**Reducing Recurrent Care Proceedings**

**Evaluation of**

**Flourish**

**(Lambeth Children’s Social Care)**

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This independent service evaluation report has been prepared by a team from the University of Essex based upon data collected by the Flourish team. The report is based on data relating to women who consented to taking part in the Flourish evaluation so that their (anonymised) data could be shared with the University.

The team, led by Prof Susan McPherson and Prof Frances Blumenfeld, developed an [evaluation toolkit](https://www.researchinpractice.org.uk/media/3967/s2-evalutaion-user-guide.pdf) for *reducing recurrent care proceedings* services and have completed evaluations and service development reports on several similar services, including: Positive Choices, run by Suffolk County Council (Cox et al, 2017); Mpower, run by Ormiston Families in Suffolk (Cox et al, 2017); Rise, run by the Marigold Children’s Centre in Southend, Essex (Blumenfeld, Taggart and Cox, 2018); Comma, run by Stockport Foundation Trust; and Venus in Sefton, Merseyside (se Cox et al., 2020). In addition, Prof McPherson led an evaluation of a parent-infant mental health service in Norfolk that works with edge-of-care families including those with previous removals (McPherson et al, 2018).

Working in conjunction with Research in Practice and Lancaster University’s Centre for Child and Family Justice Research (CCFJC), the team has advised at least 11 local authorities in England seeking to develop or extend services to reduce recurrent care proceedings (Research in Practice, 2018). The team also supported the development of a new ‘Strengthening Families’ Community of Practice facilitated by Research in Practice and the CCFJC, funded by Public Health England: <https://supportingparents.researchinpractice.org.uk/>

The evaluation work (securing appropriate ethics approvals, data collation, data analysis and draft report writing) was conducted by Trainee Clinical Psychologists Gemma Shoesmith and Leah Simmons as part of their doctorate research training, under the supervision of Professors McPherson and Blumenfeld.

**Contents**

[Executive Summary 4](#_Toc139289967)

[Background 6](#_Toc139289968)

[The Flourish service 7](#_Toc139289969)

[Evaluation Aims 8](#_Toc139289970)

[Methods 9](#_Toc139289971)

[Materials and Measures 9](#_Toc139289972)

[Outcome Measures 9](#_Toc139289973)

[Sample size 10](#_Toc139289974)

[Data Collection Methods 10](#_Toc139289975)

[Method of Data Analysis 10](#_Toc139289976)

[Ethics 11](#_Toc139289977)

[Results: Quantitative data analysis 11](#_Toc139289978)

[Brief case studies 14](#_Toc139289979)

[Results: Thematic analysis of qualitative data 19](#_Toc139289980)

[Restorative attachments: Healing harm through secure connection 19](#_Toc139289981)

[Changing the internalised narrative: ‘An alternative story’ 20](#_Toc139289982)

[‘Breaking down barriers’: A whole system response 22](#_Toc139289983)

[A forgotten and neglected population 23](#_Toc139289984)

[Discussion 24](#_Toc139289985)

[Recommendations 29](#_Toc139289986)

[Summary 31](#_Toc139289987)

[References 32](#_Toc139289988)

# Executive Summary

**Introduction:** A quarter of women involved in care proceedings are likely to reappear in subsequent proceedings within seven years. Preventative services have been developed to reduce recurrent care proceedings and support women to process the loss, create stability and access services to improve their health and wellbeing. Flourish offers an 18-month intervention for women who have experienced a court-ordered removal of one or more children.

**Aims:** There were a number of aims for this service evaluation. The quantitative evaluation assessed the effects ofthe service on client’s relationships, social context, wellbeing, engagement with services, and pregnancy outcomes. The aim of the qualitative evaluation was to explore women’s and professional’s perspectives of this intervention, including the key mechanisms that contribute to change, service barriers, challenges and views on service improvement.

**Methods:** For the quantitative evaluation, a case series approach of eight clients was used. Reliable and clinically significant change (RCSC) was calculated for wellbeing outcomes. Categorical outcomes were analysed based on client trackers. The qualitative evaluation involved one-to-one semi-structured interviews with four women who had accessed the programme and four professionals employed by the local authority.

**Results:** One woman became pregnant and sadly this child was removed from her care on a full care order.At six months, there were improvements in women’s contraception use and engagement with services. However, there was limited improvement on wellbeing measures at individual-level. Four themes were identified within the qualitative analysis, these were ‘restorative attachments: healing harm through secure connection’, ‘changing the internalised narrative: ‘an alternative story’’, ‘breaking down barriers: a whole system response’, and ‘a forgotten and neglected population’.

**Summary of findings:** One woman became pregnant and sadly this child was removed from her care on a full care order. At six months, there were improvements in women’s contraception use, engagement with services and the consistency of child contacts. Nevertheless, there was limited improvement on measures of wellbeing at individual levels and some women were still experiencing alcohol and/or substance misuse difficulties at six months, indicating that most women’s mental health needs remained high. The qualitative results revealed that the experience of a safe relationship, therapeutic interventions, increasing access to services and tackling negative attitudes about birth parents, was deemed to improve women’s self-worth, relationships, and quality of life. On the other hand, lack of adequate resources and multi-agency working, in addition to challenges of current legal, health and social structures resulted in inadequate support and acted as barriers to effective intervention.

**Recommendations:** Recommendations were provided to develop the service based on the findings of the evaluation. These include recommendations for supporting staff and recruitment; recommendations for the development of service pathways; recommendations for working with the wider system; recommendations for enhancing service user’s experiences; recommendations for data collection, evaluation and research.

