University of Essex

Evaluation of the Multi-Disciplinary Team Pilot in Tendring

(Final Report)
November 2022

Report written by:
Vanessa Baxter and Dr Vicky Boydell
School of Health & Social Care
University of Essex

Contents

Executive summary

Headlines

The University of Essex was commissioned by Essex County Council to evaluate the Multi-Disciplinary Team (MDT) pilot in Tendring. The evaluation used a mixed method approach to assess both the outcomes of the MDT pilot but also to gain insights into how the MDT pilot worked for the MDT team, Social Care staff and families. This report presents the evaluation findings from the first 18 months of its activity.

The MDT in Essex works with families where there are complex issues, who struggle to maintain positive change and who have a pattern of re-involvement with Social Care or ongoing issues that trigger re-referrals. The MDT comprises a team manager and seven subject matter experts in domestic abuse, drug and alcohol support, and mental health support of adults and children who work alongside social work and community services teams. Starting in February 2021, the MDT has so far received referrals for 90 families with 201 children. The cost of the service over the 18 month period was £590,000.

The key finding from this evaluation is that overall, the MDT programme has been successful for those families that engaged and has generated net savings of between £2.13m and £4.87m.

Family outcomes

- The MDT team engaged 89% of the families who were offered their support, despite a history of non-engagement - this is a positive outcome for the service.
- Families that have engaged with the MDT have benefited and MDT interventions have improved outcomes for the complex families they work with - the outcomes for many of these families would not have been achieved without the MDT's involvement.
- 46% (26 of the 57) children with closed cases have had their safeguarding level stepped down (22 have remained unchanged and 9 have had their level of safeguarding increased).
- A combination of parental and child risk factors have improved since the MDT intervention:
    - ✓ Substance misuse reduced for a significant number of the parents in the 41 families who have had their cases closed, and there was a fall in domestic abuse. Improved stability within the home environment was reported at case closure for two thirds of families and increased family wellbeing for nearly 70%.
    - ✓ Significantly fewer children and young people at case closure were involved with the police or criminal justice system. School attendance improved and the number of missing episodes fell from an average of 10.2 missing episodes to 1.8: neither of the young people who had gone missing 20 and 23 times at referral had gone missing at all.

Cost saving outcomes

- 31 children and young people were at risk of being accommodated at the time of referral but were not at case closure. Savings can be inferred for these 31 children and young people, including one-off savings from avoiding care proceedings of £1.21m plus annual placement savings of between £1.06m and £3.81m.
- The MDT has reduced the amount of time that Social Care staff need to spend with parents (and some children), including on crisis management, allowing them to focus on their statutory responsibilities and the needs of the child. For some families this has resulted in significant time savings for the social work teams.
- We estimate annual savings of at least £2,392 per social worker per family, translating to annual savings of £193,752 for the 81 families the MDT has worked with. The 18 children who had stepped down from a Child Protection Plan or Children in Need status are estimated to have saved social worker costs of £27,500.
- The MDT service has also had a positive/cost saving effect on other services such as the Police, health, ambulance and prison services. MDT emergency sessions have saved an estimated £110,736 for partner organisations.
- The MDT pilot has generated estimated and potential gross savings of between £2.72m and £5.46m. After offsetting these savings against the £590,000 cost of staffing the service over the 18-month pilot period, the MDT pilot has generated net savings of between £2.13m and £4.87m.

System outcomes

- The MDT pilot service is clearly seen as an effective and valuable service by social workers and other Social Care staff with clear cost savings.
- Good working relationships have been built between the MDT and Social Care staff, with good communication and distinct but complementary roles.
- The MDT offers a positive alternative support services to families that is person-centred and based on trust, consistency and immediacy.

Conclusions

The key finding from this evaluation is that overall, the MDT programme has been successful for those families that engaged. It has achieved a high level of engagement with families who have complex issues and who struggle to engage with community-based services. The outcomes for a combination of parental and child risk factors have improved as a result of the MDT intervention:

Significant cost savings for ECC have been identified as a result of the MDT's intervention with the 41 families (and 57 children) who have had their cases closed. Cost savings have also been identified for partner organisations.

The MDT is clearly seen as an effective and valuable service by social workers and other Social Care staff with good working relationships, good communication and distinct but complementary roles. The MDT offers a positive alternative support services to families that is person-centred and based on trust, consistency and immediacy.

Findings from MDT service data

Referrals
The MDT has so far (as at 30 August 2022) received referrals for 201 children and young people from 90 families. Of these families, 81 have received direct support for one or more parents. 41 children have also received individual direct support from the team[1]:

- 41 families and their children have had their cases closed.
- 26 families and their children are still receiving support.
- 4 families and their children have just started working with the service so there is no data available yet.
- The remaining families either did not meet the required threshold or were never open to/did not receive direct support from the MDT (although their children were receiving support).

MDT workers have engaged with 89% of the families who were offered their support (despite a history of non-engagement) which should be seen as a significant strength of the service. Engagement has been achieved by working at the family's pace and enabling them to lead on what support they require. Previous evaluations by the University of Essex of services working with similar client groups has shown that engagement is a key element for the success of interventions, with non-engagement acting as a significant barrier to the service.

Initial engagement
The three main reasons why prior support for families has not worked (according to the referral form) were:

- Negative family dynamics and/or a lack of positive relationships or parenting.
- Parents being in denial about their issues/the impact on their children or not opening up about the truth of their problems.
- Poor engagement with services, including disguised compliance.

Profiles of the families engaging with the MDT
The children referred have had an average of 4.9 years of involvement with Social Care and an average of 3.34 referrals to Social Care. 62% were marked on referral as at risk of being accommodated. 52% of the families (for whom this information was available) had had two or more generations of Social Care involvement.

Many children and young people face a number of issues and risks, including:

- 47% have a mental health problem.
- 48% have poor attendance at school.
- 30% have a lack of child stimulation or social interaction.
- 9% are known to the police and 4% are involved with the criminal justice system.
- 5% have a problem with alcohol, drugs or both.

[1]The MDT has not worked directly with the 31 other children in these families, although the direct work with their parents has potentially had an impact on the outcomes for these 31 children. There are two areas of support the MDT can offer children and young people, via the Targeted Youth Advisor and the Children's Mental Health worker.

The parents of families referred also face a number of issues:

- In 71% of families a parent has a mental health issue.
- 60% of families have experienced domestic abuse, either historically or within the last 12 months or both.
- 50% have a problem with alcohol and 50% with recreational drugs: 31% have a problem with both.
- The “toxic trio” (domestic abuse, mental ill-health and substance misuse) is present for 40% of families.

Positive outcomes for parents

Comparing the situation at referral and at case closure for the 41 families who have had their cases closed, there are marked changes for the parents:

- Alcohol being a problem for a parent reduced from 51% to 18% of families.
- Drugs being a problem for a parent fell from 44% to 24% of families.
- The proportion of parents with a mental health issue remained largely the same.
- The proportion of families experiencing domestic abuse within the previous 12 months fell slightly from 51% to 45%.

At case closure, MDT workers reported improved stability within the home environment for two thirds of families and increased family wellbeing for nearly 70% of families. A number of positive outcomes were noted for the families whose cases have been closed, including: improvements in the overall family situation, confidence and mental health; a better understanding of healthy relationships and safety; reductions in substance misuse and consequent police interventions; beter engagement with professionals; and a lowering of risks from domestic abuse.

Positive outcomes for children and young people

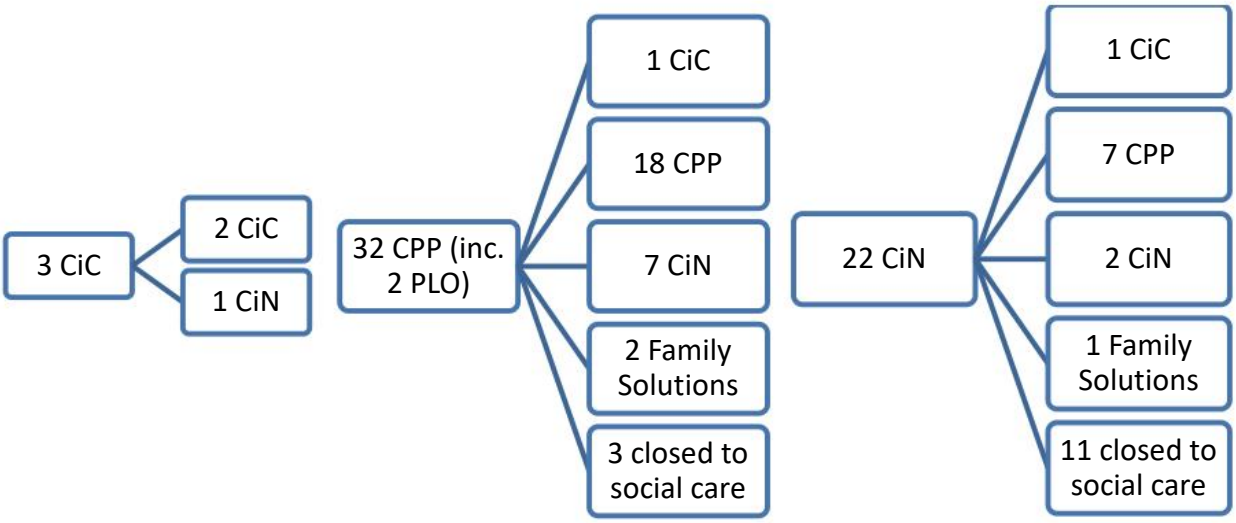
Comparing the situation at referral and at case closure for the 57 children who have had their cases closed, there are also marked changes for the children and young people:

- The number for whom alcohol was a problem reduced from 6 to 5.
- The number for whom drugs were a problem reduced from 6 to 5.
- The number known to the police and involved with the criminal justice system fell from 13 to 9 and from 7 to 2 respectively.
- The number with a mental health issue reduced from 31 to 26.
- The number with poor attendance at school reduced from 14 to 6.
- The number of missing episodes fell from an average of 10.2 missing episodes (ranging from 1 to 23 times) to 1.8 missing episodes (ranging from 1 to 4): neither of the young people who had gone missing 20 and 23 times at referral had gone missing at all.
- The number with a lack of child stimulation/social interaction fell from 12 to 9.

At case closure, MDT workers reported improved school attendance for nearly two thirds of children and young people, a reduction in anti-social behaviour issues for two thirds and a reduction in risk-taking behviours for three quarters of them. Changes in risk-taking behaviours for the children and young people who have had their cases closed included improvements in mental health, confidence and self esteem and social skills plus reductions in cannabis taking, self-harming incidents and suicide attempts.

Positive outcomes in safeguarding status
Of the 57 children and young people whose cases have been closed, at referral 3 had been Children in Care, 32 had had Child Protection Plans and 22 had Children in Need status. This means that 26 children have had their safeguarding level stepped down, 22 had remained unchanged and 9 had had their level of safeguarding increased.

Diagram 1: Status of the 57 children and young people at referral and at case closure



Although 4 children were in care at case closure, this is perhaps not unexpected due to the nature of the families that the MDT is working since many were at risk of being accommodated at the time of referral and 3 were already in care. In these types of cases, an intervention may establish that removing the child is the correct and safest course of action.

Findings from qualitative research

The qualitative research, including in-depth interviews and focus group discussions, found detailed information about the how the MDT works with social workers and with families.

Constructive relationships with Social Care
The MDT is seen to have a constructive relationship with Social Care through clear collaboration as well as being clear on respective roles and responsibilities and saving time and resources.

Collaboration
It is clear that there is a very good relationship between the MDT and the social work teams, and a mutually beneficial relationship. MDT staff are seen as very approachable, helpful, supportive, responsive and good at keeping Social Care practitioners up to date. Communication between MDT staff and social workers was felt to be good or excellent by all interviewees and survey respondents.

Survey respondents and interviewees highlighted the value of access to the MDT's specialist expertise and knowledge to support their own work in areas that they were less familiar with or less confident about. This included advice and signposting to other services and support for families that the Social Care staff were not aware of. The consultation process with social workers (even when a case has not met the MDT threshold) was seen as being very helpful and valuable also, in terms of the provision of advice and signposting.

Clear on respective roles and responsibilities

MDT workers made a distinction between them working in partnership with Social Care and working for them, describing the team as a secondary support service for social workers whereby the social worker makes a referral into the team which then provides support to a parent or child as appropriate. The social worker holds case responsibility while the MDT provides therapeutic intervention.

Interviewees agreed that the MDT offers different support to what a social worker can offer, partly because MDT workers can undertake specialist work with families that social workers are unable to do, and partly that they are supporting the parents whereas a social worker's focus is on the children. Many said it is beneficial for the MDT to be seen by parents as being distinct from Social Care, reflecting on parents' previous negative experiences with Social Care or fear of their children being taken into care, which creates a power imbalance and a barrier for parents who are vulnerable.

In some cases, parents' relationship with their social worker has improved due to the MDT's involvement as they have helped these parents develop a better understanding of why the social worker is involved and cope with the stress of Social Care involvement, for example doing work on effective communication and regulating their emotions.

Constructive relationships with families

The MDT focus group and most interviewees highlighted positive impacts on families as a result of the work done by the MDT. All of the survey respondents said that the outcomes for parents and for children and young people are more positive as a result of the work done with the MDT. Respondents also detailed how the MDT achieved these outcomes by:

1. Focusing on building relationships.
2. Putting families in the driver's seat.
3. The MDT's unique mode of delivery.
4. Having a person-centred, integrated approach.

A focus on building relationships

An important approach used by the MDT - with both adults and children and young people - is trauma-informed practice. Most of the clients working with the MDT mental health workers have experienced trauma, and often multiple traumas. However, working in a trauma-informed way is only possible where workers have enough time to build up trust with a client so that they feel able to share their trauma. This approach was linked by MDT staff to providing interventions that are also strengths based, in terms of exploring positives rather than negatives.

Engaging with families
Almost all of the interviewees stated that the MDT workers have built up good relationships with families, with many saying that these are trusted relationships. Building up a relationship with the parents takes time, and all of the interviewees felt that the fact that MDT workers have more time to support families than they do is a key success factor in this and has produced positive results. Another key strength of the MDT is the passion that the team has, individually and collectively, and the staff's commitment to clients. MDT workers have been able to build a better or more trusted relationship with parents than social workers could as they are seen as being different to Social Care. Those referred to the MDT are very vulnerable and often very suspicious of local authority and other public sector services.

Families lead the relationship
The MDT is a service that is opted into when the families felt it is appropriate, it was not a mandatory requirement or a service with limited availability. This differentially places families in relation to the MDT. The needs of the families, particularly the parents, are central. All of the interviewees highlighted that the MDT worker is a support for parents specifically, which is not something that they are used to but which has had a positive impact for clients. MDT staff also highlighted that they feel they can support and empower clients to believe in themselves and make changes because they build up such a strong relationship with them. Six interviewees specified that the support provided for children and young people by the MDT has been effective, particularly where they had not met the threshold for other services such as EWMHS or a referral had been rejected.

MDT workers can act as an advocate for their clients and as an intermediary with social workers when something has happened to upset them. Six interviewees mentioned the advocacy role of MDT workers for some of their families has been beneficial.

MDT workers felt that it is essential for clients to feel that they are being heard and that the parents and children have a voice. Five interviewees also highlighted the importance to clients of being listened to, while four said the MDT workers are non-judgemental with families, which helps to engage with them.

Having the breadth of specialist knowledge within the MDT, combined with the bespoke approach, is a core strength of the service since many clients have multiple and intertwined issues.

Mode of delivery
The MDT has unique mode of delivery. One crucial facet of the MDT service is that the support requested can be provided immediately, or very quickly, and includes swift crisis support. This is distinct from the long waiting lists to access community services when previously cases would have marked time or the family situation would have worsened.

The MDT is able to act as a bridge to community services, including working with families while they are waiting for access and supporting them to access the services themselves.

Another distinguishing feature of how the MDT service is delivered is the consistency of contact with the same key worker. This compares to other community services where there may be different staff doing the assessment, acting as key worker and running

groups etc. Additionally, clients may be referred to multiple services, each of whom replicate this with an additional barrier arising from delays in the client accessing support. Another element of delivery that is a key success for factor for engaging with families is that the MDT staff go out to see the families, rather than with community services where a referral has to be made and the client has to go to that service, which may be too intimidating for them.

Social care teams can refer a family for support for more than one specialism, so that most referrals received are multi-faceted requiring the support of more than one team member. The team has the capacity to provide wrap around support at a pace that is manageable for families. Furthermore, the families' initial 'higher level of need' can require the team to offer more than one visit per week, per specialism. Another advantage of the team is that, if they begin offering support for one area and it is apparent that the family require different support, this can be discussed and changed internally without the need for a further referral. This has proven to be a significant time saver for the families and the service.

Three members of the team have been seconded from partner agencies which has enabled Probation, EWMHS, and the Youth Service to become embedded within the team within a multi-disciplinary approach rather than a multi-agency approach. Because of the breadth of specialisms, the MDT offers wide ranging support to vulnerable families and has also facilitated the partner agencies to contribute to the improved wellbeing of many families.

Person-centred, integrated approach

Having the breadth of specialist knowledge within the MDT, combined with the bespoke approach, is a core strength of the service since many clients have multiple and intertwined issues. One of the key success factors for the MDT is that their service is very flexible and bespoke to each client so they can really work with them to get the results required or to support the plan that they are on. Almost all of the interviewees and several survey respondents contrasted this bespoke service from the MDT with what is available from community services who are set up to provide support in a very different way.

After three failures to make contact with a client, or if a client does not engage, community services will close a case, but if clients chose not to work with the MDT for a while then the team is still there ready to engage. The MDT allows clients to back away if they are not ready for the support, but then to re-engage with the team when they need to, something that a number of interviewees saw as being very helpful.

