REES CENTRE
Research in Fostering and Education
University of Oxford Department of Education

UNIVERSITY OF OXFORD

Evaluation of the Multisystemic Therapy Service in Essex: Summary of Findings

Lisa Holmes, Helen Drew, Neil Harrison, Valerie Dunn

100 YEARS LEADING RESEARCH IN EDUCATION

DEPARTMENT OF EDUCATION

UNIVERSITY OF OXFORD

Research Questions

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

Methodology

- The evaluation used a mixed method approach.
- Qualitative analysis:
- Nine interviews with twelve parents and other carers. All had completed MST within the past four months.
- One focus group with ten Social Care managers and Senior Practitioners, mainly from Assessment and Intervention or Family Support and Protection teams.

- A thematic analysis approach[1] was taken, with the research questions providing a broad initial framework.

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

Methodology

- Quantitative analysis:
- Data provided by Essex County Council for the cohort of young people who received MST including contact with children's social care before, during and after provision of MST.
- The focus was on understanding pathways to different outcomes including subsequent:
  - care placements;
  - child protection plans;
  - CiN referrals;
  - no further provision.

Qualitative findings

- What did practitioners and families hope and expect MST to achieve and to what extent have these been fulfilled?

- Practitioners: Some emphasised that expectations of MST were very high to begin with in Essex.

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

The overall consensus was that the service had a positive impact, but that MST was a better 'fit' for parents and carers who saw themselves as part of the process of change.

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

The importance of early, timely intervention was also highlighted as a key issue.

Qualitative findings

- What did practitioners and families hope and expect MST to achieve and to what extent have these been fulfilled?

- Families: Parents and carers were just desperate for a service that could help them and their child.

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

- Some were unclear about what MST could offer at the point of referral and did not have high hopes of change.
- All families we interviewed saw themselves as contributing to the process of change.

Qualitative findings

- What did practitioners and families hope and expect MST to achieve and to what extent have these been fulfilled?

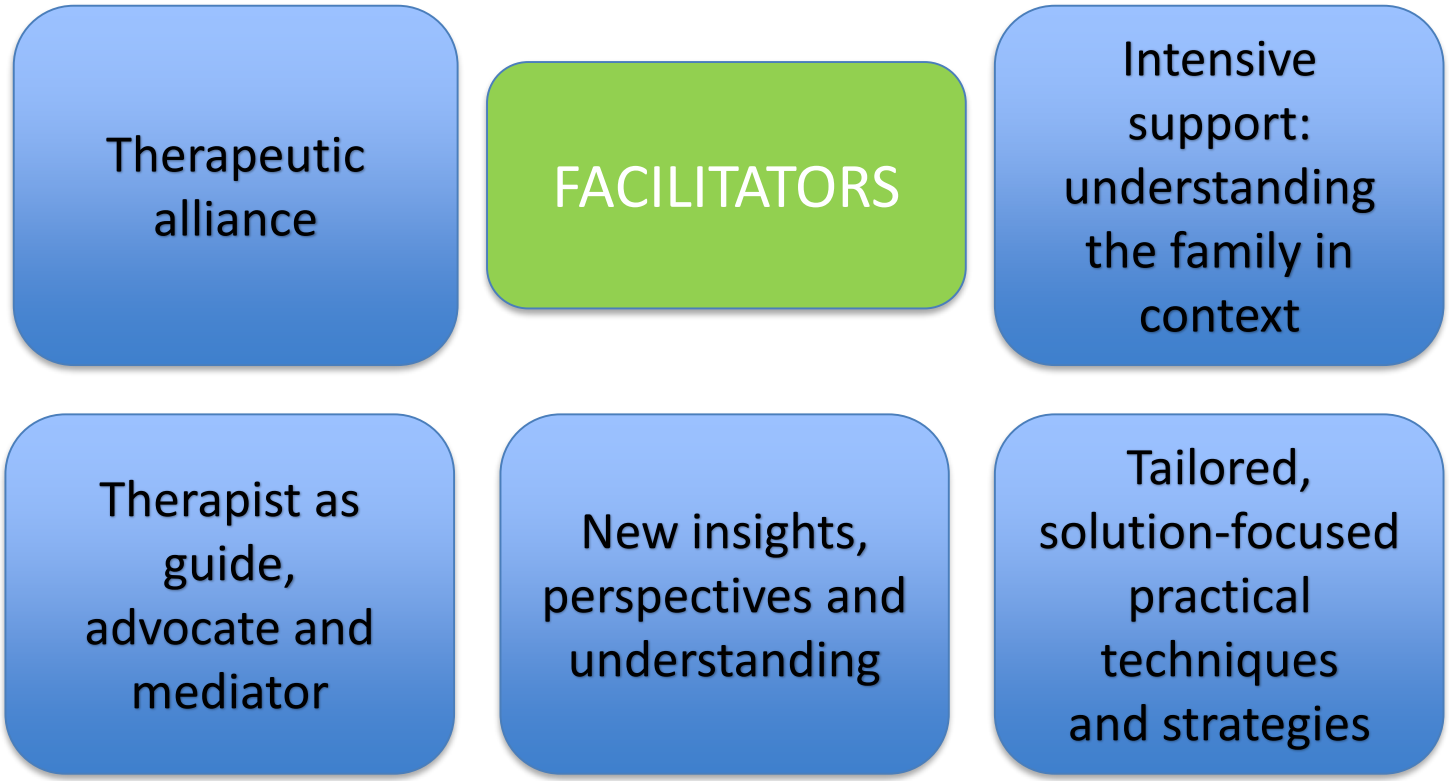
- Families: Generally MST greatly exceeded expectations and most families felt it was a very successful intervention.

