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Multi-disciplinary support for families with complex needs and children on the edge of care in the UK: a mixed methods evaluation

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ABSTRACT

Families on the 'edge of care' face complex intersecting issues that can work against positive changes and lead to the re-involvement of social care. A multi-disciplinary service working alongside social work and community services teams to respond to the multiple needs of vulnerable families was evaluated. A mixed methods evaluation drew upon service data and cost saving modelling, interviews and a survey of social care practitioners. The evaluation data relates to the period February 2021 -July 2022 and covers 81 families, of whom 41 families had their cases closed. There was a high level of engagement with families with complex issues who struggle to engage with community-based services, with improvements in parental and child risk factors. The programme was successful for many of the families that engaged and half of the children had their safeguarding level stepped down. Significant net cost savings were estimated for avoided care placements plus additional savings such as reduced social care staff hours. The service was clearly seen as an effective and valuable service by social care practitioners and was characterised as having good working relationships, good communication and distinct but complementary roles. The service offered a positive support service model to families based on trust, consistency and immediacy.

KEYWORDS

Edge of care; children's social care; vulnerable families; multi-disciplinary

Introduction

Children and young people on the 'edge of care' - those who are at imminent or potential risk of needing to be taken into care (or 'looked after') by social services – are increasingly a policy priority in the UK. In a recent survey of local authorities, 62% of the 60 local authorities responding cited 'edge of care' services as the most effective way to prevent children becoming looked after (Corliss *et al.* 2022).

Biehal (2005) amongst others highlighted the fact that many of these children and young people (and their families) have been known to social care for some years, which suggests that interventions and services have not so far been effective. There appears to be a lack of understanding and appropriate responses from services to meet their needs

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(Stein *et al.* 2009) together with service drift or service handoffs where children, young people and their families are passed from one service to the next with multiple workers, numerous and repeated assessments, making little or no gain until the difficulties escalate to crisis point (Dixon *et al.* 2015).

In England there are a number of levels of safeguarding for children and young people, as laid out in the Children Act 1989. This starts with promotion of early intervention, followed by children being recorded as a 'Child in Need', on a 'Child Protection Plan' or 'looked after'. The Children Act 1989 defines a Child in Need as *'a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled'*. Where concerns exist that a child might be at risk of significant harm from abuse or neglect, they can be placed on a Child Protection Plan following a multi-agency assessment. If they are assessed as being unable to remain within their family, they can become 'looked after' by the local authority (taken into care).

UK data on the number of children living on the edge of care are not formally collected. However, there were 50,920 with a Child Protection Plan as of 31 March 2022 in England and another 404,310 children in need. The number of referrals within the previous 12 months to children's social care was 650,270, a 8.8% rise from 2021. During the 12 months to 31 March 2022, referrals from schools rose by 59% (compared with 2021 when restrictions on school attendance were in place for parts of the year due to COVID-19), in turn driving the overall rise in referrals (DfE, 2022a).

Adolescents (aged 10–17) account for 52% of those becoming looked after and males represent 60% (DfE, 2022b). Children and young people may become looked after for a range of reasons, including parental neglect and/or abuse and factors associated with a young person that have an impact on their parent's capacity to cope (Jones *et al.* 2011). Younger children tend to become looked after because of abuse and neglect but the key factors for adolescents are more likely to be acute family stress, when family circumstances reach crisis point and breakdown, socially unacceptable behaviour, and unmet needs (Dixon *et al.* 2015). In 2021, 66% of the 76,280 children who entered the care system did so due to neglect or abuse, 13% because of family dysfunction and 7% due to the family being in acute stress (DfE, 2022b).

Addressing the needs of those on the edge of care is important because it prevents those at-risk of entering care from the adverse life-long consequences of being in care including educational attainment, mental health and physical health (Rahilly and Hendry 2014). Children who are fostered have generally lower levels of functioning than their peers from the general population (Goemans *et al.* 2016). Children in care also have poor educational outcomes at school when compared to children living at home and are much less likely to be in full-time education (Jay and Mc Grath-Lone 2019; DfE, 2020). They are more likely to have a mental health issue with an estimated 45% of children in care aged 5–17 having a mental health disorder, compared to 10% of the general population (Meltzer *et al.* 2003, DfE, 2019, Baldwin *et al.* 2019). Leaving mental health needs unmet can increase looked after children's risk of a number of poor outcomes, including poor educational attainment and placement instability (Bazalgette *et al.* 2015).

