

---

# A New Approach to Meeting the Needs of Looked After Children Experiencing Difficulties: The Multidimensional Treatment Foster Care in England Project

ROSEMARIE ROBERTS

South London and Maudsley NHS Foundation Trust, London, UK

## Introduction

The plight of vulnerable children and adolescents in the public care system has been the subject of increasing political concern in the last 20 years, and new legislation is underway in England to try to improve their outcomes (The Children Act, 2004, DfES 2006). Of special concern are those placed far away from their original homes in residential units, those who experience serial placement disruptions, school and relationship failure and concomitant difficulties such as health-risking sexual behaviours, early parenthood, drug and alcohol use and crime. This paper describes an innovative approach, funded centrally by the Department for Education and Skills (DfES), designed to improve outcomes for looked after children and adolescents across England. The programme utilises an evidence-based treatment foster care programme shown to work in the United States for children with a variety of complex difficulties. This paper will examine the rationale and context for setting up the programme, the research evidence for the model, issues that have arisen during implementation and the learning so far.

The impetus for such a programme reflects the considerable concerns regarding young people in the care system who have historically fared badly across multiple domains and are well known to have very poor long term outcomes and life chances. In 2006 there were over 60,000 children looked after in England, 38,400 of whom were children aged 10 and above. Although many children return home to their families, a significant proportion (23,000 or 28%) have been looked after for more than two and a half years (DfES website). As a group they are more troubled than others; up to 70% of looked after teenagers have psychiatric disorders compared with 10% living at home (McCann, James, Wilson, &

Dunn, 1996, Meltzer et al., 2000); two-thirds are reported to have at least one physical complaint (Meltzer et al., 2003) and their life chances are considerably poorer. In 2005, of those children in school Year 11 who had been looked after continuously for at least 12 months, 60% obtained at least one GCSE or equivalent compared with 96% of all school children, and only 11% attained at least 5 GCSEs at grades A-C compared with 56% of all children (*Outcome indicators for looked after children twelve months to 30 September 2005, England*). This is not surprising given that we know looked after children spend too much time out of school either because they do not have a school place or as a result of exclusion and 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). Children at the greatest risk are those who have more than one placement disruption, while stable placements are linked to positive outcomes, especially in respect to relationship skills, good education, and employment outcomes (Koprowska & Stein, 2000).

Social services and partner agencies have, for some time, experienced difficulties in securing appropriate placements for children and young people who are looked after. Unsurprisingly, there is a particular difficulty in securing effective placements and services for young people with challenging and antisocial behaviour and emotional difficulties. Such young people are difficult to maintain in foster placements and may eventually be placed in a sequence of expensive residential placements that do not improve their levels of functioning and at best may offer only containment. The government green paper *Care Matters* (DfES, 2006) summarises this situation;

---

Far too many placements are not meeting children's needs. Only around 25% of care homes are meeting 90% or more of the National Minimum Standards. Qualification levels of staff tend to be poor and only 23% of residential care staff are qualified to the expected standard for these settings. Fostering services have similar problems. Over a third fail to meet National Minimum Standards on suitability to work with children and one in four fail to meet the standard on providing suitable carers. A high level of placement instability and frequent breakdowns suggest that many children are not in the right placement for them or are not receiving sufficient support.

The analysis . . . also shows that we are not currently achieving value for money from our spending on placements.

[*Care Matters*: 1.36-1.38]

As a response to the need to find effective, cost effective and creative ways to tackle these difficulties the Multidimensional Treatment Foster Care in England (MTFCE) programme was established by the Department for Education and Skills to pilot and evaluate a treatment approach shown to be effective in the USA for children and young people with complex needs and disruptive behaviour.

### **Evidence for the effectiveness of MTFC**

There have been over 40 published studies of a range of interventions to improve foster care, (reviewed by Reddy and Pfeiffer, 1997), the most promising of which has been the Multidimensional Treatment Foster Care (MTFC) model devised by Chamberlain and colleagues at the Oregon Social Learning Center (OSLC). This model, based on social learning and systemic theory, provides a multi-level intervention for young people who occupy single placements in the foster home for a period of around 6 to 12 months before moving on to a long term placement or returning home to family as appropriate.

