SOCIAL FINANCE

Social Impact Bonds
September 2021

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FOREWORD AND ACKNOWLEDGEMENTS

The aim of the Essex Edge of Care Social Impact Bond was to improve outcomes for adolescents at risk of going into care. The programme ran from 2013–2018 and was commissioned by Essex County Council (ECC), funded by a group of social investors led by Bridges Ventures[1] and provided by a partnership of Action for Children (AfC) and Social Finance through a project company called CSSL (Children's Support Services Limited).

Using an intensive family-based and evidence-based intervention, Multisystemic Therapy (MST), the service combined rigorous management of operations, data and performance and an ethos of adaptation and continuous improvement to optimise outcomes. Focusing on the number of care days saved as opposed to a binary measure of whether a young person has gone into care or not means that the service was incentivised to work with even the most challenging of cases.

This report contains the final tracking data for the 389 participants aged 11–17 years who received the service and is an opportunity to share this data and reflect on the impact of the programme. The tracking period was for 30 months following case closure.

Existing literature includes the evaluation published July 2019 by the Rees Centre of the University of Oxford when data was available for 302 of the final total of 389 participants.[2] Further information can be found via the Government Outcomes Lab.[3]

We are grateful to programme partners in revisiting their files and for the peer reviewers of this report: Tim Bryson and Cathy James.

Social Finance Limited,
June 2021

1 Bridges Social Entrepreneurs Fund, Big Society Capital, The Tudor Trust, Esmee Fairbairn Foundation, Barrow Cadbury Trust, Social Venture Fund, King Baudouin Foundation, Charities Aid Foundation.

2 Drew, H., Holmes, L., Dunn, V. & Harrison, N. (2019). *Evaluation of the Multisystemic Therapy Service in Essex: Report of the Findings.* Rees Centre.

3 GO Lab (2019). Essex County Council MST. Knowledge Bank database.

Executive Summary

457 **referrals** to the MST service over 2013–2018

389 **families** received the service, with 85% completing

43 **percentage-point reduction in care days** from the baseline of 55% to 11.92%

140,807 **total care days prevented** (days that children were able to remain with their family during the tracking period due to the SIB)

£27.2 **million saved through care days prevented**, leading to net savings of £19.2 million

386 **children who were out of care** / at home with their family at the end of the tracking period (31/12/2020)

The Essex Edge of Care Social Impact Bond[4] (SIB) was the first UK SIB to be commissioned by a local authority at a time when SIBs were relatively rare. Today, there are 89 UK SIBs and over 200 Impact Bonds globally.[5] The need in Essex was to address relatively high levels of children in care in Essex with an intensive preventative service and to create a collaboration that would provide consistent effort over five years and promote operational innovation and improvement.

The Essex SIB sought to improve outcomes for children on the edge of care by acting to keep children within a family setting where their outcomes will tend to be better. Given that around half of spending on children's services is for looked after children, the financial savings from avoided care days is significant and can be reinvested in other areas of need.

The core of the service was multisystemic therapy (MST) with its strong evidence base and prescribed resourcing commitments. An important addition was an innovation fund, a discretionary and flexible resource used to sustain the positive outcomes of the MST intervention for families.

Referrals to the SIB were independently organised through the Council's quadrant panels. The cohort split was 41% females and 59% males, with age when starting MST ranging from 11-17 years, with an average (mean) age of 14.2 years.[6] The average length of therapy delivered was just over 4.5 months, within the expected MST range of 3-5 months.

The highlights of the project are grouped below under the headings prevention, collaboration and innovation.

PREVENTION

The programme achieved a **43-percentage-point** reduction in care days from the baseline of **55% to 11.92%**, significantly reducing the time spent in care against the counterfactual expectations.

These results saved Essex County Council an estimated **£26.2 million** before paying total capped outcomes costs under the SIB contract of £7.2 million. Social investors received a return of **1.45 times** committed capital of **£3.1 million**.

While **91%** of the cohort had social care provision in the two years prior to MST, only **41** young people (**11%**) had provision in the year post-MST. 41 young people (**11%**) cases were in care **28 months** after MST provision finished.

The focus on outcomes and flexible resources of the SIB structure enabled the development and testing of several adaptations distinctive to the Essex MST programme. The practical learnings gleaned have continued to advance practice going forward, both within Essex and more widely.

4 A Social Impact Bond or SIB is an outcomes-based contract designed to achieve measurable outcomes. The SIB is commissioned by government as payer of outcomes and funded by social investors whose financial returns are dependent on and aligned with the social impact achieved. See Glossary for more definitions of relevant terms throughout.

5 GO Lab (2021) Impact Bond Dataset, INDIGO Initiative.

6 Drew, H. *et al*. (2019). Evaluation of the Multisystemic Therapy Service in Essex: Report of the Findings. Rees Centre.

COLLABORATION

The SIB structure facilitated knowledge transfer between partners and included dedicated resources for upskilling and training practitioners in MST, contributing towards embedding MST in the UK context. Many of the adaptations to the delivery model which were enabled through the SIB structure were innovative and novel, enabling testing and learning which has informed ongoing practice.

Key to the impacts of the programme itself was the focus on recruiting and developing best practice leaders. The priority placed on the personal development offer for staff was critical to attracting and retaining high quality therapists, supervisors, and programme managers.

The Essex SIB expanded the national evidence-base for understanding of the key facilitators to programme success and impact. The Rees Evaluation showed the vital importance of an effective therapeutic alliance between the family, especially the parents / carers, and the MST therapist, and the fact that this is underpinned by facilitating consistency in staffing as well as matching therapists and their caseloads well.

INNOVATION

The use of a historical baseline for the counterfactual facilitated early payment of outcomes by Essex County Council. The Essex SIB was one of the first to adopt investment "recycling", by which early outcomes revenues are used to pay for the balance of delivery, thus reducing the amount of social investment required for working capital and minimising the funding costs of the SIB.

