LOCAL AUTHORITY SOCIAL SERVICES LETTER - LASSL(2005)1

To: The Chief Executive
   County Councils
   Metropolitan District Councils ) England
   Shire Unitary Councils )
   London Borough Councils
   Common Council of the City of London
   Council of the Isles of Scilly

   Chief Executive - Care Trusts
   Chief Executive - Strategic Health Authorities

The Director of Social Services              20 January 2005

SPECIAL GRANT FOR THE DEVELOPMENT OF MULTI-DIMENSIONAL
TREATMENT FOSTER CARE (ENGLAND) PROGRAMMES

Summary

1. This letter informs Councils with Social Services Responsibilities (CSSRs) of arrangements, via a bidding process, for the allocation of up to £3million in 2005/06 to support the development of a fourth tranche of Multi-dimensional Treatment Foster Care (England) Programmes.

Action

2. CSSRs who are satisfied that they meet the strict criteria to bid for Multi-dimensional Treatment Foster Care (England) programme resources (see paragraph 3 of Annex A attached) and wish to do so should:

   • plan with local health commissioners within PCTs, local education authorities, youth offending teams and youth inclusion programmes (if in existence locally) voluntary sector providers of social care for children and adolescents and carers (including birth parents and foster carers) the capacity for developing the programmes as outlined in Annex B attached;

   • draw up detailed proposals for a bid in co-operation with other relevant agencies and interest groups. The signatures of relevant partners must be included on the application form for each programme. Agreement from members of the Council should also be evidenced.
3. An application pack is available in either electronic format or hard copy from Sue McFarlane, Room 125 Wellington House, 133-155 Waterloo Road, London, SE1 8UG (Tel: 020 7972 4284, email: sue.mcfarlane@dfes.gsi.gov.uk). The deadline for receipt of completed applications is Thursday 3 March 2005. Please note that there will not be an extension to this date.

Background

4. Social Services have for some time experienced difficulties in securing appropriate placements for children and young people who are looked after. There is a particular difficulty in securing effective placements for young people with challenging and anti-social behaviour and complex needs, including offending behaviour and self-harm. Such young people are frequently placed in a sequence of expensive out-of-area placements, which do not improve their outcomes.

5. It is recognised that CSSRs find it difficult to commit resources to innovative projects when the budget is fully committed to funding current placements. The Multi-dimensional Treatment Foster Care pump-priming grant therefore provides the opportunity to develop a valuable local programme using a specific well researched and effective model that will increase the options available for placing children and young people appropriately.

6. The priority being given to improving the commissioning and delivery of children’s placements and other services (the Choice Protects Programme), the commitment to delivery of the new PSA target on placement stability as well as the PSA target to improve CAMH services and the current emphasis on multi-agency working all contribute to the timeliness of developing Multi-dimensional Treatment Foster Care (England) programmes which offer both a local placement and an effective treatment intervention. These programmes have a key role in delivering the outcomes set out in “Every Child Matters: Change for Children” for some of the most vulnerable looked after children.

Criteria for Selection of Sites

7. Annex A to this letter outlines the background to the project and provides information about the criteria for the selection of sites. Annex B provides further information about the model of Multi-dimensional Treatment Foster Care.

Cancellation of Circulars

8. This letter should be cancelled on 31 March 2008.
Enquiries

9. Inquiries about this letter should be addressed to Jim Brown, Room 125, Wellington House, 133-155 Waterloo Road, London SE1 8UG (Tel: 020-7972-4431, email: jim.brown@dfes.gsi.gov.uk).

NB:

10. The Department for Education & Skills Looked After Children Division is moving to new premises at the end of February 2005. Precise details are not known at this stage and it is therefore suggested that you contact either Jim Brown or Sue McFarlane (via email as these will remain unchanged after the move) so that they can advise on the correct address to send the hard copy of your local authority’s grant application.

DAVID HOLMES
Divisional Manager
Looked After Children Division


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The aim of the Multi-dimensional Treatment Foster Care (England) programme is to develop a locally based intervention to improve outcomes for looked after children and young people who have serious behavioural difficulties or other complex needs. The programme will replicate the model of Multi-dimensional Treatment Foster Care (MTFCE) developed by the Oregon Social Learning Center in the United States.