The MTFC model is based on over two decades of longitudinal research on the predictors of conduct problems and antisocial behavior (Patterson, 1982). Eight randomised trials and other studies have provided evidence of the effectiveness of the

programme. The first studies explored the feasibility and cost effectiveness of using the model for adolescents referred for delinquency and for children and adolescents leaving the state mental hospital as an alternative to residential treatment or incarceration. (Chamberlain & Reid, 1991, 1998). The evaluations show a greater reduction of offending behaviour and psychological symptoms in children and young people offered treatment foster care compared with treatment as usual. In addition, compared to alternative residential treatment models, the cost of MTFC was substantially lower. 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.

Later studies have examined immediate and long-term outcomes in several areas including: criminal and violent behaviour, young people with behavioural and mental health problems, attachment to caregivers, gender differences, and interventions with younger children. The research has demonstrated positive outcomes for MTFC in all these areas; for example, with fewer re-arrests and violent criminal activity and absconding rates for both adolescent boys and girls, lower rates of permanent placement breakdown, lower rates of child behaviour problems and more frequent reunifications with birth families and greater foster carer retention and satisfaction. Adaptations of MTFC for use in the 'regular' state-supported foster care system are underway. In a large randomised trial in San Diego County, California, over 700 foster and kinship families receiving a new placement were randomly assigned to enhanced services using a version of the MTFC model or to case work services 'as usual'. Foster and kinship families receiving the enhanced service had fewer placement disruptions, more frequent reunifications with birth families, and lower rates of child behaviour problems (Chamberlain & Milhalic, 1998; Fisher, Ellis, & Chamberlain, 1999; Fisher, Burraston, & Pears, 2005). This clear evidence of effectiveness across a range of domains and difficulties has led to the development of MTFC programmes across the USA and more recently in Europe.

### **The introduction of MTFC into England**

The introduction of an evidence-based, multi-

---

agency service is a significant development in government strategy for vulnerable looked after children and adolescents. The DfES have provided start up grants to local authorities across England, with their health and education partners, to meet the initial development costs of setting up this programme for looked after children and young people aged 10 to 16 years. Local authorities nationally competed for this pump priming funding in a series of competitively tendered bids between 2002 and 2006. A total of 17 teams spread across the country have now received grants and are at various stages of development. The Youth Justice Board followed this initiative setting up a pilot scheme of three teams as an alternative to custody for young offenders utilising the same MTFC model. A recent development has been the introduction of further pump priming funding from the DfES for six teams to develop MTFC-Prevention services for young children aged 3 to 6 years. These six new sites were given their first funding in early 2007 and are now beginning the set up process.

The grant is provided to cover costs for the programme for approximately 6 to 9 months during the period of recruitment and team training and to cover foster care set up costs including recruitment, assessment, preparation and training costs. Successful applicants were selected on the basis of; positive and collaborative joint planning arrangements across social care, health, education and youth justice services, commitment and capacity to sustain the programme beyond the pump priming stage, strong links with the fostering system, and an understanding of and commitment to the MTFC model. Once established, authorities are expected to cover all the placement costs of the young people and to commit to sustaining the programme beyond the pump-priming funding stage.

The general referral criteria set by DfES for local authorities recommended targeting young people, between the ages of 10 to 16 years, with complex and severe emotional or psychological difficulties and/or who are displaying severe levels of challenging/anti-social behaviour and/or self-harming and/or involved in crime and may be at risk of receiving a custodial sentence and who are likely to have had a number of placements or interventions. Teams set their own criteria within these parameters according to local need.

The model was introduced with several aims: to increase capacity for effective evidence based

interventions with this group of children looked after, to evaluate whether this model could be successfully implemented in England, and to determine what additions or adaptations might be needed to take account of legal and cultural differences between the USA and England.