The recruitment of an additional 'therapist in waiting', an approach unique to this programme, added flexibility, and enabled the bridging of service gaps resulting from sickness or leave.

Learnings from the Essex SIB have proved valuable in designing subsequent programmes such as Positive Families Partnership (PFP), a pan-London collaboration supporting families on the edge of care offering both MST and Functional Family Therapy (FFT).

CONCLUSION

The Essex SIB, using MST, proved highly effective in diverting children from entering care and helping to reduce what had been a rising level of care entry within Essex. The focus of the SIB on active performance management, a flexible innovation fund, and the investments made in the programme management, quality, and training of staff, together contributed to results which ranked amongst the best performing MST teams in the country.

However, the long-term trend has seen numbers of looked after children rising nationally since 2007/8. Numbers of looked after children are currently at their highest level since the Children Act 1989.

Despite the success of programmes like the Essex SIB that deliver intensive family-based support, there remains a rising need to close outcomes gaps for children in care and to provide effective provision for children on the edge of care.

The Social Context

There are over 80,000 children in care in England,[7] a number that has been rising in recent years. Children over the age of ten make up 63% of this total. Common reasons for becoming a child in need or a child in care include several family-level risk factors, such as family dysfunction or the family experiencing acute stress, alongside other child-level risk factors, like having a disability or experiencing abuse or neglect.[8]

The Essex SIB sought to improve outcomes for children on the edge of care by acting to keep children within a family setting where their outcomes will tend to be better.

BEING LOOKED AFTER IS ASSOCIATED WITH POORER OUTCOMES...

On average, children in care experience poorer outcomes across a range of measures compared to the general population:

- 55.9% of looked after children had a special educational need (SEN) or education, health and care plan (EHCP) statement compared with 46.0% of children in need and 14.9% of the general child population.[9]
- There is a widening 'attainment gap' in reaching expected standards between looked after children and their peers. The size of this is approximately 25–30% at Key Stage (KS) 1 (aged 7) and KS2 (aged 11), and 25% at KS4 (aged 16).
- Looked after children experience disproportionately high levels of exclusion from school, particularly when they are placed away from home.[10] This is despite additional statutory protections that apply to looked after children, which require headteachers to engage with the local authority, virtual school heads, and carers prior to any permanent exclusion.
- Over half of looked after children have emotional or behavioural difficulties.[11]
- In England in 2019, 3% (1160 out of 39620) of 10-17 year old looked after children were convicted or subject to youth cautions, or youth conditional cautions,[12] compared to a national rate of 0.4% (21,700[13] out of 5,185,725[14]) for that same age range.
- Looked after children are less likely to be in education, training, or employment.[15]

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7 80,080 looked after children at 31st March 2020, up 2% on the previous year. *Source*: ONS (2021) Children looked after in England including adoption 2019 National Tables: 2018 to 2019; 2020 figures.

8 Berridge, D., Luke, N., Sebba, J., Strand, S., Cartwright, M., Staples, E.E., McGrath-Lone, L., Ward, J. & O'Higgins, A. (2020) Children in Need and Children in Care: Educational Attainment and Progress. Rees Centre and University of Bristol.

9 DfE (2019) Outcomes for children looked after by local authorities in England, 31 March 2019.

10 McRae, J. (2006) Children looked after by local authorities: the legal framework.

11 Department for Education, March 2019, SDQ data scores.

12 ONS (2020) National – Conviction and health outcomes for children looked after continuously for 12 months.

13 Youth Justice Board (2020) Youth Justice Statistics 2018–2019. London: Ministry of Justice.

14 ONS (2020) Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019.

15 NSPCC (2019) Statistics briefing: looked after children.

...AND IT IS EXPENSIVE TO THE TAXPAYER

Around half of spending on children's services is for looked after children. This equated to around £4bn in 2018, an increase of 22% in real terms since 2010 attributable to the rising numbers of children in care.[16] Within the costs associated with the looked after cohort, most of the financial pressure facing local authorities results from the need to find specialist residential placements for children with significant additional needs.[17]

ESSEX CONTEXT

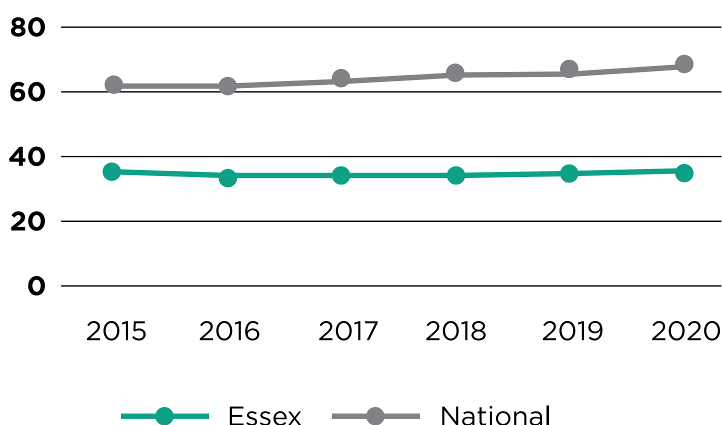
Prior to the SIB's launch in April 2013, Essex had experienced higher rates of entry to care for 10-17 year olds than the national average. Early feasibility work in Essex and case file analysis had shown that, once a child aged 11–16 years went into care, it was likely that they would spend more than 80% of the rest of their childhood in care.

The high level of need, high cost, and poor outcomes for this group led Essex to consider services that shifted towards prevention by building family strengths and resilience, which, in turn, would reduce future dependence on local authority services.

