Department for Education

Multisystemic Therapy: Family Integrated Transitions (MST-FIT) - A feasibility study

Research report

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Stephen Butler, Alisa Anokhina, Karolina Kaminska, Charlotte Watmuff, Peter Fonagy – University College London/Anna Freud National Centre for Children and Families

Children's Social Care Innovation Programme Evaluation Report 47

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Executive summary

The present report outlines an evaluation of the feasibility of Multisystemic Therapy for Family Integrated Transitions (MST-FIT) in a UK context. The programme was developed as an adaptation of Multisystemic Therapy (MST), an American-based intervention which uses principles of cognitive and behavioural therapy, motivational interviewing, and mindfulness to help young offenders return home after a period of incarceration. In the UK, MST-FIT is currently in the early stages of being adapted to help a population of young people (aged 11 to 17) return to the family home from residential care. The programme is comprised of 2 stages: first, the young person enters a 12-week therapeutic programme within a specialist MST-FIT residential home, where they take part in regular skills sessions and work towards an individualised set of goals. During this period, the parent begins work with the MST-FIT therapist within the family home. In the second stage, the young person returns to the family home, and the MST-FIT therapist continues to work with both the young person and the parent for a further 4 months.

The aims of the evaluation were to identify the systemic issues in implementing MST-FIT in the UK; and to determine whether MST-FIT is a feasible intervention for this population, and to determine to which other populations MST-FIT may be suitable.

The evaluation consisted of a series of semi-structured, qualitative interviews with the programme stakeholders, including managers, MST-FIT therapists, residential staff, social workers, young people, and parents or carers. “Pre” interviews were conducted at the beginning of programme implementation, and “post”, approximately 9 months later. We additionally interviewed young people, parents, and staff receiving “management as usual” (MAU) within similar circumstances as the MST-FIT families. Objective data was collected on demographic information, social care history, and education and youth offending.

A total of 135 interviews were conducted, yielding rich data on the stakeholders’ experience of the programme. The qualitative data was analysed using Thematic Analysis, yielding several common themes across the stakeholder groups. We present the thematic data under the following domains: thoughts going into the programme, positive aspects of MST-FIT and negative aspects of MST-FIT, outcomes for young people and families, changes to the programme between our pre and post interviews with stakeholders, and finally, facilitators and barriers to successful implementation.

Thoughts going into the programme

During “pre” interviews professionals were aware that they were in the process of adapting MST-FIT to a UK context, and that some level of flexibility would be required. Questions were raised about what constituted an appropriate referral, and whether

residential staff had the right qualifications and experience for therapeutic work. Parents felt that the most common problems they experienced with their children was poor communication, and difficulties with emotional and behavioural regulation, including anger management. Young people who came onto the programme often already had experiences with therapy, social services, and/or residential homes: because these experiences were frequently negative, young people had mixed feelings about starting MST-FIT.

Positive aspects of MST-FIT

Stakeholders often made very positive comments about MST-FIT. Professionals felt that there was currently very little being offered to this population, particularly with the behavioural emphasis of MST-FIT, so the programme was seen as valuable and needed. Both professionals and parents felt that the skills taught as part of MST-FIT were transferrable, skills for life, useful to a variety of personal and professional situations, not just for returning to the family home. MST-FIT professionals felt that returning home from residential care was often in the best interests of the young person, and MST-FIT could help support that transition. However, social workers were more apprehensive, and felt that returning home was not always the best option. A number of professionals (including social workers) felt that MST-FIT could be adapted in the future to mend foster care breakdowns. Finally, parents made a lot of positive comments about their relationship with the MST-FIT therapist, crediting the on-call and supportive nature of the relationship as major contributors to their positive outcomes, and often making favourable comparisons to other mental health professionals with whom they had worked in the past.

Negative aspects of MST-FIT

Some families found that MST-FIT was not able to help them. However, even in these cases the parents and young people tended to speak positively about the programme, but reiterated that it was simply not suitable for their particular needs. This suggests that the unsuccessful cases were unsuitable for the programme. Managers have noted that MST-FIT staff have used these cases to learn and make more appropriate decisions about referrals in the future. Within the residential home, staff initially felt anxious about delivering a programme which they felt was too clinical for their qualifications. Staff felt significantly more confident during the “post” interviews, but were still frustrated by having to balance MST-FIT work with the day-to-day duties of running a residential home. Young people also had mixed feelings about the skills groups in the residential home, with some describing them as boring or unhelpful. However, residential staff were aware of this and were gradually working on adapting the sessions to be more engaging and appropriate.

Outcomes for young people and families

Eight parents were interviewed at "post"; in 4 of these cases, the young person was still in the family home at the time of the interview. In the other 4 cases the placement had broken down and the young person returned into care. However, all stakeholder groups spoke about positive changes to young people's behaviour, such as improvements to parent-child communication; better emotional regulation for the young person; and parents being more able to stay calm under stress. Therapists felt that both parents and young people were able to learn new skills on the programme. In unsuccessful cases, both parents and professionals felt that young people's problems were too complex and ingrained for what MST-FIT could offer (for example, adoption breakdown, history of sexual abuse, transgender issues), especially within relatively short timescales.

Changes to the programme between "pre" and "post" interviews

Professionals noted a number of positive adaptations which had been made in the 9 months between "pre" and "post" interviews. These included a more structured approach to ensure that there was a definite plan for the young person to return home and that this was adhered to as much as possible; and clear individual goals for the families to work towards. Communication between residential staff and therapists had improved, and there was a greater sense of MST-FIT staff and social workers working together, facilitated by the latter's exposure to successful cases and a better, experientially-based, understanding about MST-FIT.

Facilitators

Several factors which have contributed to programme success were identified by professionals, including not only the changes which took place between "pre" and "post" interviews, but also the positive close relationship between the MST-FIT therapist and the parents, which parents felt gave them confidence to maintain the changes they made after finishing the programme. Another facilitator identified by managers and therapists was reframing parents' belief that the child was "the problem" to seeing the child's behaviour more as a symptom of ineffective parenting, which then allowed therapists to address the root causes of the problems within the family.

Barriers

The barriers to delivering MST-FIT successfully included the relationship between the MST-FIT team and social services. Professionals (including social workers themselves) felt that social workers did not have a good understanding of MST-FIT. This had

improved somewhat at the time of the “post” interviews, but social workers still suggested that they could benefit from practical workshops with the MST-FIT team. Finally, skills groups within the residential home were sometimes too challenging for the young people; seen as “boring”, and too full of “American” jargon, which suggests that further adaptations to these are necessary.

The objective data collected as part of the evaluation could not be analysed for statistical significance due to the small sample size. However, the findings suggest that young people at the Leeds site might have been more prone to offending than those in Northamptonshire, although at both sites the offending levels were relatively low in number and severity. The majority of young people were enrolled in some form of education, and it appears that enrolment might have improved following MST-FIT. Findings from the Northamptonshire residential home show a reduction in the number of missing episodes, as well as in the number of assaults against staff, and staff sickness rates. The results of a questionnaire completed by residential staff at both sites also suggests high levels of job satisfaction and motivation.

Limitations and recommendations

The evaluation had some limitations, including a small sample size; difficulties in obtaining comprehensive objective data; problems in identifying an MAU comparison group, and differences in programme delivery and structure between the 2 sites.

On the basis of the findings, we have made several recommendations to contribute to successful outcomes and further successful implementation. This includes further defining the characteristics of young people and families whom MST-FIT is most likely to benefit; improving training for residential staff to reflect their professional experience and skill set; building evaluative capacity to allow the sites to track the changes in the families over the course of the evaluation (including emotional, behavioural, communication, peer functioning, education, and so on); engaging social workers within the programme to continue building positive and productive working relationships with MST-FIT services; taking steps to assess parents’ mental health needs on referral, and considering the applicability of the programme to a foster care setting.

Overview of project

Project intentions

The evaluation was designed to assess the feasibility of Multisystemic Therapy – Family Integrated Transitions (MST-FIT) in a UK context. MST-FIT is an adaptation of MST Standard, specifically designed to aid young people in returning home from institutionalised care. MST Standard uses the 9 principles of the standard MST model (MST UK, 2017) and in addition to behavioural, CBT and family therapy interventions, it adds Dialectical Behavioural Therapy (DBT; a strategy for changing unhelpful thought patterns and behaviour); motivational interviewing (which uses the client's personal goals to motivate behavioural change), and mindfulness (a form of meditation designed to help clients to identify and accept their thoughts, feelings, and internal experiences). The programme was initially developed in the US, where it was used in the context of helping youth offenders return from custody to the community. The programme was transposed to the UK in 2014, where the aim was to adapt it to a population of children (aged 11-17) in care with the aim of permanently returning them home to their families after a short-term period in a residential home. For the young people involved in this evaluation, there was substantial variation in the length of time that they had been in care prior to receiving MST-FIT, for example, from a few months to several years.

The MST-FIT model is designed to address the barriers to the young person returning home, including difficulties in the parent-adolescent relationship, the young person and carer's ability to manage negative emotions and communicate effectively, and increasing pro-social behaviour, and involvement in school/training. In the UK context, the 'home' placement for the young person can be with birth or adoptive parents, other relatives who have made a strong investment as carers, long term foster carers or special guardians for the young person.

At the point of referral, the family works with the referring social worker and staff team to identify the particular problems which the family will be addressing over the course of the programme, and the specific goals towards which the young person and the parent will work. Although MST-FIT uses a consistent approach and structure for all families, the flexibility of the programme allows for a tailored, individualised approach. The programme is comprised of 2 phases: the Integrated Treatment Model (ITM) element of the programme in residential care is designed to last 3 months within a residential home, and is followed by an additional 4 months' Family Integrated Transition (FIT) treatment from the MST therapist in the family home. Once the young person is referred into the programme, they are transferred to an MST-FIT residential home, where they take part in the ITM portion of MST-FIT. ITM includes up to 3 group DBT skill sessions a week, plus individual sessions as needed, in which young people learn skills related to communication, and emotional and behavioural regulation. During this time the care plan

for return home is developed, including a plan for gradually increasing contact and most young people have at least weekly contact with the family, in which they return home for a day, or an overnight period. Parents and carers are also encouraged to have contact with the residential home. When the young person has been in the residential home for 4 weeks, the MST therapist starts work with the family at home to prepare them for the young person's return, including teaching the parent/carer the same DBT skills, as well as drawing up safety and behavioural plans in relation to at least 3 referral behaviours identified for the young person during the referral phrase. The therapist will have contact with the family 2 to 3 times per week and will also work closely with the residential home during this time. When the young person returns to the family home, the therapist continues working with the family as a whole, to reinforce the new skills and to address any emerging problems.

Formal referral criteria were developed at the beginning of programme, although it became clear over the course of the study that these were intended as guidelines for the pilot, and the referral process continues to be refined. The current criteria include:

- age (11-17 years old)
- the parents/carers are willing to have the young person return home and are able to provide a safe environment (as assessed by the social worker and agreed by the independent reviewing officer)
- the young person is presenting with at least one of: mental health problems, alcohol/drug misuse, antisocial or criminal behaviour, emotional dysregulation, and/or risk of continued placement breakdown

Exclusion criteria include:

- lack of primary caregiver or a plan to live independently
- suicidal, homicidal, or psychotic behaviours
- sexual offences
- pervasive developmental delays

MST therapists and residential staff had a 4 day training, followed by a weekly telephone consultation. The consultants were Dr Henry Schmidt and Joshua Leblang from the University of Washington, both of whom help insure the quality of service provision as part of the implementation of the MST-FIT programme. Booster session training to revisit principles and address specific training needs and issues identified by staff were provided 6 monthly for residential staff and quarterly for MST staff. Based on previous adherence measures developed for other MST interventions (Huey et al., 2000), there were also adherence measures for the MST-FIT therapist and supervisor, and an adherence measure for ITM was developed as part of the pilot.

Existing research

Recent systematic reviews of interventions of youth antisocial behaviour identify MST Standard as a promising intervention for reducing adolescent antisocial and offending behaviour, the need for out-of-home placement, and for improving the young person's adjustment including their relationships with family and peers (van der Stouwe et al. 2014). The replicability of the findings from the USA when MST has been implemented in other countries has been mixed. While studies in Canada and Sweden showed no significant differences between MST and control groups on time spent in custody and criminal offending indices (Leschied & Cunningham, 2002) or problematic behaviour and family relationships (Sundell et al., 2008), those conducted in the UK, Netherlands and Norway are consistent with previous US research showing significant decreases in antisocial behaviour, providing cautious evidence for generalisability to other European countries outside the US (Asscher et al, 2013; Butler, Baruch, Hickey & Fonagy, 2011; Ogden & Halliday-Boykins, 2004).

Although RCTs have been evaluating the effectiveness of MST for over 2 decades, there is limited research and no RCT evaluations of the more recently developed MST-FIT. Using a matched-control design, in which youths who participated in MST-FIT were compared with youths who met criteria for MST-FIT but lived in counties in which the intervention was not available (treatment N=104; control N=169), at 18 month follow-up young people showed 41% and 27% felony recidivism rates for management as usual (MAU) and MST-FIT groups, respectively. There was also a trend towards decreased total felony recidivism (this includes misdemeanour and felony recidivism) and violent felony recidivism in MST-FIT group, but these differences were not statistically significant ($p=.36$ and $p=.49$, respectively). A cost-benefit analysis found that, by reducing the felony recidivism, MST-FIT lowered the cost of justice system's expenses related to future re-offending, suggesting a financial benefit for MST-FIT compared to the usual services available in the youth offending system (Aos, 2004).

These findings were consistent with Trupin, Kerns, Walker, DeRobertis and Stewart's (2011) study of a group of young offenders returning from incarceration to the community. They report that the felony re-offending ratio in MST-FIT group was 30% lower than in a comparison group receiving usual services (MAU group) at 36 months' follow-up. However, they did not find significant evidence suggesting MST-FIT to be more efficient than MAU in lowering total felony recidivism (this includes felony, violent felony and misdemeanour recidivism) nor in violent felony and misdemeanour recidivism, separately.

