Clinical Leadership Arrangements: Leicester Multi-systemic Therapy (MST) and Children's Social Care

Multi-systemic Therapy (MST) is delivered in the City of Leicester to families where there is a child aged between 6 and 17and there is a risk of the child being placed into care. The programme targets those at risk of care either through physical abuse and/or neglect, or through the child's anti-social behaviours. MST is a licenced programme which is closely overseen and supported by the National Implementation Service, (NIS) as an evidence based programme to keep children at home. MST is an OFSTED supported programme.

Harper (1995) defined a Clinical Leader as '...one who possesses clinical expertise in a specialty practice area and who uses interpersonal skills to … deliver quality patient care.' It is expected that MST should have clinical leadership. This leadership role is not intended to replace or remove the responsibilities of statutory social work. It does however provide the framework for the inclusion of MST in all relevant decision making that could have impact on the long-term client outcomes. It means ensuring that the various stakeholders involved with any given MST family are coordinating care, as needed.

MST is a licensed, evidence-based program which works with the entire family in an effort to keep children with their families, and help the family resolve clinical and practical concerns so that children can be safe and secure. MST is an intensive therapy, lasting three to nine months that addresses the specific problems that brought the family to statutory services. MST is delivered in the home at times that are convenient to the family; a minimum of three sessions per week. All members of the family are involved in the treatment. Common treatment strategies include Cognitive Behavioural Therapies, Behavioural Therapies and Family Therapies to manage safety issues and promote long term changes to family functioning. The major goals of MST are to keep families together assuring that children are safe, reduce adult and child substance abuse, reduce offending by adults and children, secure and increase child attendance at school, reduce mental health difficulties experienced by adults and children, and increase natural social supports. In order to achieve this MST typically targets issues such as aggression and anger, substance abuse, mental ill health, family functioning patterns and unhelpful beliefs. MST uses Bronfenbrenners (1977) ecological theory of development, as an evidence-based approach to securing long term changes within the ecology.

Referrals in to MST

MST will take referrals that meet the eligibility criteria (Appendix A). Once the referral pathway (Appendix B) is instigated MST requires all current Social Care plans to be up to date and available to support their decision that the referral is appropriate.

MST CAN - threshold for referral

Referrals will be considered where there is a child or children aged 6-17 subject to one or more specific episodes of physical abuse or neglect within the last 180 days. In the case of neglect the Social worker should ensure specific episodes are in existence e.g. children missing medical

appointments, children missing school, lack of provisions to meet basic needs etc. within the last 6 months.

The child/ren should be at home with a risk of family breakdown / risk of care. Alternatively if the children are placed out of home, there should be an agreed plan /date to return the children home within 28 days.

Referrals normally go via Legal Planning Processes; see Appendix B.

MST Standard – threshold for referral

Referrals to MST Standard will be considered where the child is aged 11-17 for the duration of MST and there is a risk of care, custody or residential school if current problems persist. The young person must be living at home with an agreed caregiver, or there is an agreed plan to return the child home to ensure they are not placed for more than 28 days

The young person's behaviour will be of concern across more than one environment, for example, the home, school or community. An example of referral behaviours is shown in Appendix A.

Referrals are accepted from Social Care and can be made directly via the allocated Social Worker, through the Single Assessment Team (SAT), the Legal Planning Meetings (LPM), or the Leicester Access to Resource Panel (LARP).

Where a referral is accepted from the Single Assessment Team, MST will contribute to the joint assessment and planning for the child from the point of accepting any referral.

If the referral is not accepted the referrer will be informed within 48 hours of alternative, suitable provision. The MST Team Manager will record the acceptance or decline of a referral on Liquid Logic and, in the case of decline will record the reasons for this decision.

The MST Team Manager will initiate contact with the family and record this on Liquid Logic.

Initial contact

When an initial visit results in consent to work with MST being obtained by the parent/caregiver, the MST Team Manager will record this on Liquid Logic with the name and contact details of the allocated Therapist. The Therapists involvement will be added to Liquid Logic by the Business Support Officer within 48 hours.

Prior to the first visit, the Therapist will liaise with the allocated Social Worker to obtain the most immediate safety concerns and relevant safety plans. During this first visit the therapist will check that the current safety plans in place are working and amend them. In the event that a safety plan is not in existence but required, an initial safety plan will be completed during this visit.

