Department for Education

Specialist Health and Resilient Environment (SHARE) Service

Evaluation report

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Children's Social Care Innovation Programme Evaluation Report 33

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Executive summary

Summary of the project and evaluation

The aim of SHARE (Specialist Health and Resilient Environment), which is an extension or renewal of existing support services provided in routine hours, was to implement a model of supporting young people at risk of becoming engaged with statutory social care services as a result of complex emotional and behavioural problems. SHARE works with young people aged from 11 to 17 over a period of at least 12 weeks, including support for their family and access to psychiatric and psychological services. SHARE's team includes a registered manager, clinical psychologist, advanced mental health practitioners, social workers, key workers and support workers.

The primary outcome of SHARE was a reduction in the number of young people becoming engaged in statutory care services due to parents or carers being unable to manage the presenting risk in relation to complex mental health issues. To achieve the full implementation of SHARE, there were 4 objectives:

- the development of a new specialist multi-professional team
- the implementation of a new integrated duty system with a single assessment of need and single care pathway for this group of young people, enabling capacity for crisis response (see Appendices for single assessment form)
- the provision of a residential setting that could work in a flexible way to provide a crisis response to this group of young people, and bridging placements that would support transitions back to family based care
- the training of a cohort of specialist foster carers who could provide a similar model of care as described above, and support their peers in being able to provide permanent placements for this cohort, where appropriate

Methodology

An explanatory case study design was employed to explore and describe SHARE and also to develop theories of the causal mechanisms of the impact of SHARE on young people's outcomes. A quantitative, multi-level, mixed methods design was used with a qualitative component to triangulate the quantitative data. The evaluation comprised:

- routinely collected clinical data
- quantitative data at local authority level

- parents' and young people's experience data
- qualitative data (such as interviews with young people and parents, and focus groups with professionals involved in SHARE)
- SHARE's staff observation tools.

Key findings

Through the implementation of SHARE, evidence from this evaluation suggests that the primary outcome was achieved. Evidence suggests that during SHARE's single assessment, all 37 young people who entered SHARE between October 2015 and the beginning of October 2016 were reported by staff as being at risk of requiring respite or planned short term breaks (defined as a Child in Need – CIN). However, during SHARE only 7 (19%) became Children in Need (CIN). After the single assessment, an assessment by a social worker and advanced mental health practitioner identified that 19 (out of the 37) were at risk of becoming looked after (LAC) by the local authority if services did not get involved. Out of these 19, only 2 (11%) became LAC whilst in SHARE.

Contextual data showed mixed results, and future evaluations could examine the impact of SHARE on rates of LAC and LAC leaving care, as an indication of placement stability across Wigan once it is rolled out county-wide. For example, on the one hand, contextual data showed that the mean rate of 11 to 18-year old children and young people becoming a LAC in Wigan per 10,000 children decreased from Time 1 (October 2014 to September 2015) to Time 2 (October 2015 to July 2016). On the other hand, contextual data also showed that the rate of 11 to 18-year old LAC leaving care at Wigan decreased from Time 1 to Time 2. When interpreting these results, it is important to keep in mind that causality should not be inferred, as contextual data includes a larger group of children and young people than the ones accessing SHARE, and other factors than SHARE might be influencing changes and/or fluctuations in numbers in contextual data.

Implication and recommendation: a longer time-frame and a bigger cohort of young people would be needed to observe changes in LAC rates associated with SHARE at local authority level. This could provide evidence of the impact of SHARE on rates of children going into care. Nonetheless, these are useful indications of what SHARE could do in the future to evaluate their services.

The following questions arose from SHARE:

- does SHARE improve the quality of care provision for young people who are, or might become, engaged in statutory social care service?

- what might be some of the mechanisms by which SHARE reduces the number of young people becoming engaged in statutory social care services, and which aspects are most beneficial?
- what is staff's experience of SHARE?
- what are young people's and parents' experiences of SHARE?

Regarding the first question, where parents had negative expectations of SHARE based on previous experiences with other services, they reported that SHARE provided a reliable service that could be accessed easily in crisis situations. Young people reported a positive impact of SHARE's care: for example, an improved understanding of emotions; an improved ability to express emotions; increased confidence; feeling able to ask for help; more positive future thinking; working though specific difficulties such as with eating, self-harm, family relationships, or medication; and improved social communication. Outcome data showed that, as a group, young people's mental and physical health and social functioning (as reported by clinicians) improved from assessment to the second measurement point, and from the second measurement point to the third (controlling for length of time between measurements), but did not show a significant difference between assessment and last measurement point (controlling for length of time between measurements). It was not possible to conduct an analysis of the Strength and Difficulties questionnaires completed by young people and parents, because of the small sample size. In terms of implications and recommendations, larger sample sizes and longer follow-up periods would be needed to provide more robust conclusions, because changes in empowerment, mental health, wellbeing and resilience might take longer to be reflected in the standardised measures. In addition, a measure such as the Goals and Goal Based Outcomes (Law & Jacob, 2013) could be used to record the specific changes that young people are interested in and that go beyond symptom change, such as being able to take the bus or feel confident to express opinions, although it may be less suitable for use in episodes of crisis.

In terms of the mechanisms by which SHARE reduced the number of young people becoming engaged in statutory social care services, parents and staff felt that SHARE improved their mental health and wellbeing by increasing parental knowledge of their young person's treatment, and by providing them with practical skills and strategies that increased their self-confidence and enabled them to cope better in crisis situations. Young people reported that SHARE's support and out-of-hours accessibility prevented the escalation of risk and met their multiple needs. In addition, person-centred characteristics of the SHARE team, such as being down to earth, non-judgemental, relaxed, reliable, good listeners, caring, and genuine, allowed young people to feel safe, to feel comfortable and to build strong therapeutic relationships. Both young people and staff highlighted the multi-disciplinary team (MDT) as crucial to SHARE's success.

According to staff, the MDT was the mechanism by which the service more effectively met the needs of young people because – as reported by them – the right colleagues with the right areas of expertise were able to come together efficiently to address the children's, young people's and families' needs. These positive outcomes were ascribed to increased information sharing and sharing of expertise, in addition to high levels of staff support. Staff also described SHARE as filling an important gap left by other services in the care for children, young people and families, in terms of providing out-of-hours care, intensive input to the whole family and safer care resulting from information-sharing and collaboration between disparate organisations. SHARE's relational focus seems to be central to the many benefits reported in interviews by parents and young people. Therefore, this evaluation supports the change in policy of moving the focus from a transactional service to a relational one. Learning from SHARE should be spread to other services to help promote a focus on crisis service provision that is organised around the needs of children and families.

Regarding staff's experience of SHARE, staff reported high levels of job satisfaction compared to previous roles, which was explained by the ability to make a difference to the lives of children, young people and families, and collaborating with, and learning from, colleagues. In particular, feeling supported by colleagues was talked about as a source of job satisfaction, as was having ownership and flexibility to work in an innovative way. Staff also reported that, during their work with other staff members, there were opportunities to identify risks and discuss concrete plans to mitigate these risks; that everyone had the opportunity to contribute during discussions, and that all points of view were respected. Building on the success of the cross-sector working and the multi-disciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care.

Overall, parents reported high levels of satisfaction with SHARE in all data strands: all 12 interviewed parents reported a positive experience of SHARE; 7 out of the 8 parents who agreed to complete the Experience of Service Questionnaire (CHI-ESQ) after the interview reported that they were satisfied overall with SHARE; and the 5 parents who completed SHARE's feedback questionnaire, provided by SHARE's staff, also reported high levels of satisfaction with staff and the model. As with parents, young people also reported high levels of satisfaction in all data strands: all 10 young people interviewed described a positive experience of using the SHARE service; all 9 young people who agreed to complete the CHI-ESQ after the interview reported that they were satisfied overall with SHARE; and the 9 young people who completed SHARE's feedback questionnaire provided by SHARE's staff also reported high levels of satisfaction with staff and the model. This highlights the importance and impact of a holistic approach such as the one implemented by SHARE.

What were the facilitators to implementing and sustaining SHARE?

The MDT was seen as a facilitator to implementing and sustaining SHARE, as it allowed staff to share information and expertise, leading to enhanced inter-collegial support for staff and better support for children, young people, and families. In addition, MDTs made staff feel better supported by colleagues in SHARE, compared to previous positions, and therefore better able to support children, young people and families.

Related to the above, staff discussed the team approach to cases as being a unique strength of SHARE, which increased staff confidence as they then had the skills and knowledge of colleagues to draw on. Decisions were also made in an informed manner as different members of the MDT were involved.

Another facilitator was the flexibility to work in an innovative way, which meant that challenges could be efficiently and effectively addressed. This in turn brought high levels of job satisfaction and enthusiasm to make things work, which was felt by parents and young people. Flexibility also allowed SHARE to address ongoing issues and come up with solutions that were adequate for the local context.

An integrated and well-organised MDT, plus flexibility to work in an innovative way, seemed to motivate and empower staff which in turn had a positive impact on young people, parents and families.

What were the barriers to implementing and sustaining SHARE?

The implementation of SHARE was not without challenges. One of those was establishing cross-sector working through the MDT. In particular, even though the MDT was seen as a facilitator, staff reported that initially there was confusion over the different roles. This was present across the project: at the implementation board level, heads of departments had to work together to coordinate efforts, and, at implementation level, staff from different working backgrounds had to adjust their practice.

Another barrier to the innovation was the communication of SHARE to other services: some staff reported tensions with other services raised by a lack of awareness about the programme.

Despite innovation and flexibility being reported as facilitators, they were also reported as barriers because it meant that processes and procedures had to be developed from scratch. This process was described by some staff as being

unwieldy in the first instance and requiring refinement over time. In line with this, disparate information systems were a barrier to the implementation of this innovation because it led to problems of sharing information and a duplication of paperwork. This resulted in a large amount of administrative work and duplication of reports and information needing to go to different services.

Integration of SHARE with other services is crucial and requires an improvement of infrastructure and data sharing to facilitate efficient cross-sector working. This may also result in improved data collection systems, meaning additional analyses could be conducted to inform the evaluation of SHARE, such as examining whether demographic and case characteristics moderate the impact of SHARE on mental health outcomes, and the associations between using SHARE and changes in academic attainment.

How can SHARE be sustained in the long-term?

Cost-benefit analysis (CBA), conducted by our partner York Consulting, calculated an optimistic Fiscal Return on Investment (FROI) of 3.3 (i.e., all outcomes sustained for 12 months), which translates into savings of approximately £3.3 for every £1 invested in SHARE. Even under the most pessimistic scenario (which would be 50% of all outcomes sustained for 12 months), FROI remained positive and was 1.7. These results support SHARE's long-term sustainability. Wider dissemination of SHARE to increase knowledge and accessibility is needed. However, this should be contingent on confidence in future funding and staffing capacity.

Summary of implications and recommendations for policy and practice

In Wigan there is a need for SHARE to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, parents in interviews reported that their, and their children's, needs required support that other services were unable to provide, and young people in interviews said that SHARE's breadth of support met their multiple needs. Staff in focus groups stated that MDT work effectively met the needs of young people and parents because the right colleagues, with the right areas of expertise, were able to come together efficiently to address their needs.

Within this context, wider dissemination of information about SHARE would help the innovation to be embedded and to reach a greater number of young people and parents. However, dissemination would also mean that more young people and families would access SHARE, and hence more resources would be needed in order to cope with future staffing and demand. Therefore, funding for the programme

would need to be secured so that service users did not become reliant on a service that might then be withdrawn in the future.

Overview of the project

The project evaluated the implementation and initial outcomes of SHARE (Specialist Health and Resilient Environment), which is an extension or renewal of existing support services provided in routine hours. It aims to implement a model of supporting young people at risk of becoming engaged in statutory social care services as a result of complex emotional and behavioural problems. SHARE works with young people aged from 11 to 17 over a period of at least 12 weeks, including support for their family, and access to psychiatric and psychological services. SHARE's team includes a registered manager, clinical psychologist, advanced mental health practitioners, social workers, key workers and support workers.

What the project was intending to achieve

The primary outcome was a reduction in the number of young people becoming engaged in statutory social care services (for example, Looked After Child, Child Protection Plan, Child in Need) due to parents or carers being unable to manage the presenting risk in relation to complex mental health issues.

The secondary outcomes were:

- a reduction in the number of young people who become engaged in statutory social care services following discharge from an inpatient mental setting
- a reduction in the number of young people being admitted to inpatient mental health settings
- a reduction in the number of young people engaged in statutory social care services accommodated in residential care provision
- an increase in the number of young people engaged in statutory social care services accommodated in foster care or family placements
- an increase in the number of young people who could remain in the care of the parents

What the project was intending to do to achieve these outcomes

To achieve the full implementation of SHARE, there were 4 objectives:

- the development of a new, specialist, multi-professional team

- the implementation of a new, integrated, duty system with a single assessment of need and single care pathway for this group of young people, enabling capacity for crisis response (see Appendices for single assessment form)
- the provision of a residential setting that could work in a flexible way to provide a crisis response to this group of young people and bridging placements that would support transitions back to family based care
- the training of a cohort of specialist foster carers who could provide a similar model of care as described above, and support their peers in being able to provide permanent placements for this cohort, where appropriate

Overview of relevant existing research relating to this innovation

It is known that 75% of adult mental health problems begin before age 18 and, that of those adults who are diagnosed with a psychiatric disorder by the time they are 26, half had a disorder before age 15, rising to three-quarters (75%) by the age of 18 (Kim-Cohen, 2003). Children in care, and care leavers, are more likely to attempt suicide than their peers; are more likely to enter the criminal justice system; and are more likely to experience poor heath, educational and social outcomes (House of Commons, 2016). Specifically, 45% of looked after children, aged 5-17 years, were assessed as having a mental disorder (Meltzer et al., 2003). This presents as an issue for both health and social care.

The costs associated with poor mental health across the lifetime are startling. For mental health disorders, the annual short-term costs of disorders among children aged 5–15 in the UK are estimated to be £1.58 billion and the long-term costs £2.35 billion (Strelitz, 2012). For the population with emotional disorders, currently aged 5-16, the long-term effects of adolescent depression projected into adulthood, are estimated to have a total annual cost of £301 million; the cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion a year in England and Wales (Strelitz, 2012).

Changes to the project's intended outcomes or activities

The only major change to the intended outcomes or activities, as funded by the Social Care Innovation Fund Programme, is that, at the time this report was written, SHARE House was still not opened. Delays in its implementation were due to various problems with the first house that was intended to become the SHARE house, the difficulties of finding a second house, and some administrative delays with Ofsted.

A further minor modification to SHARE's activities had to do with zoning. SHARE's multi-disciplinary team was going to meet daily to review each young person and identify whether they were presenting as "high", "medium" or "low" risk. This would then indicate the levels of support or response needed for that day. This was not possible, due to everyday work related activities and the consequently inconsistent availability of staff in the office at any one time. However, they compromised and undertook the zoning activity on a weekly basis during multi-disciplinary team meetings, where each young person was discussed and the team planned the support for the next week. In addition, informal updates to team members on contemporary risk information are provided daily as required.

Thirdly, there was a low recruitment of foster carers. The original bid stated that the level of foster carers being accessed would be a minimum of 2, and, at first, 2 sets of foster carers expressed an interest to be included in the project. However, only one pair (2 people) ended up agreeing to take part. Out of those 2 people, one dropped out and one is still fully involved. The SHARE team believes that, in the future, there is a place for foster carers to remain involved as an additional support mechanism. However, the recruitment of these carers would need to be carefully considered, as foster parents need to support young people who present complex needs (for example, suicide ideation and self-harm).