Despite the promising findings from initial US studies, there are no studies investigating how well the programme succeeds in other countries, including the UK. There are significant differences in how social care manages young people in the US compared to the UK; specifically, incarceration rates are higher in the US, whereas residential

(children's home) care is prioritised in the UK (Hazel, 2008). There is no published research evaluating MST-FIT for looked-after children who are moving from the residential care to the family home or other settings. However, social care research on the factors that influence children returning home from care underlines the importance of support from Children's Services, preparation with both young people and parents in terms of what they can expect after reunification, purposeful social work in the form of helping to explain and deliver appropriate services, and the need to cultivate parent motivation and address parental mental health issues, such as substance abuse (Farmer, 2014; Farmer & Wijedasa, 2013).

Research context

2 UK sites were included in the study: Northamptonshire (one residential home) and Leeds (2 residential homes). The 2 sites were invited to take part in a pilot of MST-FIT in the UK Social care with the aim of improving outcomes for young people returning home from care. Research indicates that around a third (30%) of young people who return home will re-enter care and that their outcomes, in terms of education and mental health, are often poorer than for those young people who remain in stable placements in care (Holmes, 2014). The pilot also aimed to test whether MST-FIT/ITM would improve the skills of the workforce within children's residential care.

The Local Authorities selected for the initial pilot both had:

- a sufficiently large number of children in residential care to suggest that referrals to MST-FIT could be made (>500 LACs in each local authority) and in-house residential homes were located near to where children would be returning home
- experience of successfully implementing MST Standard
- sign up from strategic leadership across the authority

A further local authority, Reading, has also developed an MSTFIT team with the crucial difference of being targeted at foster carers. Under this adaptation, foster carers would receive training similar to residential home staff, and would work together with the MST therapist and the young person's birth parents to support the young person's transition back to the family home. Reading is a smaller local authority than Leeds or Northamptonshire, which meant that both resources (such as residential homes run by the local authority) and availability of suitable cases were limited. In addition, finding suitable foster carers was more challenging than anticipated. As a result of these factors, the site took longer than Leeds or Northamptonshire to open, although the programme is under way at the time of writing.

Trafford was another site which considered commissioning MST-FIT. Because it is a smaller local authority, the implementation was considered in partnership with

neighbouring local authorities, which proved to be more complex than anticipated. In addition, staff changes in senior leadership have taken place, and the new staff members are significantly less interested in following through with the commission of MST-FIT. As a result MST-FIT had not been implemented in Trafford.

In 2015, Leeds Children's Services reviewed their Children's Homes and concluded with a proposal to realign service delivery of their residential homes towards more family-oriented, shorter and more purposeful interventions, thus engaging with NSPCC to deliver the Reunification Framework. The strategic aim was to reduce the length of time any child spent away from a family setting, be that their own family, extended or connected ne2rk care or foster care, with the expressed belief that children should be raised in families. The opportunity to be involved in developing and delivering the Integrated Treatment Model from a children's home setting was consistent with Leeds Council's goals of reducing the need for children to be looked-after; increasing attendance at school, and reducing the numbers of children not in education or training.

In Northamptonshire, MST-FIT was commissioned by the Northamptonshire City Council (NCC), because it was felt that there were no evidence-based interventions designed to help young people to return home from care. The NCC secured funding to implement and pilot the programme in October 2014. The specific residential home was chosen for pragmatic reasons, as it was felt that the particular home was not performing well, staff morale was low, and that the home could benefit from a structured programme to focus its development.

The implementation of MST-FIT followed a period of substantial growth in MST interventions in the UK, with approximately 30 MST-Standard teams, 2 MST-PSB (problem sexual behaviour) teams, and 4 Multisystemic Therapy – Child Abuse and Neglect (MST-CAN) teams. Leeds has had an MST-Standard team for 7 years and also has an MST Child Abuse and Neglect Service: both MST-FIT sites employed MST supervisors and some therapists with previous MST experience.

While the 2 residential homes in Leeds were specifically opened as MST-FIT/ITM homes, with staff recruited and trained specifically as MST-FIT staff, the residential home in Northamptonshire was converted from a general Looked-After Child (LAC) home and staff were re-trained as MST-FIT staff. This meant that the Leeds homes included only young people who were specifically referred into the MST-FIT programme, whereas the Northamptonshire home also included 3 young people with no plan to return home. These young people took part in the ITM aspects of the programme, but were moved onto other placements or independent living part-way through the study. All new young people referred to the Northamptonshire home are now referred into the MST-FIT programme with a plan to return home.

Table 1: Demographic data of MST-FIT and MAU families

Site	Gender	Ethnicity	Age at start[1]	LAC[2] status	Previous placement (days) prior to intervention
N'ampton (MST-FIT) N=5	80% Female	80% White British	14	60% Section 20	125
N'ampton (MAU) N=3	66% Female	100% White British	15	100% Section 20	304
Leeds (MST-FIT) N=14	64% Male	71% White British	15	43% Section 20	94
Leeds (MAU) N=1	100% Male	100% White British	16	0% Section 20	Not known

[1]Mean age at start of MST-FIT, or age at first interview for MAU. The range for the sample was 12-17
[2]Percent of children classified as a "looked-after child" by the local authority, with the consent of the parents, under Section 20 of the 1989 Children Act

Source: Demographic Questionnaire

2 of the families referred to the programme were long-term foster carers (both in Leeds). In all other cases the caregiver was a biological caregiver or adoptive parent.

In Northamptonshire, the young people's Categories of Need included disorderly behaviour, abuse or neglect, and child at risk of sexual exploitation. In Leeds, the most common Categories of Need were abuse or neglect, and family dysfunction. Reasons for referral were diverse, but frequently included behavioural issues such as aggression or violence, running away from home, poor behaviour in school, self-harm, substance misuse, and risk of child sexual exploitation was also not uncommon. Referral reports often documented communication breakdown within the family, and parents' inability to control their child's behaviour.

Overview of the evaluation

Evaluation aims

- To identify and understand the systemic issues for implementing MST-FIT in the current UK context, including its effect on the professionals involved:
- To determine whether MST-FIT is a feasible intervention in a UK context for looked-after children returning home from residential care
- To assess whether this programme is acceptable and appropriate to a range of stakeholders, including young people, parents/carers, and professionals
- To determine for what other populations MST-FIT might be suitable

Summary of methodology

The methodology for this evaluation combined both qualitative (interviews) and quantitative (objective) data. The qualitative component consisted of semi-structured interviews conducted with staff members (managers, commissioners[1], therapists, residential staff, and social workers) and with families (parents/carers and young people). The aim of the interviews was to understand the subjective experiences of the professionals and families involved with MST-FIT, and the problems and barriers they encountered at this early stage of implementation, as well as the factors that promoted implementation and positive outcomes for young people and their families. Quantitative data was collected to get an objective understanding of the sample, and included demographic, social care, education, and youth offending data for the young people, as well as questionnaires for staff members to get a sense of their understanding of the MST-FIT model, and staff job satisfaction. Finally, although the number of young people receiving the intervention to date has been very small, and the programme is only recently implemented, combining qualitative and quantitative data allowed for some preliminary consideration of outcome for young people who had received the intervention.

[1] 2 of the managers were also interviewed in their capacity as programme commissioners. Different interview schedules were used to help differentiate between the different responsibilities and concerns of these roles (these can be found in Appendix 2). Where appropriate, we signpost the source of a quotation or theme, but there will be some overlap in the opinions between the participant's "manager" interview and their "commissioner" interview. This overlap was taken into account when conducting the Thematic Analysis.

Qualitative Interviews

To help understand the experiences of young people and carers who received MST-FIT, as well as the systemic issues and feasibility of MST-FIT in the current UK context, we interviewed a range of stakeholders. These included young people (N=20) and their carers (N=14); MST Therapists (N=6); MST Supervisors and Residential Home Managers (N=15); Residential Staff (N=15); Social Workers (N=4), and Commissioners (N=2). We also conducted interviews with a comparison group of Management as Usual (MAU) young people (N=4) and their carers (N=3), as well as professionals working in these residential homes (N=13).

Interview schedules were drafted with the interviewee's role and background taken into account, as well as the broader aims of the study. The schedules were intended as a rough guideline to prompt the interviewee, but ultimately we were interested in hearing what the interviewee themselves thought was important. Interviews with staff (managers, social workers, therapists, and residential staff) were conducted at the beginning of programme implementation (around October 2015), and again approximately 9 months later. The repeated interviews allowed us to document, and attempt to understand, the evolution of the programme from the various participants' perspectives, and to identify what solutions the staff team had implemented to address problems or issues that they identified at baseline, as well as issues which were still to be resolved. Interview schedules can be found in Appendix 2.

Interviews with young people and parents/carers were also conducted as the family started the programme, where possible; or at an intermediate stage, where the family was referred before this evaluation had started; (N=3); and again upon completing MST-FIT approximately 4 months later (or after dropping out of the programme).

In addition, we conducted a number of interviews with "management as usual" families. The initial recruitment criterion for MAU families was the young person being currently accommodated in social care, but where there was also a plan for the young person to return home. This criterion was chosen to mirror, as closely as possible, the circumstances of the MST-FIT families, as there was currently no other evidence-based programme that supported young people returning home from care. Where possible, we also aimed to match families on the basis of Category of Need (for example, family dysfunction, abuse or neglect, child at risk of sexual exploitation), as well as demographic variables (age, gender, ethnicity). In Leeds, we were not able to identify any young people who were in residential care with a plan to return home, so the criterion was relaxed to include cases where the young person was in residential care and having ongoing contact with the family, but without a clear plan to return home. In Northamptonshire, although 17 families could be identified consistent with this criterion, only 3 agreed to be interviewed.

The MAU group is therefore smaller than the MST-FIT group and is not an ideal comparison condition. It is also noteworthy that difficulties identifying an MAU condition appears to be related to the fact that concrete efforts to return looked-after children home in both of these local authorities are currently very limited. In Leeds, some wider work is being conducted on reunification under the NSPCC framework, but it is likely that not enough time has passed for this to affect practice. In addition to the young people and their carers receiving MAU, we interviewed several staff members from the residential homes providing MAU services.

Objective data

Objective data collection centred on information to help us characterise the MST-FIT and the MAU groups, including demographic information, social care history, education data, youth offending data, and history of involvement with mental health services (for example, CAMHS). Information was obtained via centralised databases: however, this data was sometimes incomplete, unavailable, or incorrect. To maximise the validity of the data we asked the participants to fill out self-report questionnaires (custom designed to fit the evaluation's aims and specific research questions) asking for the same information, which helped fill in some of the gaps or correct any outdated information. In addition, we reached out to social workers for a detailed history of young people's involvement with mental health services, although not all were able to respond to us in time for project completion.

A series of CYPRESS (Children and Young People – Resources, Evaluation and Systems Schedule; Gaffney, Pilling & Butler, 2013) interviews were conducted with each group of professionals (managers, therapists, and residential staff) at each of the sites. CYPRESS is a structured interview consisting of 20 items scored on a 5-point Likert scale. The 3 sections address service characteristics (for example, Do staff have a shared model of care? Are the qualifications of the staff appropriate to their work?), team operation (for example, Is there a comprehensive model of supervision? Are there quality assurance policies?), and interventions (for example, Does the range of help offered to families meet their needs? Are young people and parents involved in decisions about their care?). The results of these interviews are combined with the qualitative interviews and feedback sessions with staff to inform our understanding of implementation. They are not reported on separately.

Changes to evaluation methodology

While the evaluation methodology did not change, the very low number of participants receiving MST-FIT (N=19) across the 2 sites, and even fewer who had completed the programme during the evaluation period (N=11), precluded analysis of quantitative

outcomes. Consequently, the preliminary outcomes are derived from the qualitative interviews with a range of stakeholders, and inferences based on consideration of the objective data that was available to us.

The evaluation of MST-FIT also did not include cost effectiveness analyses because of the small sample size and developmental stage of the programme. The analysis carried out by local authorities provided some very promising emerging evidence of the potential value for money of MST-FIT. In Leeds, the operating costs per young person per year have been estimated at £46,146 (based on an 80% capacity within the residential home), compared to a cost of £80,668 within a mainstream home. In Northamptonshire, costs are estimated at £36,250 (at 90% capacity), compared to an LA cost of £51,214. It must be noted that these figures are not based on an empirical cost-effectiveness evaluation, but rather on figures collected by Northamptonshire and Leeds.

Although these preliminary local costing data are promising, they do not reflect a comprehensive health economic evaluation that would be the ideal evidence-based standard. Moreover, the small sample sizes in our feasibility study precluded effective analysis. Rather, we have co-ordinated this aspect of our evaluation with Dr Lisa Holmes of Loughborough University, who has developed a cost proforma, created in Excel, for future use by the National Implementation Service (NIS) and local authorities, to explore the cost effectiveness of MST-FIT as the programme becomes embedded into practice and is introduced into new local authority areas. The pro forma has been developed for 2 purposes: for use by the NIS to report nationally on the cost effectiveness of MST-FIT and to inform future scale and growth strategies, and for use by individual local authorities to ascertain whether MST-FIT provides a value for money service for adolescents returning home.

The pro forma provides a standardised framework to capture the cost inputs associated with MST-FIT and the outcomes that can be attributed to the MST-FIT programme which can be off-set against the cost inputs. The framework for the identification of the MST-FIT cost inputs, and potential outcome indicators for inclusion in future cost effectiveness studies, are detailed in technical Appendix 1. They are based on routinely collected indicators and also draw on the learning from the experiences of Leeds and Northamptonshire as early adopters of the MST-FIT programme.

Key findings

This section outlines the main themes which emerged from the Thematic Analysis of the qualitative interviews conducted with the stakeholders, including managers, MST-FIT therapists, residential staff, social workers, young people, parents (or carers), and MAU families and professionals.