# Background

**Recurrent care proceedings intervention: Women and professional perspectives’**

Child and family courts have seen an increase in care applications over the past decade, from 8% (2009/2010) to 10.5% (2020/2021) per 10,000 children (Cafcass, 2021). This increase has been associated with an emphasis on reactive child protection strategies and risk management since the case of Baby P. Alongside, a reduction in focus on parental rights and recognising signs of safety in families (Parton & Williams, 2017; Cox et al., 2017). The Crisis Care Review (Family Rights Group, 2018), identified recurrent care proceedings (RCP) as accounting for a significant portion of care applications. RCP describes a mother’s or family’s repeated appearance in court proceedings which typically results in the serial removal of their children (Broadhurst et al., 2015). Mothers who are involved in RCP tend to have had adverse experiences in their own childhood, and many were looked after children themselves (Broadhurst et al, 2017). Until recently, this problem has received little focus in policy, and government attempts to improve family functioning through ‘Troubled Families’ initiatives have been criticised for contributing to further marginalisation of groups experiencing structural disadvantage (Cox, 2012).

Recent national data in the area of RCP, suggest women will return to court within ten years after initial care proceedings (Alrouh et al., 2022). Researchers have begun to synthesise theories to explain the complexities of the problem of RCP. Broadhurst and Mason (2017) describe the ‘collateral consequences’ of child removal. This includes an ‘immediate psychosocial crisis’ compounded by grief, loss of the mothering role, social and legal stigmatisation and ongoing social deprivation which exacerbates existing mental health difficulties. These factors often contribute to rapid pregnancies, and these children are often removed from women by the local authority, due to women’s ongoing psychosocial stressors (Broadhurst & Mason, 2017; 2020). Rapid pregnancies have been explained as an attempt to replace the lost child known as ‘replacement baby syndrome’ (Grant et al., 2011; Novac et al., 2006), however these studies focus on relinquishment rather than forced adoption. A more comprehensive theory is needed to understand the complexity of this type of loss which occurs in the context of intergenerational trauma and social disadvantage (Broadhurst & Mason, 2020).

Preventative services have been developed to support women post-proceedings to improve their health and wellbeing, reduce subsequent rapid pregnancy and the number of children who enter the care system. These services offer a trauma-informed relationship-based programme and tailor the intervention to meet women’s psychosocial needs. The Pause programme (Boddy et al., 2022; McCraken et al., 2017) requires women to use long-acting reversible contraception (LARC); this is a debated topic and has not been adopted by all locally developed services, such as Positive Choices (Cox et al., 2017) and Reflect (Robert et al., 2018).

Service evaluations have begun to evidence the success of these programmes in supporting women to find stable housing, employment or education, improving psychological functioning, increasing self-esteem and improving the quality of women’s relationships (Cox et al., 2017; Cox et al., 2020). However, changes within psychological outcomes were small and did not occur for all participants, there was also considerable attribution which could contribute to response bias. Evaluations have also reported a reduction in cost to local authorities, rapid pregnancies and recurrent care proceedings (Cox et al., 2017; McPherson et al., 2018; Cox et al., 2020). However, some challenges were established in identifying causality, as interventions are not manualised and it is difficult to identify what contributed to the decrease in rapid pregnancies.

## The Flourish service

Pause completed a scoping review for a London Borough Council which identified that women within the area faced complex psychosocial adversities contributing to high rates of RCPs (Rickman et al., 2017). Flourish was developed in February 2021 to address these needs. The service was commissioned to run an eighteen-month programme, for women, over the age of seventeen, who are currently in court proceedings or have had a child or children removed from their care. It does not require women to take LARC, but they do support women to access sexual health services and discontinue active work if a woman becomes pregnant.

The service consists of a team manager and two practitioners with each practitioner having a small case load. The service ethos is based upon an outreach approach and systemic principles which emphasise the importance of supportive relationships for improving mental health and wellbeing. This trauma-informed intervention supports women to develop goals based on their psychological and social needs. This includes the use of therapeutic interventions which address past traumas and their impact on current difficulties, whilst teaching skills to build self-worth, resilience and stability. The final stage of the intervention involves building women’s independence and connecting them to community networks and resources.

A brief evaluation was completed at six months (between March 2021 and September 2021) to report on initial outcomes (Flourish, 2021), which showed two women were supported to gain accommodation, four women out of six accessed the sexual health pathway and one woman accessed secure employment. Outcomes were limited due to only a small number of women engaging in the programme at this time.

A recent report on RCP national data highlighted the positive impact of preventative services (Alrouh et al., 2022). However, the authors suggested the current provision may not be sufficient due to no change in the amount of RCPs. They encouraged services to conduct research projects and disseminate their results to support access to currently unpublished data; this would be crucial in order to maintain funding for services within this area.

## Evaluation Aims

This evaluation will assess the effects of the recurrent care service in a variety of ways using qualitative and quantitative methodologies. The main aims of the quantitative service evaluation were to detail the past and current contexts of the women referred to the service; to examine the changes in contraception use, pregnancy outcomes, and engagement with services; to assess changes in women’s wellbeing in relation to their health, wellbeing, relationships, stability and safety after accessing the service; and lastly to evaluate reliable and clinically significant changes in ratings of wellbeing at individual level. The qualitative service evaluation aims to encourage women and staff members to reflect on their experiences of Flourish and to gain an understanding of their perspectives on service delivery. Specially, the evaluation will identify:

1. The components of the service which act as key mechanisms for change and have an impact on women’s wellbeing, quality of life and ability to reach their goals.
2. To explore any service barriers, challenges and identify areas for service development.

# Methods

Qualitative and quantitative methodologies were used to evaluate the service. The quantitative service evaluation used a case series approach of eight women based on reliable and clinically significant change and other categorical outcomes. This design was selected based on the small number of women with paired data. Data for eight women were presented in summary tables and their cases were summarised to allow for a more detailed analysis of cases (Crowe et al., 2011). Within the qualitative evaluation, semi-structured interviews were completed with four women who had accessed the service and four professionals this included one Flourish practitioner and three children’s social workers.

## Materials and Measures

The service used two wellbeing questionnaires, and a baseline and six month review client tracker. These trackers have been used in comparable service evaluations and were developed by the University of Essex. The baseline tracker was used to collect data about the client’s past and current experiences and referral information. The six month tracker was used to collect similar information to the baseline tracker, along with changes to the client’s situation (e.g. engagement with services and pregnancy outcomes). Theservice developed a progress tool to measure women’s wellbeing across fifteen areas; two versions of the progress tool were used. Clients rated each area from one to ten (with ten indicating higher levels of wellbeing) and scores were calculated by summing each area. The progress tool has not been validated or used outside of the service.

