Comprehensive services for complex needs: assessing the evidence for three approaches

Wraparound, Multisystemic Therapy and the link worker model

Contents

Acknowledgements

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1. Introduction

1.1 Services for multiple and complex needs

Research has identified a group of people facing multiple and complex needs, who are in repeat contact with the criminal justice system. Their needs include mental and physical health problems, substance misuse, poor housing and homelessness, unemployment, poverty, low educational attainment, behavioural issues and repeat offending (Anderson, 2010). While this group remains relatively small (estimated at 58,000; LankellyChase, 2015), it is overrepresented within the criminal justice system, particularly short sentence prisoners, and among homeless people (Duncan and Corner, 2012).

Despite the overall complexity of need among this group, services regularly fail to adequately address multiple problems and individuals often 'fall through the gap' between services. Many statutory services have tightly defined remits and limited resources, focusing on severity of need and on single issues be they health, housing or drug dependency. People with multiple and complex needs often fail to meet the thresholds set by individual services, despite the fact that in combination their problems result in a high level of need (Anderson, 2010). As well as this, they are sometimes excluded from services as they struggle to keep to rigid appointments and may be seen as disruptive.

This paper introduces three service models that aim to improve outcomes for people with multiple and complex needs. These are: Multisystemic Therapy (MST), wraparound, and the link worker model. Although the three models differ from each other in many ways, all three attempt to support people who have not been helped effectively by services. All three models adopt strategies which are holistic, which respond to individual need, which incorporate client choice, which cross professional boundaries and which work specifically to address complex needs.

Table A: Introducing the models

Wraparound	A process to co-ordinate service delivery and informal support networks, in which the family have a central voice.
Multisystemic Therapy	An intensive psychological treatment programme which takes place in the family home, addressing the different areas which influence behaviour of young people.
Link workers	Link workers provide support and advocacy for their clients, linking them to services that will address their multiple needs and stabilise them.

Why review these particular models?

The three models were chosen on the basis that they are specifically aimed at people facing multiple and complex needs. They are also focused on reducing reoffending, are all based in the community as opposed to institutions, and they have some key delivery features in common: for example, they all take holistic and individualised approaches. In this sense they differ from a lot of services in the UK which are or have been set up to address one outcome only – such as substance misuse or mental health. We also anticipated that each model has a sufficient body of literature to enable detailed discussion, although the review found that the evidence base for each model varies considerably.

Similar models prominent in UK policy

A significant recent policy development in the UK is the use of the **Family Intervention Project (FIP) model**. Family Intervention Projects originated in 2006 as part of the Respect Action Plan and were aimed at families responsible for disproportionate amounts of anti-social behaviour (White et al, 2008). The FIP model has now been adapted for the coalition government's Troubled Families Initiative. A persistent, 'assertive outreach' approach is a core part of the model. Key workers provide intensive support to families with complex needs. They have small caseloads and often visit the family home several times a week. They work with the entire family in recognition of the connections between different problems faced by family members.

These aspects of the FIP model are similar to some key aspects of the three models discussed in this paper, in particular Multisystemic Therapy, in which interventions are delivered to families with complex needs in the context of the family home. Both models focus on parenting skills as well as other environmental risk factors and strengths. That said, there are some major differences. One of these is the emphasis on model fidelity; this is not routinely monitored in the Troubled Families programme. Other differences include evidence of effectiveness, theoretical underpinnings and the types of intervention used. MST is delivered by practitioners with tightly controlled therapeutic, psychological and family therapy skillsets. It has a greater emphasis on therapeutic approaches, and does not use sanctions. The FIP model also has something in common with link worker models, as key workers also co-ordinate support from services, in particular education and housing (White et al, 2008).

Family Nurse Partnerships (FNP)

The Family Nurse Partnership model was originally developed in the US and has been implemented in England since 2007. It is a preventative programme for vulnerable young mothers. Specially trained nurses offer intensive and structured home visits from early pregnancy until the child reaches two years old. They work with the young women on issues such as attachment, relationships and psychological preparation for parenthood. The model is aimed at improving future outcomes for children and improving parental mental health, and there is robust evidence for effectiveness, although this largely originates from the US (Department of Health, 2010).

The emphasis on the role of caregivers is similar to MST, and both models require the professional to build a trusting relationship with the parent. Like MST, the FNP model is a licensed programme and implementing the 'pure model' is of high importance. However, in focusing on very early intervention to improve outcomes, it clearly differs from the three models discussed here.

This paper accompanies a shorter summary briefing for commissioners (Revolving Doors Agency, 2015)[1] and provides a more detailed review of the evidence of all three models. The shorter briefing summarises the effectiveness and potential cost-benefits of all three models.

This section provides some context to this paper, briefly introduces the models and outlines the methodology.

Section two of this report describes the three models, introducing the key principles of each. It provides a short history of each model to provide a context for the available evidence and its applicability to both children and adults in the UK with multiple and complex needs. This section concludes with a comparison of the shared principles across all three models and their distinct features.

[1] Available to download at www.revolving-doors.org.uk/partnerships--development/spark/resources

Section three discusses the effectiveness of each approach by summarising and assessing the available evidence against a range of outcomes, including reducing reoffending and improving mental health. It also analyses key findings from qualitative research on why each model is effective and discusses the overlap between the models and research into desistance from offending, recovery from mental health and substance misuse, and (for wraparound and MST in particular) child development.

Section four considers key success factors across the models, and section five summarises our findings.

1.2 Methodology

Describing the models

The descriptions of the models provided in this paper are based on the review of the literature and in particular papers by key authors, often those associated with model development (Schaeffer and Henggeler for MST, Revolving Doors Agency for the link worker model). For MST and wraparound, the models have been clearly articulated in the literature. However, the link worker model is loosely defined; therefore, a list of key principles was drafted based on sources including O'Shea et al (2003), Rosengard et al (2007) and Rankin and Regan (2004). This was then submitted to practitioners within link worker services for comment. Three people responded offering useful critique and insight into the reasoning behind the principles. Their responses suggest there is not yet firm consensus on what it means to be a link worker.

Some of the evidence discusses *service navigators* rather than *link workers* (e.g. Rankin and Regan, 2004), although the term *link worker* does appear to be the most common based on the literature and the practitioners' comments. A link worker is also someone in dual diagnosis services who focuses on disseminating good practice among different professionals (Anderson et al, 2013) and can be someone supporting people with complex *medical* needs only (Halliday and Asthana, 2004). The term 'boundroid' has been linked to the term link worker; however, again this appears to focus on people straddling professional boundaries in social care (Manthorpe, 2013). These models are not discussed in this paper.

Evidence review

The literature review of evidence for each of the models took place between January and February 2014. Literature was identified through the National Wraparound Initiative website and MST Online, as well as a database search (Wiley Online, the Cochrane Library, PubMed, Google Scholar, the Social Sciences Citation Index, Science Direct) using search terms including *wraparound*, *wrap around*, *wraparound adults*, *multi systemic therapy*, *multisystemic therapy*, *link worker*, *navigator*, *service navigator* and *boundroid*. Bibliographies of identified papers were also reviewed for relevance. Priority was given to meta-analyses and systematic reviews where these were available, and to research published in the last 15 years. For MST and wraparound, much of the literature originates from the US and relates to young people, so significant attempts were made to incorporate UK-based research and research on adults where possible.

As part of the review, studies were assessed to check how faithfully the programme delivered was to the original model, using the principles articulated in the literature. Poor outcomes for programmes or services are sometimes due to the model being implemented inconsistently or incorrectly, so it was important to consider whether this was the case for any of the studies reviewed in this paper. Evidence was not excluded on the basis of other strict quality criteria such as lack of a control group; in the case of the link worker model there is no such experimental research. However, the paper does assess the strength of the evidence for certain outcomes, noting where there is a lack of rigorous evidence. Priority was given to studies where participants had multiple and complex needs (this was generally the case, due to the nature of the models).

The validity of this review

This review assesses the evidence available for all three models, and concludes that the models are promising for working with multiple and complex needs. However, further research is needed to explore how wraparound and MST might work in a UK context and to determine whether all three models work well for different groups – people from black and minority ethnic backgrounds, and women or girls facing multiple and complex needs. The scope of this paper was necessarily limited by the evidence we found.

The report aims to include as much of the evidence as possible. However, it is not a full systematic review but a comprehensive assessment and there were some gaps in the evidence found. For example, the review of evidence did not find any research into the effects of MST and wraparound on physical health but there is a small possibility that there is evidence available which we did not find.