Having a holistic approach with multi-faceted viewpoints when supporting clients who may be facing multiple issues at the same time was seen as very beneficial. Where one MDT worker has built up a relationship with a client on one issue, it is then easier for them to bring in a second MDT worker to support on a second or third issue. This form of joint or holistic support is not possible from separate community services.

The MDT being able to combine mental health support with substance misuse support or domestic abuse/relationship support builds up trust with clients as they can *"follow through"* with this support rather than having to refer onwards. Additionally, the MDT support is 1:1 and personalised to the needs of each client, whereas usually support from

community services is in the form of group work with a pre-determined agenda for each session.

Findings on cost savings

We estimate that the MDT pilot has generated potential gross savings of between £2.72m and £5.46m. After offsetting these savings against the £590,000 cost of staffing the service over the 18-month pilot period, the MDT pilot has generated net savings of between £2.13m and £4.87m.

Children avoiding care
Cost savings can be estimated for the children whose safeguarding status has stepped down. 35 of the 57 children and young people whose cases have been closed were at risk of being accommodated, of whom 31 were not in care at case closure. One-off cost savings for ECC of £1.21m can be extrapolated based on the likely costs of 'avoided' care proceedings for these 31 children and young people.

The estimated average annual cost of foster care is £34,320 per child and for residential care is £245,388 per child. Residential care is a more likely option for many of the older young people referred given their level of needs and likely age at entry into care. 13 of the 31 children at risk of being accommodated who were not in care at case closure were aged between 13 and 17. The annual placement costs saved are somewhere between £1.06m and £3.81m in total.

Stepping down safeguarding status
The cost over 12 months of ongoing support for a child with a Child Protection Plan is £1,893 while the cost of ongoing support for a Child in Need is £1,345. The 18 children who had stepped down from a Child Protection Plan or Children in Need status and were either closed to Social Care or receiving support from Family Solutions are estimated to have saved social worker costs of £27,500.

Additional future savings may also accrue given the increased likelihood of children in care having a number of adverse outcomes as adults.

MDT emergency sessions
It is possible to estimate the likely cost savings for other professionals who would have been working with the parents, children or young people if MDT workers had not been there to undertake emergency sessions. These are estimated as follows:

- Saving 318.5 hours of social workers' time: £14,651.
- Avoiding A&E attendance, GP visits and ambulance call outs: nearly £30,000.
- Avoiding police call outs: nearly £40,900.
- Avoiding prison custody: £21,391.
- Avoiding use of the CAMHS Crisis Team and Adult Crisis Team; nearly £15,300.
- Saving school staff time: £3,314.

These estimated cost savings (excluding the social worker time saved) add up to a total of £110,736.

Saving social worker time and resources
Almost all of the survey respondents said that the involvement of the MDT workers has reduced the amount of time that they need to spend with parents (and/or children and young people), including on crisis management, in order to allow them to focus on their statutory responsibilities and the needs of the child. This includes both direct work for social workers and senior practitioners and specialist services that the social worker/ senior practitioner would have been attempting to do until specialist services could start.

When asked if they could quantify the time savings for them, replies varied from a small amount to 1-2 hours per month to 1 hour per week to 4 hours per week. Taking an average of the various responses, we would suggest that the MDT's work with families is saving at least one hour per week for social workers per family, but possibly more. The average hourly salary for children's social workers is £46, which would indicate annual savings of at least £2,392 per social worker per family. This would translate to annual savings of £193,752 for the 81 families the MDT has worked with.

Table 1: Estimated cost savings

	During 18-month pilot period	Minimum per year	Maximum per year
Avoiding care proceedings	£1,213,371		
Annual placement costs		£1,063,920	£3,807,804
Social worker time savings	£290,628		
Step downs from CPP/CiN	£27,498		
MDT emergency sessions - social worker savings	£14,651		
MDT emergency sessions - partner organisation savings	£110,736		
Minimum gross savings	£2,720,804		
Maximum gross savings	£5,464,688		
Cost of service	-£590,000		
Net savings of at least	**£2,130,804**		
Net savings of up to	**£4,874,688**		

Recommendations

The key finding from this evaluation is that overall, the MDT programme has been successful for those families that engaged. Moving forward, here are several recommendations arising from this evaluation.

- Given the results for referred families in terms of safeguarding and risk outcomes for both parents and children's, and the cost-savings associated with these outcomes, there is clear benefit to continue to enable MDT staff to work flexibly with clients, drawing on their own expertise and knowledge of therapeutic tools that are beneficial to individual clients. This work should be carried out within agreed organisational guidelines. There may be benefit to increasing the size of the team and expanding it to cover more areas within Essex.

- Previous evaluations by the University of Essex of services working with similar client groups has shown that engagement is a key element for the success of interventions, with non-engagement acting as a significant barrier to the service. The MDT has been successful once families were engaged so that there is a need to explore the barriers to the service posed by lack of engagement, to establish whether in some circumstances this can be resolved, therefore allowing the MDT practitioners to impact a wider range of clients.

- MDT support has been set for a certain timeframe for a family. It would be beneficial to explore:
  1. The possibility of getting the MDT involved with families that require the service from the assessment stage.
  2. The duration of support provided to families, according to the family's level of need and also how long it takes for the family to engage with the MDT practitioners.
  3. Continue to signpost clients to additional support once they have been discharged from the service to ensure that the family's support is continued beyond the MDT service.

- Seconding team members from partner agencies has enabled specialists from Probation, EWMHS, and the Youth Service to become embedded within the team. Implementing a multi-disciplinary team approach rather than a multi-agency approach has been a key success factor and it would be sensible to retain this composition.

- It would be worthwhile to consider having dedicated workers to advise on benefits/money and debt management, housing and educational support, plus adding specialist expertise in supporting children or adults who have faced sexual abuse and/or other traumas.

Background

Over the years, the Tendring district has been an outlier in terms of having the highest number of children in care compared to other parts of Essex (58 children per 10,000 in Tendring vs. 35 per 10,000 in the whole of Essex). In response to this a pilot programme was established that used a Multi-Disciplinary Team. The Multi-Disciplinary Team (MDT) in Tendring works with families where there are complex issues, who struggle to maintain positive change and who have a pattern of re-involvement with social care or ongoing issues that trigger re-referrals.

The new Multi-Disciplinary Team went live on 1st February 2021 and provides specialist resource and expertise within the existing Children & Families infrastructure. It comprises a team manager and seven subject matter experts in domestic abuse, drug and alcohol support, mental health support of adults and children alongside social work and community services teams. It works alongside existing frontline teams providing intervention and support to families with multiple, enduring complex needs to reduce the overall numbers of children in care and re-referrals into Children's Social Care. Existing core teams from Assessment & Intervention, Family Support and Protection can access support from members of the MDT, who act as 'secondary workers' to add subject matter expertise to complex cases.

The overall aims of the pilot are to:

- Offer support to Tendring's most vulnerable families.
- Engage these hard to reach families.
- Offer immediate support to individuals who have significant and multiple disadvantages.
- Reduce the number of children becoming accommodated.
- Help clients re-engage with community services.

The University of Essex was commissioned by Essex County Council to evaluate the MDT pilot. The evaluation used a mixed method approach to assess both the outcomes of the MDT pilot but also to gain insights into how the MDT pilot worked for the MDT team, the Social Care staff and the families. This report presents the findings from the first 18 months of its activity.

Evaluation methodology

This evaluation used a mixed methods approach and drew on several different sources of data to assess the MDT pilot. This evaluation drew on the MDT's own service data, cost saving modelling, qualitative data and a survey of Social Care staff.

MDT service data
To assess the outcomes of the MDT, the evaluation drew on the MDT service data. The MDT itself regularly collects service-related data at referral and case closure on families and children. This data spreadsheet was adapted by the University of Essex for this evaluation. Data includes information on referrals, demographics, safeguarding status, risk behaviours and reasons for case closure.

This report analyses the data collected on families referred to the MDT between 1st February 2021 and 30th August 2022. The data used within this evaluation is for families and any children living at the same address. Children sharing a parent but who live at a different address from the parents and children working with the MDT team were excluded from the data.

The data was analysed within Excel using pivot tables and filtering in order to calculate frequencies and compare data at an individual client level between referral/start of work and case closure.

Cost saving data
To assess the cost savings that are associated with the MDT programme, we used the information about safeguarding status and emergency sessions plus the Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2109) supplemented by several additional sources to estimate the costs saved.

Qualitative research
The qualitative research, including in-depth interviews and focus group discussions, was used to document the how MDT staff work with social workers and with families.

A focus group was held in May 2022 with all 9 members of the MDT service. One-to-one interviews were undertaken during June and July 2022 with 13 Social Care professionals, as follows:

- 4 social workers and 2 senior practitioners.
- 3 team managers.
- 4 other professionals (reviewing officers and Child Protection co-ordinators).

Interviewees were recruited by the MDT team manager and their details passed onto the researcher. After obtaining consent to participate, the focus group discussion and interviews were recorded and then transcribed and analysed using thematic analysis. A thematic coding framework was developed following familiarisation with the transcripts and broadly followed the interview guide.

Survey of Social Care staff
To supplement the interview findings, we developed an online survey to capture the views and experience of a wider range of Social Care staff. This was sent in June/July 2022 to Social Care staff working with the MDT and had 25 responses:

- 11 social workers and 3 student social workers.
- 5 senior practitioners.
- 2 team managers.
- 2 support workers and 1 bridging worker.

19 of these respondents worked in Family Support & Protection, 4 in Assessment & Intervention and one in the Children in Care team. The survey responses were downloaded into Excel and the frequencies were analysed.

Limitations
This evaluation has several limitations. The data used within this evaluation is for families and any children living at the same address. Children sharing a parent but who live at a different address from the parents and children working with the MDT team were excluded from the data. Another limitation is that the experiences and insights from families who used the MDT service are not included so there is a risk of response bias. Response bias was addressed by triangulating service data and qualitative responses.

Ethics
Ethical approval was provided for all elements of the project by the University of Essex Ethics Sub Committee 2.

Findings from MDT Service Data

Background and contextual data about families

Referrals

The MDT has so far (as at 30 August 2022) received referrals for 90 families with 201 children and young people. Of the 90 families referred:

- 10 parents and 113 children did not receive direct support or were never open to the MDT (although their parents or siblings were receiving support).
- 9 families and 11 children did not meet the required threshold.
- The total number of cases includes 7 families and 3 children who were re-referred into the service.

This means that the MDT is working or has worked directly with 81 families (one or more parent) who engaged with the service, and it is working or has worked directly with 41 children and young people[2]. It has not worked directly with the 31 other children in these 81 families, although the direct work with their parents has potentially had an impact on the outcomes for these 31 children:

- 41 families have had their cases closed: of the 57 children within these families, the MDT worked directly with 26 and did not work with 31.
- 26 families and 15 children are still receiving support.
- 4 families and 5 children have just started working with the service so there is no data available yet.

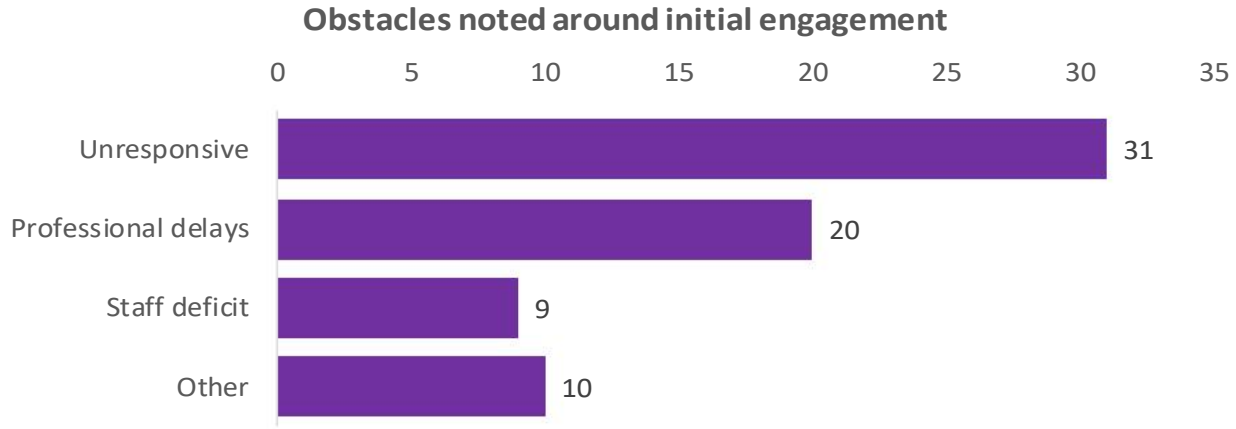
The MDT has therefore accepted 91 families for support and worked with 81. The fact that the MDT workers have managed to engage 89% of the families who were offered their support (despite these families having a preceding pattern of non-engagement) should be seen as a positive outcome for the service.

Over half of the obstacles noted around initial engagement were that the client (either parent or child) was unresponsive to calls/texts despite a number of follow ups or that they refused to engage. A number cancelled the first appointment or there was difficulty in finding an appropriate time to call. For around a third of families there were professional delays - mainly due to contacting schools during school holidays or liaising with other services – while staff deficits caused delays for just under a fifth of families.

---

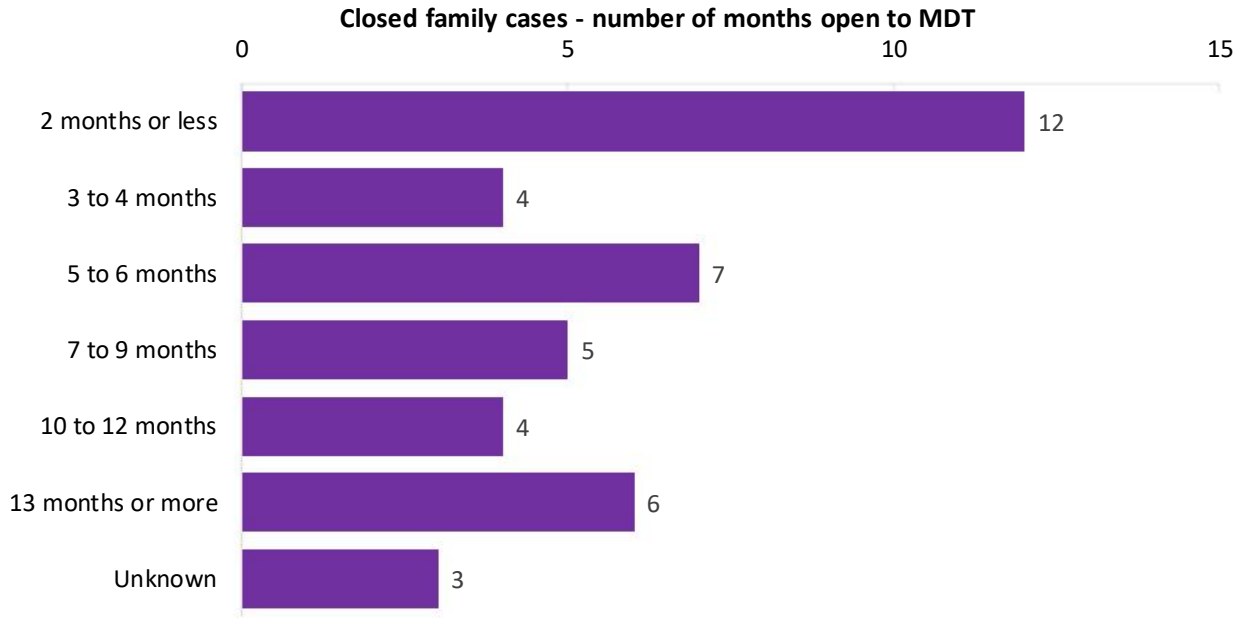
[2] There are two areas of support the MDT can offer children and young people:
Targeted Youth Advisor supports with adolescent issues, relationship advice, anger management, budgeting, sleep hygiene, sexuality and sexual health, advocacy for life, school, and home. She has also supported young people applying for college, housing, and benefits. She can also support with career planning, CV writing and interview techniques. This worker also provides respite sessions for children whose parents have significant MH issues, causing them to have poor lived experiences. In addition, she has facilitated supported family activities to strengthen family relationships etc.
Children's Mental Health worker provides the assessment, planning and delivery of individual, and where appropriate, family intervention, to support the most difficult to engage children and families. Interventions are delivered in a range of settings depending on the child's needs and what they can tolerate; this includes school, home, and other environments. It involves trauma support and play therapy. They provide specialist consultation, assessment, and advice to professionals and foster carers working with children experiencing complex mental health difficulties. They can also provide support and guidance to professionals supporting children displaying distressed behaviours and behaviours that challenge.

Other obstacles included cancellation of the first appointment, not being able to agree an appropriate time to call, the client needing more time, change of contact phone number or incorrect number, young person changing school and the client residing in a refuge.