## Outcome Measures

The short version of the Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (Stewart-Brown et al., 2009) consists of seven items. Higher SWEMWBS scores represent higher levels of mental wellbeing. The SWEMWBS does not have cut-off points. The Adult Wellbeing Scale (AWS) is based on the Irritability, Depression and Anxiety Scale (Snaith et al., 1978). Higher AWS total scores represent higher levels of irritability, depression and anxiety. The cut-off scores for the AWS subscales were used.

## Sample size

The quantitative evaluation included data from eight women who had accessed or were accessing the 18-month intervention provided by the service. The qualitative evaluation intended on interviewing only women who had accessed the programme. However, challenges with recruitment led to a decision to include professionals’ views on service delivery. Participants were recruited using a purposive sampling strategy as the service evaluation was interested in women and staff experiences. Four women and four professionals were interviewed for the purposes of this evaluation.

## Data Collection Methods

Participants completed the interview online via Microsoft Teams. The interview schedule followed a semi-structured format and was adapted from similar service evaluations of recurrent care proceeding projects (Cox et al., 2017; Cox et al., 2018). The interview schedule focused on women’s expectations and experience of the service, and staff’s perspectives of service delivery and their experiences of supporting this population of women.

For the quantitative evaluation, practitioners in the service collected all the evaluation data. The baseline tracker was used to collect data for each client at referral and initial engagement. The six-month review tracker was used to collect data every three months over 18-months. The progress tool and wellbeing questionnaires were completed across two time points (T1 and T2). At T2, outcomes were completed between three to seventeen months after commencing the intervention.

## Method of Data Analysis

Due to the small number of women with paired data (data at T1 and T2), group-level analyses were not completed to examine the effects of the service by aggregating data. Individual level change was assessed using reliable and clinically significant change analysis (RCSC) and other categorical/descriptive outcomes. An external criterion was used for RCSC calculations based on the clinical cut-off points for the AWS subscales (Snaith et al., 1978). For the SWEMWBS, non-clinical population norms (*M* = 23.6, *SD* = 4.4) were taken from Fat et al. (2017). As there were no clinical sample norms identified for women involved in recurrent care proceedings, clinical sample norms (*M* = 19.6, *SD* = 4.7) were taken from Vaingankar et al. (2017) based on a sample of adult outpatients diagnosed with depression. As advised by Hsu (1996), criterion ‘C’ was used as the cut-off (21.67) for the SWEMWBS scores.

For the qualitative evaluation, the data was transcribed verbatim and analysed using reflexive thematic analysis (TA) (Braun and Clarke, 2019). An inductive approach to analysis was conducted and key findings were extracted directly from the data. This evaluation followed six steps of thematic analysis as outlined by Braun and Clarke (2006).

## Ethics

Ethical approval was obtained from the service and the University of Essex Ethics Sub-Committee 2. Participants provided informed consent and signed consent forms before data collection. All client data was kept confidential and anonymous.

# Results: Quantitative data analysis

The demographic information for the eight women are presented in Table 1. The social contexts and engagement with services for seven women are presented in Tables 2 and 3 (note that Client H had not completed 6 months of the intervention so only seven women are seen in Tables 2 and 3). The RCSC outcomes for six women with paired data on wellbeing outcomes are presented in Table 4.

**Table 1**

*Client Background*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client | Age at referral | Ethnicity | Number of Children Previously removed | Contraception Use | Referral Source | Mental Health Difficulties at referral |
| A | 36 | Mixed-race Caribbean | 3 | None | Social Care | Yes |
| B | 36 | White British | 3 | None | Social Care | Yes |
| C | 36 | Black British | 3 | None | Social Care | Yes |
| D | 36 | Mixed-Race African | 4 | None | Social Care | Yes |
| E | 29 | White British | 2 | None | Social Care | Yes |
| F | 33 | Mixed-Race | 3 | LARC | Social Care | Yes |
| G | 31 | White | 2 | None | Social Care | Yes |
| H | 19 | Not specified | 1 | None | Social Care | Yes |

**Table 2**

*Client Social Context at 6 months*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client | ContraceptionUse | Education, Training or Employment | Domestic Abuse | Alcohol Misuse | Drug Misuse | Pregnancy | Child Contact |
| A | LARC | None | Incident in last 3 months | Not since accessing the service  | No | Supervised F2F |
| B | LARC | None | Historical  | None | Current | No | Supervised F2F |
| C | None | Employed | Historical | None | None | No | Supervised F2F |
| D | None | None | Incident in last 3 months | Historical | Increased | No | Supervised F2F |
| E | None | None | Incident in last 3 months | Current | Current | No | Supervised F2F |
| F | LARC | Employed | Historical | Not since accessing the service | Historical | No | Supervised F2F |
| G | Non-LARC | None | Historical | None | None | No | Letterbox |

*Note. F2F = Face-to-face*

**Table 3**

*Engagement with Services at 6 months*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client | Recurrent Care Service | GP Services | Child Social Care | Domestic Violence | Drug and Alcohol Services | Mental Health Services |
| A | Accessing regularly | Accessing regularly | Accessing regularly | Accessing regularly | Accessing regularly | Not referred |
| B | Accessing regularly | Accessing inconsistently | Accessing inconsistently | Not referred | Not referred | Accessing inconsistently |
| C | Accessing regularly | Accessing regularly | Accessing regularly | Not referred | N/A | Accessing regularly |
| D | Accessing inconsistently | Accessing regularly | N/A | Offered and declined | Offered and declined | Offered and declined  |
| E | Accessing regularly | Accessing regularly | Accessing inconsistently | Accessing inconsistently | Not referred | Accessing inconsistently |
| F | Accessing inconsistently | Accessing regularly | Accessing regularly | N/A | N/A | N/A |
| G | Accessing regularly | Accessing regularly | Accessing regularly | Referred but not offered | N/A | Referred but not offered |