Criteria to be met by Councils with Social Services Responsibilities (CSSRs)

1. CSSRs should only make a bid if they can show evidence of the following:

   - existing, effective joint planning arrangements and programmes across social care, health, education and youth justice services;
   - an analysis of the needs of looked after children with severe emotional or behavioural difficulties, anti-social or offending behaviour in their area;
   - clear support for the bid within the fostering team;
   - an understanding of and commitment to setting up the specific Multi-dimensional Treatment Foster Care model (see Annex B);
   - a clear commitment from the local providers including CAMHS, education and social services to participate fully in the programme team – we do not consider that virtual teams will offer sufficient hands on support for this particular project;
   - a clear commitment to work closely with the National Treatment Foster Care Team based at the Maudsley Hospital in London and Booth Hall Children’s Hospital in Manchester in developing and implementing the programme according to the requirements of the model and to undertake the central training provided (see below);
   - a commitment, capacity and a clear plan to continue the programme beyond the pump-priming funding stage. Ultimately the programme will support ten placements but initially numbers are likely to be smaller.

In addition you should be aware that:

   - only one child or young person on the treatment foster care programme should be in a placement at a time;
• agreement to a holistic assessment covering physical and mental health and education for each child entering the programme will be required. Training in the application of the assessment tools to be used will be provided;

• planning for step down arrangements as the child reaches the end of the treatment foster care placement are crucial to successful outcomes and should be considered from the outset.

Referral Criteria

2. It is appropriate to consider treatment foster care for the child or young person if they:

• are aged between 12-16 years (individual teams may agree a specific age range within these parameters);

• have complex and severe emotional or psychological difficulties;

• or are displaying severe levels of challenging/anti-social behaviour;

• or are involved in crime and may be at risk of receiving a custodial sentence;

• and are likely to be able to learn from and respond to a closely supervised individually tailored programme;

• and their birth family and other persons with parental responsibility as appropriate are able to consent to joining the programme;

• are likely to have had a number of placements or interventions.

Young people who are unlikely to be suitable for treatment foster care are those:

• who pose a very high risk to others and who are assessed as unsuitable for placement in the community e.g. indiscriminate physical violence;

• who have a significant learning disability, cognitive or receptive language difficulties with a degree of impairment likely to limit their capacity to participate in the programme;

• with significant mental health problems posing a very high risk and/or requiring in-patient treatment including severe depression and suicidality, psychosis, severe eating disorders and substance misuse requiring a detoxification programme.

Some broad guidelines to follow:

• admissions to Multi-dimensional Treatment Foster Care (MTFC) will not be on an emergency basis but as part of the child or young person’s care plan
following an assessment, which identifies MTFCE as the most appropriate programme to meet their needs;

- in the early stages Multi-dimensional Treatment Foster Care programmes should take children and young people who are easily identified as likely to make progress in the programme, in order to increase the chances of a successful outcome for the young person and to increase the skills and confidence of the foster carers and other members of the team. As the skills and confidence develop children and young people with higher levels of difficulty can be supported in the programme.

The Grant

3. The treatment foster care grant is a pump-priming grant to meet initial start-up costs. It is recognised that it is difficult to fund new projects when the budget is fully committed on current placements. The grant will therefore be provided to cover:

- all staff costs for the programme for approximately six months during the period of recruitment and team training;

- foster care set up costs including recruitment, assessment and preparation costs. Payments to carers are not included except “holding payments” made to carers post approval whilst awaiting first placement;

- It is not intended to provide funding for running costs.

Once established, CSSRs will cover all the placement costs of the young people. Placement costs of these programmes are lower than equivalents in residential care and secure accommodation. Total grant value is expected to be in the region of £400k per programme and it is likely that up to 5 new programmes will be funded for the financial year 2005/06. The support for the phase 4 programme is expected to run over the financial years 2005/06 and 2006/07.

Development Support, Training and Consultation

4. One of the purposes of this grant is to increase capacity for effective interventions with severe emotional and behaviour problems including offending behaviour and to evaluate this nationally. Accordingly the projects will be co-ordinated centrally and training in the intervention and the development of the teams will be provided to ensure coherence and consistency of delivery and fidelity to the MTFC model.

5. The developmental support, training and consultation contract has been awarded to the South London and Maudsley NHS Trust and teams will be supported from two sites based in London and Manchester.
6. A ‘readiness to place’ audit will take place at the point of children entering placements to ensure that all the essential elements of the model are in place to provide a safe and effective intervention.

Evaluation

7. The programme will be subject to rigorous national evaluation either through a Randomised Control Trial (RCT) or other similar research methodology and all individual programmes will be part of the national evaluation.

8. In addition a commitment to local evaluation to inform future policy development and support successful replication of the programmes elsewhere will be expected.

