

# **Reducing Recurrent Care Proceedings Service Evaluation: Stockport Comma**

**(Final service report)  
May 2020**

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## Background

Recurrent care proceedings account for a very significant proportion of all care proceedings in England and carry a high human cost. The authors of a landmark study (Broadhurst et al, 2015 and 2016) 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 were drawn from a dataset of 43,541 birth mothers involved in Section 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%.

Until recently, 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 a significant cause of 'revolving door' cases, whereby the same families lose a number of children in subsequent family court cases at significant financial cost to local authorities and emotional cost to those involved.

Since 2015, a number of new local services have been established to address this challenge. These include the DfE Innovation-funded Pause initiative and many others established by local authorities, often working in partnership with voluntary agencies (Ryan et al, 2019). Evaluations have been conducted for a number of these new initiatives (DfE, 2017; Blumenfeld and Taggart, 2018; Cox et al, 2015, 2017; Cox and McPherson, 2018; McPherson et al, 2018).

Stockport Metropolitan Borough Council and colleagues in the integrated children and family service began to scope local patterns of recurrent proceedings in 2015. Local data for the period 2007-2014 indicated that there were a high number of women pregnant with a second child involved in the final stages of initial proceedings, and that there was an overlap of first and second applications in 46% of cases (i.e. the mother became pregnant during proceedings). Of these local recurrent cases, 91% recorded two sets of removals. Over the 7 year period, there were 46 mothers with recurrent care proceedings and 182 going through a single care proceeding<sup>1</sup>.

The Comma service was established in 2015 to address the needs demonstrated by these data. Nested within Stockport Family, it offers parents at risk of recurrence a bespoke package of support. The service was developed, co-designed and coproduced with women who had experienced removal of a child into care and were in touch with the Letter box scheme run locally by the adoption team. Some of these women were also

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<sup>1</sup> CAFCASS data for 2007-2014, as used by Broadhurst and Mason (2017)

actively contributing to the research being undertaken by Claire Mason and Manchester and Lancaster universities. Unfortunately, we were unable to include all the data from these women in this evaluation because we did not have baseline data from their initial engagement with the service.

Parents who have been through the experience of family proceedings are often reluctant to engage with services. The service aims to establish a relationship with individual parents to build trust and give support to help them meet their own personal health and social needs. However, non-engagement is a persistent challenge and every effort is made to engage families.

## Points of intervention

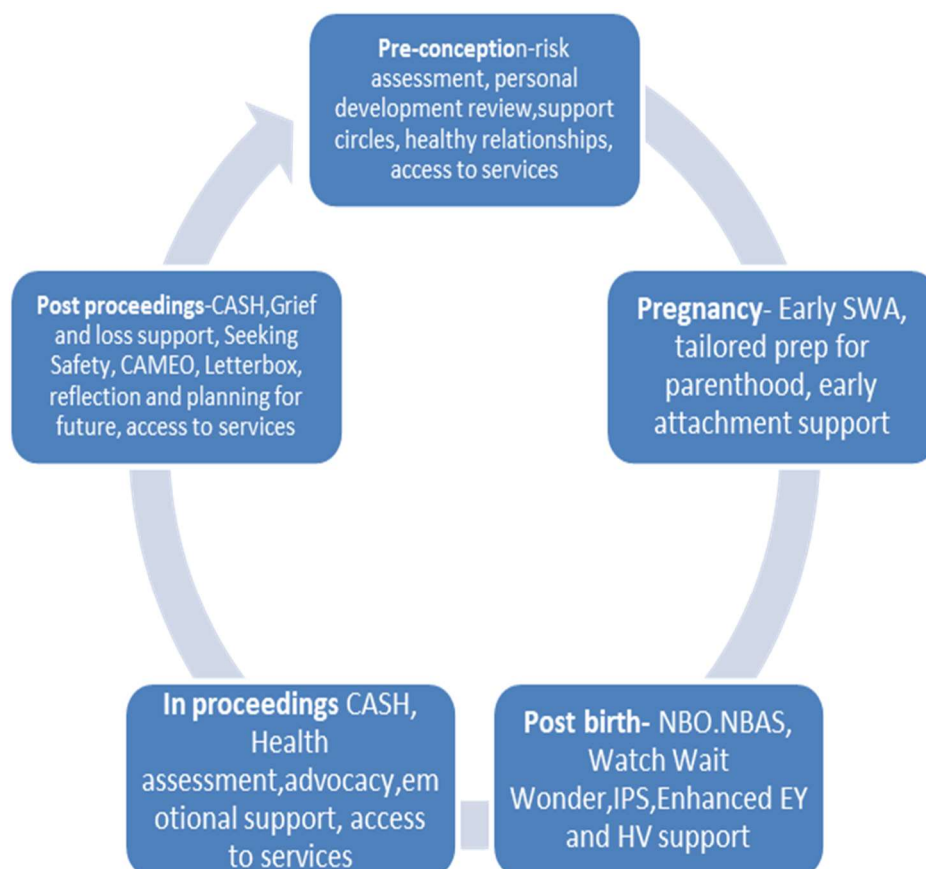
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The aim of the Comma project is to support families in their choice to place longer intervals between pregnancies and access a package of support individualised to their unique needs. Points of intervention have been identified by practitioners as follows:

