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North Wales Children and Families Partnership

Early Intervention and Intensive Support for Children and Young People Transformation Programme

Evaluation Report for North East Wales Multisystemic Therapy Service

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OXFORD BROOKES UNIVERSITY

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Executive Summary

The North East Wales Multisystemic Therapy (MST) service began working with families in May 2020, having successfully recruited and trained staff and obtained a licence to deliver the first MST standard programme in Wales during the Covid 19 pandemic lockdown. By December 2020, 27 families had accessed the service, 14 had completed and 13 were still receiving a tailor made package of interventions and support.

MST is an intensive family and community based intervention for children and young people aged 11-17, where young people are at risk of out of home placement in either care or custody. It is a well-regarded, evidence based approach that achieves excellent long term results for young people and families[1].

The evaluation carried out by the Institute of Public Care has included in-depth case file analysis of the first 9 cases to complete the programme, as well as interviews with four parents and a young person. Interviews with partner agency staff and managers and a focus group with the MST team as well as secondary analysis of management information provided other valuable perspectives. Our key findings are that:

The team moved quickly to implement a new service and adapted ways of working to ensure that delivery would not be interrupted by the pandemic. It is the first time that an MST team has successfully completed the specialist training on-line.

The 'right' families are accessing the service, by which we mean the target population of children and young people with complex Emotional and Behavioural Difficulties (EBD) linked to Adverse Childhood Experiences (ACEs), at risk of family breakdown for whom other services and interventions have not worked.

Families have engaged really well with the service. Key aspects that have facilitated the high level of engagement by families are the rapid response following referral; highly skilled workers able to build trusting relationships; the 24/7 "whatever it takes" approach, working intensively with the whole family in their home; a model of care that combines crisis support with long term behaviour change using therapeutic interventions; and a focus on empowering parents, so that change is sustainable.

A key focus of MST is to work with the "ecology around the young person". **The MST service has worked effectively alongside other agencies,** including schools, social workers, youth offending team, and voluntary sector organisations by facilitating joint planning, review and exit strategy meetings, sharing insights they were gaining from working closely with the family, and helping to manage challenges that arose in different settings. Partner agency staff said they felt more confident and supported in their work with these children and families and able to manage risk effectively working alongside the new service. They also said they were beginning to feel more confident (still early days) about the overall arrangements locally for meeting the needs of children and young people with complex emotional and behavioural difficulties.

[1] MST website (no date) accessed 18.2.2021. Available at: http://www.mstuk.org/mst-research-outcomes/international-research

Very good outcomes for children, young people and families have been achieved. In 7 out of the nine cases we looked at parenting has improved, which has empowered parents to feel more in control and able to manage their child/young person's behaviour and meet their needs. Families have become more resilient with better relationships and stronger capacity to cope with difficulties. There have been improvements in the child/young person's emotional wellbeing, fewer behavioural problems and better educational and employment outcomes. Statutory services are no longer involved with families and children/young people have remained in the family home. In the two cases where a placement was needed, it appears that this may have been because the intervention had come too late or parent(s) had severe and complex needs of their own that 'got in the way' and prevented them from engaging fully in the behaviour change work.

Overall this evaluation demonstrates that the North East Wales MST service has made an excellent start, all be it for a small number of children/young people and families. The final evaluation in a year's time will demonstrate whether the positive changes in these families have been maintained and whether the service continues to bring about positive change and improved outcomes for more families.

1 Introduction

1.1 Background to the evaluation

This report outlines findings from an early evaluation of a new Multisystemic Therapy Service (MST) for children and families in Flintshire and Wrexham, carried out by the Institute of Public Care (IPC). The service has been developed as part of the North Wales Early Intervention and Intensive Support for Children and Young People's Transformation Programme which has received funding from Welsh Government to transform approaches to working with children and families to improve outcomes.

Early work to produce a Theory of Change for the Programme identified an urgent need to address the growing numbers of children with emotional and/or behavioural difficulties (EBD) entering care in a crisis with complex needs that are currently met largely through out of area residential placements. All partners agreed that this situation needed to change and radical re-thinking and new approaches were needed to keep children out of care and improve their life chances. Key elements of the new approach include the formation of multi-disciplinary teams to ensure an integrated response; a recognition that therapeutic interventions would be needed to address Adverse Childhood Experiences (ACEs) and the work would need to include both parents and children.

From the outset it was recognised and agreed that local areas would develop their own choice of 'model of care' in response to local needs and the views of local stakeholders. The Programme as a whole is supporting areas to try out different models to test 'what works', 'with whom', 'why' and in 'what circumstances' to build an evidence base of good practice that can be shared around the region and more widely across Wales. It was also acknowledged that implementation of new models of working takes time and is likely to happen in stages.

This evaluation report focuses on the work that has been done in the East area across Flintshire and Wrexham in 2020 to establish a new service that responded to local need in a more integrated way and focused on a cohort of children and families with complex needs for whom existing interventions hadn't worked or thresholds were too high and a new response was needed.

1.2 Baseline analysis

IPC interviewed professional stakeholders from across the region in December 2019 before the Transformation Programme was implemented and identified a number of issues including that:

- It had been difficult for some parents to get help and it felt like a 'battle.'
- Some children and young people had fallen between the gaps in existing provision as their behaviours didn't match service criteria.
- Assessments and interventions had come too late.

Examples included:

"*Children caught in the gaps, for example CAMHS say they have behaviour problems not mental health issues, social services say mental health needs"*

"The issue is when we feel we don't have expertise in the (edge of care) teams about emotional and behavioural issues. CAMHS only deal with mental health diagnoses"

"*Some good stuff, but way too late*"

"One of the issues is (that) our multi-disciplinary assessments are not cohesive enough, quick enough and don't get to the root of the problem"

"Parents (still) say they need a label to get a service (for their child). Everything is (still) a big battle"

1.3 What does the evidence say about the overall approaches and models that seem to have shown the most impact on improving children's lives, including reducing the need for out of home care?

A literature review carried out by the Institute of Public Care in December 2019[2] has helped to inform the development of new 'models of care' in the region and to ensure that they are 'evidence based'. Some of the key findings about 'what works' from the literature are summarised below:

- Services with an evidence-base and clear practice model that incorporate common features which all staff are trained in and expected to apply.
- Services that build relationships with children and their family and where these relationships are the key mechanisms to enable change.
- Service models that are strengths-based and focus on building engagement – a therapeutic alliance, motivation and relationships with children and their family.
- Teams that are multi-disciplinary and include practitioners with knowledge and expertise in working with adults on domestic violence, mental health and drug and alcohol problems as well as with children of the family in addressing their specific therapeutic and other needs related to their emotional and behavioural difficulties;
- Services that are intense - offering multiple contacts every week and flexible working when required to meet family need.
- Services that are responsive including rapid response when required.
- Services that offer practical help when needed.
- Services that work with the whole family rather than focusing solely on the young person can enable the development of family relationships, provide strategies for managing difficulties without the need to involve services, and can increase the likelihood that young people remain in a stable placement;
- Services that are clearly located on the child's journey so that handovers are understood. When specialist services end, the changes made are maintained by the social worker who continues to work with the child and family.