**Table 4**

*RCSC Outcomes for Wellbeing Outcomes by Client*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Clients | SWEMWBS | Anxiety Subscale | Depression Subscale | Inward Irritability Subscale | Outward IrritabilitySubscale |
| A |  | Improved and met CSC criterion | Improved | No change | No change |
| B |  | Improved | No change | No change | No change |
| C | No change |  |  |  |  |
| E | No change |  |  |  |  |
| G |  | No change | No change | No change | No change |
| H | No change |  |  |  |  |

# Brief case studies

**Client A** was a 36 year old, mixed-race Caribbean woman who had had three children previously been removed from her care. Her youngest child was 7 years old and they had been placed on a long-term foster care placement at final order. She had experiences of growing up in care as child. At baseline, she was experiencing mental health difficulties, domestic violence within the last 3 months, and drug and alcohol misuse. She was consistently taking psychotropic medication, and was receiving support from social care, her GP and multi-agency risk assessment conferences. She was not taking any contraception at referral. She was on bail and was involved in an ongoing police investigation. She was regularly accessing child social care and housing services; she was referred but not offered support from mental health services. She had not been referred to domestic violence or probation services and was inconsistently accessing substance use services. She was regularly accessing her GP and housing services.

At six months, she was not pregnant and was accessing LARC. She had experienced domestic abuse in the last 3 months, but was no longer misusing alcohol and drugs. She was continuing to take her psychotropic medication and consistently attended face-to-face supervised court-ordered child contact. She was regularly accessing housing, GP, drug and alcohol services, child social care and domestic violence services, as well as the Flourish service. From baseline to six months, she did not participate in any education, training or employment during the intervention, and she was continuing to live in a secure and unsafe/unsuitable council housing. Based on RCSC calculations, there was ‘no change’ on her inward irritability subscale score at post-intervention, but her score on this subscale was in the non-clinical range at post-intervention. There was ‘no change’ on the outward irritability AWS subscale score at post-intervention; however her outward irritability scores were in the non-clinical range at pre- and post-intervention. She ‘improved’ on the AWS depression and anxiety subscales and she met the clinically significant change criterion on the anxiety AWS subscale (meaning her score moved from the clinical range into the non-clinical range).

**Client B** was a 36 year old, White British woman who had had three children previously removed from her care. Her youngest child was nine years old and they had been placed on a child arrangement order during and at the end of care proceedings. In the past, she had experienced domestic violence and had been arrested, but was not convicted. At baseline, she was experiencing mental health difficulties and substance misuse. She was receiving support from social care, her GP and multi-agency risk assessment conferences. She was not taking any contraception at referral. She was offered support from child social services, but declined this. She was not referred to adult social care, domestic violence services, housing services and substance use services, but was inconsistently accessing mental health services and her GP.

At 10 weeks she was pregnant, but did not continue with her pregnancy. At six months, she was not pregnant and was accessing LARC. She continued to experience substance misuse difficulties; however, she was not referred to drug and alcohol services; there was no information available about the reasons for not completing this referral. From baseline to six months, she inconsistently took her psychotropic medication, resided in secure and unsuitable/unsafe council housing, consistently attended face-to-face supervised court-ordered child contact and did not engage in any education, training or employment. At six months, she was regularly accessing Flourish, and was inconsistently accessing child social care, GP and mental health services. Based on RCSC calculations, there was ‘no change’ in her depression and outward irritability scores at post-intervention, but her scores on both subscales were in the non-clinical range at post-intervention. There was ‘no change’ on the inward irritability AWS subscale score at post-intervention and her inward irritability scores were in the clinical range at pre- and post-intervention. She ‘improved’ on the AWS anxiety subscale at post-intervention. She was continuing to receive support from Flourish.

**Client C** was a 36 year old, Black British woman who had had three children previously removed from her care. Her youngest child was four years old and they had been placed on a special guardianship order at a final court order. She had experienced domestic violence in the past. At baseline, she was experiencing mental health difficulties, and was not taking any contraception or attending face-to-face supervised court-ordered child contact.

At six months she was not pregnant, but had stopped using LARC. From baseline to 6 months, she had continued to take her psychotropic medication, reside in privately owned accommodation and engage in employment. Moreover, she continued to consistently engage with child social services, GP and mental health services, and Flourish. At six months, she consistently attended face-to-face supervised child contacts. Her total score on the progress tool slightly improved from pre-intervention (T1 = 36) to post-intervention (T2 = 39). At post-intervention, she scored higher on health and relationships domains, the same on the stability and safety domains and lower on the wellbeing domain of the progress tool. Based on RCSC calculations, there was ‘no change’ in her SWEMWBS scores at post-intervention; however her SWEMWBS scores were in the non-clinical range at pre- and post-intervention. She was continuing to receive support from the recurrent care service.

**Client D** was a 36 year old, mixed-race African woman who had had four children previously removed from her care. Her youngest child was two years old and they had been placed on a special guardianship order at a final court order. She had experienced past difficulties with alcohol misuse. At referral she was experiencing mental health difficulties, drug misuse, and domestic violence, and was not taking any contraception. She had regularly accessed support from child social care, adult social care, and her GP, as well as multi-agency risk assessment conferences (MARAC). She was inconsistently accessing housing services, but had not been referred to domestic violence and substance misuse services. She was sporadically attending face-to-face child contact supervised by her family.

At six months she was not pregnant, but had stopped using LARC. She had experienced domestic violence in the last three months, but had declined support from domestic violence services. Her substance misuse had increased, but she had declined support from substance misuse services. She was experiencing mental health difficulties, but had declined support from mental health services. She was regularly accessing her GP and housing services. She was not attending face-to-face child contact supervised by her family. From baseline to 6 months, she resided in secure and unsafe/unsuitable council housing and did not engage in any education, training or employment. She was inconsistently accessing Flourish. No psychological measures were completed with this client.