- PLO: A package of support is offered by the most appropriate practitioner to address health and wellbeing of mothers and support their choice in accessing contraception. Whether the case is stepped down into child protection or progressed to care proceedings, this work is vital to prevent additional stressors on the family.
- During the first set of proceedings to prevent recurrence: the groups at the highest risk of having children removed often allow themselves, or are allowed, the least time to achieve and sustain change. Intervention is focused on preventing a further pregnancy at that time and supporting the health and wellbeing of mothers. It is made very clear at this point that intervention would have no effect on current proceedings but is focused on preventing recurrence.
- Post proceedings: A key worker is allocated and an in depth assessment and review of historical files is undertaken. This includes consultation with the previous social worker where possible and a joint visit to the family. A collaborative work plan is developed with the woman, which considers all areas of life, including wishes and dreams. Individualised and therapeutic support is provided involving a multi-agency approach and access to appropriate services. The aim of which is to prevent recurrent proceedings.
- Pre-Conception support, a new development of the service which supports women whose aim is to have other children and parent them safely and effectively. Support is provided to realistically examine current circumstances and plan for changes, which may need to be made in preparation for parenting. This includes the provision of a pre conception Social Work assessment, which highlight strengths as well as development needs and risks and recommendations.
- Pregnancy: Early identification and referral to children's services of pregnant women who have had previous children removed by the local authority is vital especially if the women's circumstances have remained broadly unchanged. This

allows for the unborn baby assessment to commence early and for support to be offered by the Comma project if not already involved.

- Postnatally: Support continues up to school age through, for example, extended midwifery input, early health visitor allocation, assessment of attachment, targeted parenting and nursery provision are all considered.



Key to Diagram Above:

SWA - Social Work Assessment

NBO - Neonatal Behavioural Observation

NBAS - Neonatal Behavioural Assessment Scale

IPS - Infant Parent Service

EY - Early Years

HV - Health Visitor

CASH - Contraception and Sexual Health

CAMEO - Come Along and Meet Each Other (Peer Support Group)

Comma is further developing existing initiatives by the service such as:

- Pre conceptual and antenatal support working with locally developed initiatives such as Salford Strengthening Families and New Beginnings.
- The 'next steps' support pathway, currently working in partnership with the Stockport Women's Centre.
- Peer mentors.

The Comma service is flexible, bespoke and client driven. Engagement takes many forms, including face- to-face meetings in the client's home or at a safe location of their choosing, accompanying a client to appointments with other services, and the exchange of text and phone calls. The Comma project also provides a consultation and advice service to other professionals in the Stockport Family Service.

Comma is staffed by 2 part time members of staff, a specialist health visitor and a social worker. Its underpinning approach is one where a health practitioner takes a lead role to focus the service on health and wellbeing outcomes in the broadest sense. Comma workers provide a trauma informed approach and use a variety of therapeutic skills to provide specialist support. Clients will also be signposted to and supported to access other services.

This service evaluation report has been prepared by a team from the University of Essex. The team, led by Prof Pamela Cox, has completed evaluations and service development reports on five similar services:

- *Positive Choices*, run by Suffolk County Council.
- *Mpower*, run by Ormiston Families in Suffolk.
- *Rise*, run by the Marigold Children's Centre in Southend, Essex.
- *Step Together*, run by Venus Charity in Sefton, Merseyside.
- *Strengthening Families*, Salford.

Working in conjunction with Research in Practice and Lancaster University's Centre for Child and Family Justice Research, the team has advised 11 further local authorities in England seeking to develop or extend services to reduce recurrent care proceedings (Ryan et al, 2019). It is also evaluating the Community of Practice for practitioners that is currently being developed by Research in Practice (funded by Public Health England) which aims to improve sexual and reproductive health support to birth parents who have had children removed from their care.

Prof Cox is a member of Pause's evaluation advisory board. A number of Pause services, have been established in England in recent years following the extension of an initial series of DfE-funded pilots (Pause, 2018; McCracken et al, 2017). Dr McPherson recently 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). Vanessa Baxter is a Senior Research Officer at the University of Essex with extensive experience of social care research and analysis while working for Essex County Council.

# Situation Analysis

Health needs and demographic trends vary across Stockport, which is one of the most polarised areas nationally.

Low mental wellbeing is a measure beyond mental ill health and assesses the number of people who do not feel positive. In Stockport the 2012 Adult Lifestyle Survey showed that:

- 27,000-31,000 (12.2%) of adults have low mental wellbeing
- Low mental wellbeing rates are strongly linked to deprivation and rates range from just 7% in Bramhall South & Woodford areas to 17.9% in Brinnington & Central and 18.5% in Offerton

The number of looked after children in Stockport has remained low and relatively stable over many years, in contrast to the sharply rising numbers regionally and nationally. However, the number rose in 2017/18 to 355 children in care, a rate of 5.7 per 1,000 0-17 year olds (up from 5.7 in 2016/17). The increase is in part attributed to an increase in care proceedings, the courts making more care orders and therefore an increase in young people being placed at home subject to a statutory care order. Stockport's rate of looked after children continues to be the lowest in the region and below the national average.