[2] IPC (2019) North Wales Early Intervention and Intensive Support for Children and Young People Initial Literature Review

Taking on board these findings, the multi-agency steering group in the East carried out their own in depth research and investigation of specific approaches that have been successful elsewhere, including a visit to an MST service in England. They decided that this model incorporated the key elements of best practice (as described above) and would be the right approach for their area. It also offered the advantage of being fully formed and therefore more likely to be quick to implement in a Programme that was looking to see results in a relatively short period of time. With the support of MST UK and an intense period of working to meet the requirements of the licence which included recruiting and training specialist staff, they successfully obtained the licence and started taking referrals to the new North East Wales MST Service in May 2020.

1.4 The Model of Care: Multisystemic Therapy (MST)

MST UK[3] describes MST as an intensive family and community based intervention for children and young people aged 11-17, where young people are at risk of out of home placement in either care or custody.

MST teams focus on the whole world of the young person - their homes and families, schools and teachers, neighbourhoods and friends. MST staff go to where families live and work with them intensively for three to five months, including being on call to families 24 hours a day, 7 days a week. MST therapists aim to:

- Work intensively with parents or carers to empower them with the tools and resources to manage the young person's behaviours.
- Increase young people's engagement with and success in education and training.
- Promote positive activities for parent and young person.
- Reduce young people's offending and/or anti-social behaviour.
- Improve family relationships.
- Tackle underlying problems in the young person or parent, including substance misuse.

MST is based on many years of research into what works for families and therapists use approaches such as behavioural therapy, cognitive behavioural therapy and structured family therapy to work with young people and their families. This evidence base has shown that the MST approach achieves excellent, long-term results for young people and families.

1.5 Overview of the evaluation

IPC's approach to this evaluation has been to use a Results Based Accountability (RBA) approach[4] which focuses on investigating 'how much did we do'? 'how well did we do it?', is anyone better off? Our starting point is the Theory of Change (TOC) that was co-produced with the Programme team and Steering Group members from across the region, covering all workstreams and projects. The TOC addresses the following questions:

[3] MST UK website (no date) Multisystemic Therapy. Accessed 4.2.2021. available at: http://www.mstuk.org/about/about-2

[4] Based on the theory developed by Mark Friedman (2005) Trying Hard Is Not Good Enough

- What is the problem you are trying to solve?
- What steps/activities are needed to bring about change?
- What is the short/medium term measurable effect?
- What is the long term population change/outcome you will see?

Our key questions for the evaluation, based on the Theory of Change are:

- Whether the service has been delivered to the target population.
- To what extent did families receive timely, accessible and effective responses to their needs.
- To what extent multi agency working has improved.
- To what extent have children, young people and families achieved good outcomes including whether children and young people have remained at home, whether they have improved emotional health and wellbeing and whether parents are better equipped to safely support and meet the needs of their children/young people and whether families are more resilient.

A mixed method approach has been taken to this evaluation incorporating quantitative as well as qualitative research methods. The following evaluation activities were carried out in December 2020 and January 2021:

- Secondary analysis of collated management information collected by the MST Service between May and December 2020 including information relating to demand, service activity and outcomes.
- Case file analysis of 9 cases (7 from Flintshire and 2 from Wrexham) for families that had completed interventions between May and December 2020 (this represents a third of all families who accessed the service in this time frame).
- 5 semi structured interviews with families who had received a service between May and December (4 with mothers, 1 with a young person) conducted by telephone and online.
- 7 telephone and online interviews with practitioners from partner agencies working closely with the MST service.
- 10 telephone and online interviews with managers from partner agencies working closely with the MST service including members of the Steering Group.
- 1 focus group with the MST staff team.

A further evaluation method, the Warwick Edinburgh Mental Wellbeing Scale, had been identified for use in the evaluation to measure any changes in emotional wellbeing of children and young people who receive a service. However, this tool had not yet been implemented with the families whose cases had been closed at the point of evaluation. It is expected that this method will be used in the final phase of evaluation in 2021/22.

The sample sizes of data collected at this early stage are relatively small. They do however provide an in depth picture of the early implementation of the service as well as some early outcomes which will help to inform the development of the approach as it moves into its second year.

2 An analysis of needs and demand for the service

2.1 Characteristics of the children, young people and families who accessed the service between May and December 2020

50 families from Flintshire and Wrexham were referred to the Service between May and December 2020 and of these 27 accessed it. Most of the families accessing the Service were referred by social workers (25) and 2 by CAMHS. 23 referrals were either deemed not suitable by the MST supervisor or families had moved out of the area.

Gender of child / young person

	Male	Female
Management data for all cases between May and December (27)	15	12
Case files (9)	2	7

Overall, children and young people accessing the Service so far were fairly evenly split between males and females. The case files we looked at had a greater proportion of females.

Age of child / young person

	Aged 11-12	Aged 13-17
Management data for all cases between May and December (27)	5	22
Case files (9)	3	6

There were more young people aged 13 – 17 accessing the service than younger children.

Level of statutory need of child/young person

	Care and Support	Care and support at start, became Child Protection	Child Protection	Full Care Order with parents
Management data for all cases between May and December (27)	22	1	2	2
Case files (9)	7		2	

Most children and young people who were accessing the service were in need of care and support. This indicates that the cohort were at a stage when the intervention might be expected to help to prevent need from escalating to child protection or becoming Looked After (LAC).

Referral behaviours of child/young person, from management data for all cases (27) (not mutually exclusive)

Verbal aggression	**26**
Physical aggression	24
Anti-social behaviour	13
Substance misuse	7
Anti social peers	2
Missing from home episodes	2
NEET	3
Self harm	1
Property damage at home	1
None of the above	1

Child/young person needs from case file analysis (9)

Missing from home	School Refuser / poor attendance / excluded	CSE / at risk	Alcohol / Substance misuse	Mental health issues	Verbal and physical aggression	Emotional wellbeing needs	ADHD / ASD
7/9	6/9	5/9	5/9	7/9	8/9	8/9	4/9

Data was collected in a different way by the Service and in the case file analysis. Comparing the two, the incidence of verbal and physical aggression was high in both.

However the case file analysis suggested a much more complex and wide ranging picture of need that included diagnosed mental health conditions such as Obsessive Compulsive Disorder (OCD), low levels of emotional wellbeing, substance misuse, missing episodes and poor attendance or exclusion from school. It also highlighted other needs including child sexual exploitation and abuse which included online and face to face grooming, criminal exploitation, exposure to domestic abuse and diagnosis or suspected additional needs including Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

It is likely that more in-depth information was found on case files because needs often emerge over time when relationships become more established and the child / young person and family feel able to open up more fully and reveal a more complex range of need than was apparent at the time of referral.

The data suggest that the cohort accessing the Service is the right one, that is, children and young people with complex emotional and behavioural difficulties who have experienced multiple Adverse Childhood Experiences (ACEs).

