with the family to improve family functioning and implement interventions. As the parents' effectiveness increases so will their impact on the peer, school and community systems which will reduce antisocial behaviour in the young person. The changes are then sustained and generalised by supporting the drivers which are maintaining the changed pro- social context.

**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 & Trowler, 2011). The model, which has now been recognised nationally, introduced small social work teams led by a Consultant social worker and comprising of 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 a 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% over the course of the implementation of Reclaiming social work and there was a reduction of nearly 5% in costs and a 55% 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 antisocial behaviour were based on small samples and qualitative measures, and that the FIPs had not delivered sustained reductions in antisocial 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, p157). Fox made recommendations regarding learning from the experience of service users and further investigation of longer term outcomes.

In its review of 11 local authorities, Ofsted (2011) drew on the experience of 43 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) noted that in the United States (US) "implementation of the evidence based treatments of adolescent criminal behaviour requires considerable change in prevailing clinical and administrative practices" p.53 and estimated that only about 4% of this population received evidence based treatment. The challenge to the Criminal Justice service set by evidence based approaches such 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 & Fox, 2011; Butler et al, 2011).

**Overview of MST**

MST is a community based intervention for young people and their families, where aggressive, criminal and/or antisocial behaviour is significant and the young person is at risk of going into an out-of-home placement (care, custody or residential schooling). It was originally developed in the late 1970s by Scott Henggeler and his colleagues in the United States (Henggeler et al, 2009). In the UK MST standard teams specifically work with 11 to 17 year olds, although there are a limited number of specialist Child Abuse and Neglect (CAN) MST teams that work with younger children.

In 2008 the Department of Health, in partnership with the Department for Education (DfE, formerly the Department of Children, Schools and Families) and the Youth Justice Board, funded a number of pilot sites (see Fox & 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 18-month follow-up when compared to a statutory youth justice intervention (Butler et al, 2011). In 2011 there were 12 standard MST sites in England (nine of which were part of the RCT).

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 will be over 30 teams in 2013. Further sites were also developed in Scotland and Northern Ireland. There are also a number of new sites using adaptations of the standard MST intervention for specific populations, such as for child abuse and neglect (MST-CAN), 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. For the standard programmes, the inclusion criteria require that the young person is at significant risk of entering the care system due to antisocial or violent behaviour. For the MST-CAN programme, there needs to be a significant risk of child abuse and neglect. Of the nine pilot sites included in the RCT, children's social care was the main referral agency, over an approximate 18 month time frame per site, with 42% of the total number of referrals (Fonagy, START Study, personal communication, 1st March 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.

Social workers tend to take a care management approach and refer families to appropriate interventions and this may well account for higher referrals from this source than for example from Youth Offending Services (YOS) who usually carry out the work themselves drawing on the range of different professionals working within YOS. Many MST teams forged close working links with social workers who were able to see the results of MST first hand and to witness the higher levels of satisfaction reported by families about the services they received from MST.

**Barriers and Strengths of the MST model**

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

Table 1: The advantages and limitations of MST as an intervention for children on the edge of care

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

**Barriers of MST**

*Does not target everyone*

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, for example 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 antisocial 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 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 general 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 in set up and ongoing service development.

*Intervention is limited to three to five months even if family have not met outcomes*

One of the underlying assumptions of MST is that change can occur quickly (Henggeler et al, 2009). 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 put on the MST team to extend the intervention, however the evidence suggests that extending the intervention would not mean that the positive outcomes would be met. 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 caregiver(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 caregiver 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 criteria 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, for example either through 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 clearer plan for them to return home.

