University of Essex

Evaluation of a Multi-Disciplinary Team Pilot in the East of England

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Institute of Public Health and Wellbeing
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Executive summary

The University of Essex was commissioned by a Local Authority in the East of England to evaluate a Multi-Disciplinary Team (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, social care staff and families. This report presents evaluation findings from the first two years of its activity (February 2024 to December 2025).

The MDT works with families where there are complex issues, who struggle to maintain positive change and have a pattern of re-involvement with social care or ongoing issues that trigger re-referrals. The MDT comprises a team manager and nine subject matter experts in domestic abuse, drug and alcohol support, education inclusion, targeted youth work, housing, benefits and employment, and mental health support of adults and children who work alongside social work and community services teams.

This evaluation report shows that the MDT South evaluation is having predominantly positive impacts, including:

- Improvements in mental health and wellbeing outcomes for parents
- Reductions in safeguarding levels with associated estimated cost savings
- Improved levels of engagement
- Social care professionals finding that the MDT South is having multiple positive impacts on families and on their own work within the wider system

Safeguarding outcomes

The MDT South team is situated within the central part of the Children and Families service (Family Support and Protection and Assessment and Intervention) where the majority of Child Protection Plans and Child in Need plans sit and where care proceedings are initiated. Safeguarding status at referral, during intervention and at closure is available for closed cases.

Safeguarding status at referral for the 98 closed cases was as follows:

- 3 were Children in Care (CIC)
- 1 was on PLO
- 56 were on Child Protection Plans (CPP)
- 38 were Children in Need (CIN)

During the MDT intervention:

- 21 cases (21.4%) escalated indicating the high level of risk among the cases taken into the MDT service
- 19 cases (19.4%) were de-escalated to CIN
- 58 cases (59.1%) remained at the same level

By the time of case closure:

- 62 cases (63%) had been stepped down to a lower status such as Child in Need (CIN) status; or Closed to Social Care (CSC)
- 17 (17.3%) were escalated
- 19 (19.3%) stayed the same

Parent and child wellbeing outcomes

Twenty-one adults and four children completed pre-intervention and post-intervention wellbeing questionnaires.

Of the twenty-one adults

- Quality-of-life improved for 62% of adults (16/21)
- Overall health improved for 57% (12/21)
- Self-esteem improved for 45% (9/21)
- Physical health improved for 33% of adults (7/21)
- Wellbeing improved for 67% of adults (14/21)
- Family functioning saw no change for all 21 adults
- Hope improved for 57% of adults (12/21)

Statistical analysis of the adult group found statistically significant improvement (with large effect sizes) on all scales except family functioning.

For children, the data show fewer instances of improvement. Quality-of-life, physical health and hope improved for 25% of children. Overall health improved for 50%. On all other areas there appears to be either no change or some deterioration. However, for children, quality of life, overall health, self-esteem and wellbeing were relatively high at pre-intervention and so there was not much room for improvement, especially in self-esteem and wellbeing.

Spidergrams are not validated measures of wellbeing outcomes but qualitatively, where available, these show improvements in child and adult mental health as well as youth wellbeing. In domestic abuse, drug and alcohol and education average change is fairly low and data indicates some individuals were scoring worse at closure than at the beginning on certain items. This may not necessarily reflect deterioration as it could also reflect that domestic abuse, substance abuse and education struggles are more challenging issues and that when clients self-report lower scores post intervention this may reflect their growing awareness of their difficulties and better ability to recognise problems – which is necessary for longer term change.

Referrals and support

As of December 2025, the MDT received 106 referrals involving 240 children. Of the 106 referrals, 86 were accepted into the MDT service (involving 206 children); 9 were not accepted owing to not meeting the MDT referral criteria and the remaining 11 were awaiting referral consultation.

Of these 206 children:

- Children's ages ranged from 0-18 (average age 7.2 years).
- 98 children's cases are closed (involving 46 families)

- Of the 98 children's cases, 24 were closed within 6 months and 56 were closed within 6-12 months and 18 were closed within 12-18 months

As of December 2025, the MDT has provided sessions to 178 children. The number of sessions per child ranges from 1-124 (average 32.7 sessions per child).

- Drugs and alcohol represent the largest area of work (20% of sessions)
- Education represents 19% of sessions
- Children's mental health represents 16% of sessions
- Domestic abuse prevention represents 13% of sessions
- Domestic abuse support represents 12% of sessions
- Adult mental health represents 12% of sessions
- Youth work represents 11% of sessions
- Housing and benefits support represents 11% of sessions

Educational profiles

Of the 206 children the MDT has worked with to date, 185 were identified in education system records through their Unique Pupil Number (UPN). Of the 185 children:

- 17.3% are recorded as having a Special Education Need; this is higher than the national rate of 14.2% of pupils
- 68% are recorded as having persistent absenteeism; this is very high compared to the national rate of 18.4%

Professional and parent perspectives

Twenty professionals completed the professionals survey. From these responses, professionals expressed an overwhelmingly positive view of the MDT, which can be summed up in the following quote:

"*It has been a truly incredible service to work with and I can't imagine working without them now. They have changed the way we work; and the opportunities families receive which I think is the most important thing. Many services give up on families due to non-engagement. However, MDT staff continue to provide support through periods of non-engagement and don't give up on our families which is what they need.*"

Interviews were also completed with fifteen parents and eleven social care professionals working alongside the MDT.

Themes generated from parent interviews were:

- **'My MDT Team': ownership, personalisation and the benefits of direct support**. This reflected parents' sense that social workers primarily serve the needs of their children, whereas members of the MDT have a remit to provide them with direct support. This focus on their needs restored some of their faith in the social care system, which had beneficial consequences for mental health in terms of feeling 'more human' and reduced dosages of prescribed medication.

- **Creating safer and transformative conditions for children**. This theme concerned the sense that MDT support for parents created more favourable conditions for children. Perceived benefits included increased school attendance and safer living conditions.
- **Staffing gaps and waiting for assistance**. Staffing gaps in the MDT (specifically the Housing and Benefits worker) caused some uncertainty amongst parents who had started receiving advice in particular areas.
- **The MDT as an alternative lens for making sense of context and self**. Parents found that MDT professionals could offer a more complex and sympathetic perspective of underlying issues and challenges they were navigating. This could be transformative for parents expecting to be vilified by social care professionals.
- **Desire for long-term communication with the MDT.** Parents expressed disappointment about MDT support coming to an end and were often hopeful that they could receive MDT support again, if required.

Themes generated from professional interviews were:

- **Direct support and empowering parents**. This direct support for parents was felt to be critical for increasing parental engagement with other services and the proactive approach taken by MDT specialists was felt to be key to enabling parents to navigate services and take positive steps forward.
- **Timing of support and slowing escalation to legal proceedings**. It was felt that the MDT work led to delaying and in some cases preventing the escalation to legal proceedings. This meant parents had the opportunity to make more meaningful changes in their situations before decisions were taken.
- **Trusted disclosures: 'They're not social workers'**. MDT staff were able to maintain a higher level of confidentiality around parent disclosures than social workers, which was widely believed to support relational practice with positive impact on parent engagement.
- **Instant on-site CPD for social workers**. Working in the same space, social care professionals welcomed the support and continuous learning that they could instantly receive from MDT colleagues.

Estimated cost savings

All of the savings estimated below should be treated with caution as there are many unknown variables and any savings would need to be offset against the cost of running the MDT service over a period of two years (which is the period over which the evaluation was carried out).

Estimated annual savings from stepping down safeguarding status and avoiding potential care costs is £581,224. This is a cautious estimation because it is based on comparison with the proportion of cases that are stepped down in standard Children's Social Care services between referral and case closure. Figures showing changes in safeguarding status in the MDT service indicate that children were often escalated shortly after entering the MDT, meaning the true risk level at referral may have been higher than that reflected in the safeguarding status recorded at referral. Cost savings estimates may be higher if we were to consider changes in relation to the highest level of risk at any point during the MDT intervention, rather than only the safeguarding status recorded at referral. Estimates do not take account the varying ages of children when they may have been taken into care

and does not take into account potential longer-term savings relating to children in care being more likely to become young adults “not in education, employment or training”.

Based on estimates of time saved for social care professionals, the MDT is estimated to have generated potential savings of £1,422,096 per year in social worker time.

Cautious estimations of savings to other services made from provision of MDT emergency sessions total £588,307 over the course of the MDT service to date. Examples include preventing adult or CAMHS crisis team use, domestic violence police responses, exclusion from school, drug offences court events, homelessness interventions or police arrests.

Background

In February 2021, a 'Multi-Disciplinary Team' (MDT) pilot launched in Tendring with the objective of preventing children from going into care. The MDT comprised a team of subject matter experts from various disciplines and was introduced within the existing Children & Families infrastructure to support existing frontline teams working with complex families. A previous University of Essex evaluation of an MDT pilot (November 2022) found this to be successful for many of the families that engaged. Amongst a wide range of benefits reported, fourteen children avoided care and one child returned home from care because of MDT involvement. The evaluation recommended expanding the MDT to cover further areas in the Local Authority due to the benefits that could be realised for vulnerable children and their families.

Subsequently, in February 2024, a pilot of the MDT was initiated in the south of the county, with a focus on a borough and a town with relatively high levels of deprivation and disadvantaged households, complex family dynamics for children open to Children's Social Care (CSC) and poorer education outcomes and aspirations. For example, based on ONS census data, in the borough, the proportion of the population in social housing is significantly higher than the county overall (21.2% versus 14.1%); 13.2% of the population is under 10 years old (compared to 11.4% in the county overall). In the town, 62.6% of the households are deprived in at least one dimension compared to 50.8% in the county overall; while 44.4% are economically inactive compared to 38.7% in the county.

The overall aims of the pilot are to:

- Reduce the number of children coming into care;
- Reduce the safeguarding level for children;
- Reduce the re-referrals into children's social care and reduce the number of children having subsequent Child Protection plans;
- Increase the number of families engaging with services;
- Improve the outcomes for the most disadvantaged children in the identified areas;
- Improve the outcomes for families;
- Improve parental risk factors including substance misuse, domestic abuse, alcohol use, stability, mental health.

The MDT team currently comprises of the following staff members. The Targeted Youth Adviser role is currently vacant.

- MDT South Team Manager
- Business Support
- Targeted Youth Worker (vacant)
- Drug & Alcohol Worker (x 2)
- Adult Mental Health Worker
- Children's Mental Health Worker
- Domestic Abuse Prevention Worker
- Domestic Abuse Support Worker
- Education Inclusion Worker
- Housing & Benefits Support Worker (secondment)

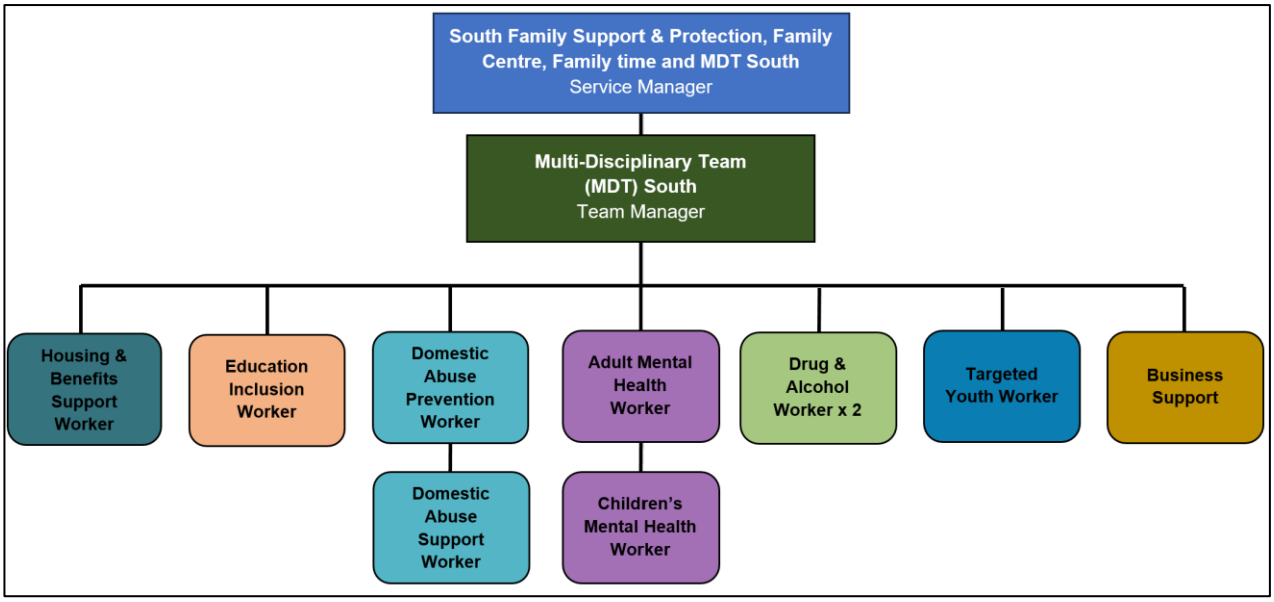

Figure 1: MDT Team Structure

The University of Essex was commissioned by a local authority in the East of England to evaluate an 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 findings from the two year evaluation period (February 2024 to December 2025).

