



University of Essex

REDUCING RECURRENT CARE PROCEEDINGS

SERVICE EVALUATION: POSITIVE CHOICES AND MPOWER

September 2013 - February 2015

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from the University of Essex

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This report is dedicated to the memory of HHJ Caroline Ludlow.

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1. EXECUTIVE SUMMARY

Positive Choices and Mpower are two pioneering services working to reduce the number of babies taken into local authority care in Suffolk. They are funded, respectively, by Suffolk County Council (SCC) and the Henry Smith Foundation (for Ormiston Families). Both focus on preventing recurrent care proceedings, offering a flexible, responsive client-led approach.

Recurrent care proceedings account for a very significant proportion of all care proceedings in England and carry a high human cost but research in this field is still very rare. The authors of a recent landmark study (Broadhurst et al, 2015 and 2016 forthcoming) have found that almost 1 in every 4 mothers in English family courts is likely to re-appear in a subsequent set of proceedings within seven years. These findings are drawn from a dataset of 43,541 birth mothers involved in 31 proceedings between 2007 and 2014 derived from national Cafcass records. The probability of recurrence within this group of mothers over the whole 7-year window was 23.7%. The probability of recurrence within this group within 1-2 years of initial proceedings was 13.2%.

At present, very few birth mothers or fathers who lose a child in this way are offered any follow-up support, despite often facing multiple challenges including addiction, mental health problems and domestic abuse. Practitioners agree that this is significant cause of 'revolving door' cases, whereby the same families lose a number of children in sequent family court cases at a cost of between £50,000 and £90,000 – and often more – for each set of proceedings alone.

The two Suffolk services are among the first in England to have been established to address the specific challenge of recurrent care proceedings. This evaluation assesses their initial impact and examines the experience of 102 of their clients (89 women and 13 male partners). Of these, 84 engaged with Positive Choices over 18 months from September 2013 to February 2015, and 18 engaged with Mpower over 12 months from March 2014 to February 2015.

All of the women and some of male clients had previously lost at least one child to local authority care. 82 clients (74 women and 8 male partners) engaged with the services for more than two weeks and 20 opted out altogether within their first two weeks. 8 of the 74 women clients who engaged with the services were pregnant at the point of referral.

This is the first academic-led evaluation of services of this particular kind. It has been conducted by an interdisciplinary team from the University of Essex (sociology, clinical psychology and health) with expertise across child protection, child abuse, domestic violence, family systems

work, compassionate care, parent-infant mental health and community mental health. As practitioners, evaluation team members also work across child and adolescent mental health, mediation, policy consultancy and an NHS court assessment service undertaking expert witness assessments and offering therapy to families involved.

1.1 KEY FINDINGS

- One participating mother has given birth as a result of planned and supported pregnancy while engaged with the services. She and her partner have, to date, been able to keep and successfully parent that child.
- The services contributed to a likely reduction in unplanned pregnancies among this client group. Of the 74 women who participated in the services for more than two weeks, 8 were pregnant before their referral and have therefore been excluded from this outcome measure. One further woman (above) was supported through a planned pregnancy. None of the remaining 65 women experienced an unplanned pregnancy during the period covered by this evaluation.
- Without intervention, and assuming Broadhurst et al's (2016) calculation that the probability of recurrence within this group within 1-2 years of initial proceedings is 13.2%, we estimate that 9 (13.2%) of these 65 women are likely to have experienced an unplanned pregnancy in the 18 month evaluation window and to have faced recurrent care proceedings. The fact that none did over the period of the evaluation is a significant achievement on the part of both teams and their clients.
- In-depth case studies of 5 clients (4 mothers and 1 male partner), combining 'before and after' clinical psychology measures and face-to-face interviews, indicate that three of the five showed significant improvement in their emotional health and well-being after 9-12 months of working with the services.
- Available data on 74 of the 82 engaging clients (74 women and 8 male partners) shows that 18 (24%) had been able to find employment and 17 (23%) to access training (noting that some accessed *both* employment and training).
- Available data on 73 of the 82 engaging clients (74 women and 8 male partners) shows that, in the opinion of their support workers, 32 (44%) had been able to establish 'average', 'good' or – more rarely – 'excellent' relationships with family and friends.
- Available data on 81 of the 82 engaging clients (74 women and 8 male partners) shows that 54 (67%) were referred to other support services as part of their engagement. Of these, 15 (19%) were referred to one service and 39 (54%) to between two and six services.

- Support workers and managers have played a pivotal role in designing and delivering these two innovative services. Their distinctive bespoke approach flexes to meet specific client needs. All reported feeling empowered and enthused by their experiences.
- Significant cost savings can be extrapolated based on the likely 'avoided' costs of 'avoided' care proceedings. Given that the cost of proceedings ranges from £50,000 to £90,000 per case and that an estimated 9 cases have been avoided, these two services have delivered gross savings of between £450,000 and £810,000 in the 18 month period studied. These savings are to be offset against the £169,000 cost of staffing the two services over that time: £34,000 for Mpower (over 12 months) and £135,000 for Positive Choices (over 18 months, @£90,000 per year).
- Cost savings for subsequent years can also be inferred – with some caution. Babies removed from birth parents in these circumstances are often adopted and therefore do not present such high on-going costs to local authorities. However, in the event that adoption arrangements cannot be made or break down, substantial on-going costs in the form of long-term foster care and associated expenditure for Looked After Children could be incurred up to age 18. The Audit Commission has estimated the average annual cost of supporting each LAC to be £50,000 per child per year (based on DfE figures for 2012-13). If we assume that all 9 of the avoided pregnancies had become LAC the annual cost to Suffolk County Council could have reached £450,000. Over 18 years, this could have amounted to £8.1 million.

1.2 KEY RECOMMENDATIONS

- The work of the Positive Choices and Mpower teams is contributing to the reduction of recurrent care proceedings in Suffolk. It is also contributing to the improvement of the well-being, functioning and quality of life of a highly marginalised group within our community. We recommend that their work continues to be supported.

We also recommend that the two services should consider making the following enhancements:

- Review referral channels and entry-level thresholds to ensure that potential clients are fully consulted by referring agencies and only accepted by the two services where staff have capacity to work with them from the outset at an appropriate level of intensity.
- Ensure that the range of support services offered to help clients strengthen their capacities involves high quality clinical services. Given the range of mental health problems and trauma-related presentations highlighted in our data, we recommend that the two services enhance their current fast track routes into local mental health and other specialist therapeutic services, potentially by

establishing new Service Level Agreements between local mental health and social care clinicians.

- Ensure that sufficient funds are put in place to ensure that the support workers themselves are adequately supported. Their work is more intensive, in-depth and emotionally demanding than their current service descriptions may indicate. This support could take the form of specialist clinical supervision, distinct from in-house managerial supervision. These services depend on the skills, insights and robustness of their front-line staff and these staff need to be nurtured.
- Ensure that case-loads remain manageable. Frequent face-to-face contact with a smaller number of clients is likely to deliver a better all-round quality of therapeutic relationship, higher retention levels and, potentially, to lower levels of unplanned pregnancy. The broad geographical area covered by the two services presents significant challenges in this respect and highlights the difficulty of reproducing 'urban' service models in rural and peri-urban areas.
- Frame transitions out of the service as part of goal-setting between clients and support workers. This is needed in order to free up capacity for new referrals and to assist clients in taking the next step in their own recovery. In recommending this we do not advocate flagging exit dates from the outset as we fully recognise the value of maintaining open-ended and flexible engagements.
- Ensure staff have continuing opportunities to share their experiences and insights with a growing national policy community focused on meeting the challenges of recurrent proceedings. Both services have created enormous learning opportunities for others and these should be maximised through training, good practice and other dissemination events.
- Both service teams should standardise baseline data collection on all clients from referral into, and transition out of, the services.
- Suffolk County Council should standardise routine baseline data collection relating to recurrent care proceedings in the county so that these can be more readily monitored as part of a broad reduction strategy.
- Ensure that staff in both services have ready access to relevant local and regional data on recurrent care proceedings and relevant recurrent pregnancy rates. Such data is vital in enabling the services to plan future activity and staffing levels.
- Secure future service funding in the immediate and longer term to extend the valuable work of Positive Choices and Mpower. A more secure base will enhance staff resilience, retention and effectiveness.



- Continue to evaluate and monitor the nationally-significant work of the two services. Future evaluations could apply emerging 'long run' methods of quantifying and financialising the 'intangible benefits' of a given intervention. However, it should be noted that even devotees of these approaches recognise that it is these 'intangible benefits' that hold the deepest personal value to clients and that these may remain simply incalculable or 'priceless'. One mother summed up the value of her involvement with the two services in very simple terms:

Well, the outcome for me is that I've kept a baby.

2. SITUATION ANALYSIS

2.1 A NATIONAL PROBLEM WITH NO NAME

Until recently, the challenge of recurrent care proceedings was 'a national problem with no name' (Cox, 2012). New research (Broadhurst et al, 2015 and 2016 forthcoming) has found that almost 1 in every 4 mothers in English family courts is likely to re-appear in a subsequent set of proceedings within seven years. These findings are drawn from a dataset of 43,541 birth mothers involved in 31 proceedings between 2007 and 2014 derived from national Cafcass records. The probability of recurrence within this group of mothers over the whole 7-year window was 23.7%. The probability of recurrence within this group within 1-2 years after first removal of a child was 13.2%.

At present, very few birth mothers who lose a child through care proceedings are offered any follow-up support, despite often facing multiple challenges including addiction, mental health problems, significant past trauma and domestic abuse. Practitioners agree that this is significant cause of 'revolving door' cases, whereby the same families lose a number of children in sequential family court cases. This is 'a national problem with no name' (Cox, 2012) which warrants immediate attention and requires new kinds of interventions underpinned by, and evaluated using, new interdisciplinary research methods.

2.2 LOCAL DIMENSIONS

In common with almost every local authority in the UK, SCC does not routinely collect data on the number of recurrent care proceedings. Figures on the number of children becoming LAC and the numbers of children being adopted are collected separately and neither set of data routinely refers to previous losses to care. Moreover, data of this kind tend to be collected around the child(ren) concerned and not around her/his mother or father. This is a national problem and not one exclusive to Suffolk.