The three models were chosen for review based on their important similarities and their relevance to those with an interest in improving outcomes for people with multiple and complex needs. However, if considering implementing any of these models, their distinctive features, target client groups, and respective bodies of evidence should be reviewed separately. In recognition of this, this paper separates the description and evidence sections for each model.

2. Wraparound, Multisystemic Therapy and the Link Worker Model

2.1 Introduction to wraparound

Wraparound originated in a grassroots context in the 1960s United States as communities looked for ways to prevent hospitalisation or imprisonment of young people with complex needs and emotional/behavioural disorders (Myaard et al, 2000). Previously, these young people were often put in psychiatric hospitals in an effort to create safer communities (Chitiyo, 2014). Since these origins, wraparound has spread to other countries, including New Zealand, and most states in the US operate a form of wraparound.

Wraparound is a largely youth-focused model catering for an age range as wide as 10-24 (Shailer et al, 2013). However, it has been extended to adults and modified accordingly. It is a process to co-ordinate service delivery and support rather than a treatment. Crucially, it takes place in the community in which the young person and their family lives, as opposed to in a formal office or institution; and members of the 'wraparound team' include people who can provide informal or community-based support. Families have a central voice and the model responds to their strengths rather than emphasising their needs. A small flexible budget enables delivery of the 'wraparound plan', for example by paying for a class the young person wants to attend.

Each plan will be unique: wraparound incorporates family strengths, individual preferences and community-based sources of support (VanDenBerg and Grealish, 1996; Shailer et al, 2013). Sometimes the grassroots nature of the model means implementation of the ten core principles (listed below) is inconsistent and not routinely monitored. Facilitators co-ordinating wraparound may not be coached on an ongoing basis. Bertram et al (2014) note that wraparound is often incorrectly interpreted as a very thorough, family-friendly form of case-management.[2] Their study of a Houston wraparound programme found that the majority of teams were generally comprised of just two family members (including the child) alongside one or more formal service providers (against principles three and five). As will be shown in section four, faithful implementation of the model is important to achieve good outcomes.

The aforementioned ten principles inform the design and delivery of the plan:

[2] In certain public sector agencies in the UK, such as probation, 'wraparound' is sometimes used as a synonym for holistic or continuous support. However, the model we are discussing here has specific principles and features and has not yet been implemented in the UK to our knowledge.

Table B: The ten principles of wraparound, paraphrased from Bruns et al (2004)

Wraparound Principles
1. Prioritise the family's voice and choice
2. A team based approach. Team should include all professionals already working with the family
3. Emphasises informal networks, such as extended family and friends, which will continue after the formal process comes to an end
4. Collaboration: everyone works together to implement a single plan
5. Support and services should be as community-based as possible
6. Culturally competent, by incorporating particular cultural mores, religious practices and linguistic requirements into service delivery
7. Individualised
8. Strengths based
9. Unconditional or Persistent. Teams work until the wraparound process is no longer needed
10. Outcome based

These principles were formally defined in 1998 (National Wraparound Initiative (NWI) Online, undated) and the philosophy has been refined in the literature. While there is emerging consensus around these principles, some ambiguities and debates remain (as discussed in Bruns et al, 2004).

Wraparound is certainly aimed at people with multiple and complex needs, referred to in the literature as those with "extensive and multifaceted needs" (Shailer et al, 2013: p.187), "complex and enduring needs" (VanDenBerg and Grealish, 1996: p.7) and simply "complex needs" (NWI Online, undated). Most recipients of wraparound are young people and their families. More recently, wraparound has been applied to adults leaving prison in Oklahoma. Wraparound facilitators begin to work with prisoners six months before release and work with them to determine their personal goals post-release (VanDenBerg and VanDenBerg, 2008).

2.2 Introduction to Multisystemic Therapy (MST)

Multisystemic Therapy is an intensive therapeutic intervention aimed at preventing children from moving into costly child protection placements and from reoffending. It originated in the US but now operates in the UK and has been commissioned by some local authorities as part of their remit in children's services and youth offending. It is approved by National Institute for Health and Care Excellence (NICE). It is generally targeted at children with serious and chronic behavioural problems including young offenders (Stambaugh et al, 2007). Specific versions of MST have been designed for different target populations, including young people with mental health problems; however, the majority of the literature tends to focus on the benefits of the approach for young offenders.

The model is strictly defined, although individualised to each child and interventions may vary. It is owned and licensed by the organisation *MST Services* (www.mstservices.com) which also monitors how faithfully

the model is implemented through things like supervision by senior clinical psychologists and psychiatrists. Services wishing to deliver MST must receive comprehensive initial training and ongoing supervision and monitoring.

The model is based on social-ecological theory which emphasises the influences of the immediate context on an individual's behaviour and vice versa (Wells et al, 2010) and the interaction between individual, interpersonal and environmental factors. MST addresses the 'systems' in which problems can occur, such as school, family and friends. In delivering interventions in the young person's context, MST can target elements of the environment that appear to sustain problems and perpetuate problematic behaviour. Other models which take a child out of their 'natural' environment may not address underlying causes of behavioural problems.

MST aims to mobilise strengths in the different 'systems' in a child's life, particularly through the role of parents or guardians who have a central role in promoting sustainable change in behaviour as well as improving health and wellbeing (Lennox and Khan, 2013). The model is intensive: therapists work with the family for a limited period (up to seven months in the UK) but visit several times a week and are available by phone 24/7 (Butler et al, 2011). Therapy is provided by practitioners with at least a Masters-level qualification in psychology or social work. Interventions can include: individual therapy, such as cognitive skills building; family therapy, such as parent management training; school interventions; and peer interventions (Henderson, 2009). Where one intervention does not work, practitioners try a new approach rather than blaming the family. Persistence is a fundamental part of MST.

Like wraparound, MST has a list of key principles, listed below (paraphrased from ***MST Services*, 2010a)**

Table C: The nine principles of MST

MST Principles
1. 'Finding the 'fit'': between identified problems and how they play out within the young person's environment
2. Positive and strengths-based
3. Increasing responsibility; for example, parenting responsibilities
4. Focused on the present. Therapists identify goals and actions that can be taken immediately
5. Targeting sequences, particularly relationships driving behavioural patterns – family or friends
6. Age and developmentally appropriate
7. Continuous effort: an intensive process
8. Evaluation and accountability: Effectiveness is continually tested during the process
9. Generalisation: lessons learned can be applied after treatment ends

2.3 Introduction to the Link Worker Model

This model originated within the UK in the early 1990s, in direct response to people falling through the gaps between services and coming into repeat contact with the criminal justice system. Link workers aim to help people who are not receiving the support they need, through linking them in with services and acting

as advocates and continuous sources of support (O'Shea et al, 2003). In the UK a number of organisations continue to provide link worker–style services, for example: Elmore Community Services, Providence Row Housing Association, P3 and St Mungo's. The model is designed for individual adults.

The model has evolved organically and is not strictly defined in the literature – most descriptions are of services rather than a 'pure' model. For example, Rankin and Regan draw on two pre-existing services to explain what they term *service navigators* (2004). The description here captures insight from a variety of sources. Broadly, link workers support people experiencing issues such as "poor mental health, substance misuse, poor social relationships, financial difficulties, lack of employability and exclusion from services" to navigate the multiple systems and services they need to access support (Cattell et al, 2011). Clients are helped to engage with and access services such as health, probation and housing. To do this, link workers act as advocates and brokers as well as supporting their clients to engage with services themselves. As well as this, link workers often work strategically with local commissioners and service providers to increase clients' access to services with high thresholds.

Link workers must have knowledge of mainstream and specialist services as well as issues such as learning disability and mental health issues (Rosengard et al, 2007; Rankin and Regan, 2004). However, the way in which link workers relate to their clients is as significant as the practical support they give. Link workers offer a consistent, persistent and assertive approach to people with multiple and complex needs. They 'role model' good behaviour and offer a positive social relationship that may have been absent from many of these individuals' lives. As well as advocacy, they offer advice and emotional support. The model is non-punitive and, where commissioning arrangements allow, open ended; services avoid rejecting clients for challenging behaviour or failing to attend appointments (O'Shea et al, 2003). Rather, the team will repeatedly try and make contact with clients if they do not attend scheduled appointments, recognising that this group may have difficulty in adhering with rigid appointment systems. This includes phoning, texting, meeting in non-traditional places such as parks, contact through social media and attending at other mandatory appointments (Patel, 2010; personal correspondence, 05.02.2014).