Context within which this innovation has been taking place

Wigan Borough includes the towns and villages of Leigh, part of Ashton-in-Makerfield, Ince-in-Makerfield, Hindley, Orrell, Standish, Atherton, Tyldesley, Golborne, Lowton, Billinge, Astley, Haigh and Aspull. Its estimated mid-2015 population was 322,022 people, of which 23% (74,777) were estimated to be under 19 years of age (ONS, 2016). Regarding gender of people under 19, 49% were female. Wigan was ranked 63rd most deprived LA out of 152 LAs in England in 2015 (1st being most deprived), with 15% of pupils in primary school and 13% of pupils in secondary school eligible for free school meals (compared to 16% and 14% in England, respectively) (GOV.UK, 2016). Of young people aged 16-18 years in Wigan, 5% were not in education, employment or training in 2015, compared to 4% in England.

In 2016, Wigan Borough had 46,386 pupils in 134 schools, 18 academies and 20 Sure Start Children Centres; 4% primary pupils' and 3% secondary pupils' first language was other than English (compared to 20% and 16% in England, respectively). The rate of looked after children (LAC) per 10,000 children aged under 18 in 2015 was 75 (and in England was 60), whilst the rate of children in need per 10,000 in 2015 was 371.9, and in England was 337.3 (GOV.UK, 2016). There are 5

residential children's homes for children in care in Wigan: 2 provide long-term care and 3 provide short term breaks (Wigan Council, 2016).

Wigan does not have an in-patient mental health facility for children and young people, but uses Fairhaven Young People's Unit, which is approximately 10 miles from Wigan's city centre. This entails that all children and young people's mental health Tier 4 admissions are made outside the LA's borders.

Wigan Council and Wigan Borough Clinical Commissioning Group report that the problem of acute mental health among adolescents, and the mental health of children in care or at the edge of care, is present across Wigan Borough, but is most prevalent in the towns and villages of Wigan, Standish, Aspull, Shevington, Winstanley, Billinge and Orrell.

In 2014, when SHARE's proposal was first submitted, Wigan Council and Wigan Borough Clinical Commissioning Group reported that in Wigan there were:

- 406 young people present at hospital with acute mental health problems – this costs the hospital £350K per annum
- 20 of the young people (above) present at accident and emergency which costs the health and social care system £861K per annum (based on a detailed analysis of costs for 7 cases and extrapolated for the 20)
- 7 young people each year become looked after for varying periods of time, due to mental health challenges which costs £63K per annum
- 95 young people with mental health challenges are currently in care within the borough, costing £6.1M per annum
- 24 young people with mental health challenges are in care outside the borough at a cost of £3.2M per annum. Cost benefit analysis suggests that preventing 4 of these 24 young people from being placed in out of Borough residential care will save the cost of this project beyond the period of investment
- 2,122 young people identified as 'in need', that have an increased likelihood of developing mental health issues and presenting themselves to the system at a crisis point

Overview of the evaluation

Evaluation questions

The primary research question was: does SHARE reduce the number of young people becoming engaged in statutory social care services?

The secondary questions were:

- does SHARE improve the quality of care provision for young people experiencing emotional or behavioural crisis, who are, or might become, engaged in statutory social care services, as measured by a reduction in the number of young people admitted to A&E and inpatient units, for example?
- what might be some of the mechanisms by which SHARE reduces the number of young people becoming engaged in statutory social care services, and what aspects of the 4 components (specifically, specialist multi-professional team, integrated duty system with a single assessment of need and single care pathway, residential setting, or training of specialist foster carers) are most beneficial?
- what is staff's experience of SHARE?
- what is the young people and parents or carers' experience of SHARE?
- what are the barriers and facilitators to implementing and sustaining SHARE?
- how can SHARE be sustained in the long-term?
- what is the feasibility of collecting economic data for cost benefit analysis?

Methodology used to address these questions

An explanatory case study design was employed to explore and describe SHARE, and also to develop theories of the causal mechanisms of the impact of SHARE on young people's outcomes. A quantitative, multi-level, mixed methods design was used with a qualitative component to triangulate the quantitative data.

The evaluation comprised the following strands:

- routinely collected clinical data was analysed to explore how appropriately young people's mental health needs were met by SHARE
- quantitative data was used to examine changes in young people's service utilisation and outcomes from before, during and after SHARE, using data

already collected as part of case management systems in Children's Social Care

- patient experience data was gathered using routinely collected experience surveys (which were administered after the implementation of SHARE – supplemented with other experience of service measures) were analysed to understand the impact of these services on young people's and parents or carers' experience of care
- qualitative data (namely, interviews with young people and parents, and focus groups with professionals involved in SHARE) was analysed to understand how experience of SHARE compared to previous experiences with other support services and how service users' and providers' needs were met; the barriers and facilitators to implementation; and what led young people to crisis, to inform how SHARE could be further revised to better meet the needs of young people to prevent crisis and placement breakdown
- participant observation tools were used to collect data by professionals in SHARE to gain detailed understanding of the experience of these services
- York Consulting led the cost-benefit analysis (CBA)

Focus groups with staff and interviews with parents, carers and young people

All SHARE staff were invited to participate in focus groups. Before conducting the focus groups, researchers explained the aims of the focus groups, provided information sheets to participants, and answered their questions. Staff consent for focus groups was recorded.

Overall, 17 staff took part in 3 focus groups conducted in December 2015, which included 5 key workers, 3 managers, thee support workers, 2 social workers, 2 advanced mental health practitioners, one clinical psychologist, and one residential care worker. All focus groups were conducted in December 2015. Five participants were male and the rest were female. The mean age of participants was 39 years (ranging from 24 to 55 years). In terms of ethnicity, all participants were white, except for one, who was black. Only 2 participants worked part-time and one participant did not answer. The average years' experience working with a similar population was 13 years (ranging from 2 to 31 years).

Parents and young people were invited to participate in interviews by SHARE staff, who provided an information sheet explaining the study. If parents of young people were interested in participating, they completed the Expression of Interest form, which was then sent to researchers at AFNCCF. Researchers then contacted potential participants and agreed on a specific date and place for the interviews. A

full explanation of the research was provided to parents and young people before the beginning of the interviews. Interviewees gave their informed consent to be interviewed, and for the researcher to record and transcribe the interview.

A total of 12 parents of 10 young people were interviewed; 11 were parents and one was a grandmother; hence, none were carers. The average age of parents was 47 (SD=10.01), and ranged between 34 and 62 years. Regarding gender, 8 parents were female, 3 were male and one did not have demographic information. Ten parents reported being white and 1 was mixed race. In terms of marital status, 6 were married, 4 were divorced and 1 had never been married. Regarding occupation, 6 worked in the public sector, 2 were self-employed, and one was retired.

Ten young people were interviewed. At the time of the interview, one young person was in foster care, one was in Tier 4, and the rest were living at home. Ages ranged between 13 and 17 (average age=16, *SD*=1.2); 6 of them were female, 3 were male and one was transgender. Regarding ethnicity, 8 were white, one mixed race and one not declared. In terms of education, one young person was in Year 9, 2 in Year 11, and 5 in college, and 2 were not declared.

Changes to evaluation methodology from the original design

Due to the extension of SHARE, qualitative data collection was also extended until end of July 2016 and quantitative data collection was extended until beginning of October 2016. As the SHARE house was not open by the time this report was written, it could not be evaluated.

The original economic evaluation partner did not have the capacity to carry out this aspect of the evaluation, due to unexpected lack of staffing. Therefore York Consulting conducted the economic evaluation. We were only expecting to be able to examine the feasibility of collecting data for CBA and as there was more data available, results of the CBA analysis are presented below.

The evaluation team at Anna Freud National Centre for Children and Families were recently (Monday 14th November) informed by Wigan Council that 2 young people who were known to SHARE had unfortunately passed away in the first 2 weeks of November; one young person who had engaged with the service for the last 6 months died by suicide and cause of death of the other young person, who had just been introduced to the service in October, is still “not stipulated”. Data collection for the evaluation was completed in the beginning of October 2016 and, therefore, we have not been able to report on these tragic deaths in our evaluation report. Nothing similar happened whilst we were conducting the evaluation. Wigan Council and their

partners via the Warwickshire Safeguarding Children Board are currently following protocols to examine what led each young person to this situation, and to determine whether there are any lessons to be learnt, and will provide details in writing to DfE once these enquires are concluded. Nevertheless, Wigan Council, SHARE, and AFNCCF wanted to include a note in our evaluation report to ensure transparency.

Key findings

This section presents a summary of all the results obtained for SHARE. For all the results that were available please refer to the Appendices, except for the qualitative analysis of the parents and young people's interviews which are available on request.

Characteristics of SHARE and of young people in SHARE

The total number of cases referred to SHARE between October 2015 and the end of October 2016 was 60 young people. Out of those, 17 (28%) were rejected by SHARE and 43 (72%) accepted. Referral rejection would occur when the young person being referred did not meet the service criteria; for example, the young person may have presented within the community with anxiety or depression but had no hospital attendance or were not at risk of Tier 4 or becoming LAC, or may have been a young person with significant social care or behavioural issues without significant mental health issues. The 43 cases that were admitted to SHARE would otherwise have been referred to Social Services, hence acceptance of those referrals implied a reduction in caseload size for social worker at Wigan.

Out of the 43 accepted cases, 17 (40%) were males and 26 (60%) females. The mean age was 16 years (SD=1.24), and ranged from 13 to 17. In addition, out of the 43 accepted referrals 22 (51%) of them were closed by late October 2016. The average length of SHARE's involvement in the closed cases was 22.3 weeks (range=5.3 to 46.3 weeks). Only one young person has been re-admitted to SHARE after being discharged.

Of the 21 cases that were open by the end of October 2016, 9 of them had been referred by Social Care, 8 by Child and Adolescent Mental Health Services (CAMHS), 3 by CAMHS Assessment and Response Team (CART) and one from Tier 4. Two social workers had 10 to 11 cases each, and 6 key workers had 3 to 4 cases each.

From September 2015 until the end of October 2016, SHARE supported young people in activities 164 times; provided therapeutic support to young people 67 times; had 3,097 telephone contacts, and visited young people on 296 occasions.

Does SHARE reduce the number of young people becoming engaged in statutory social care services?

SHARE data

During SHARE's single assessment, all 37 young people who entered SHARE between October 2015 and the beginning of October 2016 were identified by clinicians as at risk of requiring respite or planned short-term breaks (defined as a Child in Need – CIN). During SHARE, only 7 (19%) became Children in Need (CIN).

Furthermore, during the initial assessment that each young person accessing SHARE had with a Social Worker and an Advanced Mental Health Practitioner, a trajectory outlining the potential risks in this area if nothing were to be put in place was conducted. Out of the 19 young people who, during that assessment, were identified by clinicians as at risk of becoming LAC if there were no services involved, only 2 (11%) became LAC whilst in SHARE.

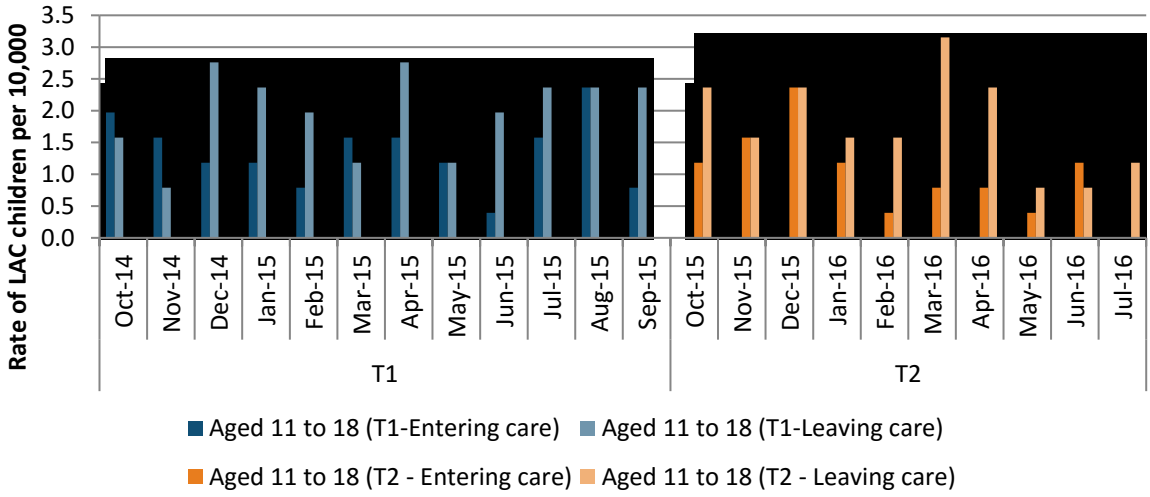
Contextual data

In order to answer this question, we compared the local authority indicators for the year before SHARE started (October 2014 to September 2015, or T1), to the period after SHARE was implemented (October 2015 to July 2016, or T2). Tables and figures for children aged 0 to 10, and 11 to 18 in Wigan, for all the indicators presented below, can be found in the Appendix. In this section we present a summary of results for children aged 11 to 18 as that is the age range covered by SHARE.

The mean number of 11 to 18- year old children who were LAC in Wigan per month increased from 200 (range= 197 to 203) at T1 to 205 (range=199 to 209) at T2. On the same lines, the mean rate of LAC children and young people aged 11 to 18 per 10,000 children in Wigan per month increased from 78.9 (range=77.7 to 80) in T1 to 80.7 (range=78.4 to 82.4) in T2.

In terms of the rate of children and young people becoming LAC per month in Wigan per 10,000 children, the mean rate for 11 to 18-year old children decreased from 1.3 (range=0.4 to 2.4) at T1 to 1 (range= 0 to 2.4) at T2. On the other hand, the rate of 11 to 18-year old LAC leaving care in Wigan per month decreased from 2 (range= 0.8 to 2.8) at T1 to 1.8 (range=0.8 to 3.2) at T2. However, data presented important fluctuations between the months that composed T1 and T2, as shown in Figure 1 below.

Figure 1: Rate of 11 to 18 year old children who entered and left care before and after the implementation of SHARE (T1 and T2, respectively) per 10,000 children in Wigan.



Source: Wigan council

The mean percentage of children aged 11 to 18 becoming LAC per month for a second or subsequent time (out of all the children who entered care), decreased from 6% (range=0% to 18%) at T1 to 5% (range=0% to 33%) at T2.

The mean percentage of children aged 11 to 18 who returned home after a period of being looked after per month (out of all the children leaving care), decreased from 9% (range=0% to 30%) at T1 to 7% (range=0% to 27%) at T2. The average number of days per month that children who left care and returned home increased from 266 (range=9 to 1400 days) at T1 to 349 (range=3 to 1645) at T2.

The mean percentage of LAC children who were in residential care per month (out of all the children who were in care) decreased from 9.6% (range=8.5% to 10%) at T1 to 8.7% (range=7.7% to 9.8%) at T2.

The mean percentage of children aged 11 to 18 who were re-referred to children's social services per month (out of all the children referred to children's services) increased from 7% (range=5% to 9%) at T1 to 8% (range=6% to 10%) at T2.