The underlying trend since 2013 in Essex has been one of improvement and stabilisation of the numbers of children in care. Over the project's life, from 2013–2018, looked after children numbers in Essex were on a declining trend from 1,255 in 2013 to 1,015 in 2018.[18]

In Essex, the number of looked after children has fluctuated over the past five years, ranging from 1,006 in 2016 to 1,071 in 2020.[19]

Figure 1: Chart showing how the rate of children looked after per 10,000 under 18 year olds has changed between 2015 and 2020, in Essex and nationally. The national rate increases from 60 to 67 over this 5-year time period, whereas the rate for Essex remains consistently lower at a steady 33/34.



16 Office of the Children's Commissioner (2019). Written evidence submitted by the Children's Commissioner for England [ACS 058].

17 *Ibid.*

18 ONS (2020). Children looked after in England including adoption 2019 LA Tables: 2018 to 2019; 2020 figures.

19 *Ibid.*

ESSEX SIB STRUCTURE AND INVESTORS

FIRST SOCIAL IMPACT BOND COMMISSIONED BY A LOCAL AUTHORITY

This was the first SIB to be commissioned by a local authority at a time when these outcomes contracts were relatively rare. This funding structure offered Essex the opportunity to target investment into a preventative evidence-based intervention to support a group of young people with complex needs. This group, more often than not, placed a great strain on the care system, and in doing so deliver direct financial savings.

The primary outcome metric on which success was measured is the aggregate number of care placement days saved, compared against a baseline historical comparison group. Investor returns were therefore determined by the reduction in days spent in care amongst the service users compared to this historical baseline. Focusing on the number of care days saved as opposed to a binary measure of whether a young person has gone into care or not means that the service was incentivised to work with even the most challenging of cases.

Young people were tracked for 30 months – two and a half years – post referral into the MST service. Outcomes were measured quarterly to generate small regular outcome payments, rather than waiting for a bullet payment at the end of the programme. This approach required a payment mechanism that assumed payments in advance with retrospective adjustment based on results which proved overly complex to administer for both parties.

SERVICE FLEXIBILITY

The core of the service was multisystemic therapy (MST) with its strong evidence base and prescribed resourcing commitments. An important addition to the overall cost budget was an innovation fund, a discretionary and flexible resource used to sustain the positive outcomes of the MST intervention for families.[20]

FINANCIAL INNOVATION THROUGH RECYCLING

The use of a historical baseline for the counterfactual facilitated early payment of outcomes by Essex County Council. This enabled the investors to reduce the amount of investment required (saving the programme finance costs) and recycle early outcomes revenues to pay for the ongoing MST service. This approach also gave investors greater visibility of the likely success of the programme and ability to adapt the service model and make best use of the flexible innovation fund. Innovative at the time, this recycling approach has since become standard for most SIB models as it is cost efficient for the commissioner.

COHORT AND REFERRALS

Over the life of the programme, the service worked with 389 young people aged 11–17 years and their families (compared with a target of 384).

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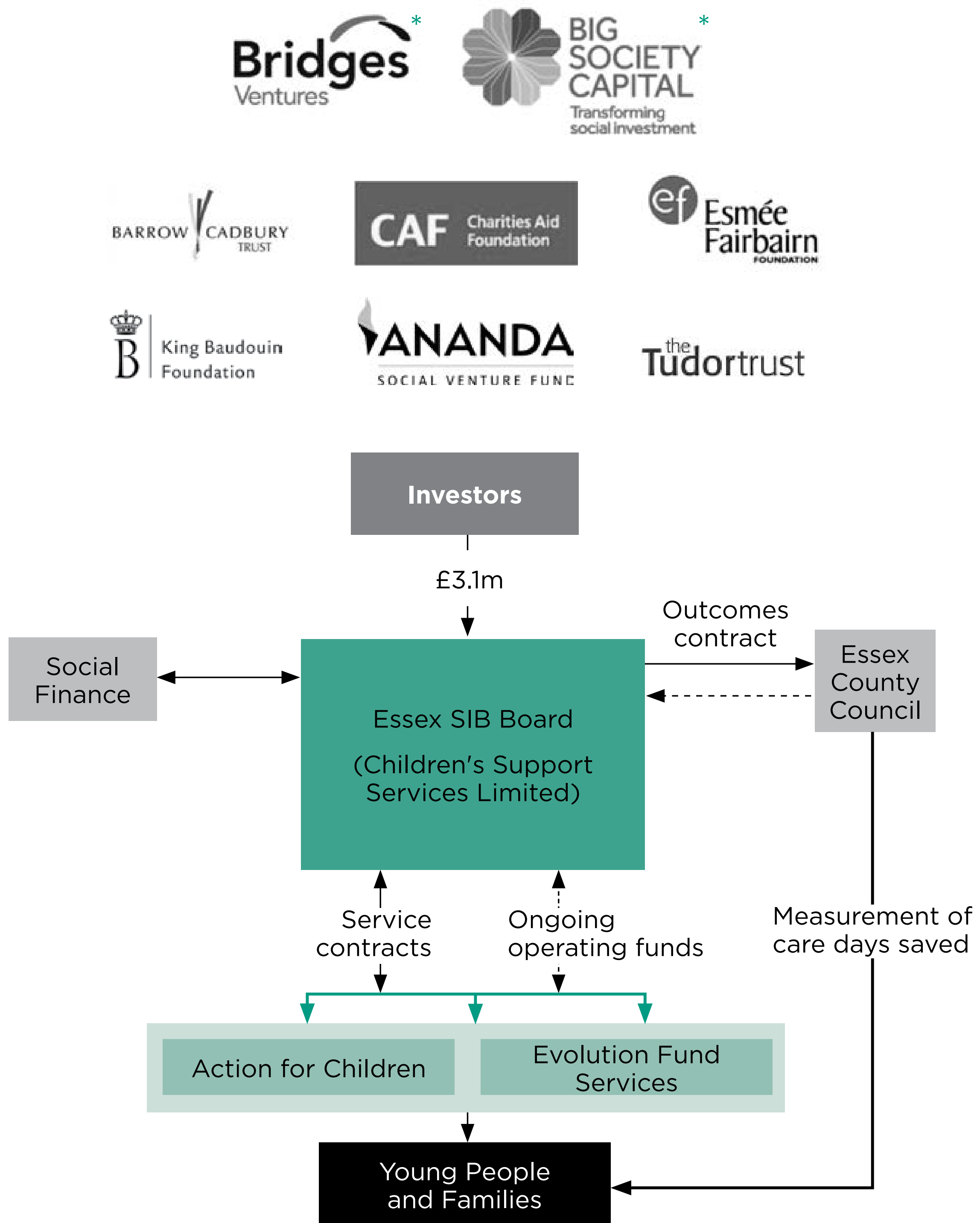
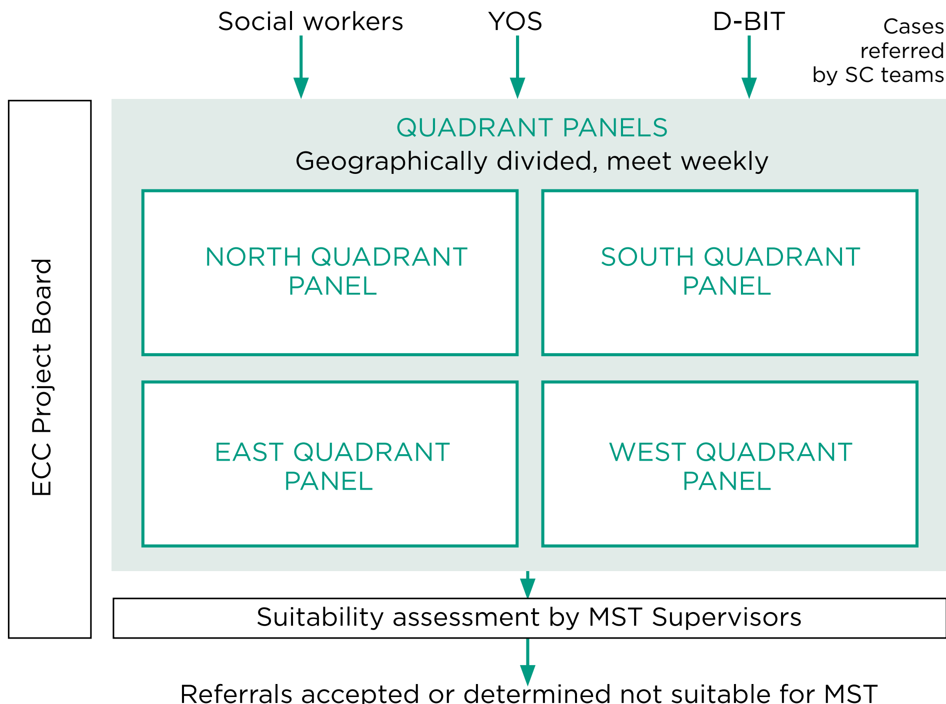
20 Examples of applications include pro-social activities such as music lessons for the young person and the provision of equipment or tickets which encourage positive family interactions such as camping equipment for family holidays. *Source:* Green, B. & Matthews, N. (2014) *The Essex Social Impact Bond: A Year In Review*, p.36. Social Finance UK.