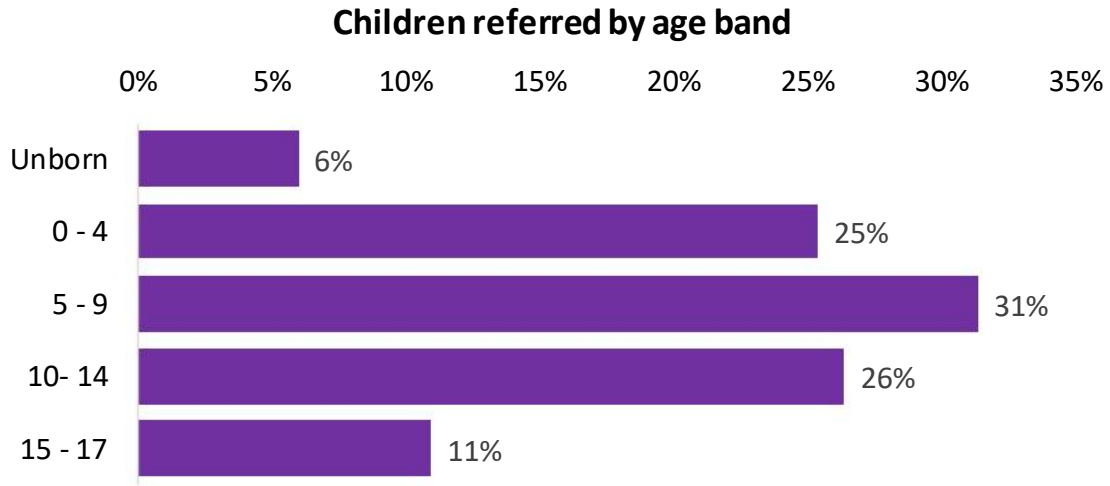


Previous evaluations by the University of Essex (into services for adolescents on the edge of care and 'recurrent care' mothers who have previously had children taken into care) has shown that engagement is a key element for the success of a service's interventions, with non-engagement acting as a significant barrier to the service.

Of the 41 closed cases, the number of months of intervention ranged from 1 to 13 or more.



50% of all the children and young people referred were female (n= 99) and 49% were male (n=98), while 1% (n=2) were unborn. The average age at referral was 7.6, with an age range from unborn to 17.



91% (n=182) of all the children and young people referred were identified as White British and 2% (n=4) were from another White background, while 4% (n= 8) were identified as from a Mixed background or Black and the remainder were unknown.

10% (n=12) of the young people referred and where the information was available identified as LGBTQ+.
42% (n=77) of the children referred were living with their mother, 16% (n=29) were living with their father, 17% (n=31) were living with both parents and 11% (n=20) were living with a relative.

59% (n=53) of the families were in rented accommodation and 4% (n=4) owned their property. However, 9% (n=8) families were in temporary accommodation and 1% (n=1) was homeless. Data for the remaining families is not known.

The majority of families live in the Clacton/Holland area.

Table 2: Home town of families

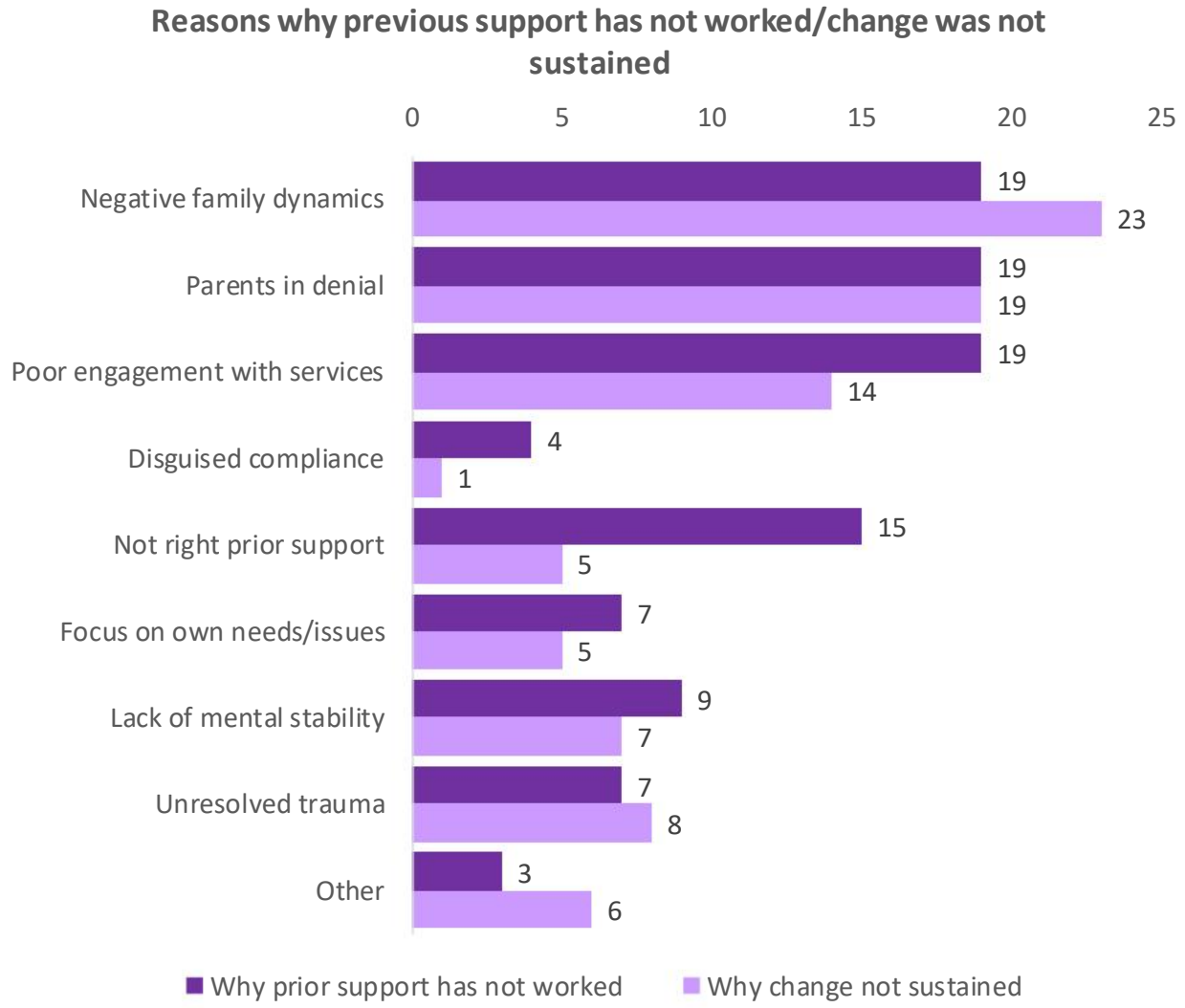
Location	Number of families
Clacton/Holland	54
Dovercourt/Harwich	10
Jaywick	8
Frinton/Kirby/Walton	7
Thorpe/Weeley	4
Brightlingsea	3
Ardleigh/Bentley/Bromley/Frating	1
Mistley/Oakley/Wrabness/Wix	1
Harwich & Kingsway	1
Out of area	1
Total	**90**

The three main reasons why prior support for families has not worked (according to the referral form) were:

- Negative family dynamics and/or a lack of positive relationships or parenting.
- Parents being in denial about their issues/the impact on their children or not opening up about the truth of their problems.
- Poor engagement with services, including disguised compliance.

Other reasons noted for a number of families were: that the prior support was not the right support; mental health issues or a lack of emotional stability; that the parent focuses on their own needs or issues and not on their children; and unresolved trauma.

The reasons why families had not previously been able to sustain changes were very similar.



Involvement with Social Care

The children referred have had an average of 4.9 years of involvement with Social Care and an average of 3.34 referrals to Social Care. 62% were marked on referral as at risk of being accommodated.

There were 30 families (52% of the families for whom this information was available) which had had two or more generations of Social Care involvement.

At referral, 58% of families were reported to have poor or very poor engagement with Social Care professionals, while 36% had poor or very poor engagement with professionals in community-based services.

Trauma and abuse

29 children and young people (19% of those where this information is available) have experienced trauma that has impacted on their behaviours.

6 young people (3%) have experienced historical child sexual exploitation (CSE), with 4 of these 6 experiencing it within the last six months.
There were 56 families (90% of families for whom this information was available) where at least one parent has experienced previous traumas, e.g. sexual abuse, physical abuse, emotional abuse.

54 families (60%) have experienced domestic abuse: 18 have experienced domestic abuse in the 12 months prior to referral, 11 have experienced it historically (12 months ago or more before referral) and another 25 families have experienced domestic abuse both historically and within the last 12 months.

Reported parental risk factors

At the time of referral:

- Alcohol was a problem for a parent within half of the families while recreational/ street drugs were a problem for half of the families: 28 of these families (31%) had a problem with both alcohol and drugs.
- Parents in nearly three quarters of families had a mental health issue. There was undiagnosed postnatal depression in 17 families (28% of those where the data is available.)
- The “toxic trio”[3] was present for 36 families (40%).

[3] The term 'Toxic Trio' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children and adults has occurred.

Table 3: Reported parental risk factors at time of referral

	n	%
Alcohol is currently a problem	45 (90)	50%
Use of recreational/street drugs is currently a problem	45 (90)	50%
Mental health issues	67 (90)	74%
Undiagnosed postnatal depression	17 (61)	28%
Domestic abuse in 12 months prior to referral/historically	54 (90)	60%
"Toxic trio" present?	36 (90)	40%

NB: The percentages in the table above exclude unknown or missing values for families.

Risk factors for children and young people

At the time of referral, the risk factors for all of the children and young people referred to the MDT were as follows:

- 3 had previously been affiliated with a gang or were at risk of gang involvement.
- Alcohol was a problem for 19 young people and recreational drugs were a problem for 24 young people: 18 had a problem with both alcohol and drugs.
- 4 young people were at risk of Child Sexual Exploitation within the previous six months.
- 10 young people were sexually active at referral, aged between 13 and 18.
- 18 were known to the police and 8 were involved with the criminal justice system.
- 72 had a mental health problem, including 54 who suffered from depression or anxiety, 12 who self-harmed and 10 with suicidal ideation.
- 16 had poor or very poor attendance at school, of whom 11 not in post-16 EET or statutory education.
- 10 had previously gone missing with an average of 7.1 missing episodes (ranging from 1 to 23).
- 27 had a lack of child stimulation or social interaction.

Table 4: Reported risk factors for young people

	At referral	
	n	%
Currently affiliated to a gang/at risk of gang involvement	3 (201)	1%
Alcohol a problem	8 (199)	4%
Use of recreational/street drugs a problem	10 (199)	5%
At risk of Child Sexual Exploitation in previous 6 months	4 (199)	2%
Known to the police	26 (194)	9%
Involved in the criminal justice system	8 (198)	4%
Mental health issue	72 (152)	47%
Poor/very poor attendance at school	33 (69)	48%
Out of post-16 EET/statutory education	14 (152)	9%
Lack of child stimulation/social interaction	48 (158)	30%

NB: The percentages in the table above exclude unknown or missing values for children and young people.

Changes between referral and case closure

It is possible to compare the situation for the 41 families and 57 children who have had their cases closed.

Parental risk factors:

- Alcohol being a problem for a parent reduced from 51% to 18% of families.
- Drugs being a problem for a parent reduced from 44% to 24% of families.
- The proportion of parents with a mental health issue remained largely the same.
- The proportion of families experiencing domestic abuse within the previous 12 months fell slightly from 51% to 45%

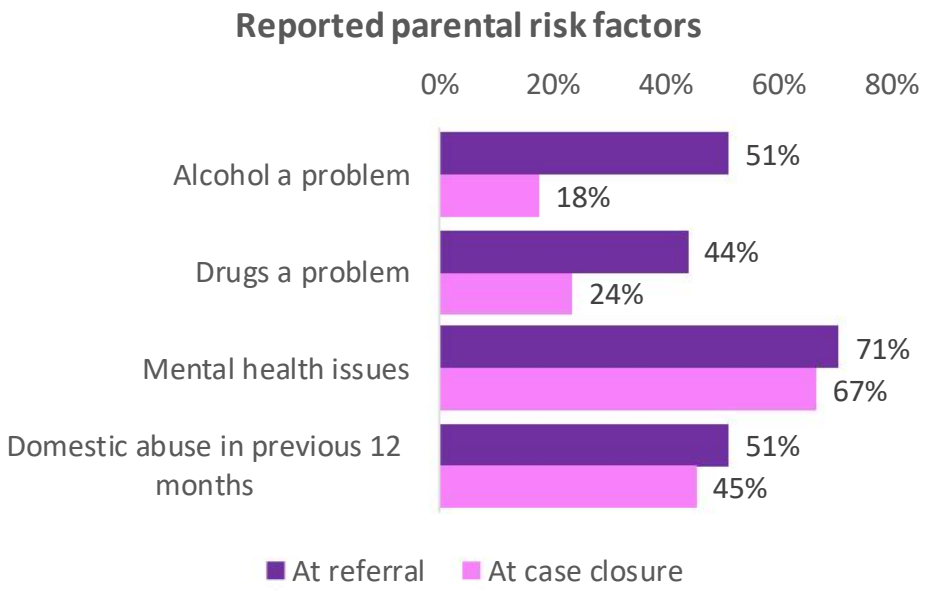


Table 5: Reported parental risk factors at referral and case closure

	At referral		At closure	
	n	%	n	%
Alcohol is currently a problem	21 (41)	51%	6 (34)	18%
Use of recreational/street drugs is currently a problem	18 (41)	44%	18 (34)	24%
Mental health issues	29 (41)	71%	22 (33)	67%
Domestic abuse in previous 12 months	21 (41)	51%	15 (33)	45%

NB: The percentages in the table above exclude unknown or missing values for families.

Risk factors for children and young people:

- 3 young people had been affiliated with a gang or were at risk of gang involvement at referral compared to 2 at case closure.
- Alcohol was a problem for 6 young people at referral but this reduced to 5 young people at case closure. Recreational drugs were a problem for the same 6 young people at referral but this reduced to 5 young people at case closure.
- 2 were at risk of Child Sexual Exploitation at referral but just 1 at case closure.
- 13 were known to the police and 7 were involved with the criminal justice system at referral, compared to 9 and 2 at case closure.
- 31 had a mental health issue at referral compared to 26 at case closure.
- 14 had poor or very poor attendance at school at referral but this reduced to just 6 at case closure.
- At referral, 5 young people had previously gone missing with an average of 10.2 missing episodes (ranging from 1 to 23 times). At case closure, 6 had gone missing with an average of 1.8 missing episodes each (ranging from 1 to 4): neither of the young people who had gone missing 20 and 23 times at referral had gone missing at all.

- 12 had a lack of child stimulation or social interaction at referral which reduced to 9 at case closure.

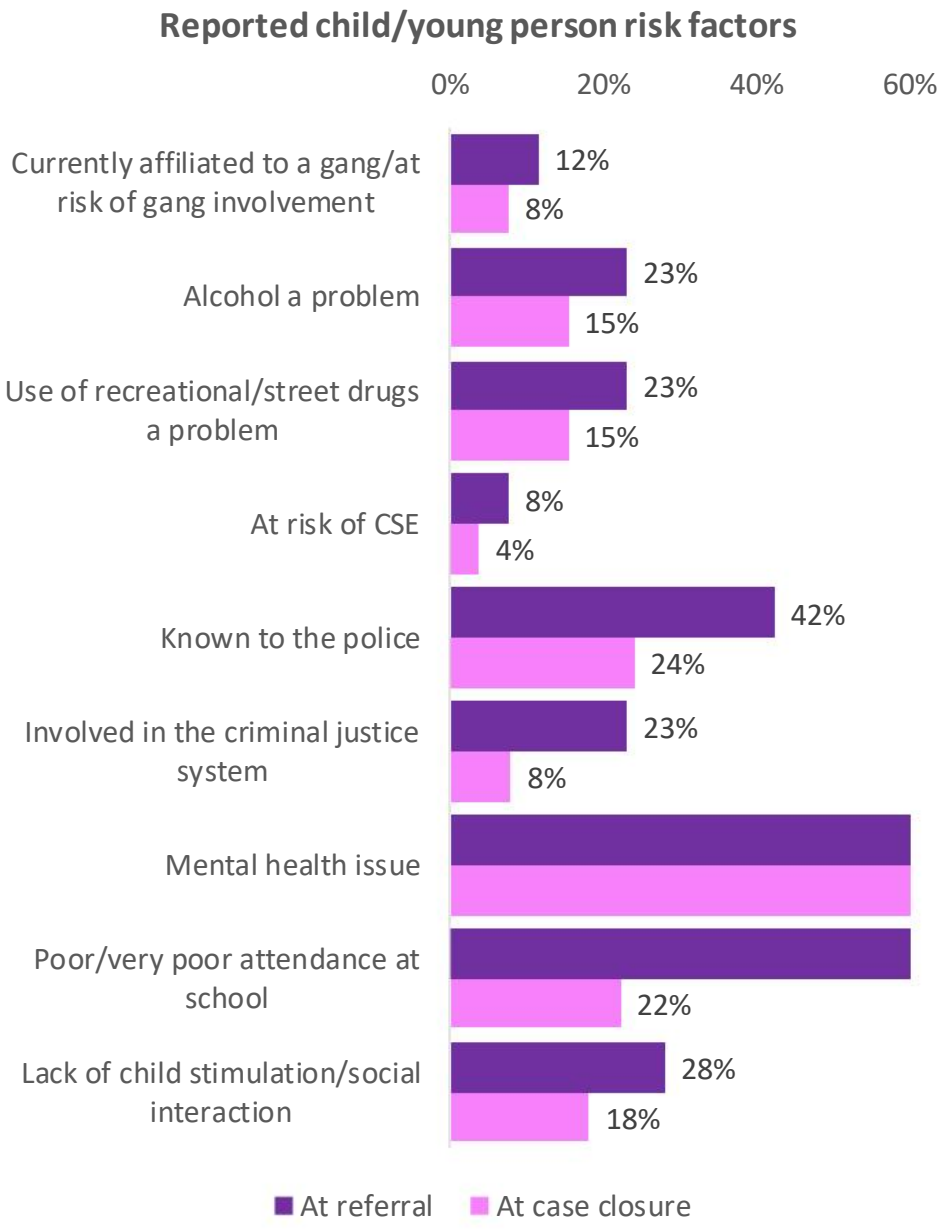


Table 6: Reported risk factors for young people at referral and at case closure

	At referral		At closure	
	n	%		%
Currently affiliated to a gang/at risk of gang involvement	3 (57)	5%	2 (57)	4%
Alcohol a problem	6 (57)	11%	5 (57)	9%
Use of recreational/street drugs a problem	6 (57)	11%	5 (57)	9%
At risk of Child Sexual Exploitation in previous 6 months	2 (57)	4%	1 (57)	2%
Known to the police	13 (57)	23%	16 (56)	16%
Involved in the criminal justice system	7 (57)	12%	2 (56)	4%
Mental health issue	31 (49)	54%	26 (48)	46%
Poor/very poor attendance at school	14 (26)	54%	6 (35)	17%
Lack of child stimulation/social interaction	12 (52)	23%	9 (49)	18%

NB: The percentages in the table above exclude unknown or missing values for children and young people.