The intention of the English national programme is to implement the OSLC model with full fidelity. The model prescribes a clear team structure and differentiated roles. The team includes the foster carers, programme supervisor, birth family therapist, foster carer recruiter/supporter, individual therapist, and skills trainer. To take account of the complex needs of this care population, the English project has added a full mental, physical and educational assessment for all children on entering the programme, plus some additions to the team structure, specifically a programme manager to provide overall management support and education staff, often a teacher, to organise school placements and co-ordinate the child's academic progress. The foster carer recruiter role has been enhanced to include support to foster carers in implementing the programme as required by the programme supervisor and to ensure adherence to UK fostering regulations and guidelines.

The foster carers are provided with specialist training, a weekly foster carer group, clear guidance to implement the programme for the young person and 24 hour support. In the USA the programme supervisor has total responsibility for the 24 hour support to the foster carers however this was not compatible with working hours culture and legislation in the UK and out of hours support is provided by three or four team members on a rota basis.

A further key implementation difference has been the need for clearer articulation of the way in which attachment theory relates to the MTFC model.

### **National training and consultation**

A further innovation has been the introduction in 2003 of a National Team to manage the implementation of the project, based at the Maudsley Hospital in London and Booth Hall Children's Hospital in Manchester. Evidence from a number of trials concludes that treatment fidelity is a major determinant of outcome and that a high level of fidelity and model adherence is associated

---

with positive outcomes (Henggeler et al., 1997; Scott, Carby, & Rendu, 2006). The National Team was commissioned to provide this consistency of training and fidelity to the model in order to ensure the best possible outcomes for the children, young people and their families. The team provides specific training in the MTFCE model (both alongside staff from OSLC and separately), plus a programme of additional training for clinical staff. The basic training programme for the clinical teams following national and on-site induction comprises a formal 3-day training course, including the theoretical and research evidence for the MTFCE model, the clinical team structure and roles, and practice in implementing the behavioural management and skills building system. Programme supervisors receive an additional training day in their role as clinical lead for the programme. Teams are also provided with guidance on using the assessment measures designed for the English project and advice on the application of this information to initial behavioural treatment goals. Two-day training courses for foster carers in the model using a combination of didactic teaching, experiential exercises and case examples are held centrally, regionally and in local team sites and over time are provided alongside the programme supervisor and foster carer recruiter in order to train them to train their own carers as programmes develop. Programme sites also attend networking and training days for their team roles approximately twice a year for each role. Clinical team and foster carer training is provided on a rolling programme and may be held nationally, regionally or locally according to need.

The National Team's original task of training and ensuring treatment fidelity has developed into a comprehensive project management role. A Site Consultant is allocated to each team to provide development support on the implementation process, clinical consultation and support in the treatment model to the clinical teams, support for local and national evaluation, and monitoring and guidance with regard to model adherence. This innovative method of project management includes formal reviews and feedback to the project teams, live supervision and videotape feedback to ensure the teams are given optimum support in taking the programme forward. The National Team received initial training in Oregon from the Oregon Social Learning Centre and maintains close relationships

with OSLC who provide regular weekly consultation. Adherence to the model is therefore ensured in a number of ways and at a number of levels: through close support, monitoring and guidance to the regional sites, standardisation of structures and procedures, and attendance at clinical and foster care meetings and videotaping of these meetings, a sample of which may be seen by the OSLC consultant, as well as direct consultancy between the OSLC and the National Team in England.

### **The MTFCE programme**

MTFCE aims to provide effective treatment via foster care provision for vulnerable, troubled and costly (or potentially costly) looked after children. Four principle mediators are considered to lead to successful outcomes; close supervision and monitoring, a positive relationship with a mentoring adult, consistent discipline and infrequent contact with anti-social peers (Chamberlain, 2003). The programme works across all areas of a young person's life; home, school, peer group and birth family and through simultaneous and co-ordinated treatments aims to provide the young person with a secure base, systematic responses to their behaviour, opportunities to develop normative and pro-social behaviours, opportunities for improved relationships with their families, and increased problem-solving, academic and relationship development skills (Chamberlain, 2003).

