
Evaluation of Multidisciplinary Approaches to Adoption Support

Final Report

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Glossary

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
ASGSF	Adoption and Special Guardianship Support Fund
DDP	Dyadic Developmental Psychotherapy
DfE	Department for Education
FASD	Foetal alcohol spectrum disorder
FTE	Full time equivalent (professional role)
GBO	Goal-Based Outcomes (standardised outcome measure)
ICB	Integrated Care Board
LA	Local authority
MD	Multidisciplinary
MDT	Multidisciplinary team
RAA	Regional adoption agency
SD	Standard deviation
SDQ	Strengths and Difficulties Questionnaire (standardised outcome measure)
SEND	Special educational needs and disabilities
TAYC(-R)	Thinking about Your Child (Revised Version) – standardised outcome measure
N/A	Not applicable

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Executive Summary

Support for adoption has traditionally been provided by teams of qualified, specialist social workers. Over the last 10 years and alongside the regionalisation of adoption services, innovations in multidisciplinary (MD) support have emerged in ‘early adopter’ regional adoption agencies (RAAs) and voluntary adoption agencies (VAAs).

Multidisciplinary is defined as *combining or involving more than one discipline or field of study*. In 2023, a ‘second wave’ of RAAs were given 2 to 3-year seed funding by Adoption England (AE) to pilot new or to extend innovations in MD adoption support including RAA or pan-regional models similar to the early adopters and newer models exploring support for specific aspects of child and family needs such as Foetal Alcohol Spectrum Disorder (FASD).

Parent and professional interest in MD support has also increased alongside an evidence base showing how children currently adopted in England are likely to have experienced one or more of the following:

- Early life trauma.
- Disrupted attachments and loss.
- Cognitive difficulties or physical disabilities.
- Neurodevelopmental differences.
- Challenges in transitioning into or remaining in education.

We are also beginning to learn more about how ongoing, persistent child difficulties or complexity can affect adopters themselves in the form of stress, secondary trauma or compassion fatigue and how, without appropriate support, these challenges (particularly ongoing violent or aggressive child behaviours) can lead to adoption disruptions, breakdowns or safeguarding risks.

However, there are significant gaps in our understanding about how MD support works in practice and its potential value. This mixed methods evaluation was commissioned by Adoption England to explore (May 2023 – March 2026):

- The **feasibility** of implementing MD approaches to adoption support.
- The **actual or potential benefits**.
- Which **outcomes and outcome measures** are useful to consider in this context.

The evaluation has heard directly from 117 parents from early adopter sites, who have participated in ‘longitudinal’ (at 3 points) or ‘retrospective’ (after MD support has finished) surveys and, in 32 cases, a 1:1 interview. Thirty of these parents also agreed to the evaluation team examining their child’s adoption support case file to explore in more depth what MD support involves, its qualities and documented effects. Outcomes and activity data contributed by early adopter and second wave sites have also provided rich sources of information about adopter experiences and how MD support may improve outcomes including family life. In addition, over 100 professionals working in or with MD

teams have participated in an interview. The evaluation did not hear directly from children and young people because almost all MD supports were directed at or through parents, workers and schools. In most cases, children would not even have been aware of the MD support being provided.

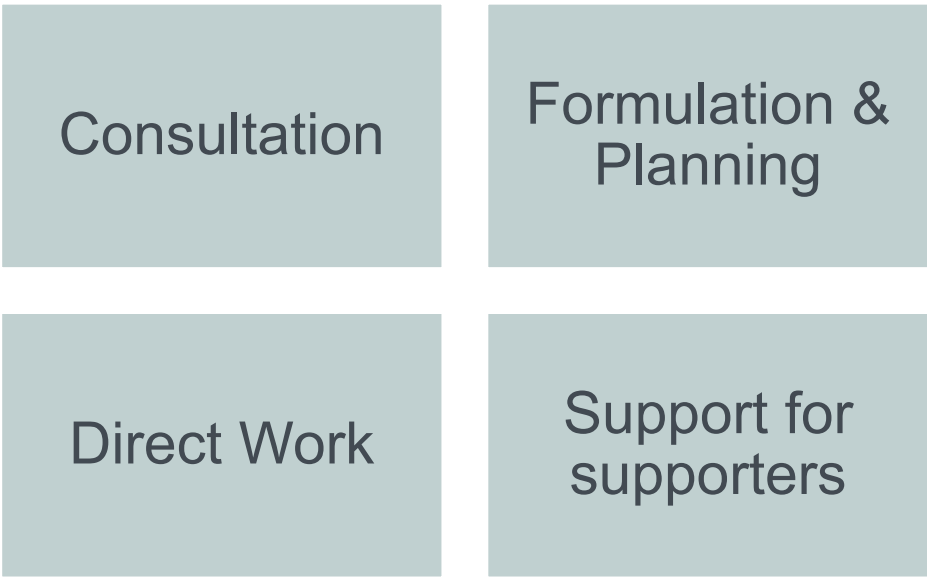
Feasibility of multidisciplinary support

The need for MD support is supported by this evaluation including with reference to the underpinning evidence base and the experiences of parents participating in this evaluation who described how, irrespective of what was known at the point of the adoption, the development needs, behaviour and/or mental health of their children emerged, worsened or became more apparent over time – particularly at times of transition, for example into primary or secondary school.

By the point of accessing MD support, almost all families were struggling with multiple issues or complex needs. The precipitating factors parents most frequently described were high levels of child emotional dysregulation or violence, or both. Other frequently described factors included a child at risk of exclusion or not attending education; concerns about a child’s developmental delay; a child with under-developed sensorimotor systems; parents experiencing extreme stress. Many families entering MD support had already experienced at least one ‘round’ of ASGSF-funded therapy that had not sufficiently met their needs. Other families had previously tried but had been unable to obtain supports from statutory services, particularly Child and Adolescent Mental Health Services (CAMHS) and health diagnostic pathways.

Case file analysis suggests **17% families recently referred for MD support in early adopter sites were at real risk of breakdown.**

Despite some early differences in the focus or composition of MD ‘teams’, **a common core model for MD support developed over time, incorporating 4 key elements:**



More information about each of the 4 elements is provided below.

Element	Detail
Consultation	One-off or sequential meetings involving relevant MD professionals gathering information and discussing or advising on the family needs with either: • Social workers alone or, occasionally, with individual family members (sometimes called ‘reflective spaces’ or ‘informal consultation’). • Social workers, parents and other key family members, often informed by MD professional assessment and formulation, sometimes described as a ‘full consultation’ or ‘formal consultation’.
Formulation and planning	Underpinned by a range of information gathering activities e.g. child observations; screening, holistic, diagnostic or specialist assessments. Synthesis of information to develop a holistic understanding of family strengths and challenges aiming to develop an evidence and needs-informed plan for the child and family including with reference to child trauma, attachment and loss, neurodevelopmental differences, cognitive difficulties and broader whole family needs including secondary trauma.
Direct work	Sequential or ‘layered’ support tailored to the needs of individual children and families including 1:1 or small group work, for example: • Therapeutic parenting support. • Sensory-informed interventions e.g. BUSS (Building Under-Developed Sensorimotor Systems). • CBT (Cognitive Behavioural Therapy). • Support to reduce violence in the home e.g. through NVR (Non-Violent Resistance) or similar programmes. • Family therapy. • Early years / education support for nursery/school transitions. • Therapeutic life story work. • Youth work (young person self-esteem, identity, advocacy work).
Support for supporters	Group-based training and 1:1 advisory support for (a) RAA social workers and (b) other people working with adopted children e.g. virtual schools, schools, CAMHS and other healthcare professionals including: • Education-focused support (work with or within schools or nurseries). • Collaborative work with Virtual School (heads and advisors). • Training for social workers and partners on e.g. ‘Therapies Explained’; Sensory Integration; ‘Trauma and the Brain’; secondary trauma; neurodiversity; worker wellbeing; PACE (Playfulness, acceptance, curiosity and empathy). • Occasionally, wellbeing focused consultations with social workers (in one site)

Many sites have also incorporated or attempted to incorporate whole-system (strategic) work to influence and improve key partner agencies' understanding of the needs of adopted children, attitudes, services and onward pathways of support.

A common core model for MD support in a single RAA, as outlined above, and serving a child population of approximately 350,000 is **estimated to cost between £350K and £375K per year.**

Families and professionals alike experienced consultation and holistic assessment & formulation as the cornerstones of effective MD support, aiming to better understand child and family needs before proceeding with tailored early support or post Adoption Order intervention(s). Case file analysis evidenced high quality, holistic assessment and formulation activity undertaken by early adopter sites with reference to national standards.

Support for social workers and other professional 'supporters' to scaffold their work with families was also described as an essential element by professionals including through training, supervision or co-delivery of group-based therapeutic programmes.

This report outlines recent activity levels and outputs of five 'exemplar' models i.e. 2 early adopter and 3 second wave sites that, by the end of the evaluation period, were fully operational and contributed data for the evaluation (section 3.1). **Across all operational sites, parents and professionals identified the following key attributes:** timely (particularly for families experiencing a crisis); being and feeling heard and held; strengths-based; holistic (incorporating different professional lenses on an issue(s)); involving professionals who can manage complexity and speak authoritatively; exploring more than one potential causal factor; including reviewable plans.

Overall, this study supports the need for and feasibility of MD support for adoption in RAA sites to benefit adoptive families with a range of needs including (predictable) difficulties transitioning from care to adoption through to more extreme challenges or crises at later stages of an adoption journey. However:

- It was challenging for sites to become fully operational within one year (from a sitting start). An 18-month window for establishing MD support seemed more realistic.
- Within the evaluation timescales, it was not feasible to operationalise MD support across a pan-regional footprint. Learning from the evaluation suggests it is better operationally to limit the geographical range to RAA footprints, although some (e.g. training) supports may be feasible to provide pan-regionally.
- A key barrier to embedding effective MD approaches was the lack of sustainable funding, with many sites relying on year-on-year funding arrangements.
- Other whole-system drivers were thought also to affect professional and parent behaviours or decisions – most importantly in relation to the ASGSF e.g. some parents continued to seek specific ASGSF-funded therapies over all other offers of support and some professionals continued to direct families into RAAs specifically to obtain ASGSF-funded support.

The report also captures (in sections 3.3. and 9.2.) further learning about the activities or resources needed to establish and sustain MD support including:

- **For models ‘starting up’ to:**
 - Involve families and social workers in developing and sustaining the model, including through ‘Voice and Influence’ mechanisms.
 - Understand and explore different recruitment options, particularly for clinical roles.
 - Be flexible and creative with staff composition to meet recruitment challenges.
 - Prioritise at least one senior clinical role to contribute to the leadership of MD support, develop and promote confidence in the intervention model and supervise other staff.
 - Carefully position the team to avoid the perception it’s all about post-Adoption Order support.
 - Clearly articulate the offer in relation to the positioning and availability of MD support alongside a theoretical basis for intervention.
 - Establish effective outcomes monitoring early.
 - Secure sufficient business support.
 - Draw on support from established MD sites.
 - Avoid replicating the core business of other key players e.g. Virtual Schools.
- **To establish sustainable models**, professionals unanimously considered they needed more sustainable funding arrangements, accompanied by changes to the ASGSF to counter some of the whole-system behaviours described above, as well as supportive governance arrangements.

Benefits of multidisciplinary support

- Almost all parents and professionals interviewed or surveyed for this evaluation placed a high value on MD support and they often described tangible improvements for individual children and families.
- By the end of a variety of MD interventions, site administered outcome measures showed **statistically significant improvements** in:
 - **Parent/child relational health**, as measured by the Thinking About Your Child (TAYC-R) measure (n=86), including in parental knowledge and skills, child responsiveness to care, family relationships and family stability. The parental skills and understanding sub-scale demonstrated particularly large improvements. A strong theme from parent survey responses, case file analysis and interviews was the foundational value of gaining a better, more holistic understanding of the child and family needs. This was considered helpful in its own right as well as to inform the selection or sequencing of onward support or simply adjustments in parenting or school support. In interview, parents also described how starting with informed, holistic assessment and formulation also gave them reassurance and greater parenting confidence.

- **Parent goals**, as measured by Goal-Based Outcomes (GBO) set by parents (n=141) at the start of and measured again at the end of MD support, for example to improve a child's wellbeing, transition between schools or family life.
- **Child emotional and behavioural wellbeing** as measured by the parent report Strengths and Difficulties Questionnaire (SDQ) (n=61). On average, children's baseline scores were in the 'very High' range, suggesting most were experiencing high levels of difficulty before accessing support. Interviews suggest that significant improvements in children's emotional or behavioural wellbeing may not be detectable in the short term as MD interventions often focus initially on consultation and/or holistic assessment and formulation¹.

These findings should be read as early signs of promise. Because of the study limitations, particularly in the lack of a control group or randomised design, it cannot be implied that MD approaches caused the positive changes in standardised measures.

- The evaluation also intended to independently capture 'before and after' outcomes data directly from parents in early adopter sites. However, this was challenging as families entering MD support were often under severe pressures and ethical constraints meant they had to independently and proactively contact the evaluation team to provide initial consent. Baseline or follow up surveys may have been administered too soon because it was difficult to identify a clear 'start date'. Findings from the small number of paired scores (n=15) collected in this way do not fully triangulate with the site collected outcomes data. Although GBO and Brief Parental Self-Efficacy (BPSES) scores improved in a statistically significant way, improvements in TAYC-R or SDQ² scores were not statistically significant. However, all parents in this small cohort did consider that their understanding of their child had increased.
- A larger cohort of early adopter site parents participated in a '**retrospective**' survey administered by the evaluation team between 1 and 36 months after support had ended (n=95). Although it was not possible to collect before and after (paired) scores this way, survey findings showed:
 - Families helped to better understand their child's needs in almost three quarters (72%) of cases.
 - Family relationships improved in about two thirds (63%) cases.
 - Child emotional wellbeing improved and/or child happier at home in approximately two thirds (60%) of cases.
 - Families more resilient in 57% cases.
 - School helped to understand the child's needs in just under one half (47%) cases.
 - Child helped to access specialist services in about one third (31%) cases.

¹ Previous studies discussed in Section 10 of this report also suggest the SDQ may not be the most useful measure of change over time in relation to the mental wellbeing of care experienced children with very high baseline scores. See Section 10 Discussion for more information.

² Ibid

- Child helped to gain a diagnosis in about one quarter (26%) cases. MD screening for child diagnoses was considered useful by parents in interview although it did not guarantee a speedy onward pathway into statutory health diagnostics.
- **Case file analysis and parent interviews** provided further in-depth evidence of improvements for individual families, in particular as a result of nursery, school or college settings taking on board MD advice and making adjustments. In many of these instances, there was evidence children had been helped to settle into a new educational setting or of them doing better in school, contributing and accessing their entitlements, feeling more confident with friendships. For other families, there had been noticeable improvements in their family life including reduced conflict, improved relationships and being able to access social activities or holidays.
- **In 5/30 or 17% of case files examined, avoidance of family breakdown was clearly evidenced.** In interview, parents and professionals often described how they had witnessed successful support at the edge of family breakdown underpinned by improvements in the child's understanding and regulation of their (own) emotions and/or reductions in child violence or risk-taking behaviours. A single child being prevented from (re)entering care results in savings of approximately £90,000 per year. Other positive outcomes, such as avoiding school exclusion or reducing reliance on ASGSF-funded therapies may also have economic benefits.
- **A large quantity of non-standardised outcomes data collected by the sites** suggests high levels of satisfaction amongst parents with a range of MD support from consultation to training - including having worries taken seriously, new insights achieved and goals for the support being largely met.
- In interview, **parents attributed improved outcomes** not only to MD support often led by clinicians but also to their social worker's relational, often therapeutically informed support for the whole family.
- **Parents responding to surveys or in interview sometimes suggested MD support could still be further improved** including for example through:
 - Becoming (even) more transparent to adopters.
 - (Even) better preparation for MD consultation with multiple professionals.
 - Improving the link between MD recommendations and the availability of timely follow-on support.
 - Having more opportunities to review MD-informed plans together at a subsequent stage.
 - RAAs providing or commissioning more support for young people, particularly for those who do not want to or cannot not access 'therapy' or who are in transition to adulthood.
 - (Even) greater openness to the potential for children to have cognitive or neurodevelopmental differences (e.g. ASD, FASD, ADHD) and improved access to specialist including diagnostic services providing by Health.
- **Parents were unlikely to notice MD support for social workers**, provided through 1:1 consultations, training, supervision and other 'scaffolding' activities. However, professionals interviewed for the evaluation and providing feedback to sites clearly valued this aspect and reported improvements in their confidence and knowledge.

- **Professionals often also valued broader systemic activities** with the potential to improve the understanding and responsiveness of key partner agencies. Associated improvements included in some cases an increased confidence in MD screenings (for onward diagnostic pathways) or the joint development of educational planning mechanisms specifically for adopted children. However, some interviewees cautioned against wasting too much time on these activities, particularly where key partner agencies were not interested or did not have the time to collaborate.

Outcome measures

This evaluation supports the hypothesis of early adopter and second wave sites outlined at an early stage in Theory of Change development, namely that MD support should initially aim to generate improvements in the understanding and attunement of parents and other people around the child to meet children's (clarified) needs.

In relation to this initially expected change, the TAYC-R and GBO measures appear to be a good fit and have demonstrated through this evaluation sensitivity to change over time in relation to starter MD supports. For some families on the edge of breakdown, another key measure of success could be the extent to which they remain together as a family.

The evaluation suggests subsequent positive changes³ that may be experienced by children and families over time (depending on their baseline needs) and measured, including:

- The child's emotional, behavioural and social wellbeing (at home and in school).
- The child's educational attendance levels and achievements.
- The family's quality of life including reductions in conflict and violence.
- The family's individual goals.

The evaluation has tested the feasibility and sensitivity of some child and family level outcome measures that relate to these 'subsequent' or longer-term outcomes. Whilst the combination of GBO, TAYC-R and SDQ goes some way to measuring all these outcomes, the limitations include that positive change in the child may not emerge to a significant degree in the short to medium term (when before and after measures are often applied) and family needs are so varied that (beyond GBO) a single measure or combination of measures will not always capture the difference an intervention makes. Alternative measures of child emotional health and wellbeing or other outcomes that may be relevant are discussed in Section 10.

³ Most of which were anticipated in the initial, underpinning Theory of Change work (see Appendix A for a composite Theory of Change).

Conclusions and recommendations

This evaluation provides well-triangulated indicative evidence of the feasibility, acceptability and early signs of promise of providing MD support on an RAA footprint. MD support also fits with an emerging national focus on timelier, tailored help for parents at their first point of contact (often the RAAs) including to support confident parents, happier, healthier children and adoption stability.

RAA leaders and other professionals involved in and around MD support for adoption have a vision, supported by the evaluation findings, that includes:

- Securing funding for MD arrangements on a more permanent footing.
- Focusing MD support ‘upstream’ to an even greater extent i.e. in the matching or early stages of an adoption journey. Leaders make a compelling case for MD support to be at least as valuable for these families as for those in crisis or on the brink of breakdown.
- An even greater emphasis on MDTs being involved in the development of adoption support assessments underpinning individual applications for ASGSF packages to enable better tailored plans and more effective therapeutic support.
- Improving the availability of evidence-informed and acceptable forms of support for young people, including alternatives to therapy.
- Implementation of broader improvements proposed by parents and professionals.

Informed by the evaluation findings, a further roll-out of MD support across other regions in England would likely also benefit from:

- **A further revised Theory of Change** that references all the key learning from this evaluation about the rationale, key mechanisms of change and short to medium term as well as longer term outcomes that may be anticipated.
- **A clear specification** (e.g. core or common elements) and quality standards located within an overall framework for adoption support that is transparent to parents and others working in the whole system.
- **Guidance** for commissioners, service managers or leaders of MD support with reference for example to starting up, recruiting to and managing MD teams, balancing the breadth and focus of the work, working with key partners and data capture including the selection of outcome measures.

Evaluation of multidisciplinary approaches to adoption support

1. Introduction

Support for adoption in England has traditionally been provided by teams of qualified, specialist social workers. Since a national programme of regionalisation starting in 2015-2016, the recruitment and preparation of prospective adopters, family finding and post-Adoption Order support⁴ previously undertaken by local authorities (LAs) has been provided or commissioned by social workers working in regional adoption agencies (RAAs)⁵ in partnership with voluntary adoption agencies (VAAs) across a footprint comprising two or more⁶ LAs⁷.

Alongside regionalisation and, with the assistance of national funding for 'Centres of Excellence', some RAAs and VAAs have experimented with providing forms of multidisciplinary support i.e. *support combining or involving more than one discipline or field of study*⁸. These 'early adopter' sites provided forms of MD support mostly for families post-Adoption Order⁹.

Alongside the programme of regionalisation, UK Government also introduced a national Adoption Support Fund (ASF), now known as the Adoption and Special Guardianship Support Fund (ASGSF) centrally funding therapeutic interventions and specialist assessments. Whilst ASGSF support (2015-17 and 2018-2022) was twice positively evaluated, unintended consequences were also noted including that statutory services (particularly CAMHS) stepped back from supporting adoptive families and that RAA social worker time was increasingly taken up with undertaking assessments to support ASGSF applications, reported also to be de-skilling (Burch et al., 2022b; King et al., 2017). Ongoing difficulties for children with a social worker in accessing CAMHS or local authority SEND support are also more recently reported (Morgan et al., 2025; Ecorys UK & Rees Centre, 2026).

⁴ Including mostly universal (for all adoptive families) and early intervention support. However, targeted and specialist supports have also always been in scope (Ecorys UK, 2022).

⁵ Including centralised (with pooled resources) or decentralised/partnership model arrangements (Ecorys UK, 2022).

⁶ On average, five (Ecorys UK, 2022).

⁷ Other adoption-related statutory responsibilities have been retained by local authorities in many but not all cases i.e. for care including permanency planning and child preparation – with advice and support from the RAAs (Ecorys UK, 2022).

⁸ Merriam-Webster Dictionary definition.

⁹ Ecorys (2022). Note: this type of support is described as 'targeted' or 'specialist' in the Ecorys report and includes mostly clinical psychology and education support.

Two pilot studies of emerging MD models of support for adoption in an RAA and VAA found positive early signs including social worker and adoptive parent appreciation of psychologically informed assessments and interventions (Young & Neil, 2020; Coram, 2016). The Young & Neil (2020) evaluation identified potential barriers to implementing MD approaches including: families approaching the service with very specific support in mind; the potential for clinical and social work staff to feel quite separate from one other; and difficulties within the whole RAA team in adjusting to rapid change (Young & Neil, 2020).

Parent and professional interest in MD support has grown alongside an evidence base demonstrating how children more recently adopted in England are likely to have experienced:

- early life trauma; and/or
- disrupted attachments and loss (Ecorys UK, 2026; Anthony et al., 2022; Paine et al., 2021; Selwyn & Gardiner, 2025)

affecting their emotional and behavioural development (Ecorys UK, 2026; Gilbert, et al., 2006; Peng, et al., 2021; Paine et al., 2021). Assumptions are often made about adoptees' opportunity and capacity to recover, concealing challenges they face in adjusting to adoptive life, including education (Brown & Shelton, 2023) and these challenges often emerge or escalate during transitions e.g. into or between schools (Selwyn & Gardiner, 2025).

Most requests for adoption support are now primarily concerned about adoptees' education, with at least one fifth of school aged adopted children on a part-time timetable (Adoption UK, 2025) and excluded adoptees becoming at increased risk outside the home (Garstang, et al., 2025).

Adopted children, particularly those requiring more targeted forms of support, are known to be at increased risk of having cognitive difficulties, physical disabilities and/or neurodevelopmental differences (or conditions) compared with the overall population (Ecorys UK, 2026; Adoption UK, 2025; Burch et al., 2021; Gregory, Reddy & Young, 2015). We are also beginning to learn more about how ongoing, persistent difficulties or complexity can affect adopters including through secondary trauma and 'compassion fatigue' (O'Marah, Hodge, & Machin, 2025) and how, without appropriate support, challenges (particularly continuing violent or aggressive child behaviours) can lead to adoption disruptions, breakdowns or safeguarding risks (Garstang et al., 2025; Selwyn & Gardiner, 2025). Similarly, we are learning how adoption social workers experience 'significant emotional labour' in working with complex, unpredictable, emotionally taxing and disturbing family situations in relation to which they may not have access to the full range of professional knowledge and solutions, and may benefit from 'epistemological¹⁰ containment', 'reflective spaces' and/or 'clinical supervision' (Thomas & Simmonds, 2024).

¹⁰ References the range of knowledge informing practice.

Whilst there is little research regarding the potential (positive) effects of MD support across an adoption journey, the national inspectorate for children's social care services, Ofsted, has begun to recognise the strengths of working in this way (Ofsted, 2026).