Looked after children are more likely to have serious behavioural problems, misuse alcohol and drugs, and be involved with the criminal justice system

(Meltzer *et al.* 2003, Jones *et al.* 2011). Furthermore, adults who have previously been in care have a greater likelihood of adverse outcomes in adulthood: 49% of young males under the age of 21 who were in contact with the criminal justice system had been looked after; 25% of homeless adults had been in care; 22% of female care leavers became teenage mothers; and care leavers were more likely to self-harm in adulthood by between four and five times (National Audit Office, 2015). Adults previously in care had an adjusted all-cause mortality hazard ratio that was 1.62 times higher than adults who had never been in care, mainly attributable to deaths categorised as self-harm, mental and behavioural causes or accidents (Murray *et al.* 2020).

In addition to the impact on children and young people themselves, there are high financial costs to local authorities of children being looked after, including the one-off cost of removal proceedings – estimated at £44,300 in 2018/19 prices (Boddy *et al.* 2020) – and annual costs for placements up to age 18 - estimated at £34,320 per child for foster care and £245,388 per child for residential care (Troubled Families Unit 2019). Residential care is a more likely option for many older young people referred given their level of needs and likely age when they become looked after.

The poor outcomes, together with the significant financial costs of looking after children in care, make a strong case for local authorities to consider interventions to prevent children from entering care in the first place whilst also addressing the potential risks associated with children remaining with their birth families (Fox and Ashmore 2015). There are a range of services and support mechanisms available with many interventions containing at least an element of a therapeutic intervention: these include multi-systemic therapy, therapeutic approaches, mediation, relationship-based practice and parenting support (Corliss *et al.* 2022).

However, providing effective support to children and young people on the edge of care and their families presents a significant challenge, not least due to their wide-ranging and co-presenting needs (Institute of Public Care 2015). Additionally, factors relating to the needs of parents – including mental health issues, alcohol/drug misuse and domestic violence – increase the risk of children becoming looked after. Adequately addressing the multiple factors that might enable change would therefore require multi-component interventions (Talbot *et al.* 2020).

There is a growing evidence base for edge of care interventions targeting, for example, intensive interventions for children in such situations (Asmussen *et al.* 2012; Fox and Ashmore 2015), parental capacity to change (Ward *et al.* 2014), solution focussed approaches (Fernandes 2015) and interventions aiming to enhance attachment relationships and reduce the risk of abuse (Schrader-McMillan and Barlow 2017). However, these interventions focus on problem-specific programmatic and therapeutic treatments rather than evidence-based service-level models with bespoke treatment plans to target a wide range of familial and parental difficulties: family relationships are one of the most crucial influences on children's early lives and there is a need for joined up services to strengthen these (Schrader-McMillan and Barlow 2017). Whilst edge of care intervention primarily falls within the remit of Children's Services, it is not possible for the allocated social worker alone to provide an intervention that successfully balances all of a family's needs. However, complementing social care intervention with a multi-professional network often results in additional complexity whereby the social worker has to try to manage

the multiple – and sometimes conflicting – perspectives and priorities of those networks (Talbot *et al.* 2020).

In this paper, we evaluate Essex County Council's Multi-Disciplinary Team (MDT) pilot programme which employs diverse specialist teams to work with families with complex needs, who struggle to maintain positive change and who have a pattern of re-involvement with social care or ongoing issues that trigger re-referrals. To date, a relatively small number of evaluations have looked at the broader relationship-based and parental wellbeing outcomes for the families involved (McPherson et al. 2018, 2020, IPC, 2022, Burridge *et al.* 2023). An examination of local service development for edge of care work should include the evaluation of attachment-based approaches and an exploration of the needs of parents with mental health challenges (McPherson *et al.* 2018).

Intervention

Over the last ten years, one district in Essex has had the highest number of children in care compared to other parts of county – 58 children per 10,000 compared to 35 per 10,000 in the whole of Essex. In response to this the Essex County Council's Multi-Disciplinary Team (MDT) pilot programme within the district employs a diverse specialist team to work with families with complex needs, who struggle to maintain positive change and who have a pattern of re-involvement with social care or ongoing issues that trigger re-referrals.

