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Hampshire County Council

Effective Interventions and Services for Young People at the Edge of Care

Rapid Research Review

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OXFORD BROOKES UNIVERSITY

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1 Introduction

The Institute of Public Care (IPC) at Oxford Brookes University has prepared this summary review of evidence for Hampshire County Council. It forms part of their Innovation Fund 'Active Agents for Change' Evaluation.

Hampshire County Council with the Isle of Wight, was successful in its application to the Department for Education (DfE) for a share of the Innovation Fund in order to undertake a major change programme relating to the way in which social care services for children, young people and families are delivered.

The overall objective for the programme is to create the right conditions and capacity for professionals to work more effectively and cost effectively with children and families in order to **get it right first time** and therefore to reduce the demand for more remedial or repeat interventions – in other words, to become 'active agents for change'.

This review has been prepared to inform the activities of the programme work stream concerned developing an edge of care service. It has also been prepared to support lines of enquiry for the evaluation of this work stream.

A number of key assumptions and implications are associated with the prospective outputs and outcomes for the 'Edge of Care' work stream and these are summarised within the relevant Theory of Change (Appendix One). This document has also suggested particular lines of enquiry for the review and critical assessment of available evidence.

The source material for this rapid research review has been obtained through a literature search comprising four main strands:

1. Thomson Reuters Web of Science and Google searches using appropriate search terms.
2. A search of the following academic journals (using the same search terms as above) for the period 2005-15: British Journal of Social Work;

Child & Family Social Work; Journal of Social Work; Research in Social Work Practice; Child Welfare; and Journal of Children's Services.

3. A search for relevant articles within two practice-focused publications: Community Care and Practice (BASW).
4. A search for relevant materials within the SCIE online resource and other on line resources from key sources such as the Department for Education website

The overall picture set out below derives from a mix of academic research-based evidence, government commissioned reviews, and best practice guidance.

2 Context

Just under ten years ago, the Green Paper 'Care Matters' (2006) argued that we "*should concentrate our efforts on avoiding the need for care, except for those who truly need its support. We must identify problems earlier and respond quickly and effectively. And our responses must be driven by what we know are the key characteristics of effective interventions:*

- ***multi-disciplinary*** *and multi-agency;*
- ***centred around the child****;*
- ***sustained****, with support continuing as long as it is needed; and*
- ***evidence-based****, i.e. grounded in robust evaluation of what works".*

The Green Paper anticipated then a shift towards implementing early and also more effective preventative action to support families so that fewer children need to become looked after.

2.1 What is the 'edge of care'?

In relation to children and young people of all ages, 'edge of care' is used to describe children and young people who **are at imminent risk of becoming looked after** or where care is a live option whilst managing risk in the home placement e.g. through a child protection plan.

In relation to the Innovation Fund, the Department for Education suggests that the term is most often used to refer to work with:

- Families where there are **significant child protection concerns**, where child protection plans are in place and during the early stages of court proceedings and where social workers are having to make decisions on whether sufficient change is possible to allow the child to remain at home (Ward et al 2014)

- Young people where the appropriate social care manager has agreed that they should otherwise be accommodated, but where an alternative intervention or support package is put in place to safeguard them – i.e. as a **direct alternative to a long-term care placement**. This would include those provided with respite care, or those who have been accommodated in an emergency where the aim is for them to return to the family quickly with appropriate support (Dixon & Biehal 2007).
- Children and young people who **cease to be looked after and** return to their parents or wider family network where further support is needed to prevent re-entry to care and to ensure they are safeguarded.
- Children and young people whom the social care manager considers will need to enter care imminently (within a matter of days or weeks) without significant support. This could be where **needs are escalating -** behaviour, family relationships or other problems are worsening and current levels of support are insufficient.

However, in many local authorities in recent years, it has become commonplace to talk about adolescents on the 'edge of care' in particular or to provide a distinct 'edge of care services' relating adolescents and their families. In practice, 'edge of care' for other age groups appears to be more incorporated into the work of generic child in need or child protection teams.