Parental Needs

	Historic Drug abuse	Substance misuse/ alcohol	Mental Health	Domestic Abuse	None
Management data for all cases between May and December (27)	11	4	11	0	13
Case Files (9)		2	4	7	0

Some interesting differences are apparent from the two sources of data regarding parental needs, most notably that the management data did not pick up any domestic abuse but did pick up historic drug abuse. Almost half were recorded as having no issues.

As with the children and young people, it seems likely that the information collected at the point of referral may have been incomplete. The case file analysis revealed a far higher incidence of the so called 'toxic trio' of domestic abuse, mental health problems and substance misuse which for some are likely to have impacted negatively on their ability to provide a safe and stable home environment and foster positive and supportive family relationships where children felt nurtured and cared for. A number of case files also noted that parenting styles were not helping, for example harsh, inconsistent or confrontational discipline, or ineffective, laissez faire approaches including a lack of boundary setting.

Open to other services

	Social Worker	CAMHS	Youth Offending Service	Other services*
Management data for all cases between May and December (27)	27	11	10	16
Case files (9)	9	5	2	5

*Other services included: Targeted Support, Neuro Developmental Service, Action for Children, NSPCC, Careers Wales, Inter2change, Youth Homelessness, Drug and Alcohol services

Family History

Apart from one case, families had a long history of referrals to and involvement with children's social care which included some or all of their children/young people being on the child protection register, or having a child protection plan, or a care order and a few had already experienced a period of time in kinship care, foster care or residential care.

The information from management data and the case files we examined suggests that the service is being delivered to the right target population. These were families at a high risk of breakdown who had been known to children's social care and other

agencies over a long period of time where a new approach was needed to address both the immediate crisis and deal with underlying causes that would improve family functioning and bring about long-term change.

3 An analysis of the quality of the service

The key areas of focus in terms of the quality of the service '*how well did we do it'* are:

- To what extent did families receive timely responses to their needs.
- How accessible was the service – how well did they engage and what were the enablers and barriers.

3.1 Timeliness

Information in the case files documents the severe and long term difficulties that families have endured and the resulting risk of family breakdown. For example, in one case mum was refusing to have her daughter home because of aggression directed at her and in another, the social worker felt the young person was at risk of criminal and sexual exploitation due to the amount of missing from home episodes and behavioural concerns and that the family was at significant risk of breakdown.

Time between referral and first contact

	Same day	Within a week	Within two weeks	More than two weeks	Not recorded
Management data for all cases between May and December (27)	5	14	5	3	0
Case files (9)	3	2	2	0	2

Data for all cases and from the cases we looked at for case file analysis indicates that a rapid response was achieved. This may be partly because it is easier to respond quickly when a service is starting up as there is likely to be more capacity at this stage. Time will tell whether this level of responsiveness can be maintained.

Some of the parents we interviewed revealed that they felt at breaking point when they were offered the service and that it came just in time:

"I was in a black void at the time, I was at the point where I really needed help. I couldn't suffer anymore. I was neglecting the younger 2 at the time. I would phone my mum up and cry down the phone…… I was at the end of my tether with x. I was feeling like she should go into Care. I thought I was going to lose them all actually"

"My 13 year old had really unmanageable behaviour, he had offended. I couldn't keep him in, he was hyperactive. It was really difficult to put boundaries in place around him. He was really aggressive when he didn't get his way. There wasn't anything more I could have done to keep him safe"

"X was at risk of being placed in residential care due to concerns about her being at risk of being sexually exploited. If x hadn't come on board, I don't know what would have happened"

3.2 Model of support

MST is a structured programme of behaviour change based on nine key principles[5]:

Principle 1: Finding the fit
Principle 2: Focusing on positives and strengths
Principle 3: Increasing responsibility
Principle 4: Present-focused, action-oriented and well-defined
Principle 5: Targeting sequences
Principle 6: Developmentally appropriate
Principle 7: Continuous effort
Principle 8: Evaluation and accountability
Principle 9: Generalisation

Therapists develop a bespoke package of work to meet the individual circumstances and needs of each family using standardised tools and resources. Interaction with the family is intensive, therapeutic, strengths based and goal orientated. Families are required to have a high level of engagement and commitment. The parent / carer is viewed as the key to long term success. North East Wales MST team members who participated in a focus group as part of the evaluation identified the following as being key components of their service:

- *"An ethos of 'whatever it takes"*
- *"Work around the family so not just 9am-5pm"*
- *"24/7 on call service to try and de-escalate incidents rather than calling the police and criminalising children"*
- *"Flipping the mindset of how we work with parents, look at whole picture rather than quick fix"*
- *"Just one service, not multiple appointments with multiple people/services – 1 therapist-1 family"*
- *"We look at struggles and strengths within family"*
- *"model is much more directed rather than random acts of intervention – goal orientated"*
- *"Don't necessarily need young person to buy-in to service, we can work around them. Focus is on ecology around the young person"*
- *"Interventions individual to families, family dictate direction of treatment"*

The following examples from the case files suggest that work was aligned with MST principles:

Example one:
The goal was to try and repair the relationship with mother and help mother to change her parenting approach and work with the young person to reduce verbal and physical

[5] MST UK website (no date) accessed 8.2.21. available at: http://www.mstuk.org/about/about-1

aggression, going missing and risk of online grooming. The approach focussed on understanding the problem and seeing how it played out in the context of the young person's environment. Therapist carried out regular and intense visits building rapport with mum who was seen on average four times a week for a substantial period each time. Work in sessions included parenting intervention and support, identifying behaviour frequency, intensity and duration, developing an 'exit and wait' strategy, safety plan and retrieval plan.

Example two
Contact between the therapist and mum was as needed. This included one to one face to face contracts and phone calls daily at one point. Specific focus was on reducing physical aggression, returning to full time education, and reducing absconding. Assertive parenting sessions were carried out with mum including tips and techniques for saying no to adolescents. Sustainability planning was carried out prior to exit.

Example Three
Areas of focus covered sequencing, retrieval planning, risk assessments and safety planning. Therapist increased face to face sessions through the summer to continue to role play/practice with mum (for example, using calm exiting strategies). Sustainability planning was done to ensure sustained change for the future for curfews and verbal aggression. Crisis happened in the middle and NSPCC worker was on annual leave. MST worker was able to support the young person.

3.3 Quality of support

Very good	Quite good	Not very good	Not at all good
9			

Positive evidence of high quality support was found on all the case files we examined.

For example, in one case it was stated that the mother would ring the therapist every morning. She developed an open, honest and trusting relationship whereby she would share very personal incidents she has been through with her son. There was evidence of strengths based and solutions focussed skills being used, and a flexible approach.

In another, case notes describe how the worker had clearly built a strong relationship with mum and the young person because the young person asked the worker for her support during a challenging time when she made an allegation that involved Police investigation.

Another notes that the support was clearly planned and structured but responded to whatever was happening in the household at the time. The therapist was said to be reliable and accessible and this enabled parents to trust her. The FITs[6] looked at positives too, evidencing the use of strengths based techniques. Overall, it was solution focussed - not dwelling on difficult moments but moving family members forward.