Table D: Link worker model principles (based on literature and expert opinion, drafted for this paper)

Link worker principles
1. Co-ordination and advocacy: helping people gain access to appropriate services
2. Consistency: link workers are a stable source of support
3. Persistent and creative. Link workers keep trying to engage their clients
4. Non-punitive: clients aren't excluded for not engaging or even abusive behaviour
5. Holistic: addresses multiple needs
6. Supportive approach to developing skills and appropriate behaviour
7. Individualised and client led
8. Open-ended. Clients may return to the service
9. Team-based approach
10. Strategic level working to negotiate flexibility of service thresholds

Based on consultation with experts and variation in the literature, principles eight, nine and ten are not always considered essential to the link worker model. Practitioners told us that often funding requirements

put constraints on the overall length of time that the service could work with clients (personal correspondence, 20.02.2014).

O'Shea et al (2003) discuss the role of attachment theory in informing the model's theory of change and how it is delivered in practice. Underlying this is the assumption that many people with multiple and complex needs struggle with forming positive relationships. This is linked to unstable attachments in infancy; much of this group experienced trauma, neglect and abuse in their early lives and may have been taken into care. This can result in difficulty in forming stable attachments in adult life, underlined by a chronic fear of both abandonment and intrusion. As a result, diagnoses of personality disorder are common (Anderson and Cairns, 2011). For this reason, link workers seek to form a trusting, positive relationship with their clients and support them to form positive attachments in their day to day lives.

2.4 How similar are the models?

Table E: Exploring similarities between origin, core principles and delivery

	Wraparound	MST	Link workers
Target group	Targeted at young people with multiple and complex needs and their families; has now been extended to include adults	Targeted at children and young people and their families with multiple and complex needs	Targeted at individual adults with multiple and complex needs
Origins	Developed as an alternative to institutionalisation (e.g. care, custody or psychiatric unit)	Developed as an alternative to institutionalisation (e.g. care, custody or psychiatric unit)	Developed to stop people going through the 'revolving door' of crisis and crime
Who is involved in support delivery	Focus on co-ordinating community-based support (e.g. extended family) as well as professionals	Focus on mobilising strengths in the systems surrounding children (e.g. parental skills, education, peer group and community-based activities)	Focus on accessing formal services but works with people based in the community
Role of choice	Family voice and choice is prioritised	Family choice is incorporated into service delivery	Individual choice is incorporated into service delivery
Strengths-based	Tailored to individual strengths and needs	Tailored to individual strengths and needs	Tailored to individual strengths and needs
Skills focused	Developing family's skills across a variety of contexts	Developing family's skills across a variety of contexts	Developing people's skills through role modelling
Individualised and person-centred	Type of plan and support varies from person to person	Type of intervention varies from family to family	Type of support varies from person to person
Time limit	Persistent and open-ended	Persistent: if treatment does not work, alternative interventions provided. Support time-limited	Persistent, open-ended where possible

Table F: What is distinctive to each approach?

Wraparound	MST	Link workers
• Focuses on informal sources of support that will continue after the process formally ends • A team working together, in which the family has as strong a voice as the professionals • Evolved within a grassroots setting • Fidelity to the core model varies as implementation is not routinely monitored	• Service provided by professionals with high level therapeutic skills • Emphasis on the positive role of parents in responding to challenging behaviour • Time limited (around 6 months) • Evolved within paediatric mental healthcare • Owned and licensed by *MST Services* which ensure high model fidelity through training and monitoring	• Particular focus on access to formal services (perhaps reflective of its UK origins) • The model was developed for adults • Evolved through service delivery • Loosely defined: the core principles are still developing. Delivery against the original model not usually monitored

3. The evidence for MST, wraparound and link workers: How effective are they in improving outcomes?

A note on which outcomes this section focuses on and why

The tables throughout this section summarise evidence against particular outcomes for the individual models and for all three. The overarching outcomes were chosen based on the issues most commonly experienced by people facing multiple and complex needs.

This includes, but is not limited to: contact with the criminal justice system and care system, homelessness, substance misuse and mental health issues. Although this review's scope was limited by the outcomes measured in the body of evidence, most studies do focus on reducing offending, reducing use of custody and the care system, improving mental health and improving 'functioning' – meaning things like coping skills and behaviour.

3.1 Evidence for wraparound

Does it work? Discussion of the quality of evidence

There is some promising US-based evidence for wraparound including a small number of high quality studies showing good results. Further rigorous research is needed, but several studies published in peer-reviewed journals have shown that wraparound is effective in reducing offending rates, improving mental health and/or improving behaviour/coping skills. There is particularly strong evidence for the effectiveness of wraparound in keeping young people in their homes and out of custody, foster care or hospital (Suter and Bruns, 2009). Pullmann et al (2006) suggest that these promising outcomes are sustained in the long-term. Most evidence applies to the US; the evidence review undertaken for this paper did not find any studies on implementation in the UK.

Although research comparing wraparound recipients with a control group has shown promising outcomes, more research employing the most rigorous research methods is required to test early, promising findings (see the Maryland Scale of Scientific Methods (Sherman et al, 1998) for an overview of standards of evidence when evaluating overall effect). In addition, results from the most reliable studies are not always consistent. A 2003 randomised control trial showed some improvements in behaviour and school attendance but no difference in recorded criminal offences between recipients of wraparound and a control group (Carney and Buttell, 2003).

Wraparound is implemented in varying ways, and is a framework for working with families as opposed to a strict model. Different elements of the process may be more or less effective in different contexts such as the participation of family and friends, the use of flexible funding and the open-ended nature of the process. In addition, the core principles are not always adhered to, even though this seems to be important for achieving positive outcomes. Non-experimental research found that outcomes in a Houston-based wraparound programme substantially improved after staff and supervisors were intensely trained and directed towards the nine principles of wraparound, particularly 'family voice' and 'natural supports' (Bertram et al, 2014). However, such systematic supervision and attention towards the core principles do not appear to be the norm.

So far, experimental research on wraparound is confined to young people in the United States. 'Treatment as usual' for young people with behavioural problems in the US is widely noted to be poor or even non-existent in some cases. The position in England is different, as baseline services are generally much better, meaning that a new intervention could have a smaller margin for improvement within which to operate (Butler et al, 2011). This means that good results from wraparound trials within the US may not be replicated here. In addition, many of the studies have a majority of white, male participants; there is less evidence of how effective wraparound is for black and ethnic minority groups or girls and women.

A meta-analysis of wraparound concluded that evidence for wraparound is promising but further and stronger research is required (Suter and Bruns, 2009). The meta-analysis assessed the results of seven studies, which qualified for inclusion if they used a control group and were available between 1986 and 2003. The researchers noted the lack of studies using random allocation and that some studies did not report or discuss attrition rates (when people drop out of a trial, outcomes may be affected as those who drop out tend to be less motivated to succeed). There does not appear to be further experimental research published since this meta-analysis; Revolving Doors did not find any in our database search.

Evidence for the effectiveness of wraparound for adults is so far limited and no formal research studies have been undertaken (Wilson, 2008: p.1). Oklahoma was the first state to apply wraparound principles to its adult offender population. Facilitators worked with offenders to determine their personal needs and goals after leaving prison and early results in reducing reoffending were characterised as promising (VanDenBerg and VanDenBerg, 2008). Wilson's literature review (2008) outlined the crossover between some "evidence-based principles" for adults leaving prison and wraparound (2008: pp.5-6). These include: service integration, flexibility, a consistent message and meeting the multiple needs and strengths of adult offenders. These factors are very similar to wraparound principle two (team based) and principles seven and eight (individualised and strengths-based). The evidence also suggests that integrating formal and informal sources of support is effective (principles three and four) and that monitoring progress is important (principle ten).

More evidence is needed to assess the cost-effectiveness of wraparound to determine how outcomes such as reduced reoffending and reduced use of inpatient psychiatric services may translate to savings. One US-based programme recorded considerable savings through the care system; after wraparound was implemented, the average overall cost of care per child dropped from over US$5,000 per month to less than $3,300 per month. However, this dates back to the 1990s and costs were not compared to those of a control group (Kamradt, 2000) so more research is needed to test these promising findings.

