

Rees Centre



Evaluation of the Multisystemic Therapy Service in Essex

Report of the Findings
July 2019

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Acknowledgements

We want to thank the parents, carers and practitioners who participated in the interviews and focus group for this evaluation. We are indebted to colleagues within Essex County Council and Action for Children, the service delivery partner for the Essex Multisystemic Therapy (MST) service, for their support and assistance, and to the CSSL Board and Social Finance for their cooperation. Thanks also to colleagues from within the National MST team, namely Cathy James and Simone Fox for their advice and guidance.

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Executive Summary

The Multisystemic Therapy (MST) Service was contracted by Children's Support Services Limited (CSSL) on behalf of Essex County Council through the Essex Edge of Care Social Impact Bond (SIB). The aim of the service was to provide therapeutic support for adolescents at risk of entering care or custody. The national children's charity Action for Children was commissioned as the MST service delivery partner and the SIB contract was managed by Social Finance, a not-for-profit organisation that partners with the government, the social sector and the financial community to tackle social problems.

The aim of the MST service in Essex was to work with 384 adolescents aged 11-17 over the funding period of five and a half years. The service had worked with 388 adolescents by the end of the funding period, just exceeding this initial target.

This report is based on nine interviews with parents and carers and one focus group with social care managers and senior practitioners, and the analysis of quantitative data collected by Essex County Council for 302 of the young people who received MST. The dataset comprised contacts with children's social care in the two years before MST, during MST and one year after provision of MST, including referrals for the case to be re-opened, either as a child in need, or a referral for placement. The dataset also captured subsequent child protection plans and referrals for other local authority services.

Main questions addressed in the evaluation

- What did practitioners and families hope and expect MST to achieve and to what extent have these been fulfilled?
- What have been the most important factors that have facilitated and/ or acted as barriers to positive impact during and after MST?
- What impact has MST had on families and young people?
- What are the outcomes for young people post-MST?
- What recommendations can be made for future MST interventions?

Key Findings

Point of referral – hopes and expectations

- Practitioners reported they had very high expectations when the service began but that as the service became more established, the development of good working relationships sustained more realistic expectations for beneficial impact. They highlighted timely intervention as a key factor for successfully engaging families, and that the service was a better match for families that acknowledged the role of parenting in contributing to change.
- Families referred to MST were facing very challenging circumstances and had often reached crisis point. The strongest themes were a sense of desperation at the point of referral and parent and carers' willingness to try anything that might help their child and family. Previous provision had not led to sustained change and so generally families did not have high expectations of MST at the point of referral. The most frequently expressed hope was that MST would help them to understand or help their child more effectively.

Facilitators to positive impact

Five key factors facilitating positive impact were identified from the interviews with parents and carers and the focus group with practitioners.

- **Therapeutic alliance** – An effective therapeutic alliance between the family, especially the parents or other carers, and the MST therapist was a key facilitator. Therapists were sometimes referred to as like a friend, but families also valued their neutrality and lack of judgement. The therapeutic alliance could be a facilitator for change for the young person when they worked directly with the therapist. Consistent support from one well-matched therapist was viewed as key to success.
- **Intensive support: understanding the family in context** - Families benefitted greatly from the '24/7' availability of MST and the intensity of the support provided. The fact that therapists worked in the real-world contexts of families – particularly in the home and educational settings – was viewed as contributing to effective understanding of the issues and provision of appropriate support. The holistic nature of MST facilitated a coherent approach.

- **Therapist as guide, advocate and mediator** – Therapists took on multiple roles to support families. They provided guidance and advice, working alongside families rather than taking on an expert role. Therapists also advocated for families, particularly with educational settings. Some therapists played a mediating role within the family context, particularly mediating difficult conversations between the young person and parents/carers or between both parents.
- **New insights, perspectives and understanding** - All parents and carers emphasised that MST had supported them to gain a better insight and understanding of themselves, the challenges they were facing, and their child’s behaviour, leading to more attuned and positive parenting. MST deepened parents understanding of the underlying reasons for different behaviours, supported more positive viewpoints and helped parents and carers to keep things in perspective, such as recognising when the young person was just displaying normal adolescent behaviour.
- **Tailored, solution-focused practical techniques and strategies** - Implementation of practical, solution-focused strategies tailored to families’ individual needs were a powerful facilitator of change. These included communication strategies, practical strategies around safeguarding, behavioural reward programs and establishing clear boundaries. All families highlighted the importance of MST strategies being tailored to their needs. This solution-focused approach was reported as being effective for young people as well as parents and carers.

Impact of MST

Practitioners commented on the positive impact MST had on their own practice, professional development and understanding. There was evidence that MST had also had a longer-term impact on social work practice in the Essex area. There appeared to have been 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.

The key take home message was that assessing impact is challenging, particularly with an intervention of this nature which can affect multiple systems around the young person. The interviews with families revealed the complexity of change, and the fact that impact cannot be easily categorised as just ‘positive’ or ‘negative’. Change did not necessarily occur for all

family members at the same time; in some families the behaviour of the young person remained challenging but the parent or carer felt more resilient and better able to cope. Some families described MST being the beginning of an ongoing journey of change. The report considers impact in three key themes: Parent and carer change; Young person change; Family change.

- **Parent and carer change** - Parents and carers had all developed a more interpersonal understanding of problems and behaviour. They had come to recognise the inter-relationship of the young person's behaviour and their own ways of responding and had become more aware of negative cycles within their family and how to break them. Many described feeling more confident, calm and patient and having a renewed sense of control.
- **Young person change** – Positive changes reported for young people included a reduction in aggressive behaviour, a cessation of running away, improved communication, more positive relationships with others, better educational engagement and outcomes, and a shift away from high risk behaviours and contexts. In all the interviews, parents and carers reported that there had been some change in peer relationships for the young person. Changes in young people were related to changes in parenting and changes the therapist had supported at school, and less frequently via direct engagement with the therapist.
- **Family change** - In some families there was a change in the whole family dynamic. Families had re-learnt how to be together and had become a cohesive unit again. Strategies learnt through MST supported this greater cohesion. There was evidence of improved parental and sibling relationships.

Barriers to positive impact and sustainability of change

Although each family's situation was unique, there were themes regarding barriers to MST's impact and sustainability:

Abrupt end to MST intervention - Families were prepared for the end of MST and given detailed sustainability plans, but some practitioners and parents and carers felt MST ended too abruptly and would have welcomed a graduated end of service. Building in a flexible period of support beyond the intensive therapeutic intervention could help some families make a more secure transition towards independence and confidence in their parenting.

Inflexibility of MST referral procedures: a need for earlier intervention – Practitioners discussed how MST's flexible approach, ability to engage with families in crisis even when

the young person didn't want to engage, and focus on addressing challenging or offending behaviours, might mean it was sometimes a better service to be offered *before* other high intensity services. It was felt that some families would subsequently be more able to engage with other services, such as DBiT in Essex.

Unmet needs of the young person: mental health and education - An ongoing challenge for several families was the young person's mental health and this could impact on the success of MST. For four families, educational issues were either unresolved or unstable after the end of MST; three of these were the families where mental health was also an issue. Issues of non-attendance or sporadic attendance at school were closely interwoven with mental health for these young people.

Context around the young person: peer group challenges - The environment around the young person, particularly their peer group, continued to be a challenge to sustaining change for some families. Although it was reported that there had been positive changes to the peer group for most young people, these changes did not always feel secure. One of the aims of MST, namely that of facilitating involvement with positive and proactive peers, did not appear firmly established from the family interviews. For three young people, moving away from risky peer groups had left them quite isolated and there were also examples of some young people engaging with much younger or older peers.

Conclusion

It is evident from this small scale, summative evaluation that the MST service has had a profound impact on the families that we interviewed. The overarching messages from the practitioners were also positive, and concerns were highlighted about the potential gap in services following the closure of the MST service.

There is evidence of positive outcomes post-MST for the wider cohort of 302 young people who received MST. Lower numbers of young people had child in need plans and child protection plans in the year following MST compared to the two years pre-MST. A key finding is that while 91% of the cohort had social care provision in the two years prior to MST, only 55% of young people had provision in the year post-MST. The data available to this evaluation facilitated a binary calculation for care entry pre and post MST, as well as a binary assessment of pre and post interactions with children's social care. We measured

whether a child entered care or not post MST but did not measure the length of time spent in care. Separately, a 7-year outcomes data measurement undertaken by the Social Impact Bond measured whether there was a reduction in time spent in care by children post-MST, compared to what was expected based on the historical comparison group. This reflects the complex reality that for some children, a short care episode can be of benefit, but overall the aim of the project was to reduce time spent in care by all children.

Our evaluation showed that on a binary in or out of care basis, just under a fifth of the children in the sample spent time in care post-MST. However, the SIB's ongoing dataset showed a significant reduction in time spent in care overall, five times less than the historical comparison group.

Recommendations

- Ensure there is clarity about the focus and approach of MST at the point of referral. Consideration should be given to parent or carer views regarding care entry and whether there is conflict between parental perceptions of the problem residing with the young person and the holistic approach of MST.
- Consider a graduated end of service or support for families after MST case closure.
- Ensure continuity of support from a well-matched therapist for the family wherever possible. If continuity is disrupted, additional support may need to be put in place or the intervention period extended.
- Ensure a strong focus on how to actively support engagement with more positive, prosocial peers in order to sustain long-term change in the peer context and reduce social isolation.
- Ensure timely access to specialist mental health provision to address underlying mental health difficulties which also impact on educational outcomes.
- Consider broader success criteria to facilitate a more comprehensive assessment of the impact of MST.
- Consider the 'optimum timing' for referrals to MST to facilitate an earlier intervention role for some families.

- Ensure there is comprehensive planning to 'fill the gap' when MST ends in a local authority.