[6] FIT means "fit" between identified problems and how they play out and make sense in the entire context of the young person's environment. Assessing the "fit" of the young person's successes also helps guide the treatment process.

3.4 What worked well – from the point of view of parents

4 parents (and 1 young person) who were interviewed mentioned a number of positive aspects (enablers) of the service which included:

The friendliness and approachability of the therapist: "*She was lovely and friendly and I felt comfortable"*

Being able to ask questions: "*I felt able to ask questions anytime"*

Having an honest relationship: "*We were honest with each other and both said what we felt. We managed to click straight away*"

The fact that it was a new approach: "*I liked how it was presented as a new thing, it hadn't been tried a thousand times over like for example, star charts*"

"Everyone who intervened hadn't any clue about how they could help. Now there was a new service for children who have problems like this. It seemed like it could help"

A non judgemental approach: *She was non judgemental. We would look at x's behaviour and how we could change it. We talked about family members and how we view each other*

Feeling listened to: *"she always listened to me*"
"h*aving x meant we had the opportunity to say what the problems really were and she would listen*"

Reliability and consistency of contact, even during lockdown: *"If she ever had to miss a face to face she would call instead so there was always contact"*
"x always rang me every Monday. I would see her once a week even during lockdown"
"*x was quick to still come out when other services would pull away. MST always made the effort to"*

The benefit of having just one professional involved: "*It was also great because we had so many services involved and it just all got too much (too many meetings etc). We had YJS, CAMHS, Social Services, Education. There were so many meetings. But when MST got involved they all backed off and it narrowed down to MST. Which made life so much easier"*

Having time for quality support: "*We would go to Morrisons for a cuppa because I am distracted by all the kids being at home here. We saw each other twice a week. It was a Monday and Thursday plus aprox 2 hours a week on the phone. She had time which SW's simply don't have"*

Working with the whole family*: "She talked to all the children*"
"We met x and she would check in weekly…. She bought pens/pencils and books for my sisters and I"

Although also to be noted is the point that several parents made about the support being mainly for the parent(s):

"*Generally there were sessions with x on a 1:1 (less often), or with my partner and I or the whole family. The majority were with my partner and I"*
"*She mainly worked with me*"
"*Actually I found it a bit strange that it all focussed on me and not x"*

A focus on change: *"She talked about everything to be honest. There was always a lot going on in my situation. We would look at what can I do to change the situation"*

3.5 What was more challenging, from the point of view of families

Some parents mentioned challenges (potential barriers), for example:

It can feel intrusive: *"My partner liked it less (than me) in the beginning because it was intense and intrusive. He came round in time*

It was demanding: *"Nothing was a break for me. Everything was about me reading that, trying that, doing that"*

It didn't feel a good fit for a child with additional needs: "*the service wasn't what I thought it would be... x said she didn't know much about additional needs. It felt like she had strategies for neuro-typical children with emotional difficulties. So it wasn't straightforward*"

Crisis management got in the way: "*I don't think the work she did helped. We didn't actually cover a lot because there was a lot of stuff going on that she was trying to sort out for us rather than doing other things. e.g. the Police would be coming out 2 or 3 times a week so we would talk about that instead. We talked about crisis stuff rather than structured sessions we should have been doing*"

These could be said to be more about their personal challenges rather than the quality of the support overall**.**

3.6 What partner agencies said about the quality of the service

Key aspects that partner agency staff identified as strengths (enablers) included:

Being in the home – "*what was great was the worker being in the home and working alongside mum and seeing the family dynamics"*

"it gave mum more confidence having x there - to see the behaviours and experience them - mum didn't feel as isolated on her own. She could reflect on what happened together"

Small case load - "*having a very small caseload of 3 or 4 families which lets them do the intense work at a time when the family really needed it - a time when with Covid she was stuck at home with 8 kids*"

The intensity of the support – "*the great thing about this service is they are seeing the family multiple times a week"*

"it is an intensive service which can be involved for up to 20 weeks"
"going in 2-3 times a week you get a truer more real picture of what is going on"
"*they offer holistic support which is intensive. When they aren't in the home they are on the phone. Parents really need this level of intense support - it's the most valuable thing about this service*"

Out of hours support 24/7: "*In the past mum would have deteriorated and afterwards not used the right strategies. She called out of hours and said this is happening what shall I do? She would take the advice and follow through with it".*
"*With MST mum can call the service 24/7 (We don't have a 24/7 service) in the event of a crisis, the YP is more likely to engage with the worker not the police. They are more likely to speak to someone they have a good relationship with"*

Whole family approach – "*very good at explaining how mum's behaviour was impacting on the children, and where the behaviour of the children was coming from. I really like that whole family approach*"
"*The whole wrap around service is truly beneficial that they work with the whole family. When there are issues it tends to affect every single person in the family"*

Empowering parents – *"empowering the parents is key… I can say where there are multiple complex issues the parents feel so disempowered. MST talked about nurturing the relationship which makes absolute sense that parents are able to provide the nurturing environment and the YP is thriving in that"*

A therapeutic approach – "*mostly it is the therapy element which is something MST has and we don't have that is so valuable*"

Lead professional role: "*great having one person do one intense role*"

An independent service – "*It fosters the relationship that is needed. Having a support worker independent of me and our team has been positive. Families often perceive the local authority as negative"*

Flexibility of support – "*sessions were structured like set times, mum prepared to have kids entertained when x was coming. But there were also times sessions diverted a little bit to deal with what was happening e.g. something the night before. This flexibility was great"*

Highly skilled workers – "*non judgmental, trusting, reflective"*

Overall it was the intensity of the service including the frequency of contact, the availability of contact at any time day or night and at weekends, the choice of contact – face to face, phone, text, WhatsApp, that was mentioned most frequently as a positive.

3.7 What partner agencies said about the challenges

It was significant that there were far fewer challenges / gaps mentioned, than strengths. The key areas that interviewees highlighted were:

The ending of the support – "*In an ideal world I would like the service to be open for longer. MST was closing at a similar time to the LA which was questionable given the circumstances"*
"*when they reached 20 weeks and ending this can feel harsh for families if difficulties are arising. I think the end point should be more flexible…. e.g. closure to MST happened in the week the young person went into foster care. There was no other support in place for the family at a really difficult time*

More direct work with the young person - *It's sold as a family therapy but only actually works with the parent and the YP has their own personalities and issues often separate from the family home".*
"*The only issue I have, and I think it should be looked at if it's reviewed, is the need for direct work for YP. It's so focussed on the parent"*

3.8 Level of engagement by the family

Very good	Quite good	Not very good	Not at all good
7	2		

Evidence of very good engagement was found on 7/9 and quite good on 2/9 of the case files we looked at (in terms of number of sessions completed, how well they had participated and the subsequent changes to behaviour observed)

We looked at **how much** as well as **how well** families had engaged.

