Revolving Doors Agency

Centre for Mental Health

Realising a better future

COMPREHENSIVE SERVICES FOR COMPLEX NEEDS:

A summary of the evidence

KEY MESSAGES

- Multisystemic Therapy, wraparound and the link worker model target people with multiple and complex needs, who are often poorly served by mainstream services
- Key outcomes addressed by these models include reducing reoffending and improving mental health
- The models illustrate the importance of a holistic, personalised approach which prevents crisis situations
- The evidence is promising that these models work, although the quality of the evidence base varies between the models. The wraparound and link worker models in particular would benefit from further research and evaluation
- All three models, if implemented faithfully, have potential to save money through reduced demand on the emergency services, the criminal justice system and the care system.

This briefing has been produced by Revolving Doors Agency and Centre for Mental Health.

Revolving Doors is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in repeat contact with the criminal justice system. Our work has three strands: policy, research and development, and service user involvement. We work with partners in the fields of criminal justice, health, employment, social care and elsewhere.

www.revolving-doors.org.uk

Centre for Mental Health is an independent national mental health charity. We aim to inspire hope, opportunity and a fair chance in life for people of all ages living with or at risk of mental ill health. We act as a bridge between the worlds of research, policy and service provision and believe strongly in the importance of high-quality evidence and analysis.

We encourage innovation and advocate for change in policy and practice through focused research, development and training. We work collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

www.centreformentalhealth.org.uk

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Introduction

Multiple and complex needs

Research estimates that there are approximately 60,000 people across England facing multiple and complex needs, with many more at risk of entering this situation. Their needs often include mental illness, offending, homelessness and substance misuse. They are overrepresented among short-sentence prisoners and repeat offenders.

Many people in this group are failed by mainstream services. They are excluded for disruptive behaviour or they do not meet rigid and complicated thresholds for access. This means they frequently come into contact with the system at crisis point. Many are repeatedly imprisoned for short periods of time; some are excluded from GP surgeries, and so repeatedly attend A&E; many are unable to sustain stable housing and end up homeless. For families with multiple and complex needs, repeated family breakdowns and a chaotic environment often result in children being taken into care.

What will this briefing cover?

This briefing summarises evidence for three ways of working with people with multiple and complex needs: Multisystemic Therapy; wraparound; and the link worker model. These models seek to address the repeated failures to help people facing multiple needs. They were developed in very different contexts and target different ages and cohorts, but all respond to a complex mixture of unmet needs and address interrelated outcomes such as reducing reoffending, improving mental health and preventing further exclusion. Table A summarises each of the models.

TABLE A: SUMMARY INTRODUCTION TO THE MODELS

Multisystemic Therapy
An intensive psychological treatment programme which takes place in the family home. Therapists work closely with young people and their families to address the different areas which influence behaviour.

Wraparound
A process of co-ordinating professional and community-based support for young people, underpinned by a focus on family strengths and the 'voice and choice' of young people and their families.

Link worker
A delivery model involving the co-ordination of multiple areas of support for adults with multiple and complex needs. Link workers also act as advocates and consistent sources of support for their clients.

Section one of this briefing introduces the models and highlights common features developed for work with people with multiple and complex needs. Section two summarises the evidence for all three models, focusing on outcomes relevant to commissioners' responsibilities. Section three outlines the financial case for the models, which focus on preventing costly outcomes such as offending and homelessness. Section four raises some key considerations and recommendations for commissioners and for further research.

This briefing will be helpful to a wide range of commissioners with an interest in:

- Reducing repeat offending, including among young people
- Reducing levels of substance misuse
- Improving mental health, particularly among young people and offenders
- Reducing incidences of family breakdown
- Reducing rough sleeping and social exclusion among adults.

1. For a more detailed consideration of the quality of the evidence available for each model, see the longer evidence review online at: http://www.revolving-doors.org.uk/partnerships--development/spark/resources

1. Understanding the models

It is important to understand the particular characteristics, core principles and target population of each model. This is fundamental to successful implementation and delivery.