In 2017/18 Stockport received 2,628 referrals to Children's Social Care, a rate of 42.1 per 1,000 0-17 year olds and higher than the rate of 36.8 a year earlier. There were 322 children subject to a Child Protection Plan, a rate of 5.2 (up from 3.9 a year earlier).

1,917 children were the subject of a domestic abuse referral in 2017/18, a rate of 30.7 per 1,000 0-17 year olds. This was down from 2,063 children or a rate of 34.2 per 1,000 a year earlier.

In 2018, there was a rate of 15.0 under-18 conceptions for every 1,000 girls aged 15-17 years in this area. This is lower than both the regional average (21.5 per 1,000) and the England average (16.7 per 1,000). Rates vary by deprivation, and are 2.7 times higher in Brinnington and Central than the Stockport average. Rates are also significantly higher in Reddish North, although not as high as Brinnington. Between 50% and 60% of teenage conceptions lead to an abortion, and 40-50% to a birth. Conceptions in areas of deprivation are more likely to result in births.

## Evaluation methodology

This evaluation was conducted using a toolkit created by a University of Essex research team to assess the impact of interventions seeking to reduce recurrent care proceedings. An overview of and guide to using the toolkit is available on the [Research in Practice website](#) or on request from the university's Health and Social Care Research Service ([hcrs@essex.ac.uk](mailto:hcrs@essex.ac.uk)).

Client data is collected by practitioners at baseline (initial engagement) and at 6 months and 12 months. This report offers an analysis of quantitative data collected on clients up to the end of February 2020, plus self-reporting information for each client.



# Executive Summary

## Headline summary

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The Comma project is meeting its initial service brief. Since being established in late 2015, Comma has (as of the end of February 2020):

- ✓ Developed new provision to meet the needs of women experiencing or at risk of recurrent care proceedings in the Stockport area.
- ✓ Established referral routes into the service.
- ✓ Recruited and trained 2 key workers.
- ✓ Engaged with 26 women (20 of whom remained engaged for at least 6 months, and 17 of whom were active clients at the end of this evaluation period). Without intervention we would expect 3 out of the 22 women to have experienced a pregnancy likely to lead to care proceedings.
- ✓ None of the clients who engaged with the service for at least six months became pregnant, thereby reducing the likelihood of care proceedings<sup>2</sup>.
- ✓ Delivered a service that directly contributed to the avoidance of 3 sets of care/removal proceedings, generating one-off savings of around £96,789 plus additional savings of up to £158,028 per year arising from the 3 children not becoming looked after. This should be offset against staffing costs of around £61,500 during the 18 month evaluation period.
- ✓ Played a role in securing the return of 2 looked after child to their mother, generating potential further savings of £105,352 per year through avoided foster care costs (noting the availability of other care options).
- ✓ Commissioned an independent evaluation from a research team at the University of Essex, collected data using the team's evaluation toolkit and worked with the team to further refine this toolkit.
- ✓ Developed contacts, and shared learning with, other agencies providing similar services around the country.
- ✓ Identified, through the evaluation process, unmet and ongoing complex psychological needs of engaging clients.

### Referrals and engagement

The Comma project received 31 referrals during the 18 month evaluation period, but 9 of these women either declined to share information about themselves or disengaged from the service soon after referral. The project therefore worked with, and obtained data relating to, 22 women up to the end of March 2020.

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<sup>2</sup> 1 woman became pregnant after referral but before engagement while one became pregnant within several months of engagement and had a termination.

Local data for 2007-2014 showed 46 mothers in Stockport going through recurrent care proceedings and 182 going through singleton care proceedings, indicating a level of unmet need in the area.

Around two thirds of these women had either been in care or had significant CYPs involvement as a child. The number of previous child removals linked to this group ranged from 1 to 3, with the mean being 1.9.

Of these 22 clients:

- 10 were still engaged with the service at the end of the evaluation period, and had been engaged for at least six months.
- 3 clients had not yet been engaged with the service for six months, so there is no follow up data available for them yet.
- 5 had been discharged from the service.
- 2 had moved out of the area, 1 had had no return contact and 1 was an inappropriate referral.

Follow up data after 6 months of engagement with the service is available for 15 clients, while there is further follow up data for 10 clients (after around 12 months).

Engagement with Comma's key workers was excellent or good for 80% of clients at the six month follow up point, but engagement with workers outside of the service was less positive. There was a similar pattern for clients at the 12 month follow up point. The other agencies most commonly involved with the clients during their engagement with the Comma service were mental health, health, housing, drug and alcohol, and social care services, plus a local women's centre.

### **Client backgrounds**

Where information was available at the start of engagement, there were high levels of reported past trauma in the client group including general trauma, physical abuse, emotional abuse and sexual abuse which occurred either in clients' childhood, adulthood or both. There was no recorded information for 2 clients, so the actual percentages may be much higher (up to 95% for general trauma and 80% for sexual abuse).

Partner abuse was also very common in the client group with 53% of those asked reporting partner abuse in the last year (including 3 clients experiencing severe force and 5 clients experiencing sexual assault) and 74% reporting partner abuse at any time in the past. Partner abuse was only identified for 5 clients at the six month follow up point, either non-physical abuse or threats/minor force.