Table G showing for which outcomes wraparound has demonstrated improvements:

Outcome	Does wraparound affect this outcome?
Reducing reoffending	Yes, it can reduce proven offending in the interim and long-term for young people. Pullmann et al (2006) found that young people in a historical comparison group were 2.8 times more likely to commit an offence than those receiving wraparound. Suter and Bruns (2009) found a small but significant[3] effect in their meta-analysis. However, results are not completely consistent Carney and Buttell (2003) found no significant effect.
Improving mental health	Yes, it can. The meta analysis of several studies found a significant although small positive effect on young people's mental health (Suter and Bruns, 2009). Stambaugh et al (2007) found that MST is more effective than wraparound for improving mental health symptoms in young people; however, wraparound recipients did show some positive change.
Improving familial relationships	There is some positive evidence suggesting wraparound can improve this outcome, although the evidence is limited and it is not always measured. Carney and Buttell (2003) found that wraparound recipients were less likely to run away from home than the control group.
Improving behaviour	Yes, it can. Some of the evidence does show a positive effect on young people's behaviour, such as a reduction in aggression and assault, although this does rely on self and parent-reported data in some cases (Carney and Buttell, 2003). The meta analysis of several studies found a small but significant effect (Suter and Bruns, 2009).
Reducing drug and alcohol use	The evidence is inconclusive. A multiple baseline study recorded a dramatic reduction in drug and alcohol use. However this was in an extremely small sample size of four (Myaard et al, 2000).
Preventing institutionalisation (hospitalisation, custody and detention, going into care)	Yes. There is rigorous evidence that wraparound works in preventing children going into foster care and in reducing imprisonment rates. For example, Pullmann et al (2006) found that 100% of a control group served some time in detention in a two year period, compared to 72% of the wraparound recipients. Evidence for improvements in these outcomes appear to be more consistent and show a stronger impact than for any other outcome (Suter and Bruns, 2009; Bruns, 2008), although again the evidence is centred on young people.
Improving housing situation and preventing homelessness	Very little relevant evidence due to the focus on young people.
Achieving employment, education or training	Some studies have found that wraparound improves school performance (discussed in Suter and Bruns, 2009). Carney and Buttell (2003) found wraparound participants received fewer suspensions and had higher attendance rates than a control group.
Cost effectiveness	More research needed; one US study shows a drop in costs incurred through care system.

[3] In this context, 'significant' refers to statistical significance. This is the case throughout this review.

How does wraparound change outcomes? Insight from qualitative research

Because each wraparound process is different, and each plan is unique, it clearly will work very differently for each young person and their family. However, Bruns et al (2014) discuss a theory of change with two distinct routes to outcomes.

Wraparound means services will cater to families' needs more effectively

The principles of wraparound, which focus on unique choice, the full gambit of needs and utilising community resources, mean that a particular family's needs should be better catered to than under a generic service model. Families may feel the process is more relevant, appropriate and useful. Spanish-speaking families who had gone through wraparound described the relief they felt when discovering their wraparound facilitator spoke fluent Spanish (Painter et al, 2011).

A case study from New Zealand (Shailer et al, 2013) shows how wraparound co-ordinates services so that multiple needs are met. In this case, the process incorporated many different services working to meet the family's unique needs:

- The wraparound facilitator took the teenage girl, Julie, to mental health appointments
- A mentor met Julie after school to help keep up attendance rates
- A social worker helped Julie's mother to claim benefits to supplement her work income.

Wraparound enhances the capacities of families

> *"I got a hold of it now, how to control him, make him be still, sit down and listen, time outs. [My facilitator] taught me how to do it."*
>
> (Painter et al, 2011: p.162)

The second route to change comes through the enhanced capacity and functioning of families themselves, rather than the effectiveness of services. The empowering approach of wraparound that incorporates family strengths means that families are better placed to "plan, cope and problem solve" (Bruns et al, 2014: p.4). Families are involved in making decisions about what is best and gain experience and insight into making choices and setting and implementing goals (Bruns et al, 2014).

Evidence shows that including all family members with caring responsibilities for the child on the wraparound team is associated with better outcomes (Bertram et al, 2014). Through the team-based approach of wraparound, the family can gain experience and awareness of working together to achieve positive results.

> *Marama started to feel more effective as a parent because she had strategies to deal with Julie's behaviour and re-established parent-child boundaries. These levels of empowerment allowed Marama to feel stronger as a parent, set limits, and effectively support her daughter.*
>
> (Shailer et al, 2013: p.203).

Wraparound's focus on natural supports also reduces dependency on formal services; families are able to use their community and social networks to seek help in the future, meaning they have a variety of tools and strategies to cope with difficult situations before they become crises.

3.2 Evidence for Multisystemic Therapy (MST)

Does it work? Discussion of the quality of evidence

There is a wider body of evidence on Multisystemic Therapy than there is for the other two models under discussion, with many randomised controlled trials evaluating the effects of MST. Much of this research has shown promising outcomes in areas such as reducing reoffending, reducing substance misuse and improving mental health. These positive outcomes are not entirely consistent, but overall MST is considered to have a positive impact on reoffending rates and to be cost-effective (Social Research Unit (SRU), 2013; Lee et al, 2012).

MST Services controls the delivery of MST and monitors its ongoing implementation, meaning evaluation of the 'pure model' is common. However, there is still variation in adherence to the core principles. Research suggests that this may account for some of the poorer outcomes and inconsistency of results. Henggeler et al (2000: p.463) noted that even where there is "significant clinical oversight and training" variation occurs.

The evidence relates predominantly to young people (usually under 18) with offending histories and other issues such as family breakdown, substance misuse and mental health issues. Generally, the model discussed here is the original model which applies to young people who offend, except for Borduin et al (2009) which evaluates an adapted form of MST targeted at young people exhibiting "problem sexual behaviours" (*MST Services*, 2010b). Much of the research has been undertaken in the United States but studies have also been completed in the United Kingdom, Canada, Sweden and Norway. Most of the evidence applies to young men from varying ethnic backgrounds.

The recent UK study (Butler et al, 2011) showed MST made a positive difference for young people assigned to Youth Offending Services (YOS), with 8% of young people receiving MST committing one or more non-violent offences compared to 34% of the control group receiving standard services (Butler et al, 2011). The study also found that providing MST to the first group saved money in the long run rather than costing more. Approximately 80% of participants in this trial were young men. However, due to low sample sizes for those committing violent offences, no significant difference was found between MST recipients and the control group for this category of offence.

Despite this promising evidence, MST is not firmly established as evidence-based treatment; the aforementioned studies in Sweden and Canada showed little evidence for the effects of MST (see discussion in Henggeler and Schaeffer, 2010; Centre for Children and Families in the Justice System, 2009). The meta-analysis by Curtis et al (2004) showed a moderate effect for MST across a variety of outcomes, including: improvement in emotional and behavioural problems, reduction in proven reoffending and better school attendance. However, the authors also argued that more evidence is needed to test the effects of MST in the 'real world', for example through comparing MST to usual services.

Littell et al's systematic review (2005) noted that some trials have failed to record or report the outcomes for those who drop out of MST, which is problematic because those who remain may be more likely to succeed anyway. This review differed from much of MST research in concluding that MST has not yet been proved more effective than 'treatment as usual' (Littell et al, 2005). While Littell et al have been criticised for "methodological anomalies" (Henggeler and Schaeffer, 2010: p.159) it is true that results of MST's effectiveness are inconsistent. Littell et al noted that of the eight studies they included in their review, seven achieved significant effects for at least one outcome but these were not consistent across all studies (2005). This may be due to inconsistent implementation, as outlined above. In the first trial in the US not involving the developers, offending rates for the MST treatment group remained high although they were still lower than treatment as usual (as cited in Butler et al, 2011).

MST is argued to be cost-effective based on the fact that it is an alternative to more expensive interventions, such as hospitalisation for mental illness, and that it appears to prevent reoffending. Some US studies have attempted to quantify the lifetime saving and estimated it to be as high as US$131,918 (£80,232) per programme participant (as cited in Littell et al, 2005). Cary et al (2013) showed that MST could generate cost-savings in the UK when compared to standard services through Youth Offending

Teams but noted some methodological limitations. They calculated a saving of £1,222 per young person within the time frame of the project. The Social Research Unit (2013) states that MST generates a return of £2 for every £1 invested through reduced use of healthcare and the criminal justice system, fewer victims of crime and increased future earnings of participants, although some of these figures seem to be based on US calculations.