Figures provided by SCC for the two years prior to these services being established show that there were 93 and 98 children who took on LAC status in 2011 and 2012 respectively. The challenges outlined above mean that it is difficult to identify how many of these were recurrent proceedings or to track changes in the incidence of such proceedings. However, data collated as part of earlier pilot project initiated by Tina Wilson (SCC Children and Young People's Service) and working with mothers targeted for pre-birth risk assessment found that 40 per cent of the 226 birth parents whose children were considered for adoption in 2005-07 had lost at least one previous child to local authority care: a collective total of 155 children. The data also revealed that one third of the 60 children with a plan for adoption in 2009-10 had one or more siblings who had already been adopted (Suffolk Children and Young People's Service, 2010).

A separate Suffolk study conducted as part of the same pilot calculated that one maternity unit in one local hospital had seen 27 newborn babies made subject to Interim Care Orders in one 10-month period (Jan-Oct 2011): 23 of these babies had older siblings who had already been removed to permanent adoption and one was the eighth child to be removed in this way from the same mother (South Suffolk Pre-Birth Working Group, 2011).

2.3 SERVICE HISTORY, PROFILES AND SUPPORT MODELS

In 2010, a South Suffolk Pre-Birth Working Group was established to address the issue of recurrent proceedings. The group was initiated by Tina Wilson (SCC safeguarding team) and involved midwives, health visitors and representatives of other adult services. Together, they offered support to vulnerable mothers facing pre-birth risk assessments. Their approach was informed by the pioneering 'Make a Change' intervention, headed by Sue Crowley, and addressing the unmet needs of Suffolk sex workers in the wake of the serial murders of five women in and around Ipswich in 2006.

With further input from Cafcass and the Suffolk Family Justice Council, then chaired by family court judge HHJ Caroline Ludlow, the remit of the Pre-Birth Working Group expanded. Prof Pamela Cox, a lay-university member of the SFJC, secured funding from the national Family Justice Council to conduct a scoping study on recurrent care cases and to map existing provision which might be extended to them in Suffolk (Cox, 2011 and 2012). As part of this study, contact was made with clinicians and other practitioners at the London Family Drug and Alcohol Court and this supported the early development of what has since become a valuable national network connecting researchers and practitioners working together to reduce recurrent care proceedings. The network is co-ordinated by Dr Mike Shaw and Sophie Kershaw of FDAC/Tavistock & Portman NHS Foundation Trust and by academic researchers Prof Judith Harwin and Dr Bachar Alrouh (Brunel) and Dr Karen Broadhurst and Dr Claire Mason (University of Lancaster).

In 2011, Suffolk County Council extended the scoping study and the work of the South Suffolk Pre-Birth Working Group to frame a new intervention which would become the Positive Choices service. Strategic planning was assisted by Graham Beamish, aligned with other SCC work to implement CYP Directorate of Looked After Children Strategy Phase 2, and shared with voluntary sector partners, Ormiston Families, a large organisation specialising in work with children and families.

Ormiston succeeded in gaining further funding from the Henry Smith Foundation to establish its own sister pilot, Mpower, which launched in November 2012, with Kym Hackett as a part-time senior practitioner/support worker and Alison Gillies as service manager (1 day per week).

Positive Choices launched in September 2013, with Roberta Owen and Ruth MacDonald as full-time support workers and Sue Crowley as service manager (1 day per week). Mpower has used volunteers to help provide additional support (three up to December 2014 and one thereafter).

The two services work closely together and see their partnership as a key part of the sustainability of this provision. They share a steering group chaired by Tina Wilson, now head of safeguarding for SCC, and are regular contributors to the above national network. Positive Choices is now functioning as an integrated service with CYPS and Mpower has funding until the end of 2016. They are two of a growing number of similar pilots and services recently developed in England including examples in Brighton, Reading, Salford and Nottingham. Notably, the Pause project, which started in Hackney, has recently received support from the Department for Education Innovation Fund to test its approach in six locations – Doncaster, Greenwich, Hull, Islington, Newham and Southwark.

Positive Choices and Mpower support women who have previously had one or more children removed from their care or who are at risk of having further children removed. They work with women, and their partners where appropriate, to take more control of their lives, prevent further pregnancy until they are in a position to parent effectively and assist them in resolving their difficulties.

Like a number of other innovative contemporary services, Positive Choices and Mpower are not tied to a fixed intervention model and do not work within a single theory of change. Rather, they offer a pragmatic, client-led approach combining motivational activities, self-reflection and forward referrals to other agencies.

Both services have developed a model of one-to-one support emphasising trust-building between the support workers and clients. Once a relationship has been established, personal goals – often very modest at first – are identified along with practical ways of achieving these. The support offered is therefore very flexible and tailored to the needs of each individual. This intervention model has been honed through successful earlier pilot projects and previous experience. Between face-to-face visits, support workers and clients maintain contact through phone calls, texts and emails as well as through personal letters and cards. Support also takes the form of assisting and encouraging clients to access other services in the community as well as supporting women to access contraception and other health services. Neither service currently sets a fixed time limit for support offered although both take steps to prepare clients to move on from the service.

The support workers all hold degree-level qualifications and all have had experience in working with marginalised and traumatised people. They tailor their work to the individual needs and wishes of their clients. This means that they engage with clients in a variety of ways and with a varying level of frequency and intensity.



2.4 CLIENT PROFILES

Women and their partners were eligible for participation in either Positive Choices or Mpower if they were 18 or older, had lost one or more children to adoption and were assessed to be at risk of having more children removed. They are typically referred through Children's Services Social Care (via Safeguarding Managers), Safeguarding Midwives and mental health services. All referrals are assessed by Positive Choices staff to determine their likely levels of engagement and willingness/capacity for change. Those who are believed to meet service entry thresholds are then allocated a support worker, either within Positive Choices or with Mpower.

This evaluation considers the experiences of 102 clients. Of these, 84 engaged with Positive Choices over 18 months from September 2013 to February 2015, and 18 engaged with Mpower over 12 months from March 2014 to February 2015.

In that period:

- 102 clients were referred into the two services (89 women and 13 male partners)
- 82 clients (74 women & 8 male partners) 'received a service' in the sense that they engaged for more than two weeks. The 20 clients opting out within their first two weeks are judged 'not to have received a service' and have therefore been excluded from some of the findings that follow.
- 8 of the 74 women clients who engaged with the services were pregnant at the point of referral
- 12 of the 82 core participants agreed to take a more detailed part in the evaluation project.

3. EVALUATION METHODOLOGY AND VALUES

3.1 THE VALUE OF A MIXED METHODS APPROACH

This evaluation was conducted by an interdisciplinary research team from the University of Essex (UoE). As a research team, we have wide-ranging expertise with specialisms covering child protection, child abuse, domestic violence, family systems work, compassionate care, parent- infant mental health and community mental health. As practitioners, team members work across child and adolescent mental health, mediation, policy consultancy and an NHS court assessment service undertaking expert witness assessments and offering therapy to families involved. We have consulted with colleagues at the Tavistock and Portman NHS Foundation Trust, notably Dr Mike Shaw, consultant psychiatrist at FDAC and co-author of key national-level studies of the incidence of recurrent care proceedings (Broadhurst et al, 2014, 2015, 2016 forthcoming).

This evaluation received ethical approval from the University of Essex in 2013 (updated in 2014) and has been conducted in consultation with the SCC Research Governance Unit. Our methodology has been shaped by our commitment to developing multi-disciplinary methods to evaluate the effectiveness of multi-agency services engaging with the multi-faceted social problem of recurrent care proceedings. It is also shaped by our belief in the emancipatory potential of inviting these birth mothers and their partners (where appropriate) to tell their stories, and to be heard, in new ways. It draws on five key elements outlined in Table 1.

3.2 QUANTITATIVE DATA: BASELINE CLIENT ENGAGEMENT

The evaluation team, in consultation with service staff, designed excel spreadsheets to capture baseline data about the duration, nature and broad outcomes of individual client engagement with their respective support workers. Formal outcomes measures included: quality of engagement with support worker and other professionals; quality of personal relationships with family and friends; level of daily self care and living skills; number of referrals/accompanied visits to other services; registration with GP; use of contraception; (un)planned pregnancy; and access to education, training employment or voluntary work. The data was based on assessment of individual client personal change by service staff. It was gathered by the evaluation team as an interim measure pending the finalisation by the two services of a more comprehensive system for capturing client progress against agreed goals and expected outcomes.

The analysis of formal outcome measures needs to be considered alongside clients' own progress towards personal goals agreed with their support workers. These vary greatly according to individual circumstance but are a vital component of the effectiveness of the two services (see sections 4.4.4 and 5.5 for more detailed discussion).

of change' – or, in other words, their shared professional view of the kinds of changes likely to reduce participants' symptomology and improve their quality of life, functioning, and their future ability to parent effectively (if this is a path they chose to follow).