Evaluation methodology

This evaluation uses a mixed methods approach and draws on several different sources of data to assess the MDT pilot. This interim evaluation draws on the MDT's own service data, qualitative data and parent or child reported questionnaire data.

MDT service data

To assess the outcomes of the MDT, the evaluation draws on MDT service data. The MDT regularly collects service-related data at referral and case closure on families and children. Data include information on referral pathways, age, safeguarding status and support received. In addition, the MDT service collects spidergraph data on individual cases which represent client outcomes in relation to drugs and alcohol, domestic abuse and mental health. These are bespoke measures adapted by the service, similar to the "Outcomes Star" assessment tools. These bespoke tools are not based on psychometric approaches to outcomes measurement and so are used as a basis for visualisation of case outcomes rather than statistical analysis. Some information from education datasets (special educational needs and absenteeism) were available where children could be matched by Unique Pupil Identifiers.

This report summarises referral, safeguarding and signposting data collected on families referred to the MDT between February 2024 and December 2025.

Parent and child questionnaires

The evaluation uses data collected from online questionnaires completed by parents and children both early on in their engagement with the MDT (within the first 2 months) and at closure (with an average intervention period of 4-9 months). The self-reported questionnaires measure overall quality-of-life, overall health, self-esteem, physical health, wellbeing, family functioning and hope. These were measured using questions and scales taken from standardised questionnaires used widely in health and psychological research.

Overall quality-of life was measured with a single item question used in the WHOQOL-BREF (WHO, 2004). The question asks, “How would you rate your quality-of life?” and is rated on a scale of 1-5 where 1 is “very poor” and 5 is “very good”.

Overall health was measured with a single item question used in the WHOQOL-BREF. The question asks, “How satisfied are you with your health?” and is rated on a scale of 1-5 where 1 is “very dissatisfied” and 5 is “very satisfied”.

Self-esteem was measured using the Rosenberg Self Esteem Scale (Rosenberg, 1965), a widely used measure of self-esteem. There are 10 statements all rated on a 3-point scale where 0 is “strongly disagree” and 3 is “strongly agree”. An example question is “I feel that I have a number of good qualities”.

Physical health was measured using 6 questions taken from the WHOQOL-BREF “Physical health” scale. The questions cover activities of daily living, dependence on medicines, energy and fatigue, pain and discomfort, sleep and rest, capacity for work.

Wellbeing was measured using the standard WHO 5-item Wellbeing Index (WHO, 2024) which has 5 statements about wellbeing, each rated from 0 to 5 where 0 means “never” and 5 means “all the time”. An example statement is “I have felt cheerful and in good spirits”.

Family functioning was measured using questions derived from existing measures of family functioning including all 3 questions in the Brief Assessment of Family Functioning scale (Mansfield et al, 2019) plus 2 additional bespoke questions. Each statement is rated on a 4-point scale from strong agreement to strong disagreement. A higher score indicates worse functioning. An example statement is “We don’t get along well together”.

Hope was measured using an adult scale and a children’s scale. The adult scale used 10 statements taken from the Adult Hope Scale (Snyder et al, 1991). Each statement is rated on a scale from 1-8 where 1 is definitely false and 8 is definitely true. An example statement is “There are lots of ways around any problem”. Children’s hope was measured using the standard Children’s Hope Scale (Snyder, 1997) which has 6 statements like “I can think of many ways in life to get the things that are most important to me”. The statements are rated on a scale of 1 to 6 where 1 means “none of the time” and 6 means “All of the time”.

Qualitative research

The qualitative research involved in-depth interviews with eleven social care professionals and fifteen parents (including two couples). Social care professionals interviewed included social workers, senior practitioners, child protection chairs and team managers.

The MDT team manager put out expressions of interest for interviews and the details of those expressing interest in being interviewed were passed onto the research team. After obtaining consent to participate, 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 Professionals
To supplement the interview findings, an online survey was used to capture the views and experience of a wider range of professionals working with the MDT. The survey was distributed by MDT staff to the wider network of professionals involved in the care of MDT clients. The survey asked professionals about the impact of the MDT on client health, wellbeing and family relationships. Professionals were also asked about whether the MDT impacted on their own workload and working relationships with those clients. The survey also asked about the level of communication and service provided by the MDT; quality of advice and support received and any suggestions for improvement. The survey included a mixture of closed and open response questions and the responses were collated and summarised. Twenty professionals completed the survey.

Methodological considerations
Numbers of children completing questionnaires both pre and post interaction with the MDT were low reflecting practical challenges gaining consent and having children complete the surveys. As with any questionnaire completion exercise, responses are self-selecting meaning there is a risk of response bias. Response bias was addressed by triangulating service data, questionnaires and qualitative responses.

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

Referrals and MDT Support

Referrals

As of December 2025, the MDT received 106 referrals involving 240 children. Of the 106 referrals:

- 86 were accepted into the MDT service (involving 206 children).
- 9 referrals were not accepted owing to not meeting MDT referral criteria
- 11 are awaiting referral consultation

The majority of referrals (78%) are from Family Support & Protection teams; 15% are from Assessment & Intervention teams; 4% from Children in Care teams and 3% from Children with disabilities.

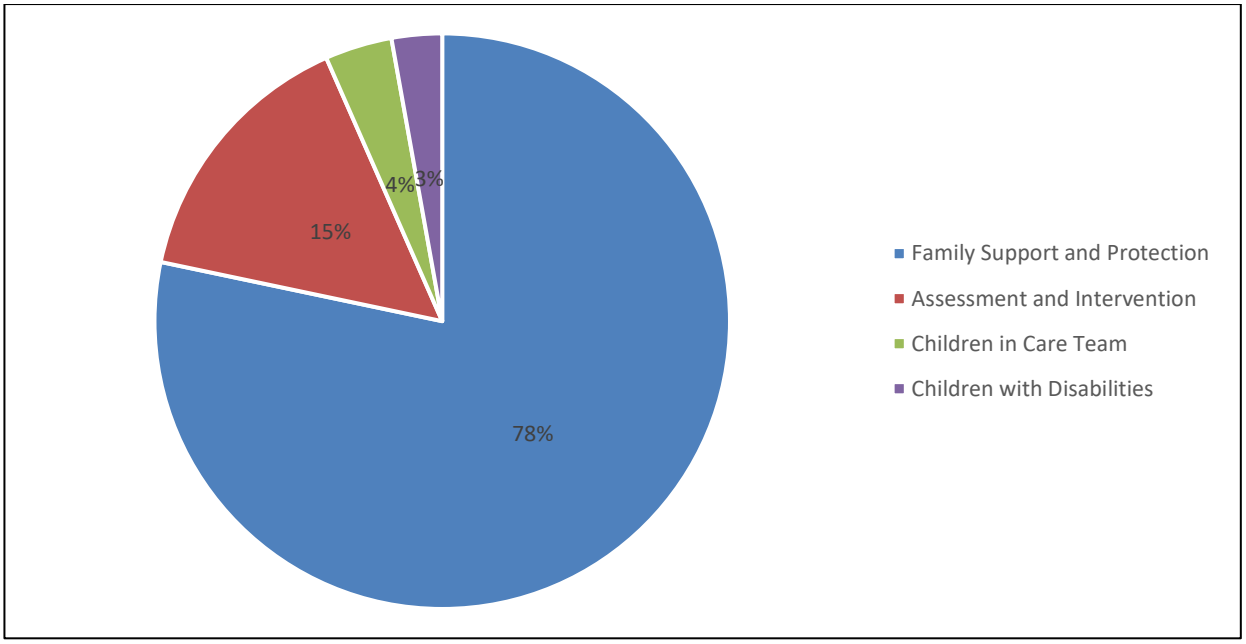

Figure 2: Referral Sources

MDT Support

As of December 2025, the MDT has worked with families involving 206 children with children's age ranging from 0-18 (average age 7.2 years).

- 98 children's cases are closed (involving 46 families)
- Of the 98 children's cases, 24 were closed within 6 months and 56 were closed within 6-12 months and 18 were closed within 12-18 months

As of December 2025, the MDT has provided sessions to 178 children. The number of sessions per child ranges from 1-124 (average 32.7 sessions per child). Table 2 shows the number of sessions provided in each area of support as well as how many of these were emergency sessions and how many of these led to signposting to other agencies.

Figure 3 shows the proportion of sessions by content area. Drugs and alcohol represent the largest area of work (20% of sessions), which may be a result of there being 2 staff members covering this area. The next most common intervention is education (19%), children's mental health (16%), domestic abuse prevention (13%), and domestic abuse support (12%) and adult mental health (12%). Youth work and housing and benefits support represents 11% each of session work.

Table 1: Number of sessions by content

Content of session	Number of non-emergency sessions	Number of emergency sessions	External signposting agency	Number of signposts
Adult Mental Health	594	58	Community D&A Service	20
			Counselling/Therapy	56
			Other*	103
			Supported accommodation	3
Children's Mental Health	904	20	Community D&A Service	2
			Counselling/Therapy	1
			Other*	7
Domestic Abuse Prevention	772	4	Advocacy	1
			Community DA Victims Service	6
			Community D&A Service	6
			Counselling/Therapy	7
			Other*	21
Domestic Abuse Support	647	15	Community DA Victims Service	38
			Other*	10
Drugs and Alcohol	1023	61	Community D&A Service	37
			Counselling/Therapy	2
			Other*	19
			Rehabilitation	2
Education	1067	25	Counselling/Therapy	1
			Employability Support	11
			Mentoring	6
			Other	2
			Post-16 Training provider	8
Housing and Benefits	225	13	Other	22
Professional Consultation	7	1		0
Youth Work	234	8	Counselling	2
			Mentoring	1
Total	**5473**	**205**		**394**

* “Other” is mostly referrals to GPs and other health care professionals

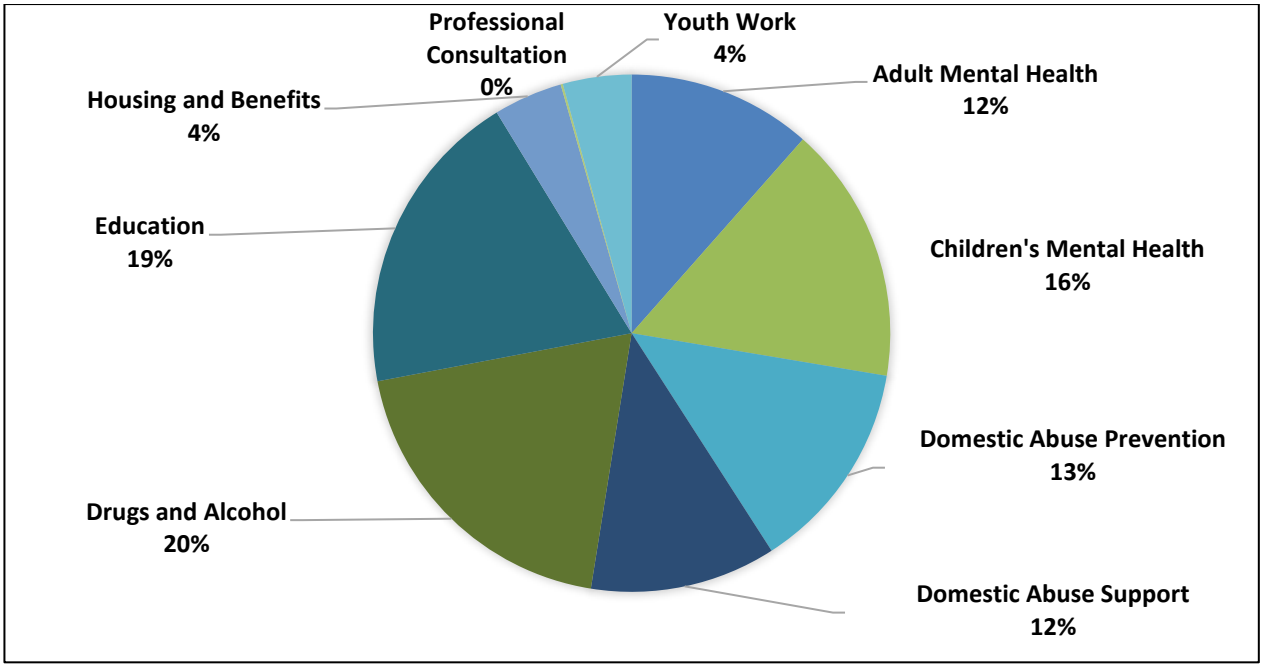

Figure 3: Individual session content (total non-emergency and emergency)

Educational profile of MDT cohort

Of the 206 children the MDT has worked with to date, 185 were identified in education system records through their Unique Pupil Number (UPN).