## **Client aspirations and challenges**

The main aspirations for clients at the start of engagement were for support to access mental/physical health support, support to prepare for having another child, and regaining custody of children or increased contact with them. Some also wanted support to access housing, education, employment or benefits, or practical support in daily life.

The main challenge in clients' lives recorded by key workers was improving or maintaining mental health, which was true for 17 out of the 22 clients. Other challenges identified included a vulnerability to unhealthy relationships/maintaining a healthy relationship with a partner or parent, accessing preparation to parenting support/preparing for parenthood, and maintaining substance abstinence. Similarly, key workers felt the main barrier that might hinder working with clients was their poor/unstable mental health, which was true for 10 out of the 22 clients. Other barriers identified included difficulty in working/engaging with professionals, difficulty in maintaining a healthy relationship with partner/vulnerability to exploitative relationships, partial or poor understanding of why their children had been removed, and an unwillingness or inability to accept (partial) responsibility for that.

Key workers also identified positive aspects of clients' lives that appeared to enable them to engage effectively with the service. The principal one was to have appropriate and/or stable housing, which was true for 14 out of the 22 clients. Other positive aspects included having a stable relationship with their partner, support from parents, family, friends or the community, contact with or access to children and volunteering or employment.

## **General outcomes**

At the six month follow up, 9 out of the 15 clients were in committed and stable relationships with either the same or a new partner while 5 were single.

The majority of clients at referral were not working, 12 because they were unable to work (55%) and 6 who were unemployed (27%). 3 clients had become students at the six month point (2 who had not been working because of disability/illness and 1 who had been volunteering) but the other 12 clients were still unable to work or unemployed.

All clients were registered with a GP at referral (except for 1 where this was unknown), and also those still engaged at six months. GP visits were of variable frequency among the group at both initial engagement and at the six month point.

13 clients (59% of all referred) were on medication for mental health problems at the start and this rose to 14 (93% of the group) at the six month follow up point.

6 clients (27%) revealed problems with alcohol use and 5 (23%) revealed problems with drug use at initial engagement. However, just 1 client said that alcohol was a problem at the six month point and only 1 client said that they had a problem with drugs at the six month point.

### **Psychological outcomes**

Psychological measures were used to assess self-esteem, grief, psychological functioning, wellbeing, psychological problems, risk, trauma symptoms, quality of life and interpersonal relating. Mean scores on these measures indicated that Comma clients had high levels of psychological need on a par with people who receive mental health services. In the case of quality of life, Comma clients reported much worse scores than even clinical populations.

Because there may be some under-reporting of symptoms and problems at initial engagement, we do not necessarily expect to see clinically significant improvements in all of these measures and may even see deterioration. However, a third of the sample improved on self-esteem and psychological distress overall, and half of the sample improved on psychological problems and trauma. These improvements were reliable statistically even if few of them moved the clients below the levels seen in clinical populations. Psychological need therefore remained high after 6 months.

### **Preventative outcomes**

Only 8 clients (37% of those referred) were using contraception at the start of engagement. However, this increased to 14 clients (93% of the group) at the six month point. During the initial engagement/ assessment with Comma, advice on long-acting reversible contraceptives (LARC) was given to 13 clients, of whom 7 had LARC put in place, 1 was considering her options and 5 refused the advice. (LARC was already in place for 3 women so no advice was needed and 3 other women relied on alternatives.)

Just 2 clients have become pregnant within six months of referral to the service: 1 client became pregnant after referral but before engagement, and this child was removed; 1 client, who became pregnant within six months of engagement, had a termination due to high risk health needs.

4 clients - all of whom had been engaged with Comma for between one and two years - were planning to become pregnant.

1 client has had the youngest of her 3 children returned to her care following extensive work with Comma and children's social care, and another has also had a child returned to her care.

Without intervention, and assuming Broadhurst et al's (2015) calculation that the probability of recurrence within this group within 1-2 years of initial proceedings is 13.2%, we estimate that 3 of the 22 women initially engaging with the Comma project would be likely to have experienced an unplanned pregnancy in the 18 month evaluation window and to have faced recurrent care proceedings. One client did become pregnant - but this was shortly after their referral to the service - and this child was removed. Another client (who is now in a supportive relationship and planned the pregnancy) became pregnant within six months of engagement with the service but had a termination. The fact that no

clients who had engaged with the service for at least six months became pregnant should be seen as a clear achievement on the part of both the service and their clients.

Significant cost savings can be extrapolated based on the likely costs of 'avoided' care proceedings. Given that the cost of care proceedings is put at £32,263 per case<sup>3</sup> and that at least 3 cases have been avoided, the Comma project would have delivered gross savings of around £96,789 in the full 18 month evaluation period. These savings are to be offset against the cost of staffing the service over that time, which was around £61,500<sup>4</sup>.

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 estimated average annual cost of supporting each Looked After Child is £52,676 per child per year<sup>5</sup>.

If we assume that 3 babies had been born and all had become looked after children, the annual cost to Stockport could have reached around £158,028. Over 18 years, this could have amounted to £2.84 million.