Multidisciplinary support for other aspects of statutory health (e.g. Swallow et al., 2013) and children's social care has also grown over the last 10 years or more, for example in relation to work with birth families on the 'edge of care' (e.g. Baxter et al., 2023).

However, there are still gaps in our understanding about MD support and its potential value to adoptive families and professionals working with them that this evaluation has attempted to fill. The evaluation has been commissioned by the body representing regional adoption agencies in England, Adoption England (AE) to explore (May 2023 – March 2026¹¹):

- The **feasibility** of implementing multidisciplinary approaches to adoption support – from the perspectives of both early adopters and second wave sites.
- The **actual or potential benefits**, including where possible costed benefits, of implementing multidisciplinary approaches and teams.
- Which **outcomes and outcome measures** are useful to use in this context.

It was intended that the evaluation would explore feasibility in relation to two 'early adopter' (Centre of Excellence) sites and seven 'second wave' sites receiving time limited funding in 2023 to establish or extend MD arrangements and teams on either an RAA or a pan-regional¹² footprint. The potential benefits and use of outcome measures would also be explored in all sites, but the evaluation would focus on in-depth including independent data capture in the early adopter sites.

In addition to the three overall evaluation questions, Theory of Change (Ghate, 2018) models were co-produced with each of the multidisciplinary sites that informed more detailed questions and data capture tools used both by sites and by the evaluation team. An overarching or 'composite' Theory of Change was co-produced at a relatively early stage of piloting (December 2024) in the context of a conference involving evaluators, funders and all pilot sites (see Appendix A).

¹¹ The original evaluation period was due to end in June 2025 but was extended to take account of the fact that many second wave sites took longer than initially envisaged to become operational.

¹² Defined as more than one RAA working together across a broader regional footprint.

2. Methodology

This was a mixed methods and realist(ic) evaluation aiming to explore not only whether and to what extent MD supports appear to ‘work’ but also how, in what circumstances and for whom (Pawson and Tilley, 1997)¹³. The evaluation received ethical approvals from Oxford Brookes University in 2023 [Oxford Brookes UREC 231714]. The key evaluation methods are outlined in Table 1 below:

Table 1: List of methods used in the evaluation

Method	Participants (N)	Time period
Longitudinal survey of parents across three timepoints (baseline; follow-up one [6 months after baseline]; follow-up two [12 months after baseline])	Adoptive parents who were in the process of accessing multidisciplinary support in early adopter sites (baseline n=22; follow-up one n=20; follow-up two n=15)	December 2023 to March 2026
Retrospective (standalone) survey of parents , across two ‘rounds’	Adoptive parents who had recently accessed multidisciplinary support in early adopter sites (n=95)	June to July 2024 and January to February 2026
Semi-structured interviews with parents	Adoptive parents who had taken part in the longitudinal or retrospective survey and consented to interview (Total 32 including 8 from longitudinal survey and 23 from retrospective survey participants)	November 2024 to March 2026
Case file analysis of adoption support files	Adoption support case files of children whose parents took part in a longitudinal or retrospective survey who consented to case file analysis (Total 30 case files examined)	February 2025 and April 2026

¹³ Within the confines of an evaluation involving a number of ‘start-up’ pilots, not all of whom were able to become fully operational during the evaluation period and without the benefit of comparison group(s) with regards effects.

Method	Participants (N)	Time period
1:1 or small group semi-structured interviews with professionals in two early adopter sites	Professionals working within the Regional Adoption Agencies and wider health and social care stakeholders working alongside adoption teams (Round one n=58 interviewees; Round two n=27 interviews, 28 interviewees)	Round one: February to July 2024 Round two: February to April 2026
1:1 or small group semi-structured interviews with professionals in seven second wave sites	Professionals working within the Regional Adoption Agencies and wider health and social care stakeholders working alongside adoption teams (n=52 interviews, 56 interviewees)	March 2025 to March 2026
Secondary analysis of data: outcome data, activity, family and professional feedback and costing data from each site	N/A	September 2023 to March 2026

2.1. Data collection processes in more detail¹⁴

2.1.1. Longitudinal survey of adoptive parents

Families about to receive MD support from early adopter sites¹⁵ received information about the evaluation from their social worker, including verbal communication and sharing of written participant information and a privacy notice explaining the purpose of the evaluation, what would be involved and their rights. The point at which professionals shared this information was intended to be as close as possible in time to the initial referral for MD support. However, this was not always possible (see below regarding study limitations).

Parents interested in hearing more or taking part then contacted the evaluation team directly (either by telephone message or email). A dedicated helpdesk researcher arranged to talk on the telephone with parents to check whether they had any questions before

¹⁴ Evaluation tools including surveys, questionnaires, topic guides etc. are not reproduced in full within this report but can be made available, upon application, to the team at the Institute of Public Care.

¹⁵ Plus one other site, technically a 'second wave' site but that was in fact extending a pre-existing MD support offer available within one LA to a new LA part of the overall RAA footprint.

agreeing to participate. Once the parent(s) confirmed they were happy to take part in the longitudinal survey, an individualised link was generated and emailed to them to complete the baseline survey. An initial follow-up survey link was emailed to the parent six months after the completion of the baseline survey, and then a further follow-up survey link six months later.

At all three survey points, it was made clear in the email to parents that they could contact the researcher if they needed any assistance, had questions about the survey or wanted to end their involvement. Where parents did not complete the survey within two weeks of the link being sent, a reminder was sent and, if the survey was still not completed, a final reminder. Analysis of the survey data responses was conducted initially in Microsoft Excel and then, where relevant, in SPSS (version 31).

The children in relation to whom a baseline survey was completed were aged 3 to 18 years, with most (15/22 or 68%) aged 3 to 10 years. Thirteen of the children (59%) were male and 9 (41%) were female. Most (19/22 or 86%) children were of White British including Welsh/Scottish/Northern Irish ethnicity.

2.1.2. Retrospective survey of adoptive parents

The evaluation team asked early adopter sites to advertise a one-off, anonymous retrospective survey for families who had accessed MD support in the last three-year period (approx.) to explore their experience of the support and the extent to which they had found it helpful. Sites issued an introductory email about the survey to eligible parents, with an information sheet and privacy notice detailing the purpose of the evaluation, what would be involved and their rights. It also provided contact details for the evaluation team, should parents wish to ask further questions of clarity. To give parents time to read and consider this information, a follow-up email was sent one week later with the link for the survey, and then a final email reminder was sent around two weeks later. Analysis of the survey data was undertaken in Microsoft Excel.

Of the 95 parents responding to the retrospective survey, about two thirds (67/95 or 71%) had received a MD support from one early adopter site (site one) and about one third (29% or 28/95) had received a MD support from the other early adopter site (site two). The age families stated their (relevant) child had been when they accessed MD support ranged from 1 year to 17 years and the average (mean) age was 9 years. On average, families had received the MD support approximately 1-2 years before completing a survey. Details of the child's ethnicity were not requested.

2.1.3. Interviews with adoptive parents

At the end of both parent surveys described above, respondents were informed that, as part of the evaluation, they could also share more about their experience in an interview. They could indicate if they were interested in hearing more about this and, if so, could provide their preferred contact details. A senior researcher would then send an email with

further information including in an information sheet and privacy notice and offer the parent a telephone call to ask questions and discuss further before deciding.

Once a family confirmed they would like to take part in an interview, this was scheduled at a convenient time for them and was conducted online, either through MS Teams or Zoom depending on their preference. Immediately before the interview, parents were reminded of the key points from the information sheet, including about confidentiality and its limits, and their rights including to stop the interview at any time without giving a reason. Interviewers followed a distress protocol. Topic guides were informed by Theory of Change contents. The interviews were recorded and transcribed. Transcripts were analysed using inductive and deductive approaches with a single senior researcher undertaking initial coding of all transcript segments before developing the themes (Braun & Clarke, 2022).

Most (25/32) parents were co-parenting but about one fifth (7/32) were solo parenting. Most of their children had started to live with them aged around 18 months or younger. Approximately two thirds (22/32) interviewees had received a service from one early adopter site (site one) with the others mainly having received a service from the other early adopter site (site two). Three parent interviewees had received a service from a second wave site that was building on an existing MD offer (rather than starting from scratch) and had therefore been involved in the longitudinal survey.

2.1.4. Case file analysis

At the end of both parent surveys, respondents were also informed that, with their consent and as part of the evaluation, their (relevant) child's adoption support case file could be examined by independent evaluators. They could indicate if they were interested in hearing more about this and if so, could provide their preferred contact details. A senior researcher then sent them an email including further summary information supported by an information sheet and privacy notice, as well as offering a brief telephone call to discuss further before deciding. This was to ensure they understood what was involved and could ask further questions before agreeing, and (for children of an age and understanding) that parents had consulted with their child to gain their agreement to participate. Because of the sensitivities and potential privacy risks associated with case file analysis and the likelihood sites would be aware of consenting parents' identities, evaluators ensured that all parents involved in the case file analysis partook in one of these calls before agreeing to participate.

After the call, the adoptive parent was asked to send a formal written (email) confirmation if they wanted to proceed with the case file analysis.

The relevant children's electronic adoption support case files were then analysed by two members of the evaluation team, including the running records and key (assessment, planning and review) documents. No historical adoption records were reviewed during this activity.

Of the 30 case files examined, 19 children and families had received MD support from one early adopter site (site one) and 11 from the other site (site two).

2.1.5. Interviews with professionals

All nine MD sites were asked identify professionals involved in projects or working closely with them (e.g. those working in the wider adoption support team, Virtual School staff, NHS staff). With permission of these individuals, sites shared the professional email addresses. The evaluation team then emailed the individuals with participant information, asking them to consider it and confirm whether they would be willing to take part in an online interview, either individually or in a small group. Where individuals expressed a desire to take part, interviews were conducted online, either through Teams or Zoom depending on their preference. Before the interview, individuals were reminded of the key points from the information sheet. The interviews were recorded and transcribed. Transcripts were analysed using inductive and deductive approaches with a single researcher undertaking initial coding of all transcript segments before developing themes (Braun & Clarke, 2022).

Interim stage interviews were undertaken within early adopter sites in around February to July 2024. A final ‘wave’ of interviews was undertaken with professionals involved in or with all sites on a rolling basis between March 2025 and March 2026¹⁶, with most being undertaken in February to March 2026. By the end of the evaluation period, the team had heard from almost all RAA leaders, relevant service or team managers from across an adoption journey (including family finding and post Adoption Order support), MD team managers, consultant clinical psychologists (sometimes also described as ‘the clinical lead’), educational psychologists, therapeutic social workers, youth workers, assistant psychologists, early years practitioners or teachers, occupational therapists, speech and language therapists and project managers. Despite efforts to reach a broader group of professionals from other (partner) agencies, only a small number were completed. These were all with professionals working Virtual Schools. One interview was conducted with RAA Parent Voice representatives.

The topic guides were informed by both Theory of Change work and Normalisation Process Theory (Murray et al., 2020) providing a helpful theoretical framework including:

1. **Coherence** – the shared understanding people have about a model and its value and purpose including with reference to ‘business as usual’.
2. **Cognitive participation** - or ‘buy in’ at operational and strategic levels. Where buy in is strong, there are legitimate reasons for stakeholders to get involved and strong(er) motivations to engage with the work.
3. **Collective action** – Where collective action is strong, there is a shared understanding about roles and responsibilities, resources available and structures in place to support confident work(ing).

¹⁶ As some staff left and some sites lost funding before the end of the evaluation period.

- 4. Reflexive monitoring** - How well are things going? How is the model implemented? How does it affect positive change / outcomes? What influences the whole system? How transferable is the model?

The evaluation team also facilitated a Community of Practice (CoP) focused on MD support that met 7 times from January 2024 to December 2025 to explore the successes, challenges and best practice relating for example to: MDT recruitment; managing demand; data sharing; outcomes data capture; concluding interventions with families; and working with families where children have FASD. Whilst not a formal evaluation activity, the outputs from CoP sessions have been used to sense check formal evaluation findings.

2.2. Outcome measures used in this evaluation

2.2.1. Measures used in the longitudinal survey

Based on early Theory of Change work¹⁷, a range of child and family level outcome measures were selected for inclusion in the longitudinal survey – intended as a main, independent source of parent-reported outcomes data capture for the evaluation¹⁸.

- Thinking About Your Child Revised (TAYC-R).
- Parental Reflective Functioning Questionnaire (PRFQ).
- Strengths and Difficulties Questionnaire (SDQ).
- Brief Parental Self-Efficacy Scale (BPSES).
- Short Warwick Edinburgh Mental Wellbeing Scale (SWEMBWS).
- Goal-Based Outcomes (GBO).

The PRFQ, TAYC-R and BPSES combination was intended to explore what was hypothesised as an initial stage change in parents, for example as they experienced assessment, formulation of a child and family needs and/or consultation support – including improved understanding of and attunement to their child’s needs, and improved parental efficacy or confidence. Other, subsequent improvements (e.g. in family relational health and stability, child or parent wellbeing) were hypothesised as occurring because of improved parental and service understanding and confidence in the plan that could be measured using the TAYC-R, SDQ and SWEMBWS. Finally, Goal-Based Outcomes were included to measure change over time relating to specific goals selected by each family.

2.2.2. Measures collected by the sites

The evaluation team also worked with early adopter and second wave MD sites to support their capture of ‘before and after’ intervention outcomes data directly from parents. Whilst

¹⁷ Including the development of an overarching Theory of Change – coproduced at a conference involving evaluators, funders and all pilot sites in December 2024.

¹⁸ More information about these outcome measures can be found at Appendix B.

in principle these outcome measures were tailored to each MD site and what they were trying to achieve, in fact all sites selected very similar outcome measures¹⁹.

- Thinking About Your Child Revised (TAYC-R).
- Strengths and Difficulties Questionnaire (SDQ).
- Goal-Based Outcomes (GBO).

Between 61 and 141 complete paired pre- and-post intervention data points were available per measure. Data was aggregated to ensure sufficient sample sizes for statistical analysis. The analysis was conducted in SPSS (version 31).

Further information about each of these outcome measures including more about what they measure and how is detailed in Appendix B.

2.3. Summary strengths and limitations of the methodology

2.3.1. Family participation

A key strength of this evaluation has been the involvement of 117 adoptive parents in completing an independently issued longitudinal or retrospective survey and:

- In 32 cases, an interview with the research team – providing rich insights into their experiences and the value they placed on MD support.
- In 30 cases, an examination of their child's adoption support case file – providing an independent appreciation of the needs of families 'entering' MD support, key features and qualities of the (particularly assessment and formulation) work and its reported effects. The case file analysis has also generated three illustrative case studies of families at different stages of an adoption journey and levels of need.

An even larger group of parents participated by providing feedback and/or longitudinal outcomes data to their MD 'site'.

The extent and depth of the data mean we can be relatively confident the evaluation is reflective of parents' recent experiences and the difference they think MD support makes. However, it is important to note that families participating in evaluator-led surveys, case file analysis and interviews were self-selecting and therefore their views may not fully reflect those of the wider adopter community involved with MD support.

This evaluation has not collected any data directly from children and young people. This is because almost all MD supports were directed at or through parents. In most cases, the children and young people simply would not be aware of the MD support provided. Where parents consented to interview, a senior evaluator discussed whether it would be

¹⁹ This was because their Theory of Change shared similar elements.

appropriate to involve the child. In no cases was it deemed appropriate for the reasons above and because the child was too young.

Key limitations of the study with regards family participation are that:

- Ethical restrictions around inviting parents to take part in the longitudinal survey meant that the evaluation team could only engage with those who independently made direct contact (after considering the participant information). These were parents who the relevant sites described as often being or feeling at crisis point (at entry into MD support) and therefore potentially much less likely to prioritise making these efforts. This meant that, despite continued efforts, the final sample size of families involved in our longitudinal survey was lower than anticipated (22 parents started the survey and 15 finished the final third wave). Follow up surveys may have been administered too soon as it was difficult to be clear about a 'start date' for MD support. Therefore, we have been careful not to place too much weight on these findings.
- With regards the analysis of outcome measures collected by the sites, both between and within sites, MD input was likely to vary to a greater or lesser degree, meaning it was not possible to consider observed changes in outcomes in relation to specific intervention components. For example, one family might receive a MD consultation followed by 1:1 occupational therapy. Another family might participate in a MDT-led therapeutic parenting group followed by 1:1 family therapy. Furthermore, because this data was collected by sites themselves, we cannot be sure all outcomes' data was collected in the same way, e.g. some follow-on questionnaires could have been administered face to face at a final session, whilst other parents could have been sent through an online form to complete. There will also be differences in the amount of time between the pre- and post-intervention data, depending on how long the intervention lasted (e.g. a therapeutic group might run over 6 weeks, but family therapy might last for longer). Nevertheless, we considered the approach to be appropriate because the purpose of analysis was not to identify the relative effectiveness of specific MD interventions, rather to obtain an indication of the extent to which overall family involvement in MD support may be associated with positive change and to determine which outcome measures appear most responsive to MD interventions.
- In relation to all outcomes data capture, an overall limitation is that this study design has not enabled comparison of child and family level outcomes with a control or 'comparison' group (not receiving MD support) which means we cannot confidently attribute positive outcomes to the MD approach. Child and family difficulties may have improved without the intervention.
- The case file sample was relatively small (n=30) and represented MD work in only two (early adopter) sites. There may have been variations in the case recording by staff affecting the amount or quality of information available to view on different files. Therefore, we have been careful to limit findings from this source to descriptive information or information about the quality or potential effects of MD support that

triangulate with and illustrate other quantitative data. Where we have relied only on data from case file analysis, we have clearly indicated the sample size and source.

2.3.2. Professional participation

Another strength of the study has been that it heard from over 100 professionals working in and around support for adoption including from: RAA leaders and service managers; social work and other professionals (e.g. clinical psychologists, occupational therapists, educational psychologists, youth workers, educationalists) working in or on behalf of RAAs; team managers working in teams accessing MD support on behalf of families – from family finding and matching to post-adoption order support.

However, voices from agencies outside of RAAs have been noticeably absent. The evaluation team made robust efforts to contact these agencies or key individuals working within them to explore key evaluation questions such as:

- To what extent does the presence of MD support affect your work including referrals into and out of your service or waiting times?
- To what extent does MD support enable better outcomes for adopted children and families?
- To what extent has MD support located within the RAA helped you or your staff to better understand the needs of or improved your offer to adopted children?

Whilst some representatives of virtual schools participated in an interview, we were unable to interview any representatives of CAMHS or Health Commissioning services. None of these services contributed data for the evaluation.

3. What were the multidisciplinary models and activities?

3.1. All models

For the purposes of this evaluation, MD models were initially described²⁰ as:

- **‘Early adopter’** i.e. with arrangements in place for several years (2 sites).
- **‘Second wave’** i.e. with funding from Adoption England to develop afresh or extend existing models between 2023 and 2026 (7 sites).

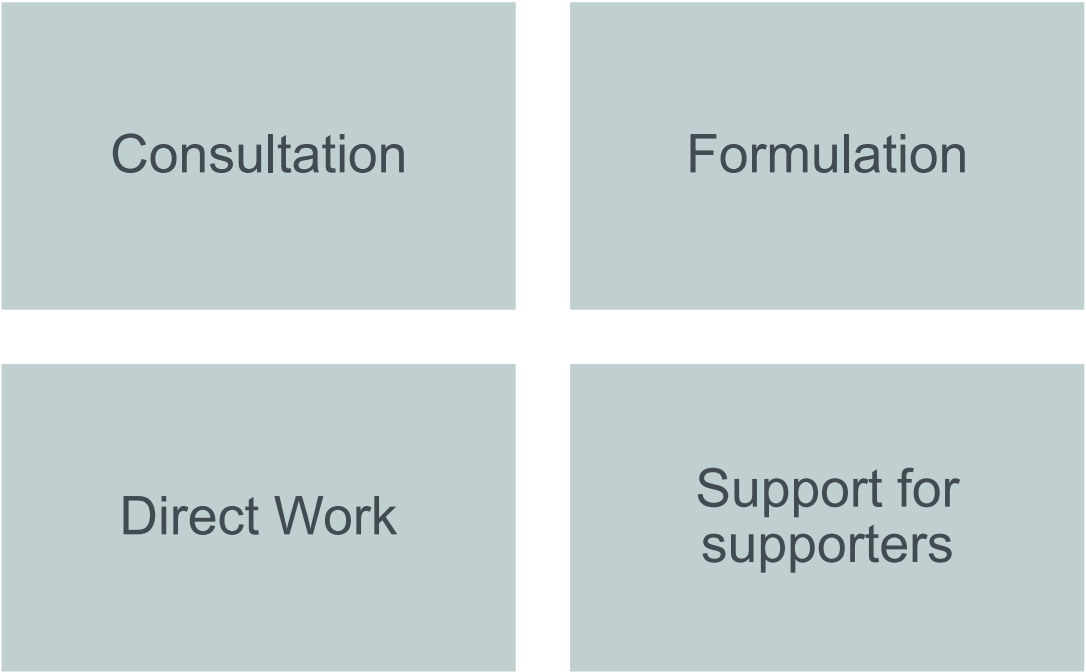
²⁰ Including in the interim report ‘Evaluation of MDT in England Interim Report – Executive Summary Jan 25 accessed here on 15/10/2026 <https://www.adoptionengland.co.uk/news/evaluation-multi-disciplinary-approaches-adoption-support>.

By the time of reporting, models could also be described in relation to:

- **Their geographical footprint** (i.e. servicing an RAA (7 sites) or pan-regional (2 sites) population of adoptive families in a range of regions across England).
- **The type and mix of professionals** forming the multidisciplinary model, e.g. social workers, therapeutic social workers, clinical psychologists, educational psychologists, occupational therapists, youth workers, speech and language therapists.
- **Their theoretical underpinnings** often aiming to improve child and family outcomes and actively reduce escalation of needs by working ‘through’ key agents of change (parents and their social workers) by exploring biopsychosocial factors and layering neuro-sequential²¹ support in a tailored way rather than immediately reaching for therapy.
- **Their child age focus.** Most models worked with children of all ages, but one early adopter site was only funded to support children up to age 12 years and another second wave site had a particular focus on supporting young people.

With regards the range of MD activities, secondary analysis of site-provided activity data outlined in more detail in Appendix C and findings from the qualitative interviews suggest that a set of ‘**common core elements**’ has evolved in all fully operational sites that can be articulated as follows in Figure 1 and Table 2 below:

Figure 1: Common Core Elements of MDTs



²¹ Aligning caregiving, education and therapeutic support sequentially alongside the child’s brain development, acknowledging how this can be negatively affected by trauma or adverse experiences. Often starting with sensory regulation before other (cognitive) interventions can be introduced.

Table 2: Detail by Common Core Element

Element	Detail
Consultation	One-off or sequential meetings involving relevant MD professionals gathering information and discussing or advising on the family needs with either: • Social workers alone or, occasionally, with individual family members (sometimes called ‘reflective spaces’ or ‘informal consultation’). • Social workers, parents and other key family members, often informed by MD professional assessment and formulation, sometimes described as a ‘full consultation’ or ‘formal consultation’.
Formulation and planning	Underpinned by a range of information gathering activities e.g. child observations; screening, holistic, diagnostic or specialist assessments. Synthesis of information to develop a holistic understanding of family strengths and challenges aiming to develop an evidence and needs-informed plan for the child and family including with reference to child trauma, attachment and loss, neurodevelopmental differences, cognitive difficulties and broader whole family needs including secondary trauma.
Direct work	Sequential or ‘layered’ support tailored to the needs of individual children and families including 1:1 or small group work, for example: • Therapeutic parenting support. • Sensory-informed interventions e.g. BUSS (Building Under-Developed Sensorimotor Systems). • CBT (Cognitive Behavioural Therapy). • Support to reduce violence in the home e.g. through NVR (Non-Violent Resistance) or similar programmes. • Family therapy. • Early years / education support for nursery/school transitions. • Therapeutic life story work. • Youth work (young person self-esteem, identity, advocacy work).
Support for supporters	Group-based training and 1:1 advisory support for (a) RAA social workers and (b) other people working with adopted children e.g. virtual schools, schools, CAMHS and other healthcare professionals, including: • Education-focused support (work with or within schools or nurseries). • Collaborative work with Virtual School (heads and advisors). • Training for social workers and partners on e.g. ‘Therapies Explained’; Sensory Integration; ‘Trauma and the Brain’; secondary trauma; neurodiversity; worker wellbeing; PACE (Playfulness, acceptance, curiosity and empathy). • Occasionally, wellbeing focused consultations with social workers (in one site)

Many MD models have also evolved also to include whole-system (strategic) work to influence and improve other agencies' understanding (of the needs of adopted children), attitudes, services and speedier onward pathways.