The MDT provides specialist resource and expertise within the existing Children's Social Care infrastructure and was piloted in one district between February 2021 and July 2022. The overall aims of the pilot were to offer support to the area's most vulnerable families; engage these hard-to-reach families; offer immediate support to individuals who have significant and multiple disadvantages; reduce the number of children becoming accommodated and help clients re-engage with community services.

The MDT is overseen by a social work qualified team manager and comprises seven practitioners who deliver support across the following disciplines: domestic abuse victim support and prevention; drug and alcohol support; adult emotional wellbeing and mental health support, children and young people emotional wellbeing and mental health support and youth work.

The MDT works alongside existing frontline teams providing intervention and support to families with multiple, enduring complex needs to reduce the overall numbers of children in care and re-referrals into children's social care. Existing core teams from social care can access support from members of the MDT, who act as 'secondary workers' to add subject matter expertise to complex cases. The aim is to relieve pressure on frontline teams by providing tailored interventions by the subject matter experts, reducing the time social workers need to spend on their complex cases. Families are channelled for other support and services within the community as part of their stepdown process.

Materials and methods

The evaluation used a mixed methods approach and drew on several different sources of data to assess the MDT service, namely routine service data, cost saving modelling, and

data collected from social care staff. Ethical approval was provided for all elements of the project by the University of Essex Ethics Sub Committee 2.

MDT service data

To assess the pilot's outcomes, the evaluation used MDT service data on families and children at referral, initial engagement and case closure. The data came from a combination of sources: extracted from the social care management information system by matching on family/child unique IDs; typed in using information provided by social workers at referral; and entered by the MDT practitioners using their knowledge of the family situation and their judgement of the issues faced. Data were mostly closed-ended, with a limited number of open-ended options, and included information on prior referrals to social care, demographics, safeguarding status, risk behaviours and reasons for case closure. Data were collected on families referred to the MDT between 1 February 2021 and 31 July 2022. The data used for families and any children living at the same address: children sharing a parent but who lived at a different address from the parents and children working with the MDT team were excluded from the data. The data were analysed within Excel using pivot tables and filtering to calculate frequencies and compare data at an individual client level between referral/start of work and case closure.

Cost savings data

The assessment of cost savings used information about safeguarding status and emergency sessions undertaken by the MDT practitioners. The assessment of cost savings used costs from the Unit Cost Database developed for the Department for Communities and Local Government's Troubled Families Unit (2019) supplemented by several additional sources (PSSRU 2021, Ministry of Justice 2020–21 and NASUWT 2020/21) to estimate the costs saved.

Qualitative research

In-depth interviews with social care staff and a focus group discussion with the MDT staff were used to document how MDT staff work with social workers and with families. An online survey was developed to capture the views and experience of a wider range of social care staff. The online survey was adapted for the MDT from questionnaires designed and piloted in previous evaluations of edge of care and recurrent care services by the research team; the adapted final version was agreed with the service funder.

Recruitment

Contact details for the social care staff interviewed and MDT staff attending the focus group were passed to the researcher by the MDT team manager. A Participant Information sheet was provided to all participants and written consent was obtained before the start of the interview/focus group. The MDT team manager emailed a link to the online survey out to 37 social care staff working with the team, explaining the evaluation and the purpose of the survey.

Participants

A focus group was held with the 9 members of the MDT service. One-to-one interviews were undertaken with 13 social care professionals (4 social workers, 2 senior practitioners, 3 team managers and 4 other professionals – reviewing officers and Child Protection co-ordinators). The online survey had 25 responses, a response rate of 67.6% (11 social workers and 3 student social workers, 5 senior practitioners, 2 team managers, 2 support workers and 1 bridging worker).

Analysis

The focus group discussion and interviews were recorded and then transcribed and analysed using thematic analysis. A thematic coding framework was developed following familiarisation with the transcripts and broadly followed the interview guide. The online survey responses were downloaded into Excel and the frequencies were analysed using pivot tables. The three types of qualitative data (from the focus group, interviews and survey) were analysed separately before the findings were combined under the key areas of interest to form a single narrative.