9. Successful applicants will be expected to use a small amount of grant monies (in the region of £1,500 per annum for up to 12 young people) to fund a Web-based data entry system to monitor young people’s responses to the programme as part of the local and national evaluation.
MULTI-DIMENSIONAL TREATMENT FOSTER CARE:-
IMPLEMENTATION IN ENGLAND
Stephen Scott and the National Treatment Foster Care Team – Maudsley Hospital

Introduction

Background

1. There is considerable concern about the outcomes for looked after children in England. As a group they are more troubled than others; up to 70% of teenagers have psychiatric disorders compared with 10% living at home (McCann et al 1996); two thirds are reported to have at least one physical complaint (Meltzer et al 2003) and their life chances are considerably poorer. About two-thirds (63% in 2001) have no formal qualifications, perhaps not surprising in view of the fact that up to 30% are out of mainstream education through exclusion or truancy (Social Exclusion Unit 1998); repeated change of schools is common, not only due to difficulties experienced there, but also due to foster care moves (Morgan 1999). Crime is also common – 38% of young prisoners had been looked after (SSI 1997). Children at the greatest risk are those who have more than one placement due to breakdown and stable placements are linked to positive outcomes, especially in respect to relationship skills, good education, and employment outcomes (Koprowska & Stein 2000).

2. The research project by Professor Ian Sinclair and colleagues at York (recently completed under the Department of Health’s Parenting Initiative research) suggests three factors are involved in placement breakdown: the foster parents’ confidence in their ability to handle problems, the severity of the child’s mental health problems, and a ‘click’ factor; the extent to which the chemistry works on how the parents get on with the children. Further analysis of this ‘click’ factor suggests that it is largely influenced by the degree of disruptive behaviour in the child. Because of this, training and supporting foster parents to look after these children as well as possible and keep them in a stable placement are likely to lead to better child outcomes.

Improving Foster Care

3. There have been over 40 published studies of a range of interventions to improve foster care, reviewed by Reddy and Pfeiffer (1997). Substantial improvements were shown overall by lengthening the placements of hard-to-manage adolescents with skilled foster carers, and improving their social skills. Most promising has been the Multi-dimensional Treatment Foster Care (MTFC) model devised by Chamberlain and colleagues at the Oregon Social Learning Center (OSLC) (reviewed in Chamberlain and Moore 1998). The main evaluations have been for adolescents from birth families who otherwise would have been sent to young offenders institutions (Chamberlain and Reid 1998); there is also one trial of its use with psychiatrically disturbed adolescents on discharge from an in-patient stay in hospital (Chamberlain and Reid 1991). All the evaluations show a greater reduction of offending behaviour
and psychological symptoms in young people offered treatment foster care compared with treatment as usual. Also, foster carers liked the training and there was a lower turnover. Aos et al (1999) calculated that for the young offenders treated, treatment foster care saved 14 US dollars for every dollar spent, making it the most cost-effective intervention studied.

The Intervention

4. Multi-dimensional Treatment Foster Care has been developed in the United States as a cost-effective alternative to residential treatment for adolescents with chronic offending and anti-social behaviour. The model has also been shown to be effective with severely emotionally disturbed and abused children and young people and those with developmental delay. The model comprises:

• training for foster carers in a social learning approach based on behavioural principles of reward for sociable behaviour and consequences for anti-social behaviour; foster carers are carefully selected, and take on only one young person at a time, and advice is available to them 24 hours a day;

• family therapy for the family of origin, with the aim of improving the relationship between the young person and their birth family, and where return to the birth or extended family is possible, work intensively with the family using a behavioural framework to help them gain skills in supporting and managing the young person effectively;

• individual therapy for the young person based on behavioural principles in order to develop social skills, and problem-solving approaches and improve emotional, attachment and behavioural functioning;

• close school liaison and support to facilitate educational progress and achievement; skills training in the community to practice social skills and promote pro-social behaviours in a variety of recreational settings;

• close mentoring and tight programme supervision to co-ordinate the elements by a separate, senior member of staff.

5. Foster carers are recruited, trained and supported to provide well-supervised placements and treatment in partnership with the clinical team. The multi-agency Multi-dimensional Treatment Foster Care team provides a coherent, structured “wrap-around” service for the young person, including individual therapy, social skills training and work with the birth or adoptive family.

6. Within the programme the foster carers are provided with intensive support and training in behaviour management methods to provide the children and young people with a warm, consistent and structured therapeutic living environment. Contact between the treatment team, the foster home and the school occurs on a daily basis. Support is also provided to biological (or adoptive) families to ensure that when the child returns home progress can be maintained by using the same methods as those in
the foster home. The foster parents implement an individualised programme for the young person designed by the clinical team to build on their strengths, and to set clear expectations, limits and boundaries with clear consequences and rewards.