During consultation with the evaluation team, service staff explained that the five areas of change that were most important to monitor were: (i) participants' feelings of self-esteem, (ii) personal autonomy, (iii) decision making skills, (iv) psychological sense of empowerment and (v) ability to form more positive, personal relationships and attachments. The measures listed in Table 1 were chosen to best represent the 'indicators for change' identified by the support workers. Each participant was interviewed using these measures at, or soon after, the point of referral to either of the projects (pre-intervention) and 9-12 months later (post-intervention). The participants were interviewed

3.3 QUANTITATIVE DATA: PSYCHOMETRIC MEASURES

From the outset, the evaluation methodology was shaped by the stated aims of the Positive Choices and Mpower services. Members of the evaluation team met with practitioners from both groups as part of the research design process to better understand these aims and the many challenges likely to be encountered in meeting them. In particular, we wished to identify their particular 'theory

Table 1

EVALUATION AIM	SOURCE OF EVALUATION DATA	EVALUATION DATA SAMPLE SIZE
1. To collect baseline data on all Positive Choices and Mpower clients.	Data recorded by Positive Choices & Mpower practitioners on all their participants	102 (of whom 82 engaged beyond 1-2 weeks and, therefore, received a service)
2. To conduct clinical assessments of participants' personal capacities as they entered and exited the services	Innovative combination of 6 self-report clinical tests administered pre- and post-engagement: (i) Adult Attachment Scale (Collins and Reed, 1990) (ii) Rosenberg Self-Esteem Scale (Rosenburg, 1965) (iii) CORE Outcome Measure (CORE System Trust: www.coreims.co.uk/copyright.pdf) (iv) Making Decisions Empowerment Scale (Rogers, Chamberlin, Ellison and Crean, 1997) (v) SCORE-15 Index of Family Functioning and Change (Stratton, Bland, Janes and Lask, 2010) (vi) Child Abuse Potential Inventory (Milner, 1986)	5 (note, 7 further individuals took part in pre-intervention assessment but not post-intervention assessment)
3. To conduct qualitative assessment of 10 participants' experiences as service users	Face-to-face semi- structured interviews	9
4. To conduct qualitative assessment of 5 practitioners' experiences as innovative service developers	Face-to-face semi-structured interviews	5
5. To compile in-depth mixed method case studies of 5 participants	Above data	5



in their homes or a mutually agreed venue by one of the two clinical psychologists (Dr Frances Blumenfeld & Dr Danny Taggart) and one trainee clinical psychologist (Ms Zara Rahemtulla). The interviewers were introduced to the participants by either the Positive Choices or Mpower support worker who sometimes remained for the duration of the meeting. After a brief introduction, and a signing of a consent form, the questionnaires were administered to the participants who were given a choice of filling in the questionnaires on their own or having them read to them by the interviewer. At the end of the interview all participants were asked about the impact of the interview on them. Some participants found some questions very difficult to answer especially when they asked about family relationships or other intimate relationships and particularly when they related to the child(ren) they had lost.

3.4 QUALITATIVE DATA: USER AND STAFF EXPERIENCES OF THE SERVICES

Practitioners in both Positive Choices and Mpower were acutely aware from the outset that their clients were likely to have negative feelings towards practitioners and professionals, especially those directly involved in the removal of their child(ren). As a result, both projects have set out to create a qualitatively different relationship with their clients. Support workers believe that such reparative relationships are likely to help clients to reappraise how they respond and react to other key people in their life. Given this, the evaluation team designed qualitative interviews to explore the specific quality of the relationship between clients and practitioners.

In depth interviews were conducted with 9 clients. Seven were conducted by one of the sociologists on the evaluation team (Dr Jackie Turton) and two by one of the clinical psychologists (Dr Danny Taggart). Two clients were interviewed twice as they wished to offer a personal update. Interviews took place in a variety of locations, including the service's premises or the clients' own home. All interviews were arranged with the assistance of the service staff who acted as intermediaries and who were sometimes in the vicinity of the conversation. Clients were encouraged to take the opportunity to freely discuss their experiences, as users, of the service provided and the factors that lead to their involvement with it. Interviews were also conducted (by Dr Caroline Barratt) with five service staff (three support workers and two managers) to explore their own assessment of their work, the progress of their respective projects and the challenges of being involved in frontline innovation.

3.5 CHALLENGES

There are many significant challenges involved in designing, delivering and evaluating effective services for these mothers and their partners. The absence, to date, of any review of such services is a clear testament to this. Particular challenges on the evaluation side are:

3.5.1 Prioritising child protection

The provision of such services and the evaluation of any such project is challenged by the tension between the desire to engage such parents and help them regain the trust of local agencies and the need to protect children who might be in their future care.

3.5.2 Control group

Our evaluation did not include a formal control condition or randomisation. This poses challenges in identifying and attributing the precise effects of the interventions. Future evaluations could consider ways of comparing the outcomes of participants with the outcomes of non-participants with a similar profile.

3.5.3 Participant resistance

These birth mothers and their partners are already a highly scrutinised group. It is unsurprising that many resisted the further documentation of their experience – either through clinical assessment or qualitative interviews. Many have very negative and recent memories of psychological assessments undertaken during care proceedings. Supported workers reported that some expressed a particular reluctance to repeat some of the psychometric measures, particularly those that asked them about their current parenting practices. Creating time for the evaluation team to engage with both service staff is crucial in reducing attrition rates across time points and maximising participation to reinforce methodological robustness and to enhance the rigour of findings.

3.5.4 Attrition bias in the data

Only a very small percentage of the mothers and fathers involved in the projects agreed to participate fully in our evaluation. Additionally, some mothers who originally engaged in the services were no longer contactable after 6-9 months. Both factors created an attrition bias in our data.

3.5.5 Evaluating personalised interventions

Support workers rightly tailored their work with clients according to the latter's needs and wishes. This meant that individuals' experience of the services offered could vary significantly. In addition, the rolling referral mechanism meant that some of the 102 clients featured in the evaluation were engaged with the services for several months and others - for example, those who only started engaging towards the end of the evaluation window - for a much shorter time.

4. CLIENT OUTCOMES

4.1 PERSONAL CHANGE: BASELINE DATA

Baseline data were collected by service staff on the level, nature and impact of client engagement with their respective services and on progress relative to the outcome measures listed in 3.2 above.

4.1.1 Duration of engagement

Table 1. Duration of engagement (n=102)

Time on programme	Mpower 'n'	%	Positive choices 'n'	%
Less than 2 weeks	0	0	20	23
2 to 4 weeks	2	11	7	8
1 to 2 months	2	11	25	30
2 to 4 months	2	11	14	17
4 to 6 months	1	6	7	8
6 to 12 months	5	28	4	5
>12 months	6	33	7	8
Total	18	100	84	100

Data was collected on the duration of engagement and attrition rates for 102 participants in both services. All referrals are channelled through Positive Choices (most via a secure email account facilitated by Suffolk County Council). The managers of both services meet once a month to allocate remaining clients who meet the relevant thresholds, with Mpower only accepting clients living in Ipswich and Positive Choices accepting clients living over a wider geographical area across Suffolk.

Mpower engaged with a smaller number of participants (n=18) over a 12 month period and saw fewer disengage during the first two-month stage (22%). Positive Choices engaged with a higher number of clients (n=84) over a longer period (18 months) and had a higher 'drop out' rate: over half (61%) in the first two months (n=52).

This warrants further investigation by the two services and the steering group. It is likely to be due in part to the fact that all referrals are first channelled through Positive Choices and that a proportion of these clients opt out before they are 'assigned' to a support worker in either service. Their reasons for opting out need to be tracked. It may be, for example, that they feel they are not in need of a service or that they feel dissatisfied with their initial experience or the manner in which they were referred by third parties.

Furthermore, Mpower's retention rates throughout the duration of the project tended to be higher than those of Positive Choices, although it is unclear whether 'holding on' to participants for a longer period was part of a broader stated strategy.

Given the high level of attrition from the Positive Choices program in the first two weeks of engagement (n=20, 23%), the decision was made to remove other data from this sub-sample as it significantly skewed all subsequent data. In addition to this there was some missing data so the total number of the sample varies for some of the descriptors.

4.1.2 Frequency, nature and impact of engagement

Mpower provided daily contact (by telephone or other means) to a significant proportion of their participants (33%), while weekly contact was the preferred telephone frequency for Positive Choices (95%). Furthermore, as table 2 shows, there was a wider range of telephone contact frequency for Mpower generally compared to Positive Choices, possibly revealing a more tailored approach made possible by the smaller number of participants recruited.

Table 2. Frequency of telephone contact (n=79)

	Mpower 'n'	%	Positive choices 'n'	%
None	0	0	0	0
Daily	6	33	0	0
Weekly	6	33	58	95
Monthly	5	28	3	5
Less than monthly	1	5	0	0
Total	18	100	61	100

The frequency of face-to-face contacts between the support workers and the clients shows greater parity between the two services with both most frequently opting for weekly contact (see table 3). Interestingly, however, even once those Positive Choices participants who disengaged within two weeks were removed from the analysis, there were still a large number of them who did not appear to have any face to face contact (n=18, 28%). Whether this was due to their preferred medium of contact being telephone/text or that they did not get to the level of engagement whereby direct contact was possible is unclear, but what can be deduced is a pattern of lower levels of face-to-face engagement by a majority of Positive Choices participants. One significant factor which may account for differing use of contact types is the larger geographical area covered by Positive Choices which may make face-to-face contact more difficult.



Table 3. Frequency of face-to-face contact (n=82)

	Mpower 'n'	%	Positive choices 'n'	%
None	0	0	18	28
Daily	2	11	0	0
Weekly	10	55	37	58
Monthly	6	7	7	11
Less than monthly	0	0	2	3
Total	18	100	64	100

There is a broad range in the rate at which each of the projects referred participants on to other services, significantly a key outcome indicator for both services (see table 4). However again with the Positive Choices project there are a large minority of participants (n=26, 41%) who do not appear to be accessing any of the available services. Overall Mpower referred their participants to other services frequently; 13, participants (72%) being referred to 3 or more services, compared to Positive Choices who had a large majority referred to 3 services or fewer (n=54, 85%). Positive Choices workers tended to accompany participants to these other services less frequently (n=35, 56%) whereas 75% of the Mpower participants were accompanied on these visits, sometimes as many as 6 times (see table 5).

Table 4. Referral to other services (n=81)

	Mpower 'n'	%	Positive choices 'n'	%
None	0	0	26	41
1	4	22	11	17
2	1	5	9	14
3	4	22	8	13
4	2	11	3	5
5	3	17	3	5
6	4	22	2	3
Blank	0	0	1	2
Total	18	100	63	100

Table 5. Number of accompanied visits to other services (n=81)

	Mpower 'n'	%	Positive choices 'n'	%
0	4	22	35	56
1	4	22	9	14
2	3	17	6	10
3	1	5	4	6
4	4	22	4	6
5	5	28	5	8
6	6	33	0	0
Total	18	100	63	100

Mpower indicated that 89% (n=16) of their participants engaged in at least an average way with the support worker whereas Positive Choices reported less positive engagement with only 39% (n=24) reporting an average or above average relationship with their support workers (see table 6). It should be stressed that these outcomes are based on opinion of the support workers themselves on the relationship and so figures are likely to contain reporter bias (in the sense of varying perceptions of what a 'good' or 'average' level of engagement might be). Additionally the larger number of Positive Choices participants may – again - have impacted on this outcome since the team were required to try to engage many more people. Average or better engagement with other services was reported to occur for about 80% (n=14) of the participants of the Mpower group and for about 48% (n=29) for the Positive Choices group.