In addition, there were 1 child in foster care who was returned to the care of their mother with a status of Looked After Child at home. The social worker has completed an assessment and is recommending to the court that this status is changed to Child Protection. Another client, who declined to share her data for the evaluation, also had a child returned to her care. This will have saved Stockport an annual cost of £105,352 for the children to be looked after.

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<sup>3</sup> This comprises legal aid costs, local authority costs, court costs and Children and Family Court Advisory and Support Service (CAFCASS) costs. Source is the Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2105).

<sup>4</sup> Staffing costs are based on the total costs for the two key workers for the 18 months of the evaluation period, but do not include the 'on costs' of management support.

<sup>5</sup> Unit Cost Database developed for the Department for Communities and Local Government's (DCLG) Troubled Families Unit (2105).

# Recommendations

The Stockport Comma Service should:

- Continue to offer the service as currently configured.
- Consider commissioning a needs-based assessment as the service has reported a higher number of women going through care proceedings than the number of referrals, indicating there may potentially be a level of unmet need in Stockport.
- Explore whether Comma can increase specialist capacity for additional psychological or therapeutic input based in order to meet clients' unmet psychological needs.
- Continue the ongoing evaluation and monitoring of client data, using a spreadsheet based on the University of Essex's evaluation tool.
- Re-visit the service design and delivery after considering the research team's full evaluation report of March 2020.
- Work with the emerging Community of Practice and similar services offered elsewhere in the northwest and across England and Wales in order to share, and gain, further insight from best practice in this field. This should include working with the Greater Manchester Children's Social Care Spreading and Scaling of Innovation programme.
- Continue to use the online resource pack, 'Working with recurrent care-experienced birth mothers' (see [website](#)) compiled by Research in Practice, and work with Research in Practice to co-produce resources for use by practitioners.

# Detailed Findings

## Referrals

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31 women were referred to the service during the 18 month evaluation period, but 9 of these women either declined to share information about themselves or disengaged from the service soon after referral:

- 1 client has actively engaged with the service for over 12 months but declined to share information for the evaluation.
- 1 woman has engaged with service but the collection of baseline information is not currently appropriate/possible due to a crisis situation.
- 1 woman engaged initially whilst proceedings were ongoing, but disengaged from all services once the final decision was made to remove the baby. Attempts to engage continue.
- The assessment began for 1 woman but then her child was placed back into her care and she disengaged.
- The assessment for 1 woman took place but she was moved out of the area to a place of safety.
- The assessments began for 3 women but they then disengaged: 1 re-engaged in March 2020 but the information has not yet been collected.
- The assessment for 1 woman began but as she was already pregnant she was transferred to a different service.

In total, the Comma Service has engaged with 26 women, 20 of whom remained engaged for at least 6 months, and 17 of whom were active clients at the end of this evaluation period.

The Comma project worked with (and collected evaluation information on) 22 women up to the end of March 2020. Around half were referred from social care teams, with 3 from health professionals and 4 self-referrals (see Table 1).

Table 1: Source of Referral

	N	%
Social care	10	45%
Social care/health professional	2	9%
Doctor	1	5%
Self-referral	4	18%
Unknown	5	23%
Total	22	100%

Of the 22 clients for whom baseline information is available:

- 86% were White British females.
- 36% were aged 24 or under while 36% were aged 25-30 and the remaining 28% were aged 31 or over: the mean age was 28.
- Where information on education attainment was available (n=18), 22% had no educational qualifications and 44% had GCSEs or equivalent.
- Where information on care history was available (n=21), 33% had been in care and another 38% had had significant CYPS involvement as a child.
- Social care involvement was current for 36% of clients.
- The number of previous child removals (n=22) ranged from 1 to 3: the mean was 1.9.
- The majority of women and their partners lived in central Stockport or within 3 miles.

## Engagement and availability of data

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Of the 22 clients for whom baseline data is available:

- 10 were still engaged with the service at the end of the evaluation period, and had been engaged for at least six months.
- 3 clients had not yet been engaged with the service for six months, so there is no follow up data available for them yet.
- 5 had been discharged from the service.
- 2 had moved out of the area, 1 had had no return contact and 1 was an inappropriate referral.

Follow up data gathered after six months is available for 15 clients. Further follow up data is available for 10 clients, and was gathered after they had been engaged with the service for around 12 months.

Engagement with Comma's key workers was excellent or good for 80% of the clients at the six month point (n=15), but engagement with workers outside of the service was not as positive (see Table 2). A similar pattern can be seen for clients (n=10) with a further follow up point.