Table H showing for which outcomes MST has demonstrated improvements:

Outcome	Does MST affect this outcome?
Reducing reoffending	Yes, there is good quality evidence that MST is successful in reducing proven reoffending rates among young people in the interim and long-term. Trials have shown a reduction in proven reoffending among serious and chronic offenders, sex offenders and among UK offenders (Borduin et al, 2009; Curtis et al, 2004; Butler et al, 2011; Lee et al, 2012). However, results are not completely consistent. An independent trial in Ontario found no significant effect.
Improving mental health	Yes, trials suggest a positive effect, for example Stambaugh et al (2007) found improvements in clinical symptoms (in comparison to wraparound); and Borduin et al (2009) found that symptoms of emotional distress decreased. However, according to Shailer et al (2013) MST is yet to show effects in the long-term for young people with serious mental health issues. This review did not find any evidence for improved outcomes related to this group.
Improving familial relationships	Evidence for 'family functioning' is particularly strong (Curtis et al, 2004) and qualitative research suggests this may be the crucial factor in contributing to other outcomes such as reduced youth offending (Huey Jr et al, 2000).
Improving behaviour	Yes, there is substantial evidence that suggests that MST results in a decrease in aggression and improved youth behaviour. This includes research undertaken in the UK. Some of the results are based on self-reported and parental-reported data, e.g. Butler et al (2011). However, this is compared against the reports from a control group thus strengthening the reliability.
Reducing drug and alcohol use	Some evidence: one trial showed that MST had a strong effect in reducing substance misuse (as cited in Curtis et al, 2004).
Developing positive peer relationships	Evidence is inconclusive in comparison to other outcomes such as family relationships; see Curtis et al (2004).
Preventing institutionalisation (hospitalisation, imprisonment, going into care)	Yes, it appears to, including in the long term. Curtis et al (2004) found in their meta-analysis a medium, negative effect for factors such as 'days incarcerated' and rates of hospitalisation. Stambaugh et al (2007) found that MST recipients were less likely to go into children's homes than wraparound recipients. In addition, an RCT addressing young sex offenders (who had also committed other crimes) found that over a period of nine years, MST reduced imprisonment rates by an average of 174.1 days per year (Borduin et al, 2009).
Improving housing situation and reducing homelessness	Very little relevant evidence due to the focus on young people.
Achieving employment, education or training	MST has been found to have a positive effect on school performance (Curtis et al, 2004).
Cost effectiveness	Promising: research shows savings at a ratio of £2 saved for every £1 invested (SRU, 2013).

How does MST change outcomes? Insight from qualitative research

Although there is some insightful qualitative research, Butler et al (2011) note that the mechanisms of change within MST are under-researched. They discuss the role of MST in building capacity, suggesting positive outcomes may occur because MST draws on family strengths to develop parents' skills and confidence to handle crises (Butler et al, 2011).

There is a clear 'theory of change' underlying MST, which focuses on the role of environment in influencing behaviour. This socio-ecological model of human development sheds light on how problematic behaviour is maintained and perpetuated through multiple systems within a person's life. MST changes the behaviour by changing the systems: peer networks, parental response, daily activities (Huey Jr et al, 2000).

How exactly MST works will no doubt depend on who is receiving the treatment. Much of the process focuses on the role of the parents, as this is of course a major 'system' within a child's life, but there are some possible insights for work with adults with complex needs.

People are empowered and upskilled to make better decisions

MST should make people feel they can make positive decisions, and give them the skills to do so. It is important that families feel they can cope with difficulties by themselves after MST ends – especially as it is time-limited. Parents are given responsibility for decision-making by therapists:

> *"To increase and promote parental responsibility, and increase Emma's consistency in tackling Tom's use of cannabis, she needed to have a clear position regarding drug use. Therefore, Emma decided that she wanted Tom to completely abstain from using cannabis."*
>
> (Wells et al, 2010: p.148)

This empowerment occurs through recognising and developing strengths. So for example, the case study of Emma's family (based in the UK) recorded several strengths, including Emma's commitment to changing her son's behaviours. The therapist responded to this by making Emma responsible for enforcing a 'no smoking cannabis' behaviour contract with rewards for compliance and worked with her to troubleshoot and iron out the details of this plan (Wells et al, 2010).

MST supports parents to feel that they are capable of effecting behaviour change and that they know how to do this. Parents are helped to control children, through things like implementing consequences/rewards for bad/good behaviour. As well as this, young people are helped to manage their emotions more appropriately. So for example, an MST therapist could teach anger management techniques to a young person and at the same time work with parents to implement a behaviour plan that rewards successful use of these techniques.

MST goes beyond just teaching good parenting strategies, however. Underlying causes of family dysfunction are addressed, as demonstrated in another UK case study:

> *The therapist noted that C's mother found it a struggle to remain warm in her relationship with her son, particularly when he misbehaved. This fuelled his negative behaviour. Through role play and observation, the therapist helped his mother to develop more positive communication skills and strategies and also completed a six-week cognitive behavioural therapy programme with her to help her depression. The therapist worked with both parents together, to enable C's father to remain supportive to his mother.*
>
> (Lennox and Khan, 2013: p.10)

Treatment is sustainable and transferable because 'natural systems' are addressed

MST takes place in the family home, not an institution. If a young person enters a prison or hospital – even if it is the most effective and well-run type of unit – they may struggle to cope when they return home and the same problems and influences on their behaviour remain, such as: anti-social peer influence; weak or absent parenting; easy availability of drugs. In working within a 'natural' context, MST responds to issues

immediately, even if they are not at first impression the issues of the child. In one case study, an MST therapist provided marital therapy to a couple in recognition that they needed to work together and avoid undermining each other in order to address their son's behavioural problems (Henggeler and Schaeffer, 2010).

MST does not just focus on addressing problems but also on providing positive alternatives, e.g. to activities like drug use and recreational criminal behaviour.

> *"Father and son had, intermittently at least, self-harmed together. The therapist introduced John to activities, such as playing football with Darren, that would help John learn other ways to foster a bond with Darren. The therapist introduced a log for John to monitor how much time he was spending with Darren, which also reduced opportunity to self-harm"*
>
> (Wells et al, 2010: p.145)

A positive social context is thought to be fundamental to desistance from offending (IRISS, 2012) and this is also a core component of MST – therapists will encourage young people to develop positive peer relationships to replace those which may be a negative influence. Partnership working may be crucial here. In the case study in Lennox and Khan (2013), both parents and the neighbourhood police were used to identify and address these negative peer influences.

The literature is not conclusive of which aspect of MST tends to be the most effective in changing behaviour. However one study (Huey Jr. et al, 2000) noted that better 'family functioning' correlated strongly with decreases in anti-social behaviour and "affiliation with deviant peers". MST uses parents as 'agents of change' and the same study found that where therapists do not engage with parents in a collaborative, trusting relationship, treatment may not be successful. Increasing the family's capability and confidence is, it would seem, crucial for success.

3.3 Evidence for the link worker model

Does it work? Discussion of the quality of evidence

The evidence base for the link worker model is much smaller than the other two models, and more robust research is needed. Currently, the body of evidence is made up of service reports and government or consultancy evaluation reports, as well as some (largely qualitative) research by Revolving Doors (O'Shea et al, 2003). These reports show early promising findings suggesting link workers can help improve wellbeing, reduce contact with the police, and use of A&E, and make substantial improvements to clients' housing situations.

However, more research is needed which compares clients' outcomes to those of a control group (we did not find any such studies). Additionally, some service data is from times when services were more focused on recording activity and outputs, rather than outcomes demonstrating real change (see for example a Supporting People report by Patel, 2010). Where there is data on outcomes, this is generally reported by services themselves, rather than independently conducted evaluations using higher-quality standards of evidence.

Promising findings based on 'before and after' data can be found in evaluation reports by the Department for Communities and Local Government (DCLG)[4], Making Every Adult Matter (MEAM) and some individual service evaluations such as the New Directions Annual Report (Cattell et al, 2011; Battrick et al, 2012 and 2014; Rinaldi, 2010). These reports showed particularly promising findings in the area of housing, suggesting that link workers improve clients' current living situations (through sorting out repairs and rent arrears), reduce rough sleeping and assist clients to move from temporary hostels to permanent housing. Battrick et

[4] Three of the models discussed in Cattell et al (2011) were link worker services. Only evidence applicable to these models is incorporated here.

al (2012) also found self- and staff-reported improvements in behaviour, including measures such as impulse control and coping skills. Cattell et al (2011) found link worker clients reduced their use of A&E and increased use of GP healthcare. The DCLG study also highlighted one link worker service as particularly promising in terms of improving overall wellbeing. There is also promising evidence to suggest that link worker services increase clients' welfare benefit incomes, which is important in both alleviating poverty and achieving stability (Cattell et al, 2011). Cattell et al (2011) did find that low employment rates continued for link worker clients but that one link worker service had influenced people's capacity to work and had helped them achieve voluntary placements.

