Evaluation of MARRS: Executive Summary, May 2024

The Multi Agency Rapid Response Service (MARRS)

The Multi Agency Rapid Response Service (MARRS) is a joint health and social care mental health crisis service for children and young people (CYP) in Cornwall, established in early 2023. MARRS was set-up because there was an increase in CYP presenting in mental health crisis both in Cornwall and nationally. These CYP often have multifaceted problems, and many have complex social situations. There was a recognised need to increase support for the most complex and to improve joint working between health and social care to meet their needs. The service was created from the existing CAHMS community crisis team and the acute CAHMS liaison team. Additional funding was allocated to integrate with social care.

Whereas the previous mental health crisis service discharged young people after the immediate period of crisis, the new MARRS provides intensive support for up to 3 months in the more complex crisis cases and shorter-term crisis support to other young people in crisis. The child and family also benefit from a multidisciplinary team approach, which may include health practitioners, social workers, family support workers and targeted youth workers. Through working intensively with the MARRS, CYP will be helped to collaboratively build resilience and coping mechanisms. Families will also develop strategies and techniques to de-escalate situations which might lead to crisis. The MARRS aims to foster a health and social care culture which moves the focus away from each service providing care in silos and towards meeting the needs of the young person in mental health crisis and their family and support network jointly, aiming to avoid the need for hospital admission or a care placement away from home.

Headline findings

This evaluation shows that the MARRS has improved joint working between health and social care and across the system. CYP have a good experience of the MARRS, in particular valuing the flexible locations of the treatment. CYP engage with their appointments. On average, their function improves during their treatment. There have been resourcing shortages, and challenges with health and social care joint working; MARRS now need to address these challenges to further improve the service.

Evaluation Methods (Chapter 2)

This was a mixed methods evaluation, which included combined descriptive quantitative analysis of routine health and social care data, with themes from qualitative staff interviews, a survey and a parent and young person satisfaction questionnaire.

This evaluation was carried out to establish:

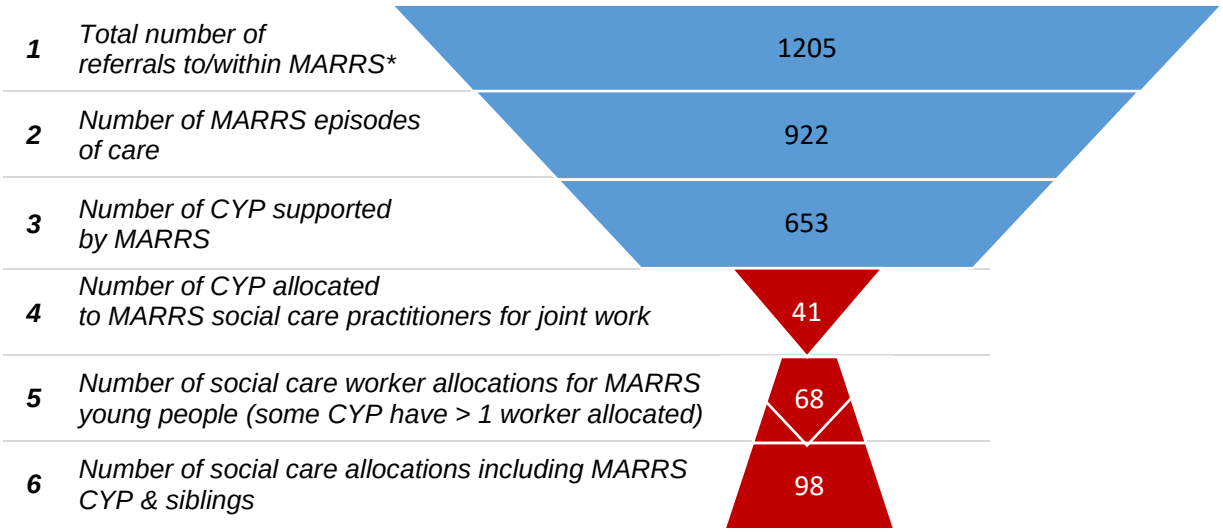
1. What are the characteristics of the CYP presenting to MARRS and what service do they receive?
2. How was the MARRS implemented and what are the learnings and challenges from implementation? How is the MARRS functioning now?
3. What has the impact of the MARRS been on young people, their families, staff and services?
4. What were the challenges with and enablers to service delivery?