MTFCE represents a departure from traditional foster care in several ways. Foster carers are considered a crucial part of the team and are specially recruited and trained in the social learning approach at the heart of the model to provide contingent reinforcement of positive behaviour, supervision and support to the young person, clear boundaries and limits and to follow through on consequences of negative behaviour in a calm, neutral and non-hostile manner. The environment developed provides constant contingent feedback in the context of a positive relationship. Escalation of behaviour and emotions is avoided through early intervention. The programme aims to be overwhelmingly positive and emphasises learning by doing; practicing coping strategies and learning new skills and responses to replace unhelpful behaviours. Only one young person is placed with a family at a time, the carers are provided with a clear programme individually designed for the young

---

person, close support from the programme supervisor, 24-hour support from the multi-agency project team, and weekly foster carer meetings with other foster carers and the programme supervisor.

The programme for the young person is designed to increase pro-social behaviours, the development of life skills, emotional regulation, participation in positive activities in home, school and community, and positive relationships with family members, adults and peers. Core components for the young person include a structured daily programme using a points and levels system that is designed to teach appropriate skills, reinforce desired behaviours and attitudes and provide consistent consequences for problem behaviour, close supervision of his/her whereabouts and peer associations, a daily school/education card, weekly individual therapy, weekly skill building and advocacy, recreational skill building and daily mentoring by foster carers. In addition, the programme provides family therapy for the family of origin focusing on engagement with hard to reach families and behavioural parent training, to improve the relationship between the family and young person, and facilitate a return home where possible or improvement in relationships and contact arrangements as appropriate where return home is not an option.

The core MTFCE treatment team staffing for 8 to 10 placements includes personnel recruited from a number of different agencies, including health, education and social services, to fulfil the following roles: Project Manager responsible for administering and ensuring the smooth running of the project, a Programme Supervisor who is the clinical lead responsible for the design and implementation of the young person's individual programme and is the main support to the carers, a Foster Carer Recruiter/Trainer who recruits, assesses and also provides support and training to the carers, an Individual Therapist for the young person to work on specific issues, increase coping strategies, increase capacity for problem solving, staying safe and, when appropriate, understanding and developing mechanisms for coping with past trauma, a Birth Family Therapist to engage and work with family of origin issues, including relationships with the young person, contact, and teaching in the use of the points and level system as appropriate, a Skills Trainer to coach the young person in practising life skills and developing

recreational activities and an education worker, for example an educational psychologist, teacher or support staff to facilitate the young person's access to and ability to cope within an educational setting..

In addition to the recommended structure, the team may include dedicated psychology and sessional psychiatry time for ongoing assessments and consultation. Each of the roles is clearly differentiated and with little overlap. The Programme Supervisor acts as the clinical lead, designing the interventions and co-ordinating the work of the other members of the team so that each is working together to provide a co-ordinated intervention around the same clearly defined goals. The clinical case example below illustrates how this model works in practice.

#### **Case example – Carrie**

Carrie is a 14-year-old girl of white working class origin who has a history of physical and verbal aggression, disruptive behaviour and fire setting. She was placed in MTFCE 6 weeks ago from a residential unit 200 miles from her hometown. This is her ninth placement since coming into care 3 years ago.

Carrie's early history is characterised by poor parenting, neglect, and rejection and possible sexual abuse. Her parents separated due to her father's violent behaviour and she was later abandoned by her mother and left in the care of her maternal grandmother when she was 8 years old. She came into care at the age of 11 years when her grandparents found her unmanageable. She subsequently had a series of foster care placements that broke down due to behavioural difficulties, particularly her aggression towards other children in the household. At 13 she was moved to a residential unit as she was considered unsuitable for mainstream fostering. Two months later, after an argument with another girl in the unit, Carrie set fire to some papers in a bin, ran away and slept on the streets for 6 days before being found by the police. The residential unit refused to have her back and she was taken to a new unit where she has been relatively settled for about 6 months before being referred to MTFCE.

Carrie had been ambivalent about coming into MTFCE and was particularly concerned about not having the freedom she was used to in the residential unit where she said 'they don't make a noise about what I do so long as I'm back by 10pm'.