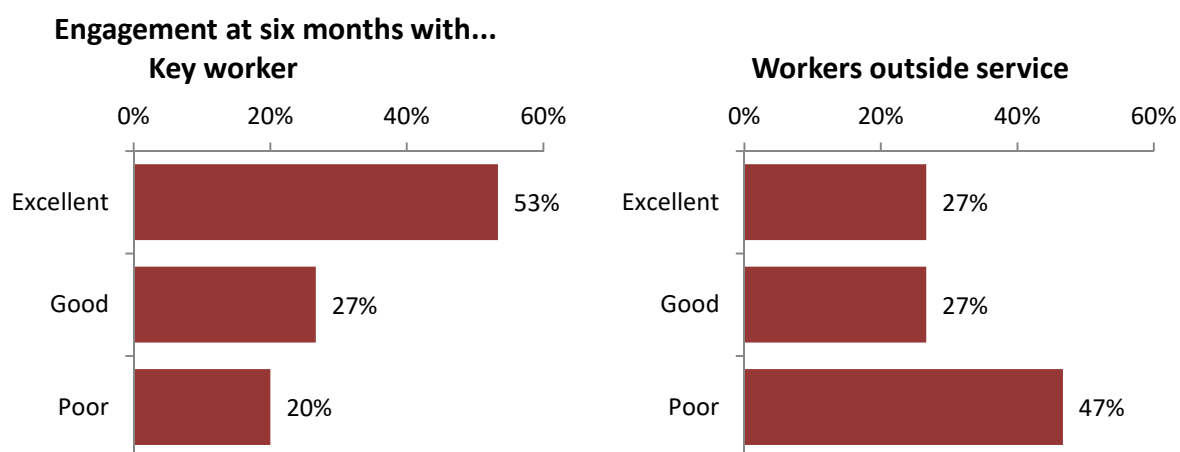


Table 2: Quality of Engagement at Six Month and Further Follow up Points

Six month follow up                      Further follow up point

	With key worker		With workers outside service		With key worker		With workers outside service	
	n	%	n	%	n	%	N	%
Excellent	8	53	4	27	4	40	4	40
Good	4	27	4	27	4	40	3	30
Average	0	-	0	-	2	20	1	10
Poor	3	20	7	47	0	-	2	20
Number	15		15		10		10	

**Contact with service:** For the clients engaged at six months, the mean number of telephone or texts per week was 1.6 while the mean number of face to face contacts per week was 0.8.

Other agencies involved with the clients during their engagement with the service were:

- Healthy Minds/mental health services (n=11).
- GP (n=8) or consultant (n=1).
- The Women's Centre (n=7).
- Housing (n=6).
- Drug and Alcohol services (n=6).
- Children's Social Care (n=6) or Adult Social Care (n=1).
- Psychotherapy/psychiatry services (n=4).
- Debt/welfare advice (n=4).
- DWP/Employment Support (n=3).
- The Prevention Alliance support service (n=3).
- Sexual Health Team (n=2).

- Domestic abuse services (n=1).
- Infant Parent Service (n=1).
- Police/Probation (n=1).
- Pure Insight charity supporting care leavers (n=1).
- ARC art therapy group (n=1).
- Volunteering service (n=1)
- The CHALLENGE programme (n=1).
- CAMEO women's group (n=1)
- Self Help Services (n=1).
- PIMP assessment (n=1).
- Anti-Social Behaviour Team (n=1).
- Church (n=1).

## Trauma and abuse

Where information was available at the start of engagement, there were high levels of reported past trauma in the client group including general trauma, physical abuse, emotional abuse and sexual abuse which occurred either in clients' childhood, adulthood or both. There was no recorded information for 2 clients, so the actual percentages may be much higher (up to 95% for general trauma and 80% for sexual abuse). See Table 3.

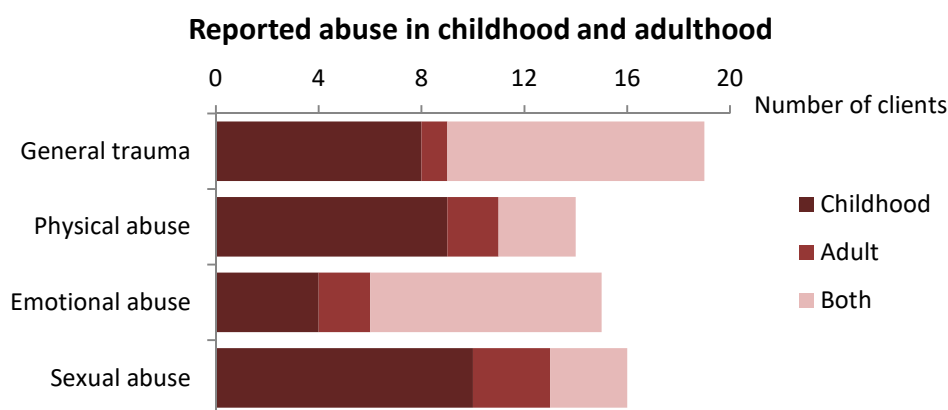


Table 3: Reported abuse in childhood and adulthood (n=22)

	Childhood		Adult		Both		At any time*	
	n	%	n	%	n	%	n	%
General trauma <sup>1</sup>	8	36	1	5	10	45	19	86
Physical abuse	9	41	2	9	3	14	14	64
Emotional abuse	4	18	2	9	9	41	15	68
Sexual abuse	10	45	3	14	3	14	16	73

<sup>1</sup>e.g. natural disaster, serious accident, death of parent, parents separating

\* There was no recorded information about this for 2 clients, so this percentage may be much higher (up to 95% of clients for general trauma and 80% for sexual abuse).