Main Report

Background

The Multisystemic Therapy (MST) Service was contracted by Children's Support Services Limited (CSSL) on behalf of Essex County Council through the Essex Edge of Care Social Impact Bond (SIB). The aim of the service was to provide therapeutic support for adolescents at risk of entering care or custody. The national children's charity Action for Children was commissioned as the MST service delivery partner and the SIB contract was managed by Social Finance, a not-for-profit organisation that partners with the government, the social sector and the financial community to tackle social problems.

The Essex SIB was the first to be launched in a local authority and to fund children's social care services. The SIB funding enabled Essex County Council to target investment into a preventative intervention for a group of adolescents and their families displaying complex needs and supported the service delivery partner to provide a longer-term service without the disruption of regular tendering exercises.

CSSL was a special purpose vehicle formed of eight investors providing a total commitment of £3.1 m to fund the intervention for five and a half years. The financial return for the investors was linked to the success of the service, with investor returns determined by reduction in days spent in care by adolescents using the service relative to a historical local baseline. CSSL and Essex County Council established an outcomes payment contract and CSSL formed a service delivery agreement with Action for Children. The MST service was overseen throughout the project by an Essex SIB Project Board consisting of Essex County Council, CSSL, Action for Children and representatives from MST-UK. The aim of the MST service in Essex was to work with 384 adolescents aged 11-17 over the funding period of five and a half years. The service had worked with 388 adolescents by the end of the funding period, just exceeding this initial target.

Aims of multisystemic therapy

Multisystemic therapy (MST) is an intensive, evidence-based family therapy for adolescents aged 11-17 years, who are at risk of entering care or custody due to significant behavioural issues. Adolescents referred to the service typically display multiple high-risk, anti-social characteristics including aggression, serious disobedience, violence, criminal behaviour and imminent risk of entry into care.

MST aims to promote positive social behaviours in adolescents and to work with family members and carers to develop their skills and confidence to manage the young person more effectively. While a key aim is to prevent the young person from entering care or custody, success is also measured in terms of wider improved outcomes including emotional wellbeing, educational outcomes and rates of offending.

Some of the key components of MST are:

- The parent or other care-giver is seen as the primary driver of change. The focus is on supporting and developing their skills to understand and manage the young person's behaviour. Therapists work with parents and other care-givers even where the young person does not want to engage with MST.
- The intervention takes a systemic approach, considering the whole environment around the young person, including school, family, peers and the wider community. Therapists often work with participants beyond the young person's home to improve behaviours and sustain change across environments.
- Therapists carry a small case load of between four and six cases at a time to support intensive work with each family over a focused time period of three to five months. This time period will not be extended even if all objectives have not been met, since a key assumption of the intervention is that change can occur quickly.
- Therapists undertake intensive training in the MST model and are supported by weekly consultations with an MST expert, to ensure the service is adhering to the treatment model, and to continually review outcomes.
- Therapy sessions are delivered flexibly in the home setting at times suited to the family to reduce barriers to accessibility.
- Families have access to therapist support 24 hours a day, seven days a week.

Structure of the MST service in Essex

The Essex SIB was delivered by two MST teams, one covering North and Mid Essex and the other covering South and West Essex. Each team comprised four therapists, a managing supervisor and a business support officer. The overall service was managed by a service delivery manager employed by Action for Children. Referrals to the service came from Social Workers and Divisional Based Intervention Teams (D-BIT) in Essex. These teams provide

support for children and young people on the edge of care, arising from breakdown of family relationships and those at risk of custody. All referrals to the MST service were routed through the Essex County Council's social care locality-based panels. These panels oversee all social care decision-making about allocation of interventions and resources for children and families and acted to ensure that referrals to MST were in line with the agreed referral protocol and criteria.

Aims of the Evaluation

This evaluation aimed to investigate whether, and how, the MST service in Essex supported young people and their families, and to what extent it supported the key aim of keeping young people out of care. Although keeping young people out of custody is also a key aim, we did not have access to this data, and so this report cannot comment on periods of custody or subsequent rates of offending. This report provides a summative evaluation, carried out over a five-month period, at the end of the five and half years of the Essex MST service provision (April 2013 to December 2018). It does not evaluate the SIB structure or the process of implementation of the SIB. A separate three-year evaluation was undertaken regarding these aspects of the SIB by the OPM group on behalf of Essex County Council.¹

The key questions addressed in this evaluation are:

- What did practitioners and families hope and expect MST to achieve and to what extent have these been fulfilled?
- What have been the most important factors that have facilitated and/ or acted as barriers to positive impact during and after MST?
- What impact has MST had on families and young people?
- What are the outcomes for young people post-MST?
- What recommendations can be made for future MST interventions?

¹ 'Top tips for developing and implementing a SIB: Learning from the Essex MST SIB', OPM group, Autumn 2016

Evaluation Design

The evaluation combines analysis of quantitative data about the MST cohort collected throughout the service delivery period, with qualitative interview and focus group data obtained at the end of the service delivery period.

Data Collection

Qualitative data collection

Semi-structured face-to-face interviews were undertaken with nine families who had recently completed the MST intervention. Although efforts were made to interview the young people in these families, they all declined to participate either in an individual interview or as part of the interview with the other family member(s). The interviews were either conducted with parent(s) or other family members. The relationship of these other family members to the young person is not described to ensure anonymity. They are referred to as 'other carers' throughout the report.

Table 1. Interviewed family demographics

Family	Family member interviewed	Gender of young person	Age of young person at time of MST (years)	Education Status	Referrer to MST services	MST intervention period (days)	Time since completion of MST (days)
A	Mother	Male	14	No information	Social worker	140	7
B	Mother	Female	15	Mainstream full-time	Children's Social Care(CSC) & School	89	66
C	Mother	Female	15	Children's Support Service (CSS) ²	Social worker	118	111
D	Mother	Female	15	Specialist provision / on roll at mainstream	CSC	135	95
E	Other carers	Male	15	Mainstream full-time	Social worker	155	60
F	Mother and father	Male	17	In work	CSC	126	27
G	Mother	Male	12	Mainstream full-time	CSC	138	20
H	Mother and other carer	Female	13	Mainstream full-time	School	140	45
I	Other carer	Male	13	CSS / on roll at mainstream	CSC	150	59

A focus group was conducted with ten social care managers and senior practitioners in either Family Support and Protection (FS&P) or Assessment and Intervention (A&I) teams. Participants had managed practitioners who had referred families to the MST service, had direct experience of referring to MST, or in some instances had worked directly with MST therapists. Throughout the report focus group participants are referred to as practitioners to distinguish their comments from those of the families who were interviewed.

² The Children's Support Service (CSS) in Essex can provide Alternative School Placement places as an alternative to permanent exclusion. The young person remains on the referring school's roll, but is taught at an allocated CSS Centre.

The semi-structured interview schedule used in the family interviews was informed by that used by Kaur, Pote, Fox & Paradisopoulos (2017) in their study of caregiver's perspectives on sustaining change following multisystemic therapy.³ The key areas covered were: families pre-intervention experiences, including previous service engagement; pre-intervention hopes, expectations and understanding of MST; experience of working with the MST therapist; the young person's engagement with MST and the therapist; whether MST had brought changes, both positive or negative; and the facilitators and barriers to change, including sustaining change post-intervention. Throughout the interview, an effort was made to encourage discussion about change, and facilitators and barriers to change, in different contexts including home, school or other educational settings, wider family, and the young person's peer group.

The key areas covered during the focus group were: the referral processes to MST; practitioners' hopes, expectations and understanding of the service; the impact of MST; the facilitators and barriers to change; sustainability of change; the impact of the decision not to continue the MST service in Essex.

Quantitative data collection

Pseudonymised child level quantitative data was provided by Essex Children's Services for 388 young people who were involved with the service over the five and a half years of service provision. In order to capture outcomes after MST, young people were excluded where less than one year's post intervention data was available. Two further young people were excluded because they had both received two separate periods of MST, and one was excluded because MST had lasted for less than one day. The final sample comprised 302 young people. Social care data was also included for two years pre-intervention.

The quantitative dataset included information about the duration of the MST intervention for each young person and about any contacts with children's social care before, during and after provision of MST. This included referrals for the case to be re-opened, either as a child in need, or a referral for placement. The data-set also captured subsequent child protection

³ Kaur, P., Pote, H., Fox, S., & Paradisopoulos, D.A. (2017). Sustaining change following multisystemic therapy: caregiver's perspectives. *Journal of Family Therapy*, 39(2), 264-283.

plans and referrals for other local authority services, including DBiT and Family Solutions which is a service providing key-worker support to families in need.

Data Analysis

The qualitative data from the semi-structured interviews and focus group was analysed using thematic analysis (Braun & Clarke 2006)⁴. Data was coded by the primary researcher who had conducted half of the interviews, but themes and sub-themes were shared and discussed with two other members of the research team who had conducted the interviews and/or the focus group to ensure validity. A deductive approach was used, informed by the key research questions, focusing on hopes and expectations, impact of MST, factors that facilitated or hindered positive outcomes, and recommendations for future MST interventions.

The quantitative data analysis focused on gaining a broader understanding of the social care outcomes for young people following MST. Pathways to different kinds of social care provision (Child in need plan, service(s), child protection plan and/or period of care) from the two years pre-MST to the year post-MST were identified. Logistic regressions were carried out to identify whether there were any predictors of a period of care, a CiN plan or any further provision post-MST.

Ethics

Ethical approval for the evaluation was obtained from the University of Oxford. Information sheets and consent forms were given to families prior to interview by the managing supervisor and business support officer of one of the MST teams in Essex and participants were invited to ask questions.

The purpose of the study was explained to all participants in the information sheets and contact details of the research team provided. Participants were informed of their right to withdraw their information up to the point when the report was written and were assured of their confidentiality and anonymity, including in written reports of the research. All participants were informed that their anonymity would only be breached if the risk of

⁴ Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

serious harm to themselves or others was disclosed during the course of the interview or focus group, in which case an agreed local authority manager would be informed.