---

However, social services had been approached by Carrie's paternal aunt who, now that her own children are grown up, is prepared to see if she could offer Carrie a home. MTFCE would therefore be a stepping-stone towards this.

The MTFCE assessment provided a diagnosis of conduct disorder, attachment disorder and moderate depression, the main features of which are low self-esteem, difficulty relating to peers, and poor sleeping and eating patterns. Family of origin assessment is ongoing and initial indications are that Carrie's aunt is willing to work closely with the programme. Risk factors identified include running away to unsafe environments where she may be subject to physical, sexual or emotional harm, including drug use and sexual exploitation, aggression and violence towards others, and fire setting. Resilience factors identified include average cognitive abilities (although she is underachieving at school), motivation to live in a family environment and the hope of a family member providing a home for the future. The initial treatment plan was to increase her social skills, and improve her peer relationships, anger management and problem solving strategies.

Young people entering the MTFCE programme remain on level 1 of the structured daily Points and Levels programme for a minimum of 3 weeks. Points can be easily earned for normal daily activities such as getting up in the morning, and are then exchanged for simple privileges the next day, such as later bedtime, TV or computer time. On this level, the young person is supervised at all times. To progress to level 2 the young person must complete at least 3 weeks in the programme and earn a minimum number of points. On level 2, points earned the previous week buy a wider variety of privileges specifically tailored to the young person's interests. This encourages the young person to manage delayed gratification and to plan ahead. The majority of changes in behaviour and skill development are seen at level 2, which can last for up to 6 to 8 months. Progression to the final level 3 may depend on the young person's age, development and readiness and is achieved through the purchase of 'bonds' over a period of 3 to 6 months while on level 2. In this way, the programme provides the foster carers with a framework for fair and consistent discipline, continuous feedback and positive reinforcement for the young person, and enables 'the programme' to

take responsibility for contentious decisions that may interfere with the relationship between the foster carer and the young person. Progress is closely monitored via Parent Daily Report (PDR) telephone calls to the foster carer each morning to enquire about the young person's behaviour in the last 24 hours using a standard checklist, and enables difficulties to be picked up at a very early stage and minor adjustments to the programme made as necessary.

Carrie earned over the minimum point requirement each day in the first 2 weeks of her placement. Her foster carers, Terri and Alan, reported she was co-operative, compliant and helpful and initially struggled to take away points feeling that her minor misbehaviours should be ignored as they were understandable in the circumstances. Although an effective technique in ordinary parenting, ignoring is often ineffective for this complex and needy group of young people, many of whom have learnt coercive techniques and are skilled at escalating behaviours that are unpleasant for adults to manage, and increase the likelihood of avoidant behaviour on the part of the adult who withdraws the demands, thereby reinforcing the unwanted behaviour (Patterson, 1984). An important aspect of the MTFCE programme is de-escalation; foster carers are encouraged to call the programme supervisor when there is a minor concern and long before the young person reaches the top of the escalation curve. Taking off a small number of points in a neutral, calm and supportive manner for minor negative behaviours gives the clear message that it has been noticed and helps prevent escalation of the behaviour. Foster carers are therefore encouraged to take one or two points in the first couple of days for even very minor behaviours in order to emphasise that this is a normal part of the programme. Young people can also gain points for maturity in gracefully accepting loss of points and thereby learn to manage their negative feelings in a positive way.

At the point when Carrie was due to transfer from Level 1 to Level 2 she ran away in the early hours of the morning, taking £20 in cash and some food. She had been doing reasonably well in the education unit and the education worker had negotiated a place for her in the local school to start after the half-term holiday, her first meeting with her aunt was about to take place, and she had the previous evening received information (via a girl in

---

the education unit) concerning her ex-boyfriend in the residential home. She was picked up by the police at the residential unit and returned to Terri and Alan the following day.