Results

The evaluation found that the MDT pilot had an impact on family outcomes, produced cost savings and was implemented within the overall system.

Study characteristics

During the evaluation period, the MDT service received referrals for 201 children and young people from 90 families. Of these families, 81 were included in the evaluation, with 190 children of whom: 50% were male, 49% were female and 1% were unborn; 91% were White British; the mean age was 7.59; and the mean number of children per family was 2.35 (minimum 1, maximum 7).

By the end of the evaluation 41 families and their children had their cases closed; 26 families and their children were still receiving support; 4 families and their children had just started working with the service so there no data available for the evaluation; and the remaining families either did not meet the required threshold or were never open to/did not receive direct support from the MDT (although their children were receiving support).

The children referred to the MDT had an average of 4.9 years of involvement with social care and an average of 3.34 referrals to social care. 52% of the families (for whom this information was available) had had two or more generations of social care involvement. 62% of children and young people were reported on referral as being at risk of being accommodated.

Many children and young people referred to the MDT had a range of reported risks and issues, as shown in Table 1. For some variables, data are missing for a number of children because the information is not known. 48% had poor or very poor attendance at school, 47% had a mental health issue and 30% experienced a lack of child stimulation/social interaction. Two young people had gone missing 20 or more times at the time of referral.

Table 1. Reported risk factors for all children and young people at referral.

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

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

Table 2. Reported parental risk factors at time of referral (all families).

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

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

Parents also had a range of reported issues, as shown in Table 2. The data provided to the research team were at a family level and did not include demographic details about individual parents. At least one parent in 74% of families had mental health issues; 60% of families had previously experienced domestic abuse; alcohol was a problem for at least one parent in 50% of families; and recreational drugs were a problem for at least one parent in 50% of families. The 'toxic trio' (domestic abuse, mental ill-health and substance misuse) was present for 40% of all families.

Family outcomes

Of those families offered support by the service, 89% engaged (despite a history of non-engagement), which should be seen as a positive outcome for the service. Engagement was achieved by working at the family's pace and enabling them to lead on what support they required.

A combination of parental and child risk factors improved after the MDT intervention. Table 3 shows the outcomes for the 57 children who had their cases closed. For some variables, data are missing for a number of children because the information is not known. Fewer children and young people at case closure were involved with the police or criminal justice system. School attendance improved and the number of missing episodes fell from an average of 10.2 missing episodes to 1.8. Neither of the young people who had gone missing 20 or more times at referral had gone missing at all.

Table 4 shows the outcomes for the 41 families with closed cases. The data provided to the research team were at a family level and did not include demographic details about individual parents. Substance misuse reduced for a significant number of the families, and there was a fall in domestic abuse. In addition, MDT practitioners reported improved

Table 3. Reported risk factors for children and young people at referral and at case closure (41 families with cases closed only).

	At referral			At closure		
	Number of children	Total number	%	Number of children	Total number	%
Mental health issue	31	49	63%	26	48	54%
Poor/very poor attendance at school	14	26	54%	6	35	17%
Known to the police	13	57	23%	6	56	11%
Lack of child stimulation/social interaction	12	52	23%	9	49	18%
Involved in the criminal justice system	7	57	12%	2	56	4%
Alcohol a problem	6	57	11%	5	57	9%
Use of recreational/street drugs a problem	6	57	11%	5	57	9%
Currently affiliated to a gang/at risk of gang involvement	3	57	5%	2	57	4%
At risk of Child Sexual Exploitation in previous 6 months	2	57	4%	1	57	2%

NB: The data above relates only to children and young people whose cases have been closed. The percentages exclude unknown or missing values for children and young people.

Table 4. Reported parental risk factors at referral and case closure (41 families with cases closed only).

	At referral			At closure		
	Number of families	Total number	%	Number of families	Total number	%
Mental health issues	29	41	71%	22	33	67%
Alcohol is a problem	21	41	51%	6	34	18%
Domestic abuse in previous 12 months	21	41	51%	15	33	45%
Use of recreational/street drugs is a problem	18	41	44%	8	34	24%

NB: The data above relates only to parents whose cases have been closed. The percentages exclude unknown or missing values for families.

stability within the home environment at case closure for two thirds of families and increased family wellbeing for nearly 70%. Mental health remained at similar levels.