**Client E** was a 29 year old, White British woman who had had two children previously removed from her care. Her youngest child was three years old and they had been placed on a special guardianship order at a final court order. She had experienced domestic violence in the past. At referral she was experiencing mental health difficulties and drug and alcohol misuse; but had declined support from mental health services. She was regularly accessing support from child social services and multi-agency risk assessment conferences and a sexual harm exploitation panel; however she was not receiving support from her GP. She was not taking any contraception at referral. She had not been referred to drug and alcohol services or her GP. She was regularly accessing housing services and was residing in a temporary and unstable accommodation (non-council).

At six months she was not pregnant, but she had stopped using LARC. She had experienced an incident of domestic violence in the last three months, and had continued to experience drug and alcohol misuse. She had not been referred to drug and alcohol services, however there was no information available about the reasons for not completing this referral. At six months, she had started to take psychotropic medication and was taking this consistently. From baseline to 6 months, she did not engage in any education, training or employment and sporadically attended face-to-face court-ordered child contact supervised by her family. She continued to reside in temporary and unstable accommodation (non-council) and was inconsistently accessing housing services. She was regularly accessing Flourish and her GP, and was inconsistently accessing child social services, domestic violence support, mental health and housing services. Based on RCSC calculations, there was ‘no change’ in her SWEMWBS scores at post-intervention and her scores remained in the clinical range. From pre- to post-intervention, her progress scores improved for the safety and housing domains. However her scores remained the same across health, sex, self-esteem and emotional wellbeing domains, and her scores deteriorated across the remaining nine wellbeing domains.

**Client F** was a 33 year old, Mixed-Race woman who had had three children previously removed from her care. Her youngest child was three years old and they had been placed on a special guardianship order at a final court order. She had experienced domestic violence and had engaged in drug misuse in the past. At referral, she had a criminal conviction and had previously been in prison. She was experiencing mental health difficulties and misusing alcohol, and was taking psychotropic medication. She was regularly accessing child social services, GP and substance misuse services. She was also receiving support from a health visitor and MARAC. She had previously accessed Flourish and was using LARC. She was not engaging in any education, training or employment. She was sporadically attending face-to-face child contact supervised at a contact centre.

At six months she was not pregnant and had continued to use LARC. She had gained employment and was not misusing alcohol. She was accessing Flourish inconsistently, and was regularly accessing child social services, housing services and her GP. She was consistently attending face-to-face child contact supervised by her family. She resided in secure and safe council housing whilst accessing the intervention programme. At post-intervention, her progress scores decreased on the safety domain, remained the same on police and courts, friends and family and sex wellbeing domains, and improved across the remaining ten wellbeing domains.

**Client G** was a 31 year old, white woman who had had two children previously removed from her care. Her youngest child was four years old and they had been placed in foster care at a final court order and was awaiting adoption. She had experienced domestic violence in the past. At referral, she had a disability and was experiencing mental health difficulties. She was inconsistently accessing housing services and was receiving support from MARAC. She was consistently attending face-to-face child contact supervised at a contact centre. She was not taking any contraception.

At six months she was not pregnant and was using contraception. She was taking psychotropic medication. From referral to six months, she was regularly accessing her GP, child social services and Flourish, residing in temporary unsafe or unsuitable council housing, and did not engage in any education, training or employment. At six months, she regularly accessed housing services. She was referred to adult social care, domestic violence services and mental health services, but was not offered support. She consistently engaged in letterbox child contact. Based on RCSC calculations, there was ‘no change’ across all AWS subscales at post-intervention. However, her scores on the inward and outward irritability subscales were in the non-clinical range at pre- and post-intervention. Her scores on the depression and anxiety subscales were in the clinical range at pre-intervention and non-clinical range at post-intervention.

At 12 months, she was residing in safe and secure council housing and was regularly accessing mental health services. She was pregnant and was supported by the service to disclose her pregnancy to children’s services and access early support. The local authority applied to the courts and sadly this child was removed from her care on a full care order.

**Client H** was a 19 year old woman who had had one child previously been removed from her care; her ethnic group was not specified. Her youngest child was two years old and they were placed with their father after care proceedings and the family were supported at a child in need level. She had a history of drug use. At referral, she was experiencing mental health difficulties, but was not accessing support. She was inconsistently accessing child social services and housing services. However, she had not accessing her GP and had not been referred to mental health services, substance use services or adult social care. She had previously received support from Flourish, but she was not taking any contraception at referral. At referral, she was street homeless and no court-ordered child contact had been agreed.

At 10 weeks, she was not pregnant and was accessing LARC. She was residing in supported accommodation. She was regularly accessing Flourish, child social services, housing, mental health services and her GP. She was experiencing drug misuse difficulties but was not referred to drug and alcohol services; the reasons for not completing this referral were not provided. She was inconsistently attending face-to-face court-ordered child contact supervised at a contact centre.

Throughout the intervention, she did not engage in any education, training or employment. She was continuing to receive support from Flourish. Based on RCSC calculations, there was ‘no change’ on her SWEMWBS score at post-intervention, but her score was in the non-clinical range at post-intervention. Her total scores on the progress tool improved from pre-intervention (T1 = 2.5) to post-intervention (T2 = 36) and improved across all wellbeing domains at post-intervention.

# Results: Thematic analysis of qualitative data

## Restorative attachments: Healing harm through secure connection

The relationship between women and practitioners was viewed as the foundation for meaningful change. At the centre of the relationship was trust which was built through the experience of genuine care, and the transparency and integrity of practitioners. This secure relationship provided a template for a new way of relating to self and others and appeared to work towards repairing previous interpersonal trauma and difficult service experiences.

**Relational safety**

Practitioners and women perceived the experience of a safe relationship as a central mechanism for change, particularly in the context of interpersonal trauma. Qualities that produced a sense of safety and trust was consistency, clear boundaries, collaboration, practical and emotional support, and making time for women to share their story. A core feature of this relationship was a sense of non-judgment which reduced women’s feelings of shame and isolation.