Carrie's concerns about rejection and shame regarding the theft, her confusion about her angry feelings concerning her ex-boyfriend, and the foster carers' feelings of being let down and 'taken in' by Carrie were all dealt with sensitively by the programme supervisor. The foster carers learnt that Carrie's behaviour was a reflection of her past experience and not to take it personally. The incident reinforced for them the need to use the programme staff and the points system rigorously. The programme supervisor agreed that Carrie could move up to level 2 but devised a work-chore as a consequence for the stealing. She is now gaining extra points for every day that she remains in the placement and doesn't run away, and for being pleasant and not moody. These extra points are being converted to tokens to buy some new jeans that Carrie especially wants.

The relationship between Carrie and her carers remains fragile but Terri and Alan feel positive about her despite her moodiness and occasional outbursts. She has told Terri that she can easily get boys to like her but not girls and the programme is currently focusing on helping her remove barriers to making female friends, to develop an appropriate positive self-image to improve her peer relationships and self-esteem. The Individual Therapist is building her skills in this area, beginning with using pictures from magazines as a basis for discussion about sexuality and self-image and the Skills Trainer is due to take her shopping for clothes to put some new ideas into practice.

It is possible that Carrie will disclose sexually abusive experiences and the programme staff are ready to respond to this but only when she is ready to take this step. The psychiatrist is due to review her in the next month to reassess her level of depression, but is currently pleased to see that the PDR charts show her to be making slow progress. The relationship between Carrie and her aunt is in the early stages and the aunt continues to work positively with the Family Therapist. An overnight stay will be arranged in the near future. Recently Terri reported how, after a day when Carrie had been uncooperative and sullen, and she had struggled to maintain her equilibrium, Carrie's comment 'You're the best foster mother I've ever

had' made it possible to feel she might just be making some progress.

The above example illustrates the programme aims of providing a secure base for young people to experience family life, address relationship skill deficits and find new ways of relating. Specifically, it seeks to encourage normative and pro-social behaviours, increase resilience and problem-solving skills, teach new skills for forming relationships with positive peers and for bonding with mentors and role models, encourage academic skill development, improve relationships between the young person and biological or adoptive family members, and support these family members to increase the effectiveness of their parenting skills.

### **Evaluation and audit**

The national MTFCE programme is currently being evaluated as part of an independent randomised controlled trial (RCT) with a 12-month follow-up by the universities of Manchester and York. The evaluation of outcomes will include pre and post data on behavioural and emotional difficulties, educational attainment, offences, drug and alcohol use, placement stability, and family and peer relationships. There will also be an evaluation of processes involved in implementing the programme and the views of young people and foster carers will be sought. Results are not expected to be available until 2008. In the meantime, programme sites are collecting audit data on all children and young people placed in the programme which is being collated and analysed by the National Team. The data provides the national programme and individual teams with general information regarding the status of children entering and leaving MTFCE, including demographic data, numbers of referrals, type and severity of difficulties experienced by the children, their families or previous carers, educational attainment and criminal offences. As the numbers of children entering the programme increase, information concerning outcomes including some indications of the factors contributing to successful placements and treatment outcomes will become available.

Analysis of audit data on 96 young people who entered the programme between April 2004 and December 2006 confirms the high levels of complex needs; over two-thirds had a history of violence towards others, over one-third had self-harmed, over half had a history of difficulties with sexual

---

behaviour and were considered a risk to themselves or others, over one-fifth had a history of fire setting, over one-fifth had criminal convictions, three-quarters had either convictions, police verbal warnings or were associating with offending peers. Nearly two-thirds had a history of absconding from previous placements, over half smoked cigarettes, over one-third drank alcohol, almost one-third had used drugs and almost one-third were in receipt of medication for psychiatric reasons. Preliminary audit data from a small group of children who had completed the programme indicated improved outcomes in a number of areas including reductions in violence towards other people, self-harm, sexual behaviour problems, offending behaviours and absconding. The numbers are low at this stage, and therefore conclusions must be interpreted with caution. These early results, however, are encouraging and indicate reductions in difficulties in the expected direction and compare favourably with current data on poor outcomes for looked after children with complex needs (Koprowska & Stein, 2000).