Preventative outcomes

Safeguarding status

Safeguarding status at referral for all of the 201 children and young people referred was as follows:

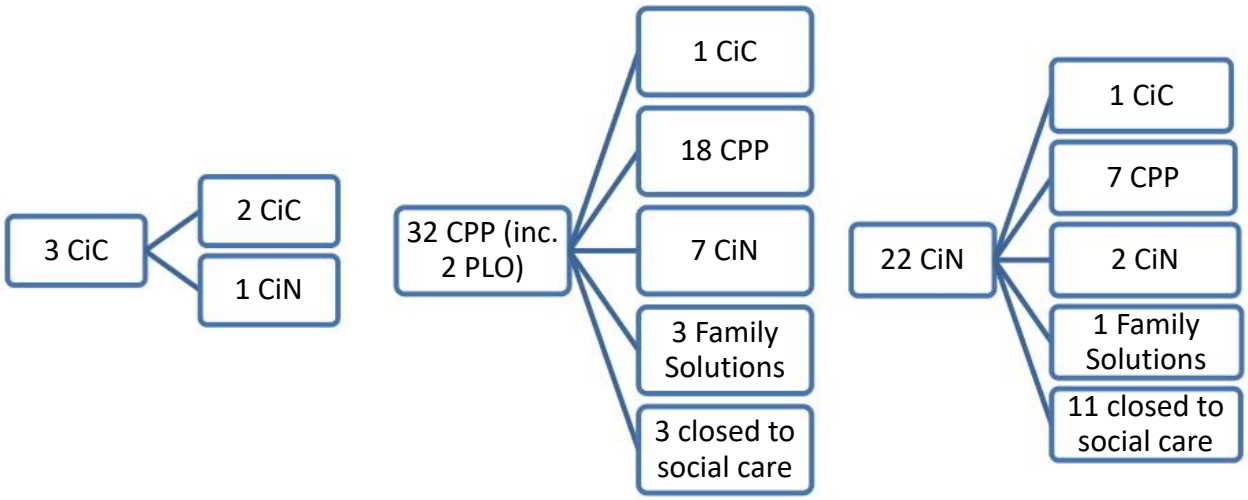
- 14 were Children in Care (CiC).
- 110 were on Child Protection Plans (CPP) of whom 2 had PLO (Public Law Outline) status.
- 74 were Children in Need (CiN).
- The status for 3 was not recorded.

Safeguarding status at closure for the 57 children and young people with closed cases was:

- 4 were Children in Care, 3 of whom were already in care at the time of referral.
- 20 were on a Child Protection Plan.
- 15 had Children in Need status.
- 4 were receiving support from Family Solutions.
- 14 were closed to Social Care.
- The data is not known for the remaining 8 children and young people.

Of these 57 children and young people, at referral 3 had been Children in Care, 32 had had Child Protection Plans (including 2 at Public Law Outline stage) and 22 had been Children in Need. This means that 26 children have had their safeguarding level stepped down, 22 had remained unchanged and 9 had had their level of safeguarding increased.

Diagram 1: Status of the 57 children and young people at referral and at case closure



Other outcomes for children

At case closure, MDT workers reported improved school attendance for nearly two thirds of children and young people, a reduction in anti-social behaviour issues for two thirds and a reduction in risk-taking behviours for three quarters of them. Changes in risk-taking behaviours for the children and young people who have had their cases closed were noted as follows:

- The mental health of one child has improved significantly, with no current self-harm or suicidal thoughts. They have increased confidence and self-worth, improved health, increased skills for independence, and are better prepared for their future career with an up-to-date CV.
- One child is still self-harming through angry outbursts, but these have decreased, while another has reduced their self-harming incidents.
- One child is still self-harming but suicide attempts are no longer ocurring.
- Two children struggle with emotions due to trauma. However, they had improved their confidence and sense of self-worth, reduced their intake of cannabis, and was better prepared for a future career with an up-to-date CV.
- One child was trying to refrain from risky behaviours in case this impacted on their career choice. They had been referred into community support and counselling for sexual abuse, which was seen as imperative for them.
- One child has mental health issues including PTSD and verbal/physical tics. However, they now have increased confidence and self-worth, are better prepared for their future career, and have been supported to increase part-time timetable hours, advocated for during communications with school. They also have strategies for sleep hygiene, and are now using contraception, have a better understanding of healthy relationships and a safety plan in the community.

Other outcomes for parents

At case closure, MDT workers reported improved stability within the home environment for two thirds of families and increased family wellbeing for nearly 70% of families. A number of positive outcomes were noted for the families whose cases have been closed:

- The mum in one family has been sober for 6 months, which has been her longest episode of sobriety since the beginning of her alcohol use. She has not obtained any charges from the police or been arrested since being sober, whereas previously she would have frequent interactions with the police when drinking alcohol.
- One mum's recovery has enabled her to move closer to her goal of living independently with her daughter in a safe environment.
- One parent had fully engaged with Rehab and despite facing a lot of challenging barriers remained resillient throughout. They engaged and improved their confidence and resilience as well as putting a solid plan in place for the future.
- One father feels far more confident in dealing with any cravings and utilising the tools he now has to deal with his cravings and anxiety.
- One parent was planning on attending a residential rehabilitation centre and had had a phone assessment.
- One family had fled to a refuge due to a domestic abuse incident. The mum has done safety planning and has an increased awareness of domestic abuse and its impact on children, the red flags and what to be aware of, rights and protective orders available, and the community resources available for support.

- One parent has significantly improved in terms of motivation and goals for future. Although they are still struggling with their mental health and physical disability situation, both children now accessing education
- Family issues are still present due to one mum's distressed behaviours but she is significantly more confident and positive about her future, plus much more aware about healthy relationships.
- One mum is getting on a lot better personally since the children were removed and since the domestic abuse risk has lowered.
- The family situation has improved dramatically for one family.
- The mum of one family was much better with engaging with professionals.

Findings from Professionals

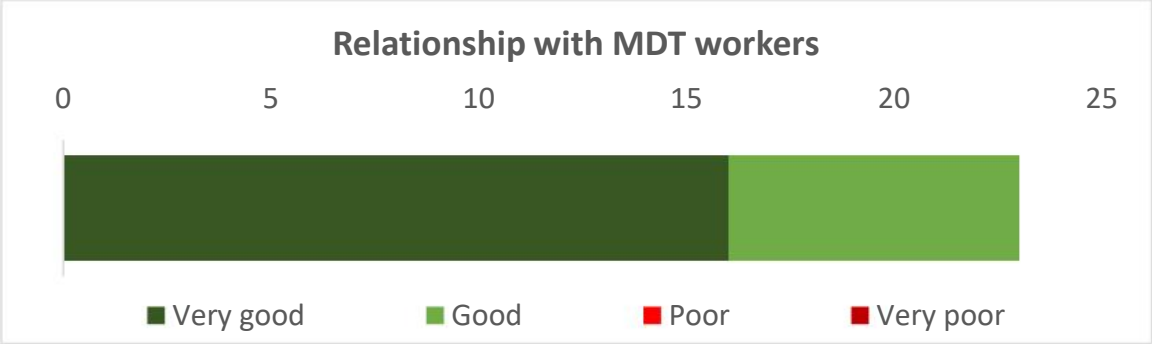
Relationships with Social Care

All of the MDT workers felt that they have a very good relationship with social workers who work with the same families, and a mutually beneficial relationship. In relation to safeguarding, this relationship is seen as central. Eight interviewees specifically stated that they have a good relationship with the MDT staff, with some also saying that they work collaboratively and in partnership.

> *"I would say they are very good relationships. They are approachable and flexible and efficient, they are very good at their jobs, if they say they are going to do something, they'll do it." (social worker)*

> *"Once I found information and passed on information and vice versa, they were there at every meeting, they were part of my plan. I worked brilliantly with them." (social worker)*

All of the survey respondents said that they had either a very good or good relationship with the MDT workers.



Many of the survey respondents commented that the MDT workers are very approachable, helpful, supportive, responsive and good at keeping Social Care practitioners up to date, views that were echoed by many interviewees. Other comments made were that they are honest about what they can provide, able to start working with families quickly.

> *"I have managed to build a good working relationship with the MDT team as they have worked on several of my cases. All workers are professional, reliable and contactable." (social worker responding to the survey)*

> *"They're lovely. Really lovely people. I think they've come into quite a stressful environment which Social Care is and some of them have never touched on Social Care before, but I think they're lovely, they're approachable." (senior practitioner interviewed)*

MDT staff feel they have a seamless referral process and joint working, plus they sometimes have joint assessments or focus on solutions together.

"It's really improved and we're having our regular case discussions when we all feel like we're stuck and we've all come together, MDT and Social Care. It's very solution focussed in the case discussions as well." (MDT worker)

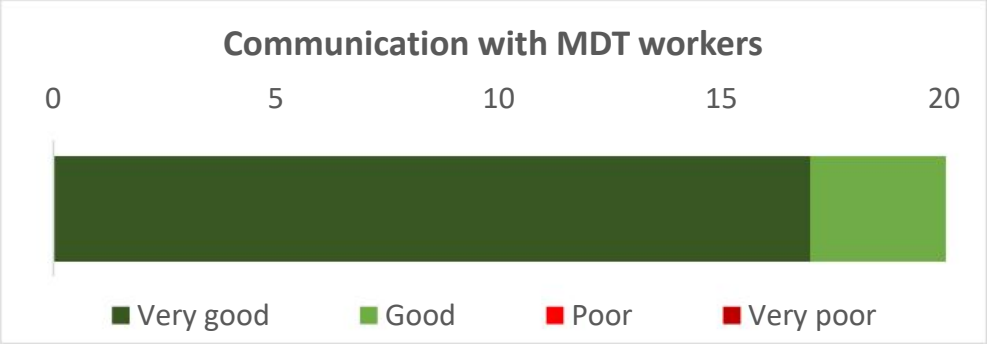
Communication

Communication between MDT workers and social workers was felt to be good or excellent by all interviewees and MDT workers, partly because the MDT staff work so closely with social workers and update them regularly, as do social workers in return.

"We have constant communication because the MDT make case notes, I make case notes, we can both access that from each other. We also have Teams, so I can message and say, 'there was an incident last night involving alcohol, I'm on my way out. I will case note later, call me if you want'". (social worker)

"And the MDT workers work really closely and really well with the social workers and attend all the CiN meetings, because again, that's something that can be quite a challenge, getting community services into meetings and being part of that multi-agency network; they don't always attend or send reports or… So, having MDT is really helpful in that respect." (other professional)

All of the survey respondents said that they had very good or good communication with MDT workers.



Survey respondents commented that the MDT are quick to respond to emails, calls and queries, and that their regular updates are very helpful whether or not they are able to attend reviews and meetings.

"They are very good at replying to emails and teams calls when needed. They are able to provide updates and let me know if they cannot attend meetings." (social worker responding to survey)

One survey respondent did say that the MDT can sometimes assume that the social worker is aware of new safeguarding concerns that can arise so that the issue is not mentioned until a review meeting is attended.

For MDT workers, the weekly case meetings are helpful in terms of discussing options and support needed.

"Through case discussion speaking about one family that three of us were supporting, we were able to identify a potentially escalating risk of further domestic abuse incident and what we were able to do was map out that and put it on a diagram and then put together, propose a care plan and propose that to the Social

Care team and also the core group… actually having all of us in the one room, that's a further advantage." (MDT worker)

Sharing knowledge and expertise

A number of the MDT workers highlighted how they had been able to share their expertise and knowledge with social workers to support their own work.

> *"I will just support the social worker, give them some tips, some strategies, some different services they could refer to. So, it's also about sharing that expertise." (MDT worker)*

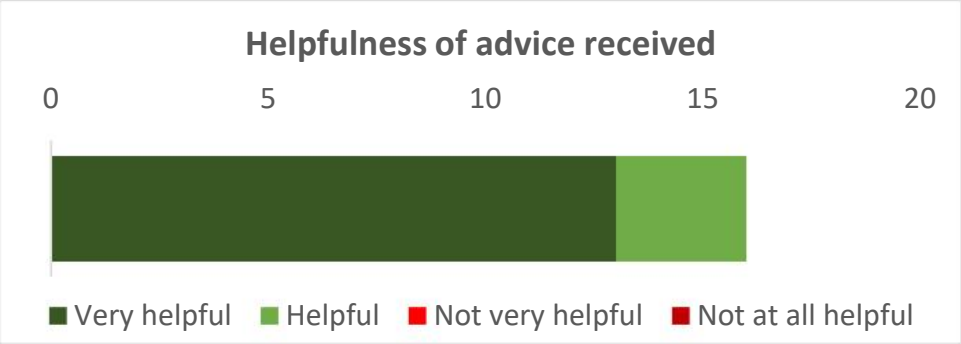
> *"A while ago, I was asked to speak to domestic abuse colleagues in Social Care about the work I used to do in probation. So they now know a lot more about what happens to a man convicted of a DA offence when he is in the criminal justice system and I suspect until I happened to come along, they were quite unaware of that." (MDT worker)*

Six interviewees also highlighted the value of being able to access this specialist knowledge in areas that they were less familiar with or less confident about. This included advice and signposting to other services and support for families that the Social Care staff were not aware of.

> *"I have spoken with a couple of the DV workers around elements, because I've got a case at the moment where the dad is actually the victim of domestic abuse and that's a little bit out of my knowledge base and I've had conversations with that." (senior practitioner)*

> *"With that particular case, it was around domestic abuse, and the MDT workers helpfully said that they would be happy to kind of support the social worker around safety planning, because she was a newly qualified social worker as well." (team manager)*

Survey respondents were asked whether they had received any advice from the MDT team that had helped them in their own work, such as specialist advice on strategies/behaviours when working with families where there is domestic abuse or substance misuse. Sixteen said that they had, with thirteen saying that this was very helpful and three saying that it was helpful.



MDT staff have also worked with Social Care colleagues regarding the language used in working with clients, *"because whether it's intentional or not, some of the words and*

phrases that get used, both verbally and in written reports, are not necessarily helpful or appropriate", suggesting alternative ways of phrasing something.

Referrals and consultation process

Since the MDT is currently a pilot, there are only four or five teams that are able to refer clients into the service. Where referrals are eligible, the team will try to support the families. The only barriers to accepting referrals is that a family does meet the criteria, but even when a case has not met the MDT threshold, the communication/consultation process with social workers has supported conversations with the team who can provide advice and signpost to other agencies.

> *"Whoever's available for a consultation will join the consultation as well and what we can do at that time is offer advice." (MDT worker)*
>
> *"We're basically a team of experts that can provide support and engagement for the families that they're working with at the moment. So, that's really useful and really helpful for them." (MDT worker)*

The consultation process was also highlighted as being very helpful and valuable by six of the social workers and team managers interviewed. This is still the case even if the MDT does not actually work with the family, as the advice from across the team's various specialisms was seen as being very beneficial.

> *"I love the consults when you start at the beginning. That works really well because it is a bit like having a team supervision, a multi-disciplinary supervision. There is questions and it helps the person referring think of things that they might not have thought before. It also gives you access to different members of the MDT which you haven't necessarily asked for that comes in and support." (social worker)*
>
> *"Just that consultation was really helpful for a family that we were working with and we didn't know. We were wanting the best areas where we should focus, and that was really good. You have all of those people on the screen who are able to say, have you tried this, have you tried that? They were able to give us really good advice. That consultation part is really valuable." (team manager)*

Working in partnership with Social Care

MDT workers made a distinction between them working in partnership with Social Care and working for them.

> *"We do work in partnership with Social Care, but we don't represent Social Care if that makes sense. We're not acting on behalf of them, so we won't go out and say Social Care are considering the removing of children or anything like that." (MDT worker)*

The MDT workers described their support as a secondary support service for social workers whereby the social worker makes a referral into the team which then provides support to a parent or child as appropriate. The social worker holds case responsibility while the MDT provides therapeutic intervention.

MDT workers felt that being located in the same office as the social work teams has helped social workers to become more aware of their service and how to refer to it, and has broken down barriers. Seven of the social workers and senior practitioners interviewed mentioned this as being beneficial to them in terms of communicating with the MDT.

> *"I think that's really appreciated by social workers whereas before they were like 'I'm not aware of that service actually. Yeah, no, I'll definitely try that', and then we've had them come back and go 'no they're not engaged in that' and then we've restarted that referral process." (MDT worker)*

> *"Because we are using the same systems, we are on the same phone network, it just makes everything so much easier and then they are in the building. If you really want to you can just wander downstairs and plonk yourself in a chair next to them. It does make a difference." (team manager)*

Distinct from Social Care

Eight interviewees said that it is beneficial for the MDT to be seen by parents as being distinct from Social Care and therefore not involved with decision making or statutory responsibilities. This reflects parents' previous negative experiences with Social Care or fear of their children being taken into care, which creates a power imbalance and a barrier for parents who are vulnerable.