As stated above, SHARE aims to reduce the number of young people becoming engaged with statutory services, and also works with young people who are in foster care, or young people who are referred to social care. Contextual data was examined to show what could be examined in future evaluations of SHARE. The contextual figures show a mixed picture. On the one hand, after SHARE's implementation, the mean rate of children entering care per 10,000 children in Wigan decreased, as also did the mean percentage of children becoming LAC, per month, for a second or subsequent time. On the other hand, after SHARE's implementation,

the mean percentage of children who were re-referred to social services per month increased, and the mean percentage of children returning home after a period of being looked after per month decreased. However, causality should not be inferred. Contextual data includes a larger group of children and young people than the one accessing SHARE, and other factors than SHARE might be influencing changes and/or fluctuations in numbers in contextual data. This is why future evaluations of SHARE, with a longer time-frame and a bigger cohort of young people, would be needed to observe changes in LAC rates associated with SHARE at local authority level.

What led young people to crisis?

Parents

Many parents reported several problems in their young person's life:

> "[young person] has a lot of issues" (Parent 4).

The accumulation of such problems developed into a crisis situation:

> "…just built up on him all at once" (Parent 1)
>
> "one thing after another" (Parent 4)
>
> "build-up of everything really" (Parent 4).

Crisis situations included self-harm and suicide attempts, parents believed several problems experienced by their young person led to such behaviour:

> "[young person] was self-harming, she'd taken 2 overdoses and it's an accumulation of what's happened" (Parent 8)

as young people were unable to cope with situations "that he can't really deal with…he just can't cope" (Parent 4).

Parents frequently discussed their experiences with self-harm:

> "he'd been admitted into hospital because they were concerned about his threatening to harm himself" (Parent 6)
>
> "he'd been self-harming and that was the reason from admission" (Parent 2)

and suicide:

> "twice he tried to commit suicide in school" (Parent 11)

> “my daughter was taken into hospital because she’d taken an overdose” (Parent 7)

> “my son ended up on the wrong side of the motorway bridge and wanted to end his life” (Parent 4)

Issues within the family were identified as one of the issues leading to a crisis situation. Parents described how their young person often did not disclose their issues:

> “he doesn’t want to express it to me what he’s feeling” (Parent 1)

> “[young person] wouldn’t speak to us, would he? Really shut us out” (Parent 5)

This lack of communication resulted in parents being unaware of the severity of the situation:

> “we don’t know why he went to that bridge” (Parent 11).

However, some parents were aware of the impact that issues within the family had upon their young person:

> “he’s had a bit of a bust up with his dad the night before and I think it had sent him a bit wrong” (Parent 4)

In many cases, parents were made aware of their child’s mental health issues through the school:

> “he had a counsellor at college, she picked him up straight away” (Parent 1);

> “they’d rung us from college to say that they were very concerned about him and they didn’t feel they could let him out of college on his own because it wasn’t safe” (Parent 6)

Parents also described the difficulties their young person had in school due to bullying:

> “people constantly having a go” (Parent 5)

> “she was getting bullied from day one” (Parent 8)

and due to the pressure of school:

> “transition from high school to college he started having problem” (Parent 9)

> “the pressures, obviously, of school, like exams and things like that” (Parent 4)

Young People

The most reported reason for hospital admission was suicide attempt:

> “I tried to hang myself…I ended up going into hospital because that’s what were best for me” (Young Person 8)

> “I was in hospital at the beginning of August for an overdose” (Young Person 2)

and self-harm:

> “because of self-harming and suicide attempts” (Young Person 4)

> “I was having a few problems and stuff like with my eating and then with self-harm, and then I got put into hospital in a unit last year” (Young Person 1)

Several young people were unable to recall events leading up to their crisis situation:

> “I was quite ill so I can’t really remember like being…the details of it really” (Young Person 6)

or briefly discussed their experiences:

> “just like problems with friends and that and family issues” (Young Person 4).

Those young people who felt able to discuss their personal experiences reported a build-up of events:

> “because I just got worse…it gradually built up” (Young Person 5)

> “it was more just building up, yeah” (Young Person 6)

This build-up of events was reported to overwhelm young people, resulting in a crisis situation:

> “they’d all just kind of come at once and it was just too much so she put me onto the ward” (Young Person 9).

Family issues were reported to lead to the young person’s mental health issues or crisis situation. These included arguments:

> “I got kicked out, well I had an argument with my dad” (Young Person 2)

the death of a loved one:

> "I lost my Nan…it proper did destroy me – and that's when I just went downhill completely" (Young Person 8),

a history of mental health:

> "I was living with my mum then and she's got mental health issues…so it was going to happen whether I liked it or not" (Young Person 7)

and abuse:

> "my dad was very abusive with my mum…and he emotionally abused me as I got older" (Young Person 8)

Does SHARE improve the quality of care provision for young people who are or might become engaged in statutory social care services?

Parents

The expectations parents had of SHARE were found to be strongly based on their previous experience of other services. As many parents reported negative feelings about CAMHS, it was relevant to compare the services received in SHARE to CAMHS during interviews. Parents had negative expectations of SHARE due to their experience with other services, which were not necessarily borne out when they engaged with the service:

> "SHARE sort of came into our lives and at the time I thought oh, here we go again, same old crap, different people" (Parent 8)

> "I was thinking, hmm they might be a bit like CAMHS and the Crisis Team…but actually they've surprised me, I'm quite impressed" (Parent 7)

> "I guess from using other services I didn't believe they'd be as good as they have been" (Parent 3)

The main difference between SHARE and CAMHS in parent-reported comparisons was the ability to contact a person directly in crisis situations:

> "there's somebody to always ring, like I can always ring here and say 'somethings happened, what do you suggest I do…whereas at Community CAMHS…they don't have the resources to be able to do something like this service" (Parent 2)

Parents reported experiencing a fragmented service at CAMHS, which led to the perception of a less integrated service compared to SHARE. As a result of a more integrated service, SHARE was better able to fulfil promises made to parents:

> "they said they were doing certain things, okay it might take 2 or 3 weeks, but it got done. It wasn't like oh, we're going to do this and then 2 or 3 weeks later you go and there's still nothing…that's what CAMHS did" (Parent 8)

Being able to do this created a sense of reliability and trust for parents in relation to SHARE, which in turn facilitated the therapeutic relationship of the service:

> "what helps with SHARE is that you get to know the people and they get to know you and it's easy to have a more open relationship with them" (Parent 3)

Another key difference between SHARE and CAMHS was parent-reported accessibility of services:

> "CAMHS service that's half an hour away from our house is really difficult. So SHARE being able to come to our house has been amazing" (Parent 3)

The home visits provided by SHARE were perceived as more personable by parents and thus were found to provide better care for young people:

> "I obviously prefer SHARE. I just think you get more of a one-to-one…CAMHS is good for what they did, but [young person] needed more…it felt like the package was put together for us and that's what we needed at the time" (Parent 4)

The specific support SHARE services provided to parents included practical support such as supporting young people to attend college, doctors' appointments, or parent or carer appointments. A key part of SHARE was providing days out for young people to provide respite for parents. These outings included taking young people "…out bowling, they've taken him out for coffee" (Parent 6) or taking him "down the town, take him out for a drive" (Parent 5).

In addition to providing support services for young people, SHARE also provided support for parents in therapy sessions and in real world situations:

> "once I was concerned about something because he's got involved with this girl who apparently self-harmed…so I rang [clinician] and I said, what shall I do because I don't want him to go to this place; so she said, 'put him on, don't worry;' so she had a chat to him, she said, 'you can't contain him, he'll have to go out, you can't make him stay in,' but, she said, 'he's promised me he'll be safe and he'll come home and he'll text you when he's there.'…I don't know what I would have done without them" (Parent 6)

In addition, SHARE services provided support for parents experiencing low mental wellbeing as a consequence of their personal experiences with mental health problems:

> "I wasn't sleeping- they knew that- and their way of giving me respite was by taking him out" (Parent 1)

This support was important for parents as "you blame yourself, you thought you'd done something wrong, is there anything you could have done, could you have done something different?" (Parent 2)

What is the impact of SHARE on young people's mental health?

This section presents the results obtained on the impact of SHARE on young people's mental health. Routinely collected data was used to make the evaluation sustainable beyond its end. In contrast with a randomised controlled trial (RCT) where random allocation of participants ensures homogeneity of groups at baseline, the methodology of this evaluation entails challenges when identifying a comparator group that is actually comparable (namely, 2 groups without systematic differences at baseline). An approach that could be used to overcome this limitation is the use of synthetic controls, which was the original intention of this evaluation when trying to obtain pre-implementation data and contextual data. In future evaluations, a synthetic control group could be used, using propensity score matching on routine clinical data from other similar services, or wider local authority, to try and make groups similar and more comparable. Despite this limitation, routinely collected data was collected and analysed in order to explore how young people are (or are not) changing after accessing SHARE.

Young people

All 10 of the young people gave examples of the positive impact which the service has had on their mental health. Examples given included an improved understanding of emotions; an improved ability to express emotions; increased confidence; feeling able to ask for help; more positive future thinking; working though specific difficulties such as with eating, self-harm, family relationships, or medication; and improved social communication. The breadth of the support they had received was noted by several young people. For instance, one young person said:

> "I think they're amazing like because in the space of 2 months – I've never worked with anyone like that… I've never worked with anyone in such a short space of time and they've given me so much help" (Young Person 8)

Most of the young people reported that they had been taught multiple coping strategies or techniques.

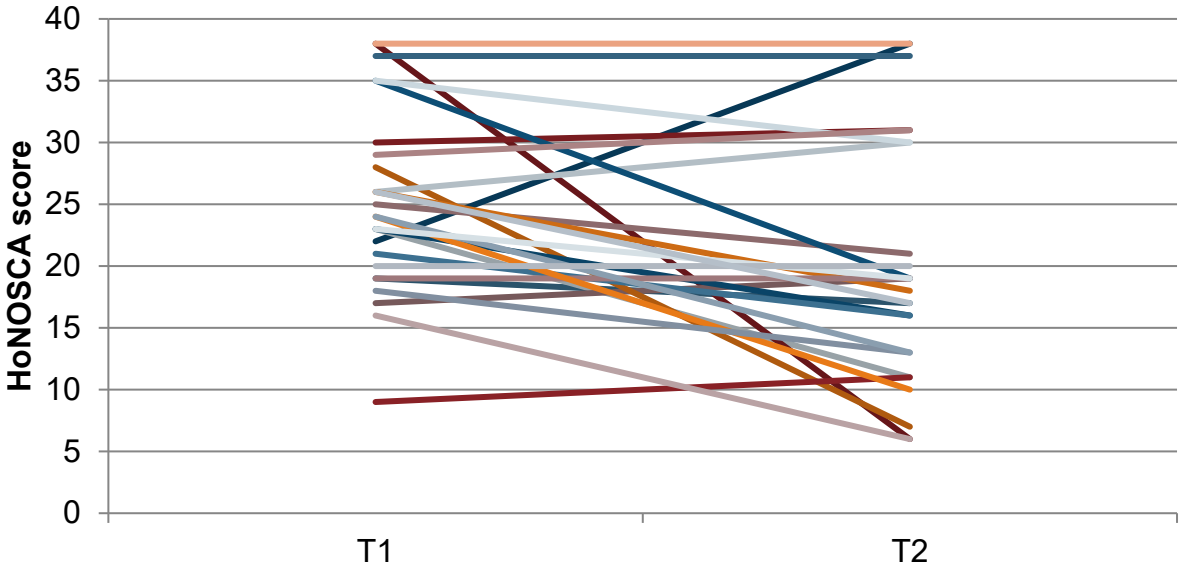
Routinely collected data

In SHARE, all young people have SDQs completed within the first few weeks of accepting the referral, whilst HONOSCA's are completed by week 3. Out of the 37 young people who accessed SHARE between October 2015 and beginning of October 2016, 29 had a recorded Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) score at assessment (T1). The reason why the remaining 8 young people did not have HoNOSCA scores is unknown, but it might be that at least some of them are from the initial stages of the project, when, due to setting-up, procedures may have been missed. In addition, 26 of those 29 had multiple HoNOSCAs recorded with an average of 3.9 (SD=2.02), and a maximum of 8 HoNOSCAs. Taking into account all data points available for each young person, results showed that they were separated by an average of 46.11 days (SD=22.44), with a minimum of 6 days and a maximum of 143 days.

Difference in mean on paired HoNOSCA scores between T1 (mean=25.04, SD=7.27) and the second assessment or T2 (mean=19.73, SD=9.71), controlling for length of time between T1 and T2, was statistically significant ($F(2,23)=4.01$, $p=.032$, $n=26$). The average days between T1 and T2 were 48, with a minimum of 9 days and a maximum of 143 days. The difference between T2 and third assessment or T3 (mean=17.9, SD=9.13), controlling for the length of time between T2 and T3, was significant ($F(2,18)=4.89$, $p=.02$, $n=21$), with 52 days on average between T2 and T3 (ranging from 28 to 85 days). Individual trajectories of paired-scores from T1 to T2 are presented in

Figure 2.

Figure 2: Individual HoNOSCA trajectories (from T1 to T2) for 26 young people in SHARE who had paired data.

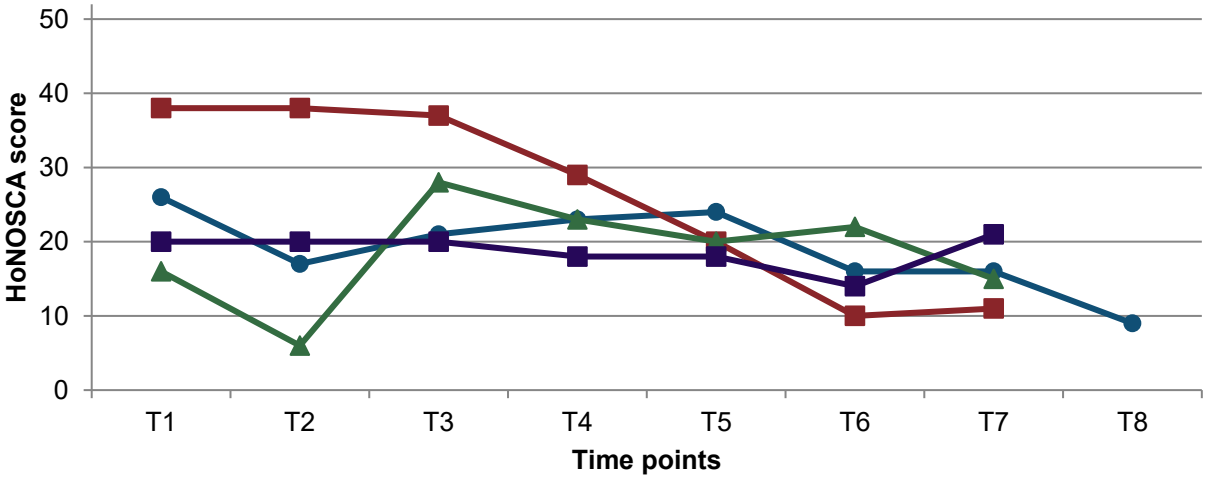


N.B. Each colour represents a different young person

Source: SHARE outcome data

As a group, young people did not present significantly lower HoNOSCA scores at their last measurement (Last score: mean=13.58, SD=8.38; F(2,23)=0.27, p=0.77, n=26), when controlling for length of time between first and last measurement. In most of the cases, treatment trajectories were not linear as can be seen in the run chart below (Figure 3) that includes the 4 young people who had at least 7 measurement points.

Figure 3: HoNOSCA trajectory of 4 young people with 7 or more data points.