### **Learning from MTFCE**

The MTFCE programme is a ground breaking government initiative importing an evidence based programme from the United States. A number of other European countries, including Sweden and Holland, are similarly developing MTFCE programmes for adolescents and for the younger age group; however, the English programme is the largest programme outside the USA and the only national initiative in Europe. The introduction of MTFCE is timely, as it anticipated the guidelines for use of evidence based programmes by the National Institute for Clinical Excellence (NICE) and with the guidance for adequate support and effective treatment for children with emotional and behavioural difficulties as indicated in the publications jointly with the Social Care Institute for Excellence (SCIE) and NICE.<sup>12</sup>

The MTFCE programme has reached a critical and exciting stage and is acquiring a solid body of

knowledge and expertise about the considerable benefits and challenges of setting up an evidence based multi-agency programme for looked after young people in England. The ongoing audit and rigorous research trial will confirm the success or otherwise of this programme in achieving the hoped for outcomes. However, staff working in the programmes are clear that this model works and that the individual lives of very vulnerable children can and have been significantly positively changed to a degree not previously thought possible.

The very real challenges of setting up and establishing these programmes within the English social care system cannot be underestimated. It is clear that ongoing work on sustainability, financial forward planning and multi-agency partnerships is crucial. Local authorities who have experienced changes in senior management personnel, structural reorganisation, political emphasis, or financial imperatives have suffered from delays in establishing the programmes, involving local authorities in protracted re-negotiations with health and education partners. Once established, changing financial priorities and concerns about budgets in the short term, the withdrawal of backing from hard pressed health partners, difficulties in recruiting and retaining appropriate foster carers, and lack of appropriate referrals of young people into the programme all threaten the viability of these new initiatives. In addition, small teams where roles are clearly differentiated and defined may be more vulnerable if key staff leave unless they are adequately supported by the wider system.

As our knowledge about how the intervention works has increased, our awareness of the complexities of the implementation and the challenges it generates have been highlighted. The lessons learned include the need for strategic planning for financial sustainability of the programme over time to ensure 'normalising' of the programme as part of the usual range of provision for looked after adolescents, passing on commitment and responsibility for the programme to new managers, and ensuring the MTFCE

---

<sup>1</sup> Social Care Institute for Excellence (SCIE). *Resource guide 04: Promoting resilience in fostered children and young people*. Published September 2004.

<sup>2</sup> *Parent-training/education programmes in the management of children with conduct disorders*. Published July 2006. SCIE has produced this guidance in conjunction with the National Institute for Health and Clinical Excellence (NICE).

---

programme is part of CAMHS strategy and is a standing agenda item at the various multi-agency partnership meetings. Ideally, MTFCE programmes would be embedded in fostering services and support and knowledge about the aims and realistic expectations of programmes should be held by senior managers across agencies. Detailed accurate calculations of the real costs of supporting looked after children with complex needs in a variety of placements would enable more realistic comparisons of the impact, effectiveness and cost effectiveness of specialist programmes such as MTFCE.

Research into the processes of implementation suggests it takes 2 to 4 years to fully establish evidence based programmes in a community (Fixen, 2005). Subsequently, the implementation site requires support to sustain the programme. Experienced and skilled staff leave and must be replaced with other skilled and well trained staff, senior managers and champions for the programme change, political focus on specific groups changes, agency partnerships ebb and flow and financial support might waver. Throughout this the implementation sites must attempt to remain flexible and accommodate the inevitable changes without compromising the integrity of the programme. Successful implementation is not just reliant on having a skilled and committed staff team, although this is obviously an excellent start, but in having the support and backing of the senior management and multi-agency partners over the longer term.

Successful implementation requires teaching and education, followed by practice, monitoring and mentoring over time. Long term support and supervision is required to enable programmes to stay on track and allow development of expertise and skills to occur. Implementation processes require systemic and cultural change both at the level of the organisation as well as the individual level. This again takes time and commitment to develop and mature. This process is common to all implementations of evidence based practices not just MTFCE but is a particular challenge in the field of social care. The considerable financial investment of both the government and local authorities in this important endeavour necessitates that plans for longer term investment to ensure the consolidation and expansion of the learning be considered as a priority.