Detailed activity data from five of the sites able to provide this information across one or more whole years' of being operational between April 2024 and March 2025 suggests:

- **Full or formal consultation** often included assessment and formulation activities undertaken together as a 'package' of support with and for families. **An average of 40 of these were undertaken per site** in 2024-2025 (range 14-71).
- **Informal consultations** or 'reflective spaces' with the social worker and/or individual family members could happen more spontaneously and therefore on a larger scale. **An average of 102 of these were undertaken per site** in 2024-2025 (range 23-249).
- **The overall number of consultations** (range 50-263) and balance of emphasis across formal and informal consultations varied by site, as did the balance of assessment/formulation/consultation with other core activities e.g. direct work.
- **Screening for specific child conditions or highly specialist assessments** were reported to be undertaken in only two of the sites (approximately 3-11 provided per site in 2024-2025).
- The nature and amount of **direct work** differed from site to site. However:
 - All sites provided group-based courses, aimed largely at parents (between 1 and 11 courses per site in 2024-2025).
 - Almost all sites also provided 1:1 therapeutic direct work (for an average of 46 families per site in 2024-2025, range 24-75).
 - All sites provided 'other' forms of 1:1 direct work including educational and youth work support (for an average of 62 families per site in 2024-2025, range 7-122).
- **Support for the supporters** included between 3 and 28 formal 'training' sessions for RAA staff and other professional groups per site in 2024-2025.

The MDTs included a range of professionals, as outlined in Table 3 below (more detail on the professional makeup of each MDT is provided at Appendix C).

Table 3: MDT professionals available by site (at February 2026)

Professional	Site 1	Site 2	Site 3	Site 4	Site 5
Clinical psychologists	✓	✓	✓	✓	✓
Therapeutic social workers	✓	✓	✓		✓
Occupational therapists	✓	✓	✓	✓	
Educational psychologists		✓	✓		
Educationalists / Teachers	✓				✓
Early years' professionals	✓				
Speech and language therapists					✓
Youth workers					✓
Psychiatrists		✓			
Project / team managers	✓		✓	✓	✓
Business support		✓	✓		

The most frequent professional component was clinical psychology, often comprising some senior or consultant clinical psychologist FTE and some more junior (including assistant) clinical psychologist FTE.

The makeup of MDTs is reported to have been affected in many instances across these 5 sites by either:

- Difficulties in securing initially desired posts (in second wave sites).
- Cuts to largely health component funding (in early adopter sites).

3.2. Interim stage evaluation reflections on early adopter models

Evaluation activities undertaken in Summer 2024 to inform interim reporting (in December 2024 – January 2025) suggested that multidisciplinary arrangements had been ‘normalised’ in early adopter sites. Where clinical professionals were employed directly by the RAA, they were perceived to be more integrated and accessible but might have weaker links or influence with key statutory partners. Where clinical professionals remained

employed by their statutory service (e.g. by health trusts), the opposite was perceived to be the case i.e. they were experienced as less integrated and accessible by the RAA but had stronger links and influence with strategic partners.

Interviews with professionals working in early adopter sites in 2024 also suggested MD support was greatly valued by RAA social workers. However, irrespective of model design, a key challenge was the short-term nature of funding and difficulties in securing sustainable funding i.e. from year to year – particularly from Health for clinical roles. There was also some evidence from interviews that, since the formation of RAAs and MDTs, health services had increasingly signposted adopted children and families to RAAs to have their health needs met.

3.3. Interim stage evaluation reflections of second wave sites

Interim evaluation findings from the early stages of implementation of multidisciplinary approaches in the 7 ‘second wave sites’ (December 2024) identified:

- **Successes**, such as being able to scope and staff MD models and teams, implementing robust governance arrangements and putting in place effective systems to measure the impact of MD support(s). A range of approaches to MD working were being tested or further tested including models that were similar in scope to early adopter sites or more targeted approaches aiming, for example, to improve support for children affected by FASD or vulnerable young adoptees in transition to adulthood.
- **Challenges** – particularly in operationalising MDT approaches in a relatively short period of time (in under 6 months from hearing about funding) or in implementing models across a very large, pan-regional footprint. Other early challenges included establishing data sharing arrangements and recruiting clinicians - although the sites were beginning to find and share creative ways to address these early barriers.

3.4. Recent multidisciplinary developments

Between interim and final stage reporting, key developments included:

- The two pan-regional sites being unable to fully operationalise, with one becoming funded under a different pilot (ASGSF) programme to provide specialist assessments only.
- Two second wave RAA sites not receiving funding for an extended year (2025-2026) of the pilots and evaluation (one of these sites becoming funded under the ASGSF pilot programme).

Professionals, including service leaders from these sites did still participate in interviews but were only able to contribute limited data.

RAA leader and practitioner perspectives were that key developments since early implementation or embedding stages included in:

- **Personnel**, e.g. some staff leaving, others joining or replacing one type of MD worker with another (e.g. educational psychologist being replaced by clinical psychologist and education adviser) or funding more senior psychology time to directly supervise other junior members of the team. Some new roles (e.g. business support) were being funded out of the RAA budget rather than through (pilot) MD funding streams.
- **Development of outcomes reporting**, including the development in some cases of MD team ‘dashboards’ used to present material to RAA Boards.
- **Focus**, particularly in second wave sites including:
 - From consultation only towards consultation and direct work. There was strong consensus across all sites about the importance of involving all practitioners, including clinicians, in some direct work rather than solely consultation, assessment and formulation. Some leaders reflected additionally that it was important not to tie up all senior clinician time with this aspect of MD work.
 - Moving from mostly crisis-driven or work with families with chronic difficulties to undertaking more preventative work at an earlier ‘upstream’ stage of adoption journeys - including to ‘scaffold’ families where it was anticipated they would experience challenges. Some sites were also beginning to offer advice at a very early (e.g. matching) stage to formulate better tailored support for transitions.
- **Increasing the involvement and direct participation of family members** in consultation activities.
- **Positioning of MD support towards being an integral part of decision making from an earlier point in families’ journeys into and through adoption support** i.e. from the ‘front door’ or ‘help desk’ to triage more effectively and/or to provide more responsive access to MD support beyond these points for families who needed it.
- **Decreasing emphasis on undertaking specialist assessments** as defined by ASGSF (because of changes to the eligibility criteria) but increasing in some cases the emphasis on holistic formulation – to establish a therapeutic plan for families.
- **Increasing ‘in house’ provision of therapies**, whether funded by ASGSF or not, including an emphasis on social worker-provided support, supervised by clinicians.
- **Beginning to review social worker assessments underpinning ASGSF applications** where it made sense to do so, for example where there had been multiple applications.
- **Providing more tailored or specialist training for RAA staff**, to meet their needs for example in relation to NVR or FASD.
- **Greater emphasis on children’s educational needs and closer working with virtual schools’ colleagues** to ensure seamless support for children, rather than signposting or providing potentially overlapping support.

4. Who needed multidisciplinary support?

This section opens with parent perspectives on their adoption journey, how their child and family needs developed to the point of triggering MD support, the process of seeking help and the extent to which and how they had been involved in the MD support process (4.1.). The section also explores professional perspectives about why families may need MD support (4.2.)

4.1. Parent perspectives

4.1.1. Parent knowledge of child needs early in an adoption journey.

Data from the surveys and parent interviews suggest most children had come to live with their adoptive parents before the age of 2 years. Many parents in interview considered their child's needs had been known or partially known at the point of matching or early adoption journey stages, with information sources being predominantly the Child Permanence Report (CPR) and/or conversations with social workers or medical practitioners.

...early on in the... process...so first done introductions, they had an appointment with a paediatrician, so like pre-adoption medical. And that was quite a difficult report, it was about their delayed development around speech and their ability to play. So that was our sort of like first wake-up call of that there will be some additional needs (Parent)

Conversely, for some parents, their child's (additional) needs had not been known as fully but became much clearer relatively soon after starting to live together.

Violence... And it happened quite quickly... [child] would try to bite... still does now. It's become habitual.. it's hard to really break ...[child would] try to gouge out our eyes... kicked, punched, head butted, threw objects (Parent)

Or needs emerged over several years:

It was... after [child] started school, it became quite apparent... had some difficulties. A lot of it was sensory difficulties ...to start with, but yeah... also, like, cognitive difficulties towards the end of Reception (Parent)

Where adoptions had taken place several (mostly over 10) years ago, parent interviewees sometimes reflected that more accurate information and support about what to expect could or should have been shared at an early stage.

[paediatrician on placement] said to avoid any labels to begin with...wouldn't give too much of the history so that [child] can have a sort of, I suppose, a fresh, you know, a fresh start without being labelled, which at the time I thought, OK, but in hindsight [it would have been useful] (Parent)

4.1.2. Development of child and family needs leading to multidisciplinary support

Whether or not there had been an understanding of children's needs at or around placement, almost all parents interviewed for this evaluation considered their child's development, behaviour and/or mental wellbeing needs had emerged, worsened or just become more apparent over time – particularly at transitions, for example into primary or secondary school.

So, I think it was when [child] started primary school...and we hadn't had kind of these challenges with our oldest [adopted child], so it was all quite new to us. We relied a bit of the time on the school and their advice, and they had an Ed psych who undertook an assessment, and they gave us some advice from that. But then really...the approach that the school was taking wasn't really working. [Our child] continued to struggle and kind of escalating behaviours and stuff like that (Parent)

Earlier or later, many parents described having reached the point at which a single factor (such as attachment or trauma or neurodiversity) had failed to fully explain their child's behaviours or needs or their needs had escalated to high levels.

Quantitative data from the surveys corroborate these parent perceptions in that:

- 60% (57/95) parents participating in the **retrospective survey** considered MD support would be helpful because their child had multiple sources of difficulty or need. In a smaller proportion of cases (32% or 30/95) parents were interested mainly in accessing support from a member of the MD Team for a single issue, mostly education. Other parents were not sure why they had been referred for MD support, and this could feel a little 'done to' if the reasons had not been sufficiently explained.
- **With regards the longitudinal survey** (n=22), the mean parent-report SDQ Total Difficulties score (22.0) at baseline suggests 'Very High' levels of need for the children being referred into MD support, including in managing relationships, anger or violence. The scores were significantly higher than population norms (Youth in Mind, 2020; Meltzer et al., 2003) and slightly higher even than the scores for children being referred into ASGSF-funded support (Burch et al., 2021). For about two thirds of families, the child's difficulties had put 'a great deal' of burden on them as parents or as a family. Parents' perceptions of their own self-efficacy and emotional wellbeing were also similarly low when compared with the ASGSF evaluation. Most parents responding to the longitudinal survey (15/22) stated that the main aim of MD support from their perspective was to help them or their child to manage their difficulties or improve their wellbeing. The next most frequently stated main aim was to improve family life and relationships (4/22). At this stage (the start of MD support), most parents completing the baseline survey indicated very low ratings in relation to these goals (e.g. mean rating of 2.4 out of 10, range 1 to 7 out of 10).

Analysis of 30 adoption support case files held by the two early adopter RAAs relating to children referred for MD support suggested that:

- Only a small proportion (4/30) had been referred for what looked like ‘single issues’ – in all cases for issues relating to their education.
- In most (26/30) cases the child and family had multiple and/or complex needs.
- Of these ‘multiple or complex needs’ families, five out of thirty (17%) were judged by researchers to be in crisis and at risk of breakdown.

4.1.3. **Child age and specific areas of need or ‘triggers’ at the point of multidisciplinary support**

The surveys combined suggest children might have been referred for MD support at any point from aged 1 to 18 plus but mostly aged 3 to 10 years (the retrospective survey suggests an average child age of 5 years). Case file analysis suggests frequently overlapping areas of need were:

- **Child aggressive or disruptive behaviour at home** including towards siblings as well as parents (13/30).
- **Concerns about the child’s behaviour** in nursery or school including aggression, controlling other children, emotional dysregulation in a classroom setting (13/30).
- **Child or young person being at risk of exclusion or not attending** an educational setting (10/30).
- **Parent concerns about a child’s development**, particularly developmental or cognitive delay or speech and language issues (10/30).
- **Child with underdeveloped sensorimotor systems** (8/30).
- **Physical coordination issues or physical disabilities** (8/30).
- **Early placement concerns** resulting from known child exposure to abuse or neglect, drugs or alcohol in utero and/or numerous placement moves before adoption (6/30).
- **Parents under extreme stress and with mental health concerns** (6/30).

Other less frequently presenting issues included:

- Toileting issues (4).
- Child questioning their life story or wanting to make independent contact with their birth family (3).
- Child with internalising mental health needs including lack of self-esteem, (separation) anxiety or excessive withdrawal / mutism (5).
- Specific child or adult safeguarding concerns (2).

Child aggressive behaviour was the most frequently described trigger by parents in interview:

So I mean, in the very early days, I experienced quite a significant amount of violence. We don't have that now ...that has lessened [after MD support]...It was several times a day in the first year... Yeah, destroy the house, you know. Hit me, kick me, threaten me with knives... Regular outbursts in terms of temper (Parent)

Many parents reported in interview feeling overwhelmed and having reached a point of crisis by the time of referral for MD support.

...we've reached desperation of how do we manage? (Parent)

There were times before we saw the MDT, we didn't feel this, but I think the professionals around us felt that there was a risk of the placement breaking down because it was such a, such a hard slog (Parent)

Data from the longitudinal survey²² (n=22) suggests some children requiring MD support from early adopter sites already had a diagnosis of one or more of the following: ASD (4); ADHD (3); FASD (1/22); an attachment disorder (3); or another diagnosis (3). Others (also) had a suspected i.e. not yet confirmed diagnosis for the same conditions. Other characteristics of children represented in the longitudinal survey included:

- Educational challenges including: difficulties with cognitive functioning, memory or concentration (8/22); difficulties with emotional regulation (7/22); difficulties with social functioning or communication (5/22); specific learning difficulties i.e. dyslexia or dyspraxia (2/22). About half the longitudinal survey respondents considered that their child's educational setting understood these needs 'somewhat'. About one quarter considered the educational setting understood the needs 'completely'.
- EHCP (6/22) or other educational support plan (6/22) in place.
- 3/22 of the children had been excluded from educational setting(s).

4.1.4. The process of seeking help

Over two thirds (17/22) parents responding to the longitudinal (baseline) survey considered it had been quite or very difficult to get the right help (9/22 very difficult) before accessing MD support. Some parents further described in their free text responses how these difficulties had related in part to navigating the whole system of support and in part to having to wait a long time for (other whole-system) supports.

Analysis of children's adoption support case files suggests, in early adopter sites, most families had also received previous supports from their RAA or VAA, including mostly:

- Universal or Early Help such as training, resources, peer support (groups), helplines, newsletters, playgroups, life story workshops, help to liaise with schools.
- Adoption support assessments leading to applications for ASGSF-funded support were sometimes but not always perceived to have been helpful by and for the families concerned.

In about two thirds of these cases, other agencies had also been involved, particularly:

²² This question was not posed in the retrospective survey, to cut down on length.

- Community Health Services including Occupational Therapy, Speech and Language; Therapy, Community Paediatrics, Disability Services or Neuro-Developmental Pathways. In some cases, children had been or were on waiting lists for these services and in some cases had received support.
- Educational Supports provided by school SENCO, Local Authority Inclusion Services or school-requested Educational Psychology Services.

Other agencies involved to a lesser extent were: private neuro-developmental diagnostic services, private counselling or therapy services for young people, local authority early help services; police and youth justice services, voluntary sector support including for young people. In only one case had statutory CAMHS been involved prior to the MD support²³. In a small number of cases, families were involved with multiple agencies at the point of accessing MD support for example, in one case, over 10 services were involved.

Whilst some parents had received MD support in the early stages of an adoption journey (because their child's needs at placement suggested this would be helpful), many others described having previously tried other supports (that had failed to help), particularly ASGSF funded therapies or specialist assessments.

...for about three years, having the intense therapy that just wasn't going anywhere at all (Parent)

... prior to this [MDT], we'd reached out for support, but the support that we'd got was just literally put out there as therapy, uh, he needs therapy... It was just a social worker who came to the house, spoke to us, and that was the outcome. And our choice then was, do you want music therapy? Creative therapy? Um, you know, just different types of therapy. And we went for music because he is quite musical... but he never actually engaged in it. So, it seemed like a waste of time (Parent)

Others had (also) tried but been unable to obtain other supports from:

- **health services** – particularly CAMHS or health diagnostic pathways, and
- to a lesser extent, **schools or education** services – particularly Educational Psychology or via the Pupil Premium Plus.

Different agencies pass off to adoption support if you've got an adoptive child ... Everyone passes off to adoption support... everyone just thinks that adoption support, oh the miracle workers, ...will solve every problem for adopted children (Parent)

²³ It was not possible to ascertain, from the case files, the extent to which children had been on CAMHS waiting lists prior to accessing MD support.

4.1.5. Family involvement in the multidisciplinary support process

Some parents experienced MD support at arms' length i.e. they were aware of a MD consultation involving their social worker but were not involved directly.

So [the] social worker [was] then ...going back to the multidisciplinary team, discussing our case and then coming forward with other suggestions... she sort of mentioned that she would collect the information...She'd go away and see what was the right outcome for us, you know, the right support. And then that would then need to be approved...so there was a sense of... further discussions behind the scenes (Parent)

Of these parents, some would have welcomed a more direct involvement. Others did not mind.

I know they had MDT meetings where they discussed what the findings were and what the needs were and what should be done next, but I felt like [social worker] navigated the process for us, if you will. I didn't feel like the onus was on me, I felt like the team did the navigating, you know, in, of course, consultation with us. But, you know, it didn't feel difficult on my side...I definitely had a sense of the team around the child working in the background (Parent)

4.2. Professional perspectives

Professional interviewees were asked to describe the circumstances in which or why MD support was needed. Key themes from their responses were:

- **Children and families with multiple or complex needs** need different angles or 'lenses' to sufficiently understand and support them.

Children who have got complex needs, whatever that means..., sometimes this is families that have been in therapy for years and it's just not shifting, and just kind of coming in and looking at things from a slightly different perspective and kind of peeling things back a little bit...I'm just thinking about the children and young people for whom...the MDT, undertake an assessment, whether that's a capacity assessment or some of the neurodivergence [screening] assessments (Service Manager)

Some service managers and MD team members hypothesised that adoptive family needs were becoming more complex than before, including because of the increased complexity within adopters themselves:

...there seems to be more complexity within the families that we're placing these children with... adults who have, you know, neurodevelopmental conditions and who maybe have complex issues in their lives and then we're bringing them together maybe with children who have complexities too. So, I guess again, that's maybe an area where the multidisciplinary team can be helpful to kind of have that holistic look at a family's

needs, not just be thinking about a child, but thinking about the network as well (MD Professional)

...helpful with adopters who have trauma in their background as well... Sometimes one of the main things is the taking the time spent really with the therapeutic social worker or the psychologist, taking them back through that and understanding why they might be responding to the child in the way that they are... I don't know whether COVID had anything to do with it, but it feels like the applications that ...we're seeing [have] a lot more applicants who may have needed to seek help themselves for mental health related issues that have happened (Service Manager)

- **Families in crisis** also need more holistic as well as intensive support from experienced, psychologically informed and trained professionals.

I think when we've had cases where one of the psychologists has been able to offer sessions with parents, that's been something that's kind of rescued a few placements that probably would have disrupted actually. And they would say that if they were here, they would say that that psychologist saved [them] from disruption (Service Manager)

- **To support potentially difficult transitions for children including into adoptive families.**

So, it's incredibly helpful, particularly prior to match where we have a family and a child or children, where we have... levels of vulnerability and we want to make sure that the support plan that's around that match and ... those transitions and the placement is robust. It's really helpful for staff to have that consultation with MDT to make sure that they've thought everything through that they need to think through and get any further ideas (Service Manager)

- **Because education is still such an issue for many adopted children** and is difficult to navigate.

I think there's a whole piece around navigating the education system, which is really challenging and difficult... [comes up] time and time again with every adopted person and family I deal with. Education system, understanding adopted children in a classroom... I know of an adopter who doesn't know what the virtual school is, right? And the fact that the virtual school has got some accountability for sorting stuff out for you or helping you (Virtual Schools Representative)

5. What multidisciplinary support was experienced?

This section outlines the one or more multidisciplinary supports parents participating in surveys or interviews described experiencing (5.1.) Data from case file analysis and interviews with RAA leaders and practitioners revealed a similar pattern. We also outline the additional support or ‘scaffolding’ typically provided for the team around a child and family, as described by professionals in interview (5.2.).

5.1. What support was experienced by families?

- **Multidisciplinary consultation, assessment and formulation activities relating to the child.** This was the most frequently identified MD ‘intervention’ by parents completing either a retrospective (55/95 or 58%) or longitudinal (14/20 or 70%) survey. In 35/95 (37%) retrospective and 8/20 (40%) longitudinal responses families had (also) been aware of a social worker only consultation with onward advice to parents.

Interviews with parents and professionals also revealed that a key element of the multidisciplinary contribution was aiming to better understand their child and family needs before proceeding with matching, early support or a post-Adoption Order intervention(s).

So, they did a very thorough assessment and they checked [child] cognition and lots of other things and they said no, [child has] got average intelligence...scored really high in problem solving and logistics... And then from there they then made some suggestions for school. One of the teachers at school really sort of took that on board and ran with that...pushed [child] out of [their] comfort zone...now thriving and achieving and dreaming and planning for the future... just a different person, you know? (Parent)

So, they came here, met with me, had discussions... observations in school... So, within this we had...psychologist, psychiatrist and ed psych... they were looking at getting a holistic view, so this is what [child is] like at home. This is what [they're] like at school. What are the underlying issues that are causing these things?...Is it neurological? Is it behavioural? Is it sensory? (Parent)

We request those [consultations] for when we're perhaps a little bit stuck with a family in terms of... We've maybe got a plan that doesn't seem to be working anymore, and it's helpful to have a consultation and formulation... helps unpick ...you know, where things are at. Families are generally involved ...as well, so it's a help, and if there's an external therapist involved, they're quite often brought in and involved as well (Service Manager)

If workers are just kind of wanting to just have a little bit of a professional-to-professional think, they can book a time and space with somebody from the MDT just to kind of, you know, run their thoughts. 'I'm thinking, there's this going on? I'm kind of thinking this

type of therapy, do you think that might be, you know, is that what you're thinking, sort of thing?' (Service Manager)

In 25/30 (83%) case files examined by the evaluation team, families had received a form of consultation, assessment or formulation. These could be broken down as follows:

Brief or single professional consultations that could be led by any member of the MDT and sometimes involved family members, at other times were for social workers only. Sometimes, these consultations were also underpinned by earlier observations of the child (in nursery or school settings).

Full consultations, often underpinned by a written holistic assessment and formulation and usually led by a consultant psychologist but sometimes a therapeutic social worker, educational psychologist or occupational therapist. They involved between 2 and 4 members of the multidisciplinary team as well as parents and their social workers in almost all cases. Sometimes schools and/or adoptees were also involved.

Holistic MD assessments often including child observation (in nursery or school), a series of family consultations and multidisciplinary assessment and formulation leading to a detailed plan for the family. Sometimes this assessment was a 'specialist assessment' as recognised by the ASGSF.

- **Child observation**, at home and in school, often as part of an overall assessment or formulation of the child's needs. This element was not specifically explored in the surveys. However, in interviews, it emerged as a key theme (activity) noticed by many parents of younger children.

And she [educationalist] went in to observe [child] for an hour, saw lots of stuff. And was able to write a report, which can now go to nursery, but also can go to school, which is incredibly valuable (Parent)

- **Initial screening or signposting for diagnoses such as ASD or ADHD or FASD** and, where appropriate, supporting onward referrals into Health diagnostic pathways including 'right to choose'; or **cognitive assessments** to explore potential learning difficulties or disabilities.

In the first follow up longitudinal survey, about one third (6/20) parents described having experienced screening activities but only 9/95 (9%) of parents responding to the retrospective survey, although the question was phrased slightly differently between each survey and more parents responded in the free text relating to 'other' that they had received a cognitive assessment for their child. The case file analysis

revealed that a MD intervention for at least 6/30 or one fifth of families included either a cognitive assessment or screening for ADHD or ASD. In some other cases, parents had obtained a diagnosis via a private assessment, or the child had already been assessed as having neurodevelopmental difference(s) by statutory services.

- **Advisory support for educational settings and for child transitions** including into nursery, between nursery and primary school, into secondary education or into college and 'into' birth family contact.

35/95 (37%) of parents responding to the retrospective survey and 7/20 (35%) parents responding to a longitudinal survey described this as being a key element of the MD intervention they had received or were receiving.