Evidence which relies on 'before and after' data – as so much of this does – is generally considered poorer quality, as we do not know if change would have happened anyway. That said, the individuals in these evaluations are described as having a long history of ineffective contact with mental health, substance misuse and homelessness services, as well as contact with the criminal justice system extending back a number of years. This suggests naturally occurring change is less likely (Battrick et al, 2012; Cattell et al, 2011), although some individuals can and do improve on their own, including in desistance from crime and recovery from mental ill-health and addiction. There is also a need for a more robust definition of the model (as we noted in the previous section, the definition relies largely on descriptions of services) and for subsequent measures to ensure it is correctly implemented and early successes are replicated.

In compiling evidence for the model, data collection is not always consistent due to some high attrition rates, reported in Cattell et al (2011) and Battrick et al (2014). Furthermore the evidence is reliant on reports by service staff and clients in many cases. This can be problematic for many reasons: people may lie, have memory lapses and have unconscious biases. However, the evaluation of the MEAM pilots (Battrick et al, 2012 and 2014) does include some independent data on costs of service use, which is generally promising and suggests that in two out of three areas clients' frequency of arrest reduced after intervention, and that clients generally moved from supported housing or sleeping rough to their own independent tenancies.

However, overall, reductions in reoffending have not been extensively measured. New Directions reported a "35% decrease in offending behaviour" among its clients, but the table cited shows a "decrease in offending behaviour" among 35% of clients (Rinaldi, 2010: pp.6-7) and it is not clear whether this is based on self-reported or official data. Cattell et al (2011) report that some organisations chose not to ask clients about their offending behaviour because they felt the responses would be inaccurate. However, O'Shea et al (2003) did report promising findings in this area, citing a small amount of 'before and after' evidence showing that link worker clients were less likely to reoffend after intervention, with recorded reoffending falling by 22% over three years in one study.

There is also very little evidence discussing the effectiveness of link worker services in improving family relationships and relationships with children. Yet service users have emphasised the importance of these areas (Revolving Doors Agency, forthcoming). Some services do provide related support: for example, the New Directions annual report (Rinaldi, 2010) states that 61% of clients were supported in rebuilding relationships with family and/or children.

Overall, there are early, promising findings for the link worker model which need building on alongside further development in defining the model. More evidence is also needed for cost-effectiveness. Both the DCLG and the 2012 MEAM evaluations concluded that the pilots they assessed cost more than they saved in the timeframe. However, both reports noted that this short-term increase in cost (incurred in part by access to important help such as housing and substance misuse support) is offset by the likelihood that money would be saved in the long term. Reflecting this, in year two of the Cambridgeshire MEAM pilot, clients' costs to services was reduced by 26% largely through reduced contact with the criminal justice system (Battrick et al, 2014). More robust evidence tracking outcomes in the long term is needed but without help the client group could continue to use emergency healthcare inappropriately and go through the criminal justice system, which is very expensive.

Table I showing for which outcomes link worker services have demonstrated improvements:

Outcome	Does the link worker model affect this outcome?
Reducing reoffending	Some available evidence suggests that it does, but more research is needed (O'Shea et al, 2003; Battrick et al, 2014). Link workers help their clients access many things which are associated with desistance – such as stable housing.
Improving mental health	Some promising findings. In Battrick et al (2012), self-reported improvements in one pilot area were inconsistent; the report suggested this could be because clients were now more aware and concerned about the severity of their problems. However, another pilot showed an overall improvement in clients' wellbeing (Cattell et al, 2011).
Improving overall health	Link worker services often successfully link their clients in with healthcare services including GPs (Cattell et al, 2011; O'Shea, 2003) but more evidence needed.
Improving familial relationships	Inconclusive; rarely measured. The literature suggests that some services do try to address this.
Improving behaviour	Some promising evidence. One report showed improvement (self- and staff-reported) in factors such as 'impulse control' and 'risk to others' (Battrick et al, 2012).
Reducing drug and alcohol use	Very little available evidence. One report based on self- and staff-reported data showed a small degree of improvement (Battrick et al, 2012).
Preventing institutionalisation (hospitalisation, imprisonment, going into care)	Very little available evidence but it is likely that link worker services help reduce imprisonment rates through helping individuals desist from offending.
Improving housing situation and preventing homelessness	Yes – evaluations have shown promising reductions in homelessness and increases in stable accommodation (pre and post intervention). For example, the MEAM evaluation (Battrick et al, 2012) noted an increase in permanent accommodation from 10% to 25%, as well as a reduction in rough sleeping (although the sample size was quite small, n=39).
Achieving employment, education or training	Inconclusive; people with multiple and complex needs may be further away from being 'ready for work'. Some evaluations have shown some services make progress in increasing a client's 'work ready' status and increase voluntary activity (Cattell et al, 2011; Patel, 2010).
Cost-effectiveness	Not yet proven, but early research shows savings incurred through reduced use of criminal justice system and A&E.

How does the link worker model change outcomes? Insight from qualitative research

More formal qualitative research is needed to test the mechanisms of change within the link worker model. Revolving Doors has published several reports on link worker services and the MEAM and DCLG reports included qualitative data. These sources, together with insight from practitioners supplied to us during the research process, suggest that the following factors play a role in successful outcomes.

Link workers help clients access services that will effectively meet their needs

Evidence shows that link workers do urgent work to help stabilise their clients' situations and also link them in to services that can further enhance their lives after emergency situations are resolved. Link workers report that they must be persistent and knowledgeable in dealing with statutory and non-statutory services (O'Shea et al, 2003). Services could include access to things such as health and housing, but may go beyond this; one service reported that they were linked with sixty local services (personal correspondence, 05.02.2014).

Accessing certain services is not easy for many people but especially for someone who is facing multiple needs which span multiple services. Advocacy, knowledge and tenacity are therefore hugely important parts of link workers' roles. Link workers operating in England have discussed the exclusionary criteria and strict regulations in housing, for example, that they must address and overcome in order to effectively support their clients (O'Shea et al, 2003).

> *[Certain pilots] took time to help clients access the benefits to which they were entitled, for example, at Cyrenians, if a client had been banned from the JobCentre, the workers would work with both the client and the centre to ensure that the former could get access to the centre's services.*
>
> (Cattell et al, 2011: p.20)

People are helped to develop the skills and confidence to engage positively with services

Link workers also support their clients to navigate services themselves. They model good behaviour and provide moral support by accompanying their clients to appointments which might be a source of fear due to previous experiences (O'Shea et al, 2003). Their optimism and persistence may be absorbed by the clients themselves (Battrick et al, 2012). This is crucial in developing people's skills and confidences to cope by themselves so that in the future a problem with (for example) benefits or health will not reach crisis point. As well as developing skills, one practitioner explained that it is about instilling confidence and self-belief:

> *"[On pro-social modelling] Yes I think there is a lot of that; but it's mainly about [saying] I am like you in a lot of ways. [...] And so, if I am a bit like you, and I can cope with this, then maybe you can cope with this".*
>
> (Personal correspondence, 20.02.2014)

People (re)gain trust of professionals through a continuous, trusting relationship

One practitioner described the role as in part that of a 'consistent trusted adult'. As detailed in section 2.3, many link worker clients have experienced abandonment repeatedly. Providing a solid and consistent source of support helps reduce fear of further abandonment, which means clients are more likely to stay engaged with the service. The creative and assertive ways of engaging the non-punitive approach and the encouragement to stay in touch in the future are all part of this. Link workers are supported to maintain this positive approach, for example through clinical supervision and sharing risk as a team (personal correspondence, 05.02.2014; O'Shea et al, 2003).