Table 6. Quality of engagement with support worker (n=80)

	Mpower 'n'	%	Positive choices 'n'	%
1 Poor	2	11	33	53
2	0	0	5	8
3 Average	3	17	10	16
4 Good	5	28	13	21
5 Excellent	8	44	1	2
Total	18	100	62	100

At the other end of engagement scale the same pattern can be seen with a larger number of Mpower participants reported as having an 'excellent' relationship with their key worker (44%) as compared to Positive Choices participants (2%). This warrants further study by the two services and the steering group. It may be linked to reporter bias (as above) or it may be linked to Mpower's more intense engagement with a smaller number of more geographically-accessible clients. It should be noted that the qualitative data suggested that those clients interviewed reported a very positive relationship with workers across the two services.

Table 7. Quality of engagement with OTHER support worker(s) (n=70)

	Mpower 'n'	%	Positive choices 'n'	%
1 Poor	3	17	23	44
2	0	0	0	0
3 Average	6	34	17	33
4 Good	6	34	11	21
5 Excellent	3	17	1	2
Total	18	100	52	100

The same pattern of differing levels of engagement with other professionals across the two projects can be delineated in Table 7, albeit to a less stark degree. Just over half of the participants in Mpower were rated as having a good or better relationship with other professionals (51%) compared to a much smaller proportion for Positive Choices (23%).

Table 8. Relationship with Family and Friends (n=73)

	Mpower 'n'	%	Positive choices 'n'	%
1 Poor	3	17	27	49
2	0	0	11	20
3 Average	6	33	13	24
4 Good	6	33	4	7
5 Excellent	3	17	0	0
Totals	18	100	55	100

As can be seen from Table 8, many participants across both projects struggle in their relationships with family and friends. Interestingly the pattern of difference across the two projects maps loosely onto the quality of relationship with key workers and other professionals. A larger proportion of Mpower participants are assessed by their key worker to have average or better (83%) relations with their family compared to their peers in Positive Choices (31%). Again, the fact that these data reflect the perspectives of service staff raises the challenge of inter-rater reliability.

The data in table 6-8 could be taken to suggest situational and philosophical differences between the two services. However, this is not supported by the qualitative interviews with staff which revealed a very strong similarity of views across the two.

Table 9. Self care (n=68)

	Mpower 'n'	%	Positive choices 'n'	%
1 Poor	4	24	28	55
2	0	0	12	24
3 Average	7	41	7	14
4 Good	6	35	3	6
5 Excellent	0	0	1	2
Total	17	100	51	100

A similar pattern of difference also emerges in Table 9 where each of the services rated their perception of participants' self-care. With Positive Choices the view is that more than half (55%) of their participants have poor levels of self-care compared to less than a quarter (24%) for the Mpower service. A majority of participants in both had levels of self-care rated as average or worse (Mpower 65%, Positive Choices 93%). This is consistent with the fact that lack of self-care is often at the heart of many difficulties with this population.

Table 10. Number of reported pregnancies among engaging women (n=74)

	Mpower 'n'	%	Positive choices 'n'	%
No pregnancy	12	92	53	87
Planned pregnancy	1	8	0	0
Unplanned pregnancy	0	0	0	0
Pregnant on referral	0	0	8	13
Total	13	100	61	100

A more objective outcome measure – and one of the most strategically crucial measures- is the number of planned and unplanned pregnancies during engagement with the services and is outlined in Table 10.

One participating mother has given birth as a result of planned and supported pregnancy while engaged with the services. She and her partner have, to date, been able to keep and successfully parent that child. This mother was initially a client of the pilot that preceded Positive Choices and was then transferred to Mpower as the first of the two new services to be established.

This data suggests that both services contributed to a likely reduction in unplanned pregnancies among this client group. Of the 74 women who participated in the services for more than two weeks, 8 were pregnant at referral and have therefore been excluded this outcome measure but are included here for information. One further woman (as outlined above) was supported through a planned pregnancy. None of the remaining 65 women experienced an unplanned pregnancy during the period covered by this evaluation.

Without intervention, and assuming Broadhurst et al's (2016 forthcoming) recurrent proceedings 'prevalence rate' of 13.2% within 1-2 years of initial removal, we estimate that up to 9 of these 65 remaining women are likely to have experienced an unplanned pregnancy in the period covered by the evaluation and to have faced recurrent care proceedings. The fact that none did over the period of the evaluation is a significant achievement on the part of both teams and their clients.

Table 11. Access to training (n=74)

	Mpower 'n'	%	Positive choices 'n'	%
Accessed training	2	11	15	27
Didn't access training	16	89	41	73
Total	18	100	56	100

Table 12. Access to work (n=74)

	Mpower 'n'	%	Positive choices 'n'	%
Accessed work	2	11	16	29
Didn't access work	16	89	40	71
Total	18	100	56	100

Available data on 74 of the 82 engaging clients shows that 18 (24%) had been able to find employment and 17 (23%) to access training (noting that some accessed both employment and training). Tables 11 and 12 show that both services struggled to enable participants to engage in work or other vocational activities (noting that this was not their primary aim). Positive Choices had more success with helping participants get into work or training (29%, 27%) compared to Mpower (11%, 11%) but, for both services, the overall level of engagement was low. This is a complex area that warrants further investigation by the two services and the steering group. It clearly connects with several factors, from personal self-confidence, self-esteem, skills and experience to the limited availability of opportunities in disadvantaged areas.

4.2 PERSONAL CHANGE: PSYCHOMETRIC MEASURES

All 82 engaging clients (74 women and 8 male partners) were invited by service staff to take part in a baseline pre and post intervention evaluation of their psychological wellbeing and functioning. The aim was to compare the participants' scores on six measures pre- and post-intervention. The number of people who agreed to take part was relatively small (n=12) and an even smaller number (n=5) were willing or able to make themselves available post-intervention for the follow up. Therefore these results should be treated with considerable caution.

The overall profile of the whole sample (n=12) on the six measures pre-intervention is described first. This is followed by an analysis of change for a sub-set of participants where pre and post intervention data (n=5) was obtained.

4.2.1 Pre-Intervention

The average pre-intervention scores indicated that the majority of participants scored highly on the measure of Family Functioning, indicating poor family functioning. On average, the Attachment scores indicated an 'anxious' attachment style, and self-esteem scores were lower than that of the non-clinical population. This suggests that a high proportion of this sub-sample would meet the threshold for some form of mental health diagnosis. The mean scores on the 'empowerment and optimism/feeling in control about the future' scale were low. On the Child Abuse Potential measure, 5 participants obtained an 'elevated' score on the 'lie' scale, 'abuse scale' and indicated problems in their family relationships. Another 5 participants scored in normal range on these domains.

4.2.3 Post-Intervention

It has been argued that conventional statistical comparisons between groups tell us little about the efficacy of a psychotherapy or treatment programme (Jacobson and Truax, 1991). These tests do not provide information on the variability of people's responses to a treatment programme, nor do they highlight the clinical impact that the intervention may have had on each individual. It is more effective to test whether the post treatment score falls within or close to the mean of the population on the construct being measured (ibid).

The analysis indicated overall improvements for the five clients. One participant showed improvement on all the measures, except the empowerment scale. Three participants showed improvement on the CORE, two participants showed improvement on the self-esteem measure and two showed improvement on the decision-making scale. In summary, three of the five participants demonstrated reliable change on at least one measure and three reached clinically significant change post-intervention. No participant showed improvement on all scales.

Although these results need to be treated with considerable caution, they do point to the positive impacts of the two services at the psychosocial level. The measures selected by the evaluation team may need further refinement but they open up an exciting new approach within mixed method evaluation, not least because they include the kinds of measures routinely used by clinical psychologists called upon to act as expert witnesses in care proceedings. The aim here was to develop ways to measure the enhanced capacity of a birth mother previously involved in proceedings to parent more effectively in the future. We explore the value of this approach further through five client case studies.

4.3 FIVE CLIENT CASE STUDIES

These case studies present a more rounded picture of the complexities of the clients' lives. Details that could potentially identify them have been replaced by a dash.

4.3.1 Alison

Alison had previously lost 3 children into the care system. She was referred to the Positive Choices programme via ___ and engaged for over 12 months, meeting face to face with her support worker every week. According to that worker, she engaged "very well" with the service and the other professionals involved. Working with the Positive Choices programme has led to 6 onward referrals for Alison and she is accessing employment and/or voluntary work and is also engaging with contraception.

Across the six clinical tests, Alison's raw scores were varied. She showed a positive increase in self-esteem levels although this difference was not clinically significant. She herself comments, "I think I am a better person, I think I have grown up more".

In regards to the other variables, clinically significant and reliable change was found for her subjective feelings of empowerment and a medium to large effect size was found for the whole group in relation to the *power and powerlessness, community activism and autonomy and optimism and control over the future* sub scales ($r = 0.46, 0.47$ and 0.47 , respectively). Alison noted, "I've learned to speak myself, my opinion and not worry about what everyone else thinks".

It is important to note that Alison's scores on the SCORE-15 Subscales (*Strengths and Adaptability, Overwhelmed by Difficulties and Disrupted Communication*) were consistently low and therefore were within 'normal clinical range' both prior to and after the intervention.

4.3.2 Tanya

Tanya had previously lost one child into the care system. She was referred to the Positive Choices programme via ___ and engaged for over 12 months, meeting face to face with her support worker every week. According to the support worker, she engaged "very well" with the service and the quality of her engagements with other professionals was rated as "average". Working with the Positive Choices programme has led to 5 onward referrals for Tanya and she is accessing employment and/or voluntary work and is also engaging with contraception.