Interviews were audio-recorded where consent was given and recordings destroyed once transcribed. All data were stored securely and confidentially in compliance with GDPR regulations including: storage of transcripts of audio recordings of interviews and focus group on a secure university server; labelling families with anonymised codes which were stored separately to other identifying details; ensuring that any potentially identifiable details were removed in publicly disseminated materials.

Main findings

SECTION 1: Point of referral - hopes and expectations

Situation at point of referral

Several practitioners indicated that MST had been established to work with families facing the most complex issues, including gang involvement, child sexual exploitation, offending and teenagers on the edge of care. Because of this, positive engagement by any service or professional was viewed as challenging. Practitioners emphasised that families were often at crisis point when they were referred to MST and this was reflected in the family interviews, where the strongest theme was a sense of desperation at the point of referral and parent and carers' willingness to try anything that might help their child and family.

All families described complex and distressing situations. Young people were displaying challenging or violent behaviour, there were repeated episodes of running away, most were not attending school or attendance was severely disrupted, and there were some accounts of repeated self-harm, mental health problems, involvement with drugs, county lines, gangs and risky peer groups. When talking about how things were at the point of referral, families spoke about '*the dark days*' (Family A) or described their child being '*in a real, dark place*' (Family C). For one family '*It was almost like in the deepest, darkest depths of depression, it was just absolutely horrific, I wouldn't wish it on anyone*' (Family H).

None of the families thought they were getting the support needed, and several were relying on emergency services such as the police to support them as crises occurred. Some families had not known where to go or what to do next.

it was like nothing was worth it, we just felt like we were going round in circles, banging our heads, nothing was worth it. So, it was just like I might as well just have sort of gone away and curled up and just shut myself away from it all (Family B).

Hopes and expectations

Practitioners in the focus group emphasised that successful acceptance onto MST involved reaching 'a high bar' and was described by two participants as 'the last chance really' and 'our last roll of the dice'. For some practitioners, the commencement of MST in Essex came with high hopes and expectations, reinforced by a stringent success criterion of 'payment by results, the child's got to stay out of care'. This could inflate hopes about what the service would be able to achieve.

I think maybe our expectations were a bit too high, because some of the families that we're asking to work with are our most difficult and challenging families.

As the MST service in Essex became more established, the development of good working relationships sustained expectations for beneficial impact. Some therapists developed a very positive reputation in the county and their involvement with a case supported positive hopes for change among other practitioners. While practitioners did not feel that they could comment on whether families had expectations that might have been too high, it was suggested that families would have been aware, with the stringent panel review process, that MST was 'not a service that's run of the mill'.

The family interviews demonstrated that there was not always a clear understanding of MST at the point of referral. Some families had little understanding of the process and reported low expectations regarding positive outcomes. One practitioner emphasised that the use of language such as 'therapy' and 'therapists' could have a negative effect on parental expectations. For parents feeling in need of support, the word therapy could sometimes

have un-welcome or intrusive connotations and be off-putting. Family expectations of MST were also tempered by their previous experiences of services. All families had received some prior interventions; DBIT, Family Solutions and the Emotional Wellbeing and Mental Health Service (EWMHS)⁵ being the most frequently referred to. While some families felt that these services had helped at the time, they had not led to sustained change for any of the families interviewed and all had found themselves in crisis again.

In the focus group discussion, practitioners highlighted the risks of offering MST too late. They referred to several cases where parents and/or the young people themselves had come to view entry into care as a positive outcome by the time they received MST.

[Families] know that when they're going to get a service put in at the top end, if that service doesn't work, then their child might more likely be taken into care. They'll sort of make that not work. That is a factor and that's quite negative, but that is a factor we have to consider.... Because they've reached crisis.

Sometimes it's the young person wants to come into care... themselves and that's why they're not engaging, because actually this is what they want and they've had enough.

These hopes conflict with the key MST objective of keeping young people out of care, the potential impact of which may need to be considered carefully and addressed at the point of referral. This raises the issue that earlier referral to MST before crisis point could support a better match between parental expectations and the aims of MST. One practitioner, referring to a family who wanted their child to go into care, emphasised that '*we missed the early intervention in that family.*'

Two practitioners highlighted that for parents in crisis it may be particularly difficult to acknowledge the role of parenting which could make them less receptive to MST's way of working.

⁵ Emotional Wellbeing and Mental Health Service (EWMHS) is the term used in Essex for the Child and Adolescent Mental Health Service (CAMHS).

...the very high-end complex cases where they don't know what to do anymore, and then they get another person coming in telling them it's them that needs to act differently and not the child.

The focus group discussion reflected this importance of considering parental expectations and perceptions of the reasons behind the difficulties at the point of referral. Some practitioners referred to a distinctive feature of MST being that they would work with parents even when the young person was not willing to engage. Whilst this increased the potential to engage some families, it made it imperative to acknowledge parental perspectives. Practitioners viewed MST as a better match for families in which parents were willing or able to recognise their own parenting practices as important facilitators to change. Where a family's perception was that the child was the sole architect of change, it was felt MST was less likely to be a good fit.

there are some parents who are able and recognise it's them that need to make the changes, and others that aren't, and for some of those it just didn't work.

In the nine families interviewed, all had completed MST with broadly successful outcomes. The fact that their expectations did not conflict with the aims of MST may have contributed to this. Although some expressed low expectations of change, the most frequently expressed hope was that MST would help them to understand or help their child more effectively. Thus, all viewed themselves as contributing to the process of change. The other hopes expressed also suggested an active view of their role; to develop better coping strategies, to bring their family back together again and to help improve the young person's behaviour. Families hoped to move away from a difficult past and find ways of solving or 'fixing' the problems facing them.

SECTION 2: Facilitators to positive outcomes

The five distinct facilitators to positive outcomes from thematic analysis of the focus group and family interviews were:

- 1) Therapeutic alliance
- 2) Intensive support: understanding the family in context
- 3) Therapist as guide, advocate and mediator
- 4) Facilitating new insights, perspectives and understanding
- 5) Tailored, solution-focused practical techniques and strategies

All five themes were highlighted as important facilitators for parental and carer change. Where themes also appeared an important facilitator of change for the young person, based on the parent and carers account, then this has been highlighted.

Therapeutic alliance

A recurring theme during the focus group was the importance of an effective therapeutic alliance between the family, especially the parents or other carers, and the MST therapist. Key elements identified by practitioners were *match* and *consistency*. Finding the right therapist, who a family could relate to, was viewed as crucial by practitioners, but sometimes difficult to predict. Despite detailed planning by the referral panel, there had been instances of '*the worker not fitting with the family, the personality, which does happen unfortunately*'.

Therapist turnover, especially in the early stages of the service, was also seen by practitioners as contributing to poorer outcomes for some families. In an intensive intervention of this nature, having the same therapist throughout was an important factor for positive outcomes. There was a recognition that families receiving MST had often had long-term involvement with other services, so would have experienced previous transitions where they had to retell their story. Practitioners discussed how changes in therapist could affect families' engagement, trust, self-esteem and willingness to feel able to open up again to somebody new.

I think probably just the human instinct is that you feel like, am I not important enough to keep the same worker really? That's probably the human response to it isn't it really?

This was echoed in the comments of one carer who did not feel MST had worked for them. Their support had been severely disrupted due to issues affecting the therapist. They explained they had not been willing to work with a different therapist and build a new relationship despite an alternative being offered, and as a result they viewed MST as a missed opportunity. The other eight families had all received continuous support from one therapist and this consistency was viewed positively. Some referred to having the right person for their family and missed the rapport with their therapist when covered by another person during annual leave.

The therapeutic relationship between parents or carers and therapist was clearly a strong facilitator of change. All nine families felt they could be open, honest and talk about anything with their therapist. Some families had been able to express to their therapist their fear of their child and the situation. The therapist's capacity to understand this helped them to move forwards:

we were scared and weren't sure what to do and how to do things, and she could see that in us (Family E).

Feeling genuinely listened to, understood and empathised with were important aspects of the relationship. Some described the therapist as like a friend or *'more family, if you know what I mean, she became part of the family, the way she was, how we could speak to her and how she listened'* (Family D).

However, although the analogies of family or friend were often used, the non-judgemental stance and neutrality of the therapist within the relationship were equally valued. One carer described their therapist as *'a neutral observer in the middle that could take it without actually making any judgements on anything that anybody was doing'* (Family E). This contrasted with the negative evaluations some parents and carers had experienced from friends and family or from other practitioners. For some families the therapeutic alliance

was facilitated by a view of MST therapists as distinct from other practitioners. One family explained that they *'didn't seem to have any parameters'* (Family H) and that they were *'outside of the system'* (Family E).

Although we did not interview any young people, in five of the families the young person had worked directly with the therapist. Some parents and carers referred to the importance of the therapeutic alliance for the young person.

The best of way of phrasing it would be that [therapist] was very empathic to him, she read him, she read what he needed and she reacted to that...she didn't try and force him to talk about things that he really felt uncomfortable to talk about...I think he saw her as a friend (Family E).

The carer believed that from this safe space, this young person then felt more able to communicate with their family.

I think, as well, when you've bottled something up, it's very difficult to tell the people close to you, but if you tell it to somebody that's neutral, first of all, you've already let that bit go, so it then becomes easier to tell the person closer to you. Whereas, if he had told [therapist] what was going on, he then felt, 'I've let that bit out, now I can go and tell [family members' names].' (Family E)

In several other families too, parents and carers described how the young person gradually developed a supportive relationship with the therapist. It was reported that some young people saw them differently to other professionals and found them less intimidating because they worked holistically, so they did not feel the 'cause' of the problems or the sole focus. One parent described how their child, who had initially refused to work with the therapist, gradually began to form a close relationship with them because the therapist took the time to find out about their personal interests. As a result, this young person rediscovered these previous interests, and developed renewed aspirations regarding how they could lead to a future career.