Thoughts going into the programme

What constitutes a 'good referral'?

Managers spoke about difficulties getting the right referrals prior the implementation of the programme; it wasn't yet clear what a "good" referral was, and it was important to match new referrals to young people who were already in the residential home, on the basis of presenting problems.

Do residential staff have enough skills and experience to deliver ITM training?

Residential staff were enthusiastic about what the model has to offer but they worried that they did not have the right skills, previous education and experience to deliver it. They also described the training as full of "brilliant ideas" (S08[2]) and an approach which helped them to "look outside the box" (S11). However, they also found elements difficult to understand, such as American jargon, and therapeutic approaches with which they were unfamiliar. They felt that they could benefit from the training being longer, as a lot of new information was covered in a short period of time. They felt anxious about delivering the programme and were lacking in confidence – it would take some time to adapt to this new model of working.

Young people's difficult journey

Many young people spoke about their past experiences with other services, such as counselling or CAMHS; these experiences were often negative, and it seems that young people did not want to be disappointed again, and therefore lowered their expectations of MST-FIT. Nine of the 14 young people also had historically negative experiences with social workers, saying that they did not listen and were unhelpful. Seven young people

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[2] The references following quotes within this section refer to the source of the quote, such as Manager (M), Therapist (T), Residential Staff (S), Social Worker (SW), Parent/Carer (P), or Young Person (YP). The numbers are assigned to identify each unique interview and to give the reader a sense of the diversity of the quotes' sources.

expressed their concerns in terms of not being involved in the referral process or not getting any information about MST-FIT prior to the treatment, which they felt would have been useful. Possibly as a result of this, several young people did not initially want to come to the residential home, and felt “nervous”, “scared”, “reluctant” or “upset” (YP16, YP21, YP19, YP25, YP68). Young people had mixed feelings about the outcomes of MST-FIT; although several expressed scepticism about whether MST-FIT could help them, they also spoke about things they did want to change, such as reducing offending, drinking, smoking, taking drugs, or self-harming, and improving their relationship with their family.

The parents’ relationship with the social worker was negative.

Similar to young people’s negative experiences going into the programme, 9 of the MST-FIT parents made generalised negative comments about having a negative history with their social workers, or about social services in general. They reported finding social workers to be unhelpful and not very supportive.

Most common problems: communication, running away, and anger management

MST-FIT parents frequently cited “communication” as an important problem with which they struggled prior to receiving MST-FIT. While they spoke of poor communication, parents did not understand why this was the case, but emphasized how poor communication led to arguing and conflict. Related to this, the majority of parents felt that their child had problems controlling their anger in their interactions with them. At post-treatment, parents noticed that conversations with the young person had become calmer; that they both got better at understanding the other person’s viewpoint; and their children felt more able to approach them and to be honest when talking to them.

Positive aspects of MST-FIT

MST-FIT is a good programme

Overall, professionals, including MST-FIT therapists, residential staff, managers and social workers made generally positive comments about MST-FIT and its potential to help families:

> "I think it's got the potential to be very, very effective. I think it's a great resource and I think, I'm a big advocate for supporting young people being at home, which is great." (SW61).

Therapists were very positive about the programme and the contribution that it could make to the current service environment for young people in residential care. They felt that this systemic intervention nicely questioned the assumption that child was the problem and that commitment from all stakeholders would be necessary to make the intervention a success. They also felt that the skills taught as part of MST-FIT were transferrable: “the emotional regulation kind of stuff every young person and probably most adults could, erm, benefit from” (T02). However, they also suggested that some quality assurance measures should be put in place in the residential homes to ensure treatment fidelity. Residential staff described MST-FIT as “proactive”, rather than “reactive”, and felt that it could really benefit young people. Managers also emphasized that flexibility of the programme during the pilot stage, which allowed them to adapt it over time. Commissioners spoke about the benefits of working with all the systems involved with the young person, and temporarily removing the young person from the home.

MST-FIT is needed

All therapists during “pre” interviews felt that MST-FIT offered something new and valuable – in particular, a behavioural focus, which is currently absent in UK care homes:

> “[T]he problem with UK care homes is the lack of behavioural focus, the lack of behavioural understanding and the lack of clear expectations around which work we’re doing with a young person” (T08).

Moreover, managers noted that there were no real alternatives to MST-FIT for this population, making the programme unique in what it offered. Commissioners also felt that, although the evidence base in the UK is still small, MST-FIT was filling an existing gap for a therapeutic, evidence-based intervention. The need to receive treatment was also expressed by MAU parents. They generally felt that their children, who had a range of complex needs, could definitely benefit from a therapeutic intervention, but that no such help was available to them. Although parents sometimes spoke about their children receiving occasional counselling, the parents received no support outside of contact with their social worker and with the staff at the residential home. This was consistent with MAU staff who felt that they had different amounts of involvement with families in different placements. Within some placements, staff often mentioned the involvement and support they had provided to young people’s families. Conversely, in other placements, staff mentioned working with families considerably less, and some described this as not part of their job role.

MAU young people claimed that being in a residential care environment, despite not receiving much formal therapy, had helped them at least somewhat. Most were looking forward to independent living and having more autonomy, rather than returning to the family home. This was consistent with MAU staff, who often described supporting young

people to be more independent by learning a wide range of skills. Additionally, staff mentioned a wide range of support young people receive from external agencies. This included staff referring young people to services, other services making visiting the placement regularly and other services sharing their knowledge with staff so that staff were better equipped to support the young people.

Young people should be returned home, where this is possible and safe

All therapists, and all but one manager, agreed that young people should return home to their families (as opposed to staying in care), wherever this was safe (there were no issues with, for example, substance abuse or domestic violence) and possible (for example, there was sufficient space in the parent/carer’s home to accommodate them), given that outcomes in care are often poor, and the financial benefit to returning home is substantial. “Home” in this case would refer to any stable family placement, whether with biological family, or foster carers:

> “I think 'home' needs to be elaborated into a safe environment for [young people] to be.” (M02).

Most MAU residential staff agreed that they believed the best place for young people would be with family, depending on whether concerns regarding the young person’s safety were attributed to parents or the young person: that is, that if the safety concerns were regarding the parents, this would not be appropriate. In contrast to other professionals, social workers disagreed that returning to the family home was always the best outcome for young people. The main barriers cited were safety, parents’ issues (for example, alcohol dependency), a foster placement providing better quality of care, and the child not wanting to return home.

MST-FIT could also be useful in a foster care setting.

About half of the managers spontaneously suggested that MST-FIT might be a useful tool for managing foster care breakdowns, and preventing the young person from coming into care, although they also recognised that this would bring with it new challenges. 2 of the social workers also felt that MST-FIT could be successfully adapted to a foster care context. Both had MST-FIT cases which were not successful in returning the young person home, but where the young person was placed in foster care: they felt that MST-FIT was very valuable in helping this transition.

The relationship with the therapist was positive.

In “post” interviews, all MST-FIT parents spoke positively about their relationship with their MST-FIT therapist, describing them as supportive, encouraging, and helpful.

Parents specifically found it helpful that their therapist was on-call and could be reached at any time for help or advice. They also felt that s/he was “on their side” (P67, P22, P62) and “really cared” (P47). In successful cases, parents felt confident about maintaining the changes they had worked to achieve during the programme. Overall, all parents spoke positively about MST-FIT, even if it didn’t help in their particular case:

> “I find it better than anything else I’ve ever come across. Social services, anything like that, it’s ten times better, I think.” (P34).

Compared to parents in successful cases, parents in unsuccessful ones made more generalised, negative comments about MST-FIT staff, although they did not attribute the outcome of their case to this. Several MST-FIT young people also described having a positive relationship with their MST therapist, describing them as “empathetic”, “supportive”, (YP38) and “down to earth” (YP19). Some young people felt that a good relationship with their therapist would contribute positively to their outcome in MST-FIT.

MST-FIT skills are “for life”.

One of the main benefits of MST-FIT, in managers' opinion, was the fact that the skills taught as part of ITM were skills for life (M01, M09): useful not just in returning home, but in education, work, and family, "useful for anybody throughout their life" (M39). This was supported also by MST-FIT parents who noticed that MST-FIT had a knock-on effect on other members of the household. Parents spoke about improvements to communication and emotional regulation, for both themselves and their child. Specific skills which they found helpful included mediation, breathing techniques, learning to express yourself better, and taking the other person’s feelings into account. These positive changes, they felt, affected the family as a whole, including, for example, siblings and partners.

Negative aspects of MST-FIT

Families’ issues are too complex

In unsuccessful cases, parents felt that the issues with which their children were dealing were too complex for MST-FIT; this included an adoption case with a possible history of abuse, and a young person who had recently come out as transgender. Following on from this, parents spoke positively about the potential of MST-FIT to help other families, but that it simply was not enough for their child’s needs: "I think MST is probably better suited to teenagers that are… having different difficulties to X" (P51) In these cases, parents also felt that their child’s behaviour did not improve, or improved for a short term only. These concerns were also supported by social workers who noted that families often have complex, ingrained, long-term issues. Social workers felt that in some cases these issues were too complex for MST-FIT, particularly given its rigid timescales.

> "X is very complex, she has CSE [child sexual exploitation] needs, she has mental health issues, she potentially has foetal alcohol syndrome, she suffers from social anxiety" (SW15).

However, this was now framed as a referral issue (that is, only referring families where the level of complexity is appropriate to MST-FIT), rather than the programme being inadequate. In contrast, residential staff claimed that the programme was adaptable to different complex needs of young people: 'their programmes are completely different. Their behaviours are completely different. So we target it differently' (S37). The programme is adjusted to their needs.

Taking on the role of therapist, teacher, and staff worker

Eight of the 11 residential staff interviewed at "pre" felt anxious about delivering the programme and were lacking in confidence – it would take some time to adapt to this new model of working. Some staff at one of the sites were also frustrated about the way their role encompassed not only their usual staff work, but also the role of therapist and also teacher (as some staff had to learn ITM principles second-hand, until the next available training session took place), without appropriate recognition or compensation.

Mixed feelings towards ITM skills groups.

Feelings about the ITM skills groups were also mixed: many young people found them "boring" (YP16) or unhelpful; however, others did find that they helped them to change their behaviour, such as coping with anger.

Outcomes for young people and families

Eight parents were interviewed in the "post" phase. Four of these cases were successful, in the sense that the young person was still at home at the time of the interview. Four cases were unsuccessful, in the sense that the placement had broken down and the young person had returned into care at the time of the interview. However, in-home placement should not be considered the only measure of success: for example, in one of the cases where the young person returned to residential care, both young person and parent spoke positively about the programme and felt that their relationship did improve significantly. By contrast, in another case where the young person remained at home, the relationship remained strained, and the parent felt that MST-FIT did not adequately address their concerns, and that they would need to seek out the support of other services.

The issue of how success should be defined in MST-FIT outcomes was also a salient point of discussion in the feedback meeting at the Northamptonshire site: staff felt that all

young people were better off after MST-FIT, compared to their predicted trajectory before the programme, even if they were not able to remain at home. The team members felt that defining success in programme outcomes should be important for building evaluative capacity in the future.

Positive improvements

In all stakeholder groups interviewees identified improvements in both young people and parents as a result of taking part in MST-FIT. During the ITM portion of the programme, residential staff noticed positive changes to the young people's behaviour, including a decrease in aggressive behaviour, less running away, better emotional regulation, and improved relationships with parents. All therapists felt that both parents and young people were able to learn new skills over the course of the programme. Even social workers, who were overall more critical of the programme compared to other professionals, noted that they had seen some improvements to young people's behaviour.

> "Erm, [the young person would] sort of fly off the handle. She couldn't really quite self-regulate. But MST has sort of taught her that, you know. She won't shout, as I say, she wouldn't get as angry, she used to, she's more calmer in her, sort of, reactions" (SW13)

Both parents and young people were also able to see positive changes. Parents spoke about improvements to communication and emotional regulation, for both themselves and their child. These improvements are consistent with what parents identified as the most important problems going into the programme. The majority of young people also felt that MST-FIT had helped them in several ways, including reducing their anger and improving the quality of communication with their parents. Equally, young people saw improvements in their parents, and have said that MST-FIT helped their parents remain calmer in difficult or stressful situations, and to understand their child better.

Half of parents also noticed that MST-FIT had a positive effect on other members of the household; for example, they were able to use the skills they learned to parent their other children, or the therapist was also able to include the parent's partner in the sessions. Finally, parents in "successful" cases felt confident about maintaining the changes they had worked to achieve during the programme.

> "There is going to be days where I may feel really down and then something will come up and it will be really bad, you know, and it will knock me for six, but I am confident that I will be able to get back up, and I will be able to start again and continue with the progress that I've made." (P40)

What went wrong in unsuccessful cases?

During “post” interviews professionals discussed the cases in which the placement had broken down and the young person returned to residential care. Managers felt that they could not identify a common cause for these cases: instead they discussed the unique circumstances which lead to the breakdown in each case. In some cases, managers felt the problems began at referral (that is, the referral itself was not a good one, and the young person was not suitable to MST-FIT to begin with). Some managers felt that unsuccessful cases most often failed because of a lack of engagement and investment from the parent, rather than any behavioural issues on the part of the young person. Therapists also touched on some of the unsuccessful cases, but like managers, tended to discuss the specific details of each case, rather than identifying common problems; for example:

> "The first time, he went straight back to his antisocial peers because there was very little work done around that. He was still contacting them all the time because [residential staff] weren’t taking his phone or anything else" (T42)

Social workers felt that the main problem in unsuccessful cases was families’ complex, ingrained, long-term issues, which could not be resolved in the timescales of MST-FIT. However, the narrative around this changed between “pre” and “post” interviews, from describing MST-FIT as inadequate for dealing with this issue, to MST-FIT being a good programme, but only when the referrals were suitable for what it can offer.