Multisystemic Therapy was designed by a US-based psychologist in 1993 and is delivered to young people and their families. It is owned and licensed by MST Services, which monitors implementation. The original model focuses on young offenders, and is based on a theory of change which emphasises how problematic behaviour is maintained and perpetuated by the environmental and social contexts in someone's life; therefore addressing these is necessary. In MST, mental health professionals (social workers or psychologists) deliver therapeutic treatment that addresses these contexts or 'systems'. The process takes place in the family home, to ensure progress is sustainable. Practitioners work intensively with a family for up to seven months and address the role of parents in responding effectively to challenging behaviour.

MST has been implemented in the UK (http://mstuk.org/).

Wraparound originated in the US in the 1960s, as communities aimed to prevent children going into care or psychiatric institutions. It is a process to co-ordinate sources of support and therefore improve outcomes. It is targeted at young people experiencing multiple and complex needs and their families, although it has also been adapted for adults leaving custody. Facilitators bring together professionals involved in a child's life along with community-based support, such as neighbours or extended families. A wraparound plan is designed and implemented, incorporating the clients' views on what should happen. The process continues for as long as necessary.

BOX 1: P3'S LINK WORKER SERVICES IN MILTON KEYNES

P3's Link Worker Services are designed to improve ways of working with people who face multiple and complex needs. The aim is to link people into local services that meet their needs. The support is not time limited and link workers go at a pace agreed with clients. They address core needs such as housing, finance and mental health but also focus on social networks, often linking in with local independent support groups.

The team work in partnership with a number of agencies, including the local Community Rehabilitation Company and Troubled Families programme.

For more information on the service, visit http://www.p3charity.org/link-workers

The link worker model originated in the UK in the 1990s, aiming to improve responses for adults facing multiple and complex needs who were repeatedly excluded from mainstream support services, with their problems rarely being addressed. Link workers support clients by navigating complicated access points to services, acting as persistent advocates for their clients, and providing a continuous source of support. They persist in engaging even in the face of very challenging behaviour.

The core principles of Multisystemic Therapy and wraparound are both relatively well defined in the literature. If these principles are not adhered to, the approach may not work as well. There is no equivalent, centrally defined link worker model as this approach has evolved organically with individual services developing their own approaches. Nevertheless, in Table B on page five we list some proposed core principles based on our research and consultation with link worker services.

TABLE B: CORE PRINCIPLES OF THE MODELS

Multisystemic Therapy (taken from the website for *MST Services*, the organisation which owns and licenses MST).	**Wraparound** (adapted from Bruns et al, 2004).	**Link worker model** (developed by Revolving Doors).
Positive and strengths-focused.	Strengths based.	Supportive approach to developing skills and appropriate behaviour.
Continuous effort.	Persistent: work until the process is no longer needed.	Non-punitive: clients aren't excluded for not engaging or even abusive behaviour.
Age and developmentally appropriate.	Individualised.	Individualised and client led.
Evaluation and accountability: Effectiveness is continually tested during the process.	Outcome based.	Consistency: link workers are a stable source of support.
'Finding the 'fit'': between identified problems and how they play out within the young person's environment.	Support and services should be community-based.	Holistic: addresses multiple needs.
Increase responsibility.	Involve informal networks, such as extended family and friends.	Persistent and creative in trying to engage clients.
Focused on actions that can be taken immediately.	Prioritise the family's voice and choice.	Co-ordination and advocacy: helping people to get access to services.
Targeting sequences: e.g. relationships driving behavioural patterns.	A team based approach.	Team-based approach to caseworking (Not always implemented).
Generalisation: lessons learned can be applied after treatment ends.	Culturally competent: people's cultural practices are incorporated.	Open-ended. Clients may return to the service (Optional as not always possible).
	Collaboration on a single support plan.	Strategic level working to negotiate flexibility of service thresholds (Not always implemented).