Intensive support: understanding the family in context

Consensus among practitioners was that families benefitted greatly from the '24/7' availability of MST; being able to receive guidance and support when needed, especially when in crisis. The service could provide '*somebody alongside them*' when most needed. This was contrasted with the lack of capacity to do this sort of intensive work by other professionals, such as social workers.

Seven of the nine families also highlighted the importance of this intensive support. Some had made use of the out-of-hours telephone support when facing a crisis, while others described the value of being able to text their therapist for rapid feedback or support. One parent highlighted the psychological impact of just knowing that support was there:

And MST, you can call at any point, they're 24 hours a day. I didn't actually need to, but I think knowing that they were there helped calm me. (Family H)

Practitioners suggested that working intensively with families, especially in their home environments, enabled MST therapists to provide a '*different lens*' from most other professionals on the challenges facing each family in their everyday context.

because a lot of other practitioners that we work alongside, like health, education, and they don't see families in their homes predominantly... not many people will go to the home, and there's something about working in that home environment, and like having a different lens and a different perspective I think is really, really helpful in that kind of very, quite intense structured way.

This was endorsed by several families in their interviews. They emphasised that because therapists worked alongside them in the home environment this provided a better understanding of the problems 'in situ' and could support more effective strategies.

Family member 1: There's the support you get elsewhere, you know, the general support, and it doesn't help because they don't know the situation.

Family member 2: It's not specific enough. But once you come into the house, you can

see more the specifics of what's going on. (Family H).

Working intensively in the 'real' context of families went beyond the home. In all nine families, the therapist liaised with educational settings and frequently with other services, including the police, children's social care and other therapists. This systemic, holistic way of working had a positive impact. Therapist involvement with education ensured a coherent approach across home and school. In five families, strategies and plans implemented at home were shared with school, and reinforced or adapted so that all environments around the young person were working towards shared goals.

Therapists' high expectations regarding school attendance and attainment were shared with young people and sometimes facilitated change:

Family member 1: I think if MST wasn't involved, [young person] wouldn't have turned up to any of his exams, so that was a huge support at the time and he needed it really.

Family member 2: She helped him focus, because he didn't know what to do and she helped him realise that it doesn't matter if you don't know what to do, but having some exams means that you've got lots of opportunities (Family F).

Therapists also made sure that their approach did not conflict with those of other professionals both during MST and beyond. In one family, who were receiving ongoing therapy from a different organisation, the MST therapist had worked closely alongside the other therapist to ensure that both approaches complemented each other. When MST ended, this facilitated the family's ability to use both approaches flexibly according to their needs. The therapist had told the family:

"use the MST when you need to, but he's your main person now," so she didn't have this territory thing, 'you have to do this, this is the way we do it'. She said, "Use us as a guide now." (Family A).

The therapist's capacity to work beyond the nuclear family was also a strength for some

families. Explaining the approach, especially to other close family members such as grandparents, meant parents received greater understanding and support as they made changes to their parenting.

Therapist as guide, advocate and mediator

MST therapists took on multiple roles that supported change. This capacity was facilitated by the first two themes – the therapeutic alliance and intensive work across contexts - as well as the breadth of expertise of therapists. Two families emphasised that the MST therapist was unusual because they could understand the multiple challenging affecting their child, such as trauma and abuse alongside educational or learning difficulties. They didn't feel most other professionals would have that scope.

Families often referred to their therapist as a guide or advisor. They explained how therapists empowered them to regain control and make decisions by providing options, choices and facilitating a 'trial and error' approach, rather than MST therapists taking on an 'expert' role, this removed a fear of failure because therapists did not advocate one correct solution and enabled parents and carers to feel supported enough to try out new strategies and techniques within a safe space.

The holistic nature of MST placed therapists in a strong position to take on the role of advocate or mediator, because they understood the complexity of relationships within and around the family. Several families identified times when their therapist had acted as an advocate, most frequently with education providers. Therapists had advocated for families on diverse issues such as home-schooling, returning to mainstream school following alternative provision, and in-school arrangements. Families had often found it difficult to make their voice heard and valued this support.

While they were involved she did a lot better, she was going to school, she was doing what she needed to...I always said the school lacked communication, so I think because everyone was there and regular emails going out and things, it helped to keep them on their toes with her and that sort of thing really....because they were having to talk to people and it wasn't a parent....they took more notice (Family B).

Families frequently identified times when the therapist had acted in a mediating role between family members. There were many instances where the presence of the therapist facilitated positive communication between parent/carer and young person, or between the two parents. The therapist acted as a neutral mediator to manage challenging conversations. One parent described how she and the young person were able to work things out together with the therapist's support:

by [therapist] being there, it made it easier to listen, because I think, with [therapist] sitting there, I felt less that she was going to kick off, because someone else was there. So, she did sort of listen and do it and then we were able to talk through it, whereas if [therapist] hadn't have been and I'd have tried, she might have kicked off (Family B).

In some families, where the therapist worked separately with the young person, they mediated between the young person and their parent / carer: *'they can see my point of view, but then they can see, say, how [young person] is feeling, they were just really good'* (Family G). Family C described how the therapist communicated the young person's view to them, for example when they had felt a punishment was too harsh, which the young person didn't always feel able to do directly. This capacity of MST therapists to bridge the gap between family members was clearly a strong facilitator for change:

instead of just feeling his way, he (young person) felt that he could put things through to [therapist]. And [therapist}, without saying exactly what he'd said, was able to give us a feeling of where we needed to go to support that. It's almost like a sort of a priest in a confessional, they won't tell you what's happened but they're able to steer things in the right direction and that is really good (Family E).

In those families where parental communication or a shared approach to parenting had broken down, the therapist also mediated conversations between parents, so that they could begin to talk and work together towards shared goals again.

I could bring up issues about her [young person] and perhaps with [husband] about how he responded to her with [therapist] there, so she was like a little mediator (Family D).

Facilitating new insights, perspectives and understanding

All parents and carers emphasised that MST had supported them to gain a better insight and understanding of themselves, the challenges they were facing, and their child's behaviour, leading to more attuned and positive parenting. Gaining a better understanding of their child was highlighted as one of the most important aspects of MST by several families.

Parents and carers felt MST had deepened their understanding of the underlying reasons for different behaviours. For example, parents or carers who had previously viewed the young person as naughty, now talked about recognising that their challenging behaviour could stem from fear, anxiety, attachment difficulties, or the impact of other conditions such as learning disabilities.

it's just loads of things that MST have actually helped me to open my eyes to realise, 'maybe it's because of this or it's because of that, he's acting like this'. So, it's loads of little things...I just thought maybe he's just being naughty, but when I've spoken to MST they've made me realise that there may be something there that is wrong and that is why he is acting that way. (Family G).

Many others emphasised that MST had provided a more positive perspective when they had felt hopeless, which helped them to keep engaging with the therapeutic process and believe in change.

So, MST helped with that, to not be so negative, to try and find the positives, and that's hard to do. But when you've got somebody guiding you, have to kind of think what good happened today, what did she do, and it could be the smallest thing, but you'd have to look for it. (Family H)

Some parents and carers also felt that therapists helped them to learn to keep things in perspective, such as recognising when the young person was just displaying normal

adolescent behaviour. This had become difficult for some because of the intensity of the challenges they had been facing.

She [therapist] would tell [Dad's name], "Look most teenagers do that, so don't worry, don't obsess on that bit, but just think on the positives. (Family A)

Seven families reported that MST helped them explore their own anxieties, personal histories, sense of shame, guilt, fear of failure, or fear of being a bad parent. They felt supported by MST to develop a different view of themselves which became a catalyst for change.

For me it gave me a chance to talk things over, how I felt, where I was at, what historical stuff just kept coming back, really. And it did, actually, give me a chance to look at it in a different light, it did give me that bit of time to think about things. (Family I)

Parents and carers frequently repeated the therapists' words of reassurance from conversations, including: not to beat themselves up if something didn't work, that they understood more than they thought about their child, they didn't have to be perfect parents (Family A), they knew what they were doing (Family B), that they could do it (Family C), and that they were the person who knew the child best (Family E). One family stated:

She wasn't criticising us as parents, we always said we're bad parents, or I always said I'm a bad parent, she said, "You're not a bad parent, you're definitely not, you are good parents, you're just lost." It's how she – how she framed it for us and how she got us to understand ourselves really. (Family D).

Therapists' words clearly resonated and supported a more positive view of themselves as being able to affect change. In three of the families, the therapist had suggested and facilitated counselling or cognitive behavioural therapy to enable the parent or carer to explore their feelings in more depth, with beneficial results.

Tailored, solution-focused practical techniques and strategies

Implementation of practical, solution-focused strategies tailored to families' individual needs were a powerful facilitator of change. These included communication strategies, practical strategies around safeguarding, behavioural reward programs and establishing clear boundaries. During the focus group, some practitioners spoke of being impressed by the creative and flexible ways in which therapists engaged with families and the practical implementation of safety plans and detailed reward charts.

Families highlighted how they had learnt to problem solve, plan ahead and work through step-by-step plans to address specific problems as they arose, such as if their child went missing again. Therapists also supported parents to gradually put in place boundaries, rewards, or consequences when agreed boundaries were not adhered to. Some families described the technique of allowing the young person gradually increasing amounts of time to go out, or gradually increasing amounts of money again, but with clear expectations in return.

All families highlighted the importance of MST strategies being tailored to their needs. Plans were constantly open to adjustment and revision, with the therapist guiding the process, until they worked effectively for the family. One parent explained what made MST different from other services, *'They're very meticulous, the way they do their job and they go through their planning of what the issues are and then they work and they pull it apart, I mean literally into minute fragments...they literally dissect it and they work on it, it doesn't matter what way, they work on it, each individual bit and it works'*. (Family C).