Similarly, for two thirds (20/30) of the case file cohort, support and advice had been provided to a child's nursery or school setting, often after a family-attended consultation. The support might include:

- Advice to nurseries or primary schools regarding trauma and attachment-related responses from children or endings / transitions (and how to support these).
- Child observations in nursery/school and subsequent advice to staff, for example about how to support a child's emotional regulation or sensory needs.
- Advice to primary and secondary schools about managing transitions.
- Whole nursery/school training about the likely needs of adopted children, including with reference to trauma, attachment, sensory needs, transitions and/or their likely in utero experiences.
- Advice following a specialist, sensory or cognitive assessment.

In interview, parents described how this form of support was also useful for them in improving home/school communications.

So, when ...[child] transitioned from nursery to primary school, we asked [therapeutic social worker] to come and do some observations and to support us and help us with that transition. And she had a load of things in her toolkit that we might never have thought about where she was saying to the school or telling us to ask the school. 'Get some pictures of the classroom, get some pictures of the teacher, so you can talk about it at home'. So, there was a load of stuff that we did over and above to prepare [child] to be ready for school, so [child] wasn't in an uncomfortable environment (Parent)

- **Follow-on or inter-woven direct work.** Parent interviews and case file analysis, also free text comments in the surveys, revealed how many families also received a form of direct support, usually after but sometimes alongside an assessment / formulation / consultation stage, including:
 - **Therapeutic parenting (group-based or 1:1) support.** Whilst some parents in interview had undertaken similar courses in the past, they often reflected on the ongoing value as "a muscle that you need to keep on training"

or because of a realisation “*that you had to be with your child and [then] understand it much more*”.

- **Therapies involving the child and family** including:
Dyadic Developmental Psychotherapy (DDP).
Family-based systemic therapy.
Therapeutic life story work.
Theraplay (group or 1:1 involving parents).
Non-violent resistance (NVR) or Therapeutic Crisis Intervention (TCI).
- **Child-focused therapies** including: group-based or 1:1 sensory-focused interventions, mostly BUSS (Building Underdeveloped Sensorimotor Systems), art or play therapies. Most direct 1:1 therapies for children and young people were commissioned rather than internally provided.
- **Child or young person-friendly spaces for young people to share concerns.**

5.2. What else was experienced by professionals?

RAA leaders and adoption support or family findings service managers also recognised the contributions of MD support for the work they undertook with adopted families, including:

- **Training for social workers.**
We have ...quarterly development days for both of our family finding...and recruitment and assessment colleagues. And the [MDT] has been a huge part in providing relevant training or talking about areas of practise that we think ... would be really, really helpful...So an example would be they recently came along and delivered a session on what you need to think about when you are either assessing adopters for siblings or placing siblings with adoptive parents. They've also done a session on neurodiversity and what we need to think about as a service in relation to that (Service Manager)
- **Training for adopters.**
The MDT are involved in aspects of our training for adopters. They also deliver the regular webinars on foetal alcohol spectrum disorders. Which, I mean... entirely appreciative of because it used to be me delivering that and now I don't have to. So, it's amazing and they do a far better job than I would (Service Manager)
- **Co-delivery of group-based therapies**, for example BUSS or Therapeutic Parenting Programmes.
[My staff] are all linked in with the MDT in different ways, some involved in delivery of ...core offer of groups that are led and supervised by the MDT (Service Manager)
- **Group-based or 1:1 clinical supervision of social workers** undertaking direct work with families or to support social workers at times of difficulty.
MDT provide clinical supervision for adoption support workers and managers...For a couple of years before we got it in place, we were saying that that was kind of essential ...just because of the kind of secondary impacts of working with families in trauma and crisis ...So each of the teams...have group clinical supervision and then the adoption support team managers will come together as a team to have their own clinical supervision (Service Manager)

- **Strategic work – to develop or help unblock onward pathways** for children and families.

They've also kind of done some work with Health in kind of unblocking some pathways...we've [now] kind of got a better working relationship and understanding of the pathway... CAMHS understanding us and us understanding CAMHS a little bit more ...and that's down to the work that the clinical psychologist in the MDT...has kind of done...for us (Service Manager)

6. What were the attributes of good quality multidisciplinary support?

So, to have the MDT and to actually speak to people that can actually help you with your child, it is just amazing (Parent)

This section outlines parent survey overall ratings of MD support received (6.1.) followed by parent and professional perspectives about the key qualities of MD support (6.2. & 6.3.) It concludes with an analysis of the quality of MD assessments, formulations and consultations, drawing on evidence from case file analysis and parent interviews (6.4.)

6.1. Overall parent ratings

Parents responding to a retrospective survey were asked to rate their overall experience of MD support where 1 was 'very poor' and 10 was 'excellent'. **The mean (average) score was 7.3 out of 10, and the mode (most frequent) score was 10 out of 10.** Less positive scores were associated with parents having to wait for initial RAA/MD or follow-on support, either from the ASGSF or from a partner agency such as CAMHS.

It has been a struggle to request further support / assessments, we are still waiting for funding after 5 months

Whilst I can't fault the initial help and assistance, I feel we've been left to go it alone with the next stage whilst pursuing CAMHS for medications

Almost three quarters (70/95) parents responding to the retrospective survey stated they were likely or extremely likely to recommend the support to other adoptive families. In their free text comments, parents explained more about why they would recommend the service, including because it been helpful to their child and family, or because they felt it should be available to all families.

6.2. Key overall qualities from the perspectives of parents

Four key themes about the key qualities of multidisciplinary support emerged from parental contributions to this evaluation (through surveys, interviews and their responses to support recorded on case files).

1. Timeliness:

Timeliness (or lack of it) particularly in terms of MD support commencing was a key theme in both surveys. Just over one half of parents completing a longitudinal survey (12/20) and about two thirds of those completing a retrospective survey (66/95) agreed or strongly agreed the MD input had been provided in a timely way. Some parents thought the support had been too slow to start, that they had waited too long for it.

The case file analysis also revealed variation in early adopter site responses to requests for MD support. Families in this cohort had received a form of MD support from within one day to 120+ days of a request. However, in about one half of cases (16/30), the wait for actual support was up to one month and in about one third between one and two months (9/30). In five cases, the wait was for a much longer period (80 – 120+ days). Generally, interventions involving a single practitioner (for example education or early years adviser) providing consultation or access to group-based supports (such as therapeutic parenting programmes, or BUSS) were associated with relatively short waiting times i.e. 1 to 28 days. Medium waiting times (1-2 months) were associated with organising and providing direct support to or observations of the child in school or nursery settings or organising and providing full and formal (whole MDT) consultations. Longer waiting times were associated with full and formal consultations informed by holistic or specialist assessments and specific child therapies. It is possible that other informal supports were provided (for example early telephone contact) but not noted on the files.

Parents interviewed for the evaluation valued timeliness highly, for example because they had put off accessing or been unable to access other forms of support before reaching a crisis, or because accessing MD support at an earlier stage had helped with imminent transitions e.g. into placement, into nursery, into a new school.

Yeah, I'd say, yeah, that was about... 4 to 5 weeks... I expected... to have to wait longer ... I don't know if [child] was rushed because of his needs. I don't know whether they genuinely had a vacancy, because it seemed... quite quick, which is brilliant (Parent)

On the few occasions where parents felt they had waited too long for MD support (after other interventions had been tried and failed or in a crisis) this was interpreted as having had or potentially having negative effects. In some circumstances the 'wait' had been for adoption support more generally, rather than specifically for the MD element.

Can you please get to it quickly? Because ... when you go to them, you're in crisis... I was chasing, chasing, chasing... I'm in crisis and I need something to happen now! Not in six months.... It's hard to be empathetic to the system when you're drowning (Parent)

2. Being and feeling heard:

A theme from parents' positive (free text) responses to the retrospective survey suggest they frequently valued being and feeling heard.

We felt everyone recognised and understood our needs. We felt listened to. The support was exactly what we needed (Parent)

Having someone understand children like mine and listen to my needs and tell me that I'm doing a great job (Parent)

Parents in interview frequently described valuing an empathetic, listening and encouraging response. This was important sometimes to counter feelings of shame or confusion.

I really felt heard at the multidisciplinary team meeting like I really felt from that really positive (Parent)

So, the first degree of support that the MDT gave us was a feeling of being listened to, was a feeling of not having to repeat ourselves every time we spoke to people... even though it was online, it felt that we weren't being gas lighted, we were being listened to as parents, so even just from that perspective, it was great (Parent)

Not feeling heard or understood from an early stage risked parent defensiveness or withdrawal of trust.

3. Holistic:

78% (74/95) parents responding to the retrospective survey agreed that it had been helpful to receive support from a team comprising different types of professionals (8% or 8/95 disagreed and 14% or 13/95 were not sure). A similar proportion (14/20) parents completing a longitudinal agreed or strongly agreed the MD input explored all their / their child's relevant needs.

In their 'free text' responses, parents said more about how and why it was helpful and a key theme from these responses was that having a range of professionals' views was akin to looking at their child and family through different 'lenses' or with 'joined up thinking' in order to identify all the relevant factors and solutions.

I had many concerns on different aspects of my [child's] development such as sensory needs, cognitive needs and attachment so was important to address all of them at the same time (Parent)

Speedy access to holistic therapies offered by or through a MD support service was also valued, including mostly to NVR, BUSS, Theraplay or specific educational supports.

Help from different professionals and all kept in one place (Parent)

The longitudinal survey responses also suggested many i.e. three quarters parents (15/20) considered the multidisciplinary ‘team’ were working well together so that parents did not have to keep repeating their story. In interview, many parents also described the value of having to tell their story only once but at the same time benefitting from more than one professional’s view or ‘eyes’ on their child and family – to better understand the needs and to formulate better plans to improve their child and family outcomes.

...because everyone was there, we just told the story once to the dozen people that were on the call. Rather than what we’d sort of got into the habit was we’d meet a new person and we’d have to tell them everything for an hour and go through our own trauma of saying how rubbish it all was and all the rest of it (Parent)

4. **Feeling held**, that concerns were shared and being jointly supported, that parents were not alone in holding these.

Parents in interview frequently described feeling ‘held’ as a key strength of their MD input.

I guess I felt like I had some back-up, someone who had our backs, and we weren't navigating it all completely by ourselves... And it felt kind of a bit of a relief not to be holding it all ourselves initially, because it felt like, okay, we've got some support now (Parent)

6.3. Key overall qualities from the perspectives of professionals

Professionals of all types identified very similar qualities of MD support to parents.

- **Timeliness of MD support** (including in comparison with both statutory health and ASGSF-funded support)
...it means that families are getting the support in a much more timely way which is, you know, absolutely what everyone wants (Service Manager)
- **Multiple perspectives or ‘lenses’ and professional curiosity to explore these.**
Yeah well, I think the clue's in the name, isn't it? It needs to be multidisciplinary. because what you always observe is that people see things through their own lenses. So, if you're a psychotherapist, you know, you've got a particular lens through which you view situations and you're more likely to attribute what you see to, you know, your discipline and what you understand. Whereas if you're an occupational therapist, you've got a slightly different lens that you'll be looking at a situation through...so it's so helpful just to have those different lenses together to lots of heads around one problem, really, which is probably the most useful thing about the MDT (Service Manager)

It's bringing a different lens into a very social work heavy system really... what's our understanding of that child's particular needs from ... a developmental trauma or a...neurodevelopmental position that might enable us to kind of communicate ...why they might be so difficult to parent (MD Team Member)

- **The quality of professional advice**, involving people who can speak authoritatively, who can manage complexity across a whole family and recommend, sometimes provide, boundaried interventions that are evidence based but avoid dependency.

...that's absolutely key because, as social workers...it gives us... just an extra voice to say what we know... But to have a psychologist as well saying that,... it makes our point more emphasized I guess (Service Manager)

So they're really boundaried and you feel that, you know, they are working with the family for that period of time, but then they know when to step back and they know when to pause and not create dependency, for example, with a family (Social Worker)

Some MD team members reflected on how this felt qualitatively different to other including statutory supports that, whilst having some of the key clinical or educational specialist knowledge, failed to understand the care experienced child or have the right skills to work with some, for example, younger children – as well as lacking in capacity to undertake the work.

Our CAMHS colleagues don't necessarily see children who've experienced loss and separation for their birth family...“Oh, you're adopted, back you [go] off to [RAA MDT support], we're not going to touch you because that's not our bag” (MD Team Member)

- **Strengths-based values and practice.** MD professionals valued approaches that encouraged and supported families to find their own solutions.
We're very strengths based. We're looking at what works. How can we do more of that? What can we do to support? (MD Team Member)
- **Able to speak the language of Health or Education.** MD professionals and RAA social workers also valued the importance of being able to speak the language of and understand the context for health and education services – to support effective child pathways through these services.

It's a different language in schools, you know, and I really...don't know how social workers are expected to challenge or, you know, advocate for families (MDT Member)

6.4. The quality of multidisciplinary assessments, formulations and consultations

With regards MD assessments and formulations, the evaluation team reviewed the available data on case files with reference to summary national quality standards and principles (Johnstone & Dallos, 2006; The British Psychological Society, 2011):

Holistic – considering different perspectives	Well evidenced, including family member as well as MD professional / broader team around the family views and perspectives.
Explores potential causal factors, presentations or hypotheses (biological, psychological and systemic or social) in relation to presenting issues and how they may relate to one another	Well evidenced, a biopsychosocial approach often generating fresh insights into the causes of a child's difficulties e.g. family trauma, transitions history, neurodiversity, attachment, motor or sensory needs, peer and family relationships / dynamics, development & cognition, physical (including sleep or feeding) history. Drawing on existing evidence and collecting fresh evidence where appropriate.
Including predisposing, precipitating (trigger), protective and perpetuating factors (keeping the issues going)	Well-evidenced across all these types of factors including in utero and transition(al) factors.
Provides a summary foundation for evidence-informed action (planning)	Mostly evidenced, including well matched, sometimes phased planning and articulation of the follow-on support that was required i.e. signposting, further assessment or support services. However, direct support proposed for young people was not always well matched or available, particularly as an alternative to 1:1 therapy.
Is open to revision and review	Mostly evidenced. Most plans were implemented in a timely way in line with MD recommendations. Delays in implementing plans were largely a result of waiting lists for more specialist assessments or ASGSF-funded support. Reviews were undertaken but not observed in every case.

With regards consultation, the case file analysis suggested that, when involving multiple MDT members, these were holistic, discussed a range of causal factors and led to new insights and recommendations. The limitations of 'standalone' consultations (i.e. those undertaken without a full underpinning assessment and formulation), particularly those

undertaken by single members of the MDT, were that they sometimes missed important factors (e.g. parent-factors or potential diagnoses) that were revealed later through ongoing intervention.

All consultation and assessment / formulation work was additionally noted by researchers reviewing the case files to be highly strengths-based and empathetic.

That is the best support that I've had. Compared to last time, it's just a million times better. I felt supported this time. I felt genuinely like they really understood and they wanted to help (Parent)

...the MDT was sort of the first people who were like, "Yeah, you're right, this is different and, yes, tell us all these things 'cos we'll be the people who help you navigate what's a normal developmental stage, what's not right, what you need an intervention for" (Parent)

In interview, parents articulated the following key qualities of consultation activity involving them (sometimes underpinned by an assessment / formulation), specifically:

- **Being made to feel welcome and reassured** (in the context sometimes of a lot of professionals also in the room) including not too formal. Attention to potential power imbalances.
- **Being included and treated as an expert by experience.**
- **Having an open conversation**, with no assumptions made initially and nothing 'off the table'.
- **Involving the key professionals who are relevant to the discussion** who 'know what they're talking about', asking good questions (curious) and proposing possible underlying causes or solutions.
- **Consideration of multiple rather than single possible causes** of issues or difficulties.
- **Following up with the development of a tailored plan** either in the meeting or soon thereafter. Undertaking and sharing this with parents. Giving parents permission to make some decisions themselves.
- **Parents being able to ask follow-on questions or have a 'review' consultation** at a later stage.

However, some interview parents wished the consultations had involved them to a greater extent, particularly where all or most conversations had happened without their presence. Alternatively, some parents participating in the retrospective survey and/or an interview could not remember having received a summary of the discussion or plan or would have liked a closer link between the discussion and further support.

It felt like we had positive suggestions from the MDT meeting but it took a very long time to be followed through and then was of little benefit (retrospective survey parent)

7. What were the observed benefits of multidisciplinary support?

This section explores the observed benefits or potential benefits with reference to findings from: site-collected standardised outcome measures and broader, mostly feedback, data from parents and professionals (sections 7.1. and 7.2.); retrospective and longitudinal surveys completed by parents for the evaluation (7.3 and 7.4.); case file analysis (7.5.); and interviews with parents and professionals (7.6 and 7.7).

7.1. Findings from site-collected standardised outcome measures

7.1.1. Thinking About Your Child Revised (TAYC-R)

In total, the evaluation team received pre- and post-TAYC-R scores for 86 families. Broadly, the types of input sites reported having provided were as follows:

- Combinations of initial assessment/consultations with MDT and tailored intervention from the MDT such as parent or family DDP-informed sessions, occupational therapist-led (sensory) support.
- Specific standalone interventions such as Foundations for Attachment group training, DDP-informed family therapy or (therapeutic) life story work.
- School observation, advice and support plans shared with schools (including specifically around suspected or diagnosed FASD).

Table 4 below presents the mean scores at pre- and post-intervention, as well as the mean change scores. Higher scores in the total score and subscales suggest better relational health within the parent-child relationship.

Table 4: MDT site provided TAYC-R pre-intervention and post-intervention scores: mean, median, range values and standard deviation (SD) (n=86)

		Pre-intervention	Post-intervention	Change
Total Score [out of 55]	Mean	37.9	43.6	+5.6
	Median	38	44	+4.5
	Range	19 to 55	28 to 55	-9 to +23
	SD	6.5	6.0	6.8
	Mean	12.8	15.4	+2.7
	Median	13	15	+3

		Pre-intervention	Post-intervention	Change
Parent Skills and Understanding [out of 20]	Range	4 to 20	10 to 20	-6 to +10
	SD	2.6	2.2	2.9
Parent Child Relationship [out of 15]	Mean	11.1	12.4	+1.3
	Median	11	13	+1
	Range	5 to 15	6 to 15	-3 to +8
	SD	2.1	1.9	2.3
Child Responsiveness to Care [out of 15]	Mean	10.4	11.3	+0.9
	Median	10.5	11	+1
	Range	4 to 15	5 to 15	-3 to +6
	SD	2.2	2.2	1.9
Placement Stability [out of 5]	Mean	4.1	4.4	+0.3
	Median	4	5	+0
	Range	2 to 5	3 to 5	-2 to +2
	SD	0.9	0.7	0.9

The data in Table 4 shows a mean increase (improvement) across all the subscales of the TAYC-R, from pre to post intervention, particularly in Parent Skills and Understanding (mean increase of 2.7), and in Total Score (mean increase of 5.6).

Normality testing of the change values for Total Score showed these were not normally distributed, $W(86) = 0.951$, $p = 0.002$. Therefore, Wilcoxon Signed-Rank Tests were undertaken on the Total Score and the four subscales. This showed that there were significant differences in the median changes (indicating improvement) from pre to post-intervention all of the subscales and Total Score: Total Score ($z = -6.342$, $p < 0.001$); Parent Skills and Understanding ($z = -6.510$, $p < 0.001$); Parent-Child Relationship ($z = -4.683$, $p < 0.001$); Child Responsiveness to Care ($z = -3.911$, $p < 0.001$) and Stability ($z = -3.346$, $p < 0.001$).

7.1.2. Goal-Based Outcomes (GBO)

In total, the evaluation team received a GBO score pre- and post-intervention for 141 families (Goal One) and for a second goal (Goal Two) for 138 families. Broadly, the types of input the MDTs reported having provided were as follows:

- Combinations of initial assessment/consultations with MDT and tailored intervention from the MDT, such as parent or family DDP-informed sessions.
- Specific standalone interventions such as Foundations for Attachment/Therapeutic Parenting or Theraplay group training, BUSS intervention (in a group or 1:1), individual DDP-informed family therapy or life story work.

Table 5 displays the mean pre- and post-intervention scores for Goal 1 and Goal 2 (scored out of 10, where 10 indicates full goal achievement).

Table 5: MDT site provided Goal-Based Outcomes (GBO) including pre- and post-intervention scores: mean, median, range values and standard deviation (SD)

		Pre-intervention	Post-intervention	Change
		Mean, <i>median</i> (range) [SD]	Mean, <i>median</i> (range) [SD]	Mean, <i>median</i> (range) [SD]
Goal One n=148	Mean	4.1	7.1	+3.0
	Median	4	8	+3
	Range	0 to 10	0 to 10	-4 to +10
	SD	2.2	2.1	2.3
Goal Two n=145	Mean	4.0	7.1	+3.1
	Median	4	7	+3
	Range	0 to 9	0 to 10	-3 to +10
	SD	2.1	2.0	2.4

The GBO data in Table 5 shows that there were good improvements in ratings from pre to post intervention on both goals, with a mean increase of 3 (Goal One) and 3.1 (Goal Two). Research suggests that the ‘meaningful change’ level for Goal-Based Outcomes is over 2.45 (Edbrooke-Charles et al, 2015).

Normality testing of the change values for Goal One and Goal Two showed that the data was not normally distributed: Goal One ($W(148)=0.955$, $p<0.001$); Goal Two ($W(145)=0.971$,

$p=0.005$). Therefore, Wilcoxon Signed-Rank tests were undertaken, which showed that the median score changes from pre- to post-intervention for both Goal One and Goal Two were statistically significant, Goal One ($z=-9.663, p<0.001$) and Goal Two ($z=-9.610, p<0.001$).

7.1.3. Strengths and Difficulties Questionnaire or SDQ (parent report)

In total, the evaluation team received pre- and post-intervention SDQ scores for 61 families. These scores were shared (in different volumes) by five out of the nine MDTs. For all these families, the subscale scores and Total Difficulties score were provided, and for 41 families, the Impact scale was also completed.

Overall, MD support was reported by these sites to have comprised the following:

- Combinations of initial assessment/consultations with MDT and tailored intervention from the MDT, such as parent or family DDP-informed sessions, 1:1 psychology sessions with young person.
- Specific standalone support such as Foundations for Attachment/Therapeutic Parenting group training, school observation, advice and support plans shared with schools, (including specifically around suspected or diagnosed FASD).

The pre- and post-intervention mean scores and mean changes are shown in Table 6 below. Higher scores for Total Difficulties, and the subscales of Emotional problems, Conduct, Hyperactivity and Peer problems (all of which are scored out of 10), indicate more difficulties. For the subscale Prosocial, a higher score means that the child/young person shows more prosocial behaviours.

Table 6: MDT site provided SDQ pre- and post-intervention²⁴ (parent reported) scores: mean, median, range values and standard deviation (SD)

Score/subscale		Pre-intervention	Post-intervention	Change
Total difficulties [out of 40] n=61	Mean	21.0	18.2	-2.7
	Median	22	19	-2
	Range	7 to 36	4 to 35	-26 to +7
	SD	6.5	7.1	5.0
Emotional problems [out of 10] n=61	Mean	4.8	3.9	-0.9
	Median	5	4	-1

²⁴ Pre- and post-intervention refer to before and after MDT input which would have been substantial enough to warrant outcome measures being collected before and after (i.e. not from a one-off consultation or single conversation).

Score/subscale		Pre-intervention	Post-intervention	Change
	Range	0 to 10	0 to 10	-8 to +4
	SD	3.0	2.8	2.4
Conduct problems [out of 10] n=61	Mean	4.6	4.1	-0.5
	Median	5	3	0
	Range	0 to 10	0 to 10	-6 to +4
	SD	2.4	2.5	1.9
Hyperactivity [out of 10] n=61	Mean	7.8	7.0	-0.9
	Median	8	7	-1
	Range	2 to 10	1 to 10	-6 to +4
	SD	2.2	2.6	2.1
Peer problems [out of 10] n=61	Mean	3.5	3.2	-0.2
	Median	3	4	0
	Range	0 to 8	0 to 7	-4 to +5
	SD	2.1	2.0	1.5
Prosocial [out of 10] n=61	Mean	5.8	6.2	+0.4
	Median	6	6	0
	Range	1 to 10	1 to 10	-4 to +6
	SD	2.4	2.4	1.9
Impact [out of 10] n=41	Mean	4.6	4.0	-0.7
	Median	4	3	0
	Range	0 to 10	0 to 10	-8 to +7
	SD	2.9	3.4	3.3

Looking at the pre-intervention data, we can see there was a wide range in levels of need in terms of child/young person Total Difficulties, with scores ranging from 7 to 36. The mean Total Difficulties score of 21.0 would be classified as ‘Very High’ in the four-band categorization²⁵. The post-intervention and change mean values show small improvements in each subscale, with the most notable subscale improvements being in Emotional Problems and Hyperactivity. The reduction in Total Difficulties being -2.7 also reduces the cohort’s mean score from the ‘Very High’ band into the ‘High’ band.