Safety management

MST will review and update safety plans throughout the duration of treatment utilising pre-existing social care safety plans. This will ensure that the family has one clear safety plan.

Where concerns arise over the adequacy of the safety planning this will be escalated to the relevant Service Manager who, in conjunction with the MST Team Manager agrees a resolution the same working day. Both parties will record this conversation onto Liquid Logic.

Crisis Management

MST operates a 24/7 on-call system to provide support to families when crisis occurs. In an out of hour's crisis situation where a child is deemed at risk, the MST Therapist will notify both the MST Manager on call and the out of hours Duty and Advice Service. The MST Therapist will record the concern and actions onto Liquid Logic within the same working day.

Where a "Need to Know" form is required for completion and escalation; the decision on who completes this form is made between the on duty MST Manager and Social Care Service Manager. The person who completes the "Need to Know" will also notify the on call Head of Service.

Decisions to bring forward review meetings will be made in discussion across all relevant parties, in line with LSCB polices. Both MST Therapist and the MST Manager will be notified by the Social Worker of any decisions as they are made.

Treatment

Within the initial four weeks of MST becoming involved with the family; safety planning and review will be the priority; alongside initial comprehensive assessment.

By week four, the Therapist will have convened a professionals meeting to include the MST Therapist, Social Worker, MST Team Manager and as relevant the Independent Chair or Independent Reviewing Officer. The purpose of this initial meeting is to establish the MST treatment plan and clarify any outstanding areas of need, how these will be met, what will be the evidence of this need being met, who will carry the task out, and by when. This meeting will be recorded on Liquid Logic by the MST Team Manager.

It will be agreed that this is the shared working plan and details of this plan will be transferred into relevant social care plans by the Social Worker at the next planned review and update.

Review

Reviews are conducted on a weekly basis through the MST group supervision and consultation process, whereby checks of quality and care planning receive a two tier approach to oversight. All cases are given full clinical scrutiny on a weekly basis by the MST Manager and the MST Consultant in advance of supervision. Any changes to the overall treatment plan will be shared within 24 hours by the Therapist to the Social Worker and recorded by the MST Therapist and Manager onto Liquid Logic within 24 hours of supervision.

It is expected that MST Therapists attend all Child in Need meetings, Core Groups, Case Conferences and LAC reviews. Where there is a Case Conference, Child in Need Meeting or Looked After Child review the Therapist will submit an overview report of advances, barriers, work completed and work planned. This report will be checked and agreed by the MST Team Manager 96 hours before the meeting. The report will be submitted by the Therapist to the meeting chair 72 hours in advance

of the meeting.

During Social Care review processes all relevant plans will be adjusted to reflect advances, barriers and goals during MST treatment.

Where there is a lack of agreement on the direction of treatment there will be an escalation to the relevant Service Manager who will work in conjunction with the MST Team Manager to agree a way forward within one day. Both parties will record this conversation on to Liquid Logic.

The Local Children's Safeguarding Board (LSCB) escalation policy will be followed in the case of any disagreement, to ensure that the child is kept safe as a priority.

Case Recording

To be read in conjunction with the MST case recording policy.

It is the responsibility of Social Workers and Social Work Service Managers to record key decisions onto Liquid Logic due to the link to statutory working. The MST Therapist will record on Liquid Logic a weekly update of treatment advances, barriers and plans. The MST Team Manager will record a management oversight entry on Liquid Logic following the weekly supervision and consultation process.

The MST Therapist will immediately notify the Social Worker and MST Team Manager of any new safeguarding risks or concerns and record the concern and actions onto Liquid Logic within the same working day.

Case Closure

Social Workers will be advised of planned closure dates at the start of MST treatment. This will be regularly reviewed and professionals updated regularly. In all MST closures, the MST Therapist will discuss and agree an exit plan with the Social Worker, to provide a minimum of four weeks' notice in respect of planned closures.

Discharge from MST may occur when few of the overarching goals have been met, but despite consistent and repeated efforts by the MST Team to overcome barriers to further success, treatment has reached a point of diminishing returns. Where diminished returns are becoming of concern, the MST Manager will discuss and agree an exit plan with the Social Work Manager.