Figure 2: **Flow chart showing the structure of the Essex SIB.**



* Represented on the Essex SIB board

Figure 3: Visualisation of the referral mechanism for the Essex MST SIB.



The cohort split was 41% females and 59% males, with age when starting MST ranging from 11–17 years, with an average (mean) age of 14.2 years.[21]

The average length of therapy delivered was just over 4.5 months, within the expected MST range of 3–5 months.

As MST was one of the external services delivered by Essex County Council Children's Social Care, a crucial element of the project was establishing the referral mechanism for the SIB and ensuring that this remained independent. Referrals came directly via Social Workers, Youth Offending Services, D-BIT (divisional based intervention teams[22]) or other services, and were reviewed by Quadrant Panels, who provided an independent assessment of cases and endorsed those which were appropriate for MST to the MST supervisors. This mitigated the risk of creating perverse incentives not to refer a child to the care system if this was the appropriate course of action. The Essex County Council Project Board oversaw the process for an additional level of accountability.

21 Drew, H. *et al.* (2019). *Evaluation of the Multisystemic Therapy Service in Essex: Report of the Findings*. Rees Centre.

22 Turney, D. and Merchant, W. (2017). *A Review of the Divisional-Based Intervention Team (D-BIT) Service*. University of Bristol.

SIB PROJECT TIMELINE

The SIB delivery period was from April 2013 to December 2018 with the 30 months tracking resulting in final data collection in February 2021.

DATE	TIMELINE
2011	Discussions about the SIB and feasibility work CSSL formed with eight investors
2012	Outcomes contract and associated agreements signed off Action for Children appointed as service provider
2013	MST service goes operational in Essex with two MST teams
2014	'A Year in Review' published 50 cases opened, 24 cases completed, 19 young people remaining at home.
2015	'Two years on' event, interim OPM evaluation report, MST Programme Manager role created and appointed
2016	CSSL staff retention scheme developed and agreed
2017	OPM evaluation report published
2018	April – outcomes payment cap reached July – referrals cease, 388 cases opened since inception September – one MST team finishes December – 335 fully completed cases, 35 YP in care. Service closed
2019	End of project learning events Rees Centre evaluation report
2021	Care outcome tracking ends Final report

MST Service Model

NATIONAL CONTEXT

Multisystemic Therapy (MST) is an intensive evidence-based therapeutic treatment, which aims to promote positive social behaviours in adolescents who demonstrate significant behavioural issues and are at risk of out-of-home placement.

MST has a global footprint – more than 500 teams in 15 countries with an evidence base covering work with 200,000 families. Each MST team can work with around 40 families per year. MST was first established in the UK in 2001 and there were 35 teams in operation when the Essex SIB was launched. The standard form of the MST programme was used for the Essex project, which typically involves working with young people aged 11–17 years and their family over 3–5 month period.