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

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

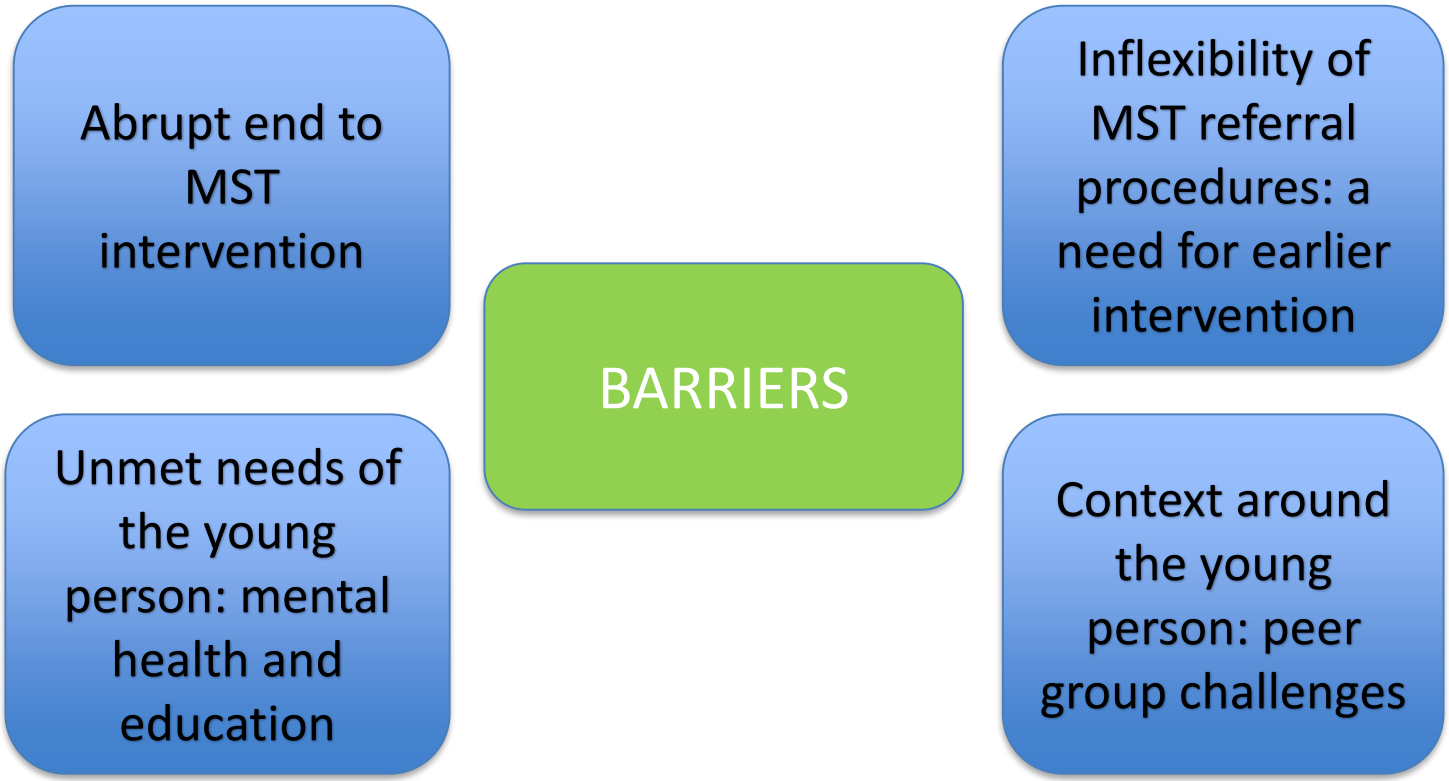
Qualitative findings

- What have been the most important factors that have facilitated and/ or acted as barriers to positive impact during and after MST?



Qualitative findings

- What have been the most important factors that have facilitated and/ or acted as barriers to positive impact during and after MST?



Qualitative findings

- What has the impact of MST been on families and young people?

Parent and carer	There had been a positive impact on all the parents and carers we interviewed. Two key themes were greater interpersonal understanding of problems and behaviour and greater parental confidence and control.
Young person	Outcomes for the young people in the families we interviewed were broadly positive. Change came via parent/carer change or sometimes via direct contact between therapist and young person. Changes in behaviour, education, peer context, sense of control and aspirations.
Family	In most families there had been a change in the whole family dynamic: the family had become a unit again. Family members were able to spend enjoyable time together and relationships were more positive between all family members including parents and siblings.

Qualitative findings

- What has the impact of MST been on families and young people?

- Assessing impact and success is challenging. It can be difficult to state that the impact of MST was either positive or negative for an individual family, since change can occur at different times for different family members.

  'She's (therapist) just given us the foundations that we can work on and we are getting there' (Family A).

  '*I found it very, very good for me personally… but it hasn't changed, no, it hasn't really changed anything within the environment we live in, apart from it's given me some new techniques'* (Family I).

- Practitioners felt that subtle but important changes could be overlooked if the sole focus was on quantitative change, such as entry into care or custody.

Quantitative findings

- Young people for whom we had data two years pre-MST and one year post-MST were included in the analyses.

- N = 302; 126 females (41.7%) and 176 males (58.3%)

  Average (mean) age at start of MST was 14.2 years

  Range was 11 – 17 years.

- Median length of MST intervention period was 142 days (about 4.5 months).

  Range was 10 days to 361 days.

Quantitative findings

Two years pre-MST

- 274 (90.7%) had some previous provision:

  Child in Need (CiN) plan; other service(s) including Family Solutions/DBiT; Child protection plan; period of care.

- CiN plan – 254 (84.1%)
- Other services – 121 (40.1%)
- Child protection plan – 27 (8.9%)
- Period of care – 29 (9.6%)