Of the 185 children, Table 2 shows the percent with special educational needs and Table 3 shows percent of children recorded as having persistent absences. Special education needs in the cohort is slightly higher than the national rate of 14.2% of pupils. Persistent absenteeism in the cohort is very high compared to the national rate of 18.4%.

Table 2: Special educational needs

Special educational need	Percent
Autism Spectrum Disorder	1.08%
Moderate learning difficulties	4.32%
Social emotional mental health	5.41%
Speech language and communication needs	3.24%
Specific Learning Disorder	2.16%
Specific Learning Difficulty	1.08%
Total	17.3%

Table 3: Persistent absentees

	Number	Percent	Missing data
Persistent absentees 2023/4	63/91	69%	94
Persistent absentees 2024/5	67/98	68%	87

Safeguarding Outcomes

Safeguarding status at referral, during intervention and at closure is available for closed cases. Safeguarding status at referral for the 98 closed cases was as follows:

- 3 were Children in Care (CIC)
- 1 was on PLO
- 56 were on Child Protection Plans (CPP)
- 38 were Children in Need (CIN)

Figure 4 shows changes to safeguarding status for the 98 children while they were working with the MDT (during the intervention). Overall 21 cases (21.4%) escalated during engagement with the MDT, indicating the high level of risk among the cases taken into the MDT service. During the course of the MDT intervention 19 cases (19.4%) were de-escalated to CIN while all other cases remained at the same level.

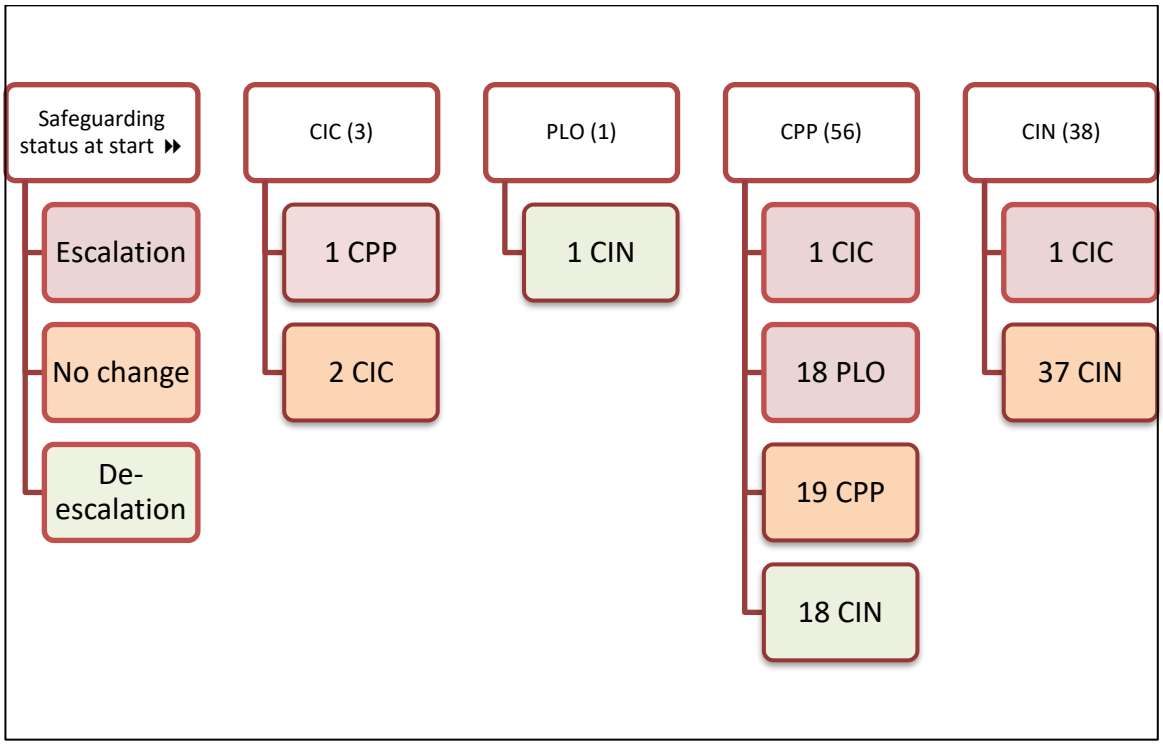

Figure 4: Safeguarding status changes during MDT intervention (closed cases)

Figure 5 shows changes to safeguarding status for the 98 closed cases between referral and case closure. By the time of case closure, 62 cases (63%) were stepped down to a lower status such as Child in Need (CIN) status; or Closed to Social Care (CSC); while 17 (17.3%) were escalated and 19 (19.3%) stayed the same.

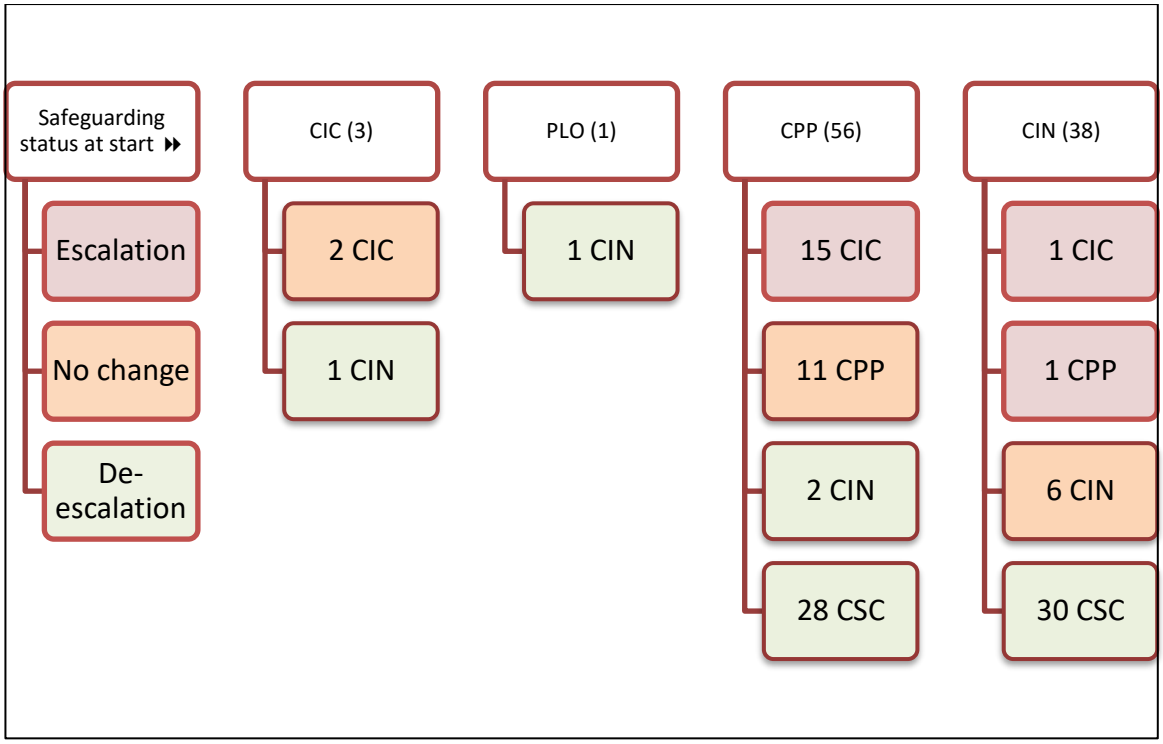

Figure 5: Safeguarding status changes from MDT start to MDT case closure

Figure 6 shows changes to safeguarding status for the 86 cases which remain open at December 2025. Changes reflect changes that have occurred to date during the course of the MDT intervention. So far, of currently open cases, 16 cases (18.6%) have been stepped down to Child in Need (CIN) status; 21 (24.4%) have escalated; 50 (58.1%) have stayed the same.

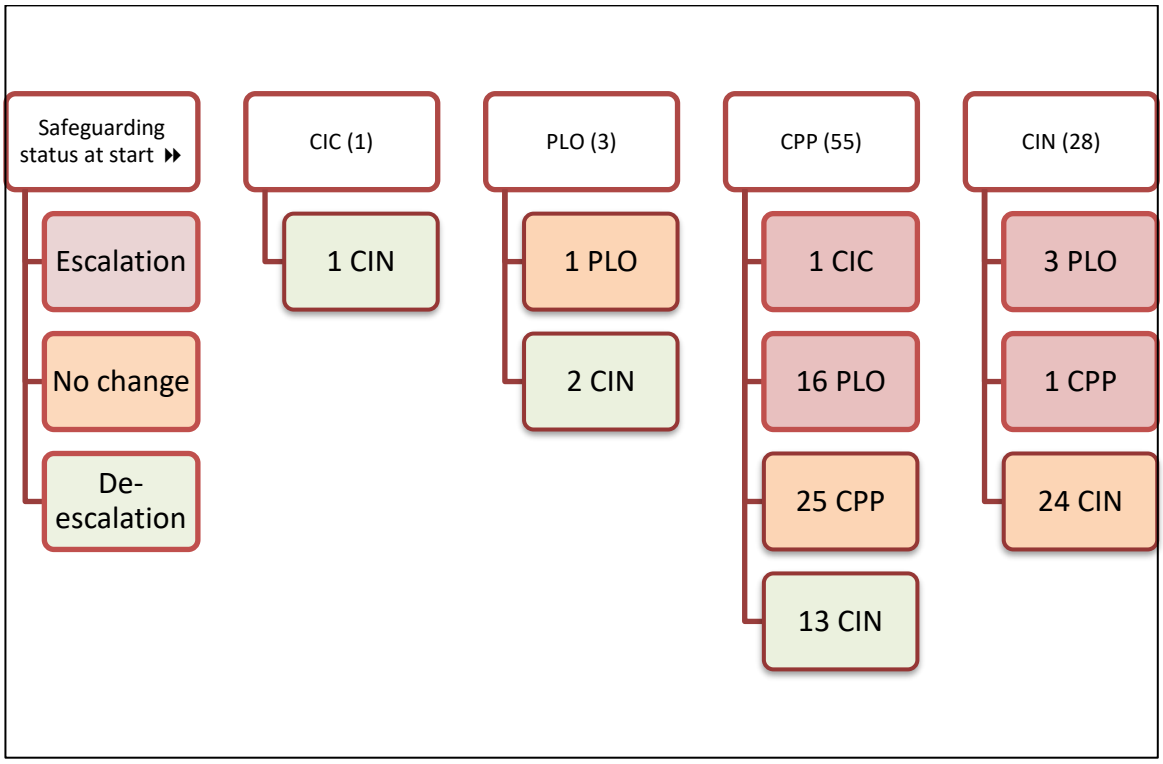

Figure 6: Safeguarding status changes for open cases

Parent and Child Wellbeing Outcomes

Self-report questionnaires

Parents and children were invited to complete online questionnaires at the start of their engagement with the MDT and at a later follow-up point. Data have been included where the parent or child completed the questionnaire at the start of their engagement and at a follow-up point. Those who did not complete the questionnaire pre-intervention and post-intervention were not included. Findings reported are for 21 adults and 4 children (Tables 5 and Table 6). Of the 21 adults completing pre- and post- questionnaires 52% were female; ages ranged from 23 to 50; 5% had a university or professional qualification; 62% were single or separated. Of the four children there were 2 males and 2 females; ages ranged from 10-15.

Statistical analysis of group level change

Table 4 below shows findings from statistical analysis of the group of 21 adults pre and post questionnaires. This shows that all measures except family functioning show a statistically significant improvement. Where there is statistically significant improvement, the effect sizes (the size of the change) are large. Because the amount of time adults were engaged with the MDT between pre and post questionnaires varied from 1.3 to 12.9 months, analysis was undertaken to find the statistical association between the change on each measure against the amount of time engaged (in months). The findings show that for most measures, the change between pre and post intervention was not significantly associated with amount of time engaged. Change in overall health was moderately associated with months engaged; change in physical health had a large association with amount of time engaged. Both these scales relate to physical health which are not the primary target of the MDT intervention and therefore may be expected to take longer to change (perhaps as secondary outcomes following changes in the other areas of wellbeing measures).

Table 4: Adult self-report change statistics

	Pre-post change Z score[a]	Effect size [b]	Change score vs months engaged with MDT
Overall quality of life	-3.246	1.16 (large)	Not significant
Overall health	-2.696	0.90 (large)	0.48 (medium)
Self Esteem	-3.486	4.76 (large)	Not significant
Wellbeing	-3.495	1.19 (large)	Not significant
Physical health	-2.882	0.82 (large)	0.67 (large)
Family functioning	-0.265	0.34 (small)	Not significant
Hope	-3.249	1.55 (large)	Not significant

[a]Wilcoxon signed ranks test – shaded cells are statistically significant P<0.001
[b]Hedges' g

Analysis of individual change

It was not possible to carry out statistical analysis of the child pre and post questionnaires. However, analysis of individual change was undertaken for both the adults and children who completed pre and post questionnaires (Table 5).