Examples of non-partner abuse/trauma include physical and/or emotional abuse or neglect from a parent, step parent or sibling, sexual abuse from a family member or neighbour when young, long term Child Sexual Exploitation, the death of a parent during childhood, and witnessing a murder as a teenager.

Partner abuse was also very common in the client group with 53% of those asked reporting partner abuse in the last year and 74% reporting partner abuse at any time in the past: there was no information about 3 clients, but it is not known whether this is due to missing information or that the clients have not experienced partner abuse. Partner abuse was only identified for 5 clients at the six month follow up point, either non-physical abuse or threats/minor force (see Table 4).

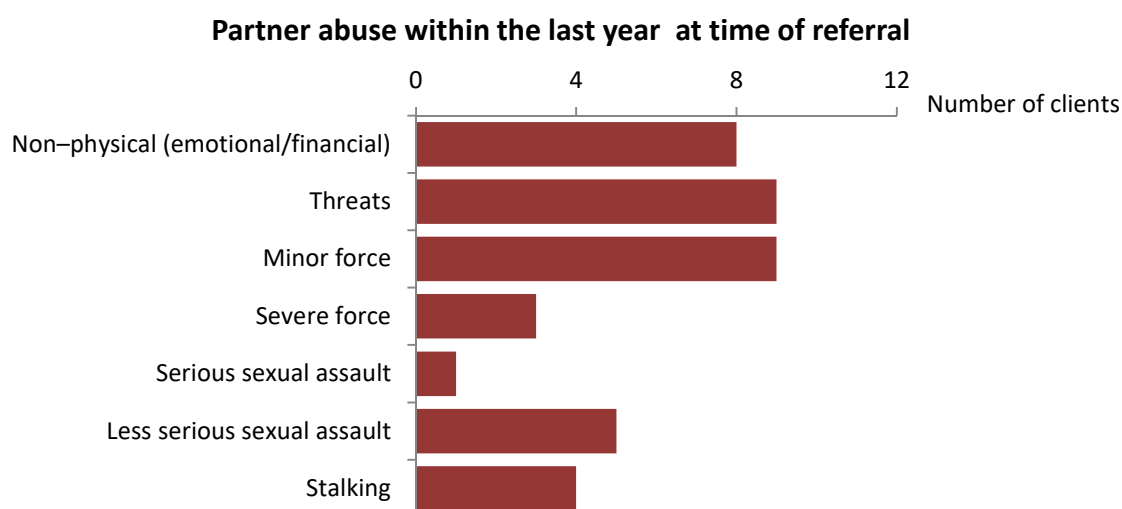


Table 4: Reported partner abuse at referral (n=22) and 6 months (n=15)

	At referral		6 months	
	n	%	n	%
<b>Partner abuse in the last year</b>				
Non-physical (emotional/financial)	8	36	3	20
Threats	9	41	1	7
Minor force	9	41	2	13
Severe force	3	14	0	-
Serious sexual assault	1	5	0	-
Less serious sexual assault	5	23	0	-
Stalking	4	19	0	-
None known about	0	-	3	20
<b>Partner abuse any time in the past</b>				
Non-physical (emotional/financial)	12	54		
Threats	10	45		
Minor force	10	38		
Severe force	10	46		
Serious sexual assault	9	41		
Less serious sexual assault	4	18		

	n	%	n	%
Stalking	5	23		
None known about	1	5		

## Client aspirations and challenges

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Examples of client aspirations at the start of engagement included:

- Support to access mental and physical health support and psychological therapy (n=11).
- Support to prepare for having another child, e.g. improving parenting skills, maintaining healthy relationships, gaining confidence (n=10).
- Regaining custody of their children, or increased contact with them (n=7).
- Support to access housing, education, employment or benefits (n=6).
- Practical support in daily life, including managing debts or help with sleeping patterns (n=5).
- Avoiding the circumstances that led to a previous child being removed or preventing another child being taken into care (n=3).
- Access to peer support from *“people who’ve been through the same thing”* (n=3).
- Support to prevent another pregnancy (n=1).
- Support to complete the recommendations outlined in a court ordered psychological assessment (n=1).

*“Help to get life back on track.”*

The main challenge in clients’ lives that was recorded by key workers was improving or maintaining their mental health, with the issues including anxiety, depression, anger management and low self-esteem/confidence: this was true for 17 out of the 22 clients. For two clients, the challenge was seen as difficulty in accessing mental health treatment. Other challenges identified were:

- Vulnerability to unhealthy relationships or maintaining a healthy relationship with a partner or parent (n=6), or conflict with an ex-partner (n=2).
- Accessing preparation to parenting support or preparing for parenthood (n=5).
- Maintaining substance abstinence (n=4).
- Improving maternal physical health (n=3).
- Finance/debt issues (n=3).
- Homelessness or housing issues (n=2).
- Accessing psychological therapies (n=2).
- Difficulty in sustaining motivation (n=1).
- Getting children back from foster care (n=1) or contact issues (n=1).