An Ofsted survey (2011) found that 'edge of care' meant different things to different local authority areas even in relation to young people, and definitional differences are also still fairly common within the literature. Examples from this review confirm that variation, for example:

- Young people aged 11 years and over for whom entry into care had been considered by the local authority, either on a voluntary basis or through legal proceedings, but who had not entered care (Ofsted 2011).
- Children who may be placed away from home because of serious child protection concerns but where parents are ready, willing and able to make sufficient changes to ensure that they are adequately safeguarded from harm (Ward et al 2014).
- Describes older children (over the age of ten) in circumstances where care is needed imminently (for example today or tomorrow) or where there is no immediate crisis but there is a likelihood of care in the near future. 'Edge of care' can also include young people who are returning home from care.
- Refers to those whose family is at risk of breakdown or, conversely, where the child is being returned to the family following a period in care (National Children's Bureau 2013).
- Where the young person has been identified as being at risk of needing care; In care before a long-term decision has been made about the future of where the young person will live; when a young person is leaving care by going home or to live with a relative (Gloucestershire County Council).

In a comparative study, Bowyer and Wilkinson (2013, p. 27) also point out that in some countries (e.g. Germany, Denmark and France) the 'edges' of care are less clearly demarcated in comparison to England. This, they believe, *reflects a different conceptualisation of placement (away from home), which is considered as a (more) positive choice among the options for intervention with a child and family.*

2.2 Which young people are to be found at the edge of care?

Young people at 'the edge of care' are of course not a homogeneous group. There are many different patterns of need that lead to a young person becoming looked after.

Asmussen et al (2012) found that children at the edge of care typically include:

- Children at risk of out-of-home placement due to parental abuse or neglect.
- Children who are in high conflict with their families and are difficult for their parents to manage.
- Children whose parents suffer from poor mental health, a severe disability or substance misuse problems.
- Children who have offended or at serious risk of offending (e.g. children excluded from school).
- Children who have previously been looked after.

However, a number of recent unpublished edge of care audits undertaken by the Institute of Public Care for individual local authorities suggest that additional groups of young people at risk of late entry into care may include:

- Young people with a disability / learning disability including those on the autistic spectrum who have been previously adequately cared for by their families.
- Young people at risk of sexual exploitation / sexual abuse.

The Department for Education Research Review (2014) found that the reasons for entering care and the level and complexity of need are far more diverse for young people than for other age groups. For example, the review found that, by the age of 14 years, abuse and neglect counts for just 42% of entries to care with 45% accounted for by a mixture of acute family stress, family dysfunction and socially unacceptable behaviour. However, it is important to note that, behind these descriptions commonly used to describe the primary reason(s) for an intervention, other factors such as earlier abuse or neglect may also exist.

The balance of child, family and environmental factors precipitating risk of entry to the care system may alter as young people get older. Alternatively,

key risks such as absent parenting, socially unacceptable behaviour and family dysfunction may all increase in tandem over time.

2.3 The impact of care

In general, the cost of care rises as age and severity of need increase. This isn't just about the more extensive use of residential provision for this cohort. Evidence shows that delaying entry into care for some children may be extremely costly both in terms of increased damage to the child's development, increasing difficulty in meeting their needs, delayed permanence as well as increased costs of placements (National Children's Bureau 2013).

In England, the biggest single group of the looked after population are aged between ten and fifteen years. It is well documented that the outcomes for this group of young people are much worse when compared to children living at home. They tend to experience a larger number of placements, a more disrupted experience of care, poorer outcomes in education and are struggling more when they leave care.

Many young people who enter care late do go on to return home at some point. However, Davies and Ward (2012) also identify that around two-thirds of maltreated children who return home from care or accommodation are subsequently readmitted; this rises to 81% in the case of children whose parents are misusing drugs.

Concerns about the overall pattern and impact of care for this cohort prompted the Association of Directors of Children's Services (ADCS 2013) recently to conclude that the current system provides neither value for money across the care sector the outcomes do not justify the costs – nor a sufficiently clear expectation of what success should look like.