Findings of individual change analysis indicate that at pre-intervention for adults, overall quality-of-life, physical health and overall health are on average in the moderate range (3.1, 3.0 and 3.1 out of 5 respectively). Wellbeing is on average poor (2.0 out of 5). Self-esteem is on average moderate (16.1 out of 30). Family functioning was on average moderate (2.4 out of 4 where higher scores indicate more distress). Average hope for adults was 5.1 out of 8.

For children pre-intervention (or early engagement) overall quality-of-life, physical health and overall health are on average in the moderate range (3.5, 3.5 and 2.9 out of 5 respectively). Wellbeing is on average good (4.0 out of 5). Self-esteem is on average good (18.9 out of 30). Family functioning was on average moderate (2.2 out of 4 where higher scores indicate more distress). Average hope for children was fairly low (2.65 out of 6).

Change at post-intervention is taken as an increase or decrease of at least 1 scale point with the exception of self-esteem where it was possible to calculate “statistically reliable” change. This means that this change is not due to chance or measurement error. This calculation is possible for self-esteem because the scale has published psychometric properties required to calculate statistical change.

The post-intervention scores indicate that quality-of-life improved for 62% of adults (16/21). Overall health improved for 57% (12/21) with 10% (2/21) deteriorating. Self-esteem improved for 45% of adults (9/21). This change was “statistically reliable” meaning that this change is not due to chance or measurement error. Physical health improved for 33% of adults (7/21) with most seeing no change. Wellbeing improved for 67% of adults (14/21) with 5% deteriorating. Family functioning saw no change for all 21 adults. Hope improved for 57% of adults (12/21) with 5% deteriorating.

For children, the data show much fewer instances of improvement. Quality-of-life, physical health and hope improved for 25% of children. Overall health improved for 50%. On all other areas there is mostly either ‘no change’ or some deterioration. However, it is important to note that for children, quality of life, overall health, self-esteem and wellbeing scores were relatively good at the beginning of the intervention and so there is not much room for improvement, especially in self-esteem and wellbeing.

Table 5: Parent wellbeing outcomes

Adult	Overall Quality of Life		Overall Health		Self Esteem		Wellbeing Scale		Physical Health scale		Family Functioning Scale		Hope Scale		Months
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	
A	4.0	4.0	4.0	3.0	20.00	19.00	3.40	3.40	4.33	4.17	2.20	2.20	7.57	7.14	1.3
B	2.0	4.0	2.0	3.0	6.00	13.00	1.00	2.00	2.00	2.00	2.40	2.80	4.00	4.57	1.7
C	3.0	3.0	2.0	2.0	12.00	20.00	1.00	2.60	2.00	2.50	2.60	2.80	2.86	6.57	2.3
D	4.0	4.0	4.0	4.0	28.00	30.00	2.40	4.00	4.83	4.83	2.60	2.20	7.43	7.43	2.7
E	4.0	5.0	4.0	4.0	30.00	30.00	3.40	3.60	4.50	4.33	2.20	2.20	7.29	7.86	3.9
F	3.0	4.0	3.0	4.0	12.00	20.00	1.60	4.00	2.67	4.17	2.60	2.60	5.29	6.57	4.0
G	2.0	4.0	1.0	3.0	1.00	8.00	0.70	1.50	1.83	2.33	2.60	2.60	3.86	5.29	4.1
H	4.0	4.0	4.0	4.0	16.00	20.00	2.60	3.60	2.67	3.83	2.20	2.60	2.14	6.00	4.3
I	2.0	5.0	3.0	4.0	17.00	23.00	0.90	2.90	3.33	3.67	2.60	2.40	5.43	6.86	4.3
J	4.0	5.0	4.0	5.0	24.00	20.00	1.70	2.80	4.17	3.33	2.60	2.40	6.43	6.29	4.4
K	5.0	5.0	4.0	5.0	19.00	27.00	3.20	4.20	4.17	4.83	2.60	2.00	7.00	7.43	4.4
L	1.0	5.0	1.0	1.0	15.00	26.00	0.80	5.00	1.33	2.17	2.40	2.20	3.71	7.71	4.9
M	3.0	3.0	1.0	2.0	15.00	16.00	2.00	2.80	2.83	2.83	2.60	2.40	2.86	4.43	5.2
N	5.0	5.0	5.0	5.0	18.00	24.00	4.80	4.40	4.67	4.83	2.00	2.40	5.00	7.43	5.3
O	3.0	3.0	4.0	3.0	17.00	21.00	3.00	2.00	3.67	3.50	2.40	2.40	6.14	6.29	5.7
P	3.0	4.0	3.0	4.0	16.00	19.00	1.50	1.40	3.17	3.33	3.20	2.40	7.00	5.86	7.8
Q	4.0	5.0	5.0	5.0	30.00	30.00	2.40	4.60	3.00	5.00	2.20	2.00	7.57	7.29	9.7
R	2.0	3.0	2.0	3.0	13.00	16.00	2.00	3.20	2.83	3.83	2.40	2.80	2.00	4.86	10.8
S	3.0	5.0	3.0	4.0	11.00	24.00	2.00	4.00	3.00	4.67	2.20	2.40	6.00	7.00	10.9
T	3.0	4.0	3.0	5.0	12.00	21.00	1.80	3.60	3.17	4.33	2.20	2.40	3.14	5.86	12.5
U	2.0	4.0	2.0	4.0	6.00	19.00	0.60	2.70	1.67	3.83	2.40	2.20	5.14	7.00	12.9
Mean	3.1	4.2	3.0	3.7	16.1	21.2	2.0	3.3	3.1	3.7	2.4	2.4	5.1	6.5	5.9
	1= very poor		*1 = very dissatisfied*		*0-14 = low self esteem*		*0= worst possible wellbeing*		*1= very poor physical health*		*0-2= satisfactory functioning*		*0=not hopeful at all*		
	5 = very good		*5 = very satisfied*		*15-25 = normal range*		*5 = best possible wellbeing*		*5= very good physical health*		*2-4 = distress*		*8 = extremely hopeful*		

Statistically reliable improvement

Improvement (+1 scale point or more)

No statistical change (self esteem) or <1 scale point change

Deterioration (-1 scale point or more)

Table 6: Child wellbeing outcomes

Adult	**Overall Quality of Life**		**Overall Health**		**Self Esteem**		**Wellbeing Scale**		**Physical Health scale**		**Family Functioning Scale**		**Hope Scale**		**Months**
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	
a	3.0	3.0	3.0	4.0	14.50	18.50	4.00	3.17	2.80	2.00	2.40	2.10	2.25	1.83	1.6
b	3.0	4.0	3.0	3.0	15.00	8.00	3.67	3.50	2.40	1.80	2.40	2.40	2.83	1.83	4.0
c	4.0	4.0	5.0	4.0	28.00	19.00	4.33	3.83	3.60	2.60	1.80	2.60	3.50	2.00	7.8
d	4.0	4.0	3.0	4.0	18.00	21.00	4.00	3.83	2.60	3.80	2.20	2.40	2.00	2.67	2.6
Mean	3.5		3.5		18.9		4.0		2.9		2.2		2.65		
	1= very poor		*1 = very dissatisfied*		*0-14 = low self esteem*		*0= worst possible wellbeing*		*1= very poor physical health*		*0-2= satisfactory functioning*		*0=not hopeful at all*		
	5 = very good		*5 = very satisfied*		*15-25 = normal range*		*5 = best possible wellbeing*		*5= very good physical health*		*2-4 = distress*		*6 = extremely hopeful*		

Statistically reliable improvement

Improvement (+1 scale point or more)

No statistical change (self esteem) or <1 scale point change

Deterioration (-1 scale point or more

Spidergrams

Spidergrams are used in the MDT by practitioners to collect client-reported assessments of wellbeing in various domains during session time. These are bespoke tools which can be used to visualise change on an individual level based on individual's subjective assessment of their wellbeing in a particular area but are not validated or reliable scales. Where spidergrams had complete pre and post data, mean change scores have been calculated for each item. Each domain usually has a maximum score of 10, although some went up to 12 (domestic abuse support) and 14 (drug and alcohol support). Table 7 and Table 8 below show average change scores on each item within each domain along with the minimum and maximum change and the number of adults completing each item. The area of greatest improvement is in housing and benefits support showing an average improvement of 3.17 scale points although these were only completed by 2 people. Child mental health shows an average improvement of 2.51 scale points, adult mental health 2.44 scale points and youth work 2.16 scale points. In domestic abuse, drug and alcohol and education, average change is less than 1 scale point with large ranges indicating high individual variation and several individuals experiencing deterioration.

Table 7: Pre-post changes on spidergram scales

	Mean change score	Minimum Change	Maximum Change	Number completing pre and post scale
Adult mental health	**2.44**	**-1**	**8**	
Anxiety / Worry	4.00	0	8	25
Attachment Support	2.60	1	4	5
Diagnosis	2.38	0	7	24
Happiness	2.56	0	5	25
Mood	2.48	1	5	25
Relationships	1.79	-1	8	24
Safety	2.00	1	3	5
Self-Esteem	3.16	1	5	25
Work, Education & Training	1.00	0	4	24
Child mental health	**2.51**	**-5**	**10**	
Anxiety / Worry	2.33	-5	7	9
Attachment Support	5.83	2	10	6
Happiness	2.29	0	7	7
Mood	2.40	-2	7	5
Relationships	3.50	0	8	6
Safety	-0.33	-1	0	3
Self-Esteem	1.50	-2	8	4
Work, Education & Training	2.60	0	7	5
Domestic abuse support	**1.05**	**-11**	**12**	
Children's Wellbeing	0.32	-10	9	44
Finances	0.55	-7	4	44
Housing	0.98	-9	5	44
Mental / Emotional Wellbeing	1.23	-4	6	44
Physical Health	0.32	-7	6	44
Safety	1.13	-11	9	48
Self Esteem	2.66	-2	12	44
Support Networks	0.89	-7	5	44
Work, Education & Training	1.39	-9	10	44

Table 8: Pre-post changes on spidergram scales

	Mean change score	Minimum Change	Maximum Change	Number completing pre and post scale
Drug and alcohol support	**0.85**	**-10**	**14**	
Confidence	0.37	-10	7	35
Coping Skills	1.41	-6	8	32
Finances	2.31	-4	14	35
Future Preparation	0.88	-10	9	34
Happiness	-0.53	-10	9	32
Mental and Emotional Wellbeing	1.68	-4	8	34
Overall Quality of Life	0.57	-10	8	35
Physical Health	-0.46	-10	9	35
Relationships	2.13	-7	6	31
Support Network	0.13	-10	8	32
Education	**0.62**	**-8**	**5**	
Aspirations	0.60	-3	5	5
Attendance	1.67	-3	4	6
Confidence	-1.17	-8	3	6
Encouragement at Home/School	1.50	0	3	6
Equipment	0.17	-1	2	6
Feelings about school	1.00	0	4	6
Friendships in school	0.00	-6	4	6
Learning	0.67	-1	2	6
Relationships	1.17	-1	3	6
Housing and benefits	**3.17**	**0**	**7**	
Benefits	4.00	4	4	2
Budgeting	1.00	0	2	2
Career prospects	0.00	0	0	2
Confidence & Independence	5.00	4	6	2
Debt management	0.00	0	0	1
Emotional wellbeing	5.00	4	6	2
Finances	4.00	4	4	2
Homelessness	3.00	3	3	1
Housing	6.50	6	7	2
Youth work	**2.16**	**-3**	**9**	
Communication Skills	1.85	-1	6	13
Confidence	2.43	0	8	14
Future Preparation	1.92	-3	9	13
Happiness	2.46	0	6	13
Independence	2.23	0	9	13
Local Participation	2.69	0	8	13
Mental/Emotional Wellbeing	2.15	-1	9	13
Physical Health	1.92	0	8	13
Relationships	1.77	-1	9	13

Parent interviews

Analysis of semi-structured interviews with fifteen service users, eleven who were mothers and four who were fathers (including two couples interviewed together), generated five over-arching themes central to the impact that the introduction of the Multi-Disciplinary Team (MDT) had upon their everyday family lives.