- The number of hours of support delivered to the families whose case files we looked at was in the range of 22 – 91.5 hours.
- The length of intervention was in the range of 6 – 20 weeks.
- The number of cancelled sessions was between 0 and 6.

Examples that demonstrate effective engagement included 1 case where mum was said to have engaged excellently especially considering previously she didn't engage well with professionals. She had successful engagement not only with the therapist but also met with a social services manager whom she didn't trust, in order to improve relations.

In another file it was noted that over the first few weeks Dad started to take responsibility for his reactions during difficult moments with his daughter and by mid-way through mum did too. Both parents felt empowered by this.

Another record showed that mum was able to engage despite having 8 children at home during lockdown. She would prepare for sessions to ensure children were occupied whilst she met MST worker and there were only 2 cancelled visits.

There were only 2 cases where engagement was not quite so good. In 1, initial engagement was good, but there were phases of reluctant or non-engagement over time. It appeared that mum only wanted the MST worker when crisis hit her daughter – she was less able to ask for help when not in crisis and the level of trust with the professional was up and down. It was noted elsewhere on this file that mum was struggling with her mental health. In another case despite great engagement in the first few weeks there was a period when she wasn't honest about her daughter's behaviour and whereabouts.

Overall, there was less information on file about the engagement with children. In one case it looked like contacts with the young person averaged fortnightly and were brief. In another there was very little engagement with the YP other than the initial visit and when she called the 24/7 line a few times. In terms of siblings there was no evidence they were to be involved in this. This mirrors what some parents said about the work being mainly with them, and the concerns expressed by some partner agency interviewees that there isn't enough direct work with young people.

4 An analysis of joint working between agencies

The Wellbeing of Future Generations (Wales) Act, 2015 [7] and Welsh Government Ten National Design Principles, 2019[8] are very clear that health and social care services need to change their siloed ways of working and become more integrated and collaborative. An important question for the evaluation is therefore the extent to which the MST service and their partners are achieving this and what the benefits have been so far.

4.1 The extent to which the MST service was working closely with other agencies

To a great extent	To some extent	Not much	Not at all	Unknown/ not recorded
4	2			3

Evidence of a multi-agency approach was found on 6/9 of the case files. In 3 cases there was no information

For example, in 1 case the therapist attended meetings at school with the young person's teaching assistant and a speech and language therapist. The MST therapist represented mother and young person at some meetings outlining progress, strengths and positives.

In another case MST liaised with the Youth Offending Team to inform a plan and to improve the way police, mum and son interact and move forward to ensure the young person is safeguarded in the community.

[7] Welsh Government (2015) The Wellbeing of Future Generations (Wales) Act. Accessed 9.2.21. available at: https://www.legislation.gov.uk/anaw/2015/2/contents/enacted
[8] Welsh Government (2019) *A Healthier Wales: Our Plan for Health and Social Care. p.17 Accessed 9.2.21.* Available at: https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

Another record notes that some services were 'paused' as per MST protocol but there continued to be very close working as evidenced by the core groups and the strong working relations particularly with the school.

One case file described close working between school and police e.g. critical incident at school, police complaint against school meant that school agreed to do a FIT with therapist around why they called the Police as opposed to calling mum first.

Many of the partner agency interviewees spoke about their positive experiences of working with the MST team. For example, one said:

"*I have a very good working relationship with x (MST therapist) - we would often catch up to review the work together. There was an incident in the summer and through that I felt we worked really well together. There were professional meetings we were all part of"*

"MST was doing intensive work with mum. I worked with mum on her early trauma and domestic abuse"

"we have a multidisciplinary meeting early on. We initiate this first meeting and see who's leading on what, and what our exit plan will be"

Interviewees also felt that there was good communication by the service about the family's progress. For example:

"The worker shared all she was doing and achieving like good insight and sharing of aims and goals, what's happening etc, and we talked about mirroring the same messages to mum"

"We have weekly case notes put on the system. Progress is recorded and shared and communication is very good"

"A day or two after the incident Michelle the worker contacted me by phone and if there were any concerns her end she would be in touch or vice versa".

Only 1 interviewee, who was from the Education sector (NEET team) felt that he was missing out on feedback about a young person on his caseload and didn't have the opportunity to be part of the exit planning.

The benefits of working in an integrated and collaborative way had helped the staff we interviewed to feel more confident and supported in their work with these children and families and able to manage risk effectively with the support of the new service. For example:

"It's been helpful for me cos I couldn't do home visits for a period of time. The other worker could see what the risks and issues were in the home. The communication has been excellent and the strategies mum put in place are keeping everyone safe in the home"

"There was a lot of risk, very high risk in the earlier days for this young person, so much has changed. Working alongside a team that can be about managing risk including social services it feels like all the bases are covered and you aren't alone holding the risk"

As a result of having the MST service in place, Staff felt more confident about the overall arrangements locally for meeting the needs of children and young people with complex emotional and behavioural difficulties. However due to it being early days and a small team, there were some concerns about capacity and unmet need going forward. For example:

"We have a very valuable service. it's still in its infancy. I think it can be adapted as it goes along to be greater. It's a very good resource to have"

"It is still work in progress. This is still a new service. It also depends on the criteria. Not every child with challenging behaviour will be able to access MST"

"I think they should open it up for others to refer, in particular in education. We have a mass of YP excluded from school and it's getting younger. Sometimes there's a massive gap between exclusions and services"

Other key benefits of working together that interviewees identified included enabling partners to have a better understanding of the family dynamics, being able to close cases sooner than they would otherwise have been able to do and reducing pressure and demand on their service.

Comments made in interviews with strategic managers also lend weight to the evidence that improvements have been made in partnership working. For example:

"The main outcome for me is the partnership working. When we talk about local authority – children's services, education, youth justice service – we have key partners around the table which are making the difference. Before MST we would struggle with these complex cases and they would go through all these different referral processes, and YP and families would then ultimately disconnect with us"

"Strong triangulation support - by this I mean between other agencies, young person and parent. MST comes to offending risk meetings. There is great communication, and awareness about who is doing what. It's a great partnership working and supportive with other agencies- agencies are no longer operating in silos"

5 An analysis of the outcomes for children, young people and families

The key areas of focus in terms of outcomes - is anyone better off? are drawn from the Theory of Change and include the extent to which:

- Children have been able to stay at home with their families and have not gone into care.
- Children have improved emotional health and wellbeing.
- Parents are better equipped to safely support and meet the needs of their child(ren).

- Families are more resilient.

The outcomes for the MST model are described as[9]:

- Supporting children's mental health and wellbeing.
- Enhancing school achievement & employment.
- Preventing crime, violence and antisocial behaviour.

The evidence we have been able to collect at this stage is somewhat limited as there were only nine cases that had completed at the point of evaluation. It is also focused on the outcomes that were achieved by the end of the intervention. Going forward, MST will be tracking the outcomes at 3, 6 and 12 months to measure whether changes have been sustained.