> *"[The] most important element of L[ink] W[orker] role is to rapidly establish a relationship of trust with [a] client: therefore workers need to be extremely good at connecting with people emotionally, establishing trust, having empathy, listening – need excellent social skills!"*
>
> (Personal correspondence, 05.02.2014)

A continuous relationship means that clients do not have to repeat sensitive and complex information repeatedly and it gives people a sense of security as they feel they do have someone on their side (see quotes from service users in Battrick et al, 2012). This contrasts to single-issue treatment wherein people get help for one thing but then must fend for themselves:

> *"I was disappointed when I was in detox because nothing was sorted out for my aftercare, and that was a big thing for me.... I said 'what's the point of detox if I get no more support?'"*

(Service user quoted in Rinaldi, 2010: p.3)

Rather than treating mental distress or substance misuse in isolation, link workers navigate the different services that, combined, can go some way to addressing multiple needs and at the same time are important in just 'being there' for a person who has experienced complex trauma and multiple rejections. Further research could address the extent to which link worker services help people develop skills themselves, in order to ultimately be self-sufficient and hold down a job or participate in civic society; or whether they simply stabilise clients to the point where they are healthier, in permanent housing and commit less crime.

3.4 Summarising the evidence for all three models

Table J summarises the evidence for Multisystemic Therapy, wraparound and the link worker model against significant outcomes relevant to the area of multiple and complex needs. It summarises how much evidence is available and what the findings are. Overall, there is less research of the highest quality assessing the effects of the link worker model and of wraparound in comparison to MST.

Table 1: Summary of evidence for all three models, by outcome

Outcome	Evidence
Reducing reoffending	Very promising. Wraparound and MST have shown reductions in offending in the interim and long-term. Most rigorous evidence is for MST. Link worker services appear to reduce contact with the criminal justice system and address factors associated with desistance.
Improving mental health	Evidence shows wraparound and MST often have significant, positive effects on mental health; one comparative study found MST more effective than wraparound. It appears that link worker services also help clients progress on this outcome.
Improving familial relationships	Evidence is promising that MST improves family relationships. Less is known about the other two models.
Reducing drug and alcohol use	Mixed. There is a small amount of good-quality evidence showing that MST reduces substance misuse but more evidence is needed for all three models.
Preventing institutionalisation (hospitalisation, imprisonment, going into care)	The evidence is promising that wraparound and MST prevent young people going into custody or care. There is less evidence addressing this outcome for the link worker model.
Improving housing situation and preventing homelessness	There is promising evidence that link worker services can improve housing stability and quality and reduce or prevent homelessness among their clients. There is less evidence for the other two models as they are largely targeted at young people living within the family home.
Achieving employment, education or training	Varies and is limited. Link worker clients are often considered far away from employment. Some evidence suggests MST and wraparound improve school attendance and performance.
Cost effectiveness	More evidence is required. All three models are likely to be cost-effective in the long term as they prevent or reduce imprisonment, reoffending, and hospitalisation. The most conclusive evidence is for MST where research has shown cost-effectiveness in the UK.

3.5 To what extent do the models echo key principles in the literature around desistance, recovery and child development?

The principles and practice of each of the models discussed echo many key principles discussed in the recovery literature (see for example South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010; also Best and Lubman, 2012) and in literature around desistance from offending (see IRISS, 2012 and Clinks, 2013).

Desistance and recovery principles both emphasise the **role of the service user** in defining their own goals: agency is crucial, rather than having a professional determine what a service user should be aiming for and how they should be spending their time. Theories around desistance from crime emphasise the importance of 'working with the offender, not on them' (McNeil et al, 2011). Wraparound, a grassroots movement, adheres to this through one of its core principles: family voice and choice. In MST, the language can be somewhat more 'top down', discussing the need to address "pathology" (Butler et al, 2011: p.1221) and reduce association with "deviant" peers (Henggeler and Schaeffer, 2010: p.150). However, all three models are **personalised** according to clients' needs, and in this sense incorporate the role of individuals in shaping their own support. Drugscope, in discussing recovery from substance misuse, argue that "there is no [...] silver bullet for recovery" (Drugscope, undated) and the three models reflect this. Wraparound plans are unique to each family; link workers respond to their clients' particular needs; and MST practitioners tailor treatment to each family, trying new interventions if required. This also means responding to **individual strengths**: key in particular to both desistance and recovery, as strengths can be used to build resilience and deal with problems. Both wraparound and MST explicitly use strengths to reduce offending behaviour.

Service users' role in providing **peer support** is also emphasised in recovery and desistance literature. Although peer support is not a core part of any of the three models, wraparound does emphasise the role of informal and community-based sources of support and one link worker service incorporated a peer support/mentoring programme into its service delivery (Rinaldi, 2010).

Hope and optimism are core principles in desistance and recovery: believing change is possible, celebrating progress and avoiding stigmatising language. Fundamental to this is an individual's belief in their own capacity to change and developing an identity separate to that of 'offender' (McNeill, 2009). MST may develop hope and optimism through an emphasis on persistence and 'trying again' if necessary (see principles eight and nine) as well as through its strengths-based approach. Its collaborative approach with caregivers and other people in a child's life may develop and empower parents. Link worker services are similarly persistent in supporting clients, rather than pessimistically dismissing clients who are deemed too hard to engage. Some evidence suggests that clients themselves absorb this optimism (Battrick et al, 2012). Wraparound is an open-ended approach, again representing the importance of hope and not giving up.

It has been argued that **social context** is of primary importance in stopping reoffending. In recovery, too, families are often crucial to success as is a meaningful role in the local community. Both wraparound and MST reflect this by focusing on the skills and capabilities of people's closest networks to address distress or problematic behaviour. Developing positive peer relationships is a major part of Multisystemic Therapy, as is improving 'family functioning'. Wraparound emphasises the importance of informal support that is located in the family's community. The link worker model tends to focus more on access to formal services rather than developing clients' informal and community-based supports; that said, link workers have discussed how they work with clients within informal and community-based locations and help clients form positive attachments to others.

A **holistic approach** to service users is inherent to all three models: in wraparound, teams from multiple agencies work collaboratively with family and community members; in MST, therapists work within and address the multiple areas of a child's life; link workers navigate numerous different services in order to address the multiple needs of their clients. A holistic approach is fundamental to supporting desistance from offending: it means people can access the full range of support necessary to meet their needs.

Recovery in mental health and substance misuse similarly emphasise the 'meaningful life' and the need to go beyond merely treating ill-health or addiction.

Finally, **being realistic and incorporating setbacks** is a key part of desistance theory, and recovery literature emphasises the sometimes complicated nature of the 'journey'. All three models recognise this: MST practitioners must be prepared to try alternative interventions if necessary; wraparound and link worker services are open-ended processes where possible, recognising that change does not come within a set time frame for most individuals.

Child development perspectives

Literature on desistance and recovery generally focuses on adults. There is also some commonality between wraparound and MST and child development theory. Research into child development recognises the environmental factors which predispose children to poor outcomes such as reoffending, as well as discussing positive factors which can be developed in order to improve outcomes (see Lennox and Khan, 2013, for a summary).

On a broad level, the ecological approach employed by MST focuses on shifting the balance of the risk factors and strength factors in the young person's environment. One example of a strength factor linked to good outcomes is a **positive bond between a family and wider community figures** such as teachers and neighbours. Wraparound actively includes these informal networks in supporting the family. **Parenting styles which are stable and positive** are also associated with positive outcomes. MST works intensively with parents to develop effective parenting strategies which maintain control without being too negative or 'harsh'.

The models also address negative factors which can increase risk of offending or other poor outcomes. **Parental mental illness** can be a risk factor for antisocial behaviour, for example. As seen through the case studies, MST sometimes provides therapy directly to parents for their own mental health issues.

Some risk factors for poor outcomes in child development can only be prevented or reversed through very early intervention. For example, exposure in the womb to maternal stress and insecure attachments in infancy are important risk factors. Clearly, only pre- or post-natal intervention models can prevent such things - but all three models do, to varying degrees, address related issues through work which is informed by psychological knowledge such as attachment theory and the effects of trauma. They therefore aim to address the negative effects of these early risk factors and in this way may improve outcomes for clients.

4. Applying key success factors of the models to adults with multiple and complex needs

Both MST and wraparound place a heavy emphasis on the role of families in influencing positive change. Yet adults with multiple and complex needs can be socially isolated and the family they do have may be a source of problems (Anderson and Cairns, 2011). There are nevertheless some potentially transferable insights from the MST and wraparound models, such as:

- It is crucial to address the role of people's social environment in influencing behaviour
- It may be worthwhile to incorporate an individual's social or familial network (if appropriate) in support planning and delivery
- It is also helpful to develop the ability of friends and family to respond to complex and challenging behaviour
- Providing alternative sources of support to services, located among peers or in the community, means that people still have support when formal services come to an end.