The themes are:

- ‘My MDT Team’: ownership, personalisation and the benefits of direct support
- Creating safer and transformative conditions for children
- Staffing gaps and waiting for assistance
- The MDT as an alternative lens for making sense of context and self
- Desire for long-term communication with the MDT

‘My MDT Team’: ownership, personalisation and the benefits of direct support

The most frequently cited benefit of introducing an MDT service to the south of the county was the sense of ownership cultivated amongst parents, especially in relation to their prior experiences of being in a position to access support only from social workers:

> [I’ve] phoned social services asking for help, ‘No, you don't. We can't do anything to help you’… and I've had that for years. So, I haven't engaged very well at all because I've asked for help, and they don't want to give it. But then it's been quite a turn around this year. Now [MDT professional] phones a doctor and she comes, picks me up and takes me to the doctor… I couldn't get that before; I do now and that that is all I ever needed… just that little bit of extra help… I think, ‘well, thanks [MDT professional]’, I've never got that before. I feel a bit more settled in my head. 'Cos, I suppose they've been the first people I've been able to trust in a long time. (Service User 1)

Central to this sense of ownership, was the constant distinction parents expressed between how a social worker primarily serves the needs of their children, whereas members of the MDT have a remit to provide them with direct support, as parents:

> They [the MDT professionals] more deal with me and not my children… like the MDT are for me. And obviously my children have a social worker, which is for them, but the MDT are purely just for me. Like if there's something going on, then they're honest with me, whereas my social worker don’t tell me things. My MDT team will find out for me. (Service User 1)

Overall, the direct support sought and received by parents restored some of their faith in the social care system, which had beneficial consequences for mental health in terms of feeling ‘more human’ and reduced dosages of prescribed medication:

> It’s got me more confidence… just having someone to talk to. Someone that actually listens. (Service User 2)

> Now I feel a lot better about myself. I'm not getting put down all the time. I'm not getting questioned all the time and things like that and I can go out without anyone nagging me… I feel a lot happier in myself. I've talked to people a bit different than what I used to before… 'cos, [now] I think like the services are there to help you. (Service User 3)

> They've made me feel better… my mental health was really bad, and now it ain’t really anymore. So, I'm on 10 milligrams of this [prescription], which I've never

> been on that lower dose ever in my life. So just having their support and doing everything I'm meant to be doing. It's quite nice, just to be to be more normal, more human. (Service User 1)

For parents who had previously attempted to engage with services and presented with simultaneous substance addiction and mental health needs, the specialist workers of the MDT were able to provide parallel and integrated support with both:

> I think they've helped us in our own way to be able to prove to people that we can change because that's all they want. They (other services) didn't want anything to do with us because of our addiction. That's what the problem was… MDT make you feel like they want to help you. They make you feel like, 'wow, I'm actually gonna get somewhere with this'. (Service Users 5 & 6)

The availability of specialist support through the MDT meant that as and when issues were identified during their time working with the service, parents could access additional personalised support, or at least be referred by the MDT and supported to maintain their engagement:

> The reason that MDTs there is like the fact that it's specified in that with different people for that different thing that you're going through and then people help you get through that. (Service User 9)

Regardless of the extent of engagement parents had with the MDT, just an awareness that the MDT service comprised a range of readily accessible specialist professionals that they could call into action provided a sense of psychological security to parents:

> They're so helpful and they genuinely listen more than what social services do if that make, it probably doesn't make sense… they get to know you more in-depth… overall, they're just so helpful in every aspect. Absolutely every… you need help with housing, you need help with, say, substance misuse. You need help with domestic abuse, that they're all there at hand, ready to help. Instead of having to refer to yourself to this service and refer yourself to that and then waiting for people to get back to you, it's just it's there, ready and waiting to be able to use. (Service User 10)

The personalised and specialist support offered by the education worker, an aspect of the MDT that was not previously available to parents in the form of an equivalent community service in the local area, produced some of the most dramatic and favourable turnarounds in the relationships between parents, schools and children:

> [professional's name redacted] going into negotiations with relationships with the school and even sitting in a meeting, just being able to talk to me and say 'but maybe, you know, I understand your anger but we need to get this done for this reason'… I was waiting for an accident report from the school for nearly two years. Not one social worker could get it. [professional's name redacted] did it within a day. (Service User 4)

Service users persistently pointed out the depth and breadth of the positive impacts working with MDT professionals had upon various aspects of their everyday life and overall

wellbeing. This was in comparison to the indirect support they had previously received from social workers. Parents also elaborated on the favourable consequences MDT support had brought about for their children.

Creating safer and transformative conditions for children

Overall, the increased awareness amongst parents of the impact their own wellbeing could have upon their children was best summed-up by the statement 'if I'm alright, my children are going to be alright' (Service User 3). Through the support the MDT provided, more favourable conditions for children were subsequently created, such as increased school attendance:

> I never used to take [daughter] to school that much either, to start with. Because obviously I didn't want to go out the house. Now, I've taken her to school every day but some days we are late but that's like issues with like alarm clocks and getting up late. She does go near enough every day now. Her attendance is well higher… it used to be like 66%, now it's 89%. (Service User 3)

Within the same family context, the MDT mental health worker gained the trust of the son to the extent that he confided in her, which had proved problematic for previous support workers who had tried to engage with him:

> He [was] like, 'no, I ain't telling you it's none of your business, my business is my business'. But [MDT mental health worker], really… I think he really opened up to her like she used to take him out to the park and figure out… like he opened up to her and she's managed to get him to go to counselling. (Service User 3)

By working with the MDT, parents also seemed to become more cognisant that the current household circumstances their children were living in would likely establish harmful norms for the type of relationships and household circumstances they would encounter as adults. In some cases, this also resulted in changes to the relationships and living conditions of families with the intention that this would benefit the children involved:

> He (partner) has to come and meet me now at where I'm at to be able to continue in a relationship because that type of behaviour I can't have around my son. So I can't have my son growing up thinking it's normal… we both (parents) already grew up in that type of household. So I don't see why he would try and do that with my youngest after already losing [care of] our other children. So he needs to get to my mental wavelength… I don't want [son's name redacted] to be like that. I don't want him thinking he can just do whatever he wants to his wife, and the wife go, 'Oh, yeah, it's alright, you're my husband'. No, I want him to be a good husband. I want him to look after his wife, not just 'Ohh, here's money. Right, See you later. I'm going to the pub'. No, no thank you. (Service User 10)

In situations where it was decided that remaining in the relationship and continuing to live together would be more beneficial for children, but some support with parenting was required, MDT professionals created and delivered bespoke parenting courses for parents:

> The course that she (MDT professional) did is actually designed for foster carers that are taking on challenging children… but she kind of adapted it to me. She's not ever done that before. But I think she did fantastically and it really gives me an insight into my parenting style. And, you know, sometimes why they react that they do, which I didn't understand before…. now I can sort of take a step back and go, 'Right, something's happened and you need to just tell me. Just tell me you're not going to get in trouble and we can talk things through'. Whereas before, I would just be really confused as to why he was kicking off… I'd end up losing my rag, because I was so frustrated (Service Users 7 & 8)

For this family, the parenting course was also accompanied by support with a change in medication dosage for one of the parents which had further benefit for their relationship with their children:

> With the medication I'm taking now, they've tweaked it and moved things back up doses… now I seem to be on a level and so I don't feel the need to lose my temper if the kids make a mess. (Service Users 7 & 8)

In another scenario, MDT workers were instrumental in a family acquiring safer living conditions, which meant parents could remove children from hostile circumstances before then making difficult changes to their permanent household make-up:

> We're in a safe environment now, obviously before we wasn't before, [living] with my elder son and his partner. He moved out, since they've (MDT) been involved… I had to remove him… I needed to flee with the family. But obviously I weren't allowed to take my daughter, and I said, 'look, I can't leave my daughter on her own, she's very vulnerable'. So, I didn't [have to] take that choice, I couldn't, and so they put us in a hotel, three times. (Service User 2)

The housing, benefits and employment adviser went on maternity leave and was not immediately replaced owing to secondment organisation's recruitment challenges. Therefore, the extent to which parents and families could have benefitted from housing support was difficult to substantiate and evaluate.

Staffing gap and waiting for assistance

The gap in housing, benefits and employment guidance that arose when the seconded adviser could not be promptly replaced following a period of planned leave caused some uncertainty amongst parents who had started receiving advice in this area:

> They started helping me. And then, because she was pregnant, and she had to leave. Well, where was the rest of the help? Now that I haven't sorted out my debts properly?... Nothing was done… the housing, the money adviser thing. Like it started, and then it just stopped. They should make sure they've got someone there… they could have got someone else to step in and take over. (Service User 3)

Some parents were also unaware that the MDT could support with housing issues,

> That's the only thing that they can't help with... I think it would be helpful if the MDT team could help with things like housing, give advice on what to do. Obviously they couldn't help us with those kind of things. (Service Users 7 & 8).

The MDT as an alternative lens for making sense of context and self

Whilst supporting families, MDT practitioners were sometimes able to offer a more sophisticated and contrasting perspective of the underlying issues being navigated by families than had previously been understood by social care professionals and the wider system:

> The most helpful thing they've done was that meeting when they spoke up for me that I, I'll be honest, I went home and cried. Because that was the greatest news I've had in so such a long time. Right now my kids are one step closer to the staying with me. They're not getting taken… no-one else wanted to speak first, they just jumped straight in. Like, 'no, I don't think they need to be on this. They're not them kind of people. We want to bring them down, we're not going to know if we don't give them a chance. Let's give them a chance', it's that simple. (Service User 11)

The alternative lens of the MDT was especially transformative for a father who frequently feared for the safety of his children due to his partner's alcohol addiction, but was often labelled as a perpetrator when actions he took to protect his children were used to accuse him of controlling behaviour:

> All the services we were involved with were so far from us that they didn't really realise the extent to which things were getting bad in the family… So it's (MDT) made this open-up to what was actually going on, which seemed to be hidden… [partner's name redacted] will be in a drunken state and she'll make comments like I'm stopping her to drive the car and the police will come and as a result of that, they said I'm controlling her, so arrest me as a result. So I felt a bit alone. I had gone to the point I complained to the police. I complained with written letters to the Member of Parliament. I wasn't having any traction from them, so having someone that I could engage with just gave me another avenue to to be able to, you know, talk about things and about how things are impacting me. (Service User 15)

The opportunity for both parents of a family to work with MDT professionals on their parenting and their relationship in an in-depth way and over an extended period of time, meant that parents also developed a more complex and appreciative understanding of each other:

> I understand some people just can't cope the way others do. Everyone has different coping strategies and it might not be normal to me but what I do might not be normal to her. So I've learned to understand differences... they're helping us bring it all together, and they've done a great job with that. They really have because she's starting to understand me. I've been understanding her, understand why she's a bit lenient on some things, and then she understands why I'm a bit stricter on other things. (Service User 11)

For some parents, the realisation of what was happening in their relationship through working with MDT professionals informed their decision to leave the relationship to benefit their self-worth:

> They helped me be able to stay on track, realise what he has done and what he's like... So he was controlling me, things like that. I couldn't see that at the time… what he was doing wasn't right, and that she showed me… obviously, that's not the way to be treated (Service User 9)

For parents who had worked with the MDT for at least a couple of months at the time of interview, it was evident that they had developed a less negative overall perspective of the social care system:

> It (the MDT) is very reassuring because anyone who has social care involved, you can imagine it's very scary.. the first thought because of everything you've read in the media is 'they're gonna take my children away'.

More broadly, the most frequently reported transformation in perspective was how parents started to gain a better understanding of the underpinning influences behind their own thoughts, feelings and behaviours:

> [MDT professionals] gave me more insight as to what it is that I'm suffering with, why I suffer from it and why I do some of the things that I do. It's had a really good impact on me, enabled me to realise what was good and why it was good. Whereas before I was more focused on what was bad and why it was bad and blaming myself for a lot of stuff. You know, the MDT sort of flipped that on its head and was, like, hang on a minute, 'You know this, this and this and that are good'. I was doing a good job with the children and that the children were happy, safe and secure. They helped me to realise all of these things and stop procrastinating about the past… because things that have happened are done, what's done is done. The MDT team from all areas just sort of reassured me. (Service Users 7 & 8)

Desire for long-term communication with the MDT

Such was the favourable, and in some instances transformative, impact of working with MDT professionals upon the everyday lives of parents and families, that some parents held reservations and expressed disappointment about this support coming to an end:

> I can't say specifically what they've said or done to make my overall health a lot better, but I'll be a bit sad once we're no longer in communication… I'm not afraid, I'm just apprehensive because I've got used to this, I can't see me going backwards now. (Service User 4)

> We don't want it to end. We don't want it to end yet, not because we have worries about falling back, but because it's like an incentive for us. Like we know there's someone there that is willing to help us, so we don't really want it to end yet, but obviously we know that it has to at some point. (Service Users 5 & 6)

Professional interviews

Analysis of semi-structured interviews with eleven social care professionals working alongside the MDT specialists generated four over-arching themes that were fundamental to the impact that the new Multi-Disciplinary Team (MDT) had upon parents and families as well as fellow professionals also working with families in the south of the county. These included social workers, senior practitioners, child protection chairs, education and community drug and alcohol workers.