Parents in the MAU sample echoed some sentiments similar to those of parents in the unsuccessful cases; the parents felt that their children had a range of complex problems, which were poorly understood by both the parent and the professionals. However, the young people themselves voiced a preference to work towards independent living and having more autonomy, rather than returning to the family home.

In cases where young people felt that MST-FIT did not help them, the reasons included parents’ inability to persist in the skills they learned, and their own difficulties in changing their old negative behavioural patterns and attitudes, and their willingness to do so. Both of these reasons were consistent with the impressions gained by managers and therapists.

Changes to the programme between “pre” and “post” interviews

Changes to structure and procedures

Most professionals felt that positive adaptations had been made to the way that the programme was being run and managed over the course of the evaluation. For example,

the programme had been changed to be more structured – specifically, the duration of young people's stay in the residential home had been limited to 12 weeks. Managers, staff, and therapists all felt that this helped for the ITM portion of the programme to be more structured, and to give families and young people a clear goal to work towards. All residential staff had noted a number of positive changes which had taken place since the "pre" interviews, such as a clearer day-to-day structure within the residential home. They felt that these changes had given them more confidence in delivering the programme, but recognised that the work to refine the programme was still ongoing.

Improved collaboration

Eight of the 10 managers said they took steps to improve the staff-therapist collaboration, including introducing regular meetings between the 2 teams, which had helped both teams gain a better understanding of the other's work. Residential staff felt that their communication with the therapist team had improved as a result.

> "[The relationship] is lot more positive, and a lot more working together for the same outcome, with the same goal of trying to get kids home." (S36)

Residential staff confidence

Residential staff felt that, even at "post" interviews they were still in the process of developing and extending their knowledge and skills. However, they were also starting to feel more confident, and said that they enjoy delivering sessions, and that coping with difficulties had helped them to develop and improve both themselves and the programme. Managers corroborated this, and have said that staff confidence and understanding of ITM improved markedly, both through ongoing training and supervision, and through hands-on experience. Therapists were also aware of these changes:

> "They've made so many improvements; seriously you won't believe how many improvements they've made in the last year" (T42).

Relationship with social workers

Over the course of the evaluation, managers dedicated some effort into improving their relationships with social workers, and felt that social workers now had a better understanding of MST-FIT, and had increased in confidence as more "successful" cases emerged. Social workers themselves felt that they could still benefit from more information about MST-FIT, particularly in terms of what makes for an appropriate referral. This would ideally not take the shape of training sessions, but, rather, of better communication with the MST-FIT team, possibly in the shape of scheduled meetings where social workers could get feedback and advice on the cases they were considering for referral.

Therapists also felt that other services (including social services) were still lacking in their understanding of MST-FIT: “I suppose another challenge is social care, schools; connected services still don’t fully understand what it is” (T55). Similarly, residential staff have said that they found social workers to be less involved with MST-FIT than they’d like them to be.

Facilitators

Several of the changes which took place between “pre” and “post” interviews were identified by professionals as facilitators to delivering the programme and achieving positive outcomes for the families. This includes a) improved residential staff confidence and understanding of ITM, b) better programme structure, including clear timescales and expectations for families, and c) other professionals (such as social services or education) coming to understand MST-FIT better.

One of the main facilitators in carrying out the work was the flexibility of the MST-FIT programme to be tailored to each individual family’s needs. A principle of motivational interviewing was to use the person’s own goals to achieve adherence to treatment. The individual goals identified at the start of the programme allowed each family to work on their own specific needs and to concentrate on the goals which they themselves wanted to achieve. This differs from a prescriptive approach, where a professional independently identifies what they believe to be the problem and communicates their findings to the family.

As mentioned previously, families tended to speak very positively about their relationship with their MST-FIT therapist, which they felt contributed to the quality of their experience with the programme, and the positive outcomes they had. Parents saw their therapist as supportive, encouraging, and helpful, and found it particularly helpful that she/he was on-call and could be reached at any time for help or advice.

> “Every problem I’ve had, MST have taken a note: ‘right, I’ll look into that; right, I’ve got the same sort of problem’ And it’s… it gives you the encouragement to be able to say what you feel is working and what you feel is not working, what needs to be looked at.” (P34)

However, 2 of the parents reported negative experiences with their therapists: one felt that the therapist was unfairly blaming the parent for the problems with their child, and the other felt that the case was closed prematurely.

Young people also described their therapist as empathetic, “supportive” (YP38), respectful, and “down to earth” (YP19). Some explicitly said that they felt a positive relationship would contribute to a positive outcome on the programme:

> "I just get along with [my therapist], so it should go well" (YP18)

However, 6 of the 8 young people expressed that they would like to be more involved in the sessions between their parent and the MST-FIT therapist, and felt that it could have contributed to better outcomes for them.

Another facilitator identified by staff members was having a therapeutic emphasis on the parents, rather than the child. Managers, for example, felt that in most cases the child's negative behaviour was usually a symptom of the family dynamic, rather than the root cause. Similarly, therapists felt that they needed to challenge the parents' mindset that the young person was the problem. As a result, managers felt that MST-FIT should aim to provide parents with better parenting skills and the confidence to use them with their child. Residential staff felt that young people sometimes struggled with the content and jargon of the skills sessions in the residential home, which young people themselves sometimes described as "boring" (YP16) or unhelpful. Staff felt that they saw better results when the sessions were more dynamic, interesting, and engaging: as an example, this could include teaching the skills through fun activities, rather than in the style of a seminar. However, even during "post" interviews some young people continued to describe the sessions as boring, and many struggled to explain how they thought they could be improved.

Barriers

Relationship with social services and associated issues

MST-FIT is, by definition, a multisystemic therapy, which refers to involving the systems and services around the young person, including their family, peers, school, mental health services, offending services, and any other systems which might be relevant. Managers and therapists felt that many of these services did not have a good understanding of MST-FIT, but this particularly had a negative effect on their relationship with social services. Social workers felt less enthusiastic and more sceptical about MST-FIT than MST-FIT professionals. They felt that returning to the family home was not always the best outcome for young people. The main barriers cited were safety, parents' issues (for example, alcohol dependency), a foster placement providing better quality of care, and the child not wanting to return home. Additionally, social workers felt that many families had complex needs that MST-FIT was not able to address.

> "X is very complex, she has CSE needs, she has mental health issues, she potentially has foetal alcohol syndrome, she suffers from social anxiety" (SW15)

As a result of social workers not fully understanding the programme, managers and residential staff felt that they did not always make good referrals. Staff gave examples of

unsuitable referrals, such as young people who were aggressive or violent, or did not want to return home, which they found challenging to work with. Managers also gave the example of referring parents who were ambivalent about having their child return home, as this would typically prevent good engagement with the parent. However, managers acknowledged, during "pre" interviews, that, because the programme was so young, it was not yet clear even to the MST-FIT team what a "good" referral was. During "post" interviews managers felt that they had a better understanding of what types of referrals were more suitable, and that social workers were also starting to make referrals which were more appropriate.

A final drawback of this theme was therapists' feelings of frustration that other services sometimes did not understand MST-FIT well, but could still have more authority in the decisions made around young people and families.

Within the residential home

Some barriers to delivering the programme were identified within the residential home, for the ITM portion of the programme. These were predominantly noted in the "pre" interviews, and some of the issues were resolved, or partially resolved, over the course of the evaluation.

Residential staff felt that elements of the ITM training they received were difficult to understand, such as the "American" jargon, and therapeutic approaches with which they were unfamiliar. They felt that they could benefit from the training being longer, as a lot of new information was covered in a short period of time. During "post" interviews several staff members suggested that they could benefit from closer involvement from the MST-FIT therapists, particularly in the form of practical input to the daily running of the home. Some residential staff also felt that young people sometimes struggled with the language and concepts of the ITM skills sessions; this was echoed in young people's interviews, in which they found it difficult to describe the skills sessions or what they'd learned from them.

Many staff also felt anxious about delivering the programme at the beginning and were lacking in confidence: they felt that it would take some time to adapt to this new model of working. Seven out of 11 managers also corroborated that they felt that residential staff were under-qualified in clinical work to deliver MST-FIT, which affected their confidence and therefore the quality of service.

Both groups felt that staff confidence and understanding of the programme had improved by the "post" interviews, but staff still felt that they were balancing their duties as therapists with the normal day-to-day running of the home without any benefits to reflect the increase in workload.

Finally, a residential home at one of the sites started out as mixed: some of the young people were on the MST-FIT programme with a plan to return home, while other young people were placed in the home indefinitely as if it were a mainstream home. The latter were still required to take part in the ITM sessions. Residential staff felt that this arrangement interfered with their ability to deliver the programme effectively, and was detrimental to the young people not on the MST-FIT programme. By the time of the "post" interviews the residential home was an MST-FIT home only.

Conditions necessary for the programme to be embedded

Following the completion of data collection and analysis, the research team was able to schedule meetings at the Leeds and the Northamptonshire sites to discuss the findings of the evaluations with the MST-FIT professionals, and receive their feedback on the research team's conclusions, as well as discuss what steps should be taken in the future, and what issues the teams continued to face.

Professionals from both sites spoke extensively during the feedback meetings about changes which still needed to take place for MST-FIT to develop. There were still improvements to be made to the availability and frequency of residential staff training, with an emphasis on practical skill building. Because the programme is new, professionals placed a lot of importance on aligning other systems, such as social workers and independent reviewing officers, around MST-FIT and fostering knowledge and co-operation with the aims of the programme. Improving confidence in social workers is also important, as they are the primary source of referrals to MST-FIT and often reluctant to take the risk of referring a young person to a new programme. Further evaluation to demonstrate the effectiveness and benefits of MST-FIT would contribute positively to assuaging these concerns.

The teams also discussed their ideas on what they would like to see in terms of future evaluation during the feedback meetings. In Leeds, discussions were already happening about introducing standardised measures to assess young people and parents' mental health, as well as family functioning at home. These measures would be administered at the start of MST-FIT, at the end of ITM training in residential care, when the young person returned to the family home, at the end of MST-FIT, and at follow-up. Professionals from both sites spoke about redefining "success" in MST-FIT. At the moment, this is predominantly defined by sustained placement of the young person in the family home: however, professionals felt that this was a narrow definition, and anecdotally reported broader benefits. Stability during the follow-up period might be a more useful outcome to focus on, as young people who have not remained at home were still able to sustain, for example, stable foster placements, or were able to secure placements at university, or job opportunities. Professionals at the Northamptonshire site had a less well-defined plan for further evaluation, but spoke positively about introducing

standardised measures and conducting an evaluation in a more systematic way. There are also plans to implement Lisa Holmes' framework and proforma relating to cost-benefit analyses, which includes young people and their families, as well as the larger systems involved in their care such as residential and social care staff. The NIS will continue to work with all MST-FIT sites to develop a standardised dataset for all sites to collect alongside this.

In the longer term, professionals spoke about changing the culture of social care itself: for example, the stigma associated with residential homes, which might make parents reluctant to agree to MST-FIT, or the current approach to managing young people's behaviour (in schools, for instance), which at the moment is not always based on a behavioural approach, and the attitude of social workers and independent reviewing officers towards plans for children to return home from care.

Objective data findings

Young people: Offending and education

Objective education and offending data was collected at both sites, where available. However, due to the small sample size the findings are descriptive only. The available data suggests that neither offending (which was infrequent and low in severity) nor school exclusions (which were infrequent) were a significant concern in this population, and any increases or decreases following involvement with MST-FIT are unlikely to be meaningful.

Education

In Leeds, immediately prior to involvement with MST-FIT, 4 young people were in full-time education, 8 were receiving alternative education provision, and 2 were not in education. On finishing MST-FIT (or during the programme, if not completed by the end of data collection), 8 were in full-time education, 4 were receiving alternative provision, and one was not in education. In Northamptonshire, 3 young people were in full-time education in the academic year prior to MST-FIT, and 2 were not. All 5 young people were in full-time, mainstream education during the academic year in which they were involved with MST-FIT.

Overall, it appears that enrolment in education might have improved following involvement with MST-FIT, although the sample size is too small to assess whether this change is statistically meaningful. School exclusions were, on average, fewer than 1 instance per young person per year (In Northamptonshire, 0.2 in 2013/14, 0 in 2014/15, and 1.0 in 2015/16; in Leeds these were on average 0.4 per young person pre MST-FIT,

and 0.1 during MST-FIT), which suggests good engagement in education for the young people who were enrolled.

Young people in the MAU group had less full-time school enrolment: none of the 3 young people appear in the full-time education census for the 2014/15 school year; however, 2 of the 3 were enrolled in 2015/16.

Offending

MST-FIT young people in Leeds had a slightly higher prevalence of offending compared to Northamptonshire, with incidences apparently decreasing over time (7 offences per young person on average in 2014, 5 in 2015, 3 in 2016). In Northamptonshire, offences were less than 1 per young person per year on average (0.2 in 2014, 0.8 in 2015, 1.2 in 2016). All offences were within the 0-4* gravity band as defined by the Youth Justice Board, indicating reasonably low levels of offence severity (for example, theft from a shop, or being carried in a stolen vehicle; offences in the 5-8* gravity band include more severe offences such as burglary or assault with intent to rob). Young people within the MAU sample also had similarly low rates of offending, with average offences less than 1 per young person per year. Although the numbers are small, these offending differences might reflect broader differences in the composition of the Leeds and Northamptonshire homes, with the latter home having more females with serious problems with emotional regulation, emotional distress and behaviour, without the more serious antisocial behaviour and instances of criminal offending.

Residential home

In Northamptonshire, data was available by year on incidents within the residential home, as well as staff sickness rates. As can be seen from Table 2, both reduced dramatically, but the small sample size did not allow for any statistical analyses.

Table 2: Residential staff sickness and incidents within the home.