Nearly half ($n = 26$) of the 57 children with closed cases had their safeguarding level stepped down. Specifically, of the 33 children on a Child Protection Plan at referral, 7 were stepped down to Child in Need status, 2 were referred to Family Solutions (the local authority's early intervention service) and 3 were closed to social care. The safeguarding level of 22 of the 57 children (38%) remained unchanged and 9 (16%) had their level of safeguarding increased. Although 4 children were in care at case closure, this is perhaps not unexpected due to the nature of the families that the MDT works with since many were at risk of being accommodated at the time of referral and 3 were already in care. In these types of cases, an intervention may establish that removing the child is the correct and safest course of action.

Cost savings

Cost savings can be estimated for the children whose safeguarding status had stepped down. At referral, 35 of the 57 children and young people whose cases have been closed were at risk of being accommodated. Of these, 31 were not in care at case closure. It could be argued therefore that there were 31 cases of avoided care proceedings. The estimated one-off cost (based on 2018/19 prices) of care proceedings for 1 child (the legal process) is

£44,300 (Boddy *et al.* 2020). The total cost of avoided care proceedings for 31 cases could therefore be estimated at £1.21 m.

In addition to the one-off costs of the proceedings, there would also have been recurring costs of children remaining in care. The estimated average annual cost of foster care is £34,320 per child and for residential care is £245,388 per child (Troubled Families Unit 2019). Depending on whether the 31 children who avoided being taken into care would have been placed in foster or residential care, the placement costs saved are somewhere between £1.06 m and £7.61 m annually up to the age of 18.

Cost savings relating to social care staffing and resources also arise owing to reduced time spent with parents (and/or children and young people), including on crisis management, allowing social care staff to focus on their statutory responsibilities and the needs of the child. When social care staff interacting with the service were asked to quantify time savings resulting from the MDT work, responses varied from 1–2 hours per month to 1 hour per week to 4 hours per week. Taking an average of the responses, we have calculated conservative savings based on one hour per week for social workers per family. The average hourly salary for children's social workers is £46 (PSSRU, 2021), which would indicate annual savings of at least £2,392 per social worker per family. This would translate to annual savings of £193,752 for the 81 families the MDT has worked with.

The cost over 12 months of ongoing support for a child with a Child Protection Plan is £1,893 while the cost of ongoing support for a Child in Need is £1,345 (Troubled Families Unit 2019). The 18 children who had stepped down from a Child Protection Plan or Children in Need status and were either closed to social care or receiving support from Family Solutions (the local authority's early intervention service) are estimated to have saved costs of £27,500.

Additional unquantified future savings may also accrue given the increased likelihood of children in care having a number of adverse outcomes as adults such as homelessness, offending and prison sentences, teenage pregnancy and self-harming (National Audit Office, 2015). The service may also have had unquantified cost saving effects on other services such as the Police, health, ambulance and prison services from avoided emergency calls. All these potential cost savings would clearly need to be weighed against the overall annual cost of running the MDT which service commissioners would need to calculate and consider in making decisions around ongoing commissioning of the service.

Qualitative findings

Analysis of data from interviews, the focus group and survey responses provide useful reflections on how the MDT pilot interacted with the overall system. This interaction was characterised within three broad themes: (1) valuing constructive, collaborative, professional relationships with social care; (2) creating positive and trusting relationships with families; and (3) using an innovative mode of delivery.

Theme 1: valuing constructive, collaborative, professional relationships with social care

The MDT was seen to have a constructive relationship with social care staff and services through clear collaboration as well as being clear on respective roles and responsibilities, saving time and resources. MDT staff were seen as approachable, helpful, supportive,

responsive and good at keeping social care practitioners up to date. Communication between MDT staff and social workers was also described as good or excellent by all interviewees and survey respondents.

> And the MDT workers work really closely and really well with the social workers. (Social care practitioner, interview)

> I have managed to build a good working relationship with the MDT team as they have worked on several of my cases. All workers are professional, reliable and contactable. (Social care practitioner, survey respondent)

Access to the service's specialist expertise and knowledge was valued by social care staff, to support their own work in areas that they were less familiar with or less confident about. The consultation process with social workers (even when a case has not met the MDT threshold) was seen as being very helpful and valuable also, in terms of the provision of advice and signposting.