Common features of these models

As Table B indicates, the models have significant common features, which are important in working with people with multiple and complex needs.

- The models were developed to prevent crisis-based interventions or outcomes: such as treatment in a psychiatric unit, imprisonment or going into care.
- Work takes place in a community or family setting where possible, not a formal office or institution.
- They are targeted at people with complex needs, and they address multiple issues.
- They operate a strengths-based approach and work on developing people's skills to cope with difficult situations.
- They incorporate the choice of service users and personalise service delivery for each person or family.
- They are persistent in working with service users, using different approaches for successful engagement until something works.

2. Summarising the evidence

These models address key outcomes such as reducing reoffending, improving mental health and reducing homelessness. There is promising evidence that these models work for people facing multiple and complex needs, although the quality and size of their respective evidence bases does vary. Commissioners and research funders have an important role in funding pilots where findings are not definitive or where the highest quality studies have not yet been undertaken.

MST has the most extensive evidence base of all three models, having been extensively researched in clinical trial conditions. Robust supervision, monitoring and training ensure MST is effectively delivered and evaluations are of a standardised model.

Evidence from the multiple studies conducted shows very promising findings on reconviction rates, observed behaviour, family relationships and mental health symptoms for young people receiving MST. Although most evidence relates to the US, one England-based study showed MST reduced the percentage of young people reoffending by 26% (Butler et al, 2011). The US-based evidence is also very promising that MST reduces use of children's homes and foster care, although more evidence is needed for England and Wales. Qualitative research suggests that MST improves family relationships by helping parents develop their skills and capabilities to respond appropriately to challenging behaviour.

BOX 2: THE BRANDON CENTRE'S MST PROGRAMME

The Brandon Centre, based in North London, offers advice and support to young people. It delivered MST as part of the first trial evaluating its impact and cost-effectiveness in the UK. The trial demonstrated that MST reduced offending rates among young people and saved money.

The Brandon Centre is involved in the development of the evidence base for MST in the UK, including an ongoing trial assessing the success of the MST - Problem Sexual Behaviour programme.

For more information go to:
http://www.brandon-centre.org.uk/multisystemic

Wraparound research is generally promising, despite a smaller number of robust evaluations than for MST. The evidence, which is largely limited to the US, suggests that wraparound keeps young people in their homes and out of custody, foster care or psychiatric units. One study showed that wraparound reduced the amount of young people serving time in custody by 28% (Pullmann et al, 2006). Wraparound can also improve family relationships and young people's mental health, again through improving the capacity of families as well as the effectiveness of service responses.

The model is not owned by any one organisation and so key measures for monitoring implementation are not routinely in place. More rigorous implementation appears to improve outcomes, as one study demonstrated: when wraparound facilitators were trained and supervised with a re-emphasis of the core principles, in particular community support, outcomes for service users improved (Bertram et al, 2014).

Wraparound has not yet been implemented in the UK, and so research is needed to test if the promising findings from the US could be sustained here.

The link worker model has a smaller body of quantitative evidence, due to its organic, service-led origins. Some studies use self-reported data, and there is no finalised definition making it difficult to assess how well the model has been implemented when reviewing the evidence. However, government and service-led evaluations have shown promising results in terms of improving housing situations, health, and coping skills. They suggest that the link worker model can stabilise clients and prevent crisis situations such as rough sleeping and A&E attendance. Additionally, a small amount of 'before and after' evidence shows that link worker clients are less likely to reoffend after intervention, with recorded reoffending falling by 22% over three years in one study (O'Shea et al, 2003).

Despite a lack of rigorous quantitative research, the link worker model has strong theoretical underpinnings which show how link workers can improve outcomes for their clients. Attachment theory informs link worker practice. This shows how relationships with caregivers in infancy can influence later development. Unstable bonds with parents or carers can result in difficulty forming stable attachments in later life. Many people with multiple needs experience neglect and abuse in their early lives, which may lead to a chronic fear of both abandonment and intrusion. In recognition of this difficulty, link workers aim to develop positive, consistent relationships with their clients.