3 Key Findings from Existing Research

Knowledge about 'what works' is improving; it is important to use existing evidence well, to ensure that interventions are selected on the basis of their proven effectiveness and to evaluate them rigorously.

(Davies & Ward 2012)

3.1 Overview

Much of the existing research in this area relates to young people with particular edge of care presentations, for example those in the research by Asmussen et al above, rather than 'newer' groups such as young people on the autistic spectrum. With this in mind, a recent review of provision at the edge of care undertaken on behalf of the Department for Education (2014) found that the research, inspection evidence and the views of those working

directly with troubled adolescents are all strikingly consistent on the most important factors in providing effective support.

The factor most commonly cited in the literature as being essential in determining the difference between success and failure of an intervention is the quality of the relationship between the worker and the young person. The ADCS (2013) argue that the professionals delivering the interventions and the relationships built between the professional and young person and their family are as important as the interventions themselves.

Other recent overview reports have identified similar findings, for example, Ofsted (2011). Specific features of effective professional / family relationships identified by Ofsted in 2011 included:

- Openness and honesty.
- Absolute clarity about the paramount needs of the young person, what needs to change and the consequences of not doing so.
- Persistence and reliability.
- Responsiveness and flexibility.
- A positive, strengths-based approach which involves the young person and family in identifying solutions focusing on the needs of the child while recognising the wider role and needs.

Mason (2012) found a number of elements that enabled the relationship between key professionals and parents to work successfully. These included:

- Respectful communication: trust, honesty and feeling safe.
- A shared goal.
- Practical assistance and an understanding of parents' own needs.
- Reliability and being available.

3.2 The organisation of services

In addition to the qualities of the professionals involved, Ofsted (2011) found that the most successful edge of care services were those which incorporated a number of features including:

- Explicit and clearly stated models and methods of intervention, and a repertoire of tools for professionals to use – encouraging programme fidelity.
- Strong multi-agency working both operationally and strategically including strategic analysis and understanding of the needs of this cohort of young people accompanied by investment in services to address these needs.
- Preventative interventions that take place alongside assessment.

- Clear and consistent referral pathways to services.
- Clear planning for case closure and for sustainability of good outcomes.

These are largely unremarkable as essential features of good provision and are applicable across a variety of organisational forms. At the same time, as a review commissioned by ADCS (2013) points out, there is no single model of adolescent care provision in operation currently in England, nor in operation elsewhere that could be adapted to better serve the needs and meet the outcomes of all adolescent entrants to the care system. In addressing the care and community elements of support and the balance between them, the requirement is for a range of provision, commissioned to address the diversity and heterogeneity of the adolescent population either in the care system or where probability of entry without intervention is assessed as more rather than less likely.

Options for local organisation typically include the following or combinations of the following:

- A range of intervention services specifically focused on this group.
- The location of staff with a preventative focus for young people within social care teams.
- A designated 'edge of care team' which might encompass services to support families to keep young people safely at home and enable those who have come into care to be reunified successfully with their families.

This review didn't identify evidence specifically endorsing any one of these or similar variations in form.

3.3 Specific interventions

There has been growing attention at national policy level to the value of evidence based programmes for looked after children and children on the edge of care or custody. These include 'manualised' interventions which have prescribed steps and procedures requiring high levels of practitioner skill and interpretation in order to ensure individual needs are met, such as Multi Systemic Therapy (MST).

These programmes are not suitable for all young people on the edge of care. For example, there is no evidence that MST is effective in young people with severe pervasive developmental delay or primarily psychiatric needs or where there is an assessed risk of suicide. Overall, many studies have found that interventions are only effective where therapists adhere to the treatment model, for example Sexton and Turner (2010).