Both the MDT professionals and interviewees agreed that the MDT offers a different kind of support compared to social worker support, partly because it can undertake specialist work with families that social workers are unable to do, and partly that they are supporting the parents whereas a social worker's focus is on the children. The team is a secondary support service for social workers whereby the social worker holds case responsibility while the MDT provides therapeutic intervention.

> We needed somebody that was separate from ourselves because our priority is safeguarding children and sometimes that's a real conflict in order to be able to make meaningful progress with families, because there is that constant power imbalance. (Social care practitioner, interview)

Theme 2: creating positive and trusting relationships with families

The interventions by the MDT created positive impacts for families, with all of the survey respondents saying that the outcomes for parents, children and young people were more positive as a result of the work done with the MDT.

Professionals who took part in interviews or focus groups often referred to the importance of using trauma-informed practice in the work of the MDT. It was noted that most of the clients have experienced trauma, often multiple traumas. However, MDT professionals commented that working in a trauma-informed way is only possible where workers have enough time to build up trust with a client so that they feel able to share their trauma. This approach was also about a strengths-based approach, in terms of exploring positives rather than negatives.

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

The relationships built with families by MDT professionals was noted by their social care colleagues. Social care staff often attributed this to the time that MDT professionals had to support families.

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

MDT professionals were able to build a better or more trusted relationship with parents than social workers could as they are seen as being different to social care: those referred to the MDT are very vulnerable and often very suspicious of local authority and other public sector services. Many interviewees noted the benefits of parents perceiving the service as being distinct from social care, because of their previous negative experiences or fear of their children being taken into care, which creates a power imbalance and a barrier for parents who are vulnerable.

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

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

Building up a relationship with the parents takes time, and all of the interviewees felt that the fact that MDT professionals have more time to support families than they do is a key success factor in this and has produced positive results.

> Because they've got the time and the space to do it. I think that's massive. Whereas social workers, we have no time or space. (Social care practitioner, interview)

A key success factor for engaging with families is that the MDT staff go out to see the families, whereas community services require the client to go to that service, which may be intimidating.

> Most community services expect people to go to them, whereas we and the MDT will go to the people and that makes such a difference . . . because they go to families and they work with them in a place where the family feels the safest. They then build that relationship in the family home that gives them a base to work from. (Social care team manager, interview)

Because MDT staff can remain available for families to engage with, rather than close the case after three failures to make contact, or if a client does not engage, community services will close a case, the MDT was seen as a bridge to community services, able to support families to access services they may otherwise disengage from.

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

Families can choose to take up the offer of support from the MDT when they felt it is appropriate: it is not a mandatory requirement or a service with limited availability. This allows parents to be in the driving seat and for the families' needs, particularly those of the parents, to be central. Social care professionals interviewed noted this as an important factor in delivering benefits for parents.

> I have a lot of parents I work with that say, 'my child's in care or you've taken my child, what about us? What about the support we can get?' (Social care practitioner, interview)

Likewise, MDT professionals felt they were in a position to support and empower parents to believe in themselves and make changes because of the nature of the relationship. MDT professionals can act as an advocate for their clients and as an intermediary with social workers when something has happened to upset them. Some social care professionals noted the value of this advocacy role.

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

MDT professionals felt it essential for clients to feel that they are being heard and that the parents and children have a voice. Some social care professionals also highlighted the importance to clients of being listened to without judgement, helping parents to engage.

> [The father] said that the support that he got from the MDT team was life changing, because it was someone that could listen to him. (Social care team manager, interview)

Theme 3: using an innovative mode of delivery

The MDT was seen as having a unique mode of delivery. MDT and social care professionals noted the importance of being able to provide immediate, or very quick, support including swift crisis support. This is unique compared to the long waiting times to access community services during which the family situation would have worsened.

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

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

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

Members of the team have been seconded from partner agencies, enabling their expertise to become embedded within the team within a multi-disciplinary approach rather than a multi-agency approach. Because of the breadth of specialisms, the MDT offers wide ranging support to vulnerable families. Having a holistic, joined up approach with multi-faceted viewpoints when supporting clients who may be facing multiple issues at the same time was seen as very beneficial.