Sustainability

At the end of MST treatment an exit plan will be produced for the family by the MST Therapist and a copy will be provided to the Social Worker. This plan is saved on the EDRMS (Social Care) system within 7 days of closure. The MST exit plan will explicitly specify progress, how progress was achieved, and how it will best sustain. Where there has been limited or no progress, the plan will specify what would help the family to move forward in making progress.

In addition, a Professionals Report will be written by the MST Therapist and a copy will be provided to the Social Worker, where one remains involved. This plan is saved on the EDRMS system within 7 days of closure. This report is intended to provide a more detailed overview of that work which has

been tried successfully and tried unsuccessfully. This will provide other professionals with a clear idea of how to sustain and plan any future work. Where areas have seen improvement, Social Workers are expected to follow the exit plan to generalise and sustain the outcomes.

Evidence suggests that with clear commitment to the exit plan by professionals, families will generalise successfully and continue to improve on progress. Evidence shows that typically there may be a short term deterioration in progress within the first 6 months after MST closure, but with strong commitment to continuing 'what works', this tends to improve at a faster and greater pace in the 6-18 months post-treatment period. The MST team will offer support and guidance on how best to generalise outcomes and can be called in to revisit the exit plan with Social Worker and the family if there is a deterioration post treatment.

One of the key MST licence conditions states that "referrals for additional services after clients are discharged from the MST program should be carefully planned and limited to those that can accomplish specific, well-defined goals. The assumption is that most MST cases should need minimal formal after-care services". Thus a key aim of MST is to close treatment to no new agencies. Where progress is noted on the MST exit plan, the family should not then be referred into new services. A family should never be kept in or referred to other services on the basis of *things might go wrong*

Authors
Sarah Whittle; MST Programme Manager (CAN)
Ivor Sutton; MST Programme Manager (Standard)

Date 12th April 2017 **Review Date** March 2018

References

Bronfenbrenner, U., 1977. Toward an experimental ecology of human development. American psychologist, 32(7), p.513.

Harper J (1995) Clinical leadership – bridging theory and practice. Nurse Educ 20 (3): 11–12