Source: SHARE outcome data

Regarding the Strength and Difficulties Questionnaire (SDQ), 17 young people completed it at T1 and 10 at T2; whilst 14 parents completed the SDQ at T1 and 5 at T2. Paired SDQ numbers were lower, with 7 completed by young people and 3 completed by parents. Time between measurements of SDQs varied from 11 to 61 days, with an average of 22.5 days (SD=19.69) for young people-report and between 10 and 22 days, with an average of 15 days (SD=6.43) for parent-report. Due to the low frequency of completed SDQs, no further statistical analyses were conducted.

The SDQ also has clinical cut-off points that divide young people in a clinical or non-clinical range for each sub-scale and the Total Difficulties Scale (Goodman et al. 2001). In the Total difficulties scale, 10 out of 17 (59%) young people were in the clinical range at T1 and 7 out of 10 (70%) people at T2 according to young people-report, whilst 9 out of 14 (64%) young people were in the clinical range at T1 and 4 out of 5 (80%) at T2 according to parent-reports.

Out of the 7 young people who had paired SDQs completed by young people, 1 recovered (moved from the clinical to the non-clinical group) and reliably improved (the change in score was not due to random fluctuations or measurement error); 5 did not recover, or have a reliable change in scores, and one deteriorated (moved from the non-clinical group to the clinical group) but did not have a reliable change in the Total Difficulties Scale.

Of the 3 young people who had a paired SDQ completed by parents, 2 did not recover, or have a reliable change in scores, and one deteriorated (moved from the non-clinical group to the clinical group) but did not have a reliable change in the Total Difficulties Scale.

Results presented in this section are mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained, especially of results that require paired data. In addition, given the short time frame in which young people and parents accessed the service, and as they were accessing the service during crisis when high levels of distress were experienced, it is unsurprising that change in mental health symptoms was not observed. A longer follow-up of those who access SHARE is necessary.

What might be some of the mechanisms by which SHARE reduces the number of young people becoming engaged in statutory social care services?

Parents

Parents discussed how SHARE increased parental knowledge of their young person's treatment:

> "because all we did was drop her off at CAMHS, she goes in, has her treatment, comes out but she didn't want to talk about it so we didn't know anything about it" (Parent 3).

Parents believed SHARE provided them with skills enabling them to cope better in crisis situations:

> "think if I was to be faced with difficulties again, I wouldn't find it quite so scary and I think that if there was another inpatient admission, I probably wouldn't feel quite as overwhelmed and out of my depth that I did feel when he went in the first time because I've had mental health put on the agenda more" (Parent 2)

> "having the psychologist come over to our house, give us advice on what to say to [young person], how to use your emotions or, you know, not use your emotions but how you're supposed to feel and what emotions you should be showing to the young person that would help them and help yourself because otherwise you just don't know" (Parent 6)

> "I kind of notice my behaviours as well as his behaviours…they've taught me how to not react to those clashes in the same way" (Parent 7).

Parents frequently discussed the support they received from the staff at SHARE and this support was found to be important for parents as "you don't think you need it but you do" (Parent 1). SHARE provided parents with the information and emotional support necessary to cope with their young person's mental health problems. In the interviews, parents also reported that SHARE provided practical support in different aspects of their lives, including returning to work:

> "they actually said, 'you need to be going back to work now' and I was like, 'but I don't want to leave him' and it was supporting through that as well" [Parent 9]).

This supportive relationship was extended to family members to improve treatment outcomes for their young person:

> “they went right, we’ve got to help you as a family unit and then once we get into that we can help everyone. And then the whole thing realistically revolves around [young person], because if they didn’t help us out…they could do whatever they wanted and it wouldn’t help [young person] because we’d still be stuck in the same rut” (Parent 8).

Overall, SHARE was reported as being effective in improving the mental health and wellbeing of both parents and young people. Firstly, parents reported improvements in their young person since using SHARE:

> “it’s getting him through the bad part and back to the good part…that’s what they’re helping with” (Parent 1)

> “there has been a huge improvement in [young person]” (Parent 9)

> “it’s the first time I’ve seen him smile in ages” (Parent 11)

Secondly, parents reported improvements within themselves as a result of SHARE service involvement:

> “I’ve started to pick out that I can tell when a mood’s going to come on and he changes” (Parent 1)

> “they’ve saved me from going schizs…and they saved my marriage” (Parent 8)

> “peace of mind…I knew he was safe, and I could relax a bit” (Parent 5)

The most commonly reported improvement in parents was found to be their increased confidence in dealing with their young person’s feelings and behaviours:

> “I’m more confident in knowledge how to deal with things now” (Parent 1)

This increase in confidence was found in both parents and their young person:

> “I would say it’s a confidence booster for both me and [young person]” (Parent 1).

Parents also discussed practical skills they learnt from SHARE services to allow them to remain calm in situations:

> “I just take a deep breath and think, right, we’ve got to think about [young person]” (Parent 6)

> “I’m here, I’m calm, I’m collected, I know what I’m saying, I know what I’m doing” (Parent 4)

and strategies they have learnt from SHARE staff that has in turn changed their outlook or behaviour:

> “what SHARE has done is say to us, okay well…it’s okay to say that, maybe don’t say that but here’s an idea…and that’s just been brilliant for us” (Parent 3)

> “now I turn round and say ‘I can’t, I’m too busy’ and I don’t feel bad about it. SHARE has given me that” (Parent 8)

Young people

Two mechanisms were identified which enabled young people to engage with SHARE, rather than statutory social care services. Firstly, young people reported finding SHARE easy to engage with due to the nature of the extended support provided. The service was reported as being very easy to access, as support was available out of hours. This was reported as being particularly important in preventing an escalation of risk:

> “Like when you're really down try and call someone or speak to someone about it instead of acting on anything” (Young Person 4)

Some young people noted the breadth of support being provided by the service as particularly helpful in meeting their multiple needs:

> “They’ve helped me find somewhere to live, I've got a job, I'm volunteering, I'm back talking to my dad. So everything I've actually asked them to help me with they have done” (Young Person 2)

Young people also identified the importance of this support extending to the whole family:

> “I find it useful not only for me but for my parents as well because obviously when I’m struggling they struggle; so they’ve been able to ring SHARE as well for their own like needs and stuff. So to know that they have support as well is more like comforting for me” (Young Person 6).

Secondly, characteristics of the team as a whole, as well as individual team members, were highlighted as being very important. Several young people noted that having a multi-professional team had many benefits. The description of how young people viewed SHARE’s team members can be found in the relevant research question below.

Focus Groups

In the focus groups, the integration and collaboration between the multi-disciplinary team (MDT) was repeatedly highlighted by all staff as crucial to SHARE's success. It was described as being the mechanism by which the service more effectively met the needs of young people because – as reported by staff – the right colleagues with the right areas of expertise were able to efficiently come together to address the children's, young people's and families' needs. These positive outcomes were ascribed to increased information-sharing and sharing of expertise, in addition to high levels of staff support.

In addition, staff described SHARE as filling an important gap left by other services in the care for children, young people and families, in terms of providing out-of-hours care, intensive input around the whole family, and safer care resulting from information-sharing and collaboration between disparate organisations.

Staff reported that by giving children, young people and families the skills to manage emotional and behavioural difficulties more effectively in the home or school, there is a likelihood of reduced access to services, and, in particular, crisis support services, in the future. In addition, by empowering families to better manage emotional and behavioural difficulties, staff discussed cases where a child going into care or becoming looked after had been avoided. Staff also described the potential for cost saving by empowering families to better manage emotional and behavioural difficulties and therefore, not having to access other social, health and justice services in the future. Examples of the impact of SHARE on children, young people and families were given in all focus groups, including preventing children becoming looked after; empowering children, young people and families; and improving outcomes, even when children and young people were taken into care. In addition, examples of the impact of the MDT on supporting staff to better support children, young people and families were also frequently mentioned.

What is staff's experience of SHARE?

Focus Groups

All staff reported high levels of job satisfaction compared to previous roles, which was explained by the ability to make a difference to the lives of children, young people and families, and collaborating with, and learning from, colleagues; in particular, feeling supported by colleagues was talked about as a source of job satisfaction, as was having ownership and flexibility to work in an innovative way.

The innovative nature of the project was described as something of a double-edged sword as, on the one hand, SHARE was providing a valuable, new service, filling a

much needed gap. On the other hand, the novelty of the service means that processes and procedures had to be developed from scratch, with lessons learnt and implemented along the way. Still, freedom to have this flexibility meant that challenges could be efficiently and effectively addressed. Likewise, transparency and clarity of aims were crucial in maintaining boundaries to this flexibility. Nonetheless, developing new processes was described by some as being unwieldy in the first instance, as they required refinement over time. Examples included referral processes, crisis management, and location and facilities.

Staff also reported high levels of uncertainty about the future of the service after the end of the project, including both whether or not there would be funding for the service and, if so, what the funding would be contingent upon: for example, some staff were concerned that their caseloads might increase, meaning they would not be able to provide the dedicated, intensive work with families that is so effective currently.

Observation tools

Four staff completed 14 observation tools from December 2015 until January 2016. Through the observation tools, most of the time (12 out of 14), staff reported that they agreed that during their work with other staff there were opportunities to identify risks and discuss concrete plans to mitigate these risks; that everyone had the opportunity to contribute during discussions; and that all points of view were respected. In addition, 13 out of 14 times staff reported that during their shift, service users had the opportunity to talk about what they wanted, and 12 out of 14 staff agreed that service users had the opportunity to ask questions, that service users felt as if they understood what was talked about and their views were listened to and respected.

As an additional comment, staff highlighted difficulties with office space to complete administrative work, building space to conduct group supervision and neutral or clinical spaces in which to hold family meetings.

What are young people's and parents' experiences of SHARE?

Parents

Overall parents reported high levels of satisfaction with SHARE: all the 12 interviewed parents reported a positive experience of SHARE; 7 out of the 8 parents who agreed to complete the Experience of Service Questionnaire (CHI-ESQ) after the interview reported that they were overall satisfied with SHARE (see Figure 4);

and the 5 parents who completed SHARE's feedback questionnaire, when requested by a member of SHARE's team, also reported high levels of satisfaction with staff and the model.

In the ESQ, parents reported that SHARE staff provided enough information; that they felt listened to by staff; and that staff took their concerns seriously and treated them well. Similarly, in SHARE's feedback questionnaire, all 5 parents reported that all the things that were important to them were covered in the sessions; they felt that their child was supported by their key worker; felt supported by staff at SHARE; felt involved in their child's Care Planning; and felt that their, and their child's, views were taken into consideration.

All 5 parents who completed SHARE's feedback questionnaire reported that SHARE was making a positive difference to their lives. When asked about more details regarding SHARE's positive difference, parents mentioned the staff and said that they had been very supportive (even during their days off), non-judgemental, positive, compassionate, understanding, hardworking and determined, not only with children and young people but also with parents.

Many parents reported how staff "…went beyond her duties" (Parent 4) or had "gone than extra mile" (Parent 8) in the care of their young person, with several members of staff working outside their hours:

> "[clinician] wasn't working, and I could just ring her" (Parent 5)

> "I texted [clinician] once and she wasn't at work, but she answered me" (Parent 6)

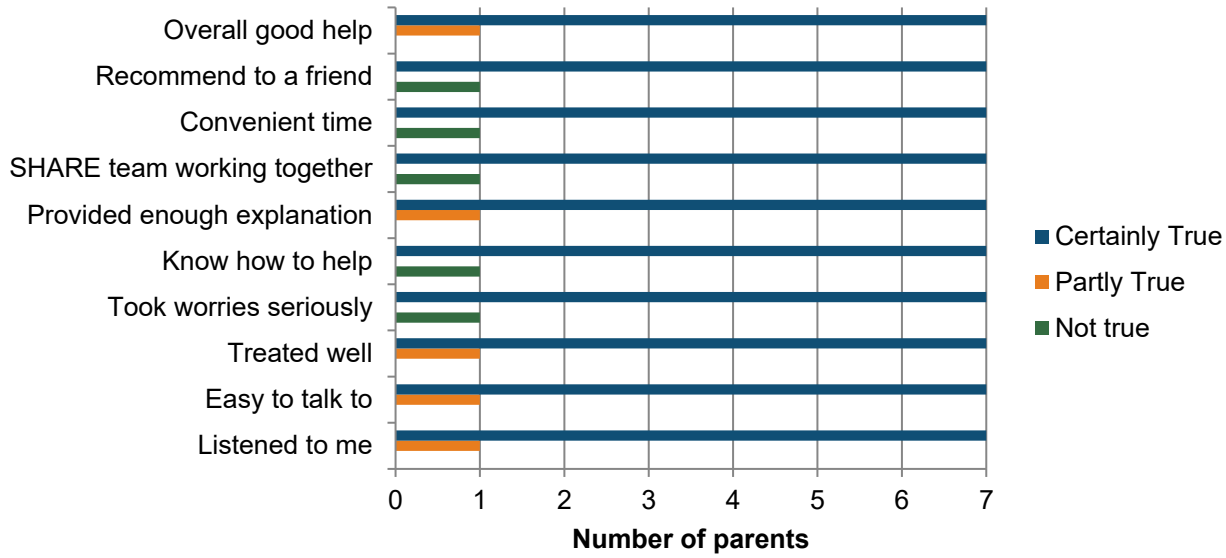
Understanding and recognising the dedication of SHARE staff in their work developed a sense of trust in parents, in terms of SHARE caring for both their young person:

> "I felt I could trust him with them, I was happy for them to take him out" (Parent 6)

and parents themselves:

> "I keep a lot of it bottled up, but she seemed to manage to grab it out of me...she's really good at what she does" (Parent 8)

Figure 4: Frequency of answers given to CHI-ESQ questions by interviewed parents.



Overall, the majority of parents were extremely positive about SHARE. When questioned about aspects of SHARE they liked least, suggestions in terms of service improvement were made rather than criticisms. These improvements included early intervention family therapy (Parent 5), managing parent support groups (Parent 5), implementing programmes similar to SHARE across the UK (Parent 2) and creating information booklets about SHARE (Parent 2). The latter suggestion was important as parents were found to lack capacity to retain information during emotional crisis situations:

> "…you're bombarded with so much information…I just didn't take it on board but if I'd had a physical document in my hand with some information about what it was, then possibly that would have sunk in a little bit more" (Parent 2)

Parents expressed fear and worry about the end of service:

> "I am quite fearful of when they do discharge us from SHARE…" (Parent 2)

> "the only thing I worry about is, [young person]'s turned sixteen…what age do they still work with you" (Parent 5)

However, parents felt SHARE had provided them with the knowledge and skills necessary to cope after the service has ended:

> "I suppose by the time it stops, she'd have given me all the confidence that I need to continue and all the information that I need" (Parent 4)

Only one parent or carer expressed a negative experience of SHARE following a session with one clinician who they found to be patronising. Two points were raised by Parent 10. Firstly:

> "I think that's the problem with SHARE, there's just not enough mental health-trained staff".

Secondly, they believed the practical support provided by SHARE was unhelpful for their young person:

> "the care that they're giving is not helping [young person]. They're taking her out to Starbucks. Well, I'm sorry that's not helping her mental health" (Parent 10)

As Parent 10 expressed a positive experience with several SHARE staff members during the interview – "[clinician]…she was fantastic, absolutely brilliant; I feel he does listen to what we say. He's got a very calming influence [clinician]" – it is reasonable to conclude this interviewee had a negative experience with one aspect of the service and not the service overall. Nevertheless, these points are important to acknowledge when considering service improvement.