> It's a lot of expertise in a team, the social work teams we have are varying levels of expertise in different things but it's quite across the board and it's really dependent on what cases you

> worked on and the training you have done as well, but to have that level of expertise right there is really helpful. (Social care practitioner, interview)

A further important factor is that the MDT service is very flexible and bespoke to each client so they can really work with them to get the results required or to support the plan that they are on. The professionals considered the 1:1 and personalised support offered by the MDT as critical to meet the needs of each client. Many social care professionals contrasted this bespoke service from the MDT with what is available from community services who are set up to provide support in a very different way.

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

Combining the breadth of specialist knowledge within the MDT with their bespoke approach was seen as a core strength of the service since many clients have multiple and intertwined issues. Social care teams can refer a family for support for more than one specialism, and most referrals received are multi-faceted requiring the support of more than one team member. The team has the capacity to provide wrap around support at a pace that is manageable for families.

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

Discussion

The service overall appears to have been successful for many of the families that engaged. It achieved a high level of engagement with families who have complex issues and who struggle to engage with community-based services: of the 90 families referred, 81 were included in the evaluation, a further 4 were at a very early stage of engagement and only 5 families had not engaged. Previous evaluations of services that work with similar client groups have shown that engagement is a key part of the success of interventions and that non-engagement acts as a significant barrier (Cox et al. 2015, 2020, 2020, 2021). The MDT appears to have been successful engaging the majority of families, enabling the service to impact a relatively wide range of clients.

For those who engaged there were several positive outcomes across various parental and child risk factors and, although we have no control group for comparison, the insights offered by professionals suggest that the MDT intervention contributed to these improvements and that outcomes for many of the complex families worked with would not have been achieved without the MDT's involvement. This aligns with existing research suggesting that many parents are able to change, even when their children are on the edge of care (Ward *et al.* 2014) and

that the kind of intensive interventions offered by the MDT offer an effective way forward.

The MDT was clearly seen as an effective and valuable service by social workers and other social care staff who commented on the good working relationships, good communication and distinct but complementary roles of professionals in the MDT. This reflects existing research showing that sharing skills and understanding and good communication between professionals are beneficial for edge of care services, with effective communication being a key facilitator in successful joint working practices (Cameron and Lart 2003, McPherson *et al.* 2018).

Research shows that where women have faced high levels of maltreatment and adversity during their childhood, this shapes adult relationships – making them vulnerable to harm in adulthood and also having a negative impact on their views about support services, creating mistrust of professional help (Mason *et al.* 2020). Higher exposure to adverse childhood experiences and trauma also correlates to a higher risk of physical illness, mental health and behavioural problems (Green *et al.* 2010, Hughes *et al.* 2017). Common benefits of trauma informed approaches for professionals include a shared language that can be used across children's services, improved family retention and engagement, and better treatment decisions (Asmussen *et al.* 2022). Many of the vulnerable parents referred to the MDT had experienced adverse experiences during their own childhood and have then continued to face trauma as adults. The MDT provided person-centred support based on trust, consistency and immediacy which may account for some of the positive perceptions of the support offered. However, mental health issues among parents remained high and so to further enhance the trauma-focused nature of the service and potential mental health benefits for parents, MDT professionals could use resources and accessible training developed for frontline staff working in similar services to embed trauma-informed approaches: https://supportingparents.researchinpractice.org.uk/working-with-parents-with-a-history-of-complex-trauma/.

One of the key components of the service identified in the qualitative analysis as central to delivering benefits was the approach to prioritising building trust and relationships and putting parents in the driving seat, empowering them and enabling choice and control. The statutory safeguarding nature of children's social care often challenges the development of trusting relationships by children and parents with their social workers. Research has highlighted the value of a supportive and sustained relationship and that positive relationships between families and their social care worker are linked to better long-term outcomes (Gilligan 2000). Moreover, building a trusted relationship with parents is considered a necessary condition for change (Winefield and Barlow 1995). A higher level of parental empowerment is associated with family cohesion, functionality and relationships (Scheel and Rieckmann 1998), whereas a lack of parental empowerment is associated with serious conflicts within the family, adversities and mental health problems in parents (Vuorenmaa *et al.* 2016). Parental empowerment is an important factor for achieving sustainable long-term outcomes for children exhibiting problem behaviours (Damen *et al.* 2021). This feature of the MDT seems to be an important component to retain, being supported by literature as well as being perceived as central to successful outcomes by both MDT professionals and social care staff liaising with the service.