Tanya showed reliable, positive and clinically significant change in relation to most of the clinical measures. This means that her scores post intervention had moved closer to a level that would be expected within the non-clinical population. Her Attachment Anxiety score moved from a mean score of 3.70 to 1.83, indicating that she may be moving towards feeling more securely attached within her romantic relationships. Her CORE scores also illustrated clinically significant change on every domain, signifying that her feelings of emotional wellbeing and ability to manage her mental health have significantly improved post intervention. Tanya spoke about the significant changes within her relationships with her immediate family – "Me and mum had a big falling out... I also hurt my younger sister... and since then we didn't talk until the beginning of this year... I was out shopping... they came through the doors and then me and mum, we cried our eyes out and hugged each other and ever since, we nearly see each other every day". Post intervention, Tanya showed clinically significant and reliable change on every subscale of the SCORE-15.

Tanya did not demonstrate any deterioration in her scores as a result of the intervention and her CAP scores remained at 'normal' level both pre and post intervention.

4.3.3 Issy

Working with the Positive Choices programme has led to ___ onward referrals for Issy and she is accessing employment and/or voluntary work and is engaging with contraception.

Issy demonstrated reliable and positive change on the majority of the measures, and reached clinically significant change on three of these. Her attachment scores in particular illustrate a clinically significant and reliable change towards a more secure type of attachment style within romantic relationships. Additionally her CORE scores all indicate reliable improvement in relation to her psychological health; specifically her feelings of subjective well-being have reached clinically significant change, indicating that she feels more positive about herself and her emotions post intervention. "I'm fully aware that it's me that can only make the changes..." Issy also did not demonstrate any deterioration in her scores as a result of the intervention and her CAP profile remained the same pre and post intervention.

4.3.4 Jess

Jess illustrated clinically significant and reliable change in regards to 4 out of the 5 domains on the CORE Outcome Measure, indicating that post intervention her mental health scores have moved closer to a level that would be expected within the non-clinical population. Clinically significant and reliable change was also found in regards to her subjective feelings of empowerment and also she appears to have developed new, close relationships within the group – "I've made a friend at X group, we are getting really close now."

4.3.5 Steve

Steve had previously lost 3 children into the care system. He was referred to the Positive Choices programme via ___ and engaged for over 12 months, meeting face to face with his support worker every week. According to that worker, he engaged "very well" with the service and the other professionals involved. Working with the Positive Choices programme has led to 6 onward referrals for Steve and he is accessing employment and/or voluntary work and is also engaging with contraception.





4.4 PERSONAL EXPERIENCES AS SERVICE-USERS

The section presents findings from detailed qualitative interviews with birth mothers and, in some cases, their partners. It covers their pre-engagement experiences (in brief) and their referral to, expectations of and experiences of the two evaluated services.

4.4.1 Pre-engagement: unheeded cries for help?

Leah offered a moving summary of her experiences with the care system prior to her engagement with one of the two services. She describes this as a 'cry for help' that was not met:

I was crying out for help the day I dropped my children off at my Mum's and knocked on the door, she opened it and I ran and left the two children there, X was a year, and X was four and I left them stood there and I legged it, and my Mum was like "where are you going?" and I kept running, that was meant to be my scream for help and then it just escalated from there and every time I've tried to ask for help from their social worker, from my Mum, anyone else, I got told I was being aggressive and angry, because you'd ask and you'd get told 'no there's no money, there's nothing we can do', and then I'd get upset. Now the other worker used to take that as anger and aggression. I'm sat there crying my eyes out, I can barely breathe and the bloke reckons I'm being aggressive, I'm not sure how that works out, but okay, and yeah, everything just, every time I tried to get it from somewhere I got told I was, I was in the wrong, so in the end I just gave up, I assumed this was me, this is the way I'm gonna be, I'm angry with the whole world and if people don't like it then that's their problem." (Leah)

Leah's frustrations were echoed by seven of the nine clients interviewed, all of whom spoke more positively of Mpower and Positive Choices.

Because I haven't had any sort of support, you know, through things that have happened to me and um, I didn't think there was any support out there but obviously I'm aware there is now and also, um, like just someone who's understanding of my situation and someone who can also be a voice for me rather than me standing on my own trying to get my message across. (Issy)

Their previous experiences had led these women to be sceptical about any interventions but having one consistent worker with whom they developed a trusting relationship made all the difference.

And then you're like, 'Well, can I trust you?' So, people who can't trust are going to have a problem working with Tom, Dick, Harry every week, they are going to have a problem, but if you have got that one consistency then they will open up a bit more and become more trusting. (Chris)

And I don't normally get that when somebody comes and knocks on my door and wants to come into my personal safe place, whereas . . . she [support worker] could knock on my door uninvited and she'd get in, whereas normally I'm a bit like, "well do you have to come to my home?" Whereas she's just so comfortable to be around, . . . I found her very, very easy. I'm still finding her very, very easy to work with. (Leah)

4.4.2 Pre-engagement: family and friendships

All the clients had complex relationships with their families and issues around mother-daughter bonding were emotionally charged concerns that were raised within several of the interviews. Issy and Leah had particular problems, as their mothers continued to have contact with the child in care.

I don't talk to my mum. . . Me and my mum don't have a good relationship and there's a lot things that she's done like in my adult life that I can't forgive so . . . She's always had mental health problems herself, . . . it's been quite difficult with her. . . So it's probably easier if she isn't in my life, especially at the moment. (Issy)

. . . if you want the truth, and I just feel like for my mum now to go and have him and pick him up and stuff and she knows I'm not allowed him and . . . she's changed her phone number and . . . wants nothing to do with me obviously so she can have a grandson in her life. How can you, y' know? She's seen my heartache, she's seen the pain I go through for not having my (child), but that doesn't bother her so she's all right isn't she, so that is all that matters. (Issy)

I'm not meaning to be horrible to my Mum, but I am in one sense angry with her cause, in my eyes, she could tell the workers I want my grandchildren to see my, their Mum. (Leah)

These highly charged emotions play out in different ways. Tanya's child was adopted outside her family circle. Her relations with her family deteriorated at that point but later improved:

So, once X was adopted, it was finalised, the court said X's been adopted, me and mum had a big falling out and um, me and my sister, the one that I don't talk to, had a fight, an actual fight, and I also hurt my younger sister, and um, since then, we didn't talk until, the beginning of this year, . . . I was out shopping. . . and um, my sister . . . came through the doors and then my mum did, and then me and mum, we cried our eyes out and hugged each other and ever since, we nearly see each other every day. (Tanya)

Others, for different reasons found maternal-type attachments with grandparents and aunts.

Yeah, everything's fine, I just, she [mother] doesn't really seem like a mum to me, it seems like, it is just the way she is, she, I don't think, she's got quite a few issues that she needs to sort out so, I think my nan is more of a mum figure for me. (Amy)

I don't see my mum . . . My mum lives in XX . . . With my dad, they split . . . My mum's, oh how can I put it, my mum is a schizophrenic, . . . And they thought I had that . . . Yeah, it runs in the genes but I haven't got it. I ain't got it, I don't see them, that is why I am close to my auntie. (Lily)

I had a nan and grandad, they used to live down there but they both died. So I ain't got them now and they used to be my rock. (Lily)

Complex family relationships creating a potentially fractured bonding process are very likely to have shaped these women's own experiences of being mothered and, in turn, their own mothering practices.

4.4.3 Pre-engagement: mental health

It was not surprising to find the number of mental health and health problems that were flagged by this group of women. Despite the small sample these issues ranged from epilepsy and ADHD to 'learning difficulties' and BPD alongside all the associated difficulties of anxiety and depression. Some of these conditions were only diagnosed after contact with the project workers.

I've had epilepsy for years but I have BPD Borderline Personality Disorder which was only diagnosed because (support worker) made it aware to my doctor. (Leah)

Those who are diagnosed and medicated have sometimes found it difficult to manage their conditions and, until entering the programme, appear to have lacked support in doing so.

I struggle and I battle with and I get severe depression and I've been diagnosed with borderline personality disorder. I find day to day it's hard, you know, ups and downs, it's quite constant, constant and um, you know, it's just a case of learning to do the best things to keep yourself well. (Issy)

And some of these difficulties were displayed as anxiety, depression or sometimes anger.

Yeah, yeah any noise would set, like get me up checking all the windows and I was very, very on edge the darker it got . . . And then as it started to get light, I'd get worse cause I'd think well if someone wanted to get in at least they would be able to see what they're doing now, cause there's a bit of daylight and it never just got any better, I was awake for four days and three nights solid. (Leah)

When I go in to town with my husband I have panic attacks on the bus so I don't think I am ready to go to the group on the bus yet. (Jess)

It was mainly my anger, I wouldn't say it was a personality disorder, what they said it was, but it was more my anger, because I kept things bottled in and then when something got to me, it really got to me and I was always, every time I drank I'd go completely, totally off my head, I would, you wouldn't be able to control me at all. He's got to scream at me, literally scream at me, to calm me down, my friends go and grab him to calm me down, it's just my anger cos, it would be so explosive then, yeah. (Chris)

4.4.4 Referrals

All the participants were asked to talk about how they first made contact with Positive Choices or Mpower. Most reported that they had been referred by social services or mental health professionals.

And I've been looking for different help for years, um, and I did a Freedom programme because of domestic violence, I came up to the Centre and done it here. [Support worker] was introduced to me by my social worker, I believe, or my children's social worker anyway. (Leah)

It was after the proceedings, the court proceeding, when I lost my daughter, I got booked through social services and the social worker who, or my daughter's social worker, she referred me to the team that was doing it and that's what came about. (Amy)

I see a mental health worker at XX . . . And I think she referred me to [support worker]. And on Monday I just got a phone call from her and that was it. (Issy)

Social services put in a request. I didn't, they did, to help me. (Lily)

4.4.5 EXPECTATIONS

Clients join both the Positive Choices and Mpower services by choice. It is therefore vital for service staff and evaluators to understand clients' motivations and expectations as these are so closely tied to their capacity for change. For some, the motivation was simply related to the need to conform to requests from professionals.