5.1 The extent to which children, young people and their parents have achieved the outcomes specified in their 'plan'/MST outcomes

To a great extent	To some extent	Not much	Not at all
7			2

We found evidence that 7 out of 9 families whose case files we looked at had achieved their outcomes to a great extent and 2 had not.

The types of positive change recorded in case files included:

Improved parenting, for example
Increased confidence in their parenting
Mum has stopped mirroring young person's aggression
Mum exiting the situation when the young person is trying to provoke and button push
Mum has identified a support network who can offer her positive support and advice

One of the parents interviewed said:

"The nurturing and high love has always been there. But it pushed me to use it. Even at the time he is most frightened, he needs nurture not more fear"

Improved relationships within the family, for example;
Parents more supportive of each other
Improved relationships between the child/young person and parent(s) for example more affectionate, more respectful
Improved relationships between siblings
Reduction in domestic abuse
Having quality time as a family

One of the parents interviewed said:

[9] MST UK website (no date) Multisystemic Therapy. Accessed 4.2.2021. available at: http://www.mstuk.org/about/about-2

"I schedule better and spend 1:1 time with each child daily. Sometimes it's only 10/15 mins and we sit down and have a cuppa and I say tell me how you are. She likes doing my hair and nails and as a family we have games night and it's UNO at the minute too! We are having so much more quality time as a family"

The young person interviewed said:

"*We had a family walk out and it was so much fun. My dad was swinging my younger sister around"*

"If I feel down I talk to my mum. Going back a year ago I wouldn't have done that then"

"*There are ups and downs now but we forgive each other. If we are arguing one day, we both start the next day fresh. I know that now"*

Changes in child/young person's behaviour, for example
Not being arrested
Reduction in missing episodes
Keeping to curfew agreements
Reduction in verbal and physical aggression / violence
Reduction in using alcohol and substances
Respecting rules and boundaries
No longer self harming
Mood improved
Improvement in emotional wellbeing
No longer at risk of sexual or criminal exploitation
Reduction in behavioural difficulties

One of the parents interviewed said:

"She knows boundaries now. She knows how far she can go. It helped with structure and routine, with kids knowing what they can and can't do. It helped her to be more emotionally stable"

The young person interviewed said:

"*I accept it now if my mum says no"*

Statutory services are no longer involved, for example:
No longer any police involvement
Case closed to children's social care
Case closed to CAMHS

Better educational and employment outcomes, for example
No longer NEET
Studying in college
Attending school and engaging in learning
Appropriate peer group
Found employment

One of the parents interviewed said:

"She started a new school, she doesn't run away from school anymore, she feels valued and she felt listened to when she went. Previously she was stealing from teachers… She has settled in brilliantly, made a small group of friends which is wonderful. She loves this. Previously she found friendships a real struggle. She's so much happier now"

Whilst it is a very positive finding that 7 out of the 9 cases have clear evidence of improved outcomes, there were 2 cases that did not achieve their outcomes and these same two young people were taken into care. Characteristics found in both cases that may have impacted on this include a high level of parental need – in one case mental health problems – depression and anxiety and in the other alcohol dependency and denial. Both had also experienced domestic violence. Both engaged well initially and there were some signs of positive change but these were not sustained. Case file notes both mention a lack of ability, motivation and capacity to change. One of the parents said:

"I don't think MST helped us at all. But I don't think anything would have helped. We always had to deal with the Police being there and we had to deal with that crisis at the time, but had I had something like this earlier it might have made a difference"

5.2 The extent to which the child has improved emotional health and wellbeing

Very much	Quite	Not very much	Not at all	No evidence
5			**2**	**2**

We found evidence that 5/9 children/young people whose case files we looked at had improved emotional wellbeing, 2 did not and for 2 there was not any evidence to make a judgement

For example, in one case self harming had stopped and aggression and violence had stopped which hugely improved their emotional health and wellbeing at point of closure.

The emotional health and wellbeing of another young person had improved so much that she felt safe enough to disclose something that had been happening for some time which helped explain why she had been behaving the way she was (putting herself at risk). CAMHS closed the case after 18 months. The young person stopped taking Fluoxetine and is now feeling stable. Her brother's emotional health and wellbeing also improved as a result of the improved relations in the household.

Parents who were interviewed had also observed positive changes, for example:

"*She says she feels loved now …. overall her emotional health has really improved. (she used to bite herself and slap herself). She doesn't do any of this anymore"*

Partner agency interviewees were also very positive:

"The YP can express her feelings in a more positive way, - she's more reflective, just like mum is and just like mum is modelling. Before, she couldn't speak out"

"They do invaluable work with families and this impacts positively on the young person's mental health and wellbeing"

The service has now started to implement the use of the Warwick Edinburgh Mental Wellbeing Scale and this will provide more in-depth data in the final phase of evaluation in 2021/22 about whether and to what extent children and young people's emotional wellbeing improves.

5.3 The extent to which parents are better equipped to safely support and meet the needs of their children/young people

To a great extent	To some extent	Not much	Not at all
6	1		2

We found evidence that in 7/9 cases that parents were better equipped to meet the needs of their children / young people (6 to a great extent, 1 to some extent, 2 not at all)

Improved parenting and family relationships
For many families, the work on parenting was key to bringing about change and enabled them to feel more in control and able to manage their children's behaviour and meet their needs. For example:

In 1 case file it stated that the approach had challenged mum to not always give in to her son which was one of the main difficulties. Mum now feels she can manage and safeguard the young person appropriately. She learnt to use strategies e.g. exit and wait to prevent escalation.

In another CAMHS worker is recorded as saying 'This has worked wonders' and feels that parents have been empowered. Parents state the main thing is the way we go about things and communicate with one another now.

Another case highlights the increase in family confidence - parents saying they feel they have 'got this.' It is now a supportive and loving home, there is high warmth and authoritarian, consistent boundary setting. The young person is responding well to rewards, rules and boundaries. Parents fed back that it had helped them to see and do things differently.

MST worker says in the closure letter that '*whilst initially working with me to improve X's behaviours across the multi-systems of her life, you have also succeeded in improving the family dynamic as a whole.*' The whole family have clearly benefited and the needs of all the children are better being met now.

Parents themselves expressed that they felt better equipped, for example:

"*Now I have learnt new techniques rather than shout like I did. I feel better equipped if x headed that way again"*

"It helped to reinforce my role of being in charge and putting boundaries in place"

"Rather than have an argument, she (therapist) would tell us to walk away until it settles down. She would say come back when you are calm. When they are kicking off I think even now I must do what x does. Otherwise you get in a row and then we go in a circle and we don't get out of it because teens think they know best"

Partner agency interviewees had noticed positive changes. For example:

"*She has a different mindset now. She is stronger- it's like "I am the parent, these are my rules". Before this mum was saying I can't keep her safe. The work also strengthened the relationship between mum and daughter. Daughter was abusive towards mum previously and now sees mum as her safe person and her protector"*

Better understanding and response to Adverse Childhood Experiences
Several partner agency interviewees highlighted the importance of the work with parents to help them understand the impact of Adverse Childhood Experiences (ACEs), in particular domestic violence and how this has negatively affected the family and what they can do to support their children.