Therapists work with family members and carers to build their confidence and skills, enabling them to communicate and engage with the young person more effectively and contributing to lasting change for the whole family. This involves working together to develop individualised treatment plans designed to target specific problems and break negative cycles, focusing on positive behaviours and the strengths of the individual, family, peers, and community.

Therapists undergo intensive training and are supported by weekly consultations with an MST expert. The service is underpinned by a rigorous assessment of adherence to the treatment model and the outcomes achieved.

Through MST, the whole environment of the young person is considered, including their school, family, peers, and community. Therapy sessions with the young person and their family are delivered in the home, reducing barriers to service access, with additional engagement outside of the home to improve behaviours across all aspects of their individual environment. Where home therapy is not possible, therapists may use videoconferencing.

MST is provided under license to MST Services Inc. in the US and, as part of this contract, MST Services oversees MST outcome and adherence data collection and oversee MST team and therapist consultation and development. At the start of the project in Essex consultation was received from an MST expert based in the US but this was transferred to a UK based MST expert, who was part of the MST-UK Network Partnership, part way through the project.

Figure 4: **MST Therapists: 24/7 therapist availability; 4–6 cases per therapist at a time; 3–5 month average treatment.**

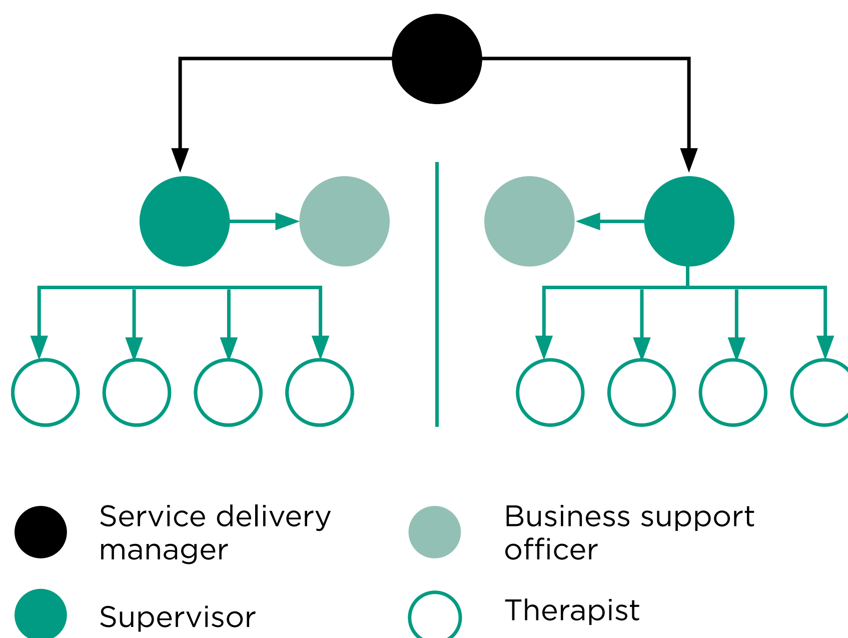
MST IN ESSEX CONTEXT

MST was especially relevant to Essex at the time the programme was established, in the context of a desire to limit the number of inappropriate care placements and a need to focus on a specific cohort of young people and families with complex challenges, particularly anti-social behaviours, youth offending, and conduct disorders, who were at heightened risk of being placed into residential care.

The MST service in Essex targeted adolescents aged 11–17 years who displayed anti-social or offending behaviour or other conduct disorders that put them at risk of an out-of-home placement. Given that Essex is a large county, the SIB was delivered by two teams of four therapists, each managed by a supervisor and supported by a business support officer. The service as whole was overseen and coordinated by a service delivery manager from Action for Children.

During the course of the five-year programme delivery period, there were changes in the profile of needs and risks associated with this cohort, including increasing problems with drugs and county lines. The MST teams operated alongside an in-house programme developed by Essex called D-BIT, which also worked with an edge of care cohort but with a more flexible referral criteria than MST. The MST programme delivered good outcomes in reducing care entry results with highly trained staff. In the end, the decision was taken not to retain an MST service beyond the life of the SIB.

Figure 5: Service structure for delivery of the Essex MST service.



Our Impacts

PROGRAMME OUTCOMES: DAYS YOUNG PEOPLE REMAINED WITH THEIR FAMILY

COMPLETION RATES

- **85%** of starters completed the full treatment course

CARE DAYS AS A METRIC FOR TIME SPENT IN CARE (PRIMARY OUTCOME)

- The programme achieved a **43-percentage-point** reduction in care days from the baseline of **55% to 11.92%**, significantly reducing the time spent in care against the counterfactual expectations.
- These results saved Essex County Council an estimated **£26.2 million** before total capped outcomes costs under the SIB contract of £7.2 million. Social investors received a return of **1.45 times** committed capital of **£3.1 million**.
- While **91%** of the cohort had social care provision in the two years prior to MST, only **41** young people (**11%**) had provision in the year post-MST. 41 young people's cases (**11%**) were in care **28 months** after MST finished.
- As at November 2018, only 46 cases (12%) of 381 completed cases experienced a conviction during their MST treatment period against a programme target of below 20%. The number continuing to offend measured four months after their MST programme completed dropped to 32.
- Success rates improved over time, but early cohorts proved too close to care entry for effective provision. There was a learning curve for both referring staff and teams, and for the MST teams regarding suitable referrals, the referral pathway, and expertise in the intervention. For example, time spent in care was 100% for Cohort 1, 66% for Cohort 2, 30% for Cohort 3, and improved with time to stabilise around 12% from Cohort 15 onwards compared to a baseline of 55%. The team learnt the appropriate level of proximity to care for engagement with the service. Through a series of quarterly assessments of outcomes, stakeholders had a much clearer idea early on of the success of the programme, and therefore more time to adapt the service delivery model as required.