Characteristics of the young people supported by MARRS (chapter 3.2)

There were **1205** referrals to MARRS between January 2023 and February 2024. Excluding handovers within the MARRS team, this amounts to **922** episodes of care for **653** young people. **41** of these young people were also supported by MARRS social care practitioners. These young people presented in both acute and community settings, with more than **50%** of young people presenting in the emergency department. **71%** of the young people were female.* Their median score on the Children's Global assessment scale was 45, indicating moderate impairment in most areas or severe in one area. Nearly 50% of the young people were referred to another service upon discharge from MARRS.

**This is based on sex assigned at birth. There is no non-binary category available in the data. A relatively high proportion of young people in this cohort do not identify with their sex assigned at birth.*

Total number of young people supported by the MARRS: Jan 2023 – Feb 2024



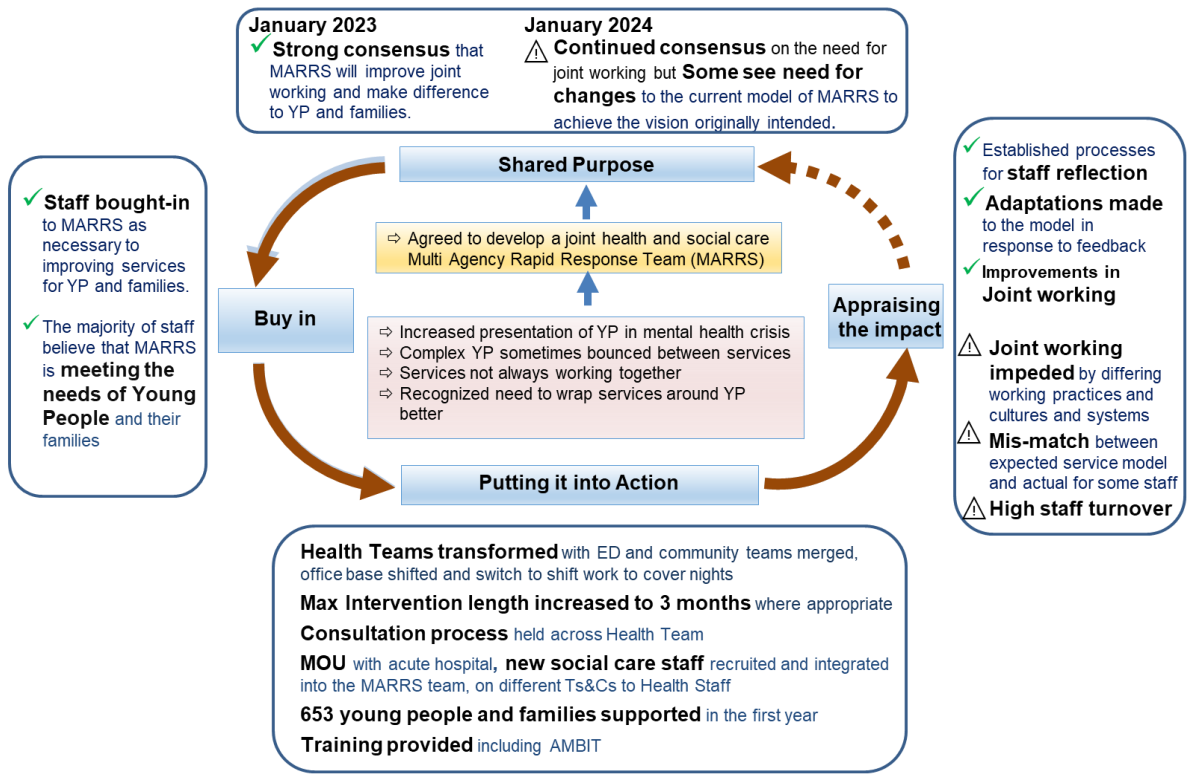
**The 1205 includes transfers within MARRS, from MARRS acute to MARRS community and vice versa, whereas the 922 includes complete episodes of care ignoring these transfers.*

There are 41 young people out of 653 who were allocated for joint work with MARRS social care; some of the young people supported by MARRS already have a pre-existing locality social worker relationship, so it is not beneficial to introduce another (MARRS) social worker. In the majority of these episodes, the period of joint working varies from less than a week (5 young people) to 30 weeks (2 young people). For approximately 50% of young people, the period of joint working is more than 8 weeks.