Summarising the evidence for all three models

Table C summarises the evidence for the link worker model, MST and wraparound, showing the evidence against outcomes important in UK public service commissioning. It highlights the key commissioners with an interest in addressing each particular outcome.

TABLE C: SUMMARY OF EVIDENCE

Outcome	Effectiveness of the models against outcome	Key commissioners and providers with relevant responsibilities
Reducing reoffending	All three models appear to help reduce reoffending. MST has also demonstrated reductions in serious offences.	Police and Crime Commissioners Youth Offending Services National Probation Service and Community Rehabilitation Companies Directors of Public Health NHS England Health and Justice Teams
Improving health, including mental health	All three models appear to improve mental health. Evaluations also suggest link workers successfully link their clients into mainstream healthcare (GPs) and reduce use of A&E.	Clinical Commissioning Groups Directors of Public Health NHS England Local Area Teams Child and Adolescent Mental Health Services
Improving family relationships	The evidence for MST and wraparound suggests they help families respond to challenging behaviour more effectively. There is so far no research assessing this for link worker services.	Troubled Families programmes Adult social care and children's services
Reducing substance misuse	More evidence is needed for all three models but there is some promising high-quality evidence for MST.	Directors of Public Health Police and Crime Commissioners Youth Offending Services
Preventing entry into custody	Link worker services help to reduce reoffending, implying less use of custody. The evidence is also promising for MST and wraparound, although originates in the US where use of custody may be more common.	Police and Crime Commissioners Youth Offending Services National Probation Service and Community Rehabilitation Companies
Preventing entry into care and use of foster care	Very promising for wraparound and MST but more UK evidence needed.	Children's services Troubled Families programmes
Improving housing situation and preventing homelessness	Evidence is very promising for the link worker model: one evaluation showed an increase in permanent accommodation for link worker clients from 10% to 25% (Battrick et al, 2012).	Local authority housing and preventing homelessness departments Mayor's Rough Sleeping Group- Greater London Authority
Achieving employment, education or training	More UK-based evidence is needed for all three models; some promising findings.	Schools Special educational needs Troubled Families programmes CCGs and NHS mental health trusts

3. The financial case

Delivering these models will require initial investment in staff and services. However, we know that without effective help, people with multiple and complex needs often come into contact with the system in very expensive ways, creating cost through repeated contact with the police, courts and prison; use of emergency rather than primary healthcare services; and through children ending up in care. As Section Two of this briefing outlined, all three models show promise in reducing such costly outcomes, suggesting a potential 'return on investment'.

Currently, there is a small amount of evidence assessing the cost-effectiveness of the models, and further research and quality data collection is required. Nevertheless, the evidence that exists suggests that these approaches will drive savings in the long run.

The financial case for MST

As noted above, there is promising evidence that MST reduces youth offending including those for serious offences. It therefore has the potential to save money on use of youth custody, probation, Youth Offending Services and secure children's homes. The evidence base also shows improved family functioning thereby preventing expensive out-of-home care placements. Some studies have demonstrated the savings:

- One UK based study (Cary et al, 2013) showed that MST saves money in comparison to Youth Offending Services (YOS). The study compared recipients of MST+YOS to YOS recipients alone. After 18 months criminal activity costs for MST+YOS recipients were less than those receiving YOS alone. While MST+YOS was more expensive upfront, taking this into account still left a cost-benefit of £1,222 per young person.
- The Social Research Unit (SRU, 2013) reports that MST saves £2 for every £1 invested, through reduced use of healthcare and the criminal justice system, fewer victims of crime and increased future earnings of participants. It reports costs per participant of £9,730.

MST's upfront costs may be quite expensive, due to the requirement for frequent supervision and training and qualified mental health professionals. However, research suggests it is not significantly more expensive than Youth Offending Services (Cary et al, 2013).