3.3.1 Multi Systemic Therapy

Multi Systemic Therapy (MST) is an intensive family intervention for children and young people aged 11-17 years and their families where young people are at risk of out-of-home placement, in care or custody and families have not engaged with other services. MST draws on theories of social ecology and uses techniques such as cognitive behavioural therapy and family therapy. In contrast to services for adolescents that focus on professionals working directly with young people, the emphasis is on supporting the whole family to make changes. The MST therapist is on-call 24 hours a day, seven days a week and provides intensive support in homes, neighbourhoods, schools and communities over a period of three to six months. The MST therapists are professionals from a range of disciplines such as psychology, social work and family therapy. Fidelity to the programme is important and the originators have developed very strict treatment protocols. For example, one of the assumptions of MST is that change can happen quickly. Once the programme timeline has been reached, the intervention cannot be extended even if families have not achieved the goals that were set at the outset.

A number of methodologically rigorous randomised control trials have been carried out in the United States and other countries by the programme developers. These have found that MST is significantly more successful than normal services in improving family relationships and reducing both the short and long-term rates of re-offending amongst serious young offenders. Studies have also shown that MST is cost effective in the long-term: £5 (in projected future costs on prison, crime, health and other services) is saved for every £1 invested in the programme. Fox and Ashmore (2014) cite cost estimates of between £8,000 to £12,000 per family for this programme and suggest that:

"[MST] can be seen as expensive when compared to other types of treatment such as parenting interventions or individual therapy provided by CAMHS…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." (Fox and Ashmore, 2014, p. 10)

Bowyer and Wilkinson (2013) cite evidence from a recent randomised control trial undertaken in England by Wiggins et al (2012) with an ethnically diverse sample of 108 families. Results showed that, compared with the control group at 18 month follow-up, MST had provided significantly reduced non-violent offending, youth-reported delinquency and parental reports of aggressive and delinquent behaviours.

In a recent review of MST intervention offered by Action for Children (2015) at various sites across the UK, they found performance in all services at the level of national expectation for MST services in that 80%-90% of young people referred will be diverted from care safely.

3.3.2 Multi Systemic Therapy for Child Abuse and Neglect

Multi Systemic Therapy for Child Abuse and Neglect (MST-CAN) is a variant of MST for families where there is evidence of child abuse and neglect. The evidence for MST-CAN is also good, involving one recently completed recent randomised control trial demonstrating significant reductions in abusive and neglectful parenting behaviours as well as out-of-home placements. In addition, parents participating in MST-CAN were significantly more likely to report improved mental well-being and increases in their informal family support networks in comparison to families participating in the control group. Significant improvements for children included reductions in post- traumatic stress disorder and other anxiety related symptoms (Asmussen et al 2012).

3.3.3 Functional Family Therapy

Functional Family Therapy (FFT) is another evidence-based programme offering intensive, 'whole family' intervention for young people aged 10–18 years with a history of offending or with violent, behavioural, school and conduct problems. It aims to address problems in children's behaviour by changing family interactions. It uses family behavioural therapy over a three-month period delivered in a variety of settings – home, youth offending forum, institution or clinic. FFT therapists come from a range of professional backgrounds such as mental health workers, probation officers and behavioural therapists. Some recent randomised control trials evaluations have shown reduced recidivism in offending youth and improved family communication, whilst others have not found significant differences (Bowyer and Wilkinson 2013).

In a more recent Scottish pilot of FFT, Action for Children (2015) found good results on young people remaining at home and school attendance together with the identification of significant cost savings for the local authority involved.

In the DfE funded 'Step Change' project with three London boroughs, Action for Children is bringing together MST, FFT and MTFC (Multi-dimensional Treatment Foster Care) as part of establishing a single pathway to improve long-term outcomes for young people on the edge of care and those and those living in residential care. The aim is to keep over 200 families together over a five year period. Arguably by delivering these three evidence-based programmes together, the most appropriate intervention can be chosen to best meet the identified needs of the individual. The project is yet to be evaluated, but it is anticipated that positive impacts for young people will be achieved as well as savings to the authorities involved.