Normality testing for the change values of Total Difficulties showed the data was not normally distributed $W(61)=0.886, p<0.001$. Therefore, a Wilcoxon Signed-Ranked Test was used for the pre- and post-scores, which showed there was a significant difference in the Total Difficulties medians pre- and post-intervention ($z=-3.979, p<0.001$). Exploratory analysis of the subscale changes found significant differences in a positive direction (reduction in score) in the medians for Emotional Problems ($z=-2.863, p=0.004$), Conduct ($z=-2.057, p=0.040$), and Hyperactivity ($z=-2.942, p=0.003$) but not for Peer Problems ($z=-1.226, p=0.220$) or Prosocial Score ($z=-0.973, p=0.331$).

7.2. Findings from secondary analysis of broader site collected data

7.2.1. Site collected data from parents

Non-standardised outcomes and feedback data collected directly from sites 1-5 have been collected in relation to parent or professional training programmes and also sometimes specialist assessments (site two), 1:1 support (site three), consultation / direct work (sites four and five) or work with schools (site five), as outlined in Table 7.

Table 7: Site generated family feedback data and illustrative quotations

Site	Quantitative Data	Illustrative quotations
One	Parent post-support survey (post-consultation or 1:1 intervention), (n=37) Extent to which session(s) addressed aims: <i>Fully: 32/37; Somewhat: 5/37</i> Overall rating of session(s): <i>Very good: 26/37; Good: 11/37</i>	<i>This has been just the right course, at just the right time for us. It has been brilliant having the time and space to think, reflect and enhance understanding</i>
	Parent post-training session feedback (n=110) Extent to which the MDT training addressed aims: <i>Fully: 75% Somewhat: 25%</i>	<i>All I can say is BUSS has been life changing for our little girl, our family and her relationships with friends at school</i> <i>Found the MDT members really listened and were keen to understand our child and family</i>

²⁵ SDQinfo.org scoring.

Site	Quantitative Data	Illustrative quotations
	Overall rating of MDT training: Very good: 64%; Good: 35% ; Neither good nor poor: 1% Foundations for Attachment post-group surveys, (n=18) Overall rating of training: Very good: 15/18; Good: 3/18	<i>The team were helpful, knowledgeable and able to give the language needed to have conversations with our children</i> <i>Support from [MDT member] has been excellent, she has given support to the family and support in school. The setting had training before, but it was [MDT member] input which really made the difference and helped to implement the approach to help our child</i>
Two	Specialist Assessment post-assessment feedback form (n=6) Recommendations from the Specialist Assessment were helpful- Certainly true: 4/6 Not true: 2/6 Overall, Specialist Assessment was good- Certainly true: 4/6 Partly true: 1/6 Not true: 1/6 Training for Parents' events feedback form (n=60) Overall rating 1 to 5 (where 5 is 'really good') 5: 62%; 4: 30%; 3: 8% Foundations for Attachment Parenting Programmes feedback forms (n=11) To what extent has it helped with relationship with child? (1-10, where 10 is 'very much'): 6/11 gave a score of '10'; 2/11 gave a score of '9'; and 2/11 gave a score of '7-8'; and 1/11 gave a score of '4'.	<i>The advice and support we received was incredible. Thoughtful, considered, well informed and practical. Our EP made time for us, attended some meetings with the school and was always caring, knowledgeable, positive and pragmatic in making suggestions to assist our son</i> <i>It was an extremely thorough, thoughtful, considered and beneficial process for us, our child and the whole family</i> <i>Overall, my experience was very positive, gave me an understanding of why my child behaves differently, and best ways of how I can help my child</i> <i>It has been instrumental in helping our family</i> <i>The service is exceptional and the team are genuinely caring and we felt supported throughout</i>
Three	Family satisfaction questionnaire (n=35) Do you feel the people in the team are working together to help you? Yes: 91% A little: 9% Were you views and worries taken seriously? Yes: 96% A little: 4% If a friend needed this help, should they come	<i>The work we have done with the therapist has been made a fundamental difference to our family life</i> <i>I feel that we now have a far greater understanding of our child's needs and why he behaves in a certain way and we feel better equipped now to help him</i>

Site	Quantitative Data	Illustrative quotations
	here? Yes: 100% Would you return to [MD Support] if needed? Yes: 100%	<i>The OT has provided us with a comprehensive assessment and a very useful sensory support plan. She also attended [child's] annual review and did a home visit. Her support has been invaluable!</i> <i>We are now more confident in advocating for our child with the school and in knowing what to do and say to help her at home now. It's been life changing. Thank you so much</i> <i>They helped us through some difficult situations, and they worked as a team and pooled their resources, to work out how best to support us</i>
Four	Feedback forms from families who accessed consultation/direct work (n=14) 10/14 agreed and 4/14 strongly agreed with the statement 'The input developed insights into the issue(s) shared'. 8/14 agreed strongly and 4/14 agreed with the statement 'The input provided lead to agreed actions which were clear, relevant and realistic'. 1/14 gave a 'neutral' response. 14/14 said they would recommend the MDT service.	<i>This was efficient and targeted support which was very welcome</i> <i>What a fantastic service! Our family is better because we had this involvement- thank you</i>
Five	Parent consultation feedback forms (n=50) Overall rating of the session(s): <i>Excellent: 70%; Good: 28%; Fair: 2%</i> 52% strongly agreed and 26% agreed with the statement 'The offer of support was relevant to my child's needs' (6% disagreed or strongly disagreed and 6% thought the question was N/A). Likelihood of recommending MDT services to another family (where 1 is not at all likely and 10 is highly likely)	<i>I feel it was very useful and a chance to all talk through the worries we had for the boys and how best to support them</i> <i>Fantastic, learned professionals, brilliant resources shared and valuable boost to confidence in being an advocate for our boy in education settings. Thank you so much!</i> <i>I feel empowered by the support I've received, and it has helped me to recognise the child's journey as well as identifying that my emotions and feelings also matter</i>

Site	Quantitative Data	Illustrative quotations
	66% gave a 10/10 score and 18% a 9/10 score. 16% gave an 8/10 score and 2% a 3/10 score. Whole School Approach parent feedback form (n=3) Would you as parents recommend the approach? Yes: 3/3 Are adopted pupils better supported as a result of the approach? Yes: 2/3 Somewhat: 1/3	<i>It was good to be reassured that certain things are going well and that some things just need times it was good meeting and very beneficial to hear all professional's points of view</i> <i>It has made an enormous difference. We now feel more valued for our input and how we can support school to support our son. It has hugely improved our relationship with school, which was in a very difficult position</i>

These findings complement those from standardised outcome measures and further evaluator-led data capture outlined below. They suggest mostly high to very high satisfaction levels with a range of MD supports and the way they were provided, including having worries taken seriously (site three) and willingness to return for support or recommend to others (sites three, four and five).

7.2.2. Site collected data from professionals

This data included feedback from social workers and other professionals about varied MD activities including mostly consultations (sites 1,2,3,4 and 7) or training (sites 1,3,4,5, 6 and 7) but also direct work with families (site 6); whole school activity (site 5) and overall (sites 5 and 7). As with the feedback from parents (in 7.2.1 above) this data suggests mostly strong satisfaction with a range of MD supports and activities and likely large improvements in professional knowledge and confidence levels in the short to medium term.

Table 8: Site generated professional feedback data and illustrative quotations

Site	Quantitative Data	Illustrative quotations
One	Professionals (RAA staff) post-consultation feedback forms (n=30) 20/30 responded ‘fully’ to the question ‘To what extent did the consultation address your reasons for attending?’ and 10/30 responded ‘somewhat’. 23/30 rated the consultation as ‘very good’; 5/30 rated it as ‘good’ and 2 as ‘neither good nor poor’. When asked about the extent to which their confidence in how to respond to the family/situation had increased, 7/30 reported the highest (5) increase and 13/30 reported a high (4) increase. 5/30 reported a medium (3) increase and 4/30 reported a low (1-2) increase. 1 gave an ‘N/A’ score. Professionals’ (RAA staff) MDT training feedback forms (n=37) To the question: ‘To what extent did the training address your reasons for attending?’ 36/37 responded ‘fully’ and 1/37 responded ‘somewhat’. To the question: ‘To what extent has your confidence in how to respond to families/situations increased?’ (1 to 5, where 5 is a high increase), 13/37 gave the highest response (5) and 17/37 a score of ‘4/5’. 3/37 gave a medium (3/5) response. 4 others gave an ‘N/A’ response.	<i>I found the training extremely beneficial. It was delivered exceptionally well, and I will take what I have learned with me throughout my teaching career</i> <i>It was really helpful to include all professionals, keeping things child focused and ensuring that there is a plan in place to support the family</i>
Two	Consultation feedback forms (n=25) Usefulness of consultation (1 to 6, 6= Very much) Mean rating: 5.7 out of 6 Confidence to take next steps after consultation (1 to 6, 6= Very confident) Mean rating: 5.5 out of 6 Professionals’ experience of service questionnaire (n=17) To the statement ‘I would recommend the	<i>Very often our families feel doors are closed to them and feel abandoned by the usual health services, but the [MD] service provides a wealth of trauma informed and attachment focused work that families feel is meaningful</i> <i>Waiting times for clinics could be quicker</i> <i>The discussion was communicated well, constructive and reflective, with professionals</i>

Site	Quantitative Data	Illustrative quotations
	MDT service to other professionals', 16/17 responded 'certainly true' and 1/17 'don't know'. To the statement 'Overall, the help was good', 16/17 responded 'certainly true' and 1/17 'partially true'.	<i>contributing role-specific insights that informed the support plan</i> <i>I came away smiling so reassured for this family that they will have what I would view as the 'gold standard' of multi-agency professionals to support them on this next stage of their journey</i> <i>Incredibly supportive and understanding of both the child's situation and our attempts so far to support them. Insightful and knowledgeable. Wealth of practical advice that took into account the context of a busy mainstream classroom and that could be implemented with minimum disruption</i>
Three	Professionals' consultation feedback forms (n=30) Confidence in supporting child/family after the consultation (1 to 10, 10=Very confident) Mean rating was 8.9 out of 10 Knowledge of issues brought after the consultation (1 to 10, 10=high) Mean rating was 9 out of 10 To the question 'Was the consultation a good use of your time?' 30/30 responded 'yes'. Training session feedback forms (n=35) Knowledge of topic before and after (1 to 6, 6 being very high) Mean pre: 3.4 Mean post: 4.9 To the statement 'I learnt something that will influence change in my work', 31/35 responded that they 'agree' or 'strongly agree'.	<i>For roughly the last 2 years Permanence Support Team have had to hold families who are in crisis whilst giving them the message that they will potentially have to wait for weeks to months for support.... It has felt so positive for them to be able to offer a service from a multidisciplinary part of the team without then having to quote long waiting times</i> <i>We are engaged as a school in trauma informed training and practices, and this training has enhanced my understanding of PACE that had only been briefly explored in the Trauma Informed training I have had so far</i> <i>We all were very inspired following the session with you and are continuing discussions as a team on how to move forward</i>
Four	Professional feedback form (RAA staff) post input from MDT e.g. training, consultation, joint planning (n=36)	<i>I found this session really beneficial; it was helpful to have a safe space to be able to reflect on how I was feeling. I was also</i>

Site	Quantitative Data	Illustrative quotations
	To the statement 'The input developed insights into the issue(s) shared', 27/36 strongly agreed and 8/36 agreed. 1 respondent was 'neutral'. To the statement 'The input provided led to agreed actions which were clear, relevant and realistic', 29/36 strongly agreed and 6/36 agreed. 1 respondent was 'neutral'. All 36/36 said that they would recommend the MDT service.	<i>provided with lots of resources which I will find really useful moving forward</i> <i>I wanted to feedback how incredibly helpful and supportive MDT are. I have had several cases now where we have worked together- they have responded quickly to my referral, with a creative, helpful and thorough intervention</i> <i>The trainers were very good- and was great to have an Ed Psych involved. Friendly and practical with good advice taken away</i> <i>Having these interventions clearly explained and explored will be very useful to all our families!</i>
Five	RAA staff survey (n=74) Rating of access to support/guidance (e.g. consultation, training supervision) in role- Very good: 42%; Somewhat good: 43%; Neither poor nor good: 14%; Somewhat poor: 1% One-off school training school staff survey (n=39) Confidence in understanding impact of trauma on brain development (1 to 10, 10=very high) Mean score pre: 5.8 Mean score post: 8.6 Whole School Approach school staff survey (n=7) To the question 'Since WSA, has recording/ sharing of adopted children's needs (trauma informed) developed?' 7/7 responded 'Yes'. To the question 'Have your expectations of the WSA been met?', 7/7 responded 'Yes'.	<i>The MDT Reflect, consultations, education and youth work are really making a difference for complex families who can access services quickly and otherwise would have struggled to speak to professionals such as speech and language, OT and clinical psychologists without any waiting list or cost</i> <i>I think the MDT has provided invaluable support to families</i> <i>It is good to feel as a professional you can consult and receive input from an MDT to help support your work with families</i> <i>Staff at [school] have developed a deeper understanding of attachment and the impact of trauma—particularly sensory memory—on adopted and previously looked-after children. Training has introduced new strategies that are being applied to support pupils more effectively, with a focus on individual needs and strengthening relationships with adoptive families</i>

Site	Quantitative Data	Illustrative quotations
Six (FASD focused)	FASD training feedback forms, from education, youth justice and children's social care professionals (n=33 training sessions) Knowledge of FASD (1 to 10, 10=high) Pre-training mean: 3.9 Post training mean: 7.8 Knowledge of strategies to support CYP with FASD Pre-training mean: 3.3 Post training mean: 8.1 Individual casework social worker feedback forms (n=18) 'The work has helped me understand how FASD could affect CYP' (1 to 5, 5= Strongly agree) Mean rating: 4.7 'School staff and I have confidence to act upon EPs' advice' (1 to 5, 5= Strongly agree) Mean rating: 4.4	<i>I think the FASD work has really helped schools to understand how to support students with FASD and I wish it was something that we could offer to families and schools on an ongoing basis</i> <i>This has been a really beneficial project that has helped families and professionals to develop their knowledge and feel supported Working with expert advice has been very beneficial to helping staff understand [child name]'s needs and how we can meet these as a school. Working together with other professionals and [child name]'s parent has ensured continuity in approaches and support offered</i> <i>Fantastic communication between all involved. Collaborative work to provide best support for [child's name] at home and school</i>
Seven (MD support embedded in the RAA)	Education professionals' webinar feedback forms (n=20) 'How helpful was the webinar?' (1 to 5, 5= very helpful) Mean rating: 4.5 out of 5 MDT Reflect Case Discussions RAA staff feedback forms (n=15) Confidence about next steps after session (1 to 5, 5=very confident) Mean rating: 3.8 out of 5 Overall rating of session (1 to 5, 5=excellent) Mean rating: 4.7 out of 5	<i>Having this opportunity to speak openly about dilemmas and bringing together our own skills and expertise is a great strength of the service</i> <i>I feel more confident in the direction of support in terms of not rushing further therapeutic interventions when there is evidence it isn't working. The MDT team helped validate the difficulties and challenges in working with the family</i> <i>I feel that I have been able to use the space to reflect on my worries and it felt very reassuring to have the team be able to empathise in the 'stuck' position that I felt I was in and the weight of the decisions that I was feeling</i> <i>I wish I'd had this information 2 years ago. Explains a lot of the things I experienced working with a family to get support</i>

7.2.3. Site collected data about family breakdown prevention

Sites were generally unable to generate data about the extent to which, through their work, they had been able to prevent family breakdown. However, in one early adopter site (site one), annual reports for 2023-24 and 2024-25 suggest around 30 referrals a year (approximately 50%) related to families on the brink of breakdown, with over 90% of these avoiding breakdown. Other sites have estimated between one fifth and 'many' families being at high to moderate risk of breakdown.

7.3. Findings from the retrospective survey of parents (n=95)

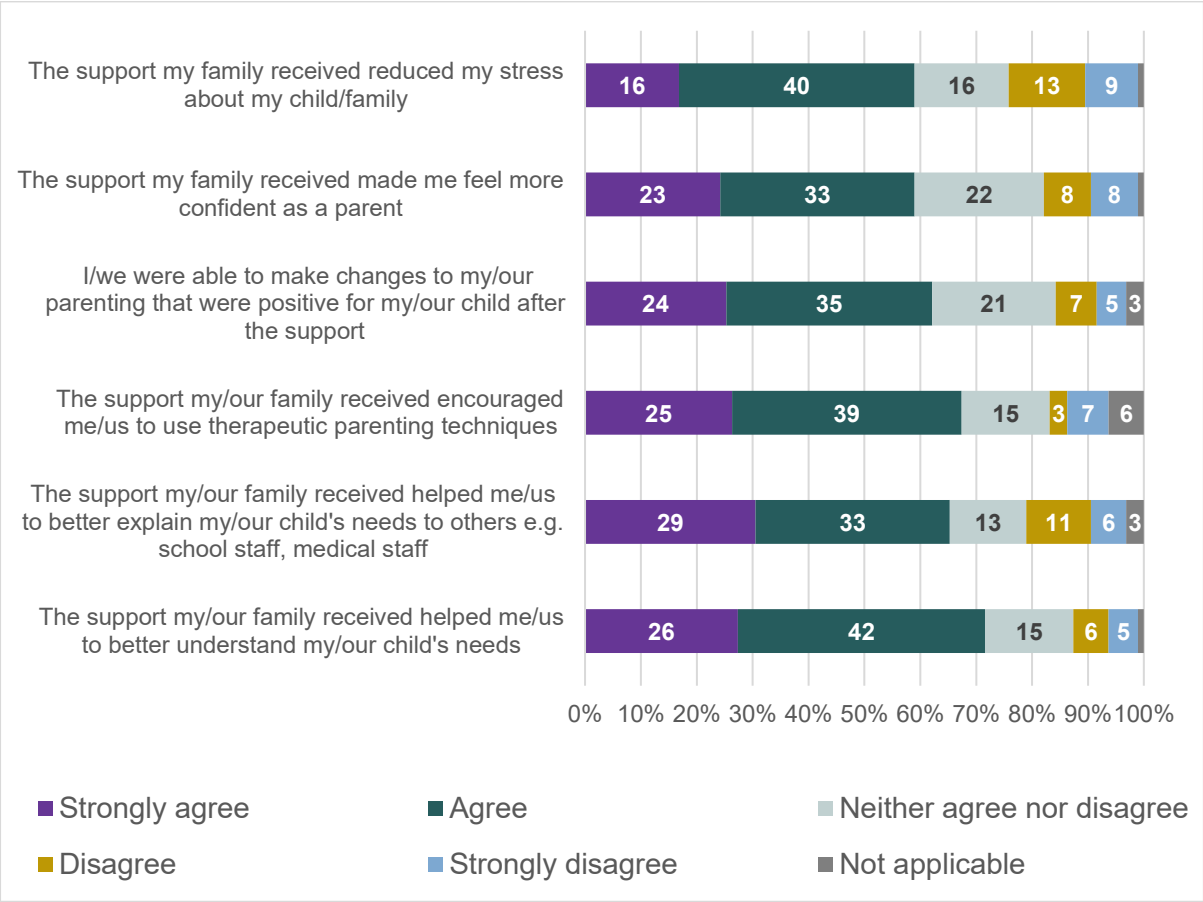
7.3.1. Effects on parenting

Parents completing a retrospective survey were asked to consider the effects of MD support on their parenting. They were presented with statements and asked to 'rate' how much they agreed with each statement, from 'strongly agree' to 'strongly disagree'.

Data outlined in Figure 2 shows that, for example:

- 72% parents for whom the question appeared applicable, and the same percentage overall agreed or strongly agreed that the support received helped them to better understand their child's needs.
- 67% parents for whom the question appeared applicable and 65% overall agreed or strongly agreed the support had helped them to better explain their child's needs to others, for example schools.
- 72% parents for whom the question appeared applicable and 67% overall agreed or strongly agreed the support had encouraged them to use therapeutic parenting techniques.

Figure 2: Retrospective survey parent ratings of impact on parenting (%) [n=95]



A large proportion of retrospective survey parents also offered, through their free text comments, further insights into the **positive effects on their parenting** including because of new skills or insights gained, or earlier learning having been reinforced e.g.

Building confidence in my ability to react therapeutically (Parent)

However, some parents responding to the retrospective survey commented that specific parenting support ‘interventions’ such as parenting programmes or Theraplay had failed to acknowledge other factors such as a child’s neurodiversity or FASD conditions and therefore were not as helpful as they might be.

Theraplay was useful at building connection, but there are aspects of the traditional therapeutic parenting approach which are not helpful and even potentially harmful for a ND child with FASD and/or PDA (Parent)

Alternatively, some parents considered that there had been overall too much focus on the ‘basics’ including therapeutic parenting or Theraplay with which they were already au fait and that they would benefit more from alternative forms of support.

The Theraplay group was very unsuitable for us, we already did a lot of games and therapeutic parenting anyway (Parent)

Parents also provided (free text) insights into how the support provided had helped them to **better understand their child's needs**. A key theme was that this was achieved through helping the parent to understand the specific reason(s) why their child behaved or responded the way they did.

We didn't understand why our son was so angry and distressed. We needed to understand him and his needs to begin to defuse the situation. Because he wasn't able to articulate this, we felt bewildered. The MDT gave us understanding (and tools) (Parent)

This naturally led, in many cases, to parents being helped to understand what techniques, approaches or strategies were appropriate or more appropriate to use:

We were given bespoke advice to help her find ways to regulate her emotions and equipped us with the tools needed to support her when she is unable to do this on her own (Parent)

Other ways in which parents described they had been helped in their understanding or where increased understanding improved outcomes included:

- Having more information to feel confident in advocating for their child in school, college or nursery.
- Increased appreciation of parents' own needs or 'triggers'.
- Increased understanding of children's (likely) perspectives.
- Being encouraged or able to connect with other adoptive parents whose children have similar needs.

Some parents completing the retrospective survey described ways in which they thought MD arrangements could improve including:

- The whole system of support (including schools etc.) to have more information about and understanding of adoptive children's needs.
- Improved links between the recommendations from MD consultation or assessment and ongoing support plans.
- Providing more support tailored to children's specific needs e.g. neurodiversity.

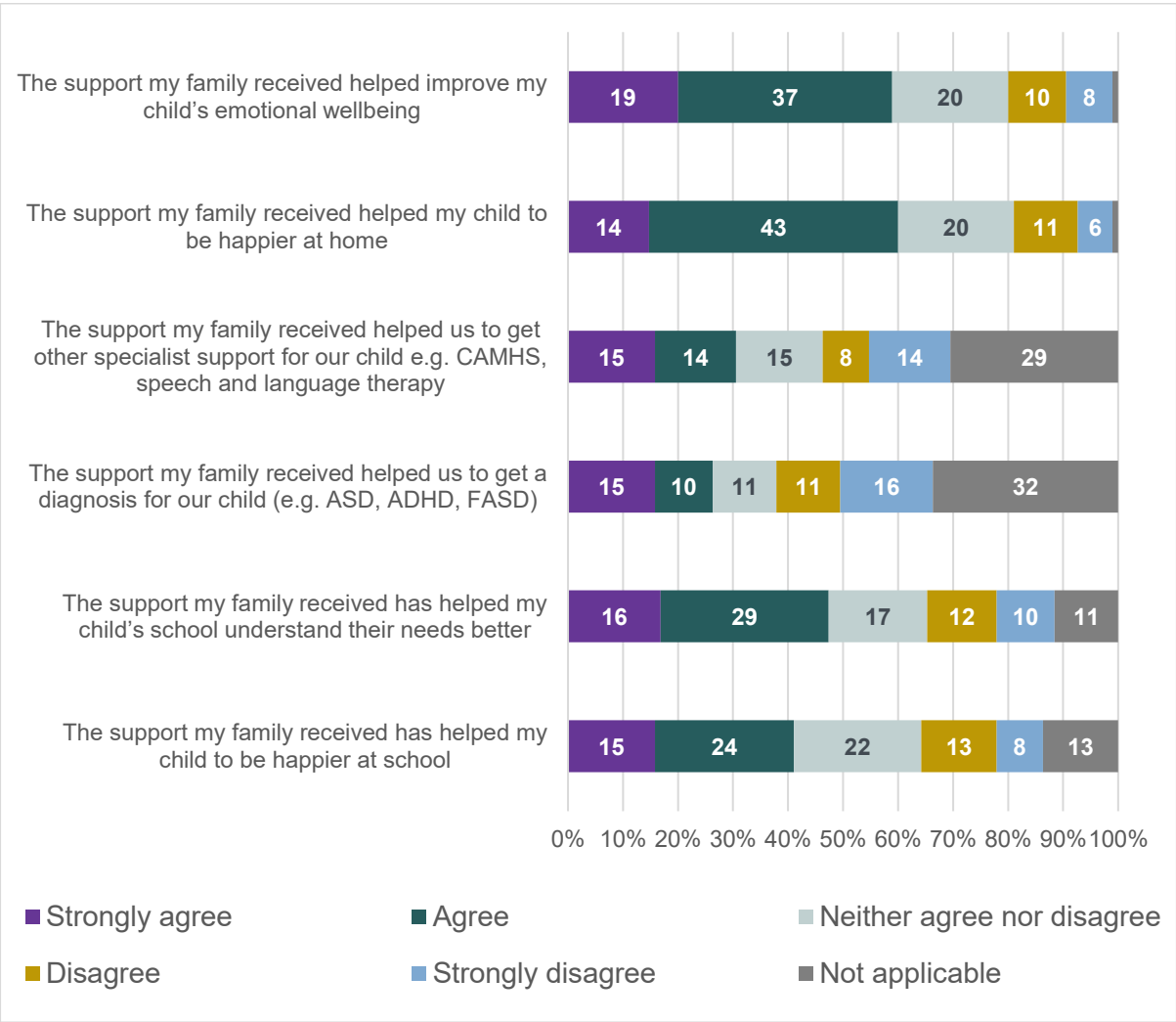
7.3.2. Effects on the child or young person

Parents completing a survey were asked to consider the perceived impact of MD support on their child. They were presented with statements and asked to rate how much they agreed with each statement, from 'strongly agree' to 'strongly disagree'. The results are displayed in Figure 3 below.