Implementing a multi-disciplinary team approach rather than a multi-agency approach appears to have been a key success factor for the service and seconding team members from partner agencies has enabled specialists from Probation, substance misuse services, mental health services for adults and children and the Youth Service to become embedded within the team. It could also be worthwhile to consider expanding the team to include additional expertise such as benefits/money and debt management, housing and educational support, plus adding specialist therapeutic expertise for parents and expertise in supporting children or adults who have faced sexual abuse and/or other traumas.

While overall the MDT programme appeared to provide many benefits for several families, not all families benefitted in all the ways possible and there were a number of ways in which the service could be improved. Given the potential cost savings delivered by this approach, it could be argued that the team should be expanded to cover a wider geographical area and good practice shared with other local authority areas. It would also be worth considering expanding the scope of the service and its approach to families that are currently out of scope for the service, helping prevent entrenchment of difficulties and avoiding families reaching crisis point. This could mean using a similar trauma-informed, holistic, person-centred approach earlier on at the stage of assessment; providing a longer intervention to be able to work with families for longer; and providing intermittent follow-up or discharge care.

It is significant that 31/35 (89%) of children and young people who were at risk of being accommodated at referral were not in care at case closure since, successful reunification after child removal is uncommon (Wilkinson *et al.* 2017). Significant cost savings for the local authority were identified as a result of these cases of avoided care proceedings and avoided longer term care arrangements. This should be welcomed against a background of spending on children in care by local authorities in England of over £5.7 billion in 2021/22, accounting for 51% of total spend on children's social care, and the fact that over two thirds of authorities are now overspending budgets in order to keep up with the rising demand to support vulnerable children (Department for Levelling Up, Housing and Communities 2022). The increasing financial cost of a child becoming looked after constitutes a strong argument for local authorities to introduce interventions that can prevent children from entering care (Fox and Ashmore, 2015). The 'intangible benefits' from avoiding care (emotional, psychological and relational) for many of the families who engaged with the service should also be considered (McPherson *et al.* 2018).

Limitations

The evaluation had several limitations. The data used within this evaluation were for families and any children living at the same address. Children sharing a parent but who lived at a different address from the parents and children working with the MDT team were excluded from the data. Since this was a pragmatic service evaluation, the data used for analysis were collected and input by the MDT professionals alongside the service's key task of supporting families. Response bias was addressed by triangulating service data and qualitative responses. However, the experiences and insights from families who used the MDT service were not included, meaning there remains a risk of response bias. The evaluation was limited

to service data and qualitative interview/focus group data and did not include any validated psychometric tools to assess family wellbeing or mental health. Evaluations of services for similar client groups in the future would benefit from pre-and post-measurement of parent and/or family functioning, mental health and wellbeing together with long term follow-up data on education and employment outcomes for children and young people. Closer analysis of specific mental health issues in parents may help direct service improvements to help address the persistently high rates noted.

Conclusions

According to Ofsted, the key factors that are associated with successful services for the avoidance of care include: a clear definition of what is meant by the edge of care; strong multi-agency working both operationally and strategically; multi-professional working with co-location and joint training; qualified social workers having a central role; consistent and clearly understood referral pathways and decision-making processes; a prompt, persistent and flexible needs-led approach; listening to the views of young people and their family and building on their strengths; having a clear plan of work based on thorough assessment and mutually agreed goals; and having a flexible, needs-led approach with long-term follow-up to assess outcomes (Rees *et al.* 2017). The MDT pilot programme incorporated many of these factors and subsequently delivered several benefits for families. The service appears to offer a good model for supporting edge of care families and avoiding children being taken into care with several successful outcomes for many families and significant potential for estimated ongoing cost savings through continuation of the service, depending on the actual costs of delivering the service. A particular strength of the MDT appears to be the offer of a positive alternative support service to families that is person-centred and based on trust, consistency and immediacy and these elements could be strengthened through enhanced trauma-informed training for MDT professionals to help address persistent high rates of mental health difficulty in parents. Overall, the evaluation suggests that multi-disciplinary services such as this pilot have much to offer local authorities and should be expanded.

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