> *"She's had quite difficult experiences with Social Care in the past. So I think just her seeing the MDT worker as not another social worker, I think, is what's helped her engage a bit better." (other professional)*

> *"We needed somebody that was separate from ourselves because our priority is safeguarding children and sometimes that's a real conflict in order to be able to make meaningful progress with families, because there is that constant power imbalance of actually the reality is they may not want to be honest with us about what's really affecting them, what's going on, because they have a fear that is going to have an impact on what we think about how they are caring for their children and that can be a real barrier for people who aren't very well and need some help." (social worker)*

The MDT workers feel that they offer different support to what a social worker can offer, since they are providing a therapeutic intervention for mostly parents while social workers are concerned mostly with the children. This therapeutic service for parents needs to be confidential.

> *"For example, if a mum is having a mental health crisis and the social worker thinks that she needs support, rather than the social worker go out, we would go out instead and build up that relationship and our unique selling point is that all families are actually saying they've never had this before where it's a worker just for them and it's about discussing their mental health, about their recovery, about their domestic abuse." (MDT worker)*

Six interviewees also highlighted that MDT workers can work in different ways to themselves. This is partly because they can undertake specialist work with families (e.g.

around mental health, substance misuse and domestic abuse) that social workers are unable to do. It is also partly that they are supporting the parents whereas a social worker's focus is on the children and partly because their role is perceived as being different to that of a social worker.

One social worker interviewed suggested that having a team manager who is a qualified social worker works is very valuable since she is able explain the Social Care and safeguarding processes, and the impact on children, so that the MDT workers have an understanding about how Social Care has to operate.

MDT workers and six interviewees mentioned cases where parents struggle with their relationship with their social worker but where this has improved due to the MDT's involvement. MDT workers are able to go out to try and support these parents to develop a better understanding of why the social worker is involved. They are able to help parents cope with the stress of Social Care involvement, for example doing work on effective communication and regulating their emotions.

> *"It's quite stressful, the process, I think, for families going through Social Care and I think that for a lot of us we do help them to manage that and their emotions around that and the conflict that comes with a relationship with the social worker." (MDT worker)*

> *"The young person's mum who is really difficult to work with, she has unstable personality disorder, I found it really difficult to communicate with her, especially when I had to say no or put some rules in place. But because she has quite intensive work with the worker, she kind of changed her strategy to cope with it. I found her much easier to communicate with and she was much more able to apply the strategy she had learnt with MDT and she was listening to me before giving an answer." (social worker)*

Over time, MDT staff and six interviewees said they have seen their clients' relationships with their social workers improve, from a starting point of being very anti- Social Care.

> *"Because they probably feel in a better place, they're not so defensive and so then when you speak to them, they're not always that confrontational conversations." (team manager)*

MDT workers highlighted how they work alongside social workers to have an input into safety plans for clients, suggesting approaches that the social worker may not have considered. They will report on instances where the safety plan is broken and the child is at risk, but not where the child has not been at risk.

> *"If their safety plan is mum or dad doesn't drink whilst they're looking after the child, that's when our confidentiality would break. So, for instance, if mum has drunk the night before and they've had the children, our side would have to let the social worker know because that's broken that safety plan, that overrides my confidentiality whereas if they were like 'yeah, no I had a drink last night but they stayed at mums', that's okay. We'll talk about 'why you had a drink last night, why did you use substances last night', but actually, they're utilising my advice as well as following the safety plan. So, it works effectively." (MDT worker)*

Support and interventions

A variety of approaches are used by the MDT including play therapy, sand tray work, figure work, arts-based therapy, non-verbal work and CBT.

An important approach used by the MDT - with both adults and children and young people - is trauma-informed practice. Most of the clients working with the MDT mental health workers have experienced trauma, and often multiple traumas. However, working in a trauma-informed way is only possible where workers have enough time to build up trust with a client so that they feel able to share their trauma.

> *"Sometimes I've had to spend a good couple of months just to get that client to build that relationship and trust me enough to actually talk about what's going on for them which is great about our work. It's not eight sessions and you're out and they've got to give you everything in eight sessions, and I think that's what makes us so effective as well, because trauma is a really difficult subject… It cannot be dealt with in eight sessions like what's offered." (MDT worker)*

This approach was linked by MDT workers to providing interventions that are also strengths based, in terms of exploring positives rather than negatives.

> *"My own experience both previously and here is that men are very blind to what they do well. They're always being told that you're a bad influence, you're negative, you're a waste of space, and you hear that often enough and it becomes your truth and if I give that man an opportunity to explore his positives, his passions, the things that he is proud of, then that's an in." (MDT worker)*

A number of interviewees highlighted the importance of the MDT approach being relationship-based as building trusted and meaningful relationships is essential to make a difference.

> *I prioritise relationship-based practice over anything, and I think the people that work, in terms of the MDT, they have the capacity to build meaningful relationships, and that's what makes a difference." (other professional)*

> *"So, it's a relationship-based practice that she using, she's working with the mum, she's working with the child and things like that. And I, hands up, I would say to you, hands on my heart, we would not have got there without [MDT worker]." (senior practitioner)*

A good example of the MDT's family approach is where a mum was struggling with mental health and domestic abuse while the child was not doing well with school. This was a stress for both of them but one that the mum did not know how to help with. Support from two of the MDT workers was provided around relationship work and input into a care plan that would reduce risks for both mum and child.

The MDT has seen a need for family therapy to support difficult relationships between children and parents, so has started to do some work with parents and also with older adults and their parents.

"It's entrenched. It goes back to their childhood and throughout their life there's just been conflict after conflict. So, I've been doing some very low-level family therapy, mediation, tackling some of them difficult things that's been going on. Particularly with adults that have been using drugs and how that's impacted their relationship with their parents." (MDT worker)

Engaging with families

Building trusted relationships

Almost all of the interviewees mentioned that the MDT workers have built up good relationships with families, with many saying that these are trusted relationships.

"I haven't seen a parent yet that has had a bad relationship with them. They feel safe. They build an element of safety and trust with them." (social worker)

"It's always positive feedback from families about MDT workers. I was in a conference yesterday where the dad said, she really likes [MDT worker] she's always really lovely to her and that was two days ago and that's quite a regular occurrence about those relationships that they build with the families and they are obviously important to those families." (social worker)

MDT workers and many interviewees highlighted that building up a relationship with the parents takes time. All of the interviewees felt that the fact that the MDT workers have more time to support families is a key success factor and has produced positive results.

"I think because they've got the time and the space to do it. I think that's massive. Whereas social workers, we have no time or space." (senior practitioner)

Person-centred

The MDT acknowledges that families are the experts in their issues, which is their systemic starting point. The clients need to shape the support they require and engage when or if they are ready to accept that support. The fact that the MDT intervention is person centred rather than process driven was seen as a key factor behind MDT staff being able to build trusted relationships with clients.

"The client is given as much control as possible over the shape of the interaction, if you like. 'Where do you want this to go, where do you need it to go?' Okay, let's bring what I can, let's see what I can bring to this process to help you achieve your goals." (MDT worker)

Commitment

MDT workers highlighted that one key strength for them was the passion that the team has, individually and collectively, and the staff's commitment to clients. Ten of the interviewees echoed that this support and commitment was a key element in the MDT service, including helping to mitigate future risks.

"I know that I can trust and have that supportive place for mum, she's got that support network with MDT." (social worker)

"It helps move the CiN plan forward, because we then have a better understanding about what support's in place and what their plan is, and that then forms part of the Child in Need or Child Protection Plan or whatever plan it is. And they're part of those discussions, in the meetings, and parents will see them there and feel more supported by them, knowing that they're attending the meetings and, yeah, I think that makes a difference." (other professional)

Perseverance

Perseverance was seen by the MDT and several interviewees as a key contributor to the impact on families and being able to engage with them.

"We don't go away." (MDT worker)

"After the first couple of sessions, we might comfortably conclude that we need to step back for a couple of weeks or whatever, to give people time to process what's going on and decide if or what way they want to work with us. And when they're ready, we'll come back." (MDT worker)

"And the MDT workers that I've worked with have been really persistent. So, with that mum that I was talking about with the history of drug misuse, right at the beginning she was really… She didn't not give consent, but she was quite reluctant to meet up. She'd cancel visits, not be in, like those kinds of things, and the MDT worker was really persistent with her, and actually, that led to them developing a really good relationship, and I think he worked with her for kind of eight months, doing regular visits, regular check-ins and that really helped to kind of progress the Child in Need plan.." (social worker)

Consistency

Consistency of contact with the same key worker was also seen as being important by the MDT and around half of the interviewees.

"I do think that being involved longer term and consistency, it provides that for the family, because they can sometimes have a lot of in and outness and a lot of people go." (team manager)

This compares to other community services where there may be different staff doing the assessment, acting as key worker and running groups etc. Additionally, clients may be referred to multiple services, each of whom replicate this with an additional barrier arising from delays in the client accessing support.

"Whereas we go in straight away. So, when they've gone, 'we're going to refer you' and then next week: 'hiya I'm here', that's not a normal thing. Say for instance… mental health actually seemed like the number one priority and when [name]had gone in and realised actually the alcohol service is needed, it is just not heard of that you can straight away go over to a colleague and go: 'oh actually, I need some support on this'. You have to refer to another service, then wait for that assessment and then you need to build up a relationship with that professional before you can even start doing things and it's just why community services are so oversaturated at the moment. There's just not that opportunity to build up that rapport." (MDT worker)

Listening

The MDT felt that it is essential for clients to feel that they are being heard and that the parents and children have a voice. Five interviewees also highlighted the importance to clients of being listened to.

> *"I think it's really good that we are able to give that voice to children and some of the sessions I have with them are literally, we go to McDonald's and we just have a chat. It's very unstructured, very casual, but those are the sessions they tend to appreciate the most because they've got all this stuff they want to say, and they don't have the professionals properly listening to them. They might go to the parents, but they're not necessarily going directly to the child." (MDT worker)*

> *"I spoke to the Dad and we had a long conversation. He said that the support that he got from the MDT team was life changing, because it was someone that could listen to him." (team manager)*

Four interviewees said that the MDT workers are non-judgemental with families, which helps to engage with them.

> *"When parents, particularly with the substance and alcohol misuse, are known to Social Care for that and then therefore known to other professionals and health professionals for that, there can sometimes be an element of them feeling really judged and looked down upon." (senior practitioner)*

Outreach

The MDT felt that a key success factor for engaging with families is that they go out to see them, rather than with community services where a referral has to be made and the client has to go to that service, which may be too intimidating for them. This was also mentioned by five interviewees. Clients may also not be able to cope with a group approach that is a standard offer from some services.

> *"If we have a family that have been in multiple times and we know what the need is e.g. a domestic violence service, but perhaps mum cannot do groups or needs somebody to come to the home. That is quite often a real issue for us, most community services expect people to go to them, whereas we and the MDT will go to the people and that makes such a difference… because they go to families and they work with them in a place where the family feels the safest. They then build that relationship in the family home, that gives them a base to work from." (team manager)*

> "So we can capitalise on that tiny crack in the door that's sometimes there would otherwise very likely shut again." (MDT worker)

Different to Social Care

A number of interviewees also highlighted that MDT workers were able to build a better or more trusted relationship with parents than social workers could as they are seen as being different to Social Care.

> *"Sometimes they can build that better relationship where we've got to go in and do the horrible stuff of removing the children or put safety in place and they are there in a supporting capacity for the parent." (senior practitioner)*

"For that particular mum, they've been through a lot. So, the children have been in care before, come out of care; I think she's had quite difficult experiences with Social Care in the past. So, I think just her seeing the MDT worker as not another social worker, I think, is what's helped her engage a bit better." (other professional)

The MDT focus group and seven of the interviewees mentioned that those referred to the MDT are very vulnerable and often very suspicious of local authority and other public sector services.

"Lots of times people are initially really suspicious: 'We do not like the local authority, jog on, off you go' and all the rest. So we just sort of hover about and maintain a kind of presence where, and it might be just 'well okay, if you don't want to talk, can I bring you round a coffee?' Anything at all. Start building up that relationship." (MDT worker)

"[Mum's] not going to be honest with me because she's terrified that we're going to take her children so no matter how much I build that relationship with her and how much I try and reassure her that I'm really just there for her for that moment, the reality is I'm not." (social worker)

Eight interviewees referenced the fact that many families working with the MDT are long-known to Social Care.

"The family that I have in mind in particular, have been open to Social Care for years. The parents themselves were known to Social Care as children and their oldest child is six. They have been open constantly throughout that time and you are looking at areas of neglect, mental health, drug use, DV." (team manager)

The MDT workers felt that in some cases families may feel compelled to engage with the MDT as they have agreed to a care or support plan, so staff allow them time and space to understand more about the support offered by the MDT and whether or not it is right for them. This consent from families, and understanding that the support is not mandatory or time limited, was seen by the MDT as the key to engagement with families.

"They've got that power to say no, I don't want to work with you right now, but then they know that we're still here… three months later they can just pick up where we left off and I think knowing that makes them feel more compelled, as you say, to work with us because there's not that pressure that they might get with other services." (MDT worker)

Non-engagement

In circumstances where families have been resistant to engaging or have refused to engage with the MDT, this has usually been because *"it is not their time":* they have to be ready to engage, this cannot be forced. MDT workers therefore listen to the families and step back, but then come forward when they are actually ready to engage.

"For drug and alcohol it's about when they're ready to take that journey. For me, it's sometimes they're just not ready to talk about, I had one case that, a lot of trauma and she just wasn't ready to explore that. So, we respect that and then we'll step back, but we can come forward when she's ready." (MDT worker)

"The fact that they don't close unless somebody says, 'I do not want to work with you' and allows that induction period to be as long as it needs. The thing is with MDT, is that you have them missed appointments at the beginning when people aren't sure if they want to engage, but very rarely once the work starts do parents miss their appointments. It is not like they are hanging about and it is not going anywhere. Once they start working with their worker, there is only a cancelled appointment for a reason and they normally book it in for the next day because they want their appointment. That hanging about at the beginning is what makes it work." (social worker)

Bespoke and flexible support

One of the key success factors for the MDT is that their service is very bespoke to each client so they can really work with them to get the results required or to support the plan that they are on.

"My client was having a mental health crisis some weeks ago and I turned up and she asked if I could take her daughter to school and absolutely, I can do that. 'You eat something and have a cup of tea and just take a minute to breathe.' And maybe some other organisations wouldn't have the capacity or time to have taken her child to school or would have just dealt with it in a different way and there was no shame there. It was just 'that's fine, that's what we're doing today'. And yeah, that was it, and that was the whole session, was that I just checked in with her for ten minutes in the doorstep and I took her child to school and actually, she felt a lot better by the end of the day and she was able to pick her up from school and it gave her a reason to get out and it's just that, that echoes how bespoke we are." (MDT worker)

This was echoed by nine of the interviewees and eight survey respondents who felt that being able to be more flexible and tailor work with families to their needs had been very beneficial.

"It's being able to make the plans more tailored and bespoke to the families. Because outsourcing to the community it's almost one box fits all, where our families don't work like that. So, it's being able to make it more bespoke." (senior practitioner)

MDT workers have a freedom with each individual client to tailor the support to what is needed, rather than having to go in with a specific agenda.

"We don't go in with any kind of set agenda, any kind of set work, we can have a couple of sessions just to do relationship building in my case. In my field anyway. And with the client, get to know them and ask what they feel is going to best and then we have the freedom to tailor it around them which I don't think any other service really has." (MDT worker)

"We can work with them in any way as well, can't we. So, for example, most of the young people I work with are face to face, but then if I've got young people that are really anxious, I can work with them online, over games and stuff like that. That's something that is rare to see in services. So, yeah, we can just offer

something a little bit different and then now he's working with me face to face after doing that." (MDT worker)

Almost all of the interviewees and several survey respondents contrasted this bespoke service from the MDT with what is available from community services who are set up to provide support in a very different way.

"One of the things that we do find is that services are very narrow in scope and they won't necessarily take into account that there might be domestic abuse and mental health. We're going into two different services which might not always be necessary and that is something that we found." (social worker)

"They get a more personable specialised approach from MDT workers that focus on their specific needs. MDT allow for parents when they cannot attend meetings or disengage but do not strike them off their service straight away like community services would do. Families can build up strong working relationships with MDT workers and begin to trust and engage with them in a way they perhaps wouldn't with community services." (social worker responding to survey)

Three of the interviewees also highlighted the stigma that attaches to mental health and substance misuse services, which can prevent parents form accessing them.

After three failures to make contact with a client, or if a client does not engage, community services will close a case, but if clients chose not to work with the MDT for a while then the team is still there ready to engage. The MDT allows clients to back away if they are not ready for the support, but then to re-engage with the team when they need to. Six interviewees saw this facet of the MDT support as being very helpful.

"That work that just wouldn't have been done because this family needed someone to get alongside them. A lot of those services, they will send an appointment and if you don't make it that's that, as you get three of those and you get written off. Whereas the MDT team will make an effort to get alongside and to work at the family's pace, which has been really helpful." (team manager)

However, all of the MDT workers reflected that the reason they can provide this bespoke and intensive service is because they have a smaller caseload overall.

Holistic support

Another effective factor is having multi-facted viewpoints when supporting clients who may be facing multiple issues at the same time. Where one MDT worker has built up a relationship with a client on, for example, mental health issues, it is then easier for them to bring in a second MDT worker to support on, for example, substance misuse or domestic violence.

"As a team, the whole is greater than the sum of its parts." (MDT worker)

"I had a client referred to me for DA, but in our first session it was quite clear that actually she had a lot of mental health issues and that maybe we should focus on that, keeping DA in mind because obviously they intertwine and that's the thing about us all being together, I can say to [mental health worker] this is what's going on with my client, do you have any recommendations of what to do next instead of pushing forward domestic abuse work and potentially making her whole mental health situation a lot worse, we can take it at her pace." (MDT worker)

One client has built a trusting relationship with the MDT mental health worker but also has alcohol misuse issues. They are very nervous so the two workers are doing joint visits initially so the client can get used to the substance misuse worker.