Implementation of the MARRS Service (chapter 3.1)

Normalising a service successfully requires a shared purpose, buy-in, putting the service into action and appraising the impact. Staff surveys and interviews showed there was a strong sense of shared purpose / buy-in when MARRS was established in 2023. The MARRS has delivered better joint working between health care, social care and other agencies. Most staff believe it is meeting the needs of young people. However, there have been challenges with delivering the service. This has led some staff to believe there is a need to adjust the current model to achieve the vision originally intended.

Implementation of the MARRS: Jan 2023 – Feb 2024



Functioning of the MARRS Service (chapter 3.3)

Staff were asked in surveys and interviews about the importance and functioning of the MARRS. All elements of the MARRS vision are functioning, but some are functioning more fully than others. Interviews showed steps are being taken to improve this. Although joint working with health and social care is only partially met, MARRS has nonetheless had a positive impact upon health and social care working together across the system. The challenges identified indicate that there has been significant progress in the first year. This is a journey and a culture change and will take time. The recommendations in this report provide a plan for continuing this journey.

Delivering the MARRS mental health crisis Intervention	✓	**Fully to mostly functioning**
Joint working between health and social care	⚠	**Partially functioning**
Joint working between MARRS and the rest of the system involved in CYP MH crisis intervention	✓	**Mostly to partially functioning**

Impacts of the MARRS Service (chapter 3.4)

✓ There is evidence that MARRS makes a difference to young people; they have a good experience of MARRS (indicator 1), and they are in more stable mental health by the time they finish a MARRS episode (indicator 8), and they remain engaged with the service (indicator 4). Qualitative findings show the high levels of engagement are likely to result from the agility and responsiveness of the service in meeting young people in a location that meets their needs and with a bespoke care package. These indicators were measured based on the current service (from January 2023) and did not have a comparator group.

? There are three indicators which were inconclusive: staff experience, earlier intervention for CYP and earlier discharge from ED. There was not enough data available to be conclusive about these indicators.

⚠ There were two indicators that showed no change from 2022 to 2023 based on complete data: there was no reductions in repeat presentations or in section 136 detentions

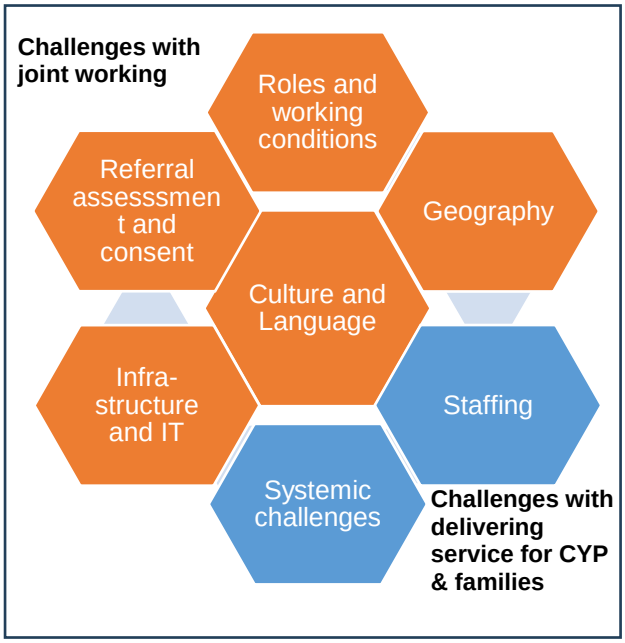
☒ Two indicators were not calculated due to unavailability of data: CYP meet their goals and CYP are discharged to a location that best meets their needs. Improved documentation of goal-based outcomes and discharge location data would support future assessment of these.

1	✓	Young people and their families have a good experience of the MARRS	**89%** of young people and families who completed the survey (n=32) reported a positive experience. Positive comments e.g. ***Without MARRS she might not be here. (Parent)***
2	?	Staff experience of delivering the MARRS	**64%** believe the staff experience of delivering the crisis service is better since MARRS was established. **23%** think it is worse.
3	?	Earlier intervention for CYP in mental health crisis	The median level of function of young people accepted onto MARRS has been **"**obvious problems" since January 2022. No clear pattern in interquartile range or maximum value to suggest identification at higher levels of function, but data not available for all young people
4	✓	CYP remain appropriately engaged with MARRS	**8%** of appointments since Jan 2023 were DNAs compared to **9%** nationally. Non-attendance for any reason was **10%** vs **16%** nationally. This includes only health figures as social care do not capture this information.
5	⚠	Reduction in repeat presentations of crisis	**No difference between 2022 and 2023 and data was complete.** **21.7%** of the YP who presented in crisis in Jan-Jan 2022 presented again in July – Dec 2022. **22.1%** of the YP who presented in crisis in Jan-Jan 2023 presented again in July – Dec 2023.
6	⚠	Reduced use of the mental health act to refer and admit young people	Comparison between 2022 and 2023 did not show a difference in the number of 136 detentions.