Young people

As with parents, young people reported high levels of satisfaction: all of the 10 young people interviewed described a positive experience of using the SHARE service; all the 9 young people who agreed to completed the CHI-ESQ after the interview reported that they were overall satisfied with SHARE (see Figure 5: Frequency of answers given by interviewed young people to CHI-ESQ questions by interviewed young people.

); and the 9 young people who completed SHARE's feedback questionnaire requested by a member of SHARE's team also reported high levels of satisfaction with staff and the model.

In interviews, the service was described by the young people as good, supportive, fun and helpful. Three young people referred to the service as 'amazing'. One young person explained that:

> "I think they are really supportive….I think I'd struggle if I didn't have them like to offer me support" (Young Person 3).

In SHARE's feedback questionnaire, all 9 young people reported that SHARE was making a positive difference to their lives. When asked to provide more details, young people said that SHARE was helping to reduce their symptoms (for example,

self-harm, low self-esteem, lack of confidence), was providing support to them and their families, and was preventing arguments at home.

Team members were described as being easy to talk to, often due to the frequency of contact with the young person:

> “I can call [staff] or [staff] or the house. And if the person that picks up isn’t someone that I know they can put me onto someone that I do know so that I can put a face to the name on the phone” (Young Person 9)

Young people described how this allowed them to feel safe, to feel comfortable and for strong therapeutic relationships to be built up:

> “Could talk to them like I knew them, like I’ve known them for years; every single one of them were like that because they’re all just nice people. And I found it easy to talk to them, really easy” (Young Person 8)

Other positive characteristics of the team which young people identified included being down-to-earth, non-judgemental, relaxed, reliable, good listeners, caring, and genuine:

> “Just like when you talk to them they don't try and interrupt straightaway and try and like solve everything straightaway, they help you run you through it slowly” (Young Person 4)

Empowerment and involvement emerged as key aspects of the young people’s positive experience. All of the young people spoke about ways in which the service had listened to them; involved them in their care, or made them feel empowered. Half of the young people reported being actively involved in the development of their care. The process was described by one young person as:

> “They give views as well and I give mine and we’d compromise” (Young Person 5)

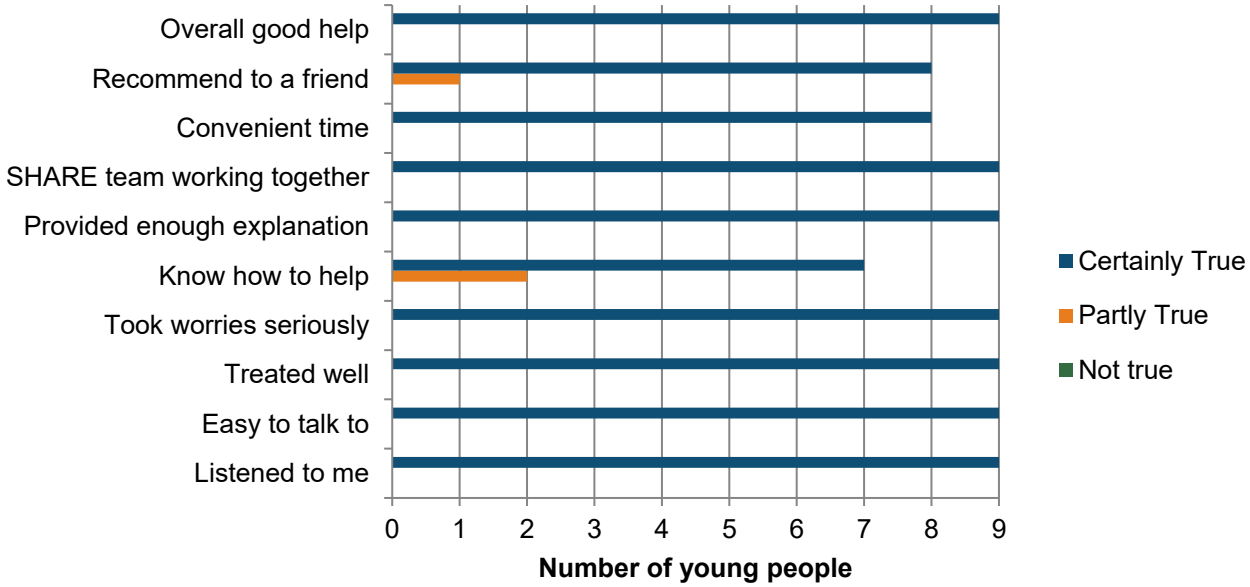
For example, support was put in place when one young person found speaking in meetings difficult:

> “So, I’d write out some questions and points that I needed to be put across previous to it; it had been suggested by [clinician] that I did that. Then I could hand it to her and she’d make sure that all of those points got mentioned and any questions got addressed and answered in that meeting” (Young Person 9)

Young people also reported SHARE asking for, and actively responding to, feedback about the service. This was mirrored in the CHI-ESQ and SHARE’s feedback

questionnaire. In the latter, all 9 young people reported that all the things that were important to them were covered in sessions; that they felt supported by their key worker and by other staff at SHARE; were involved in their Care Planning, and felt that their views were taken into consideration. In the CHI-ESQ all young people who completed the questionnaire reported that staff provided enough information, that they felt listened to by staff, that staff took their concerns seriously and treated them well.

Figure 5: Frequency of answers given by interviewed young people to CHI-ESQ questions by interviewed young people.



In the interviews, 8 of the young people identified an aspect of the service that could be improved. Five of these young people wanted an extension of the service, either in terms of an extension to other areas of the country; overnight access to the telephone support, or access to the service after age 18. Other points of improvement included needing more individual therapy and more access to groups. Two young people identified negative experiences of the service; one sometimes found the high quantity of sessions to be tiring and boring and another found the family therapy sessions unhelpful. The parent of the former was also interviewed, and was very satisfied with SHARE: “I’ve not really got any negatives to give you”. Indeed, the parent suggested implementing programmes similar to SHARE across the UK and creating information booklets about SHARE to help parents remember information during an emotional crisis:

> “…you’re bombarded with so much information…I just didn’t take it on board but if I’d had a physical document in my hand with some information about what it was, then possibly that would have sunk in a little bit more”.

What are the barriers and facilitators to implementing and sustaining SHARE?

Facilitators

Parents

Parents reported good communication both within SHARE services and outside SHARE with external services such as CAMHS:

> "good communication within SHARE and between SHARE and community CAMHS" (Parent 8)

This communication was found to be a facilitator for parents as:

> "we kept an open channel of communication going at a time of crisis, which was really, really useful" (Parent 2)

SHARE staff was found to be more impartial and pragmatic during emotional situations, which, according to parents, facilitated access to SHARE:

> "they have a more structured view than us, we're all just in crisis all the time. They can see properly in steps and phases" (Parent 5)

This external support was also found to facilitate the involvement of young people in SHARE:

> "if I was having a problem with [young person], because sometimes your relationship they get a bit fed up with you, so it's somebody else to talk to" (Parent 9)

The 24-hour support services provided by SHARE also facilitated involvement "because children just don't work 9 'till 5" (Parent 4).

Young people

Explanations that young people gave for the success of SHARE focused on the strong accessibility of the service:

> "I just think it's good that they are available most of the time on weekends and stuff and they can come out and do assessments pretty much whenever' (Young Person 3)

Furthermore, young people described the intensive support they received from SHARE during a crisis, in terms of immediate telephone or support in person, and

follow-up. Other explanations young people gave for the success of SHARE focused on the adaptability of the service to each young person's needs:

> "Yeah, they always kind of bend what they are saying towards your needs or like how you are (…) Like if you struggle with speaking about things and topics then they can like find alternatives. Like I struggle expressing my emotions a lot so I'm doing some work with a social worker on like expressing it through a scrap book in artistic ways" (Young Person 3)

Adaptability in the nature, formality and location of contact with staff was noted as a facilitator to young people:

> "Like you can just drop her a text saying, 'Do you want to go for a brew somewhere?' and she always seems to be within a couple of hours she'll come and see me. They've never not got enough time for you" (Young Person 2)

Focus Groups

In the focus groups, staff highlighted MDT as a facilitator to implementing and sustaining SHARE, as it allows sharing information and expertise, leading to enhanced inter-collegial support for staff and better support for children, young people, and families. A number of positive outcomes were also experienced by staff themselves, as staff felt better supported by colleagues in SHARE, compared to previous positions, and therefore better able to support children, young people and families.

Related to the above, in all focus groups, staff discussed the team approach to cases as being a unique strength to SHARE, increasing staff confidence as they know they have the skills and knowledge of colleagues to also draw on and decisions are made in an informed manner as different members of the MDT are involved.

Barriers

Young people

Only 2 young people identified barriers to successfully implementing the service. Both reported finding the appointments difficult at times; one young person found the number of sessions tiring and one person identified that their own difficulties with talking to people was sometimes a barrier.

Focus Groups

In terms of the barriers, as reported in all focus groups by the majority of staff, disparate information systems have led to problems of sharing information and a duplication of paperwork. This has resulted in a large amount of administrative work and duplication of reports and information needing to go to different services. Additionally, staff reported that initially, there was confusion over the different roles of the MDT, and a few staff reported tensions with other services raised by a lack of awareness about the programme.

What are the results of SHARE's cost-benefit analysis?

A cost-benefits analysis (CBA) for SHARE was conducted by an independent party (York Consulting). The following is the report prepared by John Rodger and Matthew Cutmore.

CBA Constraints

- it has not been possible to directly analyse primary cost or outcome data for the SHARE project
- the SHARE project does not have a monitoring system in place to directly calculate support costs and outcomes
- it has not been possible to establish a historical comparator group from existing SHARE records
- there is no direct evidence regarding the sustainability of outcomes achieved by the SHARE project

SHARE support typology

It is estimated that the SHARE project will support 46 young people annually across 3 typologies

1. Self-harm or suicidal: 42%
2. Social circumstances: 39%
3. Long term mental health: 19%

The Costs

- the costs take account of the total steady-state costs associated with providing support to young people

- typically, we would have sought to establish the resource cost per case. Unfortunately, data at this level was unavailable
- data relating to other services (for example, social care) supporting the young person around the same time as SHARE was also unavailable
- it has also not been possible to cost generic support typologies
- annual steady-state costs are estimated to be £433,830
- the cost per young person supported is £9,431

The benefits: removal of adverse outcomes

- benefits/cost avoidance are calculated for the 12 months immediately after the young person exits support. Outcomes data for discharged cases was provided by the SHARE team. We provided advice around key outcomes including the level of change required to claim each outcome. This was then translated into financial benefits by applying proxy values that are associated with these outcomes
- we cannot accurately predict what will happen to these young people in the future – there are too many variables. Although we recognise the work of SHARE (and other support services) may benefit young people well in to their adult lives, to keep the model robust we only capture benefits that are immediate and can be tracked
- when monetising outcomes into benefits, we have used only robust financial proxies. Benefits have been weighted to reflect the following post-SHARE statuses:
    - successful closure (Step Away): the young person requires no further direct support from social care or mental health services. This includes cases where kinship care was arranged, recognising that this, for some young people, is a successful outcome. We assume benefits are sustained for one year
    - referred/remained open to other agency: the young person requires additional support (not from social care). To reflect ongoing support costs and the likelihood of outcomes being sustained over the longer-term, we reduce the financial benefits by 25%
    - remained open to social care: The young person requires additional support from social care. To reflect more intensive ongoing support costs and an increased likelihood of regression on outcomes recorded, we reduce the financial benefits by 50%

- looked after: the young person is in the care of the Local Authority. The cost of this outweighs any benefits of the support provided. Benefits are set to zero

Estimating outcomes

The SHARE project assessed the outcomes for 11 closed cases. Status on closure was as follows:

- step Away: 4 (36%)
- step Down: 5 (46%)
- step Up: 1 (9%)
- transferred: 1 (9%)

Monetised outcomes have been weighted to reflect outcome status.

Table 1: Monetised outcomes for 11 closed cases

Case	Type	Status	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Benefit 1	Benefit 2	Benefit 3	Benefit 4	Total	Weighted Total
1	Self-harm/suicidal	Step away	Closed to support	NEET			£2,856	£4,637			£7,493	£7,493
2	Self-harm/suicidal	Step away	T4 Referral	NEET			£28,392	£4,637			£33,029	£33,029
3	Social circumstances	Step away	Normal rate LA care				£183,189				£183,189	£183,189
4	Long-term mental health	Transferred	None								£0	£0
5	Self-harm/suicidal	Step down	Stepped down to parenting support	A&E			£2,856	£117			£2,973	£2,230
6	Long-term mental health	Step up	None								£0	£0
7	Self-harm/suicidal	Step down	Stepped down to CAMHS	LAC	A&E	NEET	£2,856	£30,337	£117	£4,637	£37,947	£28,460
8	Self-harm/suicidal	Step down	Stepped down to primary care	A&E			£2,856	£117			£2,973	£2,230
9	Social circumstances	Step down	Stepped down to CAMHS	T4 Support	LAC	NEET	£2,856	£28,392	£30,337	£4,637	£66,222	£49,667
10	Social circumstances	Step down	Stepped down to CAMHS				£2,856				£2,856	£2,142
11	Self-harm/suicidal	Step away	Closed to support	T4 Admission	NEET		£2,856	£28,392	£4,637		£35,885	£35,885

Summary of monetised adverse outcomes avoided

Details of the adverse outcomes avoided as a result of SHARE support are shown below. We have calculated the annual adverse outcomes avoided based on the outcomes recorded in the sample of 11 cases and annualised to reflect 46 cases.

Table 2: Monetised adverse outcomes avoided

Adverse outcome	Count	Total Weighted Benefits
Visit to A&E	13	£1,101
Becoming LAC	8	£190,296
Being NEET	21	£87,260
High-cost looked after placement	4	£766,063
T4 admission	13	£326,508
Ongoing support	29	£68,674

The aggregate financial benefits, when account has been taken for ongoing support needs, for these outcomes is £1,439,902.