When the substance misuse worker was struggling to work solo with a parent as they always had their children around, another MDT staff member took the children off to play together allowing them both to have a session.

Six of the interviewees also highlighted the benefits of the MDT's holistic approach when supporting families with multiple issues, since this form of joint or holistic support is not possible from community services such as mental health services or alcohol and drug services.

"Even if that person is not directly supporting, they can get advice from the person that has the expertise, which creates that more holistic way of approaching a problem, because actually one of the things that we do find is that services are very narrow in scope and they won't necessarily take into account that there might be domestic abuse and mental health." (social worker)

"That's an absolute classic of being thrown from pillar to post. Where you go to mental health services and they say: 'you've got to sort out the drug and alcohol problem first' and then, yeah, it's a chicken and egg type situation. And it's long been a bugbear of mine and probably lots of other mental health workers and drug and alcohol workers. Having a combined approach on that is actually priceless… It's not unique but it's not far off and, yeah, another big strength. And it's very frustrating for the client usually." (MDT worker)

The MDT being able to combine mental health support with substance misuse support or domestic abuse/relationship support builds up trust with clients as they can "follow through" with this support rather than having to refer onwards. Additionally, the support from the MDT is 1:1 and personalised to the needs of each client, whereas usually support from community services is in the form of group work with a pre-determined agenda for each session.

"You might not want to talk about your families. You might not want to talk about your triggers, you might just want to talk about what's gone on with your week and why you feel like you want to drink. Let's have a chat about that. Like, it's not about what I want to do, it's about what you want to do and if for one week you just don't want to talk about anything, alright, let's go for a walk. I've not got to have that stringent, 'oh we were going to talk about red flags today, what are we

going to do', whereas in other community services, they need to hit them points. So you can really build up that relationship, I find." (MDT worker)

MDT staff felt that this holistic and multi-faceted approach is paying *"massive dividends"* and that they have opened up new horizons for people that would not have happened were the MDT not as flexible and as joined up as they are.

"We've managed to do that because Essex Children's Services offered us a blank canvas and said put together an approach that's going to do this and when we thought about that, we thought, if we have a can-do attitude… So, it's not about well we can't really do that because it's not within our remit. Let's see if we can stretch and map round the support to each individual that we get referred through." (MDT worker)

Three members of the team have been seconded from partner agencies which has enabled specialists from Probation, EWMHS, and the Youth Service to become embedded within the team. Because of the breadth of specialisms, the MDT offers wide ranging support to vulnerable families and has also facilitated the partner agencies to contribute to the improved wellbeing of many families. Implementing a multi-disciplinary team rather than a multi-agency approach was felt to have secured more linear thinking, planning and working, something that was seen as a key success factor.

Specialist expertise

Several members of the MDT said that they have learnt a lot while working with other members of the team, in terms of their own professional development, which has helped to improve their support for clients.

"If I wasn't part of this team, I would have had to just go, 'look, I think there might be an issue, should we maybe refer to a different service and have to pass it onto someone else?' whereas I can seek advice from colleagues and have different ways of approaching things… I've definitely developed my knowledge on different disciplines and have an appreciation, as well, of the barriers and the challenges each professional goes through and how we can overcome that." (MDT worker)

Since many clients have multiple and intertwined issues, having this breadth of knowledge within the team, combined with the bespoke approach, was seen by MDT workers as a core strength of the service. All interviewees and three survey respondents also highlighted that access to the MDT's specialist expertise, and the breadth of expertise within the team, was very important in providing support to families who have multiple issues. Many said that social workers do not have this kind of a specialist skill set.

"It's a lot of expertise in a team, the social work teams we have are varying levels of expertise in different things but it's quite across the board and it's really dependent on what cases you worked on and the training you have done as well, but to have that level of expertise right there is really helpful." (social worker)

"The work that she is doing, I have to say is pretty invaluable, because there would be nobody else who could do it. No one else is willing to do it, no one else could pick up the pieces with the skillsets that she has. I certainly haven't got

those skills in mental health services, and I'm…maybe I'm speaking slightly out of turn, but my thoughts are that the allocated social worker doesn't either." (other professional)

Immediacy of support

One crucial factor for the MDT is that the support requested can be provided immediately, or very quickly, unlike community services where there are long waiting lists.

> *"If someone's gone, 'I'm ready for this now', if you leave it that three to four weeks, they're going to talk themselves out of it. If they're going, 'I'm ready for this now', get in. You've got that golden point and you're in there, then." (MDT worker)*

> *"It's not a referring process that takes six or seven weeks, it's an immediate base of contact. So, we can be in touch with that family within 24 hours, if need be by the end of the week or within a couple of days, but it's immediate support going in. So, I think that's something that the Social Care team really appreciate and find very effective." (MDT worker)*

This element made a significant difference for one client where the MDT was able to work immediately with them, rather than the client having to wait for a referral to the substance misuse service by which time they would almost certainly have been back in prison.

Eight interviewees and four survey respondents also highlighted this swift and immediate support as making a significant difference for their families, especially when they are already in acute distress. Many of these also mentioned the long waiting lists to access community services when previously cases would have marked time or the family situation would have worsened.

> *"The fact that they will start the work with them really quickly, there is not this sort of referral lag and eventually they get round to it. I think that for families, when they reach the point where they recognise that they have an issue and say I would like some help with plan A, B or C, they want it then and the MDT help us to do that and I think that is the big difference." (team manager)*

> *"We're so lucky to have MDT, we really are. Without them I'd be pulling my hair out because I just wouldn't know what to be doing and you'd have a serious case on your hands with these poor mums and dads that just can't get the support and help that they need instantly. And it is instantly with MDT which is brilliant" (senior practitioner)*

Another important element of the MDT service is that they can offer emergency support very quickly. One example provided by the MDT focus group was a client who rang up with suicidal ideation saying that she was going to end her life. The MDT staff member was able to go out and be there within 45 minutes to talk things through with the client, whereas the mental health Crisis Team could take up to eight or ten hours to get out. Five of the interviewees also highlighted this crisis management and support as being very valuable.

"So there's that big gap where that person has got to try and manage that and potentially something serious could happen in that time." (MDT worker)

"One of my cases, mum's alcohol misuse, so when mum's been drinking, she's contacted straight to the MDT worker for support and them being able to respond immediately and being able to respond and support through that crisis alongside us." (senior practitioner)

Seven interviewees mentioned that the MDT is able to act as a bridge to community services, including working with families while they are waiting for access and supporting them to access the services themselves.

"We know she's got a mental health disorder but we're not sure whether it's ADHD or bipolar or whatever, and step by step, her and [MDT worker] have taken her through every mental health appointment that she's needed. I wouldn't know where to start! You go to the GP and ask for a thingy, but this mum has actually needed support to do those things." (senior practitioner)

"I think, sometimes, MDT workers can maybe go in and do that front bit of work to get the parents in a position where they're not disengaging from the community services, maybe. Like, they feel like they can engage a bit easier with those services. (other professional)

Support for parents

The fact that the MDT worker is a support for parents specifically, which is not something that they are used to, has had a positive impact for clients. This was highlighted by all of the interviewees as well as the MDT workers in the focus group.

"Normally professionals are coming in and going: 'don't do this, don't do that, you've done this wrong', whereas she's now got a worker for herself… They weren't used to that but it's because we hold a different role where I don't need to focus on that child's time, like 'what's going on for you right now mum? What can I do to help and alleviate some of the stress?'" (MDT worker)

"I have a lot of parents I work with that say, my child's in care or you've taken my child, what about us? What about the support we can get? There's me going through all the things we've got, the family centre, compass, it's all these things, but you're putting so much pressure on that parent to get up and go. Yes, they do have responsibility and they should be doing that, but not all our parents are that way." (social worker)

MDT workers also highlighted that they feel they can support and empower clients to believe in themselves and make changes because they build up such a strong relationship with them.

Six interviewees specified that the support provided for children and young people by the MDT had been effective, particularly where they had not met the threshold for other services such as EWMHS or a referral had been rejected.

"Often the referrals are turned down because, they're saying it's because what home life is like and that needs to be settled until we can do any work with

children. And I get that, I get that. But when you need children, you need additional emotional support that's not very helpful… I would say the mental health support has probably been extremely beneficial for the children." (other professional)

Advocacy

MDT workers can act as an advocate for their clients and an intermediary with social workers when something has happened to upset them. The MDT highlighted the importance of helping families reframe their anger to achieve more effective communication and that poor communication is a stumbling block to positive professional relationships and the team continually encourage the people they are supporting to reframe their comments.

Some have also provided advocacy for young people who are struggling to maintain their education and communicate with the school. Often this is in cases where the parent is not able to do so, or less aware of what is needed, and where they would not push back if the school suggests something that is not appropriate for the young person.

"Obviously, schools have so many pupils and it's hard to focus in on the ones that they really need to sometimes. So, I can go in and suggest alternate timetable options for them, alternate styles of learning, get to the school what that young person needs to be able to access school and that's been really successful… multiple children I've worked with are now back in education again, whereas if they didn't have that advocate, they would just be sitting at home not learning." (MDT worker)

Six interviewees mentioned the advocacy role of MDT workers for some of their families had been beneficial.

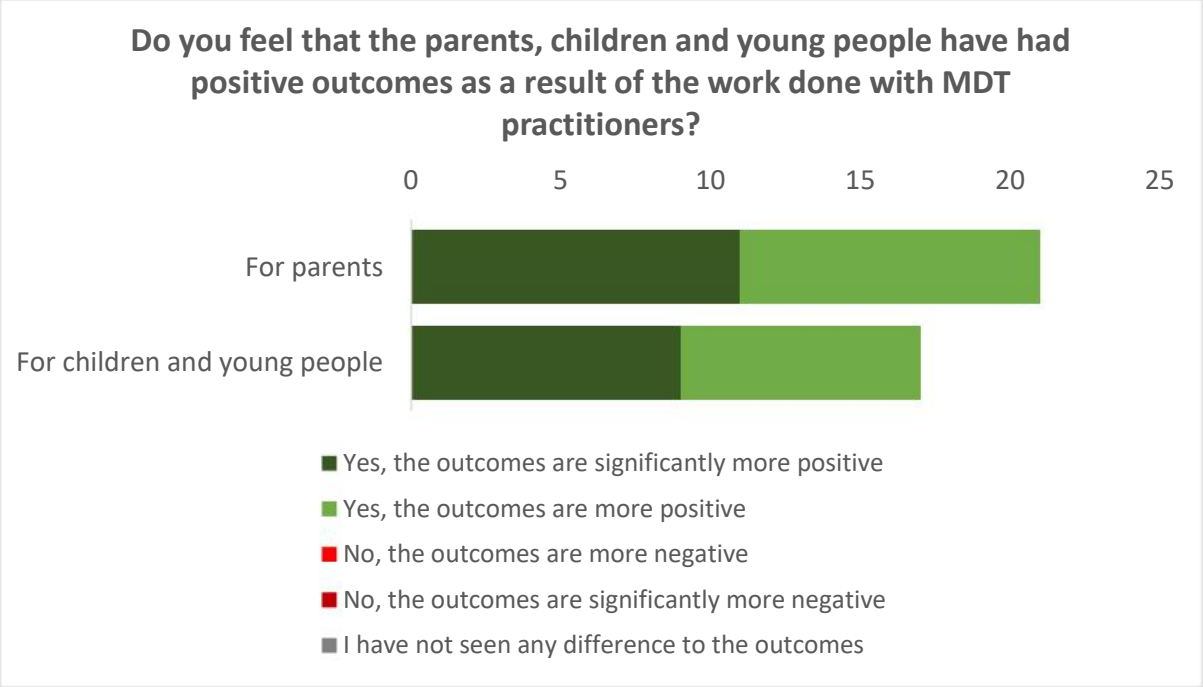
"Sometimes parents need an advocate, they need somebody who has an understanding of what's actually going on but is also in their corner, and that's something that MDT are able to do. That's difficult for other services to do." (social worker)

A child did not want to go into school and was clinging onto the gateposts. Whereas school staff were trying to prise their hands off and bring them in, the MDT worker was able to take a stool out, sit with the child and let them calm down and talk them through things.

The MDT was able to advocate with Housing for a client who struggles to read complex letters and who had left the country for some emergency dental treatment. Their housing status was removed while they were there so that they were made homeless. With the support of other professionals involved they were able to reinstate their housing.

Impact on families

The MDT focus group and ten interviewees highlighted positive impacts on families as a result of the work done by the MDT. All of the survey respondents said that the outcomes for parents and for children and young people are more positive as a result of the work done with the MDT.



One family had been open to social care for over six years due to neglect, mental health issues, domestic abuse and drug misuse, where the children were at the point of being removed. However, work with the father especially was really helpful as the MDT worker was able to get alongside him and work one-on-one to support him with specialist support that the social worker could not provide. The family's case is now about to be closed.

One mum is now in rehab and has stopped smoking, using cocaine and drinking. She is the administrator for her Whatsapp group at rehab, and is doing some volunteering work with the aim of getting a job.

> *"Empowered her to go, I'm going to do this. And she was like, 'and now, actually, I feel like I do six full days a week at a rehab, I can go and get a job. It's not actually as overwhelming as I thought. What I'm doing is volunteering'. Different person. Completely different person… I've not done it, I've not told her anything she's not aware of, I've not said anything that a community service doesn't say, but I've been available and one of the things she said… She can call me whenever she wants and I'll get back to her by the end of the day and sometimes it's just like, I need to rant to someone. Don't know who to rant to because if I don't, I'm going to let it bottle up and I know I'm going to go and have a drink, so do you have five? Not a problem, whereas community services don't have [the time]. Their case load is ridiculous." (MDT worker)*

Support from the MDT, including advocacy with Housing, was very important for one client as lack of adequate housing would have been a significant trigger for them to return to substance misuse and potentially prison.

> *"Her social worker referred her while she was in prison but knew she was being released within the next week or so. I saw her the first week of her release, so I was there straight away, managed to build up the rapport." (MDT worker)*

A young person was absconding, did not attend school and their mother was relapsing and still involved with drugs, alcohol and domestic violence. A year later, the mother is engaged with the recovery worker and has completed a nine week rehab programme so is not under the influence of drugs and alcohol anymore. The young person has a much better attendance at school and has managed to take a few GCSE exams through the support from MDT youth targeted advisor.

> *"[MDT worker] managed to challenge the school and get her on an extended timetable to sit another exam, as initially she was down to just two, maths and English, but now she has done science because it was a condition for her place at college. She has got some aspiration, fantastic aspiration and she is working towards it. I am not saying it is perfect because it is not but the risk is massively reduced. She has not absconded, the police have not been involved." (social worker)*

A family with an acute mental health need where mental health services were not providing the support that the social work team felt she needed. She was losing a lot of weight, at risk of collapsing and was very poorly. With MDT support, she is now eating, has put weight back on and is taking her medication.

> *"We're still very worried about those children, but the immediate health of mum, we don't think mum is going to keel over and fall down the stairs. There was a point where we couldn't let her be unsupervised with her three-year-old through the night because we were thinking, she's not eating, what if she falls over and hits her head or collapses herself? There's an actual real tangible improvement in her mental health since [MDT worker] has been working with her so, that's an invaluable intervention." (social worker)*

A client has been housed in a hotel for nearly nine months which significantly affected her mental health. Appropriate housing has now been found for her. Previously, she had been in a cycle where she was released from prison and within six weeks she returned to drug use and criminal activity. She was also in a domestically abusive relationship and she identified herself as both victim and perpetrator. The cycle now seems to have been broken as she has been able to stay out of prison for nine months with minimal lapses (in a controlled way, i.e. not around her children).

Impact on other services

The MDT service can have a positive effect on other services whereby the support provided by the team means that if a client is experiencing a crisis situation, the police or ambulance services are not called and an escalation is prevented.

> *"We could be there 45 minutes at the most to just give them that crisis support and in turn, that stops police attending, incidents, ambulance, it relieves crisis team." (MDT worker)*

> *"I had a client and she's now been sober since September. Previous to that, there was at least a weekly police attendance whereas there's not been any police attendances since then. Ambulance callouts, neighbourhood disturbances, the lot, whereas now, that's completely stopped." (MDT worker)*

One social worker mentioned that work by the MDT with a young person had allowed them to return home to live with their parent whereas previously they had frequently been going missing from foster care. This meant reporting them as missing to the police and the police then having to attend to look for the young person. This has also saved court time in eliminating the need to apply for recovery orders.

Another client who has been in and out of prison as a consequence of criminal activity due to drug use, has now remained out of prison for nine months, which is a significant cost saving for the prison service.

For another family, the MDT intervention has been able to keep the two children in a family attending school, avoiding the cost of tutoring. Two other children had been receiving support in school but no longer need that support as they are much more independent in school.

Effectiveness of MDT

All of the interviewees commented on the effectiveness of the MDT pilot service, with several saying that it is "invaluable".