3.3.4 Family Intervention Projects

Family Intervention Projects (FIPs) work with families experiencing family dysfunction, socially unacceptable behaviour or low income. While there are

important differences between individual FIPs, they tend to share many key features, namely the goals of preventing the placement of children with local authorities and 'strengthening' families achieved through working intensively over a short time period. Although they were originally established with the intention of preventing social exclusion, a significant minority of families that undergo FIPs have child protection issues.

The Centre for Evidence and Outcomes (C4EO, 2010) cited evidence for the effectiveness of FIPs including progress in addressing protection concerns and reductions in parental problems linked to family breakdown and maltreatment. However, in a review of interventions for young people, Fox and Ashmore (2014) noted the variations in practice and an overall lack of an extensive evidence base for interventions undertaken under the banner of FIPs, a state of affairs not acknowledged by the earlier Ofsted (2011) review. Fox and Ashmore (2014, p. 4) have drawn attention to published findings which 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."*

3.3.5 Intensive Family Preservation Services

The Intensive Family Preservation Service (IFPS) approach has been influenced by similar interventions in America operational since the 1970s. Services primarily provide short-term and intensive services. These programmes are introduced to reduce the need for placing children in care by addressing crises, improving family functioning and promoting the use of social support systems. Ward et al (2014) cite evidence from American meta-analyses showing little impact of IFPS on preventing children being placed away from home although there is some evidence for improved family functioning. IFPS have also been implemented and evaluated in the UK. For example Option 2, a Welsh intensive family preservation service aimed at reducing the need for children to enter care from families experiencing parental substance misuse. Evaluation found that although the service could delay entry it did not reduce the likelihood of entering care. Ward et al (2014, p. 107) noted that in these evaluations "*there is some indication that the brief intensive crisis intervention characteristic of IFPS may not be of a long enough duration to help families in which there are concerns about child abuse and neglect to address complex and entrenched problems sufficiently to prevent their children from coming into care.*"

3.3.6 Parenting Programmes

A number of parenting programmes and interventions have been extensively and positively evaluated but evidence for their effectiveness concerning the edge of care cohort is more variable. Ward et al (2014) find that the impact of Triple P may have been overstated and, in particular, that

the programme may be less effective with disadvantaged parents whose children are on the edge of care. Evaluation of the Webster Stratton Incredible Years Programme by contrast has found statistically significant evidence of improvements to parenting skills and a reduction in parental depression, both with large effect sizes but this programme is of course designed mainly for parents of younger children.

Parents under Pressure (PUP) is an intensive home-based parenting programme developed in Australia specifically to address the needs of multi-problem families. PUP begins with a comprehensive assessment and case conceptualisation conducted collaboratively with the family. As part of the process, specific targets for change are identified and these form the focus of the intervention which is delivered over a ten to twelve week period. Ward et al (2014) cite a small randomised controlled trial showed PUP to be effective in reducing parental stress and methadone dose, and there were significant improvements in children's behavioural problems.

Parenting programmes can also help learning disabled parents to acquire adequate parenting skills to provide sufficient and safe care, but such parents are likely to need long- term support to adapt to new challenges. There is evidence that parents with learning disabilities are able to acquire adequate parenting skills to provide sufficient and safe care for a child through parent training programmes, home based safety interventions and developing supportive peer relationships (Ward et al 2014).

Overall, elements of parent training programmes that emphasise the development of self-efficacy through learning the skills of sensitive, responsive parenting tend to have a positive impact on the types of parental problem that increase the risks of maltreatment.

3.3.7 The use of residential care

This review has identified a number of current practice pilots and linked evaluations (completed or proposed) concerned 'reframing' the role and use of residential care as part of a positive intervention at the 'edge of care'. They include a pilot of residential short-breaks with intervention enhanced by the use of the voluntary and community sectors to support key activities (in Shropshire). The Shropshire project anticipates a quarterly saving of just over £27,000 for each young person who is prevented from being received into local authority care through the offer of a short breaks support service to the family.