7	?	Young people are discharged from ED more quickly	For the period over which data is available (May 2023 – Feb 2024) there were barely any breaches of the MARRS 4-hour target (referral to discharge from the MARRS team). A comparison of ED 4-hour targets (arrival to discharge from ED) between 2022 and 2023 was inconclusive but more granular data might give a different result.
8	✓	CYP spend less time in distress / crisis and more time in stable mental health	There is a difference in the functioning of young people cared for by the MARRS of **+2.3** between their baseline and discharge CGAS scores, which is statistically significant.
9	☒	CYP meet their goals	Data unavailable, or not enough data to calculate
10	☒	CYP discharged to location that best meets their needs	

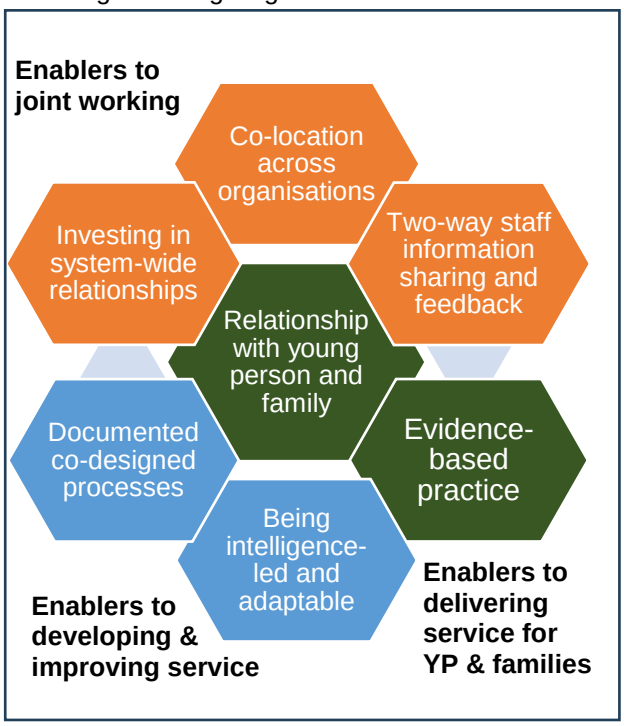
Challenges with service delivery (chapter 3.5)

Interviews suggested that while joint working between health and social care has improved, there are a number of challenges with this joint working. The health and social care staff have different roles, working hours and contractual conditions. Health staff traditionally have a crisis management role and social care a safeguarding role. Both staff groups thus have differing concepts of consent, confidentiality and safety, and different cultures and use of language. Social care staff are case responsible, whereas health staff shift work, and manage cases as allocated to them on the day. Health staff tend to work from an office base, whereas social care work in a hybrid way from different bases and out with young people in their community. The two employing agencies have different IT systems and there have been ongoing technical challenges with joint access. Although MARRS is a joint team, the health and social care input is logged in two separate systems which are not readily linked. The MARRS health routine data captures every handover as a separate episode, so does not easily allow for analysis of episodes of care. There have also been staffing challenges, with the health team having a high vacancy rate. Finally, there are system-wide challenges, with continued problems in referring in and out of MARRS.



Enablers to service delivery (chapter 3.5)

Some key enablers to service delivery were identified. When health and social care staff are co-located and are facilitated to develop strong relationships, this goes some way to addressing the challenges with joint working. Providing platforms for information-sharing and for giving feedback to improve the service has also been an important enabler. Clear and documented processes and agreements have been a key enabler for making service changes in a complex system. Staff noted that it was important that these were co-developed with staff across organisations. Enablers to developing and improving the service includes the ability to move beyond the documented processes where necessary by innovating, evolving and being flexible. This is starting to be done in a data-driven way so that the data about the service is used to monitor, evaluate and support evidence-based change. Enablers to delivering the MARRS mental health crisis intervention include building a trusting and supportive relationship with each young person and their family and using evidence-based practice and frameworks to support the intervention, in particular the Adaptive Mentalization Based Integrative Treatment AMBIT model and trauma-informed care.