- 60% parents for whom the question appeared applicable and 59% overall agreed or strongly agreed that the support had helped improve their child's emotional wellbeing and/or that it had helped their child to be happier at home.

- 54% parents for whom the question appeared applicable and 47% overall agreed or strongly agreed the support had helped the school to understand their child’s needs.
- 44% parents for whom the question appeared applicable and 31% overall agreed or strongly agreed that the support had helped them to access specialist services for their child.
- 40% parents for whom the question appeared applicable and 26% overall agreed or strongly agreed that the support had helped them gain a diagnosis for their child.

Figure 3: Retrospective survey parent ratings of impact on the child (%) [n=95]



In their ‘free text’ responses parents sometimes explained more about how they thought the support had affected their child. Key themes included that:

- Impact on children was achieved largely through an improved holistic understanding of their needs by parents and others ‘around the child’ e.g. teachers, complemented by support plans, practical strategies to help and adjustments at home and in school.

We can work together better if the school understands his background and work in the same therapeutic way and assist in helping to meet his needs (Parent)

- Changes in children were mostly about gaining a better understanding of their own emotions, improved emotional regulation and behaviour.

Our son is completely changed at home. He is happier and calmer (Parent)

Sometimes, parents noticed how significant improvements in their child were not yet perceptible, attributed to onward delays e.g. in obtaining a diagnostic assessment or evidence-informed ASGSF-funded intervention for the child and family. However, some families noted that having a MD formulation had helped to speed up those processes.

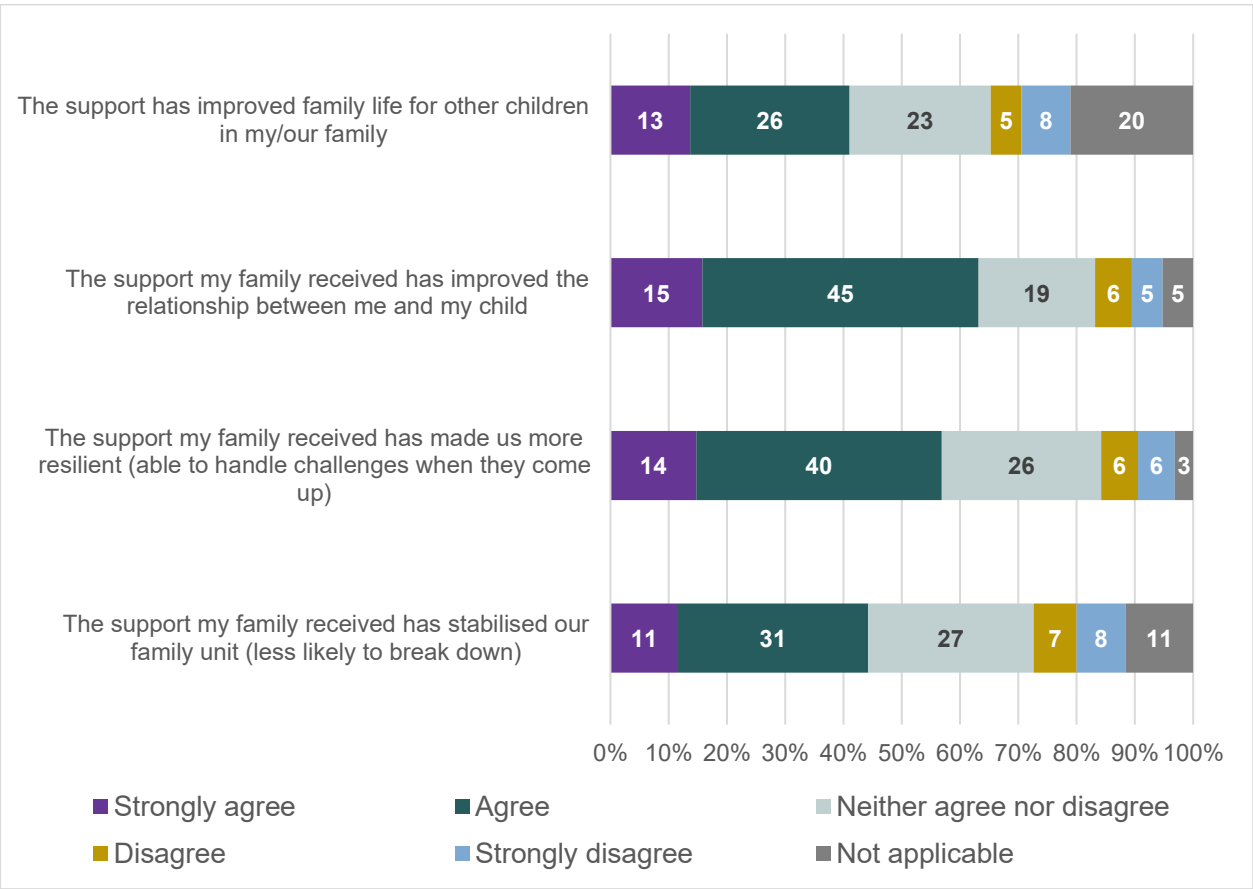
7.3.3. Effects on the whole family

Parents responding to the retrospective survey were asked to consider the impact of MD support on their family as a whole. They were presented with statements and asked to rate how much they agreed with each statement, from 'strongly agree' to 'strongly disagree'.

The results are displayed in Figure 4 below.

- The most frequently noticed improvement for families was in the relationship between parents and their child. Over two thirds (67%) parents for whom the question appeared applicable and 63% overall agreed or strongly agreed that the MD support had improved this key relationship.
- 59% parents for whom the question appeared relevant and 57% overall agreed or strongly agreed that the support had made their family more resilient.
- 52% parents for whom the question appeared relevant and 41% overall agreed that the support had improved family life for other children in the family.
- 50% parents for whom the question appeared relevant and 44% overall agreed or strongly agreed that the support had stabilised their family unit and made it less likely to break down.

Figure 4: Retrospective survey parent ratings of impact on the family (%) [n=95]



As with other questions, where parents contributed further information in the form of ‘free text’ responses to explain more about their initial responses, they often emphasised how the improvements had resulted from themselves as parents or the extended family having obtained a better, holistic understanding of the child’s needs and the reasons why they behaved the way they did – leading to improved parenting strategies.

It’s [parenting] not perfect (is it ever?) but we were originally at crisis point so I believe we’ve come a long way as a family. We are more resilient and feel we understand [child] better (Parent)

7.4. Longitudinal survey of parents (n=22 at baseline) findings

- All 20 parents (100%) participating in an initial follow-on survey described how their understanding of the child’s needs had increased: a little (12/20), quite a lot (5/20) or greatly (3/20). Parents’ free text responses suggest that discussions or assessments involving social workers and their MD colleagues had directly increased this knowledge and understanding. However, specific supports or interventions could also do so, for example talking therapies or training programmes such as Non-Violent Resistance.

- At around 6-7 months after referral, most parents who thought the question relevant (14) were a little (2/14), quite (5/14) or much more confident (4/14) in explaining their child's needs to people in educational settings.
- All but one parent participating in the initial follow-on survey responded that, where relevant, they had been encouraged to use a therapeutic parenting style (16/17) including a little (3/17); quite a lot (8/17) or a great amount (5/17). Respondents could expand on their answer with free text if they wished to. Some parents expressed that they already had a good understanding of therapeutic parenting before the MDT input. Others stated that they had learnt new techniques or that the support had reminded them of what they had learnt previously.
- By the end of the longitudinal survey period, there were 15 complete parent scores. Analysis of these scores indicate a statistically significant positive change between baseline and 2nd follow up in:
 - GBO scores relating to their self-selected goals for the MD support.
 - BPSES scores relating to parental self-efficacy.

However, there were no statistically significant changes to the child's (parent report) SDQ, TAYC-R, PRFQ or SWEMBWS scores. It should be noted that, in a number of cases, parents did not think they had yet received multidisciplinary support for their child or family.

- About one half (8/15) parents agreed or strongly agreed the MD support had improved their family functioning. Similar levels of parents agreed their quality of life had improved as a family (8/15) or that they had felt supported as a family (8/15). Most of the rest provided neutral (neither agree nor disagree) responses and free text comments suggesting they were not sure a MD intervention had yet happened.

7.5. Case file analysis findings

The effects of MD support were not always visible on the 30 case files examined for this evaluation. Sources of information included:

- Records of conversations / running records or email correspondence with parents.
- Notes from case supervision.
- Direct feedback from schools and nurseries.
- Social worker and / or (ASGSF) provider reviews of plans.
- SENCO or Team around the Family reports.
- Outcome measures.
- Transfer reports (to a new agency).
- Case closure records.

The most frequently evidenced positive impacts of MD support were in relation to:

- Parents gaining a better understanding of their child's needs and further adapting or attuning their parenting to meet these needs.

- Nursery, school or college settings taking on board MD advice and making adaptations to support.
- Child being helped to settle into a new educational setting or doing well in school including happy in school, contributing, accessing educational entitlements and progressing.
- Improvements in family life including reduced conflict, improved relationships and families more able to access social, leisure or holiday activities.

Other less frequently but sometimes important effects were: child accessing neurodevelopmental diagnoses in a timely way; improved child physical or sensory development; improved child emotional wellbeing and recognition / regulation of emotions; reduced parental stress; child more confident about birth family contact.

In 5/30 or 17% cases, there was clear evidence a family breakdown had been averted.

Ongoing difficulties for children noted on a small number of case files related to:

- Unresolved questions about child development, neurodiversity or other ‘diagnoses.
- Young people continuing to have a challenged sense of belonging, poor self-esteem or risk-taking behaviours.

Three illustrative examples of the work and impact of MD support from case file analysis are outlined below. Names and some aspects of family composition have been changed to protect the identity of family members.

Illustrative example multiple child needs: Simon

Simon was adopted before aged 2 years and referred for MD support in his early teens. There were concerns about his angry outbursts at home and in school. The family had previously received ASGSF-funded support for music therapy, but Simon had not found this therapy useful and had not fully engaged. Stress levels were building in the family around Simon’s early life story, with questions beginning to arise for Simon and parental concerns about how to share complex information as well as manage potential birth family contact.

MD support included a full consultation led by a clinical psychologist, actively involving parents and Simon and considering different aspects of their functioning including Simon’s emotional wellbeing, sensory challenges, early life experiences and school relationships. Parents were subsequently supported to engage in life story conversations with Simon, combined with a sensory (BUSS) intervention. Simon’s school was supported through further consultations with them, advice and signposting to relevant resources.

By the end of the intervention (after 10 months), there was evidence on the file that Simon:

- Was more able to express his emotions and had lower-level emotional difficulties (as evidenced by SDQ scores).

- Had ‘significant improvements’ in his sensory system (as evidenced by the provider).
- Had significantly improved behaviour in school and was thriving there (as evidenced by school reports).

Parent stress levels were lower, acknowledged by them to be linked with better understanding of their child’s needs and managing successfully to share life story information with him. Their TAYC-R scores improved from 40 to 54.

Illustrative example early intervention: Petra

Petra came to live with adoptive parents at around age 3 years and was referred for MD soon after the Adoption Order was made. There were concerns about Petra’s hypervigilance in the adoptive home, also dysregulated behaviours and a parent’s emotional wellbeing. Universal RAA support including peer support and a group-based therapeutic parenting programme had not significantly alleviated the difficulties.

MD consultation resulted in a strengths-based plan for parents to become involved with Petra in a group-based BUSS intervention alongside support for the transition from nursery into primary school and 1:1 DDP-informed therapeutic parenting support.

By conclusion of the intervention, there was evidence from social worker reviews that:

- Parents had attuned their parenting to Petra’s needs, applying their therapeutic parenting skills and knowledge.
- There were positive attachments.
- Family life had improved including children fighting less (‘fighting and biting has stopped’) and able to engage in social activities including holidays.
- The transition from nursery into primary school had gone well, including with support from an early year’s practitioner to enable Petra to express emotions and settle in the new school.
- Parents had become more resilient and were able to access support for their own emotional wellbeing (including self-care).
- Parents’ emotional wellbeing improved, including becoming more relaxed.

Illustrative example crisis intervention: Joseph

This family had experienced domestic abuse and, by the time of the MD referral, was solo parented. Joseph was in his early teens, involved in lots of fighting with siblings and damaging property, beginning to get involved in risky behaviour outside the home.

Despite earlier ‘rounds’ of ASGSF-funded therapy (including for DDP, Sensory Integration, and Theraplay) having helped to a limited extent, behaviours and violence

levels were now escalating and both child and adult members of the family were at risk of physical and emotional harm.

A referral had been made for a health diagnostic pathway, but Joseph had been on this waiting list for some time.

The family was described as being in crisis, close to breakdown.

MD support included a holistic assessment and formulation of this family's needs (exploring all preceding and precipitating factors including potential neurodiversity), followed by full consultation led by a therapeutic social worker involving the parent directly. This led to a plan including a form of therapeutic crisis intervention (TCI).

Evidence on the file suggests short to medium term:

- Improved parental understanding of and attunement to Joseph's likely needs.
- Improved family dynamics, reductions in violence.
- Aversion of family breakdown.

7.6. Findings from interviews with parents

In interview, many parents placed great value on their experience of MD support, describing significant improvements in their child and family lives.

Massive difference...Like, she is so much happier. She's not dysregulated all the time. Like she used to go into this state where she was just, I mean, she was like a wild animal. Just completely, we've not seen any of that...the connection between me and her is vastly improved (Parent)

That is the best support that I've had. Compared to last time, it's just a million times better. I felt supported this time. I felt genuinely like they really understood and they wanted to help... But now [child] understands that [they've] got the support there. And then, with the physio and [their] body feeling better...from the BUSS model and me with the life story work and the things, the grounding things that we've done ...you know, fantastic (Parent)

Some parents described in interview how the MD intervention had averted a real crisis, possibly even the breakdown of an adoption:

There were times before we saw the MDT, we didn't feel this, but I think the professionals around us felt that there was a risk of the placement breaking down because it was such a...hard slog...There had been conversations about what's the scenario if this placement breaks down. And I, you know, I just can't even envisage that that would be even a conversation anymore (Parent)

I was so grateful to have their input, and it was, as I said, such high quality, and I, you know, I honestly don't know where we would be if we hadn't had their input when we did. You know, in my darker hours I'd started to wonder if the adoption would break down, that's how bad things felt at home. So, you know, to go from that to, you know, a relatively good place is sort of transformative (Parent)

Key themes about specific improvements or positive change noticed by parents from an overall MD intervention (including anything from consultation only to a consultation, assessment, formulation and support combined) were that the intervention had given them:

- **A better understanding of their child's needs**, also enabling attunement of parenting approaches or decisions and detailed, evidence-informed communication of their child's needs to others – particularly school staff.

I think when you understand your children better, it helps you attune to them better and it helps you respond better. And it's quite empowering really, because when you're raising adopted children, all your normal parenting methods, well, you might as well rip the book up and throw it away because they don't respond in the same way (Parent)

So, I think...our expectations of [child] were completely unrealistic, we didn't understand [their] difficulties, and so we put certain expectations ...that were impossible... So, you know, I think the way that we deal with him has completely changed as a result of those interventions, completely changed, you know, our whole parenting style is different, our tolerance is completely different. You know, we just understand [child] and accept and support [them], rather than what must have felt like compounding the expectations that were on [them] all day ...all of which [they] can't meet, you know... So, we've adapted (Parent)

In some cases, parents described how their child had obtained a diagnosis (of ADHD, ASD, FASD, learning disability or other disability) including as a result of multidisciplinary team screening or onward referral into NHS pathways. In all cases, this screening was considered useful, including in the short to medium term to explain things to the child's school or extended family.

[MDT report is] almost like my Bible, I have a printed copy of it for all appointments... I don't think I'd have been able to do it without it (Parent)

Alternatively, a diagnosis had (helpfully) been ruled out by the MD screening.

...they looked at ADHD, ruled that out. They looked at ASD, ruled that out ... And it was all more developmental trauma and relational attachment ... And there was loads of sensory needs and I think that underpins everything ... No change in everything that we're doing but tweaking it to suit his centering ... It's really helped us ... so we've made changes to help him (Parent)

- **Reassurance and confidence**, particularly in the early stages of an adoption journey.

It gave us the confidence to know that we weren't failing. Actually, this was difficult and this was about trauma and it was about, you know, we were the [last of several] people to care for our [children]. And so... you know, being able to navigate through that of them not loving us and us not loving them, you know, immediately, wasn't unusual. And that compassion fatigue and all of those aspects were quite normal parts of our journey, that we just needed a bit of handholding through, or that acknowledgement that [you're] not failing, this is just how hard it is (Parent)

- **Improved child outcomes** for example children 'settled really well'; 'flourishing in school'; 'building a friendship group' (from a low base); 'gaining confidence'; 'sleeping better'; more able to discuss 'life story'; having 'improved speech'; greater 'sensory awareness and physical coordination'; 'volunteering' with other teenaged adoptees; improved 'regulation of emotions'; 'stopping self-harming'; stopping 'going missing'. Two key underpinning themes relating to child outcomes noticed by parents were:

(1) Improvements in their child's emotional wellbeing or understanding and regulation of their emotions.

So, through our work, and naming emotions, and helping them to understand their emotions and the impact they have on their behaviour, then they stand out, I think, among their peers as being able to say, "I'm feeling anxious, this is making me feel anxious," for example. So, [in] their recent [school] report, they're well adjusted, happy, caring, empathetic children that I don't think would have been the case if we'd not been having [the MDT input] (Parent)

(2) Children enabled to attend regularly and participate in nursery, school or college, including with the support of more tailored Pupil Premium Plus, adaptations informed by MDT advice, and/or an education plan 'in place' (not necessarily an EHCP).

I think particularly at school, the difference has been really big, because, yeah, in September, [child] didn't... want to go to school and was really struggling, and now [child] actually is really happy to go to school... it's a huge shift, and [they've] recently started...trying to stand up in front of class and do things like reading and stuff, which is massive, because [child] doesn't like anybody looking at [them] at all, so...it's a massive moment (Parent)

- **Improved family outcomes** including a calmer household with improved relationships, attachments and communications, and reduced (child to parent or child on child) violence.

Much more, much, much more [able to enjoy home life]. We still have immense challenges, but home is calmer, more secure (Parent)

It's made [child] happier and it's made [their sibling] happier. It's made their relationship better, yeah... [Support in school] That's empowering ... there's not so much stress in school now,...it's not coming and spilling out at home (Parent)

A broader 'spin off' impact mentioned by some parents in interview was that their child's school had become more aware of the needs of all care experienced children.

7.6.1. Attribution of outcomes

It was understandably difficult for parents in interview to attribute these outcomes to specific aspects of multidisciplinary support or what came before or after in terms of broader RAA support. However, many parents were keen to emphasise the importance of their social worker's relational, often therapeutically informed support for the whole family, providing essential continuity of relationships and coordination of universal as well as more specialist support - alongside MD elements:

I would say the [social worker] who was involved when there was the MDT stuff, that is the most solid connection [child]'s made with somebody. They developed a really, really positive relationship... there was [also] very good communication between myself and them, and I think it was at the right level when it was needed... the largest part of [the success] was, would be the ongoing work with [social worker] (Parent)

We were very fortunate we have a social worker same social worker all the way through who was very good at what she does (Parent)

7.7. Findings from interviews with professionals

7.7.1. The extent to which multidisciplinary support is helpful to families and the wider support system

All RAA leaders and service managers interviewed for this evaluation believed MD support for adoption improved their offer to adoptive families.

Oh my goodness, absolutely, absolutely, huge, huge, very, very keen to keep it. I think it's fulfilled everything and more than what we hoped it would actually (RAA Leader)

This is really good, it really works, there's a real benefit for you as an organization to buy into this, because it will reduce demand on your service further down the line, or just give an added bonus to lots of your families in your area that might divert them away from a whole range of services (RAA Leader)

RAA leaders, service managers and MD team members could identify families pulled back from the edge of breakdown as well as lighter touch MD involvements at an early stage of the adoption journey that had made a big, positive impact on children and families.

...it's supported and probably prevented a number of placements that we've made having greater difficulties....I can think of lots of cases where it's been the difference between...disrupted or not (Service Manager)

Despite the challenges, professionals also sometimes identified broader, systemic impacts, including improvements in onward pathways into Health or Education support, schools' and community health services' understanding of the needs of adopted children or improvements in staff wellbeing and sickness rates, through opportunities for clinical supervision.

Really good relationships with the virtual schools (Service Manager)

So, I would say having everybody under one roof or at least having better pathways into health as a result of some of these assessments is definitely better for families as well (Service Manager)

A shared agenda and ambitions ... the shared agenda was very much that the children we were working with [were] spilling over into Health's neurodiversity pathways... How could we collectively work to get help the right? (RAA Leader)

RAA leaders and other RAA staff sometimes reflected that, prior to this work being undertaken, statutory Health Services had been signposting adopted children to RAA support to meet their health needs (because of the promise of ASGSF-funded support).

And I guess ...clinicians were trying to be supportive to families and saying go to adoption support because they can help you...and the needs of the some ...of the children... go beyond the capability of the adoption support team and you've got children who are at high risk, you know, self-harming, you know, serious risk (RAA Leader)

Some service managers additionally emphasised potential reputational benefits, suggesting MD support was not only reassuring for current adoptive parents but could also help with adopter recruitment.

We're starting to talk to families about the challenges ahead, about the needs and the complex needs of adopted children. But alongside that, we're also able to say, but we're going to be with you because we've got this amazing kind of project and this is what we offer... And I think we've now got families that are hearing that from other families and coming to us because they've heard that...And we had a situation recently when we had somebody that was interested in coming to us for adoption but was very, very anxious, having read a recent article and we were able to meet with them and show them what we've got and how we support our families. And that has resulted them coming into the process because they felt so assured by it (Service Manager)

Only a relatively small number of interviews were undertaken with representatives of virtual schools themselves. However, those who were interviewed described a range of positive effects of MD support or joint (MD and Virtual School) initiatives:

- **Positive impact of consultation for families.**

The family seemed to feel very heard, and they seemed to take away tangible things that could change for them. So, whether that is...that a particular service might become involved or there was advice around how they could navigate things or what they needed to do next to that, that's...felt really positive for some families and some families have come out, you know, I'd say almost looking a little lighter...There's some clarity, I think, and some direction that for them felt helpful (Virtual Schools Representative)

- **Positive impact of the work of MD support on the knowledge of other professionals.**

...more professionals and I'm probably going more wider system now, starting to understand a little bit more the needs of many or some of adopted children (Virtual Schools Representative)

- **Developing education plans** for all adopted children in an area.

[It] obviously ran for a year, and I sent out a survey across the four local authorities at start of term. It's well received... schools find it really helpful...Parents find it really helpful, particularly the kind of sharing the child's story in an appropriate way so that they don't have to keep telling their story and looking at their strengths. But I think if we look at the feedback, parents still want schools to know more (Virtual Schools Representative)

- **Greater access to education advice** for adoptive families.