Families found that sometimes very small adjustments could make a big difference to the behaviour of the young person. Three families described the thorough implementation of school plans and the way regular adjustments were made if they weren't working. For example, when earning a reward for a positive day at school wasn't working for one young person, the plan changed so that rewards were earned for each lesson. This worked to motivate them to keep trying even if one lesson had not gone well.

Communication strategies were particularly important for re-establishing relationships

within the family. Families spoke about MST providing *'the scripts of how to say things'* (Family A), learning to use communication more sparingly, giving fewer choices verbally so that the young person felt less overwhelmed, and establishing key phrases so that the young person could signal when they needed to be left alone. Three families had shifted to using text or email communication with their child when they were out, rather than phoning them, which kept channels of communication open. One family used this as a broader communication strategy at home too.

whereas before we would all be very confrontational with each other and very argumentative and no one had a voice ... now if there's an issue, me and [young person] text each other, so [young person] can actually read that and then he can read it again and then he'll come back and say, "Okay mum, I understand, I'm sorry." Because he's very visual, he needs to visualise it, where if you're verbal with him, then you get the arguments back. (Family F).

MST had reminded families of the importance of positive communication. Families described learning specific techniques such as the *'sandwich technique'* - sandwiching one negative comment in between two positives - or the use of *'Socratic questions'* which help to open up issues and problems:

you'd say, "Oh that's such a shame," and you have to, sort of, sympathise, even though you might not agree with it "Well, I understand why you might feel like that. If it happened again, what do you think you could do that might have a better outcome?" Kind of let her take control. I let her think.(Family H)

This solution-focused approach was reported as being effective for young people as well as parents and carers. Family F described how previous counselling approaches had not worked for their child but that the goal-focused approach of MST did; the therapist worked successfully with them to help them achieve better exam results and a job. They emphasised that this enabled MST to reach *'more than the one type of child'* and valued the skills developed from a *'CBT approach'* which they believed would stay with their child for the rest of their life. Family E also described in detail how the therapist helped the young

person to think ahead and problem-solve different ways of managing impending challenges. For example, when they were making a difficult return to school, the therapist helped them to plan and rehearse how to respond to potentially probing questions from their peers.

SECTION 3: Impact of MST

Summary of impact on practitioners

Several focus group participants commented on the positive impact MST had on their own practice, professional development and understanding. One stated that MST was especially impactful in the early stages when the service felt *'unique and different'*.

Some practitioners had worked alongside MST therapists, visiting families and attending meetings together and valued the opportunity to talk through and approach problems together.

What I found really helpful is we seemed to work quite closely together. I didn't do all the sessions, but I was there sometimes. When we had a particular problem we went together to the family to talk about it, to see what we could both do really, and I think I really benefitted from that as a practitioner

Another social care manager who had worked directly alongside MST felt that she had gained a greater understanding from their approach.

When I went to a meeting with MST, I felt I learnt such a lot, because actually what they did is said "look, let's just put all those problems aside, we're going to focus on this little one", and that was really helpful to me, and I think social workers have learnt a lot as well.

MST practitioners sometimes alleviated the workload of social workers, particularly in terms of providing direct support to families through crises and thus allowing social workers to *'to sort of step back and let them do their work'*, gaining a better perspective.

There was evidence that MST had also had a longer-term impact on social work practice in the Essex area. There appeared to have been 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. When discussing how to fill the gap left by the closure of MST,

reference was made to social workers and family centres taking on some of this trauma-focused work.

Summary of impact on families

In terms of the overall impact on families the key take home message was that assessing impact is challenging, particularly with an intervention of this nature which can impact multiple systems around the young person.

In the focus group, some practitioners spoke very positively about MST's impact on families, expressing the view that for some MST had been 'transformative'.

People loved MST and are really sad that it's gone, and it doesn't marry up, and I know there's been research that said MST isn't working It doesn't marry up certainly with workers' experiences of working with those families.

However, other practitioners thought that the impact had been variable with MST being a better fit for some families than others. Where it hadn't worked as well, this wasn't viewed as the 'fault' of MST, but rather a reflection of the challenging issues facing the families and the fact that intervention sometimes came too late.

The interviews with families revealed the complexity of change, and the fact that impact cannot be easily categorised as just 'positive' or 'negative'. Change did not necessarily occur for all family members at the same time; in some families the behaviour of the young person remained challenging but the parent or carer felt more resilient and better able to cope. Some families described MST being the beginning of an ongoing journey of change: *She's (therapist) just given us the foundations that we can work on and we are getting there* (Family A).

In two families, where young people were still displaying aggressive behaviour, along with other unresolved issues such as mental health and education, the impact of MST was judged less positively, and sustaining change in the home seemed precarious. The carer who didn't feel MST had led to positive change stated that *'the concept of what they've got is really good'* and explained, *'I found it very, very good for me personally... but it hasn't changed, no,*

it hasn't really changed anything within the environment we live in, apart from it's given me some new techniques' (Family I).

However, in seven of the interviews, parents and carers felt that the overall impact of MST was positive, and some echoed the views of practitioners that it had been transformative. All had experienced other services prior to MST and generally MST was viewed as the most positive and effective. All families were asked if there had been any negative changes or outcomes as a result of MST, but none were expressed.

'Where we were a year ago to where we are now.... we are in such a better place... Yes, so looking back, it's improved our life no end' (Family A)

'Things got a lot better at home, she was completely off the drugs.....she seems more calmer at home and she's involved a lot more, she's not shutting herself away like she was' (Family B)

'We have good days and we have bad days, but overall, I would have been lost, we wouldn't have had a family now...There's not enough gratitude in the world for me to say thank you to them because, as I say, I don't think my family would be here the second time around' (Family C)

'Everyone has said how different he is, totally different to what he was. So yes, it has been a positive change for him' (Family E)

'She was, sort of, at the crossroads whether she could go one way or the other, and somehow we've managed to get her back on a good road, so it has saved her, really' (Family H).

Several practitioners highlighted that the key success criteria for MST of keeping the young person out of care or custody was too rigid. Sometimes entering care was viewed as in the best interests of the young person. They emphasised the importance of having a broader view of successful impact on multiple levels. Some felt that 'failure' to achieve the key success criteria should not obscure other positive changes that MST may have supported with a family, such as progress with parents or helping to 'steady' a crisis. The need to

acknowledge these kinds of 'qualitative' changes for families was a recurring point. Failure to do so could mask subtle but important changes.

Although the key objective of keeping the young person out of care or custody had been met for the nine families at the time of interview, the more detailed analysis of impact below emphasises the complex, qualitative changes across multiple dimensions as a result of MST which would not be captured by quantitative measures alone.

Impact is considered in three key themes:

- 1) Parent and carer change;
- 2) Young person change;
- 3) Family change.

Impact: Parent and carer change

Outcomes for parents and carers were diverse, but two general themes were identified: interpersonal understanding of problems and behaviour and parental confidence and control.

Developing a more interpersonal understanding of problems and behaviour was a very strong theme expressed across all nine families. The parents and carers that we interviewed had all gained a clearer perspective regarding the inter-relationship of the young person's behaviour and their own ways of responding. Without exception, they had become more aware of negative cycles within their family and how to break them. This was most frequently expressed in the context of learning when to 'pick their battles' and when to walk away. The listening and communication strategies that parents and carers had developed with the support of their MST therapist underpinned this positive change:

he's a lot less confrontational with me. So before, if I asked him to do anything, it was always shouting back at me with several expletives. Now, again, obviously I try to be more calm and keep the commands less complicated, simple, and then just leave him to it and then maybe come back and just remind him. Basically, if you raise your voice to [young person], then it just escalates (Family G).

Because families had been able to discuss previously challenging confrontations with the support of their therapist, and sometimes with the young person, they had learnt to recognise triggers and warning signals. The greater interpersonal sensitivity gained as a result was clearly expressed by this parent:

We just manage it so that we talk to her, but if she says, "Enough is enough," then we leave it, let her go away and calm down and then maybe try and talk to her at a later date....She seems more honest and she just gives a warning and we know when that warning is and we know how much further to push her or whether to say anything, how it's going to aggravate her (Family B).

In general, parents and carers had learnt to reflect upon and moderate their responses. For some families, this wasn't just about avoiding conflict; it included recognising how intense expressions of distress or praise could drive the young person away again. One parent described how their child now trusted them enough to ask for help when they had self-harmed, because they could respond calmly, even though they could be honest with their child that they would have a little cry about it later.

Many parents and carers described feeling more confident, calm and patient and having a renewed sense of control. Most felt less afraid, more able to stand their ground, and communicate clearer expectations. They gave examples of times when they now placed a greater onus on the young person to take responsibility for themselves: *'we'll say, "right if you want to be picked up, these are the terms, if you don't, it's up to you. You take ownership of this.'*" (Family A).

Some parents felt more confident in expressing their own needs; they could tell the young person when they needed some space and had become confident enough to refuse something when their own needs diverged from the young persons. One parent explained that this was a big change since prior to MST *'because of the aggressiveness I always let her rule me'* (Family D).

Most parents and carers had gained the strategies and confidence to take control of situations before they escalated into arguments or aggressive behaviour.

Now, I've learnt a new strategy on how to stop it before it even gets that far, so by problem-solving that in my own head, I can sit down and go, "Right, no, we're not doing this," just change the subject completely on things and then just watch it unfold to calmness again. (Family C)

Families generally exhibited greater resilience when faced with problems, along with confidence to manage future difficulties. Although they didn't always expect it to be easy, strategies had become embedded for parents and carers, as they continued to use and adapt approaches independently. One parent said, *'If I have a big issue, it doesn't matter what it is, whether it's [young person], family-oriented or outside, I sit there and I do the MST, I problem-solve. I don't know what I'd do without that now'* (Family C). Others spoke about strategies they had learned becoming a natural part of their approach: *'it's kind of happening automatically now, not all of it but a lot of it is, the small things, but I guess it starts with the small things.'* (Family H).