The themes are:

- Direct support and empowering parents
- Timing of support and slowing escalation to legal proceedings
- Trusted disclosures: 'They're not social workers'
- Instant on-site CPD for social workers

Direct support and empowering parents

Much like parents reported themselves, the introduction of the direct support offered by MDT professionals to the area brought about improved outcomes and care experiences for parents and their families:

> From my perspective, seeing families who've been in the system on and off or continually for a long time. It's quite easy to almost give up hope a little bit and become like 'God, what on earth is going to work? We've tried everything'. With those long-term families, I've seen some change and that's been the most powerful impact for me… I've seen a real shift with some of the families that MDT have worked with that have been here for a long time. (Professional 1)

Some of the mechanisms professionals suggested had been important to increased parental engagement with community services were the proactive approach taken by MDT specialists to introduce parents to services, ensuring parents attended services by providing transport, and advocating for parent's rights if they encountered any issues. Whereas without this support, it had been common for some services to remove parental access to services following a period of non-engagement:

> A barrier is when a parent is inactive. It falls down to non-engagement and then they get closed off to these services. So, then we end up in a bit of a rat race where we're then just going in a circle. When I've had families who have had multiple services involved, they've felt extremely overwhelmed and unable to manage. But when they've had multiple MDT professionals involved, they haven't had the same experience, and I think that is because they're actively coming to the home, and they will make sure that they're not clashing with one another. So even the logistics are so much smoother. (Professional 3)

Direct support provided by the education inclusion worker by increasing a child's attendance at school also improved household finances for families, by reducing school fines for low attendance:

> I could support a family from having a penalty fine. A penalty for a family if a child's attendance drops is £80 if they pay early, and it's £160 if they don't. So

> in helping the family and the young person improve their attendance at school is also a cost saving. (Professional 10)

The education worker of the MDT also offered a unique and new form of support for families, as no comparable type of community service was available:

> There isn't an equivalent service in the community that supports with education and supports with young people improving their attendance… a lot of the responsibility was put on schools and families. (Professional 10)

Fellow professionals described how the MDT had empowered parents by comprehensively supporting them with the initial 'steps' on their 'path' or 'journey' of navigating local services to eventually access the assistance they were entitled to:

> Seeing the MDT drug and alcohol work and mental health working in conjunction with the parents, rather than sending a parent out saying 'right, we want you to self-refer, we want you to go there, we want you to go to the GP'. Parents are so overwhelmed. But I've seen so many good examples of the MDT workers starting that journey with them at home. Empowering them to get to the next step, sometimes supporting them to go to certain groups, go to appointments that we're seeing further down the line that they're making that move themselves. It's not about the MDT workers doing it for them, it's about creating those first steps with them from home on an individual basis… then they're empowering them to go and do it on their own. (Professional 1)

This empowerment and visible change in parents could also have reassuring consequences for children:

> Often the children feel a lot more comfortable going into school because they know mum and dad have a worker, they have interventions going on during the day. They know that mum and dad might be OK… I guess almost the parents are giving permission for the young people to go out and to go to school because they've got support at home for them. So an impact that I've seen is that young people appear a lot more confident and they avoid school less because they don't need to be at home and worry about mum and dad… so they're able to just go off to school or go out to see their friends and not have that anxiety around whether mum or dad is OK at home. (Professional 10)

Accessing community services was especially problematic in cases where parents required support with mental health at the same time as support from drug and alcohol services. Although this was a systemic issue, rather than anything to do with non-engagement from parents. In these scenarios, specialist expertise within the MDT ensured that parents could get support from both areas simultaneously:

> Drug and alcohol services were saying 'we can't work with her until she gets support for her mental health'. Mental health was saying, 'we can't work with her until she's working around her substance and alcohol use'. So, we've been stuck in limbo for two years… I think MDT assigned both workers. (Professional 1)

More broadly, the social workers interviewed also emphasised how specialist expertise within the MDT could also be called upon to offer types of bespoke support to parents that were not provided within the available community services:

> Something I notice as a social worker is that we often have a lot of gaps in wider community resources around work that we can't do… MDT really fills that gap because similar to us, they will go out and work with those families. Of course, it's consent based, but I think there's that little bit more flexibility that community services don't necessarily have. (Professional 5)

MDT workers identified how they were often able to position themselves as a mediating party to draw together the different contexts that parents and statutory services have to negotiate while trying to work towards the achievement of similar outcomes,

> I think the multi-agency work is working really well… it's been helpful for the school to have another professional working with the families to support with that relationship building, I know a lot of parents and a lot of schools find it difficult to have that positive relationship… I guess they both advocate for the child to be in school but the parents get quite frustrated that they're not receiving support and the school aren't able to do much of this if the child isn't there. I think where I've been able to triangulate different information and share information, I've managed to build quite a positive relationship with different schools in the area. (Professional 10)

While professionals working alongside the MDT identified various tangible benefits and outcomes that had been realised since the team had started working in the south of the county, some also found it difficult to find the words to explain just how valuable and transformative the introduction of the MDT's expertise had been to the area:

> The changes in some of the families since they've had MDT involved, it's like it's really hard to describe it… a sense of like something is about to change, which isn't measurable… [there is] a feeling that you experience before you start to get like the evidence of the changes. (Professional 6)

Timing of support and slowing escalation to legal proceedings

Regarding the more long-term, relational and structural household consequences for parents and their children following the addition of the MDT to the local authority social care system, the ability of the MDT to put on hold legal proceedings to determine whether children should remain in their parent's care, was frequently recognised by their new colleagues:

> If the risk doesn't reduce then a legal planning meeting is required, but it's at that stage that I can say 'let's bring MDT in, what can MDT offer to change this before we need to go into legal [proceedings]?' Because we want to avoid going into the legal arena for this family wherever possible and to reduce the risk… I've been able to use MDT to come into those case discussions… it's been allowing us to slow the process down (Professional 7)

In one case, where children had been removed from a mother's care, the MDT had worked extensively with the mother and were able to maintain and improve the quality of the relationships with their children:

> Whilst we have entered proceedings, I think that there has been a marked change in Mum's presentation… she works so much with MDT. She seems much more coherent. She's able to engage better in conversations with us… we were really worried about what that was looking like for the children before… regardless of whether they return to mum's care or not, I think it will have made a marked difference on what that relationship looks like moving forward because these are not children that are ever going to not know their mum or not spend time with their mum… it's likely that as they grow up, even if they remain in care, their time with their mum is … going to drastically increase… there have been some positive safe changes made that will impact that relationship moving forward. (Professional 5)

However, in most scenarios where children were on the verge of entering local authority care, the MDT had been influential in preventing this from happening:

> I've seen some of the MDT work… preventing children from coming into local authority care, which has been really beautiful to see and it's also that accessibility of service. You know, when families are at this point where they're edge of care, there isn't that delay in them accessing that specialist service and I've seen that make a really significant difference. (Professional 5)

MDT professionals noted how they had to work flexibly in each case they worked on to produce such outcomes and being given the time and capacity to creatively match potential solutions to specific scenarios. Important considerations here included the timing of MDT involvement and the readiness for change amongst families:

> Sometimes people will agree to relationship work whereas they wouldn't agree to substance issues because they're not at that point in their cycle, where they're able to admit that there's any problems going on. So it's a consent thing as well. If they're consenting to certain things, then we have to go with the flow of what the family's ready for, really… we're able to take such a slower approach and being able to just adapt to each person that we have, we've been able to see some really, really good work. (Professional 9)

The capacity to be flexible and wait for family members to be ready for change was facilitated by the open-ended nature of the MDT's engagement with families:

> It's been beneficial to be able to be involved for a family for a long period of time as opposed to having a certain amount of time where you're involved in the family because we don't necessarily have an end day. We can stay with the family kind of as long as it takes… relationship building is one of our biggest things that I think MDT have to hold on to because a lot of other services don't have that time to do so. (Professional 10)

As well as observing a reduced number of cases escalating into childcare proceedings and the increased speed at which parents were accessing specialist services following the

funding and introduction of the MDT, social care professionals praised the money which had been saved as an additional favourable outcome of these positive changes:

> There's been times in which it's prevented cases from escalating. It's stopping cases from drifting because the support's going in there straight away... Some of the services that we have to access within the community, I think we have to pay for some. We have to go to panel to ask for the money to fund certain things… I actually haven't been to panel in a very long time… part of that is to do with MDT because I'm not having to go to the panel to ask for specific support, such as housing or rehabilitation. (Professional 3)

Trusted disclosures: 'They're not social workers'

Colleagues discussed at length the processes put in place around confidentiality. Confidentiality was considered as fundamental for MDT workers in order to maintain a trusting relationship with parents. While updates and progress information are shared in Child Protection conferences, social care professionals understood that MDT professionals would not disclose everything clients told them and only share relevant and necessary safeguarding information:

> The MDT professionals don't have to tell us everything that the parents are sharing [with them]. They only have to let us know if there's a safeguarding concern. With other services what I find is they often tell us quite a lot about what's going on, and then it can be a barrier to parents engaging with them and accessing that support. I think also that they (MDT) go to the home, and they are very hands on, they go above and beyond really and meet our parents halfway, to try and encourage and build that relationship, which is great. They really focus on that relationship building. (Professional 3)

In these descriptions of the working relationships between MDT specialists, social workers and parents, 'transparency' was often referred to as being at the crux of relational practice. Some social workers and those working in children protection leaderships roles were of the view that the transparency in the relationship between parents and MDT personnel should be prioritised to maximise beneficial outcomes for parents:

> Certain aspects of the MDT work… you know, it's between them (parent) and the [MDT] worker, but safeguarding concerns that come up they'll (MDT) update us on how things are going. So, they very much know that they (MDT) are going to share information with the social worker. It's all quite open and transparent really with them…. there are aspects of their work that stay between them, so it's not that we get access to everything… they have a safe space to talk about things. (Professional 6)

As part of maintaining confidential and trusted disclosures between MDT staff and parents, unlike social workers, MDT personnel have not until recently been providing a safety score between 0 and 10 to scale how safe or unsafe a child currently is within the care of the parent,

> The decision was made that MDT wouldn't provide a score, and I think that's very appropriate because MDT still do give feedback about what their work with

> that family member might look like, in a summary, but aren't exposing that explicit detail. There's confidentiality, unless it's a significant safeguarding concern. It's just about that relational practise with the parent. (Professional 5)

Not all colleagues were convinced that the omission of MDT members from providing safety scores was essential for upholding their relational approach to professional practice and indeed this practice has recently changed:

> We feel that MDT, in their own right, could be scoring and should be giving their recommendations. That was a difficult place to sit in for a while and we had to work and build confidence. That's still an area for development in report writing… but we're on the right path. (Professional 1)

While those working predominantly in a social work capacity were generally very positive about the impact and outcomes that the MDT team had delivered for families in the local area, it was also common for them to explain that part of this favourable influence could be attributed to the fact that MDT specialists were 'not social workers':

> There's just something different about them not being social workers… for families, meeting with social workers can be hard, they're (parents) anxious about what may come of that. (Professional 8)

> Families can find it difficult to open-up around their mental health and their substance misuse to their social worker knowing obviously we are involved for the children. So, I've found it's been helpful for families to have someone else that they can focus that work on with. (Professional 2)

> Previously… the work with mental health, with drug and alcohol services. It's not created the safety we'd hoped, and she's (parent) not built that relationship. For some reason, she really links in with the MDT workers this time and what she said in that conference last week was 'I get on with them, I'm going to be honest with them, they're not social workers'. (Professional 1)

While some social care professionals suggested the 'stigma' of child-centred social work played some part in the contrasting enthusiasm parents quickly developed for working with MDT colleagues, others highlighted the specialist skills and experiences of navigating the landscape of community services that the MDT could offer to parents in comparison to the remit of social workers,

> They (MDT) can be more specialist because as social workers we cover a lot of contexts, so we might cover drug and alcohol, mental ill health, all of those different things… for families, there's often an intersection of these factors, and we might not necessarily have capacity to support the family with all of those different needs. But equally, we're not specialists in drug, alcohol or mental health. (Professional 5)

This stigma of negative connotations attached to some job titles was also something some members of the MDT were conscious of. As an example, the domestic abuse worker chose to describe their role to parents without using their job title,

> I always describe myself as the positive behaviour advocate because I think if you come in with the label straight away, I think it really just puts the barrier up and it just makes things difficult. (Professional 9)

Crucially, there were also instances where care professionals explained how children of families had become more candid with social workers following the introduction of the MDT because they were reassured by seeing the quality of the alternative and direct support their mother was now receiving,

> Them not being social workers has really allowed these young people to trust them and to build up a relationship differently. There's a real transparency in regard to communication. The young people themselves know that they have a social worker who is going to share information... it's really allowed these two specific siblings to open-up and talk… their ambition was to be a drug dealer because they earned so much money from it, but now they are able to talk about a different ambition. (Professional 7)

Instant on-site CPD for social workers

Working from the same physical workspace as MDT specialists, social care professionals revered the support and continuous learning that they could instantly receive, to assist with their own cases,

> They (MDT) have backgrounds of working with people with mental health or substances, so they've got a lot, maybe a bigger skill set than social workers… If I have a family that perhaps isn't open to MDT, I'd be able to speak with someone in relation to a specific worry that I have and they might be able to offer me different ways to approach the situation. (Professional 4)

> We're able to sort of ask those questions from people that are experts in those fields… just to expand our knowledge and help us… To have that sort of presence in the office and to be able to say I've just come back from this conversation and I'm really kind of stumped about where to go and have someone say, 'oh, have you seen this tool? or have you seen? why don't you try doing this exercise?'… each member of the team, because of their expertise, has access to different tools and direct work, things that we may not have come across in the little social work world that we live in. (Professional 6)

Survey of Professionals

Twenty professionals completed the survey. These were mostly made up of Social Workers and Senior Practitioners but also included one each of the following types of professional: Student social worker, Child protection co-ordinator, Child Protection Chair, Domestic and Cultural Adviser, Team Manager.