> *"Their involvement is really good and really impactful for this family. This is a family for whom I never thought we would get to this point, so the change is night and day. When you have that much Social Care involvement for that many years, it is quite impossible to think that you could make that much change. It just shows that when you have the right workers going in, who have the time, the results are extreme." (team manager)*

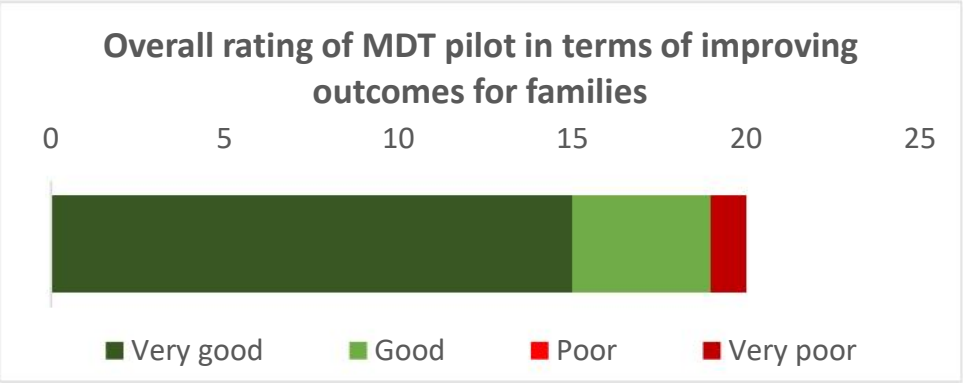
> *"I want to keep them, they're an asset to us, they make our life easier, which is what we need." (senior practitioner)*

> *"It's an absolute godsend, it's really changed the way that we can move cases forward quickly, and actually we can evidence that they don't need to be open to Social Care anymore or we need to take this a step further, we need to take them into a legal level or something like that… If it was a score out of zero, they're not effective at all, or ten, they're the most effective I've ever worked with, I would say 11. Seriously." (senior practitioner)*

Around half of these interviewees also stated specifically that the outcomes would not have been achieved without the MDT involvement.

> *"We wouldn't have been there without the MDT team. The Social Worker that works for this family is excellent and has done amazing work. But we needed that extra which we would never have achieved with drug services in the area and the DV work." (team manager)*

All but one of the survey respondents rated the MDT positively in terms of improving outcomes for the families they are working with, with most rating the pilot service as very good. The respondent who rated the MDT as very poor, however, rated the MDT very positively for all of the other questions and stated that the team was extremely helpful and supportive, which may indicate that they ticked this box in error.



What could be improved?

A number of suggestions were made MDT workers, interviewees and survey respondents, although six interviewees could not think of any improvements needed.

The MDT and two survey respondents felt that an additional mental health worker would be beneficial since so many of their clients – both adults and children - have mental health issues, and another youth worker.

One social worker interviewed and five people responding to the survey suggested increasing the team size overall, to have more of their expertise. Another felt that it would be beneficial in the longer term if the MDT could be more open to the Children in Care teams and work with more parents in this kind of extensive way.

Four social workers interviewed and two people responding to the survey suggested that having an expert who could support families with housing issues would be very helpful. The MDT and two survey respondents also felt that it would be helpful to have a dedicated worker to advise and support on benefits and debt management.

> *"Support with housing, that would be quite beneficial, someone to liaise, housing is a real issue for some families and we are not specialists. As an allocated social worker all I can do is support with a letter of support to the housing department but if they could support incorporate a multidisciplinary team someone for housing." (social worker)*

One social worker felt that having an educational support specialist would useful to help with supporting young people who are struggling in education as this has a significant impact on the wider family. This should be an education specialist for mainstream education, however, rather than for special needs education.

One social worker was not sure whether or not expertise in supporting children or adults that have faced sexual abuse would be helpful since although there are specialist agencies for this, there are very long waiting lists to access this support (eight months for one agency).

One interviewee and two survey respondents wanted the MDT to become permanent. Two social workers, who are based in Colchester (but are working with several families who have moved to Tendring) wanted the MDT to cover their areas as well. Two professionals interviewed and two survey respondents wanted to have an MDT in all areas. However, one professional highlighted that if the MDT were to become "*a victim of their own success"* and develop long waiting lists, then this would undermine the intrinsic value of what they have to offer.

One survey respondent suggested that the MDT should be involved with families that require the service from the assessment stage.

The MDT felt that while their intervention could be offered to families earlier, they should not necessarily work in this way as the range of community resources should be explored and exhausted first. A future development might be to provide an earlier "interruption" programme for families that are running a risk of needing MDT intensive intervention in the future, but this would not necessarily fall under the remit of the MDT.

One social worker felt that sometimes families can become too reliant on their MDT workers, which is contrary to Social Care's role which was seen as being to empower families to become more independent. However, this is probably due to the time and space that the MDT has that social workers do not.

Some families may need to be given a time limit to the support so that they are not trying to hold onto it forever.

One other professional interviewed felt that the MDT could have been a lot more tenacious and pushed much harder with a parent who was particularly difficult to engage with, although they were not sure that even this would have worked with this parent. A survey respondent said that workers are often led by the client so that if a family declines a visit it can take a while for them to make themselves available and that more persistency would be beneficial.

One professional highlighted an issue where the MDT worker has not always been able to attend a Child Protection Conference: however, this was felt to be an administrative issue whereby the worker has not been notified early enough of the conference dates.

> *"Quite often we have an initial child protection conference and we haven't got MDT involved at that time. It may form part of our plan, or it might be an idea that we have had. When we have a conference, at the end of each conference we book a first call group date and the first review date and I think what's happening*

is they're then coming on board part-way through and social workers aren't necessarily giving the dates… So it's not until they get an invite that they're made aware that they have got a conference to come to." (other professional)

One social worker highlighted that the wording on a report submitted was not quite correct (a young person had not been placed at their parents but had absconded there) in terms of a social worker perspective, but this was quickly rectified once the team was contacted about this.

Another said that differing perspectives can be a challenge, mainly when going to Court with two different statements that are both from ECC. They gave an example of where a statement for Court from the MDT was very different to the social worker statement: the MDT were looking at things from the view of the parent whereas the social worker was trying to provide safety for the child. However, this happens often with many professionals who work outside of the child protection remit. There is also the need to share with children's Social Care all information from MDT direct work sessions (with both adults and children/young people) that is relevant to a child protection case.

Estimated cost savings

Savings for Social Care

The MDT data and feedback from interviewees can be used to estimate cost savings for Social Care.

Children avoiding care

Cost savings can be estimated for the children whose safeguarding status has stepped down. Although 4 children were in care at case closure, this is perhaps not unexpected due to the nature of the families that the MDT is working since many were at risk of being accommodated at the time of referral and 3 were already in care. In these types of cases, an intervention may establish that removing the child is the correct and safest course of action.

In total, 35 of the 57 children whose cases have been closed were at risk of being accommodated, of whom 4 were in care at case closure, 20 had a Child Protection Plan, 15 had Children in Need status, 4 were receiving support from Family Solutions and 14 were closed to Social Care. Cost savings can be extrapolated based on the likely costs of 'avoided' care proceedings for the 31 children and young people who were at risk of being accommodated but were not at case closure.

The first component of cost savings is those attached to the cost of removal proceedings. Unit costs for these aspects have been estimated by Pause[4] as part of the development of an-house cost-benefit analysis tool. The overall unit costs are estimated at £44,300 in 2018/19 prices and are assumed to represent one-off cost savings to the local authority and other agencies.

Avoiding care proceedings for the 31 children and young people would have saved ECC £1.21m.

Cost savings for subsequent years can also be inferred – with some caution. Babies removed from birth parents in these circumstances are often adopted and therefore do not present such high on-going costs to local authorities. However, in the event that adoption arrangements cannot be made or break down, substantial on-going costs in the form of long-term foster care and associated expenditure for looked after children could be incurred up to age 18.

The estimated average annual cost of local authority foster care is £34,320 per child per year and £245,388 per child for residential care[5]. Residential care is a more likely option for many of the older young people referred given their level of needs and likely age at entry into care. 13 of the 31 children at risk of being accommodated who were not in care at case closure were aged between 13 and 17.

[4] Evaluation of Pause (2020)

[5] Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2109). The cost uses values from the PSSRU and are at 2017/18 prices.

The annual cost of foster care for these 31 children would be £1.06m. However, if the 13 young people aged 13 or over were to be placed in residential care then this would cost £3.19m per year. Therefore, the annual placement costs would fall somewhere between £1.06m and £3.81m in total.

Additional future savings may also have been accrued given the increased likelihood of children in care having a number of adverse outcomes as adults. Research[6] shows that young people who have had a background in care are more likely than their peers to have poor outcomes in later life. For example:

- 25% of those who were homeless had been in care at some point in their lives.
- 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience.
- 22% of female care leavers became teenage parents.
- Looked-after children and care leavers were between four and five times more likely to self-harm in adulthood.
- Care leavers were less likely to be in education, training or employment.

Stepping down safeguarding status

7 children had stepped down from a Child Protection Plan to Children in Need status, 4 were receiving support from Family Solutions (3 who were on a Child Protection Plan at referral and 1 who was a Child in Need at referral) while 14 were closed to Social Care (3 with a Child Protection Plan at referral and 11 who were Children in Need at referral).

The cost (over 12 months) of ongoing support for a child with a Child Protection Plan, is estimated to be £1,893 while the cost of ongoing support for a Child in Need is £1,345 (at 2017/18 prices)[7].

The 18 children who had stepped down from a Child Protection Plan or Children in Need status and were either closed to Social Care or receiving support from Family Solutions are therefore estimated to have saved social worker costs of £27,500.

Reductions in social worker time

Interviewees described cost savings as coming from a number of reductions in the time they needed to spend on a family:

- Seven social workers/senior practitioners highlighted that the MDT frees up time spent on direct work that they would have needed to do, which is still needed if the family are not accessing other services. This also includes work done by the MDT with families that the social worker/senior practitioner would have been attempting to do until specialist services could start.

  "Every time they go in, it's saving us time. It's more effective than it would often be if we went in to do it." (social worker)

[6] Care Leavers' Transition to Adulthood report, Department for Education (2015).

[7] Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2109). The cost uses values from the PSSRU and are at 2017/18 prices.

"Because they are specifically trained in certain different types of roles - drug workers, mental health, domestic abuse, relationship building. Without that it would have been me trying to collectively get different services and really try independently, as well as being the children's social worker, and dealing with the child's needs and working with the foster carer to meet those, would have been all me to get that support to mum." (social worker)

- Two of these interviewees highlighted that this is especially valuable to them as they are working with high and/or complex caseloads.

  "We would undertake that work until we could get them onto a programme which could take a week, six months, who knows. But [MDT] have been able to take that piece of work off us, which is great because we just haven't got the capacity to do it, and then you get drifts on your plans because you're trying to get that work done and you just can't do it with everything else that's going on and your 20 other cases. So, yes 100 percent, it is effective in time saving, definitely." (senior practitioner)

  "Having this MDT who is more focused on working with a specific kind of issue and time scale, it is a massive saving. It is saving time." (social worker)

- Two social workers said that the work done by the MDT with parents allowed the social worker to focus on the needs of the child.

  "Because they are specifically trained in certain different types of roles, drug workers, mental health, domestic abuse, relationship building. Without that it would have been me trying to collectively get different services and really try independently, as well as being the children's social worker." (social worker)

- One social worker and one team manager mentioned the avoidance of crisis management due to the MDT involvement (they described a case when a young person went missing frequently where the social worker had previously had to spend some part of almost every day dealing with multiple phone calls and visits to find them and persuade them to return).

  "On the weeks that there was a crisis, you would probably be looking at an extra four hours at least on what you would have spent with her. Going out to see, travelling time, notifying all the professionals and then going to do that recovery work afterwards. The extra hours because of extra crisis." (social worker)

  "Before MDT came, we were probably say there'd be some kind of, every day, and sometimes it would take up… some part of the day, and then some days it would be all day." (team manager)

- One team manager mentioned the fact that a case, that had been a *"massive drain"* on a social worker's time, and which had been open to Social Care for a long time, can now be closed due to the MDT involvement.

  "With that family in particular, who have been open to Social Care forever, we would not have been able to step them down, close them and move them on so that social worker would have still been working with them. We would have ended up with a social worker from the Children in Care Team and they would have a social worker for ever." (team manager)

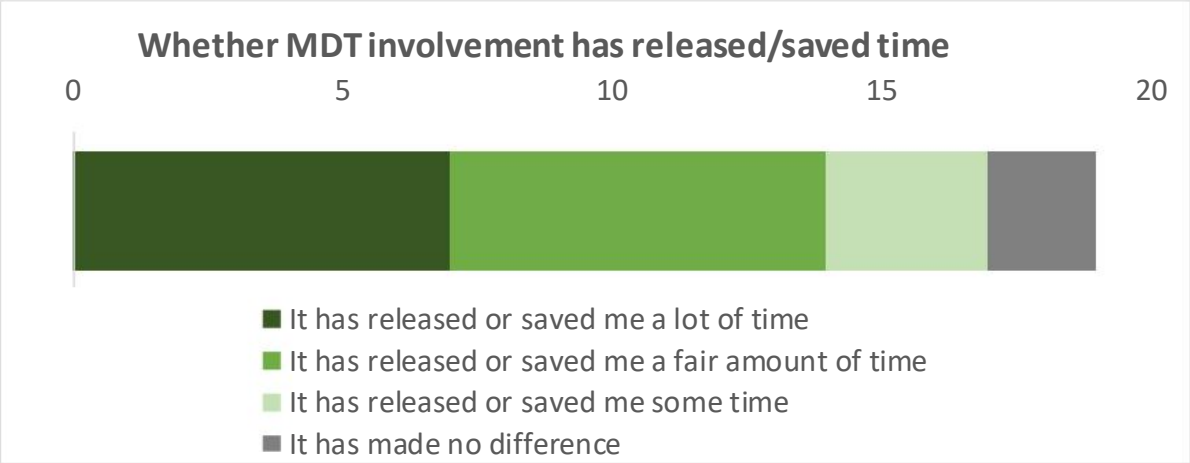
- One social worker, who took over a case where the MDT was already involved, said that the information from the MDT worker on the family circumstances and issues had saved them time.
- One senior practitioner and one other professional said that the MDT involvement saved time spent trying to find services to refer a family to or get assessments for specific mental health issues (the senior practitioner estimated this saved them about 25% of their time).

  "MDT is one place that you can go and talk about the family as a whole, and then, yeah, it's not like 1000 different referrals that you've got to make, and the same conversation over and over again; it's kind of one conversation." (other professional)

- One social worker mentioned the hours spent in trying to get services not to close when parents are referred to services and then they do not engage.
- One senior practitioner said that work undertaken by the MDT on obtaining a non-molestation order had saved them time.

  "When [MDT worker] applies for or supports parents to apply for non-molestation orders, she would just present it to me a fait accompli. It's done, there you go, put it on your system. Whereas she's done all the conversations with the mum, spoken to a solicitor, she's done all of that, so actually that's saved me because that mum needs that non-molestation order in place and actually I don't have to worry about that, that's another worry of mine which leaves me free to do the work that I need to do." (senior practitioner)

Survey respondents were asked whether the involvement of the MDT team has reduced the amount of time that they need to spend with the parents (and/or children and young people), including on crisis management, in order to allow them to focus on their statutory responsibilities and the needs of the child. Seven said that it has released or saved them a lot of time while another seven said that it has released or saved them a fair amount of time and three that it had saved them some time. Just two people said that it has made no difference.



Quantifying cost savings

When asked if they could quantify the time savings for them, the replies varied from a small amount to 1-2 hours per month to 1 hour per week to 4 hours per week. Several said that it varied according to a family's needs, with one stating that when a family is in crisis the MDT workers save them a lot of time.

> *"It has saved me at least 1-2 hours a week with the current family MDT are working with. This has been the same in previous cases, so needed to see the family fortnightly instead of weekly. As I work for A&I the families are often in crisis so need regular visits." (social worker responding to the survey)*

> *"I meet with my families on every 10 working days. This is statutory, but having MDT on board also help reduce the stress and number of time I spent on phone with them because of MDT engagement with the family." (social worker responding to the survey)*

> *"Where I work in an Assessment and Intervention Team, I would sometimes have to meet with parents twice a week for an hour to do direct work around domestic abuse or substance misuse. However, this has been reduced to once fortnightly to address other areas not related to the above." (senior practitioner responding to the survey)*

Taking an average of the various responses, we would suggest that the MDT's work with families is saving at least one hour per week for social workers per family, but possibly more. The average hourly salary for children's social workers is £46[8], which would indicate annual savings of at least £2,392 per social worker per family. This would translate to annual savings of £193,752 for the 81 families the MDT has worked with, or £290,628 over the 18-month pilot period.

Four interviewees highlighted that the involvement of the MDT resulted in them being able to close cases much sooner, mainly since they are not having to wait for families to be able to access community services.

> *"We possibly do Child In Need planning shorter because we are able to access the services that work with the family straight away. Whereas before we quite often identified the need, did the referral to the appropriate service and then sort of sat and waited. We were still working with the family on everything else but now that work starts with the MDT and probably gets to a point where we can close or step down sooner than it would have done if they were not there." (team manager)*

Two interviewees also highlighted savings in the time of other Social Care staff, including duty workers, team managers and support workers.

Two social workers mentioned that the MDT intervention had prevented a number of children being accommodated, with the consequent placement costs.

[8] Unit costs of Health and Social Care 2021, PSSRU (published Dec 2021) - Unit costs of professionals

MDT emergency sessions

Part of the MDT remit is to encourage participation with hard-to-reach families. Engagement is very difficult for the families supported, because of the vulnerabilities previously cited. Many have had a long and entrenched experience of feeling unable to engage with professionals and community services. To best promote engagement, the team commence their interventions at the client's pace, offering relational-based support to ensure that the family feel and remain in control of their situation.

The MDT has found that when families are facing crisis, offering emergency sessions enables them to maintain a link between receiving support and positive outcomes. It prevents them having to retell their story and helps them feel held by familiar workers. MDT staff responding to a crisis – rather than professionals from other organisations such as the emergency services, A&E and mental health teams - saves time and avoids delays for families. They get immediate access to expert advice, and this helps to deescalate situations and in a lot of instances avoids the need for emergency services. Responding promptly can empower the family because they have received targeted support in a timely manner.