Impact: Young person change

Parents and carers described a range of positive changes for young people, including a reduction in aggressive behaviour, a cessation of running away, improved communication, more positive relationships with others, better educational engagement and outcomes, and a shift away from high risk behaviours and contexts. In all the interviews, parents and carers reported that there had been some change in peer relationships for the young person. Most had moved away from risky peer groups, including gangs or involvement in county lines. Where they had remained within the same peer group, there had been a shift towards more positive behaviour including an end to drug taking behaviour with peers.

Changes in young people as a result of MST were related to changes in parenting and changes the therapist had supported at school, and less frequently via direct engagement with the therapist. Although in four families, there had been little or no direct therapist

involvement with the young person, the changes in parents and carers had still had a positive impact on them. Many families explained how the strategies they had learnt through MST, such as improved communication, had supported a ripple effect of positive change in the young person:

she sees how we respond to her, I suppose, and how we react to her. It doesn't make her want to go out and stay out and not want to come home, even though she might walk out, she will come back and she will text. (Family D)

One family even reported that their child would sometimes comment, 'That's very MST isn't it' when their parents responded differently and put clearer boundaries in place.

Changes in educational engagement or outcomes could be remarkable, as these parent and carer comments demonstrate:

To see her from where she started at school and to see her now, it's 100% different, she's totally different now (Family C)

[Young person] has totally changed, in fact their headmaster said 360-degree change (Family E)

These positive changes generally came about through the holistic working practices of MST which brought home and school together and enabled coherent plans to be put in place. However, these could only be effective when the young person had educational provision that they felt able to attend or they did not have specific mental health issues which made regular attendance at school challenging. Where these were issues, educational outcomes were less positive.

Some changes for the young person were related to direct engagement with the therapist. When this was the case, parents and carers referred to seeing changes such as increased sense of self-confidence, renewed aspirations and greater sense of control. These psychological changes were closely related to positive behaviour change, as young people began to make changes for themselves.

I think part of it was just that she (young person) knew that while she doing the drugs

or whatever...[therapist] talked to her about the fitness side of it and how she could help and that's what made her realise that she couldn't do what she was doing if she wanted the fitness and she needed the fitness in order to go into that career (Family B).

For the young person who worked most intensively with the therapist, the fact she *'gave him back the control'* as the carer put it, reduced his anger, frustration, and behaviours such as running away which they had also come to view as related to a need for control. The carer described the young person's response when asked by a family member why they no longer felt the need to take drugs or smoke. They had replied, *"I don't need to because I've got a life now," and that was it. He was able to get control of his own life back.'* (Family E).

Impact: Family change

In seven interviews, the parent or carer described a change in the whole family dynamic. These families had re-learnt how to be together and had become a cohesive unit again. Parents and carers spoke about how they could now do normal every day activities as a family, like going shopping, cooking together, going on holiday, sitting down to eat a meal, or just laughing and enjoying each other's company. In a few families, the young person had also reconnected with wider family members, whom they had previously withdrawn from. All these every day family events had been impossible before MST.

The holistic focus of MST had supported this change. One family explained that *'her (therapist's) focus was totally on 'How do I help this family become a unit and work together?'* (Family E), while another – when asked what was distinctive about MST – explained:

It's including everyone as a family within everything rather than doing everything in our own little areas. I think that's what we will take away from MST. (Family F)

The strategies that families had learnt, including positive listening and communication, parental boundaries, planning-ahead and a greater awareness of when to give the young person space and freedom, also supported this greater cohesion. Participants highlighted

the renewed sense of trust and respect between family members as well as the young person's awareness of how their parents had changed as a result of MST.

*I think he realises that there's a change in us...I think he sees us as a unit now, as a family, trying to help him, rather than 'my parents who don't f***** care' (Family A).*

In families where there were two parents or carers, improved parental communication had resulted in a better parental relationship. Parents described gaining a greater awareness of their different parenting styles and the ways in which this had previously contributed to family conflict. Some parents had learnt when to step back and allow the other parent to manage a challenging situation. Others described greater consistency in their current parenting practices which supported closer family cohesion.

A few parents and carers also described how sibling relationships had become more positive, which had a profound impact on those families' capacity to function effectively. One parent had been unable to go out and leave the young person and their sibling alone together prior to MST because of their violence and aggression, but that had changed. Another described a very positive change in sibling relationships from being *'at loggerheads with each other all the time'* to being *'quite funny together'* (Family F) and able to spend positive time in each other's company.

Many families displayed a greater awareness of the need to continue to work together and there appeared to be a shared sense of whole-family responsibility for future change. One parent described communicating this to their child: *'I say, "Yes, but things have changed, we've changed and you're going to change, we're all going to change together."' (Family A).*

Sustainability of change

In the focus group, practitioners raised questions about sustainability of change for the young person. In families where it had not been possible to engage the young person, it was thought that MST might have provided short-term safety planning and support to parents in crisis rather than sustained improvements.

Actually the young person didn't have to engage with it, which is a bit of an uncomfortable message as a social worker, because actually we work systemically and we think about, well, is this going to be permanent really? Are we just doing some crisis management? And I think there was an element of that.

However, this concern was not generally borne out by the family interviews. Six out of the nine families felt confident that they would be able to sustain the changes brought about by MST, although it is important to note that all families had only recently completed MST.

There was frequent reference to their detailed, personalised sustainability plans and an emphasis on how many of the sessions towards the end of the intervention were focused on sustainability. Some families described how they continued to hear their therapist's voice and used them as a guide even though they no longer received direct support:

As you're going to say something, you think to yourself, 'No, [therapist] wouldn't have done it that way, [therapist] would have steered it this way' and your mind starts to think that way and that's been really, really helpful. (Family E).

I think, 'I know this is the way we need to do it, [therapist] said this...' She's like our Bible, as it were. (Family A).

Many of the families had developed a more present and future-focused approach. They did not focus so much on the past or on trying to understand everything. There appeared to be a recognition by many that there was no quick fix, but that they were now well placed to continue working on further changes. Families often expressed optimism about a better future:

Everything that they did with me was useful to me, even looking to the future and planning ahead and all that. I feel like things do get easier, are going to get easier with what they have taught me.(Family G)

However, three of the families were less confident of sustaining change without the ongoing support of the therapist. The key barriers to positive outcomes and sustainability of change are discussed in the next section of the report.

SECTION 4: Barriers to positive impact and sustainability of change

Although each family's situation was unique, there were themes regarding barriers to MST's impact and sustainability:

- 1) Abrupt end to MST intervention
- 2) Inflexibility of MST referral procedures
- 3) Unmet needs of the young person: mental health and education
- 4) Context around the young person: peer group challenges

Abrupt end to MST intervention

Several practitioners expressed concern that families' involvement with MST was often ended too abruptly. Although they were aware that all families were given detailed sustainability plans, it was emphasised that there was a lack of bridging or transition support, with families moving from very intense support to nothing.

When they moved away then it felt there was a void really.

The need for some form of scaled down, ongoing support from MST following the intensive period of work was raised, so family members could still receive guidance with regards to their sustainability plan or have someone to speak to on the phone when needed.

What the family has benefitted from is being able to phone MST whenever they need to, so they could be guided back to the plan, because it's almost like actually could some of that service be available much, much longer term

One practitioner, who had worked with MST on a case where support had been decreased gradually, felt this had been related to transformative outcomes.

Although most families felt well-prepared to sustain the changes brought about by MST, there were three families who endorsed the view that being able to access a period of reduced support following the intensive period of therapy – such as text, telephone or email communication – would have helped maintain positive changes and sustain their own self-belief. Building in a flexible period of support beyond the intensive therapeutic intervention could help some families make a more secure transition towards independence and confidence in their parenting.

Inflexibility of MST referral procedures

The range of services available to families with complex issues is limited. During the focus group, MST was mainly discussed in comparison to DBiT, which also provides focused support to families with a child or adolescent on the edge of care or custody, with the engagement of the young person. A recurring issue was the lack of flexibility in the provision of these services. While families may access DBiT before MST, the opposite referral path was very unlikely to be approved by the panel.

One practitioner emphasised that a direct referral to MST, without previous DBiT provision, effectively reduced the duration of support by several months. It was suggested this inflexibility may have resulted in strategic referrals to DBiT when MST may have been a more appropriate initial referral. Practitioners discussed how MST's more flexible approach, ability to engage with families in crisis even when the young person didn't want to engage, and focus on addressing challenging or offending behaviours, might mean it was sometimes a better service to be offered *first*, in an earlier intervention capacity. It was felt that some families would subsequently be more able to engage with the work of DBiT. This in turn could address some of the issues related to sustaining change following MST, including provision to reinforce the safety planning put in place.

The families who were interviewed did not explicitly discuss the position of MST in relation to other services, but most had accessed multiple services prior to MST without sustained success. One parent did endorse the fact that earlier referral to MST would have been beneficial to prevent an escalation of difficulties.

I wish [YP] had MST from the start instead of Family Solutions... then I think we would have been able to have dealt with it a bit sooner rather than get to the point where she went missing all the time...but unfortunately, we had to go with the referrals and who would agree to help at the time. (Family D)

Unmet needs of the young person: mental health and education

An ongoing challenge for several families was the young person's mental health. Several parents and carers stressed how the young person's mental health needs had been ongoing but untreated or unrecognised for many years pre-MST. Self-harming behaviour, for example, remained an issue for the young people in four families. While most families at the end of MST were better able to manage self-harm through enhanced safeguarding practices and talking about it more openly, they did not always feel that the young person was getting the specialist mental health support that they needed, despite families often trying hard to get help. In the family where MST had not led to positive change in the young person, their unaddressed mental health needs were given as one key reason by their carer.