BOX 3: MST AND SOCIAL IMPACT BONDS

In recognition of the potential of MST to save public money, the Cabinet Office and Essex County Council developed a programme to deliver MST through a Social Impact Bond, funded by social investors. Action for Children delivers MST to the most vulnerable families in Essex, providing intensive support to approximately 380 families. The target is to prevent 100 young people from entering into care or custody; success is primarily measured against the reduction of days spent in care or custody, as well as improved school outcomes and improved wellbeing.

For more information about delivering MST and Social Impact Bonds, visit: http://mstuk.org/news/mst-essex-social-impact-bond

The financial case for the link worker model

Link workers help their clients achieve stability which could result in potential financial savings through reduced contact with the criminal justice system, fewer failed tenancies and reduced attendance at A&E. Some evaluations have found a short-term increase in cost but this is often for positive reasons as clients access planned support and interventions, including mental health treatment and substance misuse support. This kind of help should stabilise clients, and researchers have noted a strong possibility of long-term savings due to this increased stability, although more evidence is needed to test this.

- The 2012 evaluation of three Making Every Adult Matter pilots showed an overall increase in the cost of clients' service use for two of the three areas in the first year of operation. Increased costs of support services generally outweighed savings from reduced contact with the police and criminal justice system. However, when measured over two years in Cambridgeshire, client costs to services substantially decreased overall, with an average saving to services of £958 per client per month in year two (Battrick et al, 2014).
- The 2011 DCLG evaluation of the Adults Facing Chronic Exclusion (ACE) pilots found that one link worker service saved health services £149 per client per month and improved health for clients valued at £198 per client per month. Due to the relatively short

time frame of the analysis, this saving did not outweigh the cost of running the pilot. However, the authors stated that some of the ACE pilots may have created savings in the longer term.

- Revolving Doors have developed a Financial Analysis Model, which is in the prototype stage. Early findings, which use data from pilots such as the above, suggest the link worker model could save substantial amounts in the long term.

The MEAM evaluation also reported that the upfront cost of the pilots was relatively low: total costs per area over twelve months ranged from £34,000 - £68,000, with pilots working with on average 23 clients. These costs covered salaries, office space and other running costs, and a discretionary budget to be spent on clients as required.

The financial case for wraparound

More evidence is needed to assess the cost-effectiveness of wraparound. Yet, like the other two models, it appears to reduce costly outcomes such as reduced youth reoffending (in the interim and long term), which should create cost savings through reduced demand on probation, prisons and youth custody. Wraparound also appears to reduce use of the care system, again suggesting potential savings: indeed a US-based wraparound programme recorded considerable savings through the care system and use of inpatient psychiatric services.

4. Key considerations for commissioners and research funders

Commissioners with responsibilities for health, social care, offending and homelessness are in a position to lead in developing effective, targeted responses to people with multiple and complex needs. The three models suggest how this can be achieved and demonstrate that it is possible to respond effectively and that this group is not 'beyond help'. Although the evidence base varies between the models, and more UK based research is required for all three, the models show promising trends of effectiveness and have the potential to be cost-effective in the long run.

Commissioners looking to develop more effective services for people facing multiple and complex needs should consider:

- Key features of effective approaches to tackling multiple and complex needs
- Joint commissioning for multiple and complex needs
- Implementing models in the right way
- Building the evidence base.

Key features of effective approaches to tackling multiple and complex needs

The models highlighted in this briefing offer a direct solution to working with particular cohorts of people facing multiple and complex needs. Although they were developed in different contexts, they also have some important common themes and core principles which should be considered when commissioning any service relevant to this client group. In particular they:

- Take a holistic approach, rather than addressing single needs in isolation
- Offer intensive support, meeting clients multiple times in a week if necessary
- Respond to the individual needs and preferences of service users
- Work proactively and assertively with the client group, even in the face of challenging behaviour
- Are persistent even when clients disengage, seeking to find a solution that works
- Take a preventative approach, rather than only responding to crises
- Take place in the communities in which clients live, not in formal institutions or offices
- Focus on recognising and developing people's strengths, including the 'natural support' of families and communities
- Develop positive, supportive relationships between practitioners and clients
- Ensure the service user's voice is heard and they are placed at the heart of the approach.