 *“The main thing was to give a helping hand. I have never had a helping hand.. I thought asking for help means I am inadequate.. I am a burden on someone else... I have never had anyone there .. a good role model..”* ***(Client)***

*“seeing her as a human, as a parent, makes a difference, sometimes there is a fear of being judged*”  ***(Practitioner)***

**A changing template of relationships**

The relationship between practitioners and women modelled a different way of relating to self and others, as a result women and professionals reported women were more attuned to their own needs, able to implement boundaries and more trusting of others. This improved relationships with themselves, social services, and their children.

 *“the relationship is infectious in a sense, if you can build trust, that breaks down an extra brick for the next person they come into contact with that they might be open to trusting”* ***(Practitioner)***

*“My confidence is much better. I am able to stand up for myself a bit more and I have been looking after myself a bit more than I used to.”* ***(Client)***

## Changing the internalised narrative: ‘An alternative story’

Another important aspect of the programme, identified by women and professionals, was the impact of practitioners holding a ‘hopeful narrative’, and women engaging in therapeutic interventions, such as life story work and emotional coping skills. A changing personal narrative arose following interactions with practitioners and therapeutic work, reflecting an increase in self-worth. This supported women to imagine a future of different possibilities.

**Recognition of own strengths and resources**

Professionals described the importance of supporting women to explore and understand their life history, whilst acknowledging their internal resources and strengths. Within interviews with women, it was evident practitioners actively praised and encouraged them to recognise their talents and pursue their goals. An increase in women’s confidence and self-esteem was present across all interviews.

*“[The] team made a big contribution for me to get this job. I lost my confidence and they supported me to feel more confident and feel worth it.”* ***(Client)***

*“we have to hope that women can make changes and are survivors and they do have the resources within them to do that, it’s about tapping into those resources that they don’t recognise in themselves ….. so a lot of work is helping women with their identity”* ***(Practitioner)***

**Experts by experience**

The positive impact of expert by experience opportunities on women’s sense of purpose and self-esteem was identified in some interviews. Practitioners shared women’s views of service barriers, used their feedback to design services and encouraged mothers to share words of hope with women at the start of their journey.

*“I was asked to answer some questions from someone who has recently lost their children …. it is pretty amazing …. to share with someone and let them know they are not on their own”* ***(Client)***

**A future of hope and possibility**

Women and practitioners described the power of reinforcing the value of women investing in themselves and their lives. Women felt that being supported to break unhealthy coping strategies and encouraged to be a good role model for their children enabled them to work towards a better future.

*“working, with my children, travelling, yeah… being well today matters and it is just one day at a time.. as long as I am stable, then the rest of my life I can build on. I haven’t achieved my full potential for about two decades.. yeah I am looking forward to it”* ***(Client)***

## ‘Breaking down barriers’: A whole system response

Another main contributing factor for change, identified by professionals and women, was adopting a whole system response to RCP, which included increasing accessibility of health and social care services (through building partnerships and developing pathways), addressing power imbalances inherent in the system structures and challenging negative attitudes towards birth parents.

**Opening doors: A bridge between services**

Across all interviews, increasing access to services was considered to be a key feature of contributing to improvement in women’s lives. Women were supported to access health services (sexual, mental and alcohol and substance abuse), and practitioners acted as a co-ordinator, supporting women to maintain education, find employment and have access to stable housing and finances.

*“We met on the Monday and by Friday I already had a roof, somewhere to go, my mental health was getting sorted out…..she made me go a blood test done, we went to the sexual health clinic, she helped me with the GP, she helped with a lot of things”* ***(Client)***

**Addressing power imbalances**

Professionals and women noticed practitioners’ efforts to ensure women were treated equally and with respect, by ensuring their voices were heard within professional platforms, enforcing jargon free language and supporting women to understand court paperwork.

 *“If I didn’t have \*\*\*\*\*\* by my side, even now people will just try to ignore me and whatever I have to say, even though I am the mother”* ***(Client)***

**Stigmatised identities ‘Changing the hopeless narrative’**

Women and professionals described experiences of staff members external to the service having negative attitudes towards birth parents, including a sense of hopelessness about the possibility of change. Within professional interviews, there was appreciation of the service efforts to share the experiences of birth parents (via training workshops) to reduce judgement and encourage empathy.

 *“so it is like \*\*\*\*\* is that voice .. that helps people see me as more than just my mental health…usually professionals just see me for my mental health, they don’t see me as a person”* ***(Client)***

*“I think once you get to a certain point in social care, social workers kind of switch off and say nothing else can be done and that there is no chance for change”* ***(Practitioner)***

## A forgotten and neglected population

This theme highlights some of the challenges faced by this service from a local and broad perspective, such as national uncertainty about the future funding of RCP services which was impacting investment in local resources. Alongside, concerns about the current health, social and legal service structures which was viewed to be not meeting the needs of birth parents and families.

**Insufficient resources and future uncertainty**

Professionals voiced concerns about sustainability due to it being a ‘small non-statutory service’. The lack of resources included practitioners not receiving clinical supervision and a lack of training in specific therapeutic intervention, which prevents the service from being about to meet the population needs and impacts the practitioner’s ability to perform their role.

*“if we jump into fix, we jump into the fire with clients sometimes in order to help them…..we need to be curious outside the fire with the extinguisher rather than in the fire with them”* ***(Practitioner)***

**Mirrored Isolation: Need for systemic and multi-agency working**

Across all interviews, was the acknowledgement of women’s ongoing psychosocial difficulties, and the challenges with inaccessible services and lack of joint partnership in supporting women, this was particularly challenging when trying to access mental health services. Professionals identified the challenge of working with women in isolation of their system, and services not being offered to fathers who have the same traumatic life histories and vulnerabilities.

 *“it would be nice to get the father’s side of view, to see where they are coming from to understanding the system… the fathers take a backstage.. if they work together, it would be much better”* ***(Practitioner)***

**A failing and outdated system**

Women and professionals identified significant challenges with the current statutory and legal structures, due to lack of early intervention, unachievable court recommendations and inadequate support for birth parents during and following child removal.