Using data collected by the MDT on emergency session with clients, it is possible to estimate the likely costs savings for a number of other professionals who would have been working with the parents, children or young people if MDT staff had not been there. Please see Appendix 2 for full details of the calculations used in estimating cost savings.

Emergency sessions are estimated to have saved 318.5 hours of social workers' time over the 18-month pilot period, at a cost of £14,651.[9]

For health services, emergency sessions have avoided the following over the 18-month pilot period:

- 72 attendances at A&E at a total cost of £11,952.[10]
- 16 visits to a GP at a total cost of £512.[11]
- 72 ambulance call outs at a total cost of £17,424.[12]

They are estimated to have saved health services nearly £30,000 in total.

For the police, emergency sessions have avoided the following over the 18-month pilot period:

- 54 police call outs (mainly due to substance misuse or mental health issues) at a total cost of £16,902.[13]
- 7 call outs for domestic abuse incidents plus 41 call outs avoided due to de-escalation of domestic abuse, at a total cost of £23,952.[14]

---

[9] Based on an average hourly rate for social workers in Children's Services in 202/21 (Source is: Unit Costs of Health and Social Care 2021, PSSRU (published Dec 2021) - Unit costs of professionals.

[10] Average cost per incident of A&E attendance. Source is Unit Cost Database, calculated from the NHS Reference Costs 2017-18, updated to 2019 value.

[11] Average cost per face to face consultation with patients (average 9.22 minutes). Source is Unit Cost Database, updated to 2019 value.

[12] Average cost per call out, per incident. Source is Unit Cost Database, updated to 2019 value.

[13] Average cost to police per incident of crime, across all types of crime. Source is Unit Cost Database, updated to 2019 value.

[14] Average cost to police per incident. Source is Unit Cost Database, updated to 2019 value.

The emergency sessions are estimated to have saved the police nearly £40,900 in total.

Avoidance of police call outs

The property of one MDT client was regularly being attended to by the policed due to her being drunk and disorderly 2-3 times per week. This was a regular occurrence for at least the previous 18 months but following 5 months of support from the MDT, the police call outs completely stopped.

One client had regular police arrests and ambulance call outs approximately every four to six weeks for both services in the two years prior to MDT support. Since engaging with MDT, over a 11-month period they had just one police and two ambulance call outs.

One young person had absconded 23 times in the previous 12-month period (in effect, twice a month). Since her engagement with MDT, she has stopped absconding.

One parent had avoided prison custody for 14 months, at an estimated cost saving of £21,391.[15]

Avoidance of prison custody

Over the last 8 years this parent had been recalled to prison regularly spending sometimes only weeks on release at a time. Since their release 14 months ago, they have had no recalls: this is the longest time they have been out of prison.

For mental health services, emergency sessions have avoided the following over the 18-month pilot period:

- 29 uses of the CAMHS Crisis Team at a total cost of £1,218 [16].
- 75 uses of the Adult Crisis Team at a total cost of £3,150 [13].

They are estimated to have saved Adult and Child mental health services nearly £15,300 in total.

Schools have avoided an estimated 64.5 hours of staff time as a result of MDT emergency sessions, at a total cost of £3,314 [17].

These estimated cost savings (excluding the social worker time saved) add up to a total of £110,736 for other organisations over the 18-month pilot period.

---

[15] Based on estimate of avoiding prison custody for 34 weeks in 12 months and the average cost of holding one prisoner per week (the figure is an annual figure divided by 52 weeks). Source is Ministry of Justice, HM Prison & Probation Service Annual Report and Accounts 2020-21.

[16] Crisis resolution team for adults with mental health problems, cost per hour per team member, with the assumption that a half day of work is spent per episode. Source is Unit Cost Database, updated to 2019 value.

[17] Based on the average hourly pay of teachers in England paid on the median pay grade of M5, 2020/21. Source is the NASUWT.

Total cost savings

The table below summarises the estimated cost savings for each component, less the overall cost of the service. This shows that the MDT pilot has generated estimated and potential net savings of between £1.0m and £3.65m.

Table 7: Estimated cost savings

	During 18-month pilot period	Minimum per year	Maximum per year
Avoiding care proceedings	£1,213,371		
Annual placement costs		£1,063,920	£3,807,804
Social worker time savings	£290,628		
Step downs from CPP/CiN	£27,498		
MDT emergency sessions - social worker savings	£14,651		
MDT emergency sessions - partner organisation savings	£110,736		
Minimum gross savings	£2,720,804		
Maximum gross savings	£5,464,688		
Cost of service	-£590,000		
Net savings of at least	**£2,130,804**		
Net savings of up to	**£4,874,688**		

Comments received from parents

The MDT Service has shared a number of anonymised quotes received from parents with the evaluation team. Around half highlighted the good support that families have received form the team, while other comments refelcted positive changes made in their lives including improved confidence, feeling that they are listened to during sessions, and that they can talk to the practitioners and trust them.

“I really enjoy our meetings I feel like you listen; and I trust you.”

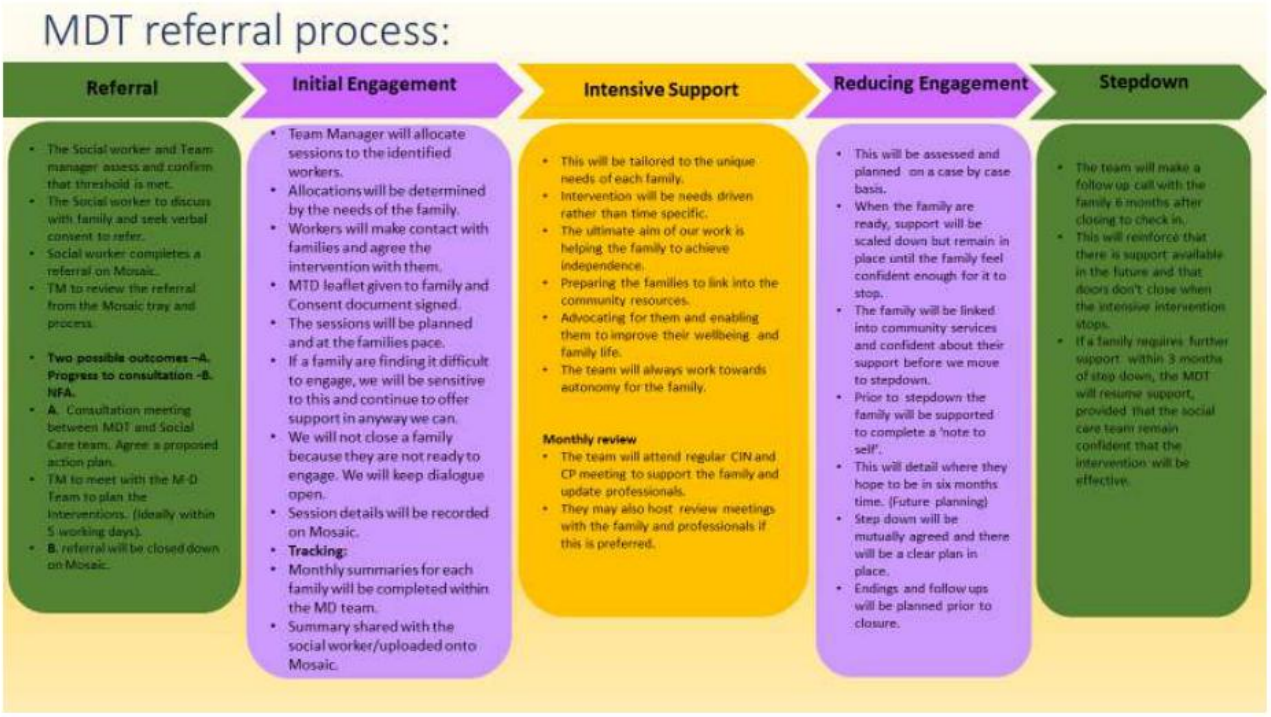
"All support has been very useful and very helpful and has helped me and my family more than you can imagine. There wasn’t anything that I didn’t find useful. It was different to other support in that it was a lot more independent and was focused on what I wanted to work on."

“I’ve never stayed clean this long, I’m sorting out my ADHD, I’m actually speaking to people and opening up more and slowly building back my confidence. I actually have money to do things with the kids, I was able to buy them Christmas presents for the first time in 9 years. I’m actually here, all the time, and being consistent, I never did that before. I just need housing now to make that next change.”

“I found the sessions relaxed and easy going. I didn’t feel pressure to talk about things, the conversations felt natural. I did find them beneficial as it gave me the space to reflect on what is going on now and what went on in the past, and how I coped and stuff. Talking with you all has helped me be more open and actually think about my behaviours and move on from them, because I had to stop holding onto my past. Everything is positive now. I have a lot more pride in myself and don’t feel like I need to avoid people any more or worry what they think of me. I can walk around with my head held high because I know all the work I’ve done. I’ve learnt now that it doesn’t matter what other people say, I will do everything at my own pace and take everything in my stride. I don’t care what other people gossip about anymore, all that is important is me and my family.”

Appendix 1: MDT service design

One of the unique elements of the MDT service is the ability to provide a bespoke package of support in a timely manner. Information provided by frontline teams based on the assessments and the intervention they have put in place provides a greater understanding of the needs of the whole family. These needs can be individually or collectively tackled by the MDT through working with the family and building relationships that support the statutory service.



The MDT is overseen by a social work qualified team manager and comprises 7 practitioners who deliver support across the following disciplines:

- Domestic abuse victim support.
- Domestic abuse prevention.
- Drug and Alcohol support.
- Adult emotional wellbeing and mental health support.
- Children and young people emotional wellbeing and mental health support.
- Youth Work.

The MDT aims to help deliver the following positive outcomes:

- A clearer understanding of the needs of children, young people and families in the Tendring area, and enabling access to the right services when they need it.
- Improving the health and wellbeing of children, young people and their families so they are safe, happy and achieving in stable home environments.
- Improved collaboration and partnership working to deliver coordinated services to children and families.
- A central point of contact for frontline teams to efficiently access a pool of specialist/subject matter expertise (SME) when they require intervention and

support quickly. This will achieve support at the right place and time particularly when families are experiencing complex issues ('toxic trio').

- Relieve pressure on frontline teams by providing tailored interventions by SMEs. This reduces the required time social workers need to spend on their complex cases and results in more manageable workloads, thus creating the environment and opportunity for meaningful, direct work across their caseloads.
- Overall reduction of Social Care involvement either through early intervention or avoiding escalation through a coordinated approach, thus creating potential to see an increase in the number of permanent exits from care.
- Cost effective method of coaching/mentoring to support development, making use of in house established skills and methods therefore increasing the skills, motivation, and confidence levels within the service.
- The multi-disciplinary approach to supporting the families that are held within the existing services will support our frontline teams to affect change in those families in a more efficient and sustained way. Work to support the specific needs of parents will also prevent these needs from escalating and thus requiring further cost intensive support services offered by our partners and commissioned services.

At the end of the intervention, the team signposts families to other support and services within the community as part of their stepdown process. Cases are only closed after the team has ensured that the family has been referred and is engaging with some community resource or support. The team then subsequently follows up with the families six months after closure with the aim of exploring and acknowledging their progress but also offering additional one-off advice if needed. The families are encouraged to predict what they would like to have achieved in those six months and this is what is discussed during the follow up call. This is a good basis for promoting momentum and helping families feel supported.

The MDT pilot is running for 18 months in order to have sufficient time to demonstrate and evidence impact on internal and external outcomes for children and families alongside cost savings for services. The University of Essex has been commissioned to provide an external evaluation of the MDT pilot.

Evolution of the team

This information is based on input received from the team manager.

Due to recruitment issues not all of the practitioners had been appointed by the start of the pilot on 1st February 2021. Three joined during February and two joined during March, but there was also a period of three months when at least one was off work. The team was unable to recruit to the adult mental health worker post until July. This meant that the team not functioning as a full team until July 2021. Additionally, as the team was recruited and went live during Covid restrictions and lockdowns there was a need to focus on staff wellbeing, team building and development while also providing the best support possible to clients.

The team of 7 practitioners came together as a group of Subject Matter Experts (SMEs) and they have worked continually to ensure that they develop support that is relational and effective. The team has a high level of combined expertise and this has ensured that they can offer support that is sometimes outside 'the box'. There is a strong sense of enthusiasm within the team and each member is determined to offer the best support possible. From the outset they have considered referrals by asking 'how can we help' rather than 'if we can help'. This tends to ensure that the team tailors its offer of support to best meet the needs of the family.

Most of the team had never worked in a Social Care setting so there has been some learning and development for them along the way. There are weekly unit meetings where, as a group of SMEs, cases are discussed to contribute to the ongoing analysis. This is an opportunity for the team to take an aerial view of the current situation. They have also been able to predict and plan to manage future risk, based on analysing patterns in behaviours and information gathered from more than one family member.

Any professional is welcome to attend these meetings and bring a case that they may have become stuck with. Being a multi-disciplinary team rather thana multi-agency one has been advantageous, because practitioners work as a full-time team and are managed by one manager, providing a commitment to children's services rather than being lent out from partner services. Practitioners have also offered coaching sessions to social workers and other professionals who have requested support with complex cases.

Another advantage of the MDT is that because they are on site the support can commence immediately. Practitioners meet with the referring team and can have made contact with the client at the close of play the following day. As a team, they can assess and debate which service is right for the client and if this needs to be changed then they can do this swiftly without a further lengthy referral processes. The team always ensures that if possible they offer a holding support to clients who need the service when the team is at capacity. For example, if the Adult Mental Health Service is oversubscribed, another worker can touch base and offer some baseline emotional support in the interim.

Another USP for the team is that they are a secondary support to the Social Care team and therefore do not hold a primary safeguarding role. The team will only speak about their clients' children if the clients bring this up themselves (other than if there are any immediate safeguarding issues). Most clients have commented on how they have never before had a worker allocated to them alone, and this is something that they really appreciate.

The team places a strong emphasis on the language used, tending to use strength-based language in communications to promote accurate, neutral and non-blaming descriptions of and for the clients. For example, the phrase 'behaviours that challenge' is used rather than challenging behaviours etc. This is important advocacy and practitioners have received positive and appreciative feedback from clients on this.

Appendix 2: Estimated cost savings due to MDT emergency sessions

Organisation/category	No. of incidents/ hours	Cost per incident/ hour	Total estimated saving	Notes
Social workers	318.5 hours	£46*	£14,651	Average hourly rate for social workers in children's services, 2020/21
A&E	72	£166	£11,952	Average cost per incident of A&E attendance, 2017-18, updated to 2019 value
GP	16	£32	£512	Average cost per face to face consultation with patients (average 9.22 minutes), updated to 2019 value
Ambulance	72	£242	£17,424	Average cost per call out, per incident, updated to 2019 value
Police	54	£313	£16,902	Average cost to police per incident of crime, across all types of crime, updated to 2019 value
Police: domestic abuse call outs	7	£499	£3,493	Average cost to police per incident, updated to 2019 value
Police: domestic abuse de-escalation	41	£499	£20,459	
School	82	£27*	£3,314	Saving of 1.5 hours of a teacher's time on average. Average hourly pay of teachers in England paid on the median pay grade of M5, 2020/21
CAHMS crisis team	29	£42*	£4,263	Crisis resolution team for adults with mental health problems, cost per hour per team member, updated to 2019 value, with the assumption that a half day of work is spent per episode
Crisis Team	75	£42*	£11,025	
Avoiding prison custody	3	£629	£21,391.23	Estimate of avoiding prison custody for 34 weeks in 12 months. Average cost of holding one prisoner per week, 2020-21

(* Indicates a cost per hour. All other costs are per incident.)

Appendix 3: References

Boddy J et al (2020). Evaluation of Pause. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932816/Pause_-_Sussex.pdf

Cox P, Barratt C, Blumenfeld F, Rahemtulla Z, Taggart D and Turton J (2015) Reducing Recurrent Care Proceedings: Service Evaluation of Positive Choices (Suffolk County Council) and Mpower (Ormiston Families). University of Essex. Available online: http://www.essex.ac.uk/-/media/documents/research/recurrent-care-proceedings.pdf

Cox P, McPherson S, Ryan M and Baxter V (2020) Reducing Recurrent Care Proceedings Service Evaluation: Salford Strengthening Families https://www.essex.ac.uk/departments/health-and-social-care/research/health-and-care-research-service

Cox P, McPherson S and Baxter V (2020) Reducing Recurrent Care Proceedings Service Evaluation: Stockport Comma (Final service report) May 2020 https://www.essex.ac.uk/departments/health-and-social-care/research/health-and-care-research-service

Cox P, McPherson S, Mason C and Baxter V (2021) Reducing Recurrent Care Proceedings Evaluation of Step Together (Phase 2 final report) *University of Essex unpublished report*.

Cox P, McPherson S and Baxter V (2020) Evaluation of the Family Action Edge of Care Service *University of Essex unpublished report*.

McPherson S, Andrews L, Taggart D, Cox P, Pratt R, Smith V and Thandi J. (2018). Evaluating integrative services in edge-of-care work. *Journal of Social Welfare and Family Law*

National Audit Office and Department for Education (2015) Care Leavers' Transition to Adulthood report. https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood.pdf

National Audit Office and Department for Education (2019) Pressures on Children's Social Care report. https://www.nao.org.uk/wp-content/uploads/2019/01/Pressures-on-Childrens-Social-Care.pdf

Research in Practice (2019) Change Project: Working with recurrent care-experienced birth mothers: Online resource pack: https://www.rip.org.uk/resources/recurrent-care/

Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2109). http://www.neweconomymanchester.com/media/1446/3316-150327-unit-cost-database-v1-4.xlsx