	2014	2015 (MST-FIT start)	2016
Northamptonshire: Missing episodes	13	11	0
Northamptonshire: Employee accidents[2]	-	30	3
Northamptonshire: Staff sickness (days)	276	215	39 (117 averaged over the year)[1]

[1]Data to April 2016 only
[2]Staff injuries from young people

Source: MST-FIT teams in Northamptonshire

Staff questionnaire

Residential staff at both MST-FIT and mainstream residential homes (where MAU young people were interviewed) were asked to complete the Staff at Work Questionnaire. The questionnaire consisted of 22 items, scored on a 6-point Likert scale, to assess staff satisfaction in 6 main areas: supervision, motivation, communication (with manager and co-workers), positive atmosphere and job satisfaction, quality of work, and contribution to the team. The questionnaire was scored on a scale from 0 (strongly disagree) to 5 (strongly agree). Scores were consistently, but not markedly, higher in the MST-FIT homes, compared to MAU.

Table 3: Average scores (standard deviations) on the Staff at Work Questionnaire.

	N'amptonshire Staff N=5	N'amptonshire MAU N=6	Leeds Staff N=5
Supervision	5.0 (0.00)	4.3 (0.57)	4.6 (0.55)
Motivation	4.6 (0.37)	4.2 (0.69)	4.5 (0.87)
Communication	4.9 (0.22)	4.2 (0.97)	4.5 (0.62)
Job satisfaction	4.2 (0.63)	4.1 (0.71)	4.3 (0.38)
Quality of work	4.6 (0.29)	4.3 (0.46)	4.5 (0.5)

Source: Work Questionnaire

The results of this questionnaire, consistent with the Ofsted reports, show that residential and MST staff endorse very positive views of the work environment, including communication amongst staff and quality of supervision, in the context of strong motivation and high levels of job satisfaction. Staff perceive the quality of their work to be high.

More broadly speaking, recent Ofsted inspections of the MST-FIT residential homes have been very favourable, and the homes have been awarded “good” or “outstanding” judgements, which indicated that the home “provides highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care” (Henderson, 2016; p.2) The report from one of the Leeds sites, for example, remarked positively on the structured and client-driven nature of the programme, the improvements to children’s safety and reduction in risky behaviours as a result of MST-FIT, the fact that staff are “excellent role models” and the “tremendous” improvements to young people’s engagement in education (Henderson, 2016; p.6). In Northamptonshire, the inspectors felt that young people formed nurturing and trusting relationships with staff, the young people had also been learning skills in “managing feelings and emotions” (Moriarty, 2016, p.3), and that risky behaviours have been decreasing within the home. In some cases, the report remarks on some young people’s “exceptional progress” (Moriarty, 2016, p.3) over the course of the MST-FIT programme.

How far have the intended outcomes been achieved?

This main purpose of the present research was to assess the feasibility of MST-FIT in a UK context. Specifically, we set out to:

- identify the systemic issues in the implementation of MST-FIT, including its effect on professionals
- determine whether MST-FIT was an acceptable and appropriate intervention for the range of stakeholders involved, including young people, their parents or carers, and professionals
- determine for what other populations MST-FIT might be suitable

We believe that we have addressed these questions as much as this is possible for this (early) stage of the implementation.

The findings related to the Innovation Programme

- Value for money across children's social care. As detailed above, Lisa Holmes and her team at Loughborough University are currently developing a methodology for assessing value for money for the MST-FIT programme, and linking this to a larger undertaking of research into the needs, costs and outcomes for looked-after children (See Appendix 1).
- Better life chances for children receiving help from the social care system. One of the recurrent themes across the interviews was that the skills taught to young people and parents in the MST-FIT programme were life skills – that is, skills which are beneficial not only in the context of returning home, but also for interpersonal relationships, in education, and (eventually) in a professional context. Several professionals noted that even in unsuccessful cases (where the young person was not living at home at the time of the "post" interview), the skills which the young person learned might have contributed to a better relationship with either foster carers or the residential home, and therefore better placement stability. Moreover, it is important to underline that the skills learnt by young people and parents were intended to help better adjustment over the long-term, and were perceived by them as important in this very way.
- Professional practice and methods in social care. Good referrals were identified as an important factor in the success of MST-FIT, although the amount of information about MST-FIT and feedback currently available to social workers could be improved (see Recommendations). However, several professionals have noted that staff turnover in social care is relatively high, and that social workers often have high caseloads, which means that there are limitations on how much these suggestions can be realistically implemented. Reports from the residential homes suggest that the introduction of MST-FIT was followed by a decrease in staff sickness, and fewer incidents of violence towards staff. This suggests that the care principles used in the programme were beneficial, not only to the young people and their families, but also to the well-being and professional experience of staff members. The Ofsted reports of the residential homes have also remarked that the staff have responded "exceptionally well" (Henderson, 2016; p.9) to the requirements of MST-FIT, that the staff feel positive about their work, the teams are well managed, the partnership with other professionals is "excellent" (Henderson, 2016, p.10), and that quality assurance mechanisms are in place to ensure continued service delivery to high standards. These findings suggest that the MST-FIT programme is significantly beneficial to social care practice and methods.
- The lives of children, young people and families. The interviewed families generally spoke very positively about MST-FIT, even in unsuccessful cases where

the placement had broken down. Parents whose children moved back home successfully spoke about significantly improved communication with their children, improvements to their child's behaviour, and a calmer household in general, which also positively affected siblings and any other family members in the household. Young people also spoke about improvements to the quality of their relationship with their parents, as well as to their own behaviour and emotional regulation.

- The perception of children, young people and families of service quality. The families which we interviewed generally spoke very positively about MST-FIT. Almost all parents and young people had an excellent relationship with their MST-FIT therapist, describing them as supportive and encouraging, and noted that having this relationship was important to their success in MST-FIT. This is in contrast to MAU parents, who often felt that they had no professional support on which they could rely.
- National systemic conditions. The current investment nationally in the mental health needs of looked after children; to family reunification; to family-based models; to collaborative practice tailored to young people, and to evidence-based practice, all combine to provide potentially fruitful, national systemic conditions. Future emphasis should be placed on considering evidence-based principles and models in residential care - that is, in training and in providing consistent psychosocial provision to young people and their parents/carers - would be very helpful, and consistent with feedback we received from residential managers and staff.
- Stronger incentives and mechanisms for innovation, experimentation and replication of successful new approaches. Although the present research is a feasibility study only, the overall outcomes appear to be encouraging about the potential of MST-FIT to benefit this group of young people and their families. These early findings are encouraging; if the programme continues to yield positive results under further investigation (see "Capacity built for future evaluation and sustainability") it could be adapted to other contexts such as foster care

Limitations of the evaluation

Because the research was designed as a feasibility study, it was mostly exploratory: therefore, there were not many methodological limitations. One of the challenges was in obtaining accurate and detailed objective data in some cases: the available databases were simply not very comprehensive, which made it difficult to characterise the sample fully. As outlined in the recommendations below, the programme might benefit from on-site data collection with respect to demographic, behavioural, and clinical data.

The number of families which could be included in the evaluation was small; there are only 3 homes which offer MST-FIT, and each has a limited capacity, which naturally limited the number of people who could be recruited into the study. The small sample sizes made most statistical comparisons (for example, in education, offending, demographic data) impossible, either between "pre" and "post", or between MST-FIT and MAU. However, it should be noted that we were able to address the main aims of the evaluation (identifying systemic issues in the implementation of MST-FIT, and assessing its feasibility in a UK context) using the rich qualitative data which emerged from the stakeholder interviews.

Identifying a comparison group within the MAU sample was also a challenge. In Northamptonshire, there were few young people residing in residential care where active steps were being taken by services to help them return home. In Leeds, we were unable to identify any young people who were on the pathway to return home from care. These findings echo the dissonance in opinions between MST-FIT professionals, who felt that returning to the family home was almost always the best course of action for young people; and social workers, who felt that this was appropriate in some cases, but not in others. Additionally, the wide variety of experiences in the MAU group made it difficult to draw direct comparisons to the MST-FIT sample.

There were also some differences between the Leeds and Northamptonshire sites; although we have highlighted the main differences in the themes which emerged from the qualitative analysis, they might still have contributed to different outcomes. For example, the Northamptonshire residential home started as a mixed home, with both MST-FIT and mainstream young people. The staff in Northamptonshire suggested that this negatively affected their ability to deliver the intervention. Fewer young people were classified under Section 20 in Leeds, which suggests that there might be differences in the referral process between sites.

A final limitation was the difference in time scale between the programme and the evaluation. Some MST-FIT families had already started the programme by the time the first interviews were able to be conducted; as a result, some "pre" interviews were not conducted, but the families were asked about their initial experiences during the programme. As with any research within this population, the interviews could only be

conducted at the family's convenience; often, parents and young people would defer the scheduled interview date for personal reasons, and the time points at which data was collected was variable as a result. 2 of the planned MST-FIT sites (Reading and Trafford) were also not at the point of accepting families by the time research concluded, so the findings are also limited in that regard.

Capacity built for future evaluation and sustainability

MST-FIT professionals were invited to attend feedback meetings with the research team in which the researchers fed back some of the findings and discussed the MST-FIT team members' opinions on building evaluative capacity as well as any further changes they envisaged to the programme and its broader systemic context. Six team members attended the meeting in Northamptonshire, and 8 in Leeds.

Future development and innovation

The programme is currently being adapted and developed for use in the context of foster care. The teams have already had some successes with young people returning to foster care through MST-FIT, although some professionals have been apprehensive about this adaptation. Professionals feel that the new sites will have the added benefit of the support and experiences of the existing sites, which can be fostered with good communication.

Conclusions

We have carried out a feasibility evaluation of 2 MST-FIT sites as they moved into their second year of operation. As noted by the developer of MST interventions, based on extensive anecdotal evidence and findings from 2 unpublished studies, the first year of operation can be particularly challenging for many new MST programmes, and outcomes improve substantially after programmes become stabilised within the provider organisation and ties with the community are solidified (Hengeller, Schoenwald, Borduin & Swenson, 2006). Additionally, synthesis of implementation research suggests that 2-4 years is necessary to achieve full programme implementation (Fixsen et al., 2005).

It is our impression that we have carried out our feasibility study over the course of a very dynamic implementation period, where the processes associated with achieving programme maturity were taking place, being identified, reflected on and shaped by decisions in each of the respective sites. For example, the decision to standardise the ITM intervention period to 12 weeks, which provided clients with a time-frame and plan that aided engagement and goal-setting, while giving the range of professionals involved a framework to contain the inevitable anxieties and cold feet associated with returning home.

As MST-FIT moves into its second year of operation in Northamptonshire and Leeds, it is characterised by strong commitments from MST and residential staff and managers, and commissioners of services. It is supported by the mandate of the local authorities to return children home from care if at all possible and to improve residential care. The staff groups that were involved in implementing MST-FIT were actively making improvements in response to ongoing monitoring, evaluation and discussion of the programme by different stakeholders. The excellence of residential staff in providing MST-FIT is noted by the recent “Outstanding” Ofsted ratings given to both residential homes in Leeds and “Good” rating for the home in Northamptonshire.

We recommended that practical training in core skills, integrated into the daily running of the home be provided, that would help address the daily needs of residential youth and the staff that work with them on a daily basis. For example, these could include training in the application of behavioural and social learning principles and skills and other important components of MST-FIT, such as motivational interview methods, that would be extremely useful in working with residential youth.

Young people and carers generally reported very positive experiences of MST-FIT, and felt that, even in cases where the young person did not successfully return home, the long-term improvements to their emotional well-being and parent-adolescent relationships were important. As we have found in other qualitative studies (Kaur et al., 2015; Tighe et al., 2012), families value the very active efforts of therapists, first, to engage them, and then to provide very strong support, and both young people and carers

value the skills learned through MST-FIT and the centrality of family relationships. Again, across a range of stakeholders, we were often told that there was “nothing like it out there”.

At the same time, the population served by MST-FIT is a complicated and difficult population, often with serious issues of risk, and successful implementation requires sophisticated relationships among stakeholders. It is understandable that continued, ongoing work is necessary, for example, with social workers to help convince them of the value of the intervention and of taking the chance of returning the child to challenging family environments that they might not always perceive to be in the best interests of the young person. As noted in our final discussions with a range of stakeholders in both sites, a cultural shift is necessary for MST-FIT, in that the risks and challenges associated with family reunification are deemed to be worthwhile in the longer-term.

The outcomes of this feasibility evaluation strongly suggest that continuing efforts be made to help consolidate the gains that have been made in delivering MST-FIT and in supporting future developments. Based on our feasibility evaluation, we are making the recommendations below to help further successful implementation and contribute to successful outcomes.

Recommendations

Referral and Assessment

Recommendation 1. A recurrent theme across residential and MST-FIT staff, as well as managers, was the uncertainty over what actually made a good referral and what types of problems MST-FIT was best suited to address. As the programme matures, it is important to further define the population of young people who are appropriate for MST-FIT, both internally and in relation to external referrers and partners. While this issue improved substantially in the 9 months interval between our “pre” and “post” interviews with professionals, it will remain important to refine a shared definition of what constitutes an appropriate referral, and what types of problems MST-FIT is best suited for, that is satisfactory to the main stakeholders and consistent with the model as applied to UK contexts.

Recommendation 2. We recommend that greater individual assessment of the young person detailing the type and severity of their problems with reference to the wider context, might be necessary with this population. This is compatible with the increased attention to the young person, and individually-focused treatment strategies that are part of MST-FIT; as well as recent government guidelines in undertaking a full mental health assessment for looked-after children prior to intervention (Department for Education, 2016).

Training

Recommendation 3. Many staff initially commented on the lack of integration between the residential staff trained in ITM and MST-specific staff in implementing the core intervention principles. The 2 main themes were:

- are residential staff trained in therapeutic practice and competent to implement MST-FIT interventions?
- is the communication between ITM residential staff and MST-specific staff good enough to achieve reasonable integration?