Figure 7: Sample of professionals responding to survey

Of these professionals, 75% sat within the Family Support and Protection Team. One sat in Assessment and Intervention, one in Quality Assurance, one in a Countywide role, one in a Children's team and one was not specified. The professionals surveyed had been working with the MDT for different amounts of time, ranging from a week up to 20 months.

Overall professionals had an overwhelmingly positive view of the MDT, which can be summed up in the following quote:

"*It has been a truly incredible service to work with and I can't imagine working without them now. They have changed the way we work; and the opportunities families receive which I think is the most important thing. Many services give up on families due to non-engagement. However, MDT staff continue to provide support through periods of non-engagement and don't give up on our families which is what they need.*"

Professionals responded in the following ways to the closed choice questions.

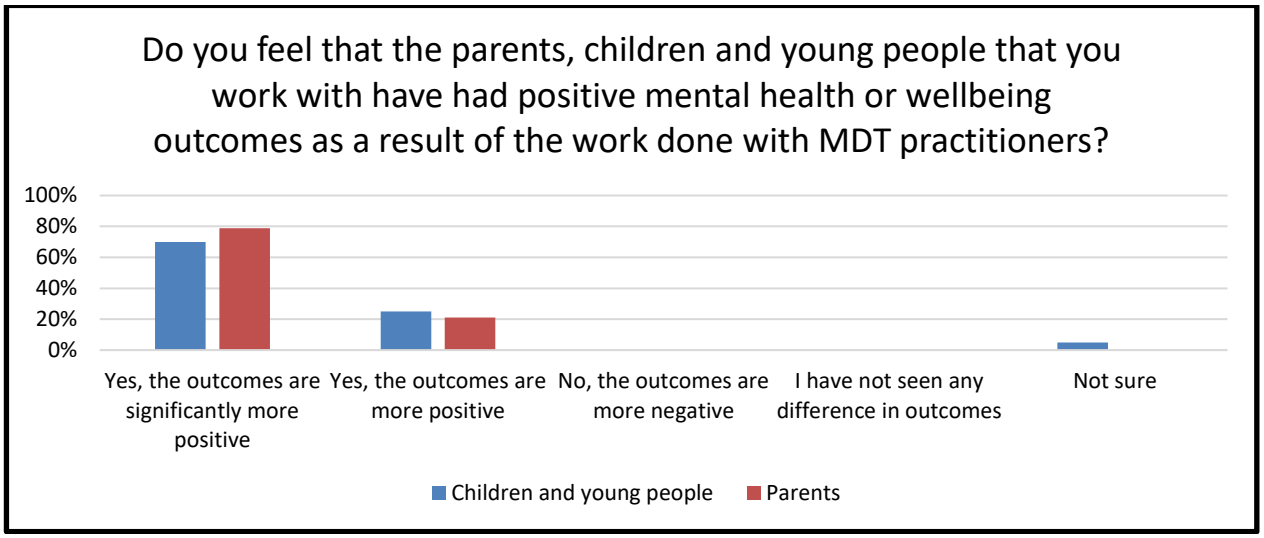

Figure 8: Professional responses: impact on mental health

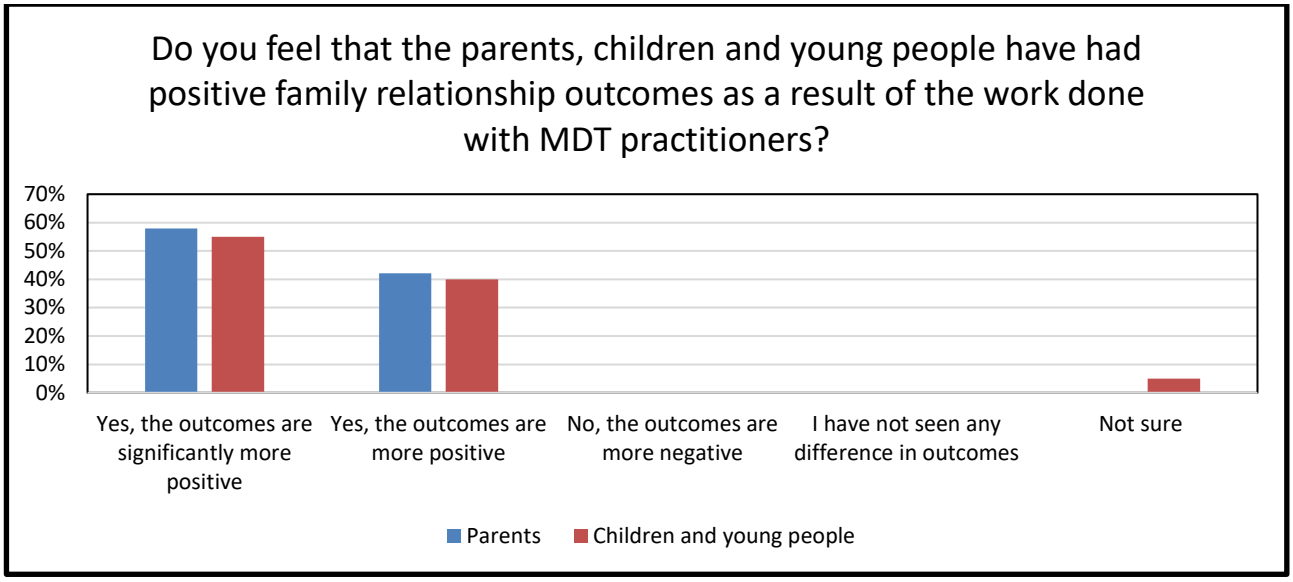

Figure 9: Professional responses: impact on family relationships

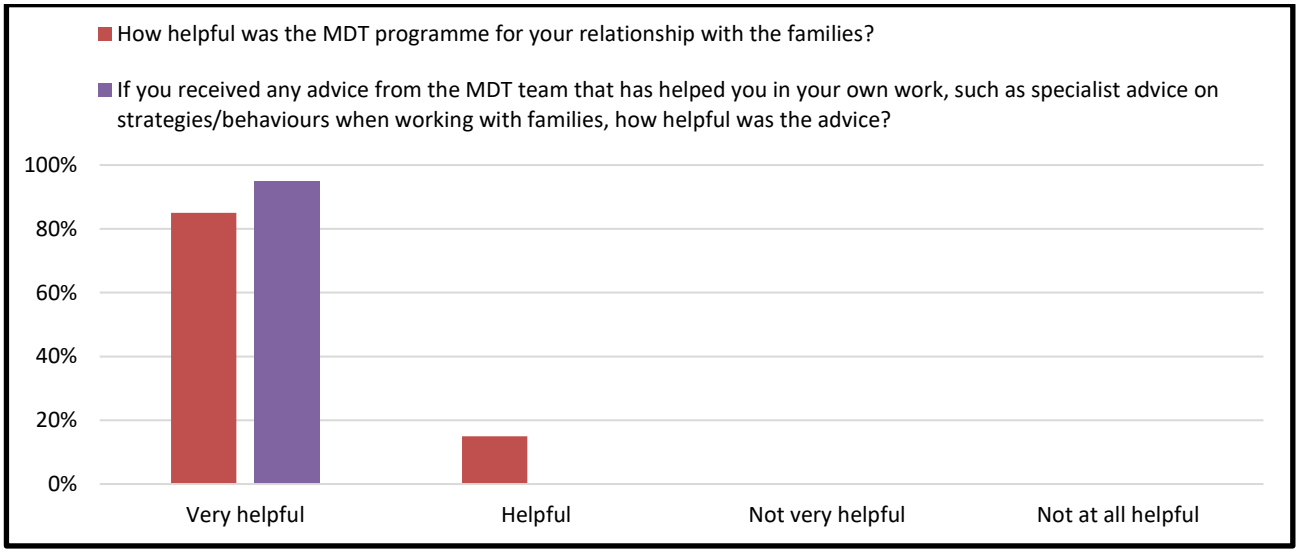

Figure 10: Professional responses: helpfulness of MDT team

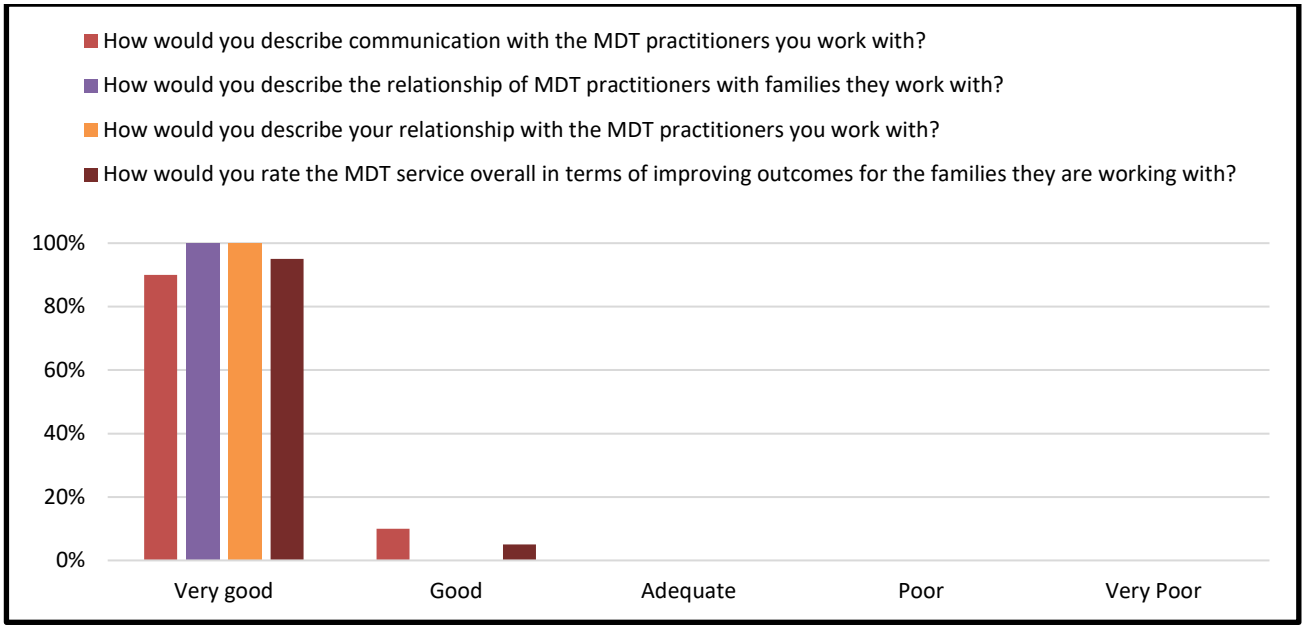

Figure 11: Professional responses: MDT service quality

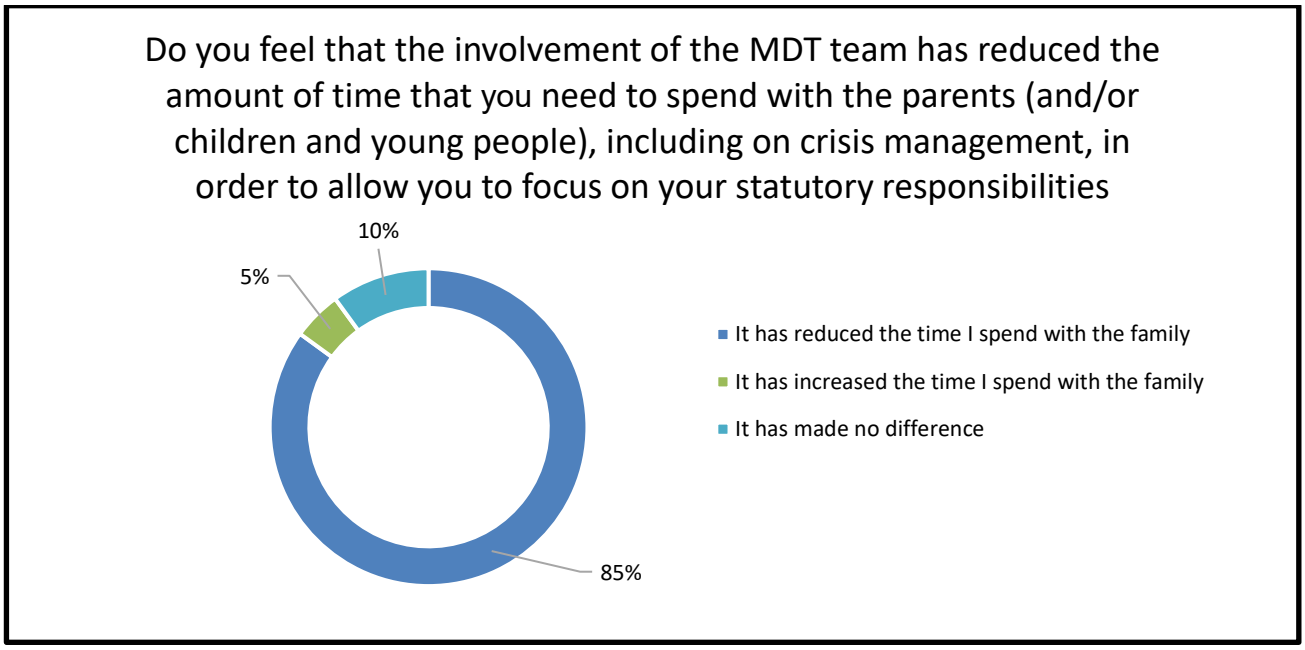

Figure 12: Professional responses: impact on social worker time

How the MDT ensures positive outcomes for families and young people

Professionals noted that the MDT has allowed both parents “to feel they have a person they have a good relationship with that they can open up to and seek support from”, empowering them both to engage in meaningful, sustainable change work.