FISCAL BENEFITS

- Gross savings to Essex County Council are estimated at **£26,190,102** (based on 140,807 actual care days saved), which is more than three times the contract cap on outcomes payments of £7.21 million (excluding VAT) that was reached, earlier than anticipated, in the quarter to March 2018.[23]
- Outcomes achieved above the contract cap represented benefits that ECC did not need to pay for. Net savings amounted to **£19,169,102** (Total Savings generated by the SIB of £26,190,102 [140,807 days x £186] less total capped outcomes payments of £7,210,00). This is equivalent to 103,060 care days saved.

23 CSSL board paper (4/12/2018) p.19.

WIDER OUTCOMES

This programme has a strong track record of evaluations, on which our final data analysis builds.

IMPACTS ON CHILDREN AND FAMILIES

Interviews with nine families conducted during the Rees Evaluation demonstrated 'a profound and positive impact' on the family dynamic as a result of the service.[24] Quantitative analysis conducted as part of this evaluation supported this with evidence of a significant reduction in child in need plans, child protection plans, and care entries following MST.

> (Parent) 'I would say there is a better family dynamic as we understand each other more. We can talk more rather than shout.'
>
> (Young person) 'Mum listens to me now and that is nice. I think my mum understands me more and some of the things I have been through, and I like that she knows these things now.'

Source: Report by Sarah Reeves, Programme Manager, March 2019

EMOTIONAL WELLBEING

Data was collected using SDQ (Strengths and Difficulties Questionnaire) scores with 171 parents participating. The starting point for these young people was relatively high with a high level of behavioural difficulties and possible mental health problems. The data collected showed a statistically significant reduction in SDQ scores from 22.4 to 17.8.[25] The results from SDQ data indicate that, following MST involvement, there was a significant improvement in the difficulties faced by young people. In addition, from the SDQ sub-scales analysis there were marked reductions in conduct problems and problems with peers, as well as an increase in prosocial behaviours. However, high levels of difficulties remained.

> (Parent) I think me recognising when things are going to kick off and then do something different before there is an escalation has led to some really big changes.'
>
> (Parent) 'I learnt how to problem solve and hadn't even realised that I could.'
>
> '(The therapist) helped me to understand how E might perceive things... I'm a lot more understanding... stopping and thinking before going off at the deep end.'

Source: Report by Sarah Reeves, Programme Manager, March 2019

24 Rees Evaluation press release (2019).

25 Sarah Reeves, MST programme manager, March 2019.

CASE STUDY: JACK

Jack was referred to the MST service alongside his brother, Harry, due to their mother, Jane, struggling to cope with their behaviour. At the point of referral Jane was finding the behaviour of the two boys so difficult to manage that she had decided that the two younger siblings should live with their father, whilst she worked with MST to effect change in the older boys' behaviours.

Jack had been through some challenging times with the death of his best friend and recently finding that who he thought was his dad, was not. Jack also presented with Tourette's, with motor and physical verbal tics, epilepsy with absent seizures as well as diagnoses of obsessive compulsive disorder (OCD) and depression.

At the time of referral Jack was presenting with a variety of challenging behaviours, including use of cannabis and cocaine, verbal and physical aggression towards his brother, property damage, and no engagement in school. Jane's biggest concern was Jack's drug use, which clearly impacted on his other behaviours. A priority goal was for Jack to cease all drug use, as demonstrated by no signs or symptoms of substance use, clean urine tests, no paraphernalia on his person or in the home, and no evidence of purchasing drugs. The therapist and Jane recognised that the main antecedents for the drug taking were lack of supervision due to Jack not attending school, Jack socialising with a group of peers who were also involved in using drugs, alongside Jane not setting out clear expectations and incentives for Jack to cease drug use.

The therapist initially worked with Jane, helping her to set clear expectations for Jack, and to consistently implement rewards and consequences. Drug testing was used as an effective intervention, with Jane randomly testing Jack for substances two or three times a week. Jack earnt a £10 voucher for each week of clean tests. Jane provided an additional bonus of a new PlayStation game every two weeks if both weeks had been clean. Consequences were put in place when Jack refused or tested positive (for substances), with Jack having his PlayStation removed for 24 hours.

Although Jack did not wish to take part in sessions initially, he was gradually able to open up to the therapist and his mother about his difficulties in refusing drugs when encouraged to do so by his peers. The therapist helped Jack develop his assertion and drug refusal skills; over time Jack also became more aware of the unhelpful influence of his peers, and decided to mix with them less. Jack, Jane, and the therapist problem-solved around other activities that Jack could become involved in, rather than meeting with his former peer group. Another focus of the work was on increasing Jack's school attendance.

Jack reported that the rewards were a big incentive for no longer using drugs, and 'why would I risk doing it[drug taking], when I wouldn't get the rewards'. He also spoke of his improved relationship with Jane, feeling that she better understood him.

By the end of the MST programme, Jack was providing clean tests, and had completely ceased all drug taking for over a month. Jane decided that she would like to continue to carry out random drug tests on Jack, and Jane and Jack talked about rewards and consequences that Jane would be able to implement in the future. Changes in Jack's social network and improved attendance at school meant that he was also less likely to be exposed to peers who were involved in drug taking, although he acknowledged that he missed 'the excitement' of this part of his life.

At case closure Jack's younger siblings were still living with their father, although Jane was preparing for them to return home.

IMPACTS ON LOCAL PRACTICE

The Rees Centre evaluation highlighted a 'shift in thinking and understanding about the need to work with and understand trauma in families, and the many systems that impact on a family's functioning' (Drew *et al.*, 2019, p.33).[26] Over the course of the programme, there was a deepening understanding of the kinds of cases for which MST is most appropriate. Namely, whilst earlier cohorts included families who were too proximate to care to be able to make the most of MST, as the service became more established locally, referrals increasingly reflected a cohort of families who were more meaningfully able to engage with the intervention.