7. The approach specifically targets those factors in each young person’s social network, which are contributing to his or her difficulties. It aims to improve relationships and social skills, decrease involvement with an anti-social peer group, enhance educational opportunities and provide positive recreational activities. Specific treatment techniques used to achieve these outcomes in this model are integrated from those therapies that have been shown to be most effective, including cognitive, behavioural, and family therapies.

**MTFC in England**

8. The plan for this project is to replicate the MTFC programme with a high degree of fidelity with looked after children with the addition of a full physical and mental health assessment including for psychiatric disorders and cognitive abilities.

9. Most of the children and young people in this project will be in local authority care due to the inability of the family to provide adequate care, for a range of long and short-term reasons. In contrast, the United States MTFC programmes have taken young offenders living at home until they were sentenced to young offender institutions. Thus in the United States, nearly all are planned to go home, whereas in England, of the more troubled young people who are likely to be offered Multi-dimensional Treatment Foster Care in England (MTFCE) some will be going home or going to relatives, but some may require long-term fostering or even adoption. Work with the family of origin will therefore have an added layer of complexity. The focus of the work with the family will be different if the child is not going home but will include attention to issues of attachment and contact.

**The Target Group**

10. The vast majority will have a range of psychiatric problems and attachment difficulties in addition to frequently displaying aggressive, anti-social and self-destructive behaviours. Therefore a key part of this programme is ensuring that local providers have the assessments available to be aware of all mental health issues, and develop skills in using the MTFCE model to address these issues.

11. To determine what the children’s needs are, all those entering MTFCE should have a thorough psychiatric and psychological assessment, using the framework devised by the National Team. This is in addition to the formally manualised OSLC model.

**Assessment**

12. *Mental health needs.* This is perhaps still an area where insufficient attention is currently given in England. As noted above, up to 70% of children in care have
psychiatric conditions, yet these are frequently missed. Substantial numbers of young people have undetected post traumatic stress disorder, depression, fears and phobias, ADHD, and autistic spectrum disorders. This is especially important for the young people since all of these conditions can be substantially improved by treatment or appropriate care (Goodman and Scott 1997).

13. **Physical health needs.** This domain is also often overlooked. A thorough medical examination (history and examination together taking 40 minutes by a child specialist: not the usual 7 minute GP consultation) not infrequently reveals problems such as short-sightedness, bedwetting and soiling, poorly managed chronic conditions such as asthma, eczema, or epilepsy. Discovering congenital syndromes is not an uncommon experience.

14. **Intellectual level and educational attainments.** Again, whilst new legislation and guidance reflect an awareness of this problem, what happens on the ground is not infrequently sub-standard due to poor resources or lack of personnel or training. Educational psychologists are often overwhelmed by a backlog of assessments for Statements of Special Educational Needs. About 10-15% of looked after children have generalised learning disability (IQ under 70), and up to 30% have specific reading retardation (dyslexia). This means the children need to be taught in a different way, and that their difficult behaviour in class is often due to unrecognised learning disabilities. Their behaviour often improves substantially when they are taught in an appropriate manner for their level, so that they understand the material presented and can gain good self-esteem from mastering it.

15. **Functioning of family of origin.** A good assessment of this is necessary to help understand what the young person has experienced, and how this has contributed to their present difficulties. Since there is rightly a responsibility to return looked after children to their families wherever possible making a careful judgement of how much capacity the family has to look after the child adequately is paramount, and will shape what help is offered them.

16. **The young person’s understanding of their personal story,** how they have made sense of it, their interests and strengths. As well as hearing what the young person has to say and their construction of their story, this requires a good understanding of what happened to them from before they were born to the present. A careful history taking may reveal events and people that are important to an understanding of the young person, but may not initially be volunteered by them.

**The Role of the National Treatment Foster Care Team**

17. The implementation of a high-quality service depends on using evidence-based practice and this requires a strong training and developmental element for the local service. To that end the National Team at the Maudsley Hospital and Booth Hall Children’s Hospital in Manchester are co-ordinating a training, development and consultation service and working closely with the locality teams to provide ongoing supervision in all aspects of the intervention, including advice on the preferred
qualifications and experience of staff appointed to the project, and of potential foster
carers. Both departments have a strong record of developing and evaluating evidence-
based interventions for both emotionally disturbed and acting out children and young
people.

18. The team’s role is to provide training in the MTFCE model, support and
consultation/supervision to ensure that the local authority treatment foster care teams
have the best support possible to deliver a high quality integrated service to their
young people. The underlying philosophy is to implement high quality treatment
foster care programmes with fidelity to the OSLC model, but also to incorporate the
principles and practice relevant to the English context as outlined above, and to
overcome the threats to successful delivery particular to our context.

Further information about this type of intervention is available on the publications and
abstracts sections of the Oregon Social Learning Centre website at www.oslc.org.

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