Where some families and children needed specific advice and support, that seemed hard to access before, shouldn't have been, but was. I think that that's been a real positive for some families. They've been able to access what I think they felt they've needed for a long time and hadn't managed to navigate the system to get what they needed... I think families are feeling more heard...and listened to (Virtual Schools Representative)

7.7.2. What were considered the most useful elements of multidisciplinary support?

All elements of the core MD offer (assessment/formulation, consultation, training for adopters and social workers / other professionals and direct work) were valued by professionals working in RAAs and beyond. However, a holistic assessment/formulation and consultation (with family members and with social workers) emerged as the key aspect of value – including to develop tailored plans of support:

There's the direct support which... is really, really helpful. But the most useful thing is the guidance and space for reflection for staff who are working one-to-one. So, it's that kind of... one step removed support. But by being one step removed and not immersed in and involved in the family and having different lenses focused, you know, it allows you to see the bigger picture and spot things that you might not spot otherwise (Service Manager)

And I think sometimes that...if they've met with the family, done the assessment, they're sort of thinking, oh, would this work, could that work? They've got the therapist to talk to so they can make a really good plan of therapy, how it's going to work, effective therapy (Service Manager)

High value was also placed by professionals on:

- Increased support or 'scaffolding' for social workers resulting from MDT training, consultation and broader activities - involving all staff members working alongside and learning from one another.
- Social workers working alongside clinicians or therapeutic social workers to provide frequently required group-based therapies 'in house' i.e. within the RAA, for example: DDP, Theraplay, sensory-related interventions such as BUSS. In-house was hypothesized as potentially providing a timelier, value for money service for families and (in the context of ASGSF reductions in fair access limits) enabling resources to be combined from across the RAA – rather than standalone ASGSF interventions.
- MD team members being able to undertake some direct work alongside assessment, formulation and consultation work not least to retain their skills (sometimes described as 'safe practice') as well as balance and interest within their overall role.

8. What are the costs and costed benefits?

This section explores first the costs of five exemplar MD sites (8.1.) including our approach to costs comparison and how we calculated average costs, followed by (8.2.) an analysis of the potential costed benefits of MD support with reference to relevant economic research and the evidence we were able to collect relating to the prevention of family breakdown. We also outline other potential economic benefits suggested by the evaluation findings.

8.1. Costs of multidisciplinary Support

8.1.1. Approach to costs comparison

Early adopter and second wave sites were asked to complete a costs and activity template requesting data on the following:

- MDT funding received and sources.
- MDT costs for both start-up and delivery.
- Resourcing of the MDT.
- ASGSF usage prior to and during MDT period.
- Activity levels for the specific services and support the MDT provided.

Four MDT sites were able to provide a completed costs and activity form (sites 2, 3, 4 & 5). Two further sites (sites 1 & 7) provided other sources of information. Overall, sufficient

responses were obtained from four RAA-embedded models and one CAMHS and RAA-embedded model (sites 1-5 in Section 3.1.).

The cost data was triangulated with information obtained through other strands of the evaluation, for example RAA annual reports.

8.1.2. Comparison of costs incurred versus grant funding by year

Grant funding was only provided to ‘second wave’ MDT sites. Analysis of the individual ‘returns on spend’ for these three sites (3, 4 and 5) provided an indication of the amount of awarded funding used and what may have needed to be carried over to subsequent years. Whilst some of the data did not fully reconcile, it gave a sufficiently representative picture of the situation.

Table 9: MDT site incurred costs versus awarded funds

	Site Three			Site Four			Site Five		
Year	2023-24	2024-25	Total	2023-24	2024-25	Total	2023-24	2024-25	Total
Awarded	£279,822	£331,942	£611,764	£224,628	£243,378	£468,006	£355,135	£523,038	£878,173
Incurred	£78,471	£358,084	£436,554	£89,863	£311,911	£401,774	£238,213	£530,093	£768,307
Difference	£201,351	(£26,142)	£175,210	£134,765	(£68,533)	£66,232	£116,922	(£7,055)	£109,866

The analysis showed that each MDT site did not use all the awarded funding in year one of the funding (2023-24) with usage ranging from 30% to 70%. This was due to the slower than anticipated mobilisation activities attributable in part to staff recruitment challenges.

Specific start-up costs were not separately identified by the MDT sites. In the absence of this data, an indication was obtained by considering the 2023-24 costs incurred as a proportion of the total and when service delivery commenced.

- Site three had a soft launch in March 2024, with formal launch in June 2024, meaning that at least 18% of its two-year costs were related to start-up.
- Site four’s service went live in June/July 2024 meaning more than 22% of its two-year costs were related to start-up.
- Site five started delivery in late 2023 / early 2024 meaning service delivery would account for a proportion of the 31%.

This suggests start-up costs being in the range of 20-25% of the total funding.

8.1.3. Analysis of relative site model costs

A degree of comparative analysis was possible between MDT sites providing a relatively complete costs and activity template. This was achieved through using an annual average cost per FTE for the most representative ‘fully operational’ period and a cost per 350,000 children under 18 years old served. To achieve this comparison, adjustments were required to the raw data provided, including:

- Aligning different National Insurance and Pension treatments e.g. cost related to NHS staff in site one data classified as ‘overhead’ and not included for other staff.
- Including costs for MD staff who were directly part of the offer but were not costed into site budgets or funding requests e.g. therapeutic social workers in site two.
- Including other staff expenses or direct costs that were not reported but would have been incurred e.g. travel expenses.
- Allowing for the incurred role vacancy periods.
- Where not provided, including overheads in the region of 15%.
- Adjusting all to a notional 12-month (2025-26) basis. Whilst the DfE funded second wave sites for 2023-25, some sites continued for a third year (2025-26). There was also data provided by the two ‘early adopter’ sites for 2025-26. The cost data of sites part of the programme until 2024-25 was escalated, as required, to 2025-26 levels applying the ONS GDP Deflator ²⁶.

Table 10: Standardised operating cost per FTE comparison of MD sites

	Site 1	Site 2	Site 3	Site 4	Site 5
Child population	505,523	371,633	362,962	379,287	425,900
Cost p.a.	£525k	£387k	£347k	£312k	£613k
FTE	9.7	5.6	5.5	5.0	9.2
Cost per FTE	£54.1k	£69.1k	£63.1k	£62.4k	£66.6k
Cost per 350k children	£364k	£365k	£335k	£288k	£503k

²⁶ [HM Treasury Deflator](#)

This analysis supports an estimated notional cost in the region of between £350 and £375K per year for an MD core model embedded in a single RAA comprising 4-5 local authorities and serving a child population of approximately 350,000.

The slightly elevated cost for site five was reported by that site to be affected by needing to procure private providers on a day rate for both the clinical psychologist and occupational therapist roles and by having a higher proportion of FTE workers for the size of child population served in the RAA area. This reflects challenges recruiting to key roles reported elsewhere in the report. Conversely, the lower cost MDT site, site four, had a lower proportion of FTE workers for the size of child population in the RAA area.

Within these MD site costs, the worker mix evolved over time reflecting challenges and learning detailed elsewhere in the evaluation. The cost analysis indicates that sites used the opportunities of vacancies to change the staff mix within their budget envelope. For example, when 1 FTE Senior Educational Psychologist left site four MDT 0.4 FTE consultant clinical psychologist and 1 FTE occupational therapist were recruited in their place.

There was insufficient data provided across the sites to compare MD costs as a proportion of adoption support costs or the whole RAA budget. Due to the differing scopes, emphases and approaches of the sites, and time against each activity not being available, it was also not possible to compare their relative 'productivity'.

8.2. Potential costed benefits

This study had not included a randomised controlled trial or other comparator sample methodology. Therefore, it is not possible to clearly attribute effects or outcomes to MD support including the costs of avoiding negative outcomes. Nevertheless, there is some triangulated data from which we can hypothesise potential costed benefits.

8.2.1. Relevant economic research

The Greater Manchester Combined Authority (GMCA) Unit Cost Database ²⁷ is a publicly available repository bringing together over 1,100 localized and national cost estimates to assist in financial modelling and social value reporting. The database is divided into thematic areas and draws from verified government reports and academic research. The relevant unit costs contained in the database that support establishing cost avoidance calculations for the education and social care issues identified in the outcome and impact data include:

- E&S1.0 - Persistent truancy: total fiscal cost of persistent truancy (missing at least five weeks of school per year), per individual per effective year.

²⁷ Accessed here: <https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/>

- E&S2.0 - Permanent exclusion from school: fiscal and economic cost of permanent exclusion from school, per individual per effective year (based on cost difference between Alternative Provision and mainstream school).
- SS1.0 - Child taken into care: average fiscal cost across different types of care setting, England, per year.

The database provides fiscal, economic and social value costs for each measure and identifies their source.

8.2.2. Potential costed benefits of preventing family breakdown

Professionals and parents interviewed for this evaluation identified instances of families in severe crises who believed, rightly or wrongly, that the MD support had averted family breakdown and the need for a child to re-enter the care system. However, it was understandably difficult for sites to 'prove' the number of breakdowns that had been averted. One early adopter site's annual reports for 2023-24 and 2024-25 suggested that around 30 referrals a year related to families on the brink of breakdown, with over 90% of these avoiding breakdown. Other sites have estimated between one fifth and 'many' families being at high to moderate risk of breakdown.

Within the case file cohort taken from early adopter sites, there was clear evidence that a family breakdown had been averted in 5/30 or 17% of the sample. One involved a teenaged child and the other a younger child earlier in placement aged 5 years.

The annual cost per child taken back into care is estimated by the GMCA Unit Cost Database to be £97,593. For a child of 5 years returning to care for at least 1 year before being placed again for adoption would therefore cost £97,593. For a child aged 14 years, the costs would be higher at approximately £390,372 (for 4 years in care).

8.2.3. Other potential economic benefits

This evaluation demonstrates how many children entering MD support were experiencing challenges with their education such as not being able to attend school regularly or being excluded. There were no quantified periods for absence or exclusion from which to develop cost avoidance estimates. However, 33% or 10/30 children in the case file audit were found to be at risk of exclusion or not attending an educational setting and, in many cases, there was evidence of improvement.

Interviews with professionals and families also suggest that, through positively received MD interventions, other savings are likely, for example through NHS services not being required or accessed or through reviewing ASGSF plans that do not represent a good match for the family and adjusting these plans, often to include less intensive or intrusive interventions that are also less costly.

9. What additional learning was generated about implementation and sustainability?

This section outlines the additional learning about implementing and sustaining MD support from the perspectives of parents, focused mostly on what support could not help with (9.1.) followed by the perspectives of professionals, focused on what could be learned with regards setting up and sustaining service models and their vision for the future of MD support (9.2.).

9.1. Additional learning gained from parent interviews

Parents often described good or excellent experiences of MD support for their child and family. When asked in interview what the support did not or could not help with (limitations of support), parents sometimes described how high demand meant that the wait was too long for MD support.

Some parents also suggested MD support, as currently configured, could not always help with:

- **Timely cognitive, ASD or FASD assessments** (for diagnoses) – meaning time was potentially lost on really understanding their child's needs.
- **Timely therapeutic interventions** (provided in-house or by external partners) by way of follow-on from consultations or assessments – largely attributed to ASGSF-related delays in obtaining funding.
- **'Leveraging' help from statutory providers**, particularly virtual schools, learning disability support services (children's and adults'), local authority (e.g. respite) services and CAMHS, where specialist mental health services were required.
- **Sufficiency of capacity in / from the social work teams** – lack of capacity meant waits for support (generally) or needing to tell the family 'story' multiple times.

Parents were also encouraged to make suggestions about improvements or further improvements to the support they had experienced. The main theme to emerge from their responses related to the consultation / assessment / formulation aspect and the need for greater consistency in the generation of timely, clear and reviewable plans.

Having some kind of follow up...some kind of written document is one [improvement that could be made]. I think knowing if it's available, to ask for another consultation, you know, is it something that is out there that we, that we should be able to access? (Parent)

Other improvements also mentioned by some families were:

- Better visibility and availability for families of MD support.
- Better preparation for consultation sessions including timescales, who and what to expect.

- Earlier openness to hypotheses outside of trauma and attachment e.g. cognitive difficulties or diagnoses such as ADHD or ASD or FASD.
- More follow-on non-therapeutic (core) adoption e.g. peer support for parents and children or support for young adoptees transitioning to adulthood.

9.2. Additional learning gained from interviews with professionals

In interview, RAA leaders of second wave sites frequently described how they had wanted to implement MD approaches previously, just did not have the funding to do so:

...it seemed a very exciting opportunity, one that I would have liked to have done before, but to be honest, we never had the money. And I think it would have been really hard as part of our RAA to get that to get any financial agreement and without proving, I guess, that it that it could work (RAA Leader)

There was an appetite for innovation and certainly, to RAA leaders and service managers from across adoption support and family finding, this kind of model ‘made sense’ in that traditional adoption support teams dominated by social workers were considered increasingly unlikely to meet the presenting needs of adopted children and families, including their psychological (trauma, secondary trauma, loss and attachment-related) but also sensory, cognitive, education-related and neurodevelopmental needs.

...to have that early intervention, to try and prevent breakdowns and crises and just a recognition that the needs of the children were incredibly complex and lifelong...huge gaps in generally, nationally, in what support we offered to families (Service Manager)

They've just got different skills and different knowledge, 'cause we can't know everything, even though we try to (Service Manager)

9.2.1. Learning for ‘start-up’ models

Many professionals had advice to give other regions who might be in the early stages of a MD journey about recruitment (of non-social work members of the team), in particular to:

- **Understand the different recruitment options and their pros and cons** to secure the ‘right people’ with interest and skills transferable to this area of work and the right mix of operational and strategic experience. This was particularly true for clinicians.
...as employees, as associates, as private providers, as commissioned or partnership services (MD Team Member)
- **Be flexible and creative with staff composition** to meet recruitment challenges, without compromising model aims and priority areas. For example, if it is difficult to recruit to a particular role or by a particular route (such as direct employment) try another reasonable ‘work around’ for example recruiting to slightly less senior roles if they have the right background and can be supervised by a more senior role. Alternatively, commissioning rather than employing professionals. Some sites commissioning rather than employing clinicians could see the benefit of only paying if

the commissioned partner ‘delivers’. However, others thought that commissioned services could still be more expensive overall.

- **Prioritise at least one senior clinical role** – to contribute to the overall leadership of MD support, develop and promote confidence in the intervention model and supervise other staff. Ideally, this clinician would have significant experience of working with adopted and/or other care experienced children.

And again, the psychological kind of component to it is really, really essential in a lot of the things that we think about and do and, again, we're not trained in that respect to the same degree... For me, the biggest benefit is just having access to a psychologist that you can just speak to about things. It's just so invaluable (Service Manager)

I've left a team before because they took away the clinical lead, because I was just like, ...if you're running a clinical team, you need a clinical lead in the team...How can you do a therapeutic job if you've got no clinical oversight? (MD Team Member)

Where existing arrangements involved mixed leadership, e.g. (therapeutic) social worker alongside senior psychologist, very positive views were expressed about this combination as it was described as having the potential to combine clinical and social worker expertise and knowledge of the system.

It's useful to have somebody that understands almost like the social work process, which you know, sometimes therapy psychologists don't... helpful to have somebody that sort of kind of understands how the adoption process works and how it relates to the social workers that are delivering that (MD Team Member)

- **Consider what other (clinical) roles are required and at what level for all key MD functions** e.g. assistant psychologists (APs), youth workers for direct work with young people. More experienced APs with relevant experience might undertake consultation work, with supervision, and/or provide training. Occupational therapists with experience of sensory work and educationalists (including educational psychologists, teachers or early years workers) were also likely to be required, given the demand for this type of support.

...we know that [education] is a need for more 80 something percent of our children ... and school is a huge challenging time for families and children... We hear from our experienced adopters, that education has been the one time when they've really floundered. And now we're able to say we've got this education offer (Service Manager)

- **Secure sufficient business support** including to protect MD professionals' time to provide the core elements and enable efficient (outcomes and other key) data capture and analysis to inform team development.

Other non-recruitment related themes with regards advice for other sites included to:

- **Carefully consider the positioning of MD staff members or Teams** including to avoid the perception that their work is ‘all about’ post-adoption support.
So, I suppose we see it overall as something that's ... both ‘in’ family finding and recruitment and assessment (Service Manager)

- **Bring the rest of the RAA team and adoptive families along with any new MD developments.** Effective, ongoing communication or ‘selling’ the offer whilst respecting the contributions of all team members was described by RAA leaders as crucial to avoid workers and families mistrusting or avoiding the offer and to achieve lasting culture change.

We needed cultural change from the social workers, but we also needed it from ...the adopters and you know, I would advise my new self that...whatever level of communication we thought we'd achieve, double it, then triple it, and you'll probably be halfway there. So, there was a lot more. There was more to do than we perhaps realised (RAA Leader)

So obviously, that's brilliant for the social workers because they do listen, learn, absorb that information. But also, I think it's equally good for that therapist to know what the social workers are up to...there's more respect in terms of, you know, therapists seeing the value in social, the social work role for families...and vice versa really (Service Manager)

- **Articulate the offer and basis for intervention clearly,** including the rationale for taking a particular (clinically evidenced) approach and balance of different aspects of the work. RAA leaders and service managers counselled against taking on too much direct work at the start (or risk becoming overwhelmed) and for working ‘through’ others where possible, including social workers but also virtual school and other educational supports, particularly where demand is high.

Who you gonna work with and why? (MD Team Member)

We work neuro sequentially...we go from sensory to relational to, you know, kind of thinking stuff. There's a really good model that embeds our thinking, what we do and what we roll out and disseminate that I think is really consistent and coherent (MD Team Member)

It's [about] being really clear about what your offer is and who it's for... Clarity is key when there's only a limited resource in terms of people understanding what you're doing and why you're doing it and what they can get from you (MD Team Member)

- **Establish effective outcomes monitoring early** including expectations that all MD supports will be measured for impact, although not always in the same way. For example, the impact of holistic consultations or assessments/formulations may be ‘felt’ initially by and through parents where a TAYC-R type measure may be useful.

Direct MD interventions with children and families might be felt by and through children as well as adults (where an SDQ or equivalent and/or parent wellbeing measure might be useful). All types of MD intervention with individual families may benefit from a Goal-Based Outcomes (GBO) approach.

We're still not great at it, but you need to be evidencing what you're doing (MD Team Member)

- **Avoid pan-regional delivery models as they are harder to achieve**, particularly as a start-up, because their component RAAs also have such different models, accountability for strategic and operational decisions is too dispersed and these models find it harder to connect with local health and education services.
...really hard to manage something like this ... harder to have that common ground when you are such so vast (RAA Leader)

However, RAA leaders considered that some aspects of the core offer, such 'training' for parents and staff or some supervisory functions could potentially be provided pan-regionally.

- **Recognise it will take time** to develop and then embed and sustain arrangements so that they become 'business as usual'.

because it takes a long time to embed ...it took us longer than we'd thought (RAA Leader)

I know, I mean, I think they've just been really open to learning and I think I think it's ...taken the time that it's needed to take to embed that (Service Manager)

- **Involve families, social workers and other professionals working in the area in developing the service** so that what you provide is grounded in what they think is needed.

I think we were consulted most of the way along...And we were quite, I mean...we started out saying, if you want the two of us, we're going to be honest and critical if we need to be...They did come back pretty much every step. We spoke quite often, didn't we, in the beginning when they were first setting it up...And ...I wouldn't still be involved to a little bit years later if I didn't think they were listening (Parent Voice Representative)

Gathering information from your service users is really valuable..., how you capture the children's voices, the wider professionals that are working with families and what it is that they will be looking for (MD Team Member)

- **Draw on support from other agencies** who have implemented before as well as others starting up.

There's lots of early advice and guidance. Rather than making your own headway, it's almost like you need somebody to be able to go and say this is how you do it (Service Manager)

- **Try not to duplicate the role(s) and responsibilities of other agencies**, particularly virtual schools or CAMHS, or to take children out of important statutory processes or systems.

What we don't want is duplicating plans with the same objectives and they need to dovetail (Virtual Schools Representative)

I would say some of the challenge [currently] is how...the work connects to wider systems...When you take a specific group of children and families and create a new process or system around it, sometimes...if it's not carefully managed...takes children out of normal process, which I think is a good thing sometimes because actually adopted children might need something else, they might need something more (Virtual Schools Representative)

An area where professionals sometimes differed in terms of their advice to others starting or beginning to embed MD support was the degree to which effort should be put into generating good 'connectivity' with other agencies.

- Many professionals interviewed for the evaluation considered it was important or even 'essential' for MD models to include building and maintaining good connections with other agencies, particularly virtual schools and community health services - including to promote effective onward pathways for children and families and reduce potential overlaps.

...absolutely essential [to work with other agencies] because it all forms part of that child's life, doesn't it? An experience. So...agencies need to be talking to each other to make sure that services are aligned and providing what they need to... Particularly school, because it's literally the biggest problem that we have (Service Manager)

It is really important to do that work because otherwise we come subsumed in stuff that should be happening in the community and we need to keep our families in the community...Yeah, so we have ...a meeting with virtual schools and we also include kinship actually once a term, just so everybody's updated and everybody knows who everybody else is ...[advising on] what a transition might look like (MD Team Member)

- Other interviewees counselled against directing or even 'wasting' too much time and energy on this strategic task, because Education and Health had their own (nationally determined) priorities that did not include adopted children that could not be resolved regionally.

...lots of conversations with Health, and it's hard work, you don't get responses ... It's really variable. I think that's one of the challenges of being regional... where the

relationships are more established or stronger, it's easier to keep that stuff going. It's really hard where there isn't...there are limits to what we can do (MD Team Member)

[CAMHS are] not able to be responsive in terms of waiting lists and things for families. ...There was a time when we worked well with CAMHS and had good relationships...now it's ASGSF, you know. CAMHS are not wanting to add that to their workload because there's another route (Service Manager)

- Some professionals suggested a third way i.e. to make connections on a 'case by case' basis (as needed for individual children).

9.2.2. Learning about sustaining models including ongoing challenges and enablers

Challenges. From the perspectives of RAA leaders, service managers and team leaders, ongoing challenges for MD working included:

- **Year on year or time-limited pilot funding** which gets in the way of sustaining a workforce and being taken seriously by other agencies. This was considered the most significant barrier by all RAA leaders.
...because year-on-year funding and not knowing until, you know... February of every year whether you're going to have funding from the beginning of April... it is incredibly difficult for staff to be managing that constant uncertainty...it doesn't allow you to plan...So it just, at the moment, it's very difficult to see how we could ever, sort of, evolve things significantly and change things significantly with the current formula and the current arrangements (RAA Leader)
...because why would anyone leave a secure job in the NHS to a, you know, moving from an NHS to a non-NHS establishment is a is a jump anyway, but if you come on a time limited contract then that presents other risks for that employee (RAA Leader)
- **Other drivers in the system affecting professional and parent behaviours and decisions, most importantly the ASGSF** considered by RAA leaders as the primary barrier, in its current state, to children's needs getting met in a timely way and to MD aspects of RAA work informing appropriate selection of (therapeutic) support.
...because there is a fair access limit, and they [some parents] look to spend that every year on therapeutic intervention and support. And actually, if we remove that, then the conversation becomes very different, because it becomes more about what's the assessed need of the child (RAA Leader)

Other challenges reported by RAA managers included: being regional (may mean you lose local service connections); having too narrow age or other eligibility criteria (restricting access for some families); not being connected administratively with the RAA social work teams; ongoing issues with trying to recruit clinicians with the right kind of experience (of

care experienced children); staff cultures (meaning people are stuck in their professional views or processes).

Broader systemic barriers drivers identified by professional interviewees included: ICB's being in a state of uncertainty or turmoil; a lack of clarity nationally about the expectations (on Health commissioners or providers; schools and virtual schools) for adopted children.

Virtual schools' representatives agreed there was a lack of clarity nationally:

We have a statutory function to provide advice and guidance... to all previously looked after children, parents, to social workers and to schools, but it is only advice and guidance... We are not case holding and we don't hold any funds, but we are case involving because we do get involved. We can't offer advice and guidance without getting involved... there's variation in the interpretation of the duties and the offer might vary [from LA to LA] (Virtual Schools Representative)

Virtual schools' representatives described varying levels of work they or colleagues actually undertook with regards adopted children, from 'signposting' to 'working closely with social workers' to 'attending consultations' or 'working closely together to provide education support plans' (despite this not being part of statutory duties) or 'co-facilitating training' for adopters or social workers.

We worked with three other local virtual schools and an adoption agency to create an education support plan...to focus on the specific needs of our care experienced, trauma experienced young people who've experienced loss. And, whilst that's not statutory, we obviously promote that as best practise and we've carried out surveys and taken feedback from users...[developed] with them, yeah, with the with the education psychologist, yeah (Virtual Schools Representative)

In some areas, even more systemic work was described, including virtual schools providing advice to an RAA about establishing the MDT or meeting regularly to discuss the whole system of support for adopted children.