When she first knocked on my door my expectations were zero to be honest. I was letting her in to try and please my social, my children's social worker and I spent a long time just worrying about that, so I was expecting absolutely nothing. I was expecting to tell the Freedom programme, tell the worker that I did it and that kind of be that, that'd be something else on his list that I could tick off, I wasn't too worried about, I knew I needed

support and things, but I didn't think I was getting it from the ladies that was stood at my door, that's for sure. I was expecting nothing and what I've got back in return has been humungous, they really have proved me wrong, definitely. (Leah)

For others the motivation was clearly linked to their 'lost' child or the prospect of having another baby.

It was mainly the fact that my son doesn't live with me. . . He lives with (a member of the family). . . I need somebody to hear me and so I can get where I wanna be with the situation. (Issy)

I was hoping that they can help me have contact. . . and maybe access. . . and things like that. I feel they can help me. (Jess)

I was so upset, I felt like I wanted to end it, but she's given me, and she said to me that I just need to fight and keep going on and hopefully soon that I'd be able to have another kid, that is what we are working towards and that's what she is helping us do. (Tanya)

4.4.6 SUPPORT MECHANISMS

Relationship with support worker

All of the interviewees viewed these services as different from others they have experienced. There are a number of factors here including issues of trust and confidence briefly discussed above. For instance Leah noted that the support worker was less 'intimidating' and when asked to comment further explained:

She, she'll make it clear, but she doesn't have that whole professional look about her and she's not all in your face trying to tick boxes and she does that without you even realising that she's done it, and you make a step forward without you even realising and then she'll come back and say, "Do you remember when this happened?" and you go "Oh yeah" and just the way she is... she's been so different to everybody else that I have ever tried to work within the past. (Leah)

Others commented about the 'approachability' of the workers and talked of having someone to listen (Chris) as well as someone offering a 'voice' on occasions when clients feel unable to speak for themselves (Issy). The amount of contact available for clients varies according to their assessed need. Some clients have found weekly contact (or more frequent) at first are necessary (Jess, Tanya, Chris, Issy, Alison) and these are gradually decreased - though as nearly all the interviewees pointed out the support workers are always accessible by phone or email – and return calls as soon as they can. In other words, they can be relied on. Clients expressed feelings of confidence in their workers.

I think in a way it is probably better than what like social care and that could actually give you cos they, (support worker) does a lot really, like with all the classes, therapy, counselling, she does speak to a lot of people and she is always like, I could ring her and she's like, "Oh, I'm a bit busy at the minute, I will phone you back in a minute", and then like 10 minutes later, she's rang. (Chris)

All of the women have found being involved with these services has offered them access to a variety of other support groups and therapeutic services. However, for some, just having the door opened is only part of the story as they experience feelings of anxiety and lack of confidence when faced with new situations. This consequently involves further one-to-one support from the support workers.

Well, she takes me to XX group because I am not confident enough to get on a bus yet. (Jess)

Goals and targets

This supportive relationship plays a key part in enabling these women to reconsider their lives and focus on goals and targets for change. These are agreed and modified between clients and support workers. In the early stages, a client's goals can be highly instrumental and informed by their view of what 'the courts' and others want them to achieve:

Yeah, as long as I have done my counselling, that is one up on me, the courts can't hold that against me, that is what social services are waiting for, I've passed everything else, it is just my counselling I need to do, if I do counselling like they said for couple of months, I have done it, like they said, once I have done my counselling, that's the only thing they've, basically that is the only thing they have got on me is my counselling, they have told me that, or therapy or whatever, I need to have one of them. (Lily)

However, as relationships with the support workers progresses, the clients who stay with the service typically begin to develop a clearer sense of proportion. Change is not easy and often entails a series of small steps, thus any goals need to be realistic for each client.

It's a goal sheet with three goals on it and we've set targets. One was to identify healthy relationships because I found a lot of my friends weren't actually that great. . . [Another was] learning to work with my children's social worker, because there was just something about him and I'd lose my temper with him straight away. . . [and the last was] regulating my moods enough to carry on doing my support groups on a Tuesday. We've only got three for now cause if I have any more than three it overwhelms me. (Leah)

Taking and keeping ownership of these goals was also important – sometimes in the face of others' scepticism about apparently inconsequential targets.

We pick small things, to be fair, [but] my Mum was like "They're a bit petty, aren't they? Couldn't you have picked a decent goal?" and I just looked at her and went "But that's where you don't understand Mum because these are actually quite large goals, you have to look at it differently than the way you are," but everybody's different, I suppose. (Leah)

Thus these women are not only confronted with complex decisions about personal targets but may need to defend these when challenged by family and friends.

4.5.4 PERSONAL CHANGE

Contraception

All of the clients interviewed except one have been accessing some form of contraception since joining Mpower or Positive Choices. The exception is Chris who had a planned pregnancy following a risk assessment during her time with the service. She and her partner have successfully managed to change their situations and keep their new baby. The remainder of the women interviewed recognised the importance of contraception at this stage, some fearful of losing another child (Lily, Tanya) to the care system. Amy commented on the urgent need for early contraception.

I think where women lose their children, the problem is they've lost something, so they try and lose something. You really can't cope. Honestly, after I lost my daughter to social services, I wanted another baby. . . It just, I don't know why, it just, I wanted another baby but I knew I couldn't but I just needed, I had that urge that I needed a baby, so I needed to be pregnant again. So, no, that (counselling about contraception) is really good. (Amy)

Amy's observations indicate the need to ensure early access to appropriate sexual health support for women in this situation.

Education and work

Only one woman interviewed had ever had a job and educational attainments were low within the sample. Improving their employment prospects as a group is certainly challenging. Even so, many had been encouraged to realise the importance of, for examples, taking active steps in this regard.

[Support worker] is helping me to try and get work. She is doing my CVs, helping me with my CVs. (Tanya)

I did drop out of school and then I went and done, a couple of courses, I done my level 2 maths. I've also done a couple of other courses and got qualifications. Yeah, just at the moment, where I am not working, it is just filling that time with building a good CV. (Amy)

For some, building a CV entailed re-entering education or training or often short part-time courses. However, Jess has been offered a place on a two-year hairdressing course at the local college, in part as she has some high GCSE grades including one in maths, despite her learning difficulties. This success has been a turning point for her. Others find short-course options rather a disappointment. For example, Issy wanted to undertake a more demanding college course but had to settle for less.

I've just started a computer course. . . Um, I did wanna go to college but funding was a problem, so I can't. (Issy)

Despite this setback, Issy has been helped to access a work placement that she loves and hopes to take up a part-time job with the organisation concerned.

Others have struggled to find work.

I applied for (a job), and apparently I don't meet their needs even though I've got an NVQ Level 2 in retail. I'm inadequate or something like that. I've applied for another job, which was. . . van driving, they will keep my details on record. This is all I get all the time. (Tanya)

Success and change

A successful outcome for Chris and her partner was instantly easy to measure.

Well the outcome for me is that I've kept a baby. (Chris)

She attributed this, to a large degree, to her experience of the service.

I probably say getting the help that I couldn't get before, because it is not just me running out there saying, 'I need this help, blah blah blah... Can you get me this and that?'. Instead, there is actually someone else working for you as well, trying to get for you, cos us, as normal people, we come up against walls, all the time, brick wall there, brick wall there, no matter where you turn, brick wall, but like someone like (support worker) working for a project like this, then they just go out there and say, 'I've got this person, needs this sort of help, can you sort something out?' And then you've got an appointment within a couple of weeks. Usually it is just brick wall after brick wall. (Chris)

Emotional awareness and anger

All of the interviewees were positive about the ways in which the support workers had supported their anger management and emotional awareness. For example, Chris recognised that this was an important factor for change.

As I was saying, with my next door-but-one neighbour, with her referrals and stuff like that, it's because she can't keep children, she's in the same place I was and just keeps having them and having them and having them,



and hoping, just hoping and that's what her problem is with us. And if it wasn't for (support worker), and all this therapy and that, trust me, if I was what I was like three and half years ago, I would have been round there by now, I would have wrung her neck and I'd probably have been in prison, I would have, but (support worker) and what she has done has kept me grounded. (Chris)

Anger was also a problem for Leah and this did not just cause those around her problems but created a spiralling cycle of low self-esteem.

I've never been aggressive to her, but I'm so irate and upset and I wouldn't be able to work with someone like me, even now I still couldn't, but she does it. I just found just having someone help me learn how to help me regulate my moods better and just having that diagnosis has helped so much, cause I think I was so irate that I didn't know what was wrong that I was making myself worse which then made me fit so, cause if I get too worked up as I'm calming down I have what they call a stress fit. And that's not that fun cause it can take two hours and you've calmed down and walked all the way into town and the next thing you know you're on the town centre floor with everyone around you, but we've just, I've learnt so much through (support worker) that everything seems [easier], even in less than a year. (Leah)

Both Issy and Alison reported an improved ability to manage their emotions.

I handle things better now. Cos I did an emotional awareness course too, which has helped me but it is a case of putting that into practice still. Like mindfulness, like ways of coping. . . you kind of, you have to be mindful of the mindfulness for it to work. (Issy)

I've learnt to speak for myself, my opinion and not worry about what everyone else thinks. I [recently] said to my mum what my opinion was, whether she agreed on it or not, that's her problem not mine. . . I used to always just be really shy about things and about saying things. But now I've learnt speak out. (Alison)

There was considerable agreement about the effects of the support received through the two services and on-referrals to other services. As Issy very decisively stated, 'I am more positive now.' Similarly, Leah recognised a change of focus.

My main motivation is me . . . It used to be just the children, but (support worker) taught me over the last year that, obviously, if I'm not okay, then they're not gonna be okay anyway. (Leah)

4.5.5 FIVE YEARS' TIME

The research team considered it important to hear the interviewees' views as to where they would like to be in their lives in five years' time. As could be predicted, perhaps, this resulted in some fairly normative responses.

Steve's vision was of a secure family and secure employment.