Fiscal return on investment (FROI)

- the Fiscal Return on Investment (FROI) shows the benefit/cost ratio for the SHARE service
- total benefits (adverse outcomes avoided) were calculated to be £1,439,902
- total annual steady-state costs were calculated to be £433,830
- based on the above Fiscal Return on Investment is shown to be 3.3
- this demonstrates a positive cost benefit outcome equating to a saving of £3.30 for every £1 invested in the SHARE project

Sustainability

In order to take into account sustainability of outcomes, we have calculated the Fiscal Return on Investment under 3 scenarios:

- optimistic: (all outcomes sustained for 12 months) = FROI 3.3
- base: (75% of all outcomes sustained for 12 months) = FROI 2.4
- pessimistic: (50% of all outcomes sustained for 12 months) = FROI 1.7

Conclusions

- due to data limitations, it has been necessary to make a number of constraining assumptions to conduct the SHARE cost benefit analysis
- based on annual costs of £433,830 and estimated annual benefits of £1,439,902, the programme reveals a positive FROI of 3.3. A saving of approximately £3 for every £1 invested
- even under the most pessimistic scenario of 50% outcome sustainability, the FROI remains positive at 1.7

Recommendations

- the SHARE project needs to calculate the staff time associated with different types of interventions and fine tune the costs
- the project needs to record outcomes against every young person supported on an annual basis to improve the robustness of estimated benefits
- the project needs to track young people 12 months after support to check the sustainability of outcomes
- the project should repeat this CBA exercise, based on the information generated above, in 12 months' time to test and improve CBA estimates

Limitations of the evaluation and plans for the future

Limitations of this evaluation

- as the implementation and the evaluation of the programme started at the same time, delays in implementation entailed delays in the evaluation and made the evaluation of SHARE house not possible within the timeframe. In addition, this also meant that some of the interviews with young people or parents were conducted when the young person was still experiencing high levels of emotional and behavioural difficulties, which introduced higher levels of uncertainty to the outcome that parents thought SHARE could achieve. Furthermore, this also added an extra layer of complexity to the implementation of the project because, when the team was organising processes and procedures, they also had to recruit young people and parents for the interviews
- data at local authority level was used to compare indicators before and after SHARE's implementation. However, causality should not be inferred. This is not only because SHARE is currently reaching a small percentage of children and young people who could benefit from such a programme, but also because factors other than SHARE are likely to be influencing changes and/or fluctuations in numbers in contextual data
- focus groups were conducted in December 2015; hence, some of the results reported here might have changed since then
- even though most of the young people completed the questionnaires when admitted to SHARE, only a few had paired data (for example, 3 young people had paired SDQs completed by parents and 7 had SDQs self-completed). Therefore, results presented were mostly descriptive, and our confidence in the findings is very likely to change when a bigger sample is obtained. Furthermore, given the short time frame in which young people and parents access the service, and as they are accessing the service during crisis when high levels of distress are experienced, it is unsurprising that change in mental health symptoms was not observed. A longer follow-up of those who access SHARE is necessary
- as data was routinely collected, as opposed to being collected under controlled conditions, there may be variations in how data was collected and recorded. Even though this limitation is present in all service evaluations, it is important to acknowledge as it might have an influence on the results of future SHARE evaluations too

- local authority indicators were compared for the year before SHARE started (October 2014 to September 2015), to 9 months after SHARE was implemented (October 2015 to July 2016). This difference was due to the timing for data collection, analysis and report writing
- even though efforts were made to have a comparator group for exploring the impact of SHARE on young people's mental health, it was not possible to obtain routinely collected data for a comparable group of young people
- interviews were all conducted with parents as no carer showed interest in participating. Hence, as opposed to the original plan, carers' views of SHARE could not be included in this evaluation

Appropriateness of evaluation approach

Bearing in mind the above limitations, the strengths of the evaluation were that it addressed the central questions from different perspectives (those of staff, young people, and parents) using a number of data sources. This allowed a triangulation of data, which resulted in more reliable findings. The evaluation drawing on quantitative data can also be sustained by SHARE after the end of our evaluation. It would be useful to continue to capture qualitative data from service users. However, this would be more sustainable if open-ended responses to questionnaires (such as on the CHI-ESQ) were used, as opposed to interviews or focus groups.

Capacity built for future evaluation and the sustainability of the evaluation

In line with the evaluation strategy, onsite quantitative data was generated and collected by SHARE in order to promote sustainability of the evaluation. Hence, it is expected that SHARE's evaluation will be sustainable in the future. Nonetheless, we will work with the implementation team to feed back findings from the evaluation to ensure lessons learnt about barriers and facilitators to implementation are considered when sustaining SHARE after the end of the project. We will be particularly focused on advising how best to continue service evaluation. This may include:

- recommendations about additional measures to collect (such as experience or outcome measures)
- embedding the use of the participant observation tool as a tool for self-reflection and evaluation
- developing templates for the implementation team to update analyses when new data is collected (for example, run charts of routine clinical data)

- recommendations about the use of the synthetic control group, using propensity score matching on routine clinical data from other similar services or wider local authority, to try and make groups similar and more comparable.

The exit strategy will involve the implementation team reviewing the evaluation report and providing feedback, and a handover period where the implementation team can ask evaluation questions post-exit. The exit strategy will be particularly focused on ensuring the implementation team is left with the skills, understanding and planning to collect, analyse, interpret and disseminate outcomes in accordance with the medium- and long-term aims.

Recommendations for future evaluation

In addition to the above, the following recommendations are made:

- a measure such as the Goals and Goal Based Outcomes (Law & Jacob, 2013) could be used to record specific changes that young people are interested in, and that go beyond symptom change, such as being able to take the bus or feel confident to express opinions. This measure consists of a recording sheet where the young person and clinician record up to 3 goals. At T2, the young person states on a scale from 0 to 10 how close he or she feels to reaching those goals. This measure may be less suitable for use in episodes of crisis
- in order to examine the medium-term impact of SHARE and whether its positive effects are sustained, we recommend a follow-up evaluation in 8 to 12 months, including a mixture of outcome measures and qualitative data from service user feedback questionnaires
- continuing the evaluation for a longer time frame, and for a larger number of young people, is also recommended. Outcome results presented in this report were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained

Implications and recommendations for policy and practice

Capacity and sustainability of this innovation

As shown above, the CBA report from York Consulting stipulated that, in order to take into account sustainability of outcomes, we have calculated the Fiscal Return on Investment (FROI) under 3 scenarios:

- optimistic: all outcomes sustained for 12 months = FROI 3.3
- base: 75% of all outcomes sustained for 12 months = FROI 2.4
- pessimistic: 50% of all outcomes sustained for 12 months = FROI 1.7

This implies that SHARE is sustainable even in a pessimistic scenario, in which a saving of approximately £1.7 for every £1 invested is projected.

Sustainability of SHARE will also depend on workforce and wider service transformation, i.e., change in focus from a transactional service to a relational one. As evidenced in interviews, young people and parents responded positively to SHARE's relational service, in which SHARE team and families established personable and trusting relationships.

Conditions necessary for this innovation to be embedded

Specific recommendations to support the embedding of this innovation are included in the next section. Overall in Wigan there is a need for SHARE to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, in interviews, parents reported that their, and their children's, needs required support that other services were unable to provide; and young people in interviews said that SHARE's breadth of support met their multiple needs. Staff in focus groups stated that MDT work effectively met the needs of young people and parents because the right colleagues with the right areas of expertise were able to come together efficiently to address their needs.

Within this context, wider dissemination of information about SHARE would help the innovation to be embedded and to reach a greater number of young people and parents. However, dissemination would also mean that more young people and families would access SHARE, and hence more resources would be needed in order to cope with future staffing and demand. Therefore, funding for the programme would need to be secured so service users did not become reliant on a service that might then be withdrawn in the future.

Consideration of future development of this innovation and wider application

Future developments of SHARE as identified in the evaluation include:

- longer time-frame and a bigger cohort of young people would be needed to observe changes in LAC rates associated with SHARE at local authority level. This could provide evidence of the impact of SHARE on rates of children going into care. Nonetheless, these are useful indications of what SHARE could do in the future to evaluate their services
- larger sample sizes and longer follow-up periods would be needed to provide more robust conclusions. This is because changes in empowerment, mental health, wellbeing and resilience might take longer to be reflected in the standardised measures. In addition, a measure such as the Goals and Goal Based Outcomes (Law & Jacob, 2013) could be used to record specific changes that young people are interested in and that go beyond symptom change, such as being able to take the bus or feel confident to express opinions, although it may be less suitable for use in episodes of crisis
- SHARE's relational focus seems to be central to the many benefits reported in interviews by parents and young people. Therefore, this evaluation supports the change in policy of moving the focus from a transactional service to a relational one. Learning from SHARE should be spread to other services to help promote a focus on crisis service provision that is organised around the needs of children and families
- building on the success of the cross-sector working and the multi-disciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care
- young people and parents were highly satisfied with a relational and flexible service, which was felt to be more attuned to the needs of the whole family than previous services. This highlights the importance and impact of a holistic approach such as the one implemented by SHARE
- an integrated and well-organised MDT, plus flexibility to work in an innovative way, seem to motivate and empower staff, which in turn has a positive impact on young people, parents and families
- integration of SHARE with other services is crucial and requires an improvement of infrastructure and data-sharing to facilitate efficient cross-sector working. This may also result in improved data collection systems, meaning the additional analyses could be conducted to inform the evaluation of SHARE, such as examining whether demographic and case characteristics

moderate the impact of SHARE on mental health outcomes, and the associations between using SHARE and changes in academic attainment

- wider dissemination of SHARE to increase knowledge and accessibility is needed. However, this should be contingent on confidence in future funding and staffing capacity

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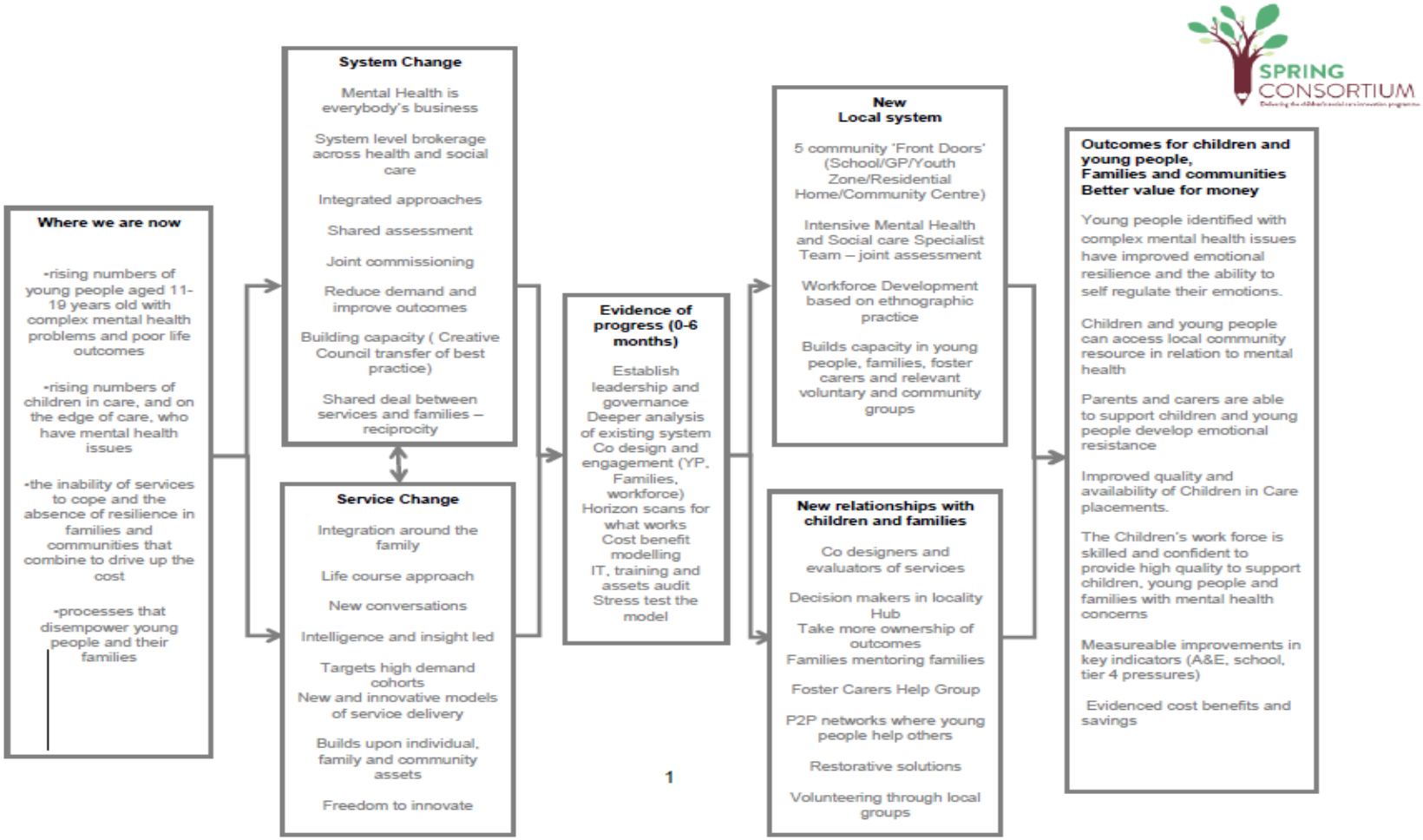
Appendices

Appendix A: Wigan's theory of change



Appendix B: SHARE Looked After Children (LAC)/ Child In Need (CIN) figures

Updated 7th October 2016:

Number of young people accessing/accessed SHARE: 37

Number of young people with LAC trajectory (the trajectory is completed by a social worker following the completion of the Single Assessment and identifies whether the young person would be at risk of becoming looked after by the local authority if there were no services involved): 19

Number of young people who have become LAC (relates to the young people who have become looked after despite interventions): 2

Number of young people at risk of CIN: 37

Number of young people CIN: 7 (includes 2 who have become LAC)

The criteria for CIN is whether the young person requires respite or planned short term breaks. If the SHARE team have concerns regarding wider safeguarding issues, they would refer to the locality teams of generic social workers, who would complete a Child and Family (C&F) assessment to identify risks and form an action plan.

Appendix C: SHARE routinely collected data (September 2015 to Sept 2016)

The Health of the Nation Outcome Scales, Child and Adolescent Mental Health (HoNOSCA)

- measures the severity of physical, personal and social problems associated with mental illness; 0 - 52 possible minimum and maximum scores

The average HoNOSCA score for each time-point are presented in the Table below, and shows a decline in average scores from T1 to T6.

Table 3: Descriptive statistics of HoNOSCA

	N	Min	Max	M	SD
T1	29	9	38	24.66	7.48
T2	26	6	38	19.73	9.71
T3	21	1	37	17.90	9.13
T4	13	4	29	15.77	8.01
T5	12	4	24	14.17	6.52
T6	7	7	22	12.43	5.38
T7	4	11	21	15.75	4.11
T8	1	9	9	9.00	n/a

Strengths and Difficulties Questionnaire (SDQ)

- possible individual scores go from 0 to 40 in Total Difficulties scale and 0 to 10 in sub-scales)

Table 4: Descriptive statistics of all the SDQ sub-scales and Total Difficulties Scale

		T1					T2				
		N	Min	Max	M	SD	N	Min	Max	M	SD
Young people	Emotional	17	2	10	7.12	1.83	10	4	8	6.30	1.34
	Conduct	17	1	10	4.06	2.44	10	2	6	3.80	1.69
	Hyperactivity	17	1	10	6.06	2.73	10	3	9	6.80	1.87
	Peer	17	0	8	4.24	2.08	10	2	9	4.90	1.85
	Tot diff	17	0	10	7.18	2.65	10	3	10	7.10	2.51
	Prosocial	17	5	29	21.5	6.09	10	16	30	21.8	4.42
	Impact	17	1	8	5.76	1.95	10	2	8	4.80	2.39
Parents	Emotional	14	1	9	6.36	3.10	5	5	9	7.40	1.52
	Conduct	14	0	7	3.43	2.31	5	0	5	2.40	1.82
	Hyperactivity	14	2	10	6.29	2.30	5	4	10	6.80	2.39
	Peer	14	0	7	4.36	2.06	5	3	10	5.80	2.68
	Tot diff	14	4	10	7.43	1.95	5	4	9	6.60	2.30
	Prosocial	14	6	30	20.4	7.26	5	15	30	22.4	6.73
	Impact	14	2	9	4.50	2.21	5	3	9	6.40	2.70

Table 5: Frequency of young people who were in the clinical and non-clinical group according to young people and parents in all the SDQ subscales and the Total Difficulties Scale

		Young People		Parent	
		Non-clinical	Clinical	Non-clinical	Clinical
Emotional	T1	5	12	3	11
	T2	5	5	0	5
Conduct	T1	11	6	8	6
	T2	7	3	4	1
Hyper	T1	10	7	7	7
	T2	5	5	2	3
Peer	T1	13	4	4	10
	T2	8	2	1	4
Prosocial	T1	15	2	13	1
	T2	8	2	4	1
Total diff	T1	7	10	5	9
	T2	3	7	1	4
Impact	T1	1	16	0	14
	T2	0	10	0	5