Follow-up interviews indicated that, as a result of adaptations made to the structure of the programme, residential staff were feeling increasingly competent and confident about implementing ITM and integrating their work with MST-specific staff. The initial training of residential staff in ITM should include attendance by MST staff: this has already been implemented in the third site in Reading. Regular contact between the MST-FIT supervisor and the children’s home manager will maximise information transfer, and the ability of these teams to apply MST-FIT principles in an integrated way to achieve the

best outcomes for young people and their carers. This has already been added to the UK manual for MST-FIT.

At the recommendation of some residential home staff, it might be beneficial for therapists to assist or lead some of the skill sessions to give the residential staff some practical ideas on conducting and managing the sessions. Therapists might also wish to spend some time at the residential home to give some hands-on direction about how some situations can be managed in line with MST-FIT principles. This can be particularly helpful to new staff, especially while regular induction training for all residential staff is not possible.

Recommendation 4. Following the completion of the UK version of the MST-FIT manual, the NIS could explore developing UK-based trainers for both the MST-FIT and ITM elements of the programme to ensure that the training is better suited to staff in residential homes; to reduce the use of US based references and terminology, and also to provide better value for money for local authorities.

Documenting Change

Recommendation 5. The MST-FIT programme is strong in identifying goals for change with young people, carers and a range of stakeholders, and in tracking changes with young people over time.

We recommend that these processes of documenting change be complemented with some standardised measurement from the main stakeholders - such as the young person, carer and/or teaching staff, as appropriate - and to look at these over time; for example, from starting the intervention to 6 months following termination. As staff are currently stretched and engaged in quite stressful work, it would be useful to engage additional staff such as a research assistant, where possible, to complement work done between therapists and families with standardised evaluation founded in the literature on working with these types of young people and families. This will allow for greater definition and specificity regarding areas of change (for example, within self; parent-adolescent relationship; school) over time, as well as contribute to better assessment and evaluation of young people’s complex and varied mental health needs. Work is currently under way led by the National Implementation Service, to develop a national dataset for UK based MST-FIT sites.

Professional Issues

Recommendation 6. Although the number of social workers interviewed was small, they were an important group of professionals as they had responsibility for care planning to

return young people home and had clear views about the strengths and limitations of the intervention.

Social workers were increasingly positive about the benefits of MST from “pre” to “post” interviews, especially regarding any potential benefits it can offer to families with a specific range of needs. At the same time, they remained steadfast in their belief that MST-FIT was not necessarily able, nor suited, to address the range of complex needs presented both by young people and their carers. It would be vital to continue engage social workers in a meaningful discussion about the nature of MST-FIT, its rationale for trying to return young people home, and it strengths, limitations and strategies for addressing the complex needs of YP and their carers that might be beyond the MST-FIT intervention. This would include how MST-FIT is situated in relation to the larger mental health and social care context in their area, and how issues about which they are uncertain that MST-FIT can improve will be attended to. As part of this, it might be useful to develop a shared understanding of the families’ needs and goals, and explicitly address the conditions under which the young person can return home In Leeds an event is planned for late March to update all staff in social care on the progress of MST-FIT and the outcomes of the completed pilot period; and sessions on all MST programmes are being integrated into social workers’ induction programmes.

Recommendation 7. It is not surprising, given the historical role of social workers in protecting children, and occasional conflict with parent needs and wishes around very emotive issues, that many carers expressed negative views about their relationships with social workers.

Nonetheless, given the importance of all professionals working together in relation to the needs and goals of the young person and carer(s), it would be important to think with social workers about whether it would be useful to address these parental perceptions, and how to go about addressing them in a productive way. As a first step, it would be important to be explicit about these issues and to learn about the strategies employed by social workers in the past to help modulate these tensions. It might also be important to clarify the social worker role in MST-FIT and to highlight its importance and relevance for having the child return home.

Recommendation 8. Managers, social workers and the carers themselves all identified the carers’ mental health problems (for example, anxiety and depression) as significant and related to the young person’s difficulties, and as strong contributing factors to the breakdown of unsuccessful cases, where the parent’s mental health problems became overwhelming. Consequently, the MST-FIT teams, in addition to the work they provide to specifically address parental mental health problems, should have clear criteria, including thresholds, for making referrals for parent mental health difficulties, as well as clear referral pathways and protocols for improving integration between MST-FIT, adult mental health services, and any individual parent work.

Recommendation 9. Several professionals believe that MST-FIT could be successfully adapted to a foster care setting; in fact, there have already been several one-off foster care cases which have successfully been through the programme. In Northamptonshire an analysis of how MST-FIT could work with foster carers is being completed. In a third site, Reading, work is already underway to train foster carers to work alongside the MST-FIT team to support young people to return home. There is, therefore, some evidence that MST-FIT can be expanded to this context, and we recommend that this avenue be explored further. It might also be useful to consider whether the population with which the intervention was developed in the U.S. - namely young people returning from custody - might be useful in the UK.

Finally, it would be important to build on this feasibility study to develop the necessary systems to implement an effectiveness evaluation when there is clear evidence that the number of participants would be sufficient and the implementation context ready to support this type of evaluation. Additionally, one of the exciting aspects of MST-FIT in the UK is its development with different populations than those in the U.S.

Next steps

Recommendation 10. The local authorities involved in the pilot of MST-FIT are supported to sustain and expand their current service to work with a larger group of children and families so that lessons learned to date on implementation can be used in the future and the outcomes for a larger sample of young people can be evaluated. The NIS could work on further dissemination of the programme in partnership with these pilot authorities, which could include local authorities working with private and voluntary children's homes, as well as in-house provision.

MST-FIT consultancy and training is currently being provided by US-based staff, as is the case in the earlier stages of implementation. While staff generally speak positively about the quality of support being provided, there are a number of logistical problems, from scheduling training sessions to the time differences in phone calls. It would be beneficial to develop a team who could deliver these services from the UK.

Tools for the standardized assessment of young people's and the families' needs, emotional and behavioural problems, and mental health profile are currently being developed for MST-FIT. Implementing these consistently across the sites (and any sites which might implement MST-FIT in the future) would allow for a better understanding of the population referred into the programme, as well as tracking improvements. Moreover, as complementary to the work done to systematically improve data collection around outcomes and to develop a national database, it would be useful to broadly consider what constitutes improvements and positive outcomes, given that professionals concurred that young people's lives improved through participation in MST-FIT

irrespective of whether they returned home (for example, through greater emotional stability, greater participation in education and employment).

The findings of the present evaluation, as well as independent findings from the local authorities and Ofsted, suggest that MST-FIT offers the benefit of evidence-based, systematic principles which can be applied by staff within the residential home to the vast majority of their cases. These principles allow staff to better understand young people's needs and the clinical underpinnings of behavioural change, but also offer a structured model to which staff can work. This contrasts with mainstream work, which some of the staff described as "fire-fighting", and suggests that these principles could also be of huge benefit to mainstream homes. Consequently, it would be useful to consider implementation of some of these fundamental therapeutic principles for working with young people with complex needs in residential settings, such as applying social-learning theory to behaviour and interpersonal interactions; building on strengths in the young person and in their relationships, and helping young people to identify and manage difficult emotions.

As noted throughout this report, there are a number of improvements which can be made to help the programme reach its potential and ensure the best possible outcomes for young people returning home from care. Active steps are currently being made to support the existing teams, and the Reading site is currently beginning an evaluation of the suitability of MST-FIT for young people in foster care. An MST-FIT manual is currently also being developed by the existing sites, which will incorporate the lessons that have been learned from the pilot phase. Combined with the fact that both families and professionals have mostly responded to the intervention positively and enthusiastically, we are positive about the potential of MST-FIT to be successfully adopted within other local authorities, once the programme, and the processes around it, are more streamlined and clearly defined.

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Appendices

Appendix 1: Cost-Effectiveness

Cost inputs: approach to costing

When agencies engage in implementing a new innovation, the costs incurred can be organised into three 'cost categories' (Saldana et al. 2014; McDermid, Holmes and Trivedi, 2015):

1. The ongoing costs associated with the innovation itself.
2. The costs associated with implementing the new innovation.
3. The costs associated with being part of a pilot programme.

Distinguishing between these different types of costs facilitates a more comprehensive understanding of the overall costs of MST-FIT, because the expenditure associated with introducing an innovation will change as the agency moves through the various stages of implementation (Fixsen *et al.* 2005; Holmes, Westlake and Ward, 2008). It is likely that the costs of implementing the innovation will peak during the set up stage, as the activities required to introduce the new practice are underway. If the model is found to be cost effective, the costs should start to reduce during the full implementation stage as the innovation becomes embedded. The costs are lowest when the host service reaches Sustained Implementation as the new practice has now become embedded and the financial benefits are realised.

The cost analysis also makes a conceptual distinction between cost saving and costs avoided. A 'cost saving' is a reduction of current or actual expenditure. A 'cost avoided' is a change in the projected or predicted expenditure. For example, a reduction in expenditure to a Youth Offending Service will be achieved because a child ceases to offend; this is a 'cost saving' and no longer requires intervention from the service. If a child who is identified as at risk of offending due to their challenging behaviour, does not offend (and therefore does not incur a cost to Youth Offending Services), a cost has been 'avoided' (Holmes, McDermid and Trivedi, 2014).

Potential costs avoided

The costs of MST-FIT might be offset by potential costs avoided as a result of the impact of the programme. These costs might relate to organisational outcomes, which include changes in wider organisational functions that are attributable to the MST-FIT programme, staff level outcomes (such as reduced staff sickness) or child level outcomes, which relate to the impact of the practice on individual children (McDermid, Holmes and Trivedi, 2015).

The outcome measures to be included in the proforma are also determined by the availability of the data. A series of initial outcome measures have been discussed and agreed with the NIS, based on routinely collected data held in local authorities. These data items are based on the data outlined in Annex A of the Ofsted framework for the inspection of children's homes (Ofsted, 2015) and child level data items pertaining to placement length, return home and re-entry to care reported in the SSDA 903 statistical return.

At this stage in the development of the MST-FIT programme, the associated evidence is not yet comprehensively available for examining the costs avoided that resulted from MST-FIT, and the analysis of costs at this stage of implementation has focused on local level, short-term outcomes in terms of reduced number of days in care. Future cost effectiveness analyses will seek to include a comprehensive set of outcome indicators for the children and young people and their families.

To measure the cost effectiveness of the MST-FIT programme we need a series of outcome indicators, and these need to be based on data that is routinely collected, either on an ongoing basis by the National Implementation Service, or at a local authority or provider level.

Possible staff/home indicators:

Staff vacancy rates [LA/home specific data]

Staff sickness rates [LA/home specific data]

Staff retention rates [LA/home specific data]

Staff motivation [Staff at work questionnaire]

Staff communication [Staff at work questionnaire]

Atmosphere/satisfaction [Staff at work questionnaire]

Quality of work [Staff at work questionnaire]

Possible nationally-applicable, home-level indicators and sources, available at a local level, aggregate data, broken down by home:

Number of children admitted to the home [Ofsted – Annex A]

Number of children that left the home [Ofsted – Annex A]

Number of incidents of restraint [Ofsted – Annex A]

Number of times children went missing [Ofsted – Annex A]

Number of times children were away without authorisation [Ofsted – Annex A]

Number of children currently at risk of CSE [Ofsted – Annex A]

Number of children subject to CSE [Ofsted – Annex A]

Number of complaints from children [Ofsted – Annex A]

Number of complaints from others [Ofsted – Annex A]

Number of allegations against staff [Ofsted – Annex A]

Number of sanctions [Ofsted – Annex A]

Number of child protection referrals [Ofsted – Annex A]

Number of children subject to a deprivation of liberty (DOL) order [Ofsted – Annex A]

Possible nationally-applicable, child-level indicators and sources, available at a child and local level, include the following:

Placement indicators

- Placement type [SSDA 903 INDICATOR]
- Placement duration [SSDA 903 INDICATOR]
- Placement stability/breakdown [SSDA 903 INDICATOR]

Education indicators

- Special educational needs, by primary type of need [NPD]
- Changes of school [NPD]
- Absences from school, authorised and unauthorised [NPD]
- Fixed term exclusions from school, number and duration of fixed term [NPD]
- Permanent exclusions [NPD]
- GCSE results, when applicable [NPD]
- Education, employment and training (EET) at age 18, 19 and 20 [SSDA 903 INDICATOR]

Wellbeing/high risk behaviours

- SDQ [SSDA 903 INDICATOR]

- Missing from placement/unauthorised absences [SSDA 903 INDICATOR]

Appendix 2: Interview schedules

Interview schedule 1: Managers (Pre)

General: Prior experience and knowledge

- I wonder if you can tell me a little about your professional background and what led you to become involved with MST-FIT?
- What did you know about MST-FIT prior to becoming involved in this way of working?
- Tell us specifically about your own role in the current implementation of MST-FIT?

MST-FIT: Expectations and Applicability

- Did you have any expectations about how MST-FIT would relate to the services available for looked-after adolescents where there is a plan to return home?
- What aspects of MST-FIT do you think will help with services for this group of young people?
- Are there any aspects of MST-FIT that you might consider to be unhelpful?

(for those who already have cases) As you have now implemented the MST-FIT model, is it in any way different to what you thought it would be

- What kind of challenges do you think clinicians and teams will face delivering MST-FIT? How will you help services overcome them?
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this assumption?

Characteristics of Young People and Families

- Tell us a bit about the young people and families you think are best served by MST-FIT and therefore constitutes a good referral
- Tell us a bit about the young people and families you think are not well-served by MST-FIT

- How do you feel MST-FIT addresses the complex nature of looked-after adolescents where there is a plan to return home? (Prompts: Strengths and limitations)

- What outstanding challenges remain in working with this group of young people and families?

Working within the larger systemic context

- What are some of the major challenges that you believe services regularly face working with looked-after adolescents?

- How does MST-FIT fit within the larger systemic context in terms of other services?