Evidence based programmes may fail not because the programme does not work but because the processes of implementation fail. Instruction manuals on shelves and staff training alone do not ensure a treatment programme is carried out as intended by the designers and researchers. Initial financial investment in new programmes risks being wasted if there is insufficient consideration given to planning for future support and sustainability. The long term continuation of evidence based programmes such as MTFCE may be dependent on having a system in place for monitoring implementation progress, access to ongoing support in the implementation of the main tools of the programme, the ability of the organisation to manage risks, and the belief of staff and managers in the benefits, effectiveness and cost effectiveness of the programme.

For some Local Authorities the introduction of MTFCE has created a step change that is beginning to influence wider practice not only within fostering services but across the spectrum of services for children and young people within the care system. For example, in re-evaluating the support and supervision for foster carers, the development of foster carers skills and expertise in managing children's behaviour whilst also increasing young people's skills and abilities to manage their environment and relationships; consideration of the degree of supervision and monitoring being received by young people in children's homes, and how positive frameworks and clear models and approaches to encourage and shape children's behaviour and life skills can be used effectively and ethically. This cultural and whole system change is the key to the establishment and survival of effective and cost effective long term programmes which offer real hope of change for looked after children and young people.

## References

- Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (1999). *The comparative costs and benefits of programs to reduce crime: A review of national research findings with implications for Washington State*. Olympia, WA: Washington State Institute for Public Policy.
- Chamberlain, P., & Mihalic, S. F. (1998). Multidimensional treatment foster care. In D.

- 
- S. Elliott (Series Ed.), *Book eight: Blueprints for violence prevention*. Boulder: Institute of Behavioral Science, University of Colorado at Boulder.
- Chamberlain, P., & Reid, J.B. (1991). Using a specialised foster care treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.
- Chamberlain, P., & Reid, J.B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66, 624-633.
- Chamberlain, P. (2003). *Treating chronic juvenile offenders. Advances made through the Oregon Multidimensional Treatment Foster Care model*. Washington DC: American Psychological Association
- DfES, (2006). *Care matters: Transforming the lives of children and young people in care*. London: DfES.
- Fisher, P. A., Burraston, B., & Pears, K. (2005). The Early Intervention Foster Care program: Permanent placement outcomes from a randomized trial. *Child Maltreatment*, 10, 61-71.
- Fisher, P. A., Ellis, B. H., & Chamberlain, P. (1999). Early intervention foster care: A model for preventing risk in young children who have been maltreated. *Children Services: Social Policy, Research, and Practice*, 2, 159-182.
- Fixen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., Wallace, F., (2005) *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louise de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231)
- Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, 65, 831-833.
- Koprowska, J., & Stein, M. (2000). The mental health of 'looked-after' young people. In P. Aggleton, J. Hurry & I. Warwick (Eds.), *Young people and mental health*. London: John Wiley & Sons Ltd.
- McCann, J.B., James, A., Wilson, S., & Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 1529-1530.
- Meltzer, H., Gatwood, R., Goodman, R. et al. (2000). *Mental health of children and adolescents in Great Britain*. London: The Stationery Office.
- Meltzer, H., Corbin, T., Gatward, R., Goodman, R., & Ford, T. (2003). *The mental health of young people looked after by local authorities in England*. London: Office for National Statistics.
- Morgan, S. (1999). *Care about education: A joint training curriculum for supporting children in public care*. London: National Children's Bureau.
- Patterson, G.R. (1982). *Antisocial boys*. Oregon: Castalia Press
- Patterson G. R., & Reid, J. B. (1984) Social interactional processes within the family: The study of moment by moment family transactions in which human social development is embedded. *Journal of Applied Developmental Psychology*, 5, 237-262
- Reddy, L.A., & Pfeiffer, S.I. (1997). Effectiveness of treatment foster care with children and adolescents: A review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 581-588.
- Scott, S., Carby, A., & Rendu, A. (2006). Impact of therapist skill on outcomes of parenting programs for child antisocial behaviour. Manuscript submitted to *Journal of Consulting and Clinical Psychology*.
- Social Exclusion Unit (1998). *Truancy and school exclusion*. London: HMSO.
-