These lessons from the wraparound and MST research literature should be kept in mind when developing and testing models applicable to adults with multiple and complex needs, including the link worker model. It is also crucial to remember the importance of robust and faithful implementation ('model fidelity'), as poor implementation is associated with poorer outcomes in the MST and wraparound literature. This is discussed in more detail in the following section.

Below we also consider what may be the key success factors common to all three models, which could all potentially apply to adults. Further evidence could test which aspects are critical to success, for whom, and why.

4.1. Potential success factors common to all three models

Often services do not operate in accordance with clients' individual needs but are delivered according to a rigid 'one size fits all' structure. But the models described in this report generally respond to people with **flexibility and comprehensiveness**, increasing access to those labelled 'hard to reach'. MST therapists visit the family in their home and are always available by phone; link workers are prepared to meet their clients wherever is convenient; and wraparound services take place in the community in which the family lives. Meeting a client on their territory means issues are addressed within their wider context.

The services also meet their **clients' multiple needs**. In doing so, the three models are necessarily personalised to individual and social contexts. For example, a core principle of wraparound is understanding and responding to clients' cultures, which may require a facilitator who speaks a parent's language. In MST, specific issues affecting a family may be directly addressed, such as the case of a therapist providing marriage counselling to a couple who were struggling to parent their child consistently. In O'Shea et al (2003), link workers discuss the breadth of needs they address: assistance with benefits and finance, negotiating mental health thresholds, accessing primary care, as well as access to local sources of support.

These models also focus on **providing clients with positive activities and sources of informal support.** They do this through responding to **strengths** and, particularly with wraparound, finding and using informal **sources of support** such as a religious leader, neighbour, community group etc. This means that clients will not lack support when formal services end and can pursue interests, activities, education and employment with an increased understanding of their own strength. However, link worker services

appear to focus more on access to formal services; this may reflect their origins in the UK where the provision of statutory services and welfare benefits is currently more extensive than in the US. Nevertheless, a focus on natural supports and one's own strengths may help in developing the individual's confidence in their ability to change – which is particularly associated with desistance.

Similarly**, empowerment** and **developing skills** also help clients cope with difficult situations and reduce challenging behaviour. MST therapists teach parental skills and observe parents practising them. Link workers role model appropriate behaviour in formal contexts. Consequently individuals and families have the skills and confidence to cope with problems in the future, as the testimony of some participants has shown.

Finally all three models promote **relationships between clients and professionals** that are positive and, where needed, persistent and assertive. Much of the wraparound literature emphasises the need to stop viewing families through a list of their deficits and to avoid rejecting a family: a core principle is persistence. MST also operates under the principle of persistence too: therapists should change their approach if treatment isn't working, not blame the family. Link workers develop the trust of their clients by continually trying through assertive engagement.

4.2 The importance of good quality implementation in ensuring success

Research into implementation suggests that faithful implementation ('model fidelity') of any model or programme is critical to success. This should be an ongoing consideration when developing the body of research on models working with adults facing multiple and complex needs. Poor implementation can undermine the expected results of even the best tested programmes, as well as hampering attempts to reproduce success on a larger scale. Successful programmes have tended to pay closer and more systematic attention to high quality implementation practices (Fixsen et al, 2005).

As the evidence review shows, MST has sustained good results and has specific measures in place for ensuring faithful implementation. Currently, many factors important to successful implementation still need to be developed for the link worker model and to a lesser extent for wraparound. The link worker model in particular would benefit from further qualitative research to refine its definition and develop and test a more robust theory of change.

The following factors are important to good implementation (Fixsen et al, 2005).

A clearly defined theory of change

A theory of change provides a clear explanation of how an intervention expects to support change, incorporating:

i. What will be different in the short term and longer term as a result of the intervention, and how this change is expected to happen
ii. The assumptions and evidence (lived experience, academic and practitioner) which tell us what changes are likely
iii. What range of activities have the best chance logically of promoting these changes
iv. Checking whether activity is on course to achieve or has achieved desired changes.

There is some evidence that if a programme has clearly defined rationale, aims and core components it will be more successful (Bauman et al, 1991; Dale et al, 2002; Winter and Szulanski, 2001). Crystallising the core components of a programme can also make it easier to measure the right outcomes and replicate the model on a larger scale.

High quality staff developed through systematic and ongoing training

Recruiting staff with the right qualities and skills is important for success. Key skills will vary based on the model but some of the qualities suggested by the literature on these models include: an ability to maintain a positive, non-judgemental approach; skills in forming relationships; and local and system knowledge in order to meet specific needs. The specific models also require skills such as mental health qualifications (in the case of MST) or ability to engage with informal and community-based sources of support (in the case of wraparound).

However, recruitment for specific skills is not sufficient to determine success. Successful programmes require ongoing training to help transfer learning into practice, develop and refine expertise, and support fidelity to the 'core model'. In the UK based trial evaluating MST, therapists had weekly supervisions, weekly telephone consultations with an MST expert, quarterly training sessions and the MST expert reviewed the quality of the implementation biannually (Butler et al, 2011). Senior staff with protected time to 'troubleshoot' aspects of implementation, feeding back problematic patterns to central administration if necessary, may help maximise consistency of outcomes.

The importance of the wider context and culture

Implementation takes place within a context of organisational structures and cultures, policy and funding environments and the challenges and strengths found in local communities. Although less robustly investigated, the literature suggests key features of the policy and organisational contexts that can help achieve promised results. This includes things such as:

- Good quality systems and methods to measure progress against outcomes, which can be used by a range of partners involved in delivery. Mechanisms to share data should be in place (e.g. sharing reconviction data for those on a wraparound programme with commissioners and researchers).
- A sympathetic policy context, including local strategic buy-in and support from key partners. Community and partnership buy-in and local 'champions for interventions' are also important for preparing communities for intervention and driving local awareness (Rogers, 2002; Fixsen et al, 2005). This may require protected time for senior management to build strategic links with the community and key partnership agencies.
- Sustainable and stable funding and sufficient resources to allow staff to remain faithful to the model. For example, in MST low caseloads are required, with the therapists in the UK trial working with a maximum of three families each. There may be opportunities for joint commissioning to fund interventions sufficiently, given that the range of outcomes evidenced for these models cut across different local commissioners' priorities.

5. Conclusion: Summarising the evidence

All three models show promising results in terms of improving mental health, reducing reoffending and promoting more beneficial and less damaging behaviour. Wraparound and MST can reduce use of the care system, while link worker services may help improve their clients' housing situations. There is also reason to believe that all three would be cost-effective in the long term because they work to prevent crisis situations such as hospitalisation, homelessness and imprisonment. Research is strongest for MST in terms of cost-benefit analysis, but all three models are likely to produce long-term savings through reduced use of emergency services and the criminal justice system.

MST shows reliable positive results against outcomes such as reducing reoffending and imprisonment (in the long and short term), improving mental health, and personal and family functioning/behaviour. Wraparound shows very promising evidence for reducing reoffending, use of custody and foster care rates, and also appears to have positive effects on a range of other outcomes. However, its evidence base is relatively small. There is very little formal evidence for the link worker model but early findings are promising, particularly in reducing homelessness and rough sleeping and improving access to services including healthcare. When expanding the link worker evidence base, it will be important to develop a robust theory of change and to seek consensus around the proposed 'core principles'. MST shows the importance of a robust definition for good-quality implementation, alongside structured supervision of delivery.

The evidence for MST and wraparound is concentrated solely on young people and families with multiple and complex needs. However, this review outlined some transferable insight from the qualitative research, such as the importance of addressing the 'systems' in people's lives and of developing people's capacity to cope with challenging situations. Wraparound has been applied to adults in the US but more robust research is needed to determine if and how this is effective.

While all three models vary in their respective evidence bases, exact client groups and methods of delivery, they all aim to improve outcomes for people facing multiple and complex needs – a group whose needs are often neglected and unmet. They also have some key features in common: their focus on developing skills, their personalised approach and their emphasis on working creatively and persistently until something works. Their approaches and core principles also echo research and theories on desistance and recovery, which focus on the totality of people's experiences and needs, and on the importance of building a meaningful life. In their positive, creative and persistent approach to people with multiple and complex needs, all three models stand out. They avoid blaming people with multiple and complex needs for their exclusion from services and instead offer guidance and optimism in finding out what *does* work for these individuals.

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