- How does ITM relate to MST-FIT work? (prompt: work together/or not work together)

- What do you believe facilitates the implementation of MST-FIT? What are some of the barriers?

- How does one convince the range of stakeholders about the usefulness of MST-FIT? (Prompt: Assuming that MST-FIT is really worthwhile, who needs to be convinced to implement this intervention? And how?)

ITM Training (for those who receive ITM training)

- Tell me about your experience of ITM training?

- How relevant do you think is it to your and clinicians' work?

- What aspects of ITM did you find were the most useful? (and why?)

- What aspects of ITM did you find were the least useful? (and why?)

- Are there any aspects of the training that you would change?

- Could you see ITM skills that you have learned being used for a wider range of young people than those going home? Who?

- What other opportunities do you think there are to use the ITM skills in Northamptonshire

Interview schedule 2: Managers (Post)

General: Prior experience and knowledge

- Could you please tell me your general experience of MST-FIT?
- What has been your role in the implementation of MST-FIT?

MST-FIT: Expectations

- What aspects of MST-FIT do you think helped this group of young people?
- Are there any aspects of MST-FIT that you considered unhelpful?
- What kind of challenges do you think clinicians and teams faced delivering MST-FIT? (prompt: How did you deal with them?)
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this assumption?

Characteristics of Young People and Families

- How well do you feel MST-FIT addressed the complex nature of looked-after adolescents where there was a plan to return home?
- Tell us a bit about the young people and families you think were best served by MST-FIT? (prompt: any not well-served)
- What outstanding challenges remain in working with this group of young people?

Working within the larger systemic context

- What facilitates the implementation of MST-FIT? What are some of the barriers?
- How does MST-FIT fit within the larger systemic context in terms of other services?
- How does ITM relate to MST-FIT work? (work together/or not work together)
- Is there anything you would change about MST-FIT?
- Would you recommend MST-FIT it to other stakeholders? Why/why not?

Outcomes

- Were there any ways in which you think MST-FIT changed YP's lives? Parent's/carer's lives?

- Were there any ways in which the child's behaviour changed since becoming involved in the programme?

- If MST-FIT did not work, do you have any idea what happened?

ITM Training (for those who receive ITM training)

- Tell me about your experience of ITM training?

- How relevant do you think is it to your clinicians' work?

- What aspects of ITM did you find were the most useful/least useful? (and why?)

- Are there any aspects of the training that you would change?

- Could you see ITM skills that you have learned being used for a wider range of young people than those going home? Who?

- What other opportunities do you think there are to use the ITM skills in Northamptonshire

Interview schedule 3: MST therapists (Pre)

General: Prior experience and knowledge

- I wonder if you can tell me a little about your professional background and what led you to become involve with MST-FIT?
- What did you know about MST-FIT prior to becoming involved in this way of working?

MST-FIT: Expectations and Applicability

- Did you have any expectations about how MST-FIT would relate to your ways of working? (for those who already have cases: As you have now implemented the MST-FIT model, is it in any way different to what you thought it would be?)
- What aspects of MST-FIT may help you with your work (and why)?
- What aspects of MST-FIT may be unhelpful for your work (and why?)
- How might MST-FIT change YP's lives? Parent's/carer's lives?
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this assumption?
- What are the challenges that you face delivering MST-FIT? (Prompts: What are they? How do you overcome them?)

Characteristics of Young People and Families

- How does MST-FIT address the complex nature of the young people and families that you work with? (Prompts: Strengths and limitations)
- What young people and families do you think are best served/not well-served by MST-FIT?
- What outstanding challenges remain in working with this group of young people and families?

ITM Training (for those who receive ITM training)

- Tell me about your experience of ITM training?
- How relevant is it to your work?
- What aspects of ITM did you find were the most useful? (and why?)

- What aspects of ITM did you find were the least useful? (and why?)
- Are there any aspects of the training that you would change?
- Could you see ITM skills that you have learned being used for a wider range of young people than those going home? Who?

Working within the larger systemic context

- Tell us about the major challenges that you regularly face working within the service system for looked-after adolescents?
- How does MST-FIT fit within the larger systemic context in terms of other services?
- Tell us about MST staff working alongside residential staff? (Prompts: what promotes effective collaboration and what are the barriers?)
- How does ITM relate to MST-FIT work? (prompt: work together/or not work together)
- What other opportunities do you think there are to use the ITM skills in Northamptonshire?

Interview schedule 4: MST therapists (Post)

General experience and knowledge

- How was your general experience of delivering MST-FIT?
- What aspects of MST-FIT did you find the most useful? The least useful?
- Have you received any additional training or support since we last spoke (8-9 months ago)?

MST-FIT: Expectations and Evaluation

- Now that you have had experience in delivering MST-FIT, is it in any way different to what you thought it would be?
- What difficulties, if any, did you come across when delivering MST-FIT? (Prompt: How did you overcome them?)
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this assumption?
- Is there anything you would change about the MST-FIT model?

Characteristics of Young People and Families

- How does MST-FIT address the complex nature of the young people and families that you work with? (Prompts: Strengths and limitations)
- Tell us a bit about the young people and families you think were best served/not well-served by MST-FIT?
- What outstanding challenges remain in working with this group of young people and families?

Outcomes

- In what ways has MST-FIT changed YP's lives? Parents'/carers' lives?
- Have you seen any changes in young people's behaviour? In parents'/carers' behaviour?
- Tell us about any situations where MST-FIT did not seem to work with young people. What do you think happened?
- Would you use MST-FIT again in the future? (Why/why not?)

Working within the larger systemic context

- Can you tell us about working with other services involved with MST-FIT families? For example, residential staff, social workers, schools, police. (Prompt: What were the main challenges in working with other service?)

- How does ITM relate to MST-FIT work? (Prompt: work well together/or not work together)

Interview schedule 5: Residential staff (Pre)

General: Prior experience and knowledge

- I wonder if you can tell me a little about your professional background and what led you to become involved working within this ITM placement and MST-FIT. (Prompt: any previous experience working with looked-after adolescents moving back home? techniques/ approaches you used?)

- What did you know about ITM model prior to becoming involved in this way of working?

ITM and placement therapies

The next few questions will be around the ITM model and the work you undertake in (insert placement name).

- Can you tell me a bit about the ITM model of working?

- What aspects of the ITM model do you think might be most useful/least useful in your work? (and why?)

- What is it about the ITM model that may make (insert placement name) different from other services offered to YP where there is a plan to return home?

ITM Training

The next couple of questions are regarding the ITM training you received.

- Can you tell me about your experience of ITM training?

- Are there any aspects of the training that you would change?

- Could you see ITM skills that you have learned being used for a wider range of young people than those going home? Who?

Characteristics of Young People and Families

The next couple of questions will be about the young people involved with your service and the MST-FIT programme

- Can you tell us a about the young people and families you think are best served/less well served by your service?

- How do you believe your service addresses the complex nature of the young people and families that you work with? (Prompts: Strengths and limitations)

- What outstanding challenges remain in working with this group of young people and families?

MST-FIT expectations and applicability

The next questions are regarding the expectations of the MST-FIT service.

- How might MST-FIT change YP's lives? Parent's /carer's lives?

- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this assumption? (Prompts: Is this achievable /realistic?)

- What do you believe MST-FIT needs to offer adolescents to help them successfully return home once they have left your service?

Working within the larger systemic context

The next few questions are regarding the support system and services that are involved in the care of adolescents

- Tell us about the major challenges that you regularly face working within the service system for looked-after adolescents?

- How does your service work in conjunction with other agencies? (Work well? communication?)

- Tell us about how you work alongside MST staff (What is this relationship like? What is good about it and what are the barriers?)

Manager Specific

- What types of challenge do you believe staff within this placement will face in delivering ITM? How will you help them overcome this?

- How does one convince the range of stakeholders about the usefulness of ITM and this way of working? Prompt assuming ITM is really worthwhile who needs to be convinced to implement this intervention?

Interview schedule 6: Residential staff (Post)

ITM and placement therapies

I’d like to start by talking about the ITM model and the work you do in (insert placement name).

- Can you describe to me what day-to-day life is like in [Placement]?
- Can you tell me a bit about the ITM model of working?
    - Prompt: What are your thoughts and feelings about working with young people in this way?
    - Prompt: What aspects do you find the most useful? Not very useful?
- How do young people respond to the ITM model of working?
    - Prompt: Are there ways in which it is helping/ not helping?
- What is it like delivering the ITM skills groups?
    - Prompt: Has there been any change in how you feel about delivering skills groups now than you were at the beginning?
- Have you received any additional training/ help/support for delivering ITM since we last spoke (in the last 6-9 months)?
    - If yes: What are your thoughts about it? Was is useful? Would you change anything?

Characteristics of Young People and Families

The next couple of questions will be about the young people in this residential home and the MST-FIT programme

- In your opinion, what type of young people and families do you think MST-FIT (and ITM) would benefit the most?
    - Prompt: And who would it not be very useful to?
- Looked-after children and their families often have a lot of complex needs. How does MST-FIT fare in addressing their complex needs?
- In your opinion, what outstanding challenges remain in working with this group of young people and families?

MST-FIT expectations and outcome

The next questions are regarding the expectations of the MST-FIT service.

- Have you seen or noticed any changes in young people's behaviour since becoming involved in MST-FIT?
- In your view, what may influence whether families benefit from MST-FIT, or not?
  - Prompt: If MST-FIT did not work, what do you think went wrong?
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell us your thoughts about this (Prompts: Is this achievable /realistic?)
- What do you believe MST-FIT may offer young people once they have left your service?

Working within the larger systemic context

The next few questions are about working with other services that are involved in the care of young people

- Tell us about working with other services, such as social workers, police, or schools.
  - Prompt: What kind of challenges do you most often face with them?
  - Prompt: Has working with other services changed since we last spoke (6-9 months ago)?
- Tell us about working with MST therapists; what is this relationship like?
  - Prompt: Has the relationship changed since we last spoke?

Manager Specific

- Since we last spoke, what types of challenge do you believe staff in this placement faced in delivering ITM?
  - Prompt: Were you able to do anything to help them with these challenges?
- After having a bit more experience with MST-FIT, would you recommend it to other stakeholders (other placements, social workers, families)? Why/why not?

Interview schedule 7: Social workers (Pre)

General: Prior experience and knowledge

- I wonder if you can tell me a little about your professional background and what led you to become involved with MST-FIT? (Prompt: any previous experience working with looked-after adolescents moving back home?)
- What can you tell me about MST-FIT?
- How is your role/service related to MST-FIT?

MST-FIT: Expectations and Applicability

- What are you hoping MST-FIT may change in YP's lives? Parent's/carer's lives? (Prompt: what do you hope users will gain?)
- What aspects of MST-FIT do you think may be helpful when working with young people moving back home, and their families?
- What aspects of MST-FIT do you think may be unhelpful when working with young people transitioning home, and their families?
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. Tell me your thoughts about this assumption (Prompt: Realistic?)

Referral Process

- Can you tell me about the process of making a referral to MST-FIT?
- Why did you refer to MST-FIT as opposed to other services?
- Are you likely to refer to MST-FIT again? Why/why not?

Characteristics of Young People and Families

- What do you believe MST-FIT may offer this complex group of people to help them with their return home?
- What outstanding challenges do you believe remain in working with this group of young people and families?

If have a case already open to MST-FIT

- Have you noticed a difference in the adolescent's behaviour since becoming involved with MST-FIT?

- How do you believe the individual finds working with MST-FIT? (Feedback? Positive? Negative?)

Working within the larger systemic context

- Tell me a bit about your experiences of working within the larger systemic context. Can you describe the involvement of the other stakeholders (that is, residential care, school, police)?

- How does MST-FIT work in conjunction with your service?

If no open cases, or only ITM cases:

- What are your expectations of working alongside MST-FIT therapists? What sort of things might you find helpful? Unhelpful?

If already has an open MST-FIT case:

- How involved are you in the work completed by the MST-FIT therapist? With residential staff (who deliver ITM)? (Are you informed on progress regularly? Do you communicate with the therapist?)

Could you please tell me what are the challenges that you regularly face working within the service system for looked-after adolescents?

Interview schedule 8: Social workers (Post)

General: Prior experience and knowledge

- How has your general experience with MST-FIT been so far?
- Have you received any training or guidance on MST-FIT since we last spoke (8-9 months ago)? (Prompt: Do you feel that you now have a good understanding of MST-FIT?)

MST-FIT: Experience and Applicability

- Do you think MST-FIT has changed anything in the young people's lives? In their parents'/carers' lives?
- What aspects of MST-FIT do you think have been helpful to young people and their families? What aspects haven't been helpful?
- An assumption of MST-FIT is that the looked-after adolescents be returned home if at all possible. What are your thoughts about this assumption? (Prompt: Realistic?)
- How well do you think MST-FIT addresses the complex needs of these young people and their families?
- Have you seen any changes in their behaviour of the young person or their parent/carer since they started MST-FIT?
- What outstanding challenges do you believe remain in working with this group of young people and families?

Referral Process

- Can you tell me about the process of making a referral to MST-FIT?
- Why did you refer to MST-FIT as opposed to other services?
- Are you likely to refer to MST-FIT again? Why/why not?

Working within the larger systemic context

- How did you find working with other professionals involved with MST-FIT? (Residential staff, MST-FIT therapists) (Prompt: What has worked well? What hasn't worked well?)

- How do you feel about the way your role fits into the larger systemic context around the young person (that is, with MST-FIT, schools, police, other services such as RISE)?

Interview schedule 9: Commissioners

- Can you tell us specifically about your role as commissioner and how it ties in with the MST-FIT programme?
- How did you become involved in considering MST-FIT as a commissioned programme?
- From a commissioner's point of view, what is the appeal or the benefit of MST-FIT, compared to other types of support available to young people returning home from care?
- What, in your view, are the alternatives available to the young people in MST-FIT?
- How would you describe your experiences with commissioning MST-FIT cases so far?
- What are some of the drawbacks?
- If you were speaking to another commissioner, why would you recommend MST-FIT?
- If you were speaking to another commissioner, what would you say were some of the limitations of MST-FIT?