"*The older children witnessed serious Domestic Abuse and the worker could unpack how this impacted on the family and then what happened in incidents and how this impacts on ACEs for the children"*

"I would say that mum is feeling better about the past and understands more the impact on the family. Feeling more in control and better able to put in boundaries and is better able to recognise that if they do act out it is not a failing of hers"

"*I think it's really helped with the domestic abuse, helping mum get her confidence and self esteem across and helping her to understand how her trauma impacts on her, and how her older children witnessed and how they could easily feel dysregulated (due to witnessing DV in the past) and how they could be supported to feel more safe now"*

"*They are able to unpick the difficulties (ACEs) & reflect on their own parenting. It enables them to step back and consider how we can change our behaviour. Change comes from the parent"*

Severity of parental need
2 partner agency interviewees drew attention to the 2 families (see table) they were aware of who had accessed MST but were not better equipped to safely support and meet their child(ren)'s needs. In both cases, it was felt that complex and significant parental mental health problems were the cause.

"*The collapse of some parents, it has been because of more complex mental health needs and that's where the plan has become unstuck. It's entrenched and in some cases undiagnosed. It's complex*"

"*Dealing with the significant mental health of parents has been the failure of MST. The issues are so entrenched with parents"*

5.4 The extent to which families are more resilient

To a great extent	To some extent	Not much	Not at all
7	1		1

We found evidence in eight out of nine cases that families were more resilient (seven to a great extent and one to some extent).

Examples noted on case files that demonstrate greater resilience include:

A successful family group meeting took place with everyone around the table better able to communicate and a retrieval plan is in place.

They are communicating better and feel empowered, they have more of a handle on any situation. They seem stronger in themselves, and therefore are more resilient and can manage any situation as opposed to things feeling out of control like before.

There is so much improvement and change in 6 months, it appears developing resilience is key. I am not sure the family are there 100% but there is a safety net and exit strategy for the next few months if things slip.

Parents are confident in what they need to do to meet the YP's needs, manage her behaviour and keep her safe.

Even one of the cases where the child had gone into care, it was felt that the work carried out with mum had helped to build her resilience to some extent and this was likely to benefit her younger daughter.

Parents said:

"We are stronger as a family unit. There are far much less fallouts between all of us"

"We are all calmer, not shouting and not stressed out like we were".

"x made me feel like I was on the right track. It was strengthening and helpful whereas other agencies made me feel I was the problem….I feel empowered by it all, some of things she advised I went ahead and did"

"When there are arguments at home, I think of what we agreed I would do i.e. walk away. We have the strategies. I always was ok with my parenting skills but yes we are stronger now"

Responses from partner agency interviewees were equally assured:

"*I don't think mum would say again 'I can't cope with that" - she is far more resilient - she can stop situation escalating a whole lot more"*

"it's the premise of their work, to promote resilience. It comes from the parent to manage their parenting and manage the crisis and that's the bulk of their support"

"I can at this point reference that this service stopped this young person going into care. Mum was more empowered to manage the behaviour of the young person"

"We had really successful outcomes. And closure to children's services shortly after MST closure. The family haven't come back in through the front door yet. The most successful we must have closed 3 months ago. They are accessing only universal services now rather than targeted"

5.5 The number of children/young people who have remained at home with their families and the number taken into care

Stayed at home	Taken into care
7	2

A key outcome for the service is to enable children/young people to remain safely in the family home and prevent them going into care, where that is appropriate. In our sample of nine cases, seven out of nine were living at home at the end of the intervention and only two had gone into care. This is a significant achievement for a new service that has been up and running for less than a year.

For the two who did go into care this wasn't necessarily a bad outcome. Both families had engaged in the intervention to some extent and one of them spoke positively about it, but the complexity and severity of the needs of the parents suggests that in the end they were not able to safely look after their child at that time.

5.6 Cost avoidance

At a basic level the available unit cost figures suggest that there is potential for the MST service to save money over time by enabling children/young people to remain at home and avoid care experience and placement costs (table below).

Type of provision	Average weekly cost per child	Average weekly saving
MST intervention including supervisor time clinical supervision and licence	£232	
In-house fostering	£500	£268
Independent foster agency	£900	£668
Specialist residential care placement	£8,000 -£10,000	£7768 – £9,768

In addition, it is possible that MST interventions might result in (unquantifiable) cost savings to other services, for example, fewer police call outs, YOT and Children's Social Care cases being closed earlier than expected. However, such calculations need to be undertaken very carefully. For example, there are at least 3 very different scenarios:

- Some children may have avoided the need for a care experience as a direct result of the MST intervention.

- For others who also avoided a care experience, this might have happened anyway, even without the MST intervention.
- For other children where the MST intervention was followed by a care experience, it could be argued in some cases in purely financial terms that costs ended up being higher overall than if the MST intervention had not been undertaken.

On the basis of the small cohort supported to date we do not think it is appropriate to conjecture on the level of cost avoidance so far. This will need to be built up over time for the whole cohort of children and young people using the service, and recognising more subtle measures of impact such as length of care experience, quality of life or achievements and outcomes. Further work will be needed to develop these metrics and to ensure data is collected in the coming year so that the final evaluation will include a more detailed analysis of costings against the benefits in order to make a judgement about the sustainability of the service beyond the grant funding.

6 Key Findings and Recommendations

This evaluation was carried out at a very early stage in the development of the service. Our key findings are based on small numbers and it is not possible to draw robust conclusions yet. However it does suggest that things are moving in the right direction and it provides a baseline to compare against in the final evaluation in a year's time.

Finding One: has the service been delivered to the target population?
The North East Wales MST service appears to be targeting the cohort of children/young people and their families that were identified as needing a new approach to meet their needs. We found evidence on case files and from stakeholder interviews that children and young people had significant and complex needs including emotional and behavioural difficulties linked to ACEs which manifest in challenging and risky behaviour. Their parents/carers were struggling to provide care and support and meet their children's needs at home. There was significant risk of family breakdown and the child being taken into care.

Finding Two: have families received timely responses to their needs?
All families whose case files we looked at were quickly offered help after their referral was received. In three cases this was on the same day. The cases we looked at were the first to access this new service and therefore it is not surprising that the service could respond fast.

Finding Three: how accessible was the service – how well did families engage and what were the enablers and barriers?
We found evidence of high levels of engagement by all families whose case files we looked at. Only two out of nine parents disengaged after a promising start. The rest all successfully completed the intervention. The key elements identified by parents that helped them to engage and develop open, honest and trusting relationships with the therapist were: the friendliness and approachability of the therapist; feeling able to ask questions; being listened to in a non-judgemental way; the reliability and consistency of contact; only having one professional to work with; having enough quality time to work together on difficult issues; the focus being about change; the whole family being involved and that it was a new approach.

Professional stakeholders highlighted the following as being key to keeping parents engaged: being in the home; the intensity and flexibility of the support and it being available 24/7; highly skilled workers with small caseloads who took on a lead professional role; an approach that empowered parents, was therapeutic and involved the whole family; being independent of the local authority.