Quantitative findings

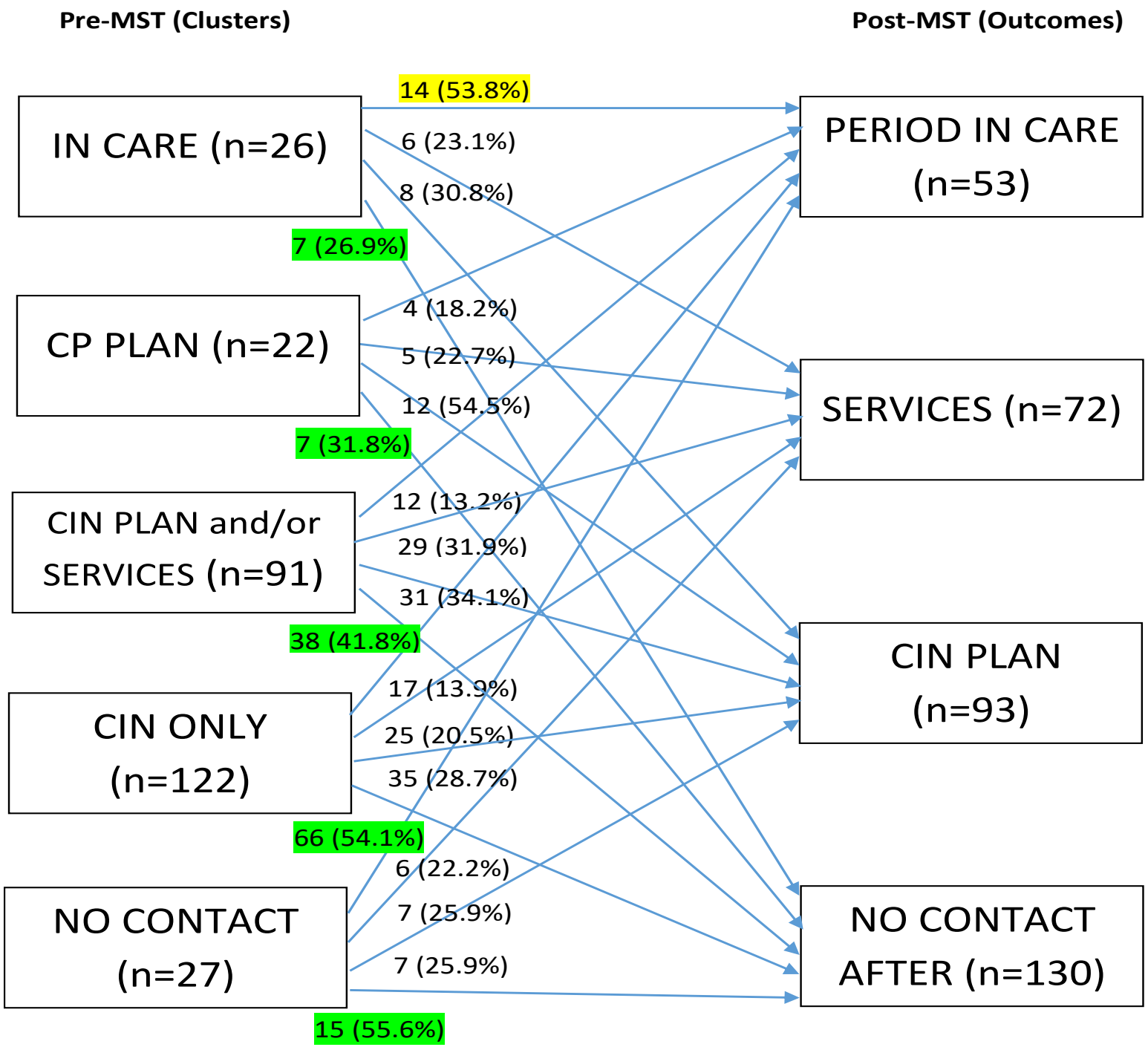
What are the outcomes for young people post-MST?

One year post-MST

- 165 (54.6%) had some further provision, 137 had no further provision (45.4%). This compares to the pre-MST figure of 274 (90.7%) having prior provision.

- CiN plan – 98 (32.5%)
- Other services – 74 (24.5%)
- Child protection plan – 12 (4%)
- Period of care – 56 (19.2%); only 22 (39.3%) of these had no period of care pre or during MST.

Note: no gender differences for pre or post service provision


Pre-MST (Clusters)
Post-MST (Outcomes)
IN CARE (n=26)
CP PLAN (n=22)
CIN PLAN and/or SERVICES (n=91)
CIN ONLY (n=122)
NO CONTACT (n=27)
PERIOD IN CARE (n=53)
SERVICES (n=72)
CIN PLAN (n=93)
NO CONTACT AFTER (n=130)
14 (53.8%)
6 (23.1%)
8 (30.8%)
7 (26.9%)
4 (18.2%)
5 (22.7%)
12 (54.5%)
7 (31.8%)
12 (13.2%)
29 (31.9%)
31 (34.1%)
38 (41.8%)
17 (13.9%)
25 (20.5%)
35 (28.7%)
66 (54.1%)
6 (22.2%)
7 (25.9%)
7 (25.9%)
15 (55.6%)

Quantitative findings

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

- Having a period of care pre-MST was the only thing that predicted a period of care post-MST.
- Being younger at start of MST and a longer MST intervention period predicted having a CiN plan post-MST.
- Being older at start of MST, and not having other services or care pre-MST predicted no further provision post-MST.

Recommendations

- The need for clarity about the focus and approach of MST at the point of referral.
- Consideration of a graduated end of service and/or support for families after MST case closure.
- Whenever possible, the need for continuity of (a well-matched) therapist for the family.
- Underlying mental health difficulties need to be addressed by mental health support services.
- Consideration of referral to MST at an earlier stage, rather than it being used as a ‘last resort’ intervention.