Table 6: Clinical change in young people reported by young people and parents in all the SDQ subscales and Total Difficulties Scale

	Young People			Parent		
	Recovered	No change	Deterioration	Recovered	No change	Deterioration
Emotional	2	4	1	0	2	1
Conduct	1	5	1	0	3	0
Hyper	1	5	1	0	3	0
Peer	1	6	0	0	3	0
Prosocial	0	6	1	0	2	1
Total diff	1	5	1	0	3	0
Impact	0	6	1	0	3	0

Table 7: Reliable change in young people reported by young people and parents in all the SDQ subscales and Total Difficulties Scale

	Young People			Parent		
	Reliably Improved	No change	Reliably deterior-ated	Reliably Improved	No change	Reliably deterior-ated
Emotional	0	7	0	0	3	0
Conduct	0	7	0	0	3	0
Hyper	0	7	0	0	3	0
Peer	0	7	0	0	3	0
Prosocial	0	7	0	0	3	0
Total diff	1	6	0	0	2	1
Impact	2	5	0	0	2	1

Table 8: Reliable change and clinical change in young people reported by young people and parents in all the SDQ subscales and Total Difficulties Scale

			RCC – Young People			RCC – parents		
			Reliably Improved	No change	Reliably deterior-ated	Reliably Improved	No change	Reliably deterior-ated
Emotional	CT	Recovered	0	2	0	0	0	0
		No change	0	4	0	0	2	0
		Deteriorated	0	1	0	0	1	0
Conduct	CT	Recovered	0	1	0	0	0	0
		No change	0	5	0	0	3	0
		Deteriorated	0	1	0	0	0	0
Hyper	CT	Recovered	0	1	0	0	0	0
		No change	0	5	0	0	3	0
		Deteriorated	0	1	0	0	0	0
Peer	CT	Recovered	0	1	0	0	0	0
		No change	0	6	0	0	0	0
		Deteriorated	0	0	0	0	0	0
Prosocial	CT	Recovered	0	0	0	0	0	0
		No change	0	6	0	0	3	0
		Deteriorated	0	1	0	0	0	0
Total diff	CT	Recovered	1	0	0	0	0	0
		No change	0	5	0	0	2	0
		Deteriorated	0	1	0	0	1	0
Impact	CT	Recovered	0	0	0	0	0	0
		No change	2	4	0	0	2	1
		Deteriorated	0	1	0	0	0	0

Appendix D: Experience of Service Questionnaire (CHI_ESQ)

Parents

What was really good? (7 comments)

- felt listened to (5)
- helpful advice and care (3)
- individualised care / treated like a person (2)
- empathetic staff (1)

What needs improving? (3 comments)

- have residential house open (1)
- more mental health trained staff (1)
- more people aware of SHARE (1)

Anything else? (3 comments)

- brilliant / helpful service (2)
- helped us to get support from other services (1)

Young people

What was really good? (7 comments)

- having someone to speak to / someone to listen (4)
- amount of contact / always had time for me (3)
- lovely, friendly staff (2)
- help in crisis / time of need (2)
- coping strategies for whole family (1)

What needs improving? (2 comments)

- more 1:1 therapy / outreach work (1)
- be supported by service for longer (1)

Anything else (1 comment)

- staff are amazing (1)

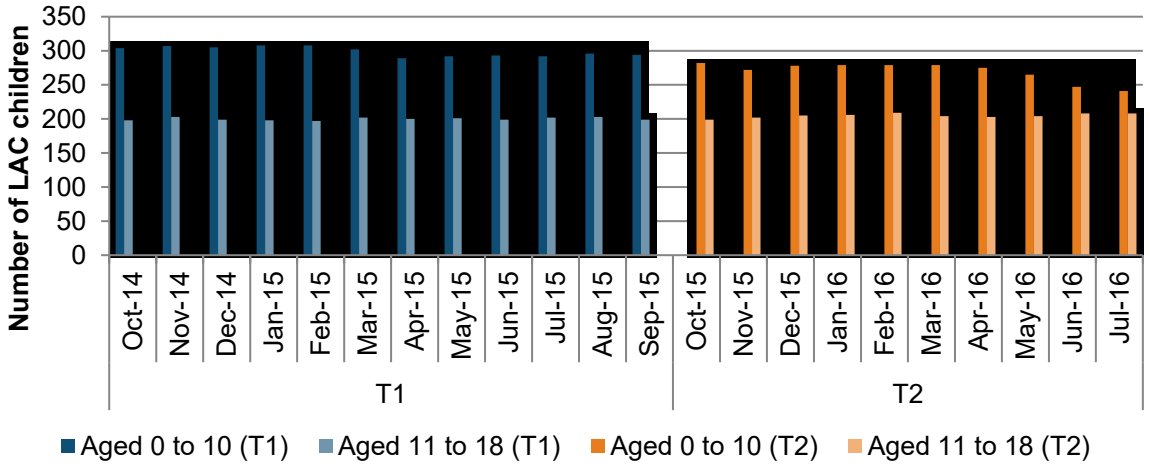
Appendix E: Contextual data (Source: Wigan Council)

Number of children in care

Table 9: Number of children who were in care by age and month

	T1											T2										
	Oct-14	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**
Under 11	304	307	305	308	308	302	289	292	293	292	296	294	282	272	278	279	279	279	275	265	247	241
11 plus	198	203	199	198	197	202	200	201	199	202	203	199	199	202	205	206	209	204	203	204	208	208
Total	502	510	504	506	505	504	489	493	492	494	499	493	481	474	483	485	488	483	478	469	455	449

Figure 6: Number of children who were in care by age and month

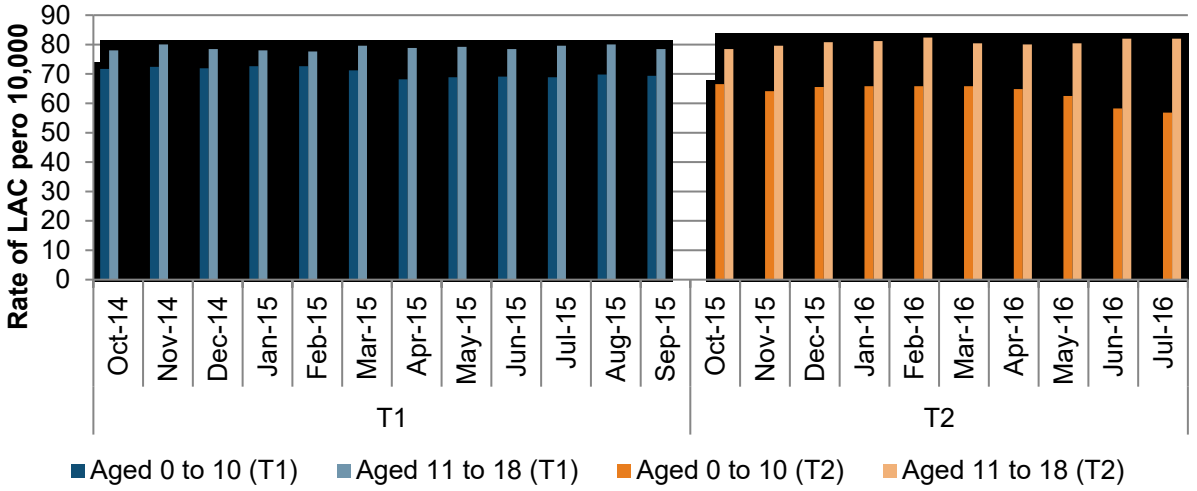


Rate of children in care

Table 10: Rate of children in care per 10,000 children in Wigan by age and month

	T1											T2										
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Under 11	71.7	72.4	71.9	72.6	72.6	71.2	68.2	68.9	69.1	68.9	69.8	69.3	66.5	64.2	65.6	65.8	65.8	65.8	64.9	62.5	58.3	56.8
11 plus	78.1	80.0	78.4	78.1	77.7	79.6	78.8	79.2	78.4	79.6	80.0	78.4	78.4	79.6	80.8	81.2	82.4	80.4	80.0	80.4	82.0	82.0
Total	74.1	75.3	74.4	74.7	74.5	74.4	72.2	72.7	72.6	72.9	73.6	72.7	71.0	69.9	71.3	71.6	72.0	71.3	70.5	69.2	67.1	66.3

Figure 7: Rate of children in care per 10,000 children in Wigan by age and month

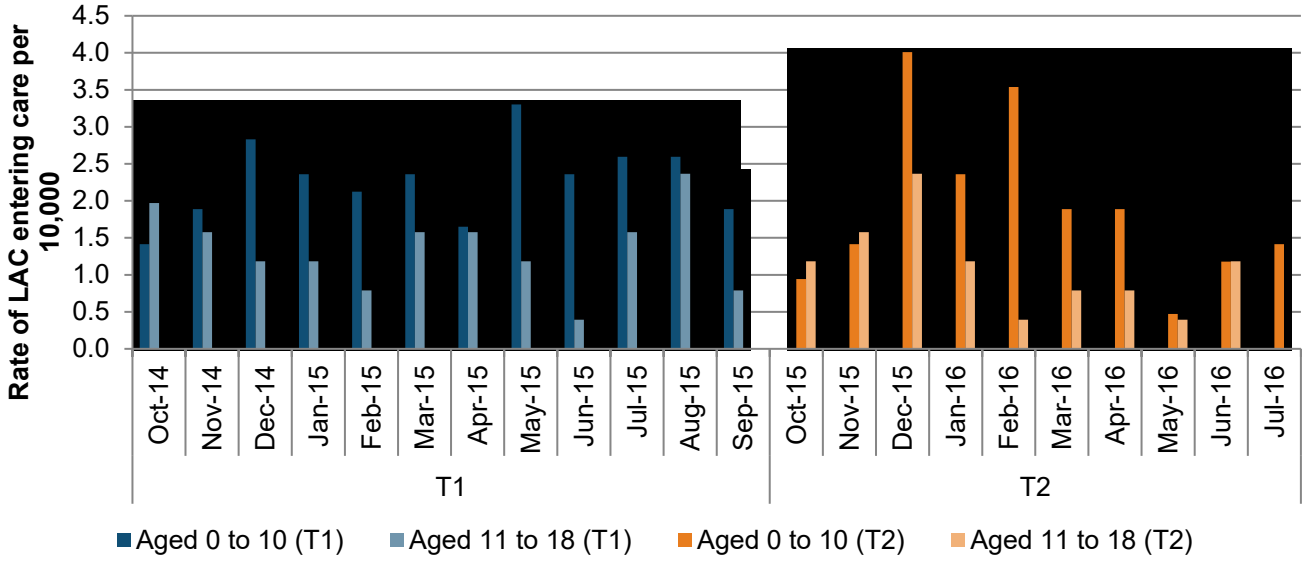


Rate of children entering care

Table 11: Rate of children entering care per 10,000 children in Wigan by age and month

	T1											T2										
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Under 11	1.4	1.9	2.8	2.4	2.1	2.4	1.7	3.3	2.4	2.6	2.6	1.9	0.9	1.4	4.0	2.4	3.5	1.9	1.9	0.5	1.2	1.4
11 plus	2.0	1.6	1.2	1.2	0.8	1.6	1.6	1.2	0.4	1.6	2.4	0.8	1.2	1.6	2.4	1.2	0.4	0.8	0.8	0.4	1.2	0.0
Total	1.6	1.8	2.2	1.9	1.6	2.1	1.6	2.5	1.6	2.2	2.5	1.5	1.0	1.5	3.4	1.9	2.4	1.5	1.5	0.4	1.2	0.9

Figure 8: Rate of children entering care per 10,000 children in Wigan by age and month

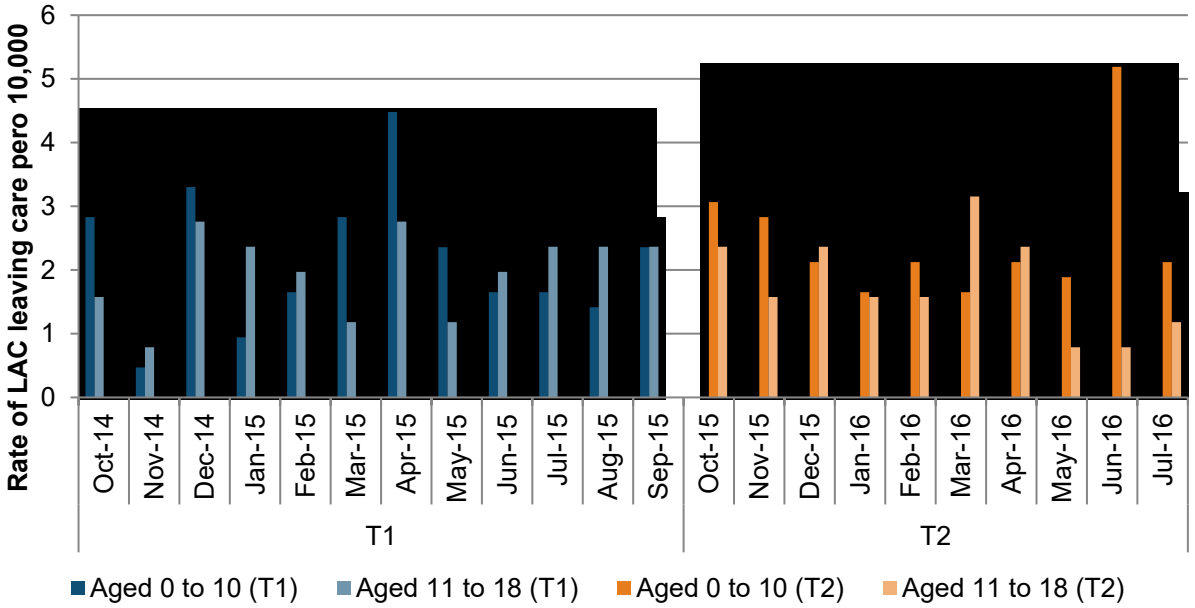


Rate of children leaving care

Table 12: Rate of children leaving care per 10,000 children in Wigan by age and month

	T1											T2										
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Under 11	2.8	0.5	3.3	0.9	1.7	2.8	4.5	2.4	1.7	1.7	1.4	2.4	3.1	2.8	2.1	1.7	2.1	1.7	2.1	1.9	5.2	2.1
11 plus	1.6	0.8	2.8	2.4	2.0	1.2	2.8	1.2	2.0	2.4	2.4	2.4	2.4	1.6	2.4	1.6	1.6	3.2	2.4	0.8	0.8	1.2
Total	2.4	0.6	3.1	1.5	1.8	2.2	3.8	1.9	1.8	1.9	1.8	2.4	2.8	2.4	2.2	1.6	1.9	2.2	2.2	1.5	3.5	1.8

Figure 9: Rate of children leaving care per 10,000 children in Wigan by age and month