In five years . . . having a nice family together again . . . And a good job and being able to actually be quite skilful cos I am already a qualified mechanic but cos of all the things we have been through then I can't get a job being a mechanic at the moment, so hopefully five years down the line then I will hopefully be in the garage working, under a bonnet, just doing what I love. (Steve)

Tanya also expressed a similar hope.

Hopefully have a family that social services won't be involved with. Y'know, maybe, we'll have been living here a year now and we have only got 5 years left on this tenancy, maybe hopefully in a new place, a home with a garden . . . But hopefully a future with a family, a kid, maybe a couple of kids. Cos we have always wanted three, y'know, yeah we are going to miss XX, we do miss him but I am sure he'd want us to still have our life. (Tanya)

Leah recognised the need to maintain control of her mental health and also wanted to support others with similar conditions and in similar situations.

Just be a lot more involved with my kids; be a lot more stable with my mental health that I can look into helping other people with mental health problems. (Leah)

Amy has a less definite vision for the future. She does not want any more children. She seeks a 'settled' life.

I have no idea. It is just, um, career, I think, that is about it really. Just a career and hopefully a nice settled happy life, that's all I want. (Amy)

For some of these women such goals may be a long way off but most appeared to recognise one key factor: that they need support to change.

What if?

Finally, clients were asked where they thought they would be now if they had not become involved with Mpower or Positive Choices.

If it weren't running, I don't know where I would be right now . . . I really don't know where I would be. I wouldn't have no confidence at all. (Jess)

I wouldn't be seeing my children at all. I think my Mum would have cut me off from my children. To be honest, without the workers being involved, I probably wouldn't have my flat. I'd probably go to the extent of jail, on drugs - and I've never took drugs, but I was that ill that I didn't seem too worried about trying anything. I didn't but I was close. Or dead. Now I know that sounds extreme but how ill I was last year. . . it's not even an understatement. I would put my head through a window and not worry if it sliced my throat on the way and now I wouldn't even dream of cracking a window, because you don't break windows, it's not normal. I would definitely say homeless, on drugs, in jail or dead. (Leah)

I think we would be extraordinarily miserable. (Alison)

I'd have felt horrible. I felt horrible, I felt wrong, I didn't feel myself, I didn't go out at all, I didn't do anything, but the moment (support worker) come into my life that seemed to change and every week I'm getting stronger and stronger and stronger so. . . (Jess)

These interviews are drawn from a small sample. However, they provide valuable evidence that women and their partners have been offered, and have – in most cases – learned to work with, significant support from Mpower and Positive Choices. They have regarded the services as offering a lifeline and a rare opportunity to change.

5. STAFF OUTCOMES

Four main issues emerged from interviews with five service staff: the distinctiveness of the services; the belief that this distinctiveness was based on developing strong relationships; the value of responding creatively to client needs; and the value of combining rewards and challenges.

5.1 OFFERING SOMETHING DIFFERENT

The support workers and managers in both services were keen to emphasise that they were offering something that had not been previously available to women who have had children removed and that differed from other support services. This reflected the interviews with service participants, explored above, who certainly experienced the services as different from support they had previously been offered. According to one support worker at Positive Choices:

There's not been anything like this. You would have services if you have drug or alcohol problems or services if you have a learning disability but this is a specific service. . . So it's new. (PC 2)

The Positive Choices manager described how the language they used around the service was deliberately different from other services. She gave the example of using the word 'notification' instead of 'referral' when speaking to clients, because the latter 'implies to parents that, actually, yet again, they are part of a system'. Both services felt that distinguishing themselves from standard statutory services was important for establishing trust with clients; given the negative experience many of the clients had had with those services over the course of their lives.

Mpower staff expressed the importance of their voluntary sector status and their independence from social services. One stated 'we're not 'a threat', we're not social care'. She also pointed to the responsiveness of the service to individual need as a key feature making it different from other services:

...what they love about the service [is that] it's not just about a hour a week. It's 'please help me when I really need somebody there to help me' - so that's what we do.

This emphasis on the difference from clients' previous experience of statutory and other support services is important when thinking about how services like this should be organised and run.



5.2 DEVELOPING RELATIONSHIPS

The staff interviews suggest that establishing a positive, trusting relationship with clients is the main way in which the evaluated services distance themselves from other services and is fundamental to generating positive outcomes for clients. This was also evident in the interviews with service participants. Staff appear to be able to overcome initial mistrust through sustained, empathetic interaction with clients. A Positive Choices support worker described how they go about establishing a relationship with clients:

We try and do it gently in the first instance and then we just spend time getting to know each other. There is no expectation for either one of us. We encourage them not to tell us too much...because they have been in the care proceedings things have happened to them, so they just tell you their whole life... [So we say] 'You don't have to share every detail of your life' and kind of, empower them about control of what they say...that's quite a big thing - to say 'It's OK, we don't need to know everything, you know, we meet you here as you are now'. (PC 2)

Staff from both services talked a lot about building trust and the importance of this for the work that they do:

We do build up a very warm relationship where they've never had that ...They've had a difficult time with professionals as you can imagine and they've been in and out of care and not had good, strong bonds or guidance. (MP 1)

When that trust is there you can start broaching things slowly, talking about their child, for most people the loss of the children is at the forefront so that can take a lot of our first sessions can be talking around the injustice of what happened, as that starts to shift slightly we can move forward. (PC 1)

All the support workers talked about the challenges of building the relationships initially so that trust had time to grow. This is well illustrated by this example from a Positive Choices worker:

I've had one woman I've worked with who'd say she had two addresses, one with her boyfriend and one on her own, and she'd often ask to meet at one address and she'd be at the other so I'd just drive there. I had a lot of to-ing and fro-ing and once I'd passed that test and done it a few times, she was where she said she was going to be. It's almost like she needed to test me out really. (PC 1)

The support workers also referred to needing a thick skin and sense of humour in order to cope with the responses of clients especially in initial meetings.

5.3 RESPONDING TO THE NEEDS OF INDIVIDUALS

All three support workers emphasised the need to respond to the individual needs of each person they work with. Although they observed commonalities – e.g. mental health problems, drug and alcohol abuse, experience as victims of sexual abuse – the way in which the problems were addressed and the speed at which the issues were explored reflected the needs and wishes of the clients. There were no set rules about how things should be done. Much depends on the skills and judgements of the support workers, who described a variety of approaches:

Again it depends. It can be a meeting at a coffee shop, they dictate it...it can be a meeting in the home; it can be a meeting with the professional that's referred them. It's whatever they feel the most comfortable with...some people they have had a better relationship with the social worker or a youth worker or a Catch-22 worker and that's the natural introduction so that works quite well. It depends on them. (PC1)

All the support workers reported using methods other than face-to-face contact to keep in touch with clients, notably phone calls and texting. In section 4.1 data on contacts shows that non-face-to-face contact was more frequently used within Positive Choices than MPower. However, the underlying ethos expressed by the support workers was very similar across both services.

All support workers reported setting goals with clients. These included identifying short-term needs such as immediate issues around housing or benefits but also longer-term goals reflecting clients' own longer-term ambitions. The support workers found goal-setting to be useful:

It's person-centred, task-centred. It's rewarding for them to see they are moving forward. They often feel that themselves but it's nice to have goals to punctuate work so they can say 'I know I'm going somewhere. (PC2)

However they also suggested that the fact that many of the goals are about emotions, thoughts and feelings meant that progress towards these could be quite much harder to capture and quantify (PC1).

All the support workers showed high levels of insight into their clients' needs, expectations, fears and social experiences. This influenced decisions made about the nature of support and 'realistic' goals:

Simple things like going for a coffee...I don't think people realise how nice that is. But our client group, they don't do that, they don't have the money for a coffee. Even to be able to face mainstream society rather than be taken into an office room, they feel it's quite a respectful thing actually. (PC 2)

Although the services emphasised their responses to individuals' needs there were two issues that were tackled with each client: contraception and understanding why they had children removed. The support workers reported that they tackled the issue of contraception early in the partnership and that most of the women they worked with were open to using some form of contraception when it was fully explained and when they were supported in accessing it. A Positive Choices support worker illustrated how the reality of tackling the sensitive issue of contraception had differed from her initial expectations:

We assumed, when we first started, that everyone was avoiding contraception or couldn't be bothered...What we've found is that people didn't know how to access contraception or haven't got the bus fare...or they can't understand the map, or they can't read the leaflet that someone handed them in hospital when they had their last child. We've one woman who was very open and said 'I'm only pregnant again... because I didn't know how to get the contraception'...she didn't know the area, didn't know how to get her bus fare - £8.50 to town - she just hadn't got it. So it seems ridiculous but when your life is so chaotic and you're so up in the air, something as simple as that...but it's difficult. (PC1)

The Mpower support worker described how she now received texts from her clients letting her know they were going for contraceptive appointments rather than her having to remind them.

Helping clients to begin to reflect on why their children had been removed was tackled in different ways. It was generally done very gently and only once a good relationship had been established. The support workers often described their role as a critical friend: questioning and challenging some of their clients' thinking. A Positive Choices support worker describes how they might explore the issue of domestic violence, for example, and its effects on a child in the home:

Domestic violence is a common one and they'll say 'Oh, she never saw any violence'. [I might say] 'So how did she feel going to school knowing that mummy had a black eye? Were you still talking to her? Do you think they'd be an atmosphere?' [She might say] 'Oh yeah, but she didn't see anything.' [I might say] 'So how did she feel when she was eating her breakfast and going to school and wondering what was happening with you and Daddy?' You sort of go through scenarios and they go 'Shit, yeah'. So it's that exploring. It's very hard. Don't think that I could do it actually. (PC 2)

This quote highlights the difficulty of the work undertaken here and the potential for clients to develop potentially painful insights into their own behaviour. An Mpower support worker sheds light on this challenging process:

And often they'll say to me, 'Oh God, it's starting to make sense now', they have a light bulb moment and there's a lot of tears sometimes during that period of, 'Oh God, what an idiot', 'Was that because of that?', and because I don't judge them and I help them to understand how that happened, they kind of get it and once they've got it it's, 'OK I can't really blame other people can I?'. (MP 1)

In addition to trust, as discussed above, the interviews with the support workers revealed four other key themes: respect, choice, empathy and critical friendship. They also emphasised the importance of acknowledging the love that their clients had for their children and the deep shame many feel for having them removed.