Recommendations

Showcasing, Implementation and Understanding data for improvement

1. **Sharing and showcasing**: The insights developed in this evaluation and in the next phase will be of great value to other organisations who are interested in innovative ways to support young people in mental health crisis. The MARRS leadership should seek fora to share the challenges, enablers and data insights across the region and nationally.
2. **Data for improvement**: This evaluation has enabled linkage of MARRS health and social care data for the first time, allowing analysis of episode duration, characteristics of the cohort and the extent of joint working. This has offered great insight to the MARRS leadership, but has also raised multiple additional questions. There is a need to use similar analysis methods to understand the entire service that young people in crisis receive across health and social care, not just from MARRS, and to segment the young people into different groups so that the MARRS can plan in the future which groups should receive which service.
3. **Implementation**: Following any further analysis of data, there is a need to interpret the insights and translate them into actionable recommendations.

Joint Working between health and social care

4. Culture and language challenges are best overcome by building relationships, co-working and communicating. The MARRS health and social care staff should **continue to co-locate** 2 days per week and seek opportunities for shared work / shadowing where possible.
5. Now that MARRS social care staff have developed expertise in young people's mental health crisis, consideration should be given to how, in addition to holding their own caseloads, they can **deploy their expertise in an advisory capacity** to cases held by other social workers.
6. **Lack of joint system access is a real barrier** which needs concerted efforts to overcome.

Pathways and processes

7. Different procedures on referral, assessment and consent need to be addressed through development of processes, testing with staff, monitoring for compliance, and iteratively improving.
8. Procedures developed should aim for **joint assessment** where possible.
9. The service should **track and report on each assessment made** about joint working for each young person, so that data is available on: i) which young people are being worked with jointly by health and social care, ii) which have their own (non-MARRS) social workers, iii) which are not being cared for by a social worker, either MARRS or non-MARRS and why the decisions were taken.

System-wide working

10. **Proactively plan about discharge** / transfer / step down to other children and adolescent mental health services in advance so that YP does not enter a waiting list for CAMHS on discharge from MARRS. This should also include **planning for transfer into adult services.**
11. There is similarly a need to plan **discharge from MARRS social care practitioners** to other social care practitioners after the mental health crisis pathway has ended. If MARRS social care practitioners continue to hold cases for several months longer than MARRS health practitioners, this may limit future joint working.
12. Support system joint working and discharge planning by **clearly communicating to system partners** about what the MARRS is (an integrated health and social care mental health crisis pathway for young people) and what it is not (health and social care staff are not employed by the same agency and are not able to bypass statutory requirements and embedded systems.)
13. Support and maintain **enthusiastic champions** in different organisations to share information about the MARRS service (e.g. police).
14. Measures to help address **retention of Health staff** could include buddying, providing more support during indication and opportunities to shadow colleagues.

Continued Use of Data

15. Continue **using data to inform service developments**. This should include predicting demand, modelling future likely caseloads for single and joint working.
16. **Streamline the data** that needs to be recorded, only asking staff to record essential data.
17. Continue informing staff that they need to **collect Routine Outcome Measures (ROMs)**.
18. **Share reports on the paired ROMs** to the staff providing the data via the business meetings, as this will improve data quality.
19. **Monitoring indicators over time** will help continuously improve the service. The indicators should be reviewed to establish which are the most realistic. This evaluation has shown there may be a need to **focus indicators on the high-intensity user** of the service in addition to all users.
20. Given that this evaluation was carried out before the service was properly implemented, treat this as a baseline with the need for **future evaluation or mini-evaluations.**

Clinical model and voice of the child

21. MARRS has documented the model in terms of components and pathways. There is also an opportunity for MARRS to document the **clinical model,** i.e. which clinical interventions work best for this cohort and what are the mechanisms through which these work over an extended period to support young people out of crisis period and into stabilization.
22. Continue using and rolling out **AMBIT**.
23. Continue using the **experience of service questionnaires** in business meetings to improve the service. Consider other ways to include the voice of the child more in service development.

Note, this is a summary document. For the full MARRS evaluation, contact:
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