A few things identified by parents as being off-putting included that it could feel intrusive, it demanded a lot of effort and commitment and it might not be a good fit for a child with additional needs. One parent felt that she had not got the best out of the intervention as so much time had been taken up trying to de-escalate crises. A couple of professional stakeholders also felt that the reason why two parents had not been able to maintain their engagement was due to severe and complex (unaddressed) needs of their own, including mental health problems and substance/alcohol misuse.

It is important to note that half of all referrals were turned away. It is unclear whether this is because they were not considered appropriate or because there was not enough capacity to take them on.

Finding Four: to what extent has multi-agency working improved?
We found clear evidence that the MST service was working closely with partners throughout the intervention. Collaboration began with the multi-agency meeting right at the beginning to discuss needs, through to jointly developing exit strategies. The MST model requires the therapist to take on the role of lead professional and for other services to step back during the period of the intervention. Partner agency interviewees gave examples of how they had been kept well informed for example, the therapist had shared case notes with insights about the family and the progress they had made.

Overall these interviewees said they felt more confident and supported in their work with these children and families and able to manage risk effectively working alongside the new service. They also felt more confident about the overall arrangements locally for meeting the needs of children and young people with complex emotional and behavioural difficulties. However, although it was felt to be a step forward in the right direction, it was still early days and there were still some concerns around capacity and unmet need.

Other key benefits of working together that interviewees identified included enabling partners to have a better understanding of the family dynamics, being able to close cases sooner than they would otherwise have been able to do and reducing pressure and demand on their service.

Finding Five: to what extent have children, young people and families achieved good outcomes?
We found evidence that seven out of nine families whose case files we looked at had achieved the outcomes that had been set at the beginning of the intervention. These included improved parenting, improved relationships in the family, positive changes in child/young person's behaviour, better educational and employment outcomes, statutory services no longer involved and seven out of nine children/young people remaining in the family home with only two going into care.

In five out of seven cases children and young people had improved emotional wellbeing. For example, self harming behaviour had stopped, children/young people felt able to

express their feelings and were feeling more positive about life. It is expected that there will be more robust findings regarding any changes in emotional wellbeing in the final phase of evaluation, drawing on data from the Warwick Edinburgh Mental Wellbeing Scale (WEMWS) that is now being collected by the service.

In seven out of nine cases, we found evidence that parents were better equipped to meet the needs of their children / young people. The work on parenting was key to bringing about change and enabled them to feel more in control and able to manage their children's behaviour and meet their needs. In additional valuable work had been done to help parents understand the impact of Adverse Childhood Experiences (ACEs), in particular domestic violence and how this had negatively affected the family and what they could do to support their children to recover.

In eight out of nine cases, families were more resilient. Both parents and professional stakeholders expressed the view that they had strengthened their capacity to cope with difficulties that might arise as opposed to feeling out of control.

7 Areas for further discussion

- Ensure that the offer is made at the right time to the right families – consider whether parent(s) have ability, capacity and motivation to change. What might get in the way e.g. parent has serious and unaddressed substance/alcohol misuse issues or significant mental health difficulties. Or family is in constant crisis, firefighting, not in a stable place to reflect and do the work required for long term sustainable change. The planned addition of a short term residential facility in 21/22 will be a welcome addition that will provide a safe space and respite for parents to enable them to address their needs and challenges so they are more likely to succeed in the behaviour change work.
- It's a 'parent heavy model' – does more consideration need to be given to working directly with the child/young person and / ensuring they get any specialist help they might need e.g. for alcohol/substance misuse? In some cases we looked at this was happening alongside the work with the parent but didn't appear to be in others.
- Partnership working was good overall but there seemed to be some people in Education who weren't receiving feedback at the end of the intervention and some who were unaware that they could make referrals after consultation.
- Can there be a greater degree of flexibility about when cases are closed? Some partners felt that some families would have benefited if they could have had input for longer, in particular if there were other changes that were happening at the same time, for example transition to a new school.
- Families have the opportunity to give feedback at the end of treatment but could they also be more involved in the development of the service?

Appendix One

MST management information between May and December 2020

Table 1: Number of referrals from Social Workers and CAMHS, by location who accessed the service

		FCC	WCBC	Total
Number of referrals from social workers		15	10	**25**
Number of referrals from CAMHS		2	0	**2**
Total				**27**

Table 2: Age of child at start of MST

Age	FCC	WCBC	Total
11	2	1	**3**
12	2		**2**
13	3	2	**5**
14	3	3	**6**
15	4	1	**5**
16	3	3	**6**
Total			**27**

Table 3: Gender of child

Gender	FCC	WCBC	Total
Female	8	4	**12**
Male	9	6	**15**
Total			**27**

Table 4: Number of days between referral and start of MST (first visit)

Number of days	FCC	WCBC		Total
Same day	5			**5**
1 – 7 days	9	5		**14**
8 – 14 days	2	3		**5**
More than 2 weeks	1	2		**3**
Total	**17**	**10**		**27**

Table 5: Number of days in treatment at close, summarised

Number of days, or open	FCC	WCBC	Total
Less than 1 month	2	0	**2**
1-3 months	4	0	**4**
3-5 months	4	1	**5**
More than 5 months	3		**3**
Total	**13**	**1**	**14**

Note: 13 still ongoing

Table 6: Level of need of child

	FCC	WCBC	Total
Care and support	16	6	**22**
Care and support at start, but now child protection		1	**1**
Child protection	1	1	**2**
Full care order with parents		2	**2**
Total	**17**	**10**	**27**

Table 7: Frequency of mentions of behaviours

	FCC	WCBC	Total
Verbal Aggression	16	10	**26**
Physical Aggression	15	9	**24**
Anti-social Behaviour	6	7	**13**
Substance Misuse	7	5	**12**
Anti-social Peers	2	5	**7**
Missing From Home Episodes	2	3	**5**
NEET	3	0	**3**
Self-harm	1	0	**1**
Property Damage at Home	1	0	**1**
None	1	0	**1**
Total	**54**	**39**	**93**

Table 8: Frequency of other services involved

	FCC	WCBC	Total
Social Worker (all cases)	17	10	**27**
CAMHS	6	5	**11**
Youth Justice	4	6	**10**
Neuro	2	1	**3**
Action for Children	2		**2**
Inter2change		2	**2**
Targeted support	1		**1**
NSPCC	1		**1**
Careers Wales	1		**1**
Education packs (school refuser)	1		**1**
On a Tag (8pm-8am)	1		**1**
Drug & Alcohol services		1	**1**
Pass		1	**1**
Youth Homelessness		1	**1**
None	1		**1**
Total	**37**	**39**	**64**

Table 9: Cases with parental issues mentioned - summarised

	FCC	WCBC	Total
Historic Drug Abuse	8	3	**11**
Substance Misuse / CAIS charity	2	2	**4**
Mental Health	6	5	**11**
Other		2	**2**
None	8	5	**13**
Total	**24**	**17**	**41**