*“once the whole proceedings is over, it’s like they forget you .. the mum is just left there to grieve having kids removed and you don’t get support”* ***(Client)***

*“so they are left, the majority of the time in vulnerable states with this whole list of things that they need to do to change and they have no idea of how to start”* ***(Practitioner)***

# Discussion

Qualitative and quantitative methodologies were adopted within this service evaluation. The quantitative sample included eight women who had a high prevalence of historical and current mental health difficulties, domestic violence and alcohol and substance misuse; these findings were consistent with research examining risk factors associated with recurrent care proceedings (Broadhurst et al., 2017). Seven women had at least two children removed from their care. As noted by Broadhurst et al. (2017), these patterns highlight the need to identify and support this population both locally and nationally at a far earlier point in their lives and before difficulties emerge. The qualitative sample consisted of four women who have accessed the intervention and four professionals, which included one internal and three external practitioners (children’s social workers). The results of both quantitative and qualitative methodology will be described collectively within this discussion.

**Contraception outcomes**

In line with previous evaluations (e.g. Roberts et al., 2018), the women’s use of contraception increased from baseline, with at least half of the women accessing contraception at six months. In line with previous work, the findings indicate that these women developed their capacity to care for their sexual and reproductive health (Broadhurst et al., 2017). In contrast with some service models, these findings demonstrate that this population can be supported to exercise their reproductive autonomy without making contraception a requirement and limiting their reproductive rights (see Cox, 2012).

**Pregnancy outcomes**

Based on the prevalence rate of 13.2% for recurrent care proceedings within one to two years without intervention (Broadhurst et al., 2015), it was estimated that one woman in this sample was likely to have experienced recurrent care proceedings. The results revealed that one woman became pregnant and was supported to access early support.

The local authority applied to the courts and sadly this child was removed from her care on a full care order. Taken together, these findings support the argument for policy and practice developments to address significant gaps in service provision across England in order to reduce recurrent care proceedings nationally (Bedston et al., 2019; Mason & Wilkson, 2021).

**Promoting connections with family**

The findings revealed that most children continued to see their birth mothers face-to-face and the consistency of child contacts increased for a number of women at six months. The service supported mothers to maintain positive contacts with their children, which was in line with research demonstrating the benefits of maintaining parent-child relationships such as improved stability of children’s placements and attachments with new caregivers (Mason & Wilkinson, 2021).

**Multi-agency working**

The psychosocial challenges and lack of multi-agency support was another barrier identified by this service evaluation. This has been termed ‘immediate psychosocial crisis’ and ‘cumulative and enduring collateral consequences of child removal’ (Broadhurst & Mason, 2017; 2020). Whilst Flourish aims to build partnerships with local organisations they are often working in isolation with women. This is a common challenge for most RCP services, who often experience difficulties supporting women to access mental health services. Women within this population often have the highly contested label of borderline personality disorder (BPD), and when referred to mental health services are informed they do not reach criteria or there is a considerably long waiting time for a psychological intervention (Morriss & Broadhurst, 2022).

The theme ‘breaking down barriers: a whole system response’ was deemed a vital part of the intervention and appeared to be the team’s approach in tackling systemic disadvantage by increasing access to services, addressing power imbalances and reducing stigma. This has been partly described in other evaluations as ‘widening choices’ (Cox et al., 2020). Current literature suggests the challenges of examining individual factors such as adverse childhood experiences (ACE’s) to the exclusion of systemic and social-economic factors (White et al., 2019), which suggest services have a responsibility to adopt a systemic response to societal challenges such as RCP.

**Service Provision**

There was acknowledgement of the need to expand the service to work with fathers. Fathers who have experienced RCP have often experienced childhood adversity, which has impacted their mental health and parenting capacity (Phillips et al., 2020; 2021; Alrouh et al., 2022). Research highlighted the importance of understanding how parents’ difficulties (trauma histories, substance misuse and communication patterns) intersect rather than focusing on one individual in isolation (Bedston et al., 2019). Both sets of results provide support for the need of a policy response to mandate services to support whole families (Philip et al., 2021), and further research on recurrent fathers to fully address the issue (Bedston et al., 2019).

**Engagement**

At six months, six women were accessing at least three services, all women were accessing their GP and the number of women living in safe and secure housing increased. Moreover, the majority of women had accessed Flourish consistently. These results indicate that most women were able to maintain relationships with professionals. The low levels of non-engagement reported could be explained by the service’s use of trauma-informed approaches to promote women’s relationships with professionals and epistemic trust (Mason et al., 2020). Qualitative results identified the relationship between women and practitioners have been regarded as the central feature of the intervention within this and similar RCP service evaluations (Cox et al., 2017; Taggart et al., 2018; Cox et al., 2020; Boddy et al., 2020). Cox et al. (2020) named this theme ‘developing trust within the context of past trauma’, which closely maps onto findings within this evaluation, suggesting that the relationship serves a restorative function supporting women to rebuild trust and heal from interpersonal trauma. This was demonstrated in the evaluation through women’s reported improvement in their relationships with their family, children and social workers. These findings provide support for the service to continue to use trauma-informed approaches to minimise mother’s disengagement.

**Mental health and wellbeing of women**

An important part of the intervention was building women’s self-worth, through unconditional positive regard and reinforcing their value and strengths. Women within this population often develop a ‘negative self-concept’ characterised by shame from experiencing childhood adversities, which is compounded by social stigma and isolation following child removal (Herman, 1992; Maercker et al., 2013; Broadhurst & Mason, 2020). The development of self-esteem and confidence, alongside access to opportunities enabled women to set and work towards future goals; this theme was identified in similar evaluations (Cox et al., 2020).

The quantitative results revealed that there was limited improvement for women on measures of wellbeing at individual levels. Only two women “improved” reliably, one of whom also met the clinically significant change criterion for the anxiety subscales of the AWS (moving from the clinical range to non-clinical range). Only one woman “improved” on the depression subscale but did not meet the clinically significant change criterion. These findings indicated that some women felt less anxious and depressed post-intervention. Nevertheless, most women’s wellbeing did not improve at post-intervention and their scores remained in clinical ranges, suggesting an ongoing need for more intensive psychological support. Two women stopped misusing alcohol and one woman stopped misusing substances at six months; however three women were still using drugs and one woman still misusing alcohol. Taken together, these findings indicate that most women’s mental health needs remained high at six months, which was consistent with previous evaluations (McPherson et al., 2019). Future research should explore why some women benefit from these services more than others (Cox et al., 2017).