> (Parent) 'Our therapist wasn't judgemental, and I felt like she has respect for us, which is unusual. I felt supported rather than blamed.'
>
> (Parent) 'She would tell us how it is, and I liked that because I felt like she was being truthful, and was also able to challenge us on some of the things we were doing.'
>
> **Source: Report by Sarah Reeves, Programme Manager, March 2019**

Benchmarking of the programme against MST national averages showed above-average retention and utilisation of staff. The MST service in Essex was one of the best-performing nationally. Proactive management in the early stages of establishing and embedding the service led to a reduction of staff turnover, from turnover of 40% in year one of delivery, to nine percent in year two and 20% in year three.[27] Throughputs were also high throughout the service delivery period, with teams holding case volumes which were higher than the national average whilst maintaining above-average performance. Although not the highest level of utilisation of all existing sites in UK and Ireland, this is indicative of improvements to efficiency in the Essex model.

Action for Children were experienced providers of MST elsewhere, but the Essex SIB was a distinctive experience for them in terms of the intense and demanding model and high degree of ambition for change. Many of the adaptations to the delivery model that were enabled through the SIB structure were innovative and novel, enabling testing and learning which has informed ongoing practice. The SIB structure facilitated knowledge transfer between partners and included dedicated resources for upskilling and training practitioners in MST, contributing towards embedding MST in the UK context.[28]

IMPACTS ON NATIONAL PRACTICE

Although the service was not re-commissioned beyond the five-year delivery period, it has had a significant legacy. The Commissioners' decision not to continue the service was related to the needs of the target population in Essex changing as rates of children entering care decreased and the focus shifted towards more urgent issues including county lines. However, elsewhere in the UK, where there remains a vital need to target those families with children or adolescents on the edge of care with behavioural issues, the Essex SIB has opened doors for the development of further impactful programmes.

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26 Drew, H. *et al*. (2019). *Evaluation of the Multisystemic Therapy Service in Essex: Report of the Findings*. Rees Centre.

27 Sin, C.H. (2016). *Evaluation of the Essex Multi-Systemic Therapy Social Impact Bond: Findings from the first three years.* Office for Public Management (now Traverse).

28 *Ibid*. p.26.

LESSONS LEARNED FROM DELIVERING THE SIB

This final section of the report collates lessons learned from reflecting on the programme overall, following its completion. The learnings outlined here build on the extensive evidence of impact captured in previous evaluations (particularly the 2019 Rees Centre Evaluation, which focused on assessing the MST intervention itself as well as the whole programme).

The distinctive programme structure and funding of the Essex SIB enabled innovation in service delivery and helped to inform similar initiatives at scale, most notably the London multi-borough SIB Positive Families Partnership.

TEST & LEARN FACILITATOR

The focus on outcomes and flexible resources of the SIB structure enabled the development and testing of several adaptations distinctive to the Essex MST programme. The practical learnings gleaned have continued to advance practice going forward, both within Essex and more widely.

REFERRALS AND PROGRAMME LEADERSHIP

Recruitment delays early in the programme reflected in part the squeezed nature of the commissioning process whereby recruitment initiatives had to start before the contracts were executed. Building in and funding an adequate mobilisation period is a common challenge in these outcomes contracts.

The SIB recruited and paid for an expert programme manager, with clinical experience of MST, whose engagement with staff across Essex and particularly social workers helped to build an understanding of the MST service and the families who would most benefit from it. This is considered to have played a significant role in the improved outcomes of families participating in the programme once it was more established, compared with those in earlier cohorts. The SIB was also able to start work with some cases where parents/ families could engage but the child was not yet willing, which distinguished the SIB offer from the alternative provision available in Essex.

INVESTMENT IN STAFF AND TRAINING

Key to the impacts of the programme itself was the focus on recruiting and developing best practice leaders. The priority placed on the personal development offer for staff was critical to attracting and retaining high quality therapists, supervisors, and programme managers. This included prioritising resources for team management incentives and training, including sending some practitioners to train in MST in the US and Europe, alongside investing early in building a team which incorporated well-regarded senior oversight and supervision along with clinical skills and experience.

Interviews with practitioners conducted by the Rees Centre reflected a consensus that training and experience in MST had benefited their own practice, through contributing to a deeper therapeutic understanding of behaviours and bolstering practitioners' resilience and ability to cope.

The recruitment of an additional 'therapist in waiting', an approach unique to this programme, added flexibility, and enabled the bridging of service gaps resulting from sickness or leave.

This contributed to a highly efficient and effective team culture, with the service standing out as one of the best-performing MST services in the UK at the time. The outstanding work of one

member was recognised through winning MST Services Whatever It Takes Award. These initiatives also contributed to a remarkably high degree of staff retention over the five-year programme.

Whilst the motivation of the SIB stakeholders towards staff retention to optimise delivery was particularly important in the latter stages of the programme, throughout it provided a consistency which was essential for families, who often experience constant changes to their allocated social workers. In the final year of the service, as it became clear that it would not be re-commissioned, there was a higher risk of the service suffering if people were to begin to move on. Additional flexibility from having an extra 'therapist in waiting', coupled with a retention payment and a three month extension for one MST team, enabled the service to keep delivering the same quality of service until the final day of delivery, as reflected in the data that demonstrate sustained outcomes.

FLEXIBLE INNOVATION FUND

There were multiple benefits to combining an evidence-based core intervention with a flexible innovation fund, most notably improving family engagement. The flexibility and accessibility of the fund was highly valued by the MST therapists and by Action for Children, who found that it enabled the rapid removal of barriers for families in a personalised and holistic way.[29] The fund also enabled young people to take up pro-social opportunities such as joining a gym or a club, or for the whole family to undertake activities or outings that improved relationships and communication. The SIB was also able to retain some funding to sustain family contacts post therapy and help families through moments of family crisis.