Interview schedule 10: MST-FIT parents (Pre)

Engaging the parent:

- Could you tell me about the first time you heard about MST-FIT?
- What led up to the MST-FIT team working with your family?
- How do you feel about starting MST-FIT? (prompt: How involved did you feel in the decision to start MST-FIT?)
- What do you hope MST-FIT might change for you?
- Do you have any worries or concerns about starting MST-FIT?

Expectations of MST-FIT:

- What do you think MST-FIT will be like?
- What sorts of problems are you hoping MST-FIT will be able to help you with?
- What sorts of changes in your life would you like to see?
- In what ways do you think MST-FIT may help you with your child's move back home?
- In what ways do you hope MST-FIT will be different/similar to your work with other professionals?

Adolescent's experience

- How do you think your child feels about coming back home?
- What do you hope may change for your son/daughter?
- What might being involved in MST-FIT be like for them?

Process of Change:

- What kinds of things do you think are helpful for young people moving back home after residential care?
- What sort of things might affect your success with MST-FIT?

Is there anything else you'd like to say?

Interview schedule 11: MST-FIT parents (Post)

General/Overall Experience:

- What was MST-FIT like?
- How involved did you feel in the MST-FIT sessions?
- What has been most helpful? Anything that you did not like or that bothered you
- If you were talking to your friends about MST-FIT, what would you say?

Working with the therapist:

- What was it like having someone to talk to and work with on problems?
- What did you like / not like about the way ______ worked?
- How was it similar or different to previous work with other professionals?
- Do you feel that you have learnt anything from working with [therapist]?

Adolescent's experience

- How do you think the experience was for your son / daughter?
- Any particular things that you felt were helpful/unhelpful for them?
- What things did the 2 of you find helpful/unhelpful?

Working on problems:

Process

- Do you feel that your views were important during MST-FIT sessions?
- Were there ways in which the therapist was able to appreciate the good things about your family and to use them in their work with you?
- Tell me a bit about work between sessions that was part of MST-FIT?
- What was it like finishing MST-FIT?
- (if there have been positive changes) How confident do you feel that that you can maintain the changes, now that your child has returned home?

Content

- Tell me a bit about the work done to help you with the transition from residential care to moving back home?
- ...help you get on better as a family once you moved back home
- How do you think your child felt about coming back home? Are there any ways in which they found MST-FIT helpful for the transition? Less useful for coming back home?

Expectations and change:

- Was MST-FIT what you expected?
- In what ways, if any, has it helped you with your life?
- Tell me any ways in which your son/daughter is behaving differently now?

(Prompts: in the ways he/she behaves? treats you? Ways you get along?)

- Do you see your son/daughter any differently after having received MST-FIT?

Life now:

For the parent

- Tell me about whether you continue to use any of the MST-FIT ideas or strategies now?
- Has MST-FIT influenced your views of yourself as a parent? Can you tell me about that?

Processes of change

- If you had a friend in the same situation (they had a child in residential care but was going to move back home), would you recommend MST-FIT to them as something that could help?
- Is there anything you think should have been done differently?

Is there anything else you'd like to say?

Interview schedule 12: MST-FIT young people (Pre)

- Engaging the adolescent
- Could you tell me about the first time you heard about MST-FIT?
- What led up to the MST-FIT team working with your family?
- How do you feel about starting MST-FIT? (Prompt: How involved were you in the decision to do MST-FIT?)
- What do you hope might change for you working with MST-FIT?
- If you were talking to your friends about MST-FIT, what would you say?

Expectations of MST-FIT:

- What do you think MST-FIT will be like?
- What sort of things do you think you'll do or talk about during MST-FIT?
- What sort of problems are you hoping MST-FIT will be able to help you with? (prompt: How do you feel about MST helping you plan to go back home?)
- What sort of changes in your life would you like to see?

Working with the therapist:

- What will it be like to have someone to talk to and work on problems?
- In what ways do you hope MST-FIT will be similar or different to previous work with other professionals?
- In what ways do you think MST-FIT may help you with the transition back home?

Experience for parent

- What might be the experience of MST-FIT be like for your parent?
- What do you hope may change for your parent? (prompt: as a person, as your parent?)

Processes of change

- What kind of things do you think are helpful for young people moving back home after residential care?
- What sorts of things might affect your success with MST-FIT?

Is there anything else you'd like to say?

Interview schedule 13: MST-FIT young people (Post)

General/ Overall Experience:

- What was MST-FIT like?
- How involved did you feel in the MST-FIT sessions?
- What's been most helpful? Anything you didn't like/bothered you?
- If you were talking to your friends about MST-FIT, what would you say?

Working with the therapist:

- What was it like having someone to talk to and work with on problems?
- What did you like / not like about the way ______ worked?
- How was it similar or different to previous work with other professionals?

Experience for parent

- What do you think MST-FIT was like for your parent?
- Any particular things that you feel were helpful/unhelpful for them?
- What things did the 2 of you find helpful/unhelpful?

Working on problems: Process

- Do you feel that your views were important during the MST-FIT sessions?
- Do you feel that you learnt anything from working with [therapist]?
- Were there any ways in which the therapist was able to appreciate the good things about your family? (and use that to help your family)
- What was it like finishing MST-FIT?
- (if there have been positive changes) How confident do you feel that that you can maintain the changes, now that you are back home?

Working on problems: Content

- Are there any particular things that MST-FIT tried to help you with?
- Tell me a bit about the work done to help you with the transition from residential care to moving back home
- ...help you get on better as a family once you moved back home

ITM at residential home

- Tell me a bit about sessions that you participated in the residential home (Prompts: did you find them useful/ not useful? Why?)
- Were there any ways in which the sessions delivered in residential care prepared you to come back home?

Expectations and change:

- Was MST-FIT what you expected?
- In what ways, if any, has it helped you with your life?
- Have things changed that you hoped would change? Things that haven't changed that you hoped MST-FIT would help with?
- Tell me any ways in which your Mom is behaving differently now? (Prompts: in the ways she parents you? treats you? Ways you get along?)
- Do you see your parent any differently now?

Processes of change

- If you had a friend in the same situation (staying in residential care but going to move back home), would you recommend MST-FIT to them as something that could help? Why? Why not?
- Is there anything you think should have been done differently?
- Anything else you'd like to say?

Interview schedule 14: MAU parents (Pre)

General information and expectations:

- Could you tell me a little about your current family situation, and how you became involved with social services? (Prompt: what led to the child going into residential care?)
- What do you know about the sort of support your child will be receiving while in residential care?
- Do you know what sort of support you might be receiving during this time?
- What do you hope therapy for you and/or your child might change for your family?
- Do you have any worries or concerns about starting therapy?

Parent

- What sort of difficulties are you expecting to face when your child returns home?
- What sort of support would you like to help with these difficulties?
- Thinking about the support you'll be receiving, how do you think it might affect your child's transition back home? (Prompt: Will it help? Will it make it more difficult?)
- How do you feel about working with a therapist? (Prompt: What might you find helpful? What might you find difficult?)
- What do you hope will change after therapy?

Young person

- How do you think your child feels about coming back home?
- How do you think they feel about the support they are receiving?
- In what ways do you think their behaviour will change?

Interview schedule 15: MAU parents (Post)

General/Overall experience

- Could you tell me a little about your current family situation, and the types of support you've been receiving since you became involved with social services?
- What sort of support has your child been receiving?
- What were the main problems in your family which you wanted help with, when your child went into residential care?

Parent

- How did you feel about the support you've been receiving?
- What were your relationships like with the key people involved? (Prompt: therapist, social worker, residential placement staff)
- How did you find the support you've had in helping your child return home?
- What has therapy changed for you?

Young person

- How do you think your child felt about coming back home?
- How do you think they felt about the support/therapy they've been receiving while in the residential home?
- What has therapy changed for your child?

Is there anything else you'd like to say?

Interview schedule 16: MAU young people (Pre)

Engaging the adolescent

- Can you tell me what led up to social services working with your family?
- Could you explain to me what sort of help you're receiving, or about to receive, at the moment?
- How do you feel about the type of help you're receiving/going to receive? (Prompt: did you feel that your opinion was important in the decisions to get this help?)
- What are the sort of things you want to change after you come back home?
- If you were talking to your friends about the type of support you're receiving, what would you say?

General/ Overall Experience:

- (If applicable) What do you think your therapy will be like?
- What sort of problems are you hoping to get help with? (Prompt: at school? With parents? With friends?)
- (If applicable) What do you think will be the most helpful about therapy?
- (If applicable) What sort of things do you think you'll find difficult about therapy?
- How do you feel about going back home?

Working with the therapist:

- What do you think it will be like (is like) to have someone to talk to and work on problems?
- What sort of support do you think would be useful in returning home?

Experience for parent

- Do you know if your parent will be receiving any support or help? (Prompt: what do you think about it?)
- What are you hoping will change for your parent? (Prompt: about how they think or behave? About their relationship with you?)

Processes of change

- What kind of things do you think are helpful for young people moving back home after residential care?

Anything else you'd like to say?

Interview schedule 17: MAU young people (Post)

General/Overall Experience

- Could you tell me what is your experience of living here in [name of residential home)? (Prompt: What do you do in residential home? Any kind of activities? What do you think about them?)
- What sort of help have you been receiving while you were in the residential home?
- What's been most helpful? Anything you didn't like or bothered you?
- If you were talking to your friends about your experiences with the type of help you received, what would you say?

Working with the therapist /residential staff/ social worker

- What was it like having someone to talk to and work on problems?
- What did you like/not like about the way your therapist/ residential staff/ social worker worked?
- How was this type of help different to other types of support you've had before? How was it similar?
- Did you feel that your views were important?

Working on problems:

- Starting out, were there any specific things that you wanted to change? Things you wanted help with?
- Do you feel like the help you received has helped you in changing these things?
- Could you tell me whether you are coming back home? (if not, why?, if yes/no: what are your feelings/ thoughts about it?)
- Do you feel like you and your family can maintain these changes after coming back home?

Experience for parent

- Did your parent receive any type of help? What do you think it was like for them?

Residential home

- Tell me a bit about your experiences at the residential home. Did you receive any type of help or support there? What did you think of it?

Expectations and change

- Have things changed that you hoped would change? What things do you still want to change or be different?
- Is your parent behaving any differently now? (Prompt: in the way they parent you? Treat you? How you 2 get along?)
- Is there anything you think should have been done differently?

Is there anything else you'd like to say?

Interview schedule 18: MAU residential staff (Pre)

General: Prior experience and knowledge

- I wonder if you can tell me a little about your professional background and what led you to working here? (Prompt: any previous experience working with looked-after adolescents moving back home? techniques/ approaches did you use?)
- Did you have any specific training when you started working here?

Placement support and therapy (if any)

The next few questions will be around day-to-day life at [placement]

- Can you tell me what happens in an average day at [placement]?
- What sort of support do the young people here receive?

If "nothing", prompt: Do you think being here is helpful to them in any way?

- What are the main challenges you face working here?
- How does this placement compare to other similar residential homes?

Characteristics of Young People and Families

The next couple of questions will be about the young people involved with your service

- Can you tell us about the young people here? (Prompt: what sort of issues are they dealing with?)
- Can you tell us about their families (parents/carers)? What sort of relationships do they have with the young people? What sort of problems do they have?
- Do you know if the parents/carers are receiving any help themselves while their children are in the home?

Returning home

The next questions are regarding the potential for young people to return home

- Is there a plan for the young people here to return home at some point?
- Do you believe that most young people in this setting should return home eventually?

- What sort of help do you think young people and their families need to successfully return home after living in residential care?

Working within the larger systemic context

The next few questions are regarding the support system and services that are involved in the care of adolescents

- Tell us about the major challenges that you regularly face working within the service system for looked-after adolescents?
- How does your service work in conjunction with other agencies? (Work well? communication?)

Manager Specific

- What types of challenge do you believe staff within this placement face?

Change

- Have you seen any changes since we last spoke (for example, young people's behaviour)

Is there anything else you'd like to add?

Interview schedule 19: MAU residential staff (Post)

General: Prior experience and knowledge

- Have you received any new training since we last spoke (6-9 months ago)?

Placement support and therapy (if any)

The next few questions will be around day-to-day life at [placement]

- What sort of problems are the young people here struggling with? (Prompt: Behaviour? Emotional regulation? Relationship with family? Drugs/alcohol abuse? Violence/law breaking?)
- What sort of support do the young people here receive?
- Have you seen any improvements in the young people who live here since we last spoke (6-9 months ago)?
- What sort of help do you think these young people need? (Prompt: What are their needs? Behavioural? Emotional?)

Characteristics of Young People and Families

The next couple of questions will be about the young people involved with your service

- Can you tell us about the young people's families (parents/carers)? What sort of relationships do they have?
- Do you know if the parents/carers are receiving any help themselves while their children are in the home?

Returning home

The next questions are regarding the potential for young people to return home

- Is there a plan for the young people here to return home at some point? Have any young people left the residential home since we last spoke (6-9 months ago)?
  - If yes: What did they go on to do? (for example, return to family, foster home, independent living, another residential home)

Working within the larger systemic context

The next few questions are regarding the support system and services that are involved in the care of adolescents

- Have there been in any changes (in the last 6-9 months) in how you work with other services (for example, social care, schools)?
    - Prompt: has anything improved? Has anything gotten worse?
    - Is there anything you think needs to change in how you work with other services?

Manager Specific

- Have there been any changes (in the last 6-9 months) to the staff's day to day work?
    - Prompt: Have they received any training? Any changes in policy/procedures? If young people have left/started, is the dynamic in the house different now?

Is there anything else you'd like to add?

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Any enquiries regarding this publication should be sent to us at: richard.white@education.gov.uk or www.education.gov.uk/contactus

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