In particular, work around domestic violence was felt to have resulted in positive outcomes through understanding patterns of behaviour. Professionals felt that the MDT had supported families to reduce concerns and keep families together. Where proceedings had to be initiated, professionals noticed that the working relationships the MDT had built with families reduced the emotional impact of separation and enabled

parents to continue accessing support within proceedings. Work with perpetrators was noted as particularly positive, in not only labelling them as a perpetrator but working with genuine interest in their other identities such as “father”.

The availability of the MDT team was noted as a huge support, giving families reassurance they could reach out when needed. Factors associated with positive outcomes included the individualised, tailored approach of each worker providing nuanced guidance and learning adapted to particular needs and styles and 1-1 support as needed. This allows parents and children to recognise that they are being seen as the expert and supported to make long term changes. It was suggested that families view the MDT as an extension of social care and at times feel more able to build meaningful relationships with experts relevant to their lives. Critical features noted included consistency, flexibility and perseverance.

The mixed expertise in the MDT team was felt to have allowed families to be observed through different lenses. The team were felt to be approachable and empathetic whilst also honest, challenging families when necessary and enabling families to have open reflective conversations in child protection conferences. It was felt important that MDT staff attend homes and bridge the gaps between accessing services and support. This has allowed for significant movement for families and prevented escalation within social care.

How the MDT facilitates positive relationships

Professionals felt that providing parents with additional support through the MDT enabled social workers to focus more on completing social work-based interventions and responding to safeguarding related issues. Support on domestic violence was particularly valued for supporting the parent to safeguard and protect the children and enabling better safety planning. The MDT strong working relationship with the family was felt to enable other professionals to focus on the needs of the child and avoid conflicts of interest. The holistic and collaborative approach was felt to help families gain important insights and feel less overwhelmed and defensive. It was also felt to give professionals increased confidence to be able to speak to families around sensitive subjects.

MDT work was felt to support families to strengthen their relationships within their family and extended family networks. Families were considered to have felt extremely supported, heard and understood which enabled families to feel safe to share information and to ultimately create change. Although, it was also noted that families are not always ready for change.

Professionals found parents speak very positively about MDT staff and their relationships. They found that parents looked forward to their MDT sessions or finding that the MDT staff made them feel comfortable and listened to and that the support felt consistent. Professionals also noted that the MDT communicated clearly and consistently with the wider professional network. The team’s working style was described as persistent, relational, available, friendly, approachable, non-judgemental, therapeutic and strengths based, creating safe spaces to explore vulnerabilities. The staff were described as empathetic, caring and nurturing with both professionals and families, often going above and beyond and being receptive to suggestions. Professionals note that the MDT has enabled a shift even in families where social care had reached a point of

hopelessness. In addition, professionals commended the team for the case notes being always up to date.

The following were noted as particular aspects of the service that work well:

- Specialist knowledge and specialist advice
- Alleviation of pressure in managing specialist areas alone.
- Building confidence and knowledge among the professional network
- Appropriate level of confidentiality creating additional levels of trust
- Helping parents/carers to help themselves to create sustained change
- Strong communication and multi-agency working
- Intense family work
- Individualised, holistic nature of work
- Use of screening tools for mental health and alcohol consumption
- Efficient processes (accepting referrals and getting alongside the family quickly)
- Home visits and outreach support
- Collaborative working
- Excellent case recording and conference reports

How the MDT service could be improved

The following potential improvements were noted:

- A larger MDT service would provide more availability to support a greater number of families
- Offering the service countywide to all quadrants
- To have access to the mosaic recordings and direct work materials.
- An additional adult mental health worker
- Ensuring that the staff positions are filled quickly (particularly the housing worker)
- Larger variety of services e.g. specialism for young parents

Some professionals noted changes over time in the MDT service which may indicate ways in which the service are beginning to address some of the needs for improvement noted above. One professional noted that the team has improved communication and relationships over time; has gradually expanded services in terms of location and staff employed. Another noted the team's understanding of the social care workforce and practice in the area has grown over time and likewise the social care profession has increasingly understood the work of the MDT. There have been some inconsistencies with changes to the Substance Misuse workers and Peabody workers. However, it was noted that the MDT is now stable, established and is working so well.

Estimated cost savings

Limited estimations of cost savings are possible with the information available. Any cost savings indicated would need to be offset against the cost of running the service over a two year period.

Unit costs

Any cost savings estimates would be based on estimations of unit costs and should be treated with caution. Relevant unit costs include:

- The cost of Child in Need case management over 12 months = £4,334 (Unit cost database 2022)
- The cost of a child being taken into care (average fiscal costs across different types of care setting per year) = £97,593 over 12 months (Unit cost database 2022)
- Social worker average salary of £53 per hour – Unit costs of Health and social care 2023

Stepping down safeguarding status

Of the 95 children (who were CIN, CPP or PLO at referral), Table 9 notes the following expected and observed outcomes:

Table 9: Expected and observed safeguarding outcomes

	Expected*	Observed	Difference
Remained on CIN/CPP	41 (43%)	21 (22%)	↓20 (down 21 percentage points)
Stepped down	46.5 (48%)	58 (61%)	↑11.5 (up 13 percentage points)
Taken into care	9.5 (9%)	16 (17%)	↑6.5 (up 8 percentage points)

*According to a Department for Education report in 2018, the typical trajectory for children known to social care is as follows: "children who were CINP or CPP tended to either remain at that level of support one year on (43%) or de-escalate (48%)". Children in Need of help and protection: Preliminary longitudinal analysis (2018)

These figures indicate that over the two-year evaluation period, more children were stepped down than expected (13%) but also more were taken into care than would be expected (8%). Offsetting the additional children stepped down (11.5) against those additional children taken into care (6.5), the overall benefit of the MDT would be 5 children potentially prevented from being taken into care. We can estimate approximate savings of 5 children (potentially) being prevented from going into care: £97,593x5 = £487,965. This cost would be saved on an annual basis until each child left care. In addition, one child who started as a Child in Care was stepped down to CIN status which would save £97,593 per year, while incurring Children in Need case management costs of £4,334 (total savings = £93,259). In total, estimated annual savings from avoided case costs is therefore £581,224. This is a cautious estimation, since figures on the movement between safeguarding status show that children were often escalated shortly after entering the MDT. Therefore, the safeguarding status at the start of the MDT intervention may not have reflected the true level of severity. Cost savings estimates may be higher if we were to consider changes in relation to the highest level of risk at any point during the MDT intervention, rather than only the level of risk at the start of the intervention. Other limitations to these estimates include different ages of children; not being certain about how long each child might remain in care; not taking account of long-term future costs of children in care becoming young adults "not in education, employment or training" (NEET). In addition, any estimated savings would need to be offset against the cost of running the MDT over a two year period.

In the professional survey, many respondents commented on the ways that the MDT reduced the time they spent on a case or allowed them to focus on other aspects of the

case such as safeguarding. We asked professionals to estimate this in terms of hours per week saved. Most were unable to put a figure on this, but 6 professionals offered an estimate which ranged from 2 to 6 hours per week. Based on an average social worker salary of £53 per hours, this saves £106-£318 per week (£5,512-£16,536 per year) per family. For the 86 families seen by the service to date, this represents a saving of £1,422,096 per year. Again, this would need to be offset against the cost of running the MDT service over a period of two years.

Emergency sessions

It is possible to make some very cautious estimations of cost savings derived from emergency sessions. Table 10 indicates some possible interventions that may have been avoided by the MDT provision of emergency sessions based on indicative costs from the Unit cost database 2022.

Table 10: Emergency sessions and avoided interventions

Content of session	Number of emergency sessions	Avoided interventions	Estimated savings
Adult Mental Health	58	Adult crisis team use £54	£3,132
Children's Mental Health	20	CAMHS crisis teams use £285	£5,700
Domestic Abuse Prevention	4	Domestic violence with injury response £2,622	£10,488
Domestic Abuse Support	15	Domestic violence without injury response £1587	£23,805
Drugs and Alcohol	61	Drug offences court event £3,827	£233,447
Education	25	Permanent exclusion from school £11,973	£299,325
Housing and Benefits	13	Homelessness advice/support £954	£12,402
Professional Consultation	1	-	-
Youth Work	8	Arrest £960	£7.680
Total			**£588,307**

Recommendations

Recommendations for supporting staff and recruitment

- MDT staff may find it helpful to join the Community of Practice and access the Recurrent Care Resource Pack (Research in Practice 2019) for ongoing CPD and access to shared learning from similar services nationwide.
- Consider ways to manage staffing gaps and recruitment timescales. If the service model is expanded across the county, consider whether staff can be pooled across areas to prevent gaps in provision when staff leave. Consider training and development requirements to skill up workforce around the MDT way of working.
- When filling vacant posts, consider reviewing the mix of support workers at the time of replacement. Early on in the evaluation it was suggested an additional adult mental health worker would be welcome whereas later on suggestions were for additional housing work and additional specialisms such as support for young parents. Demand may vary over time and need regular review and adjustment.
- Maintain manageable caseloads to enable ongoing intensity of support required, consistency and focus.
- Consider how team members are supported to reduce risk of staff burnout and compassion fatigue.

Recommendations for working with the wider system

- Consider expanding the MDT service and offering the service across all quadrants to provide more availability to support a greater number of families and social work teams
- Continue to build rapport with wider social care system and agencies in the community to grow understanding and manage expectations of what MDT offers and what it is not able to offer.
- Work on building partnerships with mental health services, for example to work towards creating 'fast-track' pathways for vulnerable parents with more severe psychological problems and developing ways for MDT staff to advocate for more specialist mental health care.
- Continue to prioritise relational practice with parents, balancing transparency and confidentiality to ensure engagement and maximise benefits for parents and children. Consider reviewing whether social workers should or should not have access to MDT Mosaic records and client case notes.

Recommendations for data collection, evaluation and research

- The number of children completing online outcome measures was low. In any future evaluation, consider alternative ways to capture the experiences of children in the service to enable better assessment of service effectiveness in the future.
- The bespoke spidergrams used by the service are not based on validated tools. Consider using the full version of the University of Essex evaluation toolkit "Client Report Measures". The recommended suite of outcome measures are validated; found to be acceptable to clients in other RCP services; and include measures of self-esteem (Rosenberg scale), grief (Adult Attitude to Grief), psychological wellbeing (CORE), quality of life (QLESQ), and trauma (PCL-C). An online demonstration survey including all measures is available from University of Essex (see here).
- Service level data could be improved using a joined up system. Consider using the University of Essex evaluation toolkit "Client Tracker" to keep data on each family in one system. Specifically, missing service data are history of care, trauma history, living arrangements, parent marital status, housing security, parent mental health, parent employment status, parent drug use or medication use, reasons for referral, presenting risk factors, risk factors at closure, history of involvement with police or criminal justice system, educational outcomes.
- Demographic data is not captured in service data and this prevents monitoring of equity of access and addressing any inequalities. Consider collecting this data routinely to improve future evaluation and to be able to address inequalities in future.

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