**Resources and funding**

A significant challenge identified for this service was insufficient resources and uncertainty around future funding. Whilst there has been significant expansion of RCP services in the UK, they are underfunded and have no reliable funding stream which has been linked to austerity measures and spending cuts to local authority budgets (Wilkinson & Mason, 2021).

Flourish currently only has two full-time members and one vacant post.

It was currently not possible for the service to offer a service in line with recent research and population need, for example working with parents pre and during proceedings, younger parents, fathers, couples and different ethnic groups (Wilkinson & Mason, 2021; Alrouh et al., 2022), due to lack of staffing and the importance of maintaining small caseloads.

Within trauma-informed relational work clinical supervision is highly recommended as practitioners use the self and the relationship as a therapeutic tool (Pearlman & Courtois, 2005). Practitioners within this RCP service are currently not receiving any clinical supervision, which may present a risk as research shows a lack of clinical supervision and high caseloads can contribute to burnout, vicarious trauma, compassion fatigue, and high staff turnover (Newell & MacNeil, 2010).

**Wider Context**

A theme within the qualitative evaluation identified the broad challenges in relation to current health, social and legal service structures and procedures governing child protection cases. The challenges described include inadequate emotional and legal support during court proceedings, short time frames for change and unrealistic expectations placed on birth parents. Long waiting lists for psychological interventions mean that court recommendations for birth parents to maintain their children are often unachievable (Morriss & Broadhurst, 2022). Problem-solving courts such as Family Drug and Alcohol Court (FDAC) take a different approach to disrupting patterns of RCP. They offer prolonged involvement to complete an intervention, with a focus on tackling substance abuse and monitoring family progress. This approach has been shown to have better outcomes than traditional models of care proceedings (Harwin et al., 2016; 2018; Shaw et al., 2021).

# Recommendations

***Recommendations for supporting staff and recruitment***

* Maintain small caseloads to continue with trauma-informed and assertive outreach programme.
* Each member of the team should receive weekly clinical supervision to reduce risk of staff burnout and compassion fatigue.
* Fill vacant post and apply for funding for family support workers and additional practitioners to implement service improvements and pathway developments.
* Consider expanding the availability of specialist therapeutic interventions for mothers with more entrenched mental health difficulties.

***Recommendations for the development of service pathways***

* The service should continue to offer current pre and post proceedings pathways.
* Expand current or develop new pathways to promote earlier intervention. This could include supporting women during their initial set of court proceedings and working with women in foster placements and mother and baby units.
* Develop new pathways for supporting fathers and couples who have experienced RCP. In time, develop pathways to increase access to services for vulnerable groups such as younger parents and parents from different ethnic minority groups.
* Include an option for parents to self-refer to the service.

***Recommendations for working with the wider system***

* Maintain simple referral routes for professionals to ensure service accessibility.
* Continue to build partnerships with mental health services and work towards creating ‘fast-track’ pathways for vulnerable parents to access therapy immediately after court proceedings.
* Continue to run workshops and develop reflective practice groups for professionals to challenge assumptions and encourage reflexive practice.
* Offer training to professionals in the wider system and involve experts by experience in training offered to facilitate mentalisation and empathy relating to the experience of birth parents.

***Recommendations for enhancing service user’s experiences***

* Continue to offer and develop the service alongside mothers, families and professionals.
* Consider expanding service capacity by developing a parent mentor role (see Shaw, 2021), peer-to-peer support and group intervention between the women where appropriate.
* Apply for funding to source own venue to reduce risk of re-traumatisation and create a context for therapeutic work.

***Recommendations for data collection, evaluation and research***

* The number of clients included was very small compared to other similar evaluations undertaken by the evaluation team. Other RCP service evaluations have included: 75 clients over 5 years; 22 clients over 18 months; 65 clients over 3 years. Flourish should consider a further evaluation in 2-3 years which would aim to include a larger number of clients to allow better assessment of service effectiveness.
* Future service evaluations (with larger client numbers) should include a cost benefit analysis to calculate potential cost savings (See McPherson et al., 2020).
* Amend the service’s consent form to include statements of consent to share anonymised data for evaluation, research and audit purposes in order to help increase the number of clients included.
* Consider using the full version of the University of Essex evaluation [toolkit](https://www.researchinpractice.org.uk/media/3967/s2-evalutaion-user-guide.pdf) “Client Report Measures” in place of current outcome questionnaires (AWS, SWEMWBS). The recommended suite of outcome measures are validated; found to be acceptable to clients in other RCP services; and include measures of self-esteem (Rosenberg scale), grief (Adult Attitude to Grief), psychological wellbeing (CORE), quality of life (QLESQ), and trauma (PCL-C). An online demonstration survey including all measures is available from University of Essex (see [here](https://essex.eu.qualtrics.com/jfe/form/SV_0xH3vHQ9hSrc15r)).
* Explore the barriers to the women accessing education, training and employment, and possible ways to address these.
* Add information on the progress tool about the direction of clinical gain and add response options on the wheel to make it easier to complete (See Gries et al., 2018).

# Summary

In summary, the results of this service evaluation revealed that one woman became pregnant and sadly this child was removed from her care on a full care order. At six months, there were improvements in women’s contraception use, engagement with services and the consistency of child contacts. Nevertheless, there was limited improvement on measures of wellbeing at individual levels and some women were still experiencing alcohol and/or substance misuse difficulties at six months, indicating that most women’s mental health needs remained high. The qualitative results revealed that the experience of a safe relationship, therapeutic interventions, increasing access to services and tackling negative attitudes about birth parents, was deemed to improve women’s self-worth, relationships, and quality of life. On the other hand, lack of adequate resources and multi-agency working, in addition to challenges of current legal, health and social structures resulted in inadequate support and acted as barriers to effective intervention. A number of recommendations were provided to address the limitations of this service evaluation and improve the service.

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