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29 Sin, C.H. (2016). *Evaluation of the Essex Multi-Systemic Therapy Social Impact Bond: Findings from the first three years.* Office for Public Management (now Traverse).

SCALE FACILITATOR

Learnings from the Essex SIB have proved valuable in designing subsequent programmes such as Positive Families Partnership (PFP), a pan-London collaboration supporting families on the edge of care offering both MST and Functional Family Therapy (FFT).

INTEGRATED AND COMPLEMENTARY REFERRAL ROUTES

PFP has established effective referral routes across children's services and youth offending services to mitigate against the risk of excluding families through siloed services, drawing on learnings from Essex around the importance of investing early in establishing integrated referral routes. This approach is also reflected in a continuing trend of adaptation of referral pathways in MST nationally.[30]

The PFP service was designed to offer either FFT or MST depending on need, engagement level of the young person, and caseload intensity. This contrasts with the early experience of the Essex SIB, which was not designed with such close engagement with existing operational delivery and, as a result, experienced challenges in securing referrals in the first few months of the service.

SIMPLIFIED PRICING MODEL

The payment and verification mechanism in Essex was well-targeted, basing payments on a frequency measure of care days saved. This encouraged consistent effort across the whole cohort and aligned impact with the primary financial / cost measure of success.

The Essex SIB further provided for payments to be made in advance and then adjusted based on performance in order to smooth cashflows and limit the amount of investment capital required. This proved too complex and a simpler approach was adopted for PFP. Here, regular payments are made for each day in which participants stay out of care with aggregate payments being subject to an overall cap. The Essex partners shared results from initial cohorts, along with learnings regarding how and why outcomes improved as the service became more established. These outputs from the Essex SIB provided valuable data to help establish appropriate baselines and targets for PFP.

EFFECTIVE THERAPEUTIC ALLIANCE

The Essex SIB expanded the national evidence-base for understanding of the key facilitators to programme success and impact. The Rees Evaluation showed the vital importance of an effective therapeutic alliance between the family, especially the parents / carers, and the MST therapist, and the fact that this is underpinned by facilitating consistency in staffing as well as matching therapists and their caseloads well.[31]

Learnings from Essex also highlighted the need for holistic provision, for example complementing the MST intervention with specialist support in cases where young people were experiencing underlying mental health problems, as well as the challenges to accessing this.[32]

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30 Cathy James, MST Lead UK and Ireland. (2021).

31 Drew, H. *et al.* (2019). *Evaluation of the Multisystemic Therapy Service in Essex: Report of the Findings*. p.6. Rees Centre.

32 *Ibid*. p.7.

Conclusion

The Essex SIB, using MST, proved highly effective in diverting children from entering care and helping to reduce what had been a rising level of care entry within Essex. The focus of the SIB on active performance management, a flexible innovation fund, and the investments made in the programme management, quality, and training of staff, together contributed to results which ranked amongst the best performing MST teams in the country.

As a Social Impact Bond, the Essex programme has a legacy. The first to be commissioned by a local authority without central government subsidy, it demonstrated the potential value to commissioners of preventative interventions where the positive impact is well evidenced, and the avoided costs are significant. It also established the pattern of future SIBs in being funded using recycling of investor capital, such that outcomes revenues received are used to pay for the balance of delivery in priority to investor returns, thus helping to reduce the overall cost of finance to the project.

However, the long-term trend has seen numbers of looked after children rising nationally since 2007/8. Numbers of looked after children are currently at their highest level since the Children Act 1989.[33] This is in the context of even greater increases in rates of other child protection activity, such as the number of child protection investigations (Section 47 enquiries) and Child Protection Plans (CPPs).[34]

There is evidence to suggest that the cost per child in care is also rising.[35] Anne Longfield, as Children's Commissioner for England, noted in written evidence submitted to the Housing, Communities and Local Government Committee in May 2019, that "several councils have reported to us that spend on placements for children in care has increased by 30% over the past two years".[36]

Despite the success of programmes like the Essex SIB which deliver intensive family-based support, there remains a rising need to close outcomes gaps for children in care and to provide effective provision for children on the edge of care.

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33 Family Rights Group (2018). *Care Crisis Review: options for change.*

34 Housing, Communities and Local Government Committee (2019). *Funding of local authorities' children's services.* London: Parliamentary Copyright House of Commons.

35 Note that the costs associated with families on the edge of care, the participants in this intervention, are likely greater than that indicated by the data available for children on the edge of care. However, there is little evidence available regarding the costs associated with whole families on the edge of care.

36 *Ibid.*

Glossary

'Child': here, we use this term to refer to all those under the age of 18, in accordance with the definitions incorporated into the Children Act 1989 and the United Nations Convention on the Rights of the Child. In some instances, 'young person' may also be used to refer to those aged 14–17.

Child in Care (CIC): Where the court places a child in the care of the local authority, for example in a foster family or in a children's home.

Child in Need (CIN): Where a child is receiving social work services due to concerns over their health or development, or because they are disabled. They usually remain living with birth parents or relatives, supported by a multi-agency Child in Need Plan (CIN); or, when there are greater concerns over safety, by a Child Protection Plan (CPP).

Divisional Based Intervention Teams (D-BIT): An internally commissioned Essex County Council service that works with a similar group of young people to those supported through Multisystemic Therapy, where there is a risk of entering care or custody.

Looked after child: Children who are being looked after by their local authority.

Social Impact Bond (SIB): A Social Impact Bond or SIB is an outcomes-based contract designed to achieve measurable outcomes. The SIB is commissioned by government as payer of outcomes and funded by social investors whose financial returns are dependent on and aligned with the social impact achieved.

Strengths and Difficulties Questionnaire (SDQ): This short behavioural screening questionnaire describes the emotional and behavioural health of looked after children, as recorded by a main carer. It should be completed for every child looked after for at least 12 months and aged 5–16 years.

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