I think when you're dealing on that cusp of mental health, where you're not in that area, the world becomes a bit muzzy, and your general stuff that you work for behaviour doesn't quite work. It's difficult to explain but it doesn't work so well. (Family I)

For four families, educational issues were either unresolved or unstable after the end of MST; three of these were the families where mental health was also an issue. Issues of non-attendance or sporadic attendance at school were closely interwoven with mental health for these young people. Despite close liaison with education by the MST therapist, the young people were either not ready to attend or the current provision was deemed inappropriate by the parents/carers or young person.

Family I described how a planned return to mainstream education from specialist provision led to a severe decline in the young person's behaviour. The carer and therapist both

recognised this as the young person communicating their fear at the proposed change. Although the MST therapist intervened successfully to defer the move, this example highlights how rapidly unresolved fears or concerns around education can lead to behavioural decline. For this young person, underlying anxiety, which had not been treated, was a key factor.

Unresolved educational issues were inhibiting positive progress for the young people. Parents and carers expressed concerns about lack of qualifications, reduced opportunities for socialisation and the loss of a supportive, regular routine that regular education could provide.

Context around the young person: peer group challenges

The complexity of the environments around families, in terms of the risk of child sexual exploitation and complex peer environments including gangs, were ongoing issues mentioned frequently during the focus group. The family interviews highlighted that sometimes the environment around the young person, particularly their peer group, continued to be a challenge to sustaining change.

Although it was reported that there had been positive changes to the peer group for most young people, these changes did not always feel secure. For one young person, whose attendance and attainment at school had greatly improved during MST, there had been a gradual decline following the end of MST in their behaviour at school, resulting in an exclusion. Their parent's view was that this was partially related to the peer group.

I think part of it, it's like the act of her friends are playing up, so she's got to play up with them and be with them. (Family B).

One of the aims of MST, namely that of facilitating involvement with positive and proactive peers, did not appear firmly established from the family interviews. For three young people, moving away from risky peer groups had left them quite isolated and parents and carers reported that they mostly stayed at home. There were also examples of some young people engaging with much younger or older peers; the process of not quite '*finding their tribe*'

(Family A) as one parent put it, was an ongoing one. For another young person, there had been a gradual return of previous peers into their life, with the associated risk of a return to previous negative group behaviours.

Filling the gap beyond MST

Sustainability beyond MST and how to 'fill the gap' with the closure of the MST service in Essex was a related issue raised during the focus group and family interviews.

Practitioners reported that some fears of Assessment and Intervention Services at the prospective closure of MST had not been realised because other services, particularly DBiT, were expanding their role to fill the gap. There had also been moves by family centres and practitioners, including social workers themselves, to try and extend their working practices to do more direct intervention and work around trauma with families.

This view, however, was not seen as sufficient by all practitioners in the focus group. Although several practitioners believed that social workers themselves had the skills to do similar work to the MST therapists, issues of time and capacity meant that it was unlikely they could provide the intensive support and build the therapeutic relationships which they viewed as so important for change. Several expressed concern and uncertainty about how they would effectively support families with complex needs.

I think that's to their [Essex] detriment...as far as the outcomes, because I think there's probably between ten and twenty cases I can think of in our service, in Assessment and Intervention, at the moment that would be absolutely perfect cases for MST to work on. So, I am noticing that gap massively.

Even with extensions to DBiT, there was still a fundamental difference in approach; the general view being that MST and DBiT could complement each other and work more flexibly together, rather than one being able to fill the gap left by the other. Although this report is written too close to the end of the service to comment on longer-term effects in Essex, there was concern from practitioners about future outcomes.

I think there is a gap that DBiT service, being very solution focused, cannot work with the families we have in crisis, and that gap will start to seem...maybe our figures...children going into care rising...

Families were not able to comment on any recent changes or extensions to existing services, but seven of the nine families expressed sadness and frustration that the service in Essex was not receiving ongoing funding, along with genuine concern for the support available for future families.

They're absolutely mad, shutting it down, absolutely mad. There are so many families that could use this service in Essex, absolutely mad (Family C)

If it ended, it would be an absolute shame, it would be an absolute shame because it reaches everybody, it's not just focused around the child that's having the issues (Family F)

I really hope they bring it back or do something, because it was really good (Family H)

Section 5: Outcomes for young people after MST

As we outlined at the start of the report, our evaluation included a quantitative analysis of the pathways and social care contact of the MST cohort. Of the total 388 young people who received MST in Essex over the five-year period, 302 young people formed the cohort for our quantitative analyses⁶. The cohort included 126 females and 176 males. Their age when starting MST ranged from 11 to 17 years, with an average (mean) age of 14.2 years.

The length of MST intervention ranged from 10 to 361 days, with an average (median) length of 142 days (just over 4.5 months). There were 42 young people who had an intervention period of less than 90 days, which would be the expected minimum period for MST if successfully completed. This was sometimes due to the young person beginning a

⁶ Our quantitative analysis only included young people for whom we had at least one year of post MST data (i.e. the most recent cases were not included).

period of care. Analyses showed that those with less than 90 days of MST were significantly more likely to have had care pre, during and post-MST.

Provision of social care

While preventing entry into care is the key outcome of MST, this evaluation sought to gain a broader understanding of the social care interactions and outcomes for young people following MST. The aim was to understand the pathways to different types of social care provision (child in need plan, service(s), child protection plan and/or period of care) from the two years pre-MST to the year post-MST. Table 2 shows the number of young people who had each type of provision at each time point. Many young people had more than one type of provision, and so are counted in multiple categories. There were no gender differences for any aspect of social care provision pre, during or post-MST.

Table 2: Provision pre, during and post MST

	Pre-MST	During MST	Post-MST
Provision ¹	274 (91%)	171 (57%)	165 (55%)
Child in need plan	254 (84%)	150 (50%)	98 (33%)
Other service(s) ²	121 (40%)	2 (<1%)	74 (25%)
Child protection plan	27(9%)	12 (4%)	12 (4%)
Period of care ³	29 (10%)	36 (12%)	56 (19%)

¹ The number of young people who had social care provision of some kind including CiN plan, service(s), CP plan and/or period of care

² The nature of the service received was generally unspecified apart from where the service was DBiT or Family Solutions. Because only four young people had DBiT or Family Solutions in the pre-MST period and two in the post-MST period, these figures were collapsed with other services.

³ New and continuing periods of care were counted in each category (pre, during and post-MST). In the case of all other provision only new instances were counted.

A key finding is that while 91% of the cohort had social care provision in the two years prior to MST, only 55% of young people had provision in the year following MST. The number with child in need plans, other services and child protection plans were all reduced following MST. Although the number of young people having a new or continuing period of care post-MST was higher than the figure pre-MST, this still represents just under a fifth of the sample. Given that MST is an intervention focused on young people on the edge of care or custody, this is a lower figure than one might expect, although we cannot draw conclusions without a comparison sample.

It is important to note that this evaluation used a binary calculation for care pre and post MST, categorising children as in care if they had any period of care during these times - whether 1 day or 100 days - rather than calculating length of time in care. By way of comparison, the CSSL Social Impact Bond (SIB) tracked time spent in care by young people in Essex receiving MST against a historical baseline using a formula known as the care proportion. Against this historical comparison, the cohort of young people who received MST treatment via the SIB, spent five times less time in care. The SIB methodology calculated the care proportion, defined as the 'total care days/total child days' (i.e. the total number of days spent in care by the MST cohorts as a proportion of the total number of child days across the measurement period).

The cumulative care proportion at March 2019 was 10.8% against a historical 'pre-MST' baseline of 55%. There was a reduction of over 96,000 days spent in care amongst the young people compared to the historical baseline during the course of the project.

For more information about the CSSL analysis go to:

<https://www.socialfinance.org.uk/essex-edge-care-sib>.

Because many young people had more than one type of provision pre-MST a hierarchical cluster analysis using Ward's method was carried out to create clusters based on pre-MST social care provision. The variables entered in the cluster analysis were whether or not the young person had a CiN plan, service(s), child protection plan and/or care in the two years pre-MST. The young people were clustered as follows:

- No provision (N=27)
- CiN plan only (N=122)
- CiN plan and service (N=82)
- Service only (N= 9)⁷
- Child protection plan (some with CiN and/or service too, but not care) (N=22)
- Period of care (some with CiN, services, CP plans too) (N=26)

⁷ Because the service only cluster only included 9 young people, it was merged with the CiN plan and service cluster to form a cluster of 91 young people entitled CiN plan and/or service represented in Figure 1.

Figure 1 shows the number of children in each cluster who went on to have a period of care, service(s), a CiN plan or no further contact with social care in the year following MST. Only 12 young people had a new child protection plan in the year following MST and so this is excluded as an outcome in this analysis. There are two key things to note from these pathways. Firstly, a much higher percentage of young people who experienced a placement in care pre-MST went on to have a new or continuing period of care post-MST. Secondly, the percentage of young people having no further social care provision in the year post-MST gradually decreases based on the intensity of their pre-MST provision. Only 27% of those having a period of care pre-MST have no further provision, while this rises to 56% of those who had no provision pre-MST.