Because initially there was a debate whether they would do it in-house, right? And we were like, yeah, you need somebody in-house. You need somebody that's there... we kept finding was that reoccurring, having to repeat, repeat, repeat a story, repeat, because you're going to one professional to another... to another, you just get bounced from one to the other. And that was one of the first things we discussed... we went over the names and the branding...how you access the service... [Recently] there's been quite a lot of discussion about the ASGSF and what impact is that having on families (Virtual Schools Representative)

Enablers In addition to the positive learning factors identified in relation to getting started on an MD journey and in contrast to the challenges described above, the key enabler of a sustainable model reported by professionals working in operational sites was having supportive governance arrangements.

9.2.3. Professionals' vision for the future

People working in or with RAAs were asked in interview about their vision for the future of MD arrangements. The following four key aspects emerged from their responses.

- **One: Secure funding for MD support on a permanent footing.** This was the most frequently described element to address the barriers to sustainability associated with ongoing short-term funding.

I'd like to stay on a sustainable track that's there for, in perpetuity, you know. It's not going to have to have its funding renewed in a year, in another year, in another year, because ...it's almost like they're kicking the problem down the road a bit ... you're not going to say...we're going to fund the NHS for the next year. And actually, I see this as almost like a primary care service. (Parent Voice Representative)

If ASGSF funding became devolved²⁸, some interviewees proposed there would be even more value associated with having a MD offer for families to ensure that packages of support were aligned with child and family needs, agreed in a timelier way and likely to reduce reliance on long term therapy. Other benefits might include freeing up social workers' time to undertake direct work with families (rather than continuously completing ASGSF-related assessments).

I mean, we know the ASGSF is going to be different going forward, don't we? So, I hope that within that there will be some money for MD teams...it's got to be that hasn't it? Because, you know, the money's got to come from somewhere. But I do think it would also be a chance to...look at the ASGSF and rightly so in my view (RAA Leader)

Potential changes to ASGSF funding also raised a dilemma for some RAA leaders, particularly those who considered statutory Health services should be contributing more (as well).

- **Two: An even greater focus on 'upstream' (more preventative) applications of multidisciplinary support.** Including, where appropriate, holistic assessments and formulations of some children's needs very early in an adoption journey to inform how parents and the whole system of support attuned to their needs. Some MD team leaders reflected that, to achieve this, it would take more including more sustainable funding.

We would like to see them become involved with our stage one families and kind of support all the way through...it's really good and we want more of it (Service Manager)

²⁸ As mooted in the DfE Adoption Support Consultation

...have like a some psychological consultation to all the streams of adoption, so that, you know, the recruitment and assessment and the family finders and the adoption support and the advice, you know, you'd want to have a space for everybody to...you know, bring in that psychological perspective (MD Team Member)

...the majority [of children] are being adopted at a younger age. And if you can catch it at that age and start working with them from that age, that will have an impact on the later development of how they interact with society, how they handle, you know, just mental health issues...So actually, in the long run, it's saving as well, you know, it's saving a lot (Parent Voice Representative)

- **Three: A greater emphasis on reviewing ASGSF-funded therapeutic packages** of support to ensure they meet the needs of families and avoid multiple rounds of therapy that have little effect. RAA leaders drew sometimes on their recent reviews or audits of ASGSF usage to make this point, including to emphasise the potential risks to young people of being encouraged into long term therapy rather than other forms of support that might be more acceptable and impactful.

And we've just had the results of the questionnaire to adopters...One of the questions is what services have you had and for how long? Well, some adoptive families have had therapy via the fund for, like, 7, 8, 9 years. And what we would want is ...for them to have something different... But for a child to think they needed to be in some sort of therapy for 7, 8, 9 years can't be great, can it? (RAA Leader)

I've had some interesting feedback from some adopters recently around that therapeutic relationship and how, once you're in it, you're in it and it's very difficult to...change therapeutic providers... because, once that therapeutic relationship is established, you know, you're almost stuck, unless there's a really clear reason to move (RAA Leader)

- **Four: Focus more on understanding and providing alternatives to therapy for young people** or young people in transition to adulthood (i.e. beyond age 18).

[I'm] thinking about what we could do around teenagers... it has been very limited [so far] (MD Team Member)

Some RAA leaders also expressed a desire to:

- **Undertake more complex assessments and formulations 'in house'.**
- **Provide more and different therapies 'in house'** including to fill current ASGSF gaps such as couples' therapy i.e. within the RAA including to draw on whole team resources and provide a more responsive service – whilst recognising the need for an ongoing mixed market of therapeutic support provision.
- **Work with other care experienced children and families**, for example children living in kinship care.

Other agency representatives proposed various ideas for future development at a national level including: working together (with virtual schools) to improve training for schools about the needs of adopted children; working with local authority colleagues to close the gaps on some support services (such as short breaks from caring); making the adoption offer of support (including MD support) more consistent across all regions, to provide equity of access.

10. Discussion and recommendations

This evaluation provides well-triangulated indicative evidence of the feasibility, acceptability and early signs of promise of providing MD support on an RAA footprint. MD support also fits with an emerging national focus on timelier, tailored help for parents at their first point of contact (often the RAAs or VAAs) including to support confident parents, happier, healthier children and adoption stability.

The overarching Theory of Change (Appendix A) co-produced by evaluators, funders and MD sites in the early stages of the evaluation was largely validated in the sites that were or became fully operational during the evaluation period, although not all measures could be fully tested. An essential concept, that the multidisciplinary support should seek initially to generate positive effects in parental knowledge, understanding and attunement to their child's needs was particularly well tested, with initial child and family level effects found to extend into parent/child relational health, child responsiveness to care and family stability.

Based on all the learning generated, a post-evaluation (revised) Theory of Change and allied impact or outcome measures would benefit from greater emphasis on:

- The potential for this model to assist families at different stages of an adoption journey including at matching or in the early stages of becoming a family – to help new parents process information and anticipate their child's needs (before problems arise).
- The incorporation of additional aspects of a good quality service including, for example: involving professionals who can manage complexity and speak authoritatively, exploring more than one causal factor, developing reviewable plans.
- The foundational value of providing a combination of multidisciplinary consultation, formulation and planning activities aiming to improve parent knowledge, understanding and attunement.
- The likely subsequent or 'delayed' effects on more specific child and family outcomes, with reference to the implementation of tailored, multidisciplinary-informed support plans.
- A stronger recognition that several of the originally specified whole-system outcomes (e.g. 'RAA social worker time freed up to focus on other things than ASGSF-related assessments') are likely to be dependent on broader changes to the whole system.

The standardised child and family-level outcome measures that may be useful to consider in this context are outlined in Table 11 below:

Table 11: Standardised outcome measures useful to consider for MD support

Stage	Measure	Measuring what?
Initial involvement with MDT (incorporating assessment, formulation and consultation) – measures should include:	Thinking about Your Child (Revised Version) – TAYC-R (Adoption Plus, 2021)	(Changes in) relational health between parents and children including: parent skills and understanding; parent/child relationships; child responsiveness to carer; family stability (also relevant to subsequent tailored support– see below)
	Goal-Based Outcomes (GBO) (Jacob et al., 2020)	(Changes in) specific parent/family member goals established at the start of a journey into support services e.g. to help a child back into school or to reduce family conflict.
Subsequent intervention(s) , based on support plan – relevant measures may include	Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)	(Changes in) child emotional health and behaviour.
	Brief Assessment Checklist for Children and Adolescents (BAC C and A) (Tarren-Sweeny, 2013)	(Change in) trauma and attachment-related child mental health and behavioural difficulties.
	Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (NHS Scotland, University of Warwick and University of Edinburgh, 2020)	(Changes in) parent mental wellbeing.

Note: More information about the standardised outcome measures used in the evaluation can be found at Appendix B.

This evaluation underscores what is already known about the tested measures' positive acceptability to parents (including with reference to length) and specificity to adoptive families²⁹. However, the evaluation also raises a question, alongside other recent research

²⁹ Measures' validity or reliability were not tested in the evaluation.

(Sprecher et al. (2025); The Tavistock Institute, 2017; Burch et al., 2022c) as to whether the SDQ is suitable for use in measuring change in children with complex, high-level needs. The BAC C and A measure is not tested in this evaluation, but the evaluation team note that it may be more specific to care experienced including adopted children.

Other non-standardised measures, including those focused more on child and family experiences of support, may also usefully be combined into a single ‘before and after’ questionnaire for parents / family members alongside other site-generated activity and professional as well as parent-generated impact data, examples of which can be found in this report. It is important not to over-burden families with too many requests for information so these questionnaires should be and feel relevant at each stage.

With regards the further normalisation of MD support for adoption, RAA leaders and other professionals involved in and around the early adopter and second wave pilot sites have a vision, supported by the evaluation findings, that includes:

- Securing funding for MD arrangements on a more permanent footing.
- Focusing MD support ‘upstream’ to an even greater extent i.e. in the matching or early stages of an adoption journey. Leaders make a compelling case for MD support to be at least as valuable for these families as for those in crisis or on the brink of breakdown.
- An even greater emphasis on MDTs being involved in the development of adoption support assessments underpinning individual applications for ASGSF packages to enable better tailored plans and more effective therapeutic support.
- Improving the availability of evidence-informed and acceptable forms of support for young people, including alternatives to therapy.
- Implementation of broader improvements proposed by parents and professionals.

Informed by the evaluation findings, a further roll-out of MD support across other regions in England would likely also benefit from:

- **A further revised Theory of Change** that references all the key learning from this evaluation about the rationale, key mechanisms of change and short to medium term as well as longer term outcomes that may be anticipated.
- **A clear specification** (e.g. core or common elements) and quality standards located within an overall framework for adoption support that is transparent to parents and others working in the whole system.
- **Guidance** for commissioners, service managers or leaders of MD support with reference for example to starting up, recruiting to and managing MD teams, balancing the breadth and focus of the work, working with key partners and data capture including the selection of outcome measures.

Appendix A: Overarching Theory of Change Multidisciplinary Support for Adoption³⁰

Rationale	Key mechanisms	Anticipated short to medium term effects	Anticipated medium to longer term outcomes
Adopted (and other care experienced) children are at increased risk of developmental or mental / emotional wellbeing difficulties affecting their family, friendships & school life. Difficulties can result from (intertwined) factors including developmental trauma, disrupted attachments, loss, sensory needs, neurodiversity, FASD, learning difficulties, parent/carer secondary trauma. Transitions can present opportunities but also pose risks.	Multidisciplinary teams comprising e.g. clinical psychologists, educationalists, occupational therapists, youth workers working together with social workers to provide proactive, informed, holistic and tailored: - Assessments, formulations and consultations. - Direct work with children and families (1:1 or group-based). - Team around the child & family support e.g. with and for schools, health. - Support for social workers and schools e.g. consultation, training, reflective spaces.	Accessible, supportive advice & triage into the right help at the right time. Family members feel heard, held, empowered & hopeful. Holistic, swift formulation & matched, proportionate interventions – families don't have to tell their story over & over. Parents adopt or normalise therapeutic parenting. Social workers, parents and schools are more informed and	For individual children and families: Improvements initially in parental understanding (of child needs), attunement, efficacy and confidence (parenting adjustments are well-informed). Subsequent improvements in family functioning and quality of life including better communication, relationships & realistic expectations. Child becomes more settled in an educational setting & accessing entitlements, experiencing better transitions including to adulthood. Subsequent improvements in child mental / emotional wellbeing.

³⁰ Co-produced at a December 2024 conference exploring commonalities across the pilot sites, informed by all sites' individual Theory of Change

Rationale	Key mechanisms	Anticipated short to medium term effects	Anticipated medium to longer term outcomes
Children may feel isolated, unworthy, unwanted. Parents are often experts by experience and trained in therapeutic parenting, but this may not provide all the answers. Children often need help in school. A settled educational placement is a key factor in lifelong positive outcomes - but schools may not understand their needs. Professionals acting in isolation may not be fully sited on all factors or in a position to formulate a holistic plan – resulting in missed opportunities to intervene. Whole-system responses may be late/slow, sequential or inaccessible.	Multidisciplinary work enables the right worker(s) to engage with the child or family, with the full support of the full team. Work with the whole system to help develop onward pathways (into other including diagnostic services) and to raise awareness of the needs of adopted children.	confident to make (informed) decisions – even if the work is challenging. Reduced need for specialist assessments and better informed, brokered onward referrals (including with screening to inform diagnoses) with ‘on board’ partners. Mindsets begin to shift from ‘reaching for therapy’ to being supported to enable a child to thrive. Tighter hold on budgets / intervention choice – reduced reliance on multiple private contractors. RAA social workers & clinicians, the whole system become more informed and confident about lifelong support needs of	Reduced parental stress. Children with complex needs get specialist help quicker. Reduced risk of disruptions / crises. Families trust they can come (back) for support if they need it. Families are better connected with community supports. For the whole system of support: Broader, more accessible range of support on offer. Professional, whole-system (psychological & adoption & FASD) knowledge and confidence is sustained.

Rationale	Key mechanisms	Anticipated short to medium term effects	Anticipated medium to longer term outcomes
ASGSF funds therapeutic interventions (and specialist assessments) but there are gaps e.g. for children affected by FASD, for formulation & consultation work. Prospective adopters may be put off adoption if they think the right support will not be there.		adopted people and what it's like to be an adoptive parent.	Positive impact on RAA staff – as it becomes more rewarding to work in this way. Positive impact on adopter recruitment – and prospective adopters feel more confident about adopting a child, for example, who may be affected by FASD. Saves money e.g. less reliance on ASF or substantial 1:1 packages; whole-system savings e.g. to Health.

Appendix B: Details of the Standardised Outcome Measures used in this Evaluation

Thinking About Your Child Revised (TAYC-R)

TAYC-R is a validated measure completed by parents or carers (Adoption Plus, 2021). Designed specifically for use with children who have experienced trauma, it measures the relational health between the parent and child or young person (Adoption Plus, 2024) across four key dimensions: Parent/Carer Skills and Understanding (out of 20); Parent/Child Relationship (out of 15); Child Responsiveness to Care (out of 15) and Family/Placement Stability (out of 5). In each subscale and overall, higher scores represent better relational health.

Parental Reflective Functioning Questionnaire (PRFQ)

The PRFQ is a validated measure of three aspects of parent's reflective functioning linked to the healthy emotional development of children - interest and curiosity in mental states: certainty about mental states, and pre-mentalizing modes (Luyten et al., 2017). It is suggested by questionnaire developers that high scores in pre-mentalizing modes suggest a parent's inability to put themselves in the mind of their child, and that scores that are extremely high or extremely low in Certainty about Mental States can indicate issues with parents being over or under-certain about how their child is feeling (Luyten et al., 2017). A higher score in Interest and Curiosity in Mental States is seen as positive (Luyten et al., 2017).

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a validated measure of a child or young people's emotional and behavioural functioning. Within this evaluation, versions used were the parent-reported versions for children under four years, and aged four years and over (Goodman, 1997; Goodman, 2001). It asks parents to answer the statements based on their child/young person in the past six months. There are five subscales of five items each (emotional symptoms; conduct problems; hyperactivity; peer relationship problems and pro-social behaviour) each of which are scored out of ten, where ten represents the most difficulty. Four of the subscales (all but prosocial behaviour) are also totalled to form the Total Difficulties score. Researchers have categorized different scores within the subscales, and the Total Difficulties score into categorizations of severity-Close to Average; Slightly Raised; High; Very High (Youth in Mind, 2020). There is also a supplementary impact scale which is scored out of ten, where ten represents the most impact. Scores can be compared with population norms (Youth in Mind, 2020; Meltzer et al., 2003).

Brief Parental Self-Efficacy Scale (BPSES)

The BPSES is a non-validated five-item scale measuring self-efficacy i.e. the belief of parents that they can parent effectively (Woolgar, Humayun, Scott and Dadds, 2023). Each item on the scale is scored out of five, and a higher total score represents a higher level of self-efficacy.

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

SWEMWBS is a validated measure of mental wellbeing in adults (NHS Scotland, University of Warwick and University of Edinburgh, 2020) including seven items rated on a scale of 1 to 5, with the scores for each statement being added and transformed into a metric score, where a higher score represents more positive mental wellbeing. There are population norms for the SWEMWBS calculated using data from the 2011 Health Survey for England which included over 26,000 adults' responses (Ng Fat et al., 2017).

Goal-Based Outcomes (GBO)

GBO are individual goals which people rate on a scale of 0 to 10, where 0 is not having achieved the goal at all, and 10 is having completely achieved the goal. The suggested 'meaningful change' level for Goal-Based Outcomes, according to research by Edbrooke-Charles et al. (2015) is over 2.45, although more recent research suggests this should be an increase of 3 or more points (Jacob, Costa da Silva, Sefi, & Edbrooke-Childs, 2020). Although the goals selected will be different for different families, GBO is still a useful measure to understand families' perception of progress towards what is important to them, and it is used as one of the measures to indicate impact for ASGSF-funded therapies³¹.

³¹ <https://www.healthynottinghamshire.org.uk/media/kjgmw3aq/asfintroductiontoomtforfamiliesissued.pdf>

Appendix C: Multidisciplinary sites' activity levels and staffing

Within this appendix, we outline in detail five MD sites³² recent activity levels across whole year periods between 2023 and 2026 and staffing composition at around February 2026. The different ways in which sites have described their activities means it is not possible to very precisely compare levels of activity.

Table 12: Site One - Early Adopter Site with RAA footprint

Activity Type	Activity levels 2023-2024	Activity levels 2024-2025
Consultation (formal sessions, underpinned by MD assessment and formulation)	71	60
Consultation (sessions – informal, for professionals)	147	71
Screening assessments (for cognitive difficulties / neurodevelopmental differences etc.)	3	4
Parent training programmes (e.g. Foundations for Attachment; BUSS; Therapeutic Play) approx. 6-9 families per programme	10	10
Social worker training programmes (sessions on recognising blocked care; therapeutic life story etc.)	3	3
Education worker training programmes (sessions on working with adopted children)	5	5
Direct therapeutic work programmes 1:1 with families (families receiving DDP-informed family therapy; 1:1 BUSS; therapeutic parenting support)	14	41
Other 1:1 direct support for families (families receiving SLT or Early Years /Education support e.g. for transitions)	172	117
Helpline (education / life story) calls	148	78
Whole-system work to build relationships with neurodevelopmental pathways & education	N/A	N/A

³² Other sites either could not provide sufficiently full activity or staffing mix data, mainly because they had not become fully operational during the relevant evaluation period (the pan-regional sites) or had only been funded for 18 months of the pilot period, focusing mostly on strategic development work.

This all-age early adopter model did not receive AE funding (2023-2026) and some roles and offers (particularly SLT support) have been lost between 2024 and 2025 because of cuts to the Health component of its mixed (RAA and Health) funding. The most recent (early 2026) staffing composition (organised from highest to lowest FTE) was:

Staff member	FTE
Senior Therapeutic Social Workers	1.8
Occupational Therapist	1.2
Clinical Psychologist	1.2
Business Support Officer	1
Multidisciplinary Team Manager	1
Education Lead	1
Early Years Practitioner	1

Table 13: Site Two - Early Adopter site with an RAA imprint

Activity Type	Activity levels 2023-2024	Activity levels 2024-2025
Consultation for social workers (adoption support focused, including planned and ad hoc for 2024-25)	19	39
Consultation for social workers (specifically transitions focused) underpinned by formulation	30	29
Specialist assessments	11	11
Wellbeing focused consultations for social workers i.e. focusing on their own wellbeing		17
Parent training programmes (e.g. programmes on therapeutic parenting or Theraplay) approx. 6-9 families per programme	6	6
One off sessions for parents e.g. on education transitions; the teenage brain; self-care for parents.	8	5
Professionals' training programmes for social workers or other professionals e.g. on working with schools; empowering adopters; worker wellbeing	6	6
Direct 1:1 therapeutic support for families (families supported with e.g. sensory attachment; therapeutic parenting)	76	75

Activity Type	Activity levels 2023-2024	Activity levels 2024-2025
Other 1:1 direct support for families (families receiving support with school transitions, or advice to educational settings)	57	41
Whole-system work to build greater understanding e.g. through adoption transitions guidance; leading virtual school group	N/A	N/A

This site not funded by AE between 2023 and 2026 was established to work with children up to the age of 12 years and their families. Between 2023 and 2026, the MDT lost some clinical psychology and psychiatry resource because of cuts to the Health component of its mixed (RAA and Health) funding. The most recent (early 2026) staffing composition was:

Staff member	FTE
Therapeutic Social Workers	2.6
Clinical Psychologist	1.1
Occupational Therapist	0.4
Educational Psychologist	0.4
Assistant Educational Psychologist	0.4
Research Assistant / Assistant Psychologist	0.4
Business Support Officer	0.4
Psychiatrist	0.2

Table 14: Site Three - Second Wave site with an RAA footprint

Activity Type	Activity levels 2024-2025	Activity levels 2025-2026
Consultation for families (underpinned by holistic assessment and formulation)	49	101
Consultations for professionals including social workers, school staff, virtual schools	61	41
Parent training programmes (Foundations for Attachment; emotional regulation) approx. 15 families per year	3	3

Activity Type	Activity levels 2024-2025	Activity levels 2025-2026
Social worker training programmes (sessions on sensory integration, secondary trauma, neurodiversity and education etc.)	10	4
Training for wider workforce (sessions on sensory integration in schools, PACE, trauma and the brain)	18	4
Direct 1:1 therapeutic work with families (sensory; NVR; DDP-informed family therapy; YP support)	42	94
Other 1:1 direct support for families (Education support e.g. for transitions or with learning needs assessments or education support planning)	23	21
Whole-system work to build relationships with key partners	N/A	N/A

This site developed and implemented an all-age adoption-focused service, based on earlier MD support for care experienced children. Between April 2024 and March 2026, the offer of consultation to and direct therapeutic work for families doubled in size whilst other elements remained at about the same level or declined.

At early 2026 the staffing composition was:

Staff member	FTE
Clinical/Counselling Psychologist	1
Educational Psychologist	1
Occupational Therapist	1
Therapeutic Social Worker	1
Business Support Officer	0.6
Service / Team Manager	0.5
Consultant Clinical Psychologist	0.2

Table 15: Site Four - Second Wave site with an RAA footprint

Activity Type	Activity levels 2024-2025
Consultation for social workers working across different parts of an adoption journey	23

Activity Type	Activity levels 2024-2025
Consultation for families underpinned by holistic assessment and formulation	27
Parent training programmes including co-facilitated with RAA social workers (e.g. programmes on DDP-informed therapeutic parenting, 6 families per group; webinars on child to parent violence and sleep and toileting difficulties)	4
RAA training and support for social workers (e.g. on safeguarding in the context of adoption; domestic abuse through an adoption lens; therapies explained)	3
Direct therapeutic 1:1 support (parents receiving support with therapeutic parenting, secondary trauma and young people receiving support with self-esteem, identity, digital story, CBT for anxiety)	24
Other 1:1 direct support for families (families receiving Early Years /Education support e.g. for transitions or with education support planning; supporting families in key e.g. TAF meetings)	7
Whole-system work to build relationships with key partners e.g. creation and implementation of an 'Education Support Plan' with virtual schools	N/A

At the time of collecting data, this site was able to share activity data representing a first whole year of implementation (2024-2025). This site has emphasised strengthening whole-system working to a greater extent than others (including working with virtual schools and schools locally to develop education plans for adopted children) whilst still offering core MD activities supported and supervised by a highly experienced consultant clinical psychologist. At early 2026 the staffing composition was:

Staff member	FTE
Senior Assistant Clinical Psychologist	3
Occupational Therapist	1
Project / Service Manager	0.6
Consultant Clinical Psychology	0.4

Table 16: Site Five - Second Wave site with an RAA footprint

Activity Type	Activity levels 2024-2025
Full consultations including professionals and families	14
Single MDT professional one-off consultations for family members e.g. with a clinical psychologist, OT, SLT or youth worker	249
Parent workshops (e.g. workshops on education transitions, SEND, advocacy)	12
Parent training programmes (i.e. a rolling programme focusing on sensory movement)	1 (rolling programme)
RAA staff training (lunch and learn sessions on e.g. FASD)	2
Training for education professionals (workshops on e.g. PACE in schools; sensory processing; trauma and attachment)	3
Direct 1:1 work with young people (YP receiving in-depth 1:1 youth work and advocacy)	10
Group based support for young people (YP attending youth club)	2 groups- 16 YP
Other 1:1 direct support for families (families receiving education support worker support for planning and advocacy; peer support; and tailored support for schools)	96+
Whole-system supports including facilitated sessions of voice and influence groups of adoptees and adopters	N/A

This model received DfE MD funding to develop and explore a MD model including core elements and additionally aiming to fill gaps in support for young people aged 10 to 17 years and their families at high risk of breakdown. Therefore, unlike other models, it includes a youth worker element. At early 2026, the staffing composition was:

Staff member	FTE
Youth Worker	3
Education Support Worker	2
Team Manager	1
Business Support Officer	1
Advanced Social Work Practitioner	0.5
Speech and Language Therapist	0.4
Clinical Psychologist	0.4

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