An earlier study into the role of residential respite care as a preventative intervention found some positive benefits for the young people concerned and their families:

"Periods of respite not only relieved pressure but gave young people and parent's time to reflect and to respond to the interventions by the professionals involved." (Dixon and Biehal, 2007, p. 74)

The cohort of children involved in this study had a range of multiple and complex needs, including some with challenging behaviour. Overall, the impact of a combined respite care/community support intervention seemed more likely to be successful in families where parenting was *perhaps rather weak and inconsistent, but parents nevertheless felt some continuing commitment to their children, despite the difficulties they were experiencing with them* (Dixon and Biehal, 2007, p. 76). Behavioural strategies, e.g. anger management, boundary setting, which formed part of the offer tended to be less successful where parental engagement was poor and there had been a longer history of parental rejection and emotional abuse. The authors nonetheless conclude that respite care can form a key element to an integrated family support service for young people at the edge of care and may make an important contribution to preventing long-term family breakdown. The study did not address issues of cost or cost-effectiveness.

Dowling et al (2012) in a review of the literature on disability provision found strong indications in the literature that unmet family support needs impact on parental ability to continue caring for their disabled child at home, particularly for parents of children presenting with multiple and complex needs or challenging behaviour. Insufficient domiciliary or residential short break support is reported to cause some families to seek permanent out-of-home placement for their child.

The argument for the provision of enhanced short-break provision drawing on residential resources is endorsed in a review by McConkey et al (2011) of a specialist model of short break **and** intensive outreach support for families and disabled young people presenting with severely challenging behaviour (up to 19 years old) delivered by a national voluntary organisation in three UK cities. The model was found to be effective for families in continuing to manage challenging behaviours within the home environment and in the view of the authors demonstrated the need for specialist short break provision to be included in the network of service supports available to families.

4 Summary of Key Messages

Young people's needs cut across organisational and service boundaries. There is no single model or approach that will effectively tackle the diverse needs of adolescents in or on the edge of care.

All young people at risk of care or entering custody should have access to evidence-based interventions which aim to enable them to remain safely at home. There is a developing evidence-base of what is and what is not effective for this cohort. At the same time, care including residential care is

the right option for some children. Abused or neglected children tend to do better in care than those who remain with or return to parents who are unable to change.

There is a predominance of crisis admission into care for this cohort. At the same time, the reasons for entering care, and the level and complexity of need, are especially diverse amongst this group. This points to the need for a range of responsive, adaptable and flexible services and interventions on offer across local systems.

The quality of the relationship between key workers, the young person and their family is consistently found to be the central factor in making the difference between intervention success and failure.

Intensive, multi-faceted and integrated interventions for families with complex needs are more effective than routine services. Support plans should reflect the need to step-up and to step-down the intensity of support as required. The intensity of whole family interventions should be increased where there is a real risk of care for a young person.

There is clear evidence that disabled children are more likely to be looked after, remain in care for longer and have a higher risk of being placed inappropriately in comparison to non-disabled children. In addition, young people with ASD-related conditions/ADHD and with parents who have mental health problems are at particular risk of late accommodation. The use and impact of interventions not involving residential provision is, however, poorly researched for this cohort at the edge of care.

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Appendix One

Hampshire and Isle of Wight Theory of Change: Edge of Care

What's the problem? What needs to change?	What do we need to do to effect change?	What will look different by November 2016 if we do these things?	What longer term outcomes will result if we succeed?
Too many young people coming into care late in adolescence when this may not be the best option for them.	▪ Create additional capacity within the whole system to enable more creative and bespoke packages of support to be constructed for young people who are on the edge of care for example: respite options; positive activities.	▪ More suitable options available for young people on the edge of care to support continued safe living at home.	▪ More young people (aged 14+) safely prevented from coming into long term care / safely living at home including some with ongoing support packages for example with regular respite. ▪ More young people who have been on the edge of care are subsequently engaged in education, employment or training and have better outcomes more generally. ▪ Other children of the family are better parented and have better outcomes.