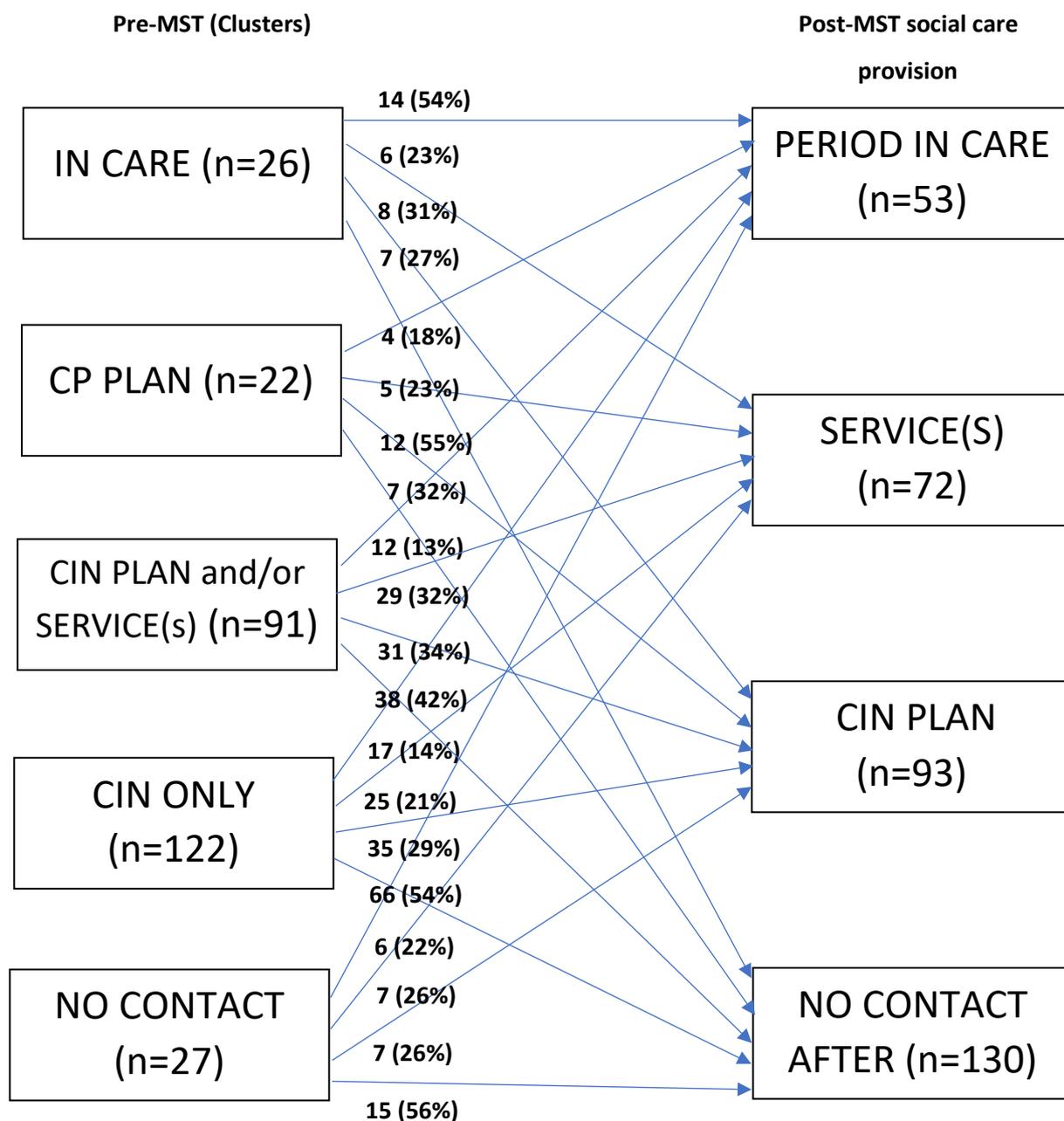


Figure 1: Pathways from pre-MST cluster to post-MST social care provision⁸

⁸ The information in Figure 1 is based on 288 out of the 302 young people, because 14 young people were excluded from the clusters due to missing pre-MST service or care data. So, for example, only 26 of the 29 young people who had care pre-MST are included here, because 3 had missing pre-service data. The post-MST figures have also been adjusted to account for this. It should be noted that the young people from each cluster could have more than one post-MST social care provision and so the percentages from each cluster do not add up to 100%.

Care pathways

Care pathways are varied and complex and this evaluation does not report on number of placements, category of need or placement type. The focus was on understanding pathways through care and factors that might predict whether a young person had care or not post-MST. Of the 56 young people who had a period of care in the year post-MST, 17 had had a period of care in the two years pre-MST. The other 39 had a period of care beginning either during MST or post-MST.⁹ Table 3 provides a detailed summary of the care pathways for the 29 young people who had a period of care in the two years pre-MST and Table 4 summarises the care pathways for the 43 young people who did not have a period of care in the two years pre-MST.

Table 3: Care pathways for the 29 young people who had a period of care pre-MST

Description of care pathway	Number of young people
Period of care pre-MST only	9
Period of care pre-MST that continued during MST	3
In care continuously pre, during and post-MST	5
Period of care pre-MST, no care during MST, and a new period of care post-MST	5
Period of care pre-MST that continued during MST; a new placement during MST that continued post-MST; no new period of care post-MST	2
Period of care pre-MST; a new period of care during MST that continued post-MST; no new period of care post-MST	4
Period of care pre-MST, a new period of care during MST that continued post-MST and a new period of care post-MST	1

⁹ It should be noted that there were eleven young people in the sample who had missing care data. They appeared to have some care history, but dates and placement details were missing and so it was not possible to categorise their care period as pre, during or post-MST.

Table 4: Care pathways for the 43 young people who did not have a period of care pre-MST

Description of care pathway	Number of young people
No care pre-MST, no care during MST, but a period of care beginning post-MST	22
Period of care during MST that continued post-MST, but no new periods of care post-MST	12
Period of care during MST and a new period of care post-MST with no continuing care across these periods	5
Period of care during MST, but no care pre or post-MST ¹	4

¹These four young people are not counted in the pre or post-care figures of 29 and 56 respectively, because their only period of care is during MST.

Predictors of social care provision post-MST

Analyses¹⁰ tested whether gender, age at start of MST, length of the MST intervention and pre-MST social care provision (pre-CiN plan, pre-service, pre-CP plan; pre-care) predicted outcomes post-MST.

Having a period of care in the two years prior to MST was the only factor that significantly predicted a period of care in the year post-MST, and this remained a significant predictor even when excluding the five young people who had a continuous period of care pre, during and post-MST. Those who had care pre-MST had almost five times the odds of having a period of care post-MST compared to those who had not had care pre-MST.

Being younger at the start of MST and having a longer MST intervention period were the factors that significantly predicted having a new CiN plan in the year post-MST. For every additional year of age at the start of MST, the odds of having a CiN plan post-MST decreased by almost 30%. For every additional day of MST the odds of having a CiN plan increased by 0.7%, so for every additional week the odds increased by almost 5%.

Being younger at the start of MST, having a service pre-MST and having a period of care pre-MST were the factors that predicted any type of further social care provision post-MST. For

¹⁰ Binomial logistic regressions were used for these analyses.

every additional year of age at the start of MST, the odds of having further provision post-MST decreased by 38%. Those who had a service pre-MST had almost 2 times the odds of having further provision compared to those who had no service pre-MST. Those who had care pre-MST had just over 3 times the odds of having further provision compared to those who had no care pre-MST.

Taken collectively, these findings point to the importance of the young person's pre-MST experiences. Those who are youngest when referred to MST may be more likely to go on to need further provision. For young people who have already had care or services pre-MST, there is a higher likelihood of care or further provision later. MST may be most timely if it can be offered to families before any periods of care.

Conclusion

It is evident from this small scale, summative evaluation that the MST service has had a profound impact on the families that we interviewed. The overarching messages from the practitioners were also positive, and concerns were highlighted about the potential gap in services following the closure of the MST service.

There is evidence of positive outcomes post-MST for the wider cohort of 302 young people, included in our quantitative analysis, who received MST. Lower numbers of young people had child in need plans and child protection plans in the year following MST compared to the two years pre-MST. A key finding is that while 91% of the cohort had social care provision in the two years prior to MST, only 55% of young people had provision in the year post-MST. Just under a fifth (19%) of the sample had a new or continuing period of care post-MST. Given that MST is an intervention focused on young people on the edge of care or custody, this may be a lower figure than one might expect although we cannot draw firm conclusions without a comparison sample.

Recommendations

Although a decision has already been taken to discontinue the MST service in Essex, the information provided by the focus group and family interviews, and our quantitative analysis of the pathways of the MST cohort in Essex support recommendations for MST provision in other local authorities.

- 1) At the point of referral, families' hopes and expectations should be considered carefully. Time should be taken to ensure that families are clear about the focus and approach of MST. This will enable misconceptions and potential underlying conflicts to be addressed. Consideration should be given to parent or carer views regarding care entry and whether there is conflict between parental perceptions of the problem residing with the young person and the holistic approach of MST.
- 2) This report recognises that MST is an intensive and time-limited intervention which prevents families becoming dependent on their therapist and aims to facilitate families' own capacity to sustain ongoing change. However, there are some families who would benefit from a graduated end to MST support. Reduced support following the intensive intervention - such as access to text, email or telephone support - could support confidence and sustained progress.
- 3) This report clearly identifies the importance of the therapeutic alliance in MST. Continuity of support from one therapist, well-matched to the family, was perceived as leading to better outcomes. When a family experiences disruption to the therapeutic relationship, additional support may need to be put in place, or the intervention period extended.
- 4) It can be difficult to sustain long-term change in the peer context and moving away from risky peer groups may leave some young people isolated. There should be a strong focus on how to actively support engagement with more positive, prosocial peers. Although this is an aim of MST, this was not apparent from the family interviews.

- 5) Some young people need more timely access to specialist mental health provision. Continuing issues around school attendance and achievement were also closely related to mental health difficulties. Change may be difficult to achieve, or sustainability of change compromised, if underlying mental health needs are not addressed.
- 6) Greater breadth in success criteria would facilitate a more comprehensive assessment of the impact of MST. The primary focus on quantitative outcomes such as care entry does not fully capture the complexity of change that MST can support.
- 7) Some families would benefit from earlier referral to MST and further consideration is required about the 'optimum timing' for referrals. Greater flexibility in referral processes, particularly with regards to where MST sits with other intensive services, could facilitate an earlier intervention role for the service. Some families would benefit from MST followed by another service rather than MST being the 'last resort' for families.
- 8) There is a need for comprehensive planning to fill the gap when a service of this nature ends. Practitioners need to be clear about future referral paths and there may be a need to extend the capacity, skills and working practices of practitioners in other services, including children's social care.