Joint commissioning for multiple and complex needs

As people with multiple and complex needs are a group relevant to many different outcome frameworks, jointly commissioning services for this group across both professional and geographical boundaries makes sense and will reduce pressure on individual budgets. Many existing models are jointly commissioned: for example the Tower Hamlets Link Worker Service (Providence Row) has been commissioned by the local Clinical Commissioning Group and the local authority (via Supporting People, a funding stream for housing related support).

Joint commissioning could involve any of the following partners:

- Police and Crime Commissioners
- Local authority Directors of Public Health and commissioners of substance misuse services
- NHS England Local Area Teams and Health and Justice Teams
- Clinical Commissioning Groups
- Community Rehabilitation Companies, the National Probation Service and Youth Offending Services
- Adult Social Care, Children's Services and Troubled Families initiatives
- Local authority housing departments and homelessness prevention teams
- Schools (which now have responsibility for Special Educational Needs budgets).

Commissioners may also wish to consider the different ways to finance models for people with complex needs. While standard payment by results models may prove challenging to implement for this group, exploring Social Impact Bond schemes to help pilot and build the evidence base could be a useful way of leveraging further funding for a scheme upfront while a justice reinvestment model could help to shift funding towards this kind of preventative work.

Implementing models in the right way

When models for service delivery are put into practice, they are not always implemented accurately and what is being delivered is not true to the original model design. Yet poor implementation of a model may result in poorer outcomes than the evidence suggests is possible and can make reproducing success on a large scale difficult. One important way to test model fidelity is to check faithfulness to the core principles of the model (outlined in Table B on page five).

KEY SUCCESS FACTORS TO IMPLEMENTATION

Staff with the right skills and qualities who receive ongoing training	Training and development initiatives could be structured around the core principles of a model
Good quality systems measure progress against outcomes	Mechanisms to share data between different agencies involved in delivery should be in place
Sufficient resources and wider, ongoing support for the model	Pilot evaluations lasting two years rather than one will allow for implementing the right systems, support and resources as well as initial training
A clear theory of change	This will use practitioner experience and research to outline what will be different as a result of intervention, and how.

Building the evidence base

There is potential for research funders to play an important role in developing the evidence base for all three models. Key areas for future evaluation could include:

- Evaluating the effects of MST and wraparound on reoffending rates, use of the care system, health and wellbeing, and drug and alcohol use, in a UK context
- Evaluating the impact of link worker services, particularly in comparison to a control group which so far has not been undertaken
- Developing and expanding on existing theories of change through exploring how change is achieved, for whom, and why.

Commissioners also have a potential role here in funding evaluations and pilot schemes, and ensuring outcomes are monitored and made publicly available where possible.

Visit and get in touch with existing services in the UK

The boxes throughout this report show where these models are already being delivered. Website addresses are included to find out more, or alternatively contact admin@revolving-doors.org.uk if you would like further information about a particular scheme.

More information

Useful sources

These sources are publicly available. A full bibliography is available with the longer evidence review.

Anderson, S. (2010). *Summing Up: Revolving Doors Agency's key learning 2000-2009.* London: Revolving Doors Agency.

Battrick et al (2012). *Evaluation of the MEAM pilot.* London: FTI Consulting LLP.

Cattell et al (2011). *Adults facing Chronic Exclusion: Final Report.* London: Department for Communities and Local Government.

MST Services Online http://mstservices.com

National Wraparound Initiative Online http://www.nwi.pdx.edu/

Contact

To receive a copy of the longer evidence review, to read our other SPARK briefings or simply to find out more about our work, please contact:

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