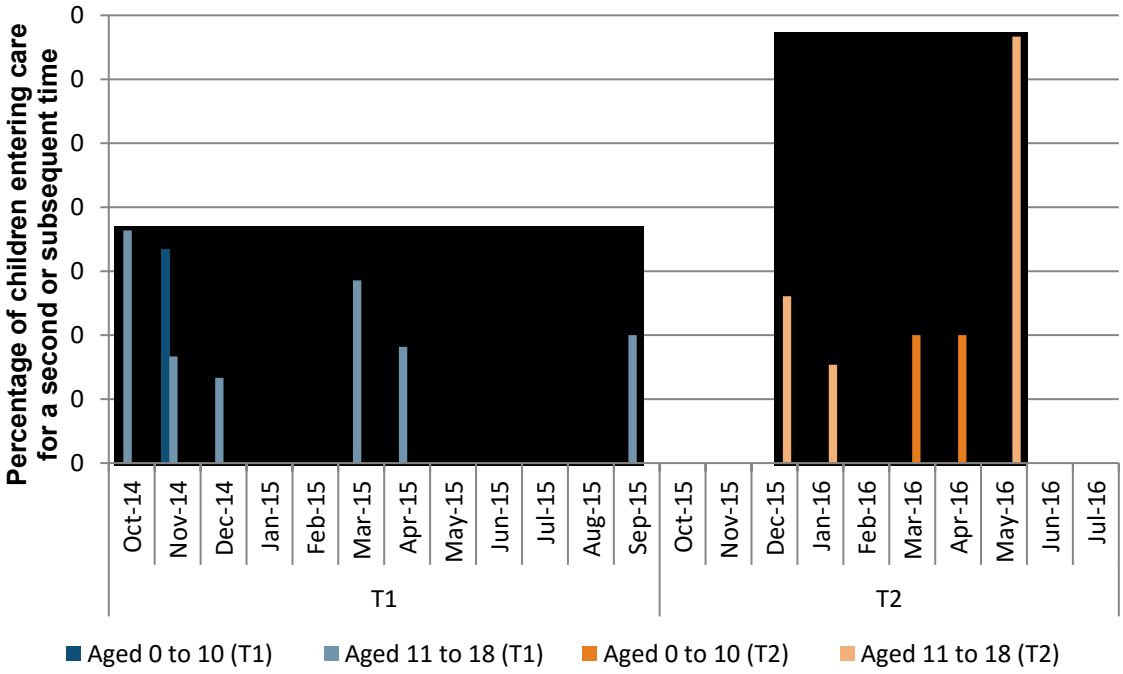


Children entering care for a second or subsequent time

Table 13: Number and percentage of children entering care for second or subsequent time out of all the children entering care in Wigan by age and month

Month	Aged under 11			Aged 11 plus			Total		
	Entering care	2nd time+	% 2nd time+	Entering care	2nd time+	% 2nd time+	Entering care	2nd time+	% 2nd time+
Oct-14	6	0	0%	5	2	18%	11	2	18%
Nov-14	8	2	17%	4	1	8%	12	3	25%
Dec-14	12	0	0%	3	1	7%	15	1	7%
Jan-15	10	0	0%	3	0	0%	13	0	0%
Feb-15	9	0	0%	2	0	0%	11	0	0%
Mar-15	10	0	0%	4	2	14%	14	2	14%
Apr-15	7	0	0%	4	1	9%	11	1	9%
May-15	14	0	0%	3	0	0%	17	0	0%
Jun-15	10	0	0%	1	0	0%	11	0	0%
Jul-15	11	0	0%	4	0	0%	15	0	0%
Aug-15	11	0	0%	6	0	0%	17	0	0%
Sep-15	8	0	0%	2	1	10%	10	1	10%
Oct-15	4	0	0%	3	0	0%	7	0	0%
Nov-15	6	0	0%	4	0	0%	10	0	0%
Dec-15	17	0	0%	6	3	13%	23	3	13%
Jan-16	10	0	0%	3	1	8%	13	1	8%
Feb-16	15	0	0%	1	0	0%	16	0	0%
Mar-16	8	1	10%	2	0	0%	10	1	10%
Apr-16	8	1	10%	2	0	0%	10	1	10%
May-16	2	0	0%	1	1	33%	3	1	33%
Jun-16	5	0	0%	3	0	0%	8	0	0%
Jul-16	6	0	0%	0	0	0%	6	0	0%

Figure 10: Percentage of children entering care for second or subsequent time out of all the children entering care in Wigan by age and month

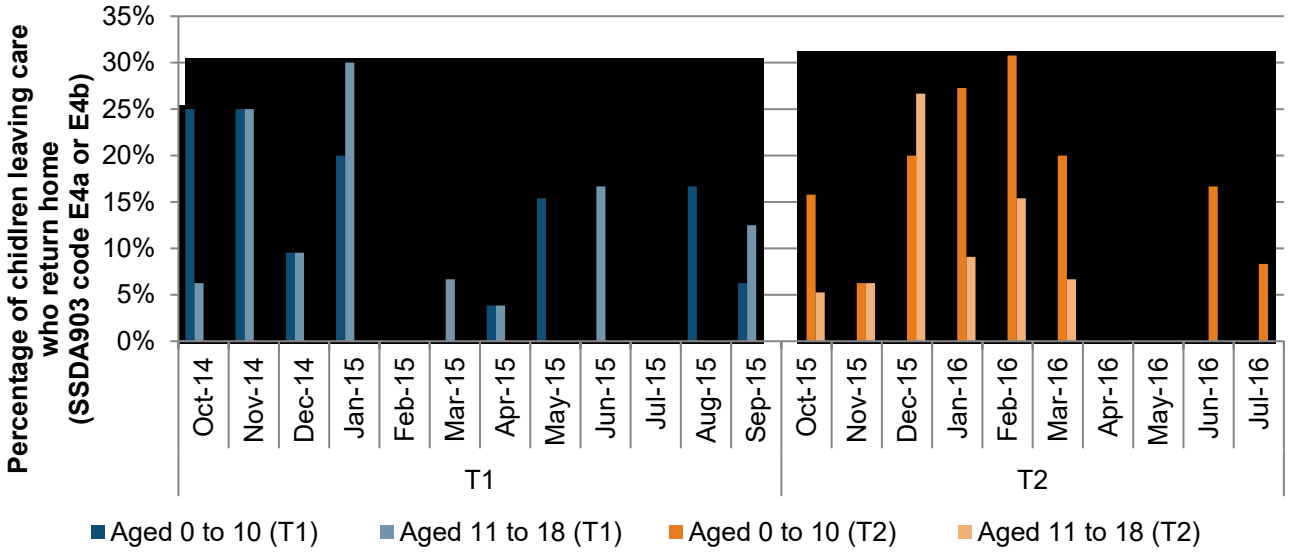


Children returning home

Table 14: Number and percentage of children returning home out of all the children leaving care in Wigan by age and month

Month	Aged under 11			Aged 11 plus			Total		
	Leaving care	Returning home	% Returning home	Leaving care	Returning home	% Returning home	Leaving care	Returning home	% Returning home
Oct-14	12	4	25%	4	1	6%	16	5	31%
Nov-14	2	1	25%	2	1	25%	4	2	50%
Dec-14	14	2	10%	7	2	10%	21	4	19%
Jan-15	4	2	20%	6	3	30%	10	5	50%
Feb-15	7	0	0%	5	0	0%	12	0	0%
Mar-15	12	0	0%	3	1	7%	15	1	7%
Apr-15	19	1	4%	7	1	4%	26	2	8%
May-15	10	2	15%	3	0	0%	13	2	15%
Jun-15	7	0	0%	5	2	17%	12	2	17%
Jul-15	7	0	0%	6	0	0%	13	0	0%
Aug-15	6	2	17%	6	0	0%	12	2	17%
Sep-15	10	1	6%	6	2	13%	16	3	19%
Oct-15	13	3	16%	6	1	5%	19	4	21%
Nov-15	12	1	6%	4	1	6%	16	2	13%
Dec-15	9	3	20%	6	4	27%	15	7	47%
Jan-16	7	3	27%	4	1	9%	11	4	36%
Feb-16	9	4	31%	4	2	15%	13	6	46%
Mar-16	7	3	20%	8	1	7%	15	4	27%
Apr-16	9	0	0%	6	0	0%	15	0	0%
May-16	8	0	0%	2	0	0%	10	0	0%
Jun-16	22	4	17%	2	0	0%	24	4	17%
Jul-16	9	1	8%	3	0	0%	12	1	8%

Figure 11: Percentage of children returning home out of all the children leaving care in Wigan by age and month

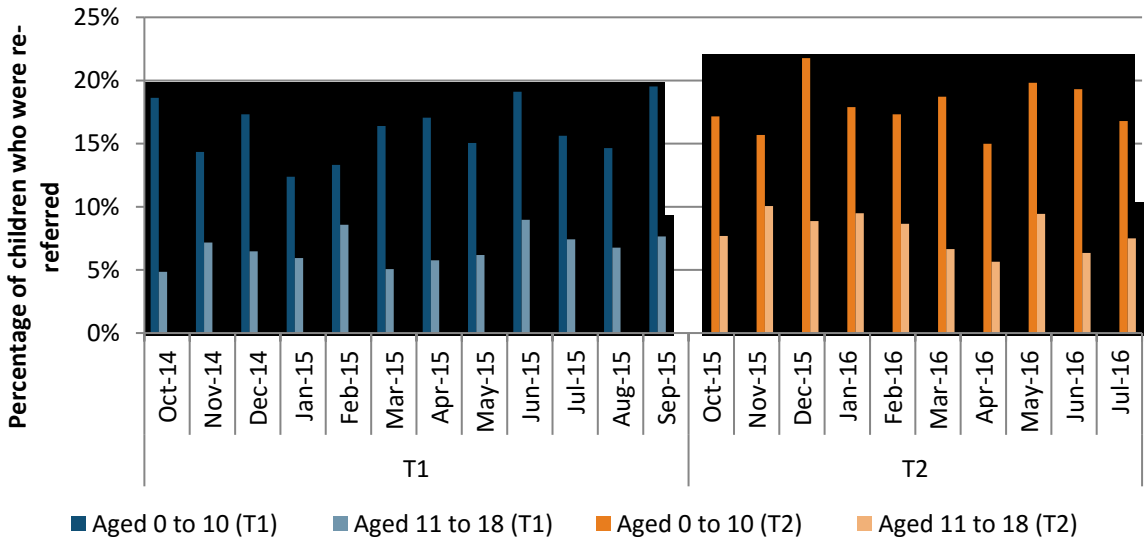


Children re-referred to social services

Table 15: Number and percentage of children who were re-referred to social services out of all the children referred to social services

Month	Aged under 11		Aged 11 plus		Total		
	Re-referral	% re-referral	Re-referral	% re-referral	Re-referral	% re-referral	Total referrals
Oct-14	73	19%	19	5%	92	23%	392
Nov-14	70	14%	35	7%	105	22%	488
Dec-14	75	17%	28	6%	103	24%	433
Jan-15	50	12%	24	6%	74	18%	404
Feb-15	59	13%	38	9%	97	22%	443
Mar-15	81	16%	25	5%	106	21%	494
Apr-15	74	17%	25	6%	99	23%	434
May-15	56	15%	23	6%	79	21%	372
Jun-15	81	19%	38	9%	119	28%	424
Jul-15	80	16%	38	7%	118	23%	512
Aug-15	52	15%	24	7%	76	21%	355
Sep-15	74	20%	29	8%	103	27%	379
Oct-15	58	17%	26	8%	84	25%	338
Nov-15	53	16%	34	10%	87	26%	338
Dec-15	81	22%	33	9%	114	31%	372
Jan-16	66	18%	35	9%	101	27%	369
Feb-16	58	17%	29	9%	87	26%	335
Mar-16	76	19%	27	7%	103	25%	406
Apr-16	61	15%	23	6%	84	21%	407
May-16	84	20%	40	9%	124	29%	424
Jun-16	67	19%	22	6%	89	26%	347
Jul-16	47	17%	21	8%	68	24%	280

Figure 12: Percentage of children who were re-referred to social services out of all the children referred to social services

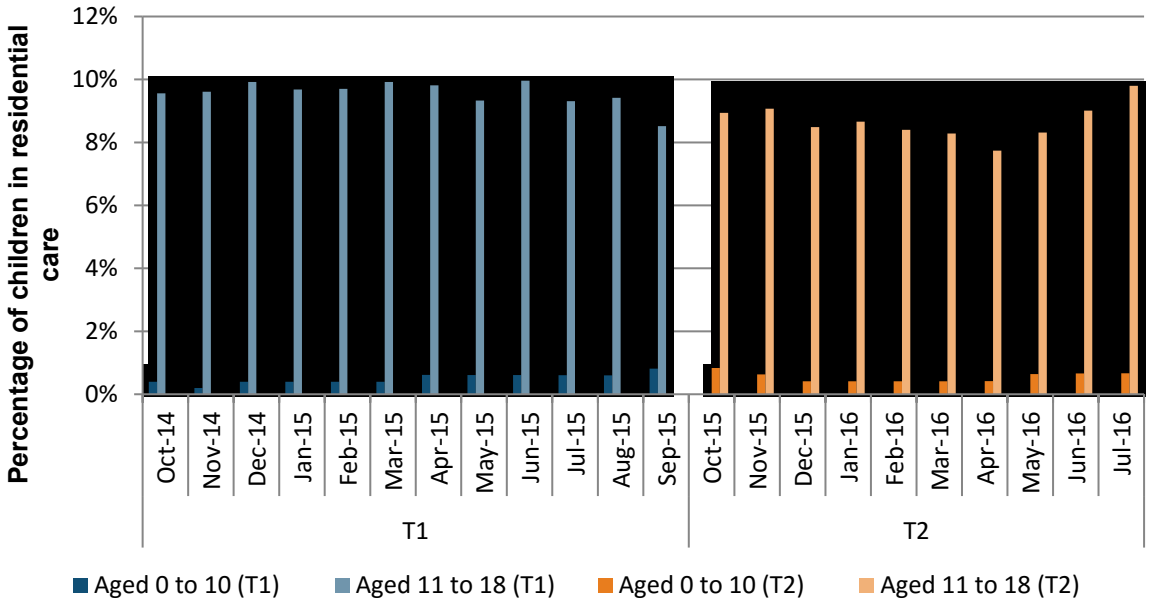


Children in residential care

Table 16: Number and percentage of all the children in care who were in residential care

Month	Aged under 11		Aged 11 plus		Total		
	In residential care	% in residential care	In residential care	% in residential care	Total in residential care	% Total in residential care	Total in care
Oct-14	2	0.4%	48	10%	50	10%	502
Nov-14	1	0.2%	49	10%	50	10%	510
Dec-14	2	0.4%	50	10%	52	10%	504
Jan-15	2	0.4%	49	10%	51	10%	506
Feb-15	2	0.4%	49	10%	51	10%	505
Mar-15	2	0.4%	50	10%	52	10%	504
Apr-15	3	0.6%	48	10%	51	10%	489
May-15	3	0.6%	46	9%	49	10%	493
Jun-15	3	0.6%	49	10%	52	11%	492
Jul-15	3	0.6%	46	9%	49	10%	494
Aug-15	3	0.6%	47	9%	50	10%	499
Sep-15	4	0.8%	42	9%	46	9%	493
Oct-15	4	0.8%	43	9%	47	10%	481
Nov-15	3	0.6%	43	9%	46	10%	474
Dec-15	2	0.4%	41	8%	43	9%	483
Jan-16	2	0.4%	42	9%	44	9%	485
Feb-16	2	0.4%	41	8%	43	9%	488
Mar-16	2	0.4%	40	8%	42	9%	483
Apr-16	2	0.4%	37	8%	39	8%	478
May-16	3	0.6%	39	8%	42	9%	469
Jun-16	3	0.7%	41	9%	44	10%	455
Jul-16	3	0.7%	44	10%	47	10%	449

Figure 13: Percentage of children who were in residential care out of all the children in care



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