*Demanding role for MST professionals*

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 24 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 12 to 24 young people. As intervention is on average four months, at most the annual capacity of a fully staffed team ranges from 36 to 72 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. One of the main strengths of MST is that there is a strong body of evidence, especially from the US but increasingly across other countries, that it is effective both in the short term and in the long term in reducing 'out-of-home' placements and antisocial behaviour and improving family relationships (Borduin, 1999; Henggeler et al, 2009; Fonagy et al, 2002). Favourable outcomes have also been achieved when comparing MST to 'usual interventions' both in the US, Norway and the UK (Schaeffer & Borduin, 2005; Ogden & Hagen, 2006; Butler et al, 2011).

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% decrease in recidivism were found. The same families were followed up at 13.7 years (Schaeffer & Borduin, 2005) and 21.9 years (Sawyer & 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 22 years previously were also significantly lower. This is seen as indicative of MST's model on improving family relations. These studies would seem to show that this improvement was persisting well into the next generation.

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.

*Cost savings*

MST has been estimated to cost around £8-12000 per family (Author's own, 2013), 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 and 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 his 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). MST aims to empower the parent in increasing responsibility and improve 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, both in the short and 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 24 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, 2011). 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, 2009) 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 & Pinsof, 1986).

*Families do not feel judged or blamed*

There is some evidence to suggest that neither caregivers and nor young people feel judged by the therapist and this helps to improve the therapeutic alliance (Tighe et al, 2011; Kaur et al, in submission; Paradisopoulos et al, in submission). In one qualitative study that interviewed young people up to two years after treatment, specific therapist qualities such as flexibility, warmth and humour as well as the young person feeling respected, listened to and understood helped to foster this relationship (Paradisopoulos et al, in submission). In a similar study of caregivers, the therapist was viewed as neutral, more collaborative and focused on helping the family to move forward (Kaur et al, in submission). Rather than individual family members feeling blamed for behaviours, the intervention helped to develop a shared sense of responsibility for overcoming difficulties. Young

people and parents were able to acknowledge the impact of their behaviours on other parts of the system (Paradisopoulos et al, in submission; Kaur et al, in submission).

*Present focused*

The intervention does not dwell on historical events and there is a clear present-focus to the work. There is evidence that parents, many of whom have been asked to repeat negative events in the past to professionals on numerous occasions, like the shift to focusing on the here-and-now (Paradisopoulos et al, in submission). 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 and these provide a rich source of data that helps with intervention development. Even when treatment has not been successful, or when all goals have not been achieved, 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.

*Strong emphasis on training and development and organisational support*

The MST model has a strong emphasis on staff training and development which is felt to help with preventing burnout. Although staff enter MST from a range of backgrounds, all therapists and supervisors will be trained in the MST model (a five-day training) and will receive quarterly boosters from MST services. The booster topics are relevant to current issues that a particular team may be

experiencing with their clients, for example around peer or school factors. As well as weekly group supervision and consultation, each therapist will receive individual supervision where their own learning and development needs are identified and planned for.

The MST licence agreement details a number of programme practices and characteristics which are required to ensure that the MST is well supported organisationally such as the supervisor taking the lead on clinical decision making and therapists not carrying any additional non- MST cases or having other jobs outside their agency. The extent to which each MST service has met the required programme practices is monitored routinely through the Programme Implementation Review and the results can be relayed back to stakeholders.

*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 recording in their own words and are amalgamated into three or four overarching goals for MST treatment.

In the case of the above, 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 child protection 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, an 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.

*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 rather than rely

on statutory services after MST has ended. 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 practice 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 18 months in the UK (Butler et al, 2011), two years in a Norwegian study (Ogden & Hagen, 2006) and 13.7 years (Schaeffer & Borduin, 2005) and 21.9 years (Sawyer & 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 both at an individual and societal level, preventative services 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 both at a national and international level, high levels of quality control, the cost savings and the strong emphasis on engagement and alignment with the family, amongst others.

In terms of the implications for social work, although MST is not available in every local authority it is important that what is available is reviewed. In general, evidence based interventions are not systematically used or available for 11-17 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 around re-allocating resources in favour of robust research based practice which has been shown to have an impact on reducing care costs.

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