5.4 REWARDS, CHALLENGES AND THE NEED FOR SUPPORT

All the service workers could reflect on cases where it had been very difficult to develop a relationship with a client or others that had been particularly challenging. These difficulties took two main forms. The first was the challenge of carrying out the work within time constraints. Positive Choices faced the extra challenge of covering a large geographical area which may contribute to the higher levels of non face-to-face contact seen within this service. The support worker in Mpower described her strategy for managing cases by noting that she could only cope with a small number of clients on 'red alert' at any one time. Once the situation had improved for a particular person she was able to withdraw a little and put in place other forms of support, for example, using volunteers.

The second difficulty was being exposed to the clients' very challenging circumstances. Support workers and managers in both services spoke of the emotionally charged work of listening to traumatic life-stories on a daily basis. Although the support workers are not trained as therapists, a great deal of the work they do involves listening to the clients and then gently challenging them to generate understanding and insight. The support worker from Mpower when discussing a male client's disclosure of childhood sexual abuse, stated:

You don't want to...call it therapy because it isn't recognised as therapy. But it must be quite therapeutic for them because we often get disclosure. They've said 'I've flatly refused to discuss that with anyone else'.

The service managers, in particular, were concerned about their support workers and wanted to protect and support them as much as they could, although both felt they could not do enough, given the limited time they have to work on these specific services. The Positive Choices manager described her concerns:



I just worry about them because I know how dedicated they are. I know how much they do in terms of holding onto [the client's] stories, which they will then hold for a bit because they are then effectively feeding it back bit by bit so that that can be processed by the parent. But they're carrying all of that. Having been involved in this kind of work myself - and having friends working in child protection for years and years - I know what damage has been done to me in the past and I bear the scars of that.

Uncertainties around long-term funding and day-to-day budget constraints increased the stress of running the services and constrained managers' ability to ensure continually supportive work environments. Positive Choices workers often operate from home, for example, which added to the manager's concern about the levels of support available to them.

However, interviews with Positive Choices staff showed that they operated as a closely-knit team. In particular, the relationship between the two support workers was considered to be very strong, helping them overcome their potential isolation. It also helped their clients because the strength of their relationship enabled them to find innovative ways of working. Although there was only one support worker at Mpower, she had a strong relationship with the service manager. In mid-2014 a form of clinical support was put in place so they both had additional help in processing what clients discussed with them. Both manager and support worker viewed this as a very positive step.

This challenging work has powerful rewards. All support workers reported a strong sense of satisfaction when they saw their clients' progress – even where this involved an apparently small step.

I've had to slow right down and really celebrate the really tiny, little things...(PC 1)

The commitment of all the service staff was tangible throughout all the interviews. As the Mpower support worker put it:

To know that you are doing something worthwhile, seeing changes in these people that kind of everybody had given up on, you know? It's very rare that any service user is everything that the media portrays them to be. I think, 'Come into my world for a bit to see what they have been through and they are still standing...at least they are giving it their best shot. Could you have done the same thing?' But for me, I feel I get just as much from the job as I hope they get out of the service. (MP 1)

6. COST-BENEFIT ANALYSIS

There have been few attempts to conduct cost-benefit analysis of interventions of this kind across England. Like Positive Choices and Mpower, other interventions are in their early implementation phase and are only now moving into their evaluation phase. In conducting our own analysis, we have drawn on data provided by SCC regarding the costs of court proceedings. We offer an estimate of cost savings from the key outcome for both services – the likely reduction in the number of babies taken into care. Whilst we believe that a range of other positive outcomes described in this evaluation, such as improvements in well being and mental health, may also result in very significant cost savings in the long term it is beyond the remit of this evaluation to assess these. The importance of this for future evaluations is discussed below.

6.1 COSTS, SAVINGS AND BENEFITS

Both services had predicted their own cost saving in their own 'project initiation documents'. Mpower calculated cost saving estimates based on one 'child removal case' being avoided for each of the women (40 in total) who engaged in the project over 3 years. This was based on the assumption that 100% of the women would have become pregnant again without the service intervention and that any resulting babies would have been taken into care at birth. Similarly, Positive Choices, who expected to work with 50 mothers per year, estimated that in the first year 2.5 new removals would be avoided and 5 per year would be avoided in subsequent years. These are very different estimates leading to very different savings projections: Mpower suggested local authority savings of £3,200,000 (based on the assumption that the cost of removing a child at birth until permanence is £80,000). Positive Choices estimated the cost per child at £50,000 and estimated that 12.5 women over the 3 years would be prevented from having a child that would have been taken into care.

In the absence of reliable statistics on recurrent care proceedings trends in Suffolk, we have calculated cost savings by applying Broadhurst et al's (2015, 2016) calculation of the probability of recurrence (13.2%) within 1-2 years of initial proceedings to the women clients who a) engaged in the two services, b) were not among the 8 pregnant on referral. We estimate that 9 (13.2%) of these 65 women are likely to have experienced an unplanned pregnancy during the 18 month period studied and to have faced recurrent care proceedings.

Significant cost savings can be extrapolated based on the likely 'avoided' costs of 'avoided' care proceedings. Given that the cost of proceedings ranges from at least £50,000 to £90,000 per case and that an estimated 9 cases have been avoided, these two services have delivered gross savings of between £450,000 and £810,000 in their first 18 months. These savings are to be offset against the £169,000 cost of staffing the two services over that time: £34,000 for Mpower (over 12 months) and £135,000 for Positive Choices (over 18 months, @£90,000 per year).

Cost savings for subsequent years can also be inferred. Babies removed from birth parents in these circumstances are often adopted and therefore do not present such high on-going costs to local authorities. However, in the event that adoption arrangements cannot be made or break down, substantial on-going costs in the form of long-term foster care and associated expenditure for Looked After Children could be incurred up to age 18. The Audit Commission has estimated the average annual cost of supporting each LAC to be £50,000 per child per year (based on DfE figures for 2012-13). If we assume that all 9 of the avoided pregnancies had become LAC the annual cost to Suffolk County Council could have reached £450,000. Over 18 years, this could have amounted to £8.1 million.

6.2 FUTURE COST-BENEFIT MODELS

Policy evaluation methodologies are increasingly focused on the challenge of quantifying and financialising the 'intangible benefits' of a given intervention. Health economists and others have developed numerous indexes for measuring wellbeing and quality of life (McDowell, 2006). In the fast-growing field of social investment finance, others have developed mechanisms for calculating appropriate returns on social impact bonds (Mulgan et al, 2011) and the impact of justice reinvestments (Fox, Albertson and Warburton, 2011; Brown, Schwartz and Boseley, 2012). All recognise the challenges of gathering the necessary fine-grained long-run data and of conducting systematic reviews of evaluations of programmes based on bespoke interventions with small client populations. Future evaluations of these services could certainly investigate ways of applying these long-run approaches. However, even devotees of these approaches recognise that it is these 'intangible benefits' that hold the deepest personal value to clients and that these may remain simply incalculable or 'priceless'.

7. RECOMMENDATIONS

The main finding of this evaluation is that:

- The work of the Positive Choices and Mpower teams is contributing to the reduction of recurrent care proceedings in Suffolk principally by reducing unplanned pregnancies among women who have already lost at least one child to care. It is also, and equally importantly, contributing to the improvement of the well-being, functioning and quality of life of a highly marginalised group within our community. We strongly recommend that their work continues to be supported.

We also recommend that the two services should consider making the following enhancements:

- Review referral channels and entry-level thresholds to ensure that potential clients are fully consulted by referring agencies and only accepted by the two services where staff have capacity to work with them from the outset at an appropriate level of intensity.
- Ensure that the range of support services offered to help clients strengthen their capacities involves high quality clinical services. Given the range of mental health problems and trauma-related presentations highlighted in our data, we recommend that the two services enhance their current fast track routes into local mental health and other specialist therapeutic services, potentially by establishing new Service Level Agreements between local mental health and social care clinicians.
- Ensure that sufficient funds are put in place to ensure that the support workers themselves are adequately supported. Their work is more intensive, in-depth and emotionally demanding than their current service descriptions may indicate. This support could take the form of specialist clinical supervision, distinct from in-house managerial supervision. These services depend on the skills, insights and robustness of their front-line staff and these staff need to be nurtured.
- Ensure that case-loads remain manageable. Frequent face-to-face contact with a smaller number of clients is likely to deliver a better all-round quality of therapeutic relationship, higher retention levels and, potentially, to lower levels of unplanned pregnancy. The broad geographical area covered by the two services presents significant challenges in this respect and highlights the difficulty of reproducing 'urban' service models in rural and peri-urban areas.



- Frame transitions out of the service as part of goal-setting between clients and support workers. This is needed in order to free up capacity for new referrals and to assist clients in taking the next step in their own recovery. In recommending this we do not advocate flagging exit dates from the outset as we fully recognise the value of maintaining open-ended and flexible engagements.
- Ensure staff have continuing opportunities to share their experiences and insights with a growing national policy community focused on meeting the challenges of recurrent proceedings. Both services have created enormous learning opportunities for others and these should be maximised through training, good practice and other dissemination events.
- Both service teams should standardise baseline data collection on all clients from referral into, and transition out of, the services.
- Suffolk County Council should standardise routine baseline data collection relating to recurrent care proceedings in the county so that these can be more readily monitored as part of a broad reduction strategy.
- Ensure that staff in both services have ready access to relevant local and regional data on recurrent care proceedings and relevant recurrent pregnancy rates. Such data is vital in enabling the services to plan future activity and staffing levels.
- Secure future service funding in the immediate term to extend the valuable work of Positive Choices and Mpower. A more secure base will enhance staff resilience, retention and effectiveness.
- Continue to evaluate and monitor the nationally-significant work of the two services. We would be willing to discuss future possibilities with all parties.

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