Appendices

Appendix A

MST-CAN Eligibility Screening Form

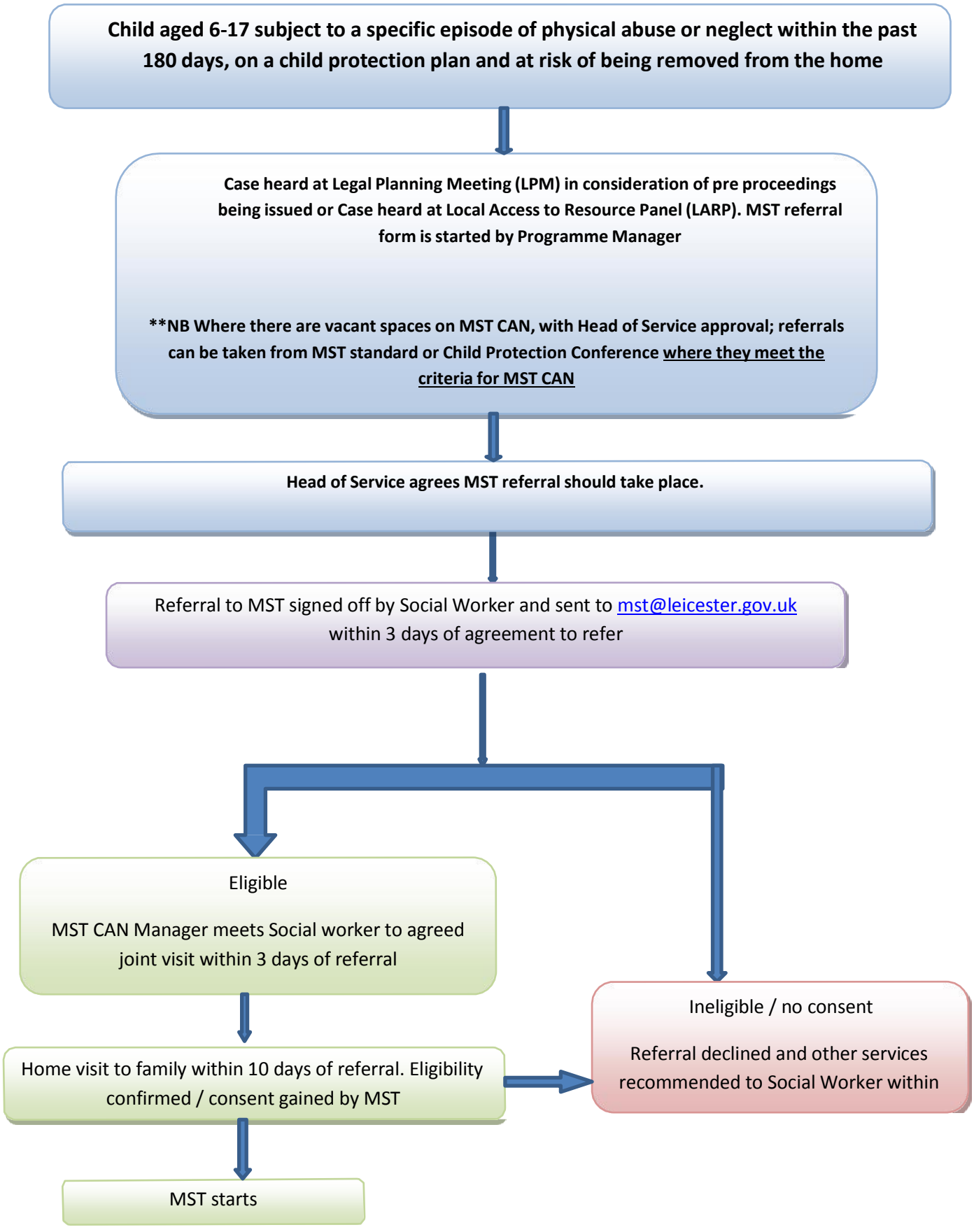
Inclusionary Criteria	**Yes (Eligible)**	**No (Ineligible)**
There is a child/children aged 6-17 subject to one or more **specific episodes of physical abuse or neglect** within the last 180 days ** *Re neglect, please ensure specific episodes are in existence e.g. children missing medical appointments, children missing school, lack of provisions to meet basic needs etc* ***within the last 6 months***		
There is a risk of family breakdown which contributes to a risk of care		
The children are living at home or there is an agreed plan/date to return the children home within 28 days		
The child has gone to LPM or LARP and has Head of Service agreement to proceed to MST CAN OR The case is on a Child Protection Plan for neglect or physical abuse and has the agreement of the Head of Service that it meets the criteria for referral to MST CAN		
Exclusionary Criteria	**Yes (Ineligible)**	**No (Eligible)**
Families where a Section 47 Investigation has not found evidence of abuse or neglect.		
There is active sexual abuse.		
Active partner violence is occurring in the absence of child physical abuse and neglect.		
Children are in care or other placement for which the plan does NOT include reunification within 28 days of placement.		
Child is actively suicidal, homicidal, or psychotic.		
Childs whose psychiatric problems are the primary reason leading to referral or who have severe and serious psychiatric problems.		
Child or adults who have committed sexual offences against family members or other persons.		
Child with moderate to severe difficulties with social communication, social interaction, and repetitive behaviours, which may be captured by a diagnosis of autism.		

MST- Standard Eligibility Screening Form

Criteria	Yes (Eligible)	No (Ineligible)
The young person is aged 11-17 for the duration of MST (3-5 months)		
The young person has a risk of care, custody or residential school if current problems persist		
The young person has **more than one referral behaviour* across more than one environment** *Referral behaviours at home, school, community (not exhaustive): • Young people who are physically or verbally aggressive • Young people who go missing • Young people using drugs or alcohol • Young people committing "traditional" anti-social behaviours in the community • Young people making threats of harm to others • Young people who are committing crimes such as (not exhaustive): o Theft o Burglary o Robbery o Public order offences (affray, section 5 etc.) o Initiation o TWOC o Assaults (GBH/ABH etc.) o Possession/supply drugs o Breach of an order		
The young person is living at home with an agreed caregiver or there is an agreed plan to return the child home to ensure they are not placed for more than 28 days		
Criteria	**Yes (Ineligible)**	**No (Eligible)**
Young People living independently, or for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.		
Young People referred where there are concerns related to current suicidal, homicidal, or psychotic behaviors		
Young People whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.		
Young sex offenders (sex offending in the absence of other delinquent or antisocial behavior).		
Young people with significant learning disabilities or pervasive developmental delays		

Appendix B

MST CAN Referral Pathway



MST Standard Referral Pathway