Similarly, key workers felt that the main barrier that might hinder working with clients (other than a previous child being in care/lack of appropriate support) was their poor/unstable mental health: this was true for 10 out of the 22 clients. Other barriers identified were:

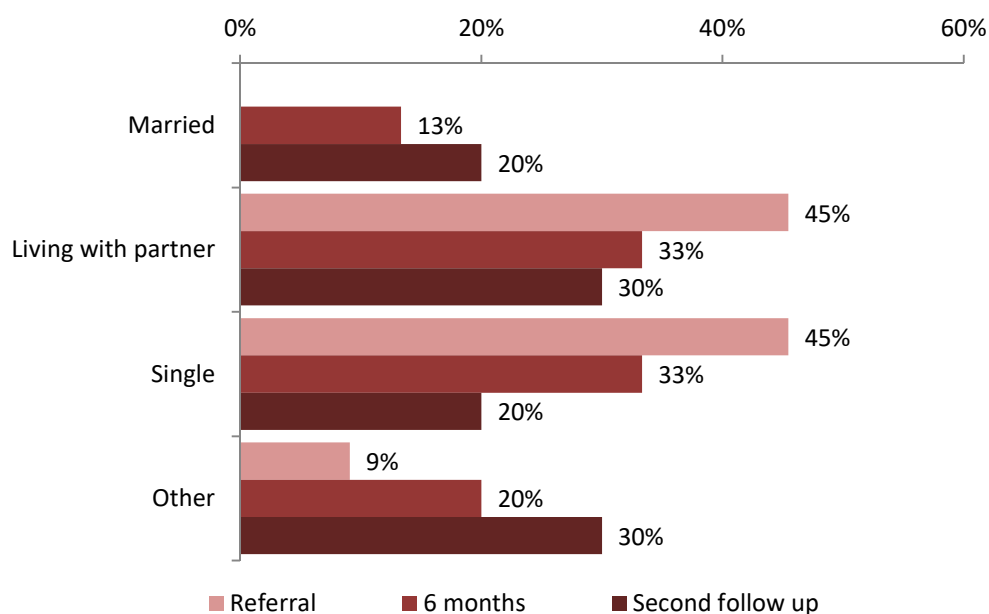
- Difficulty in working/engaging with professionals (n=8).
- Difficulty in maintaining healthy relationship with partner/vulnerability to exploitative relationships (n=7).
- Poor insight into why children were removed/not accepting responsibility (n=5).
- Substance misuse by self/partner (n=3).
- Learning difficulties (n=2).
- Clients' chaotic lifestyle (n=2).
- Unstable housing (n=1).
- Difficulty in maintaining motivation (n=1).

Key workers also identified positive aspects of clients' lives that might enable them to engage well with the service. The principal one was to have appropriate and/or stable housing: this was true for 14 out of the 22 clients. Other positive aspects included:

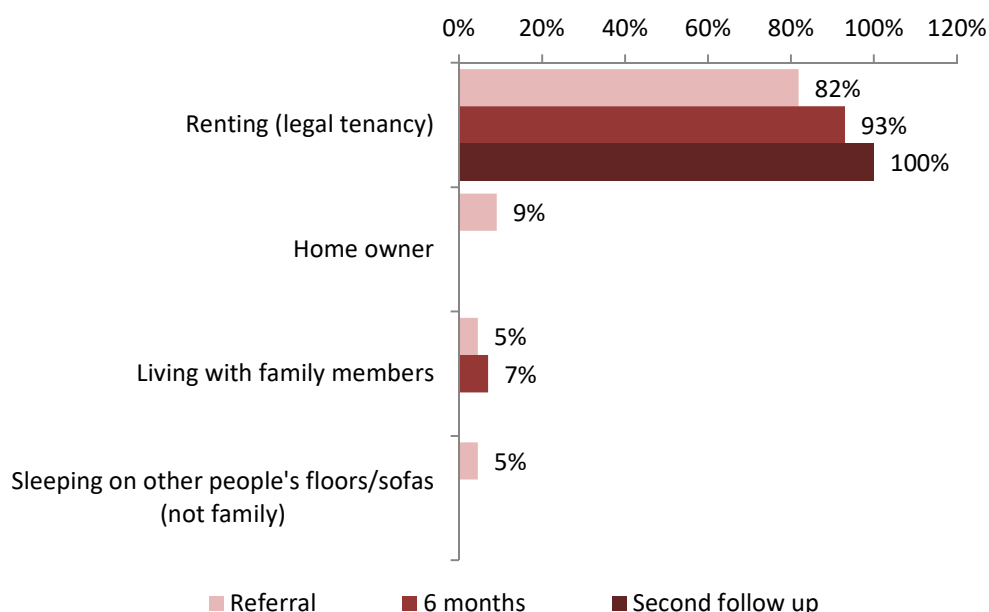
- Stable relationship with partner (n=9).
- Support from parents, family or friends (n=7).
- Contact with or access to children (n=6).
- Volunteering or employment (n=5).
- Involvement with and support from a local church community (n=3).
- Access to mental health support (n=2).
- Engagement with services (n=2).
- Partner being abstinent and accessing support from the probation service (n=1).
- Starting an English course (n=1).
- Good maternal health (n=1).
- Pets (n=1).
- Financially secure (n=1) or starting to save money (n=1).
- Improvements made in the client's life (n=1).
- Commitment to change (n=1).
- Giving up smoking (n=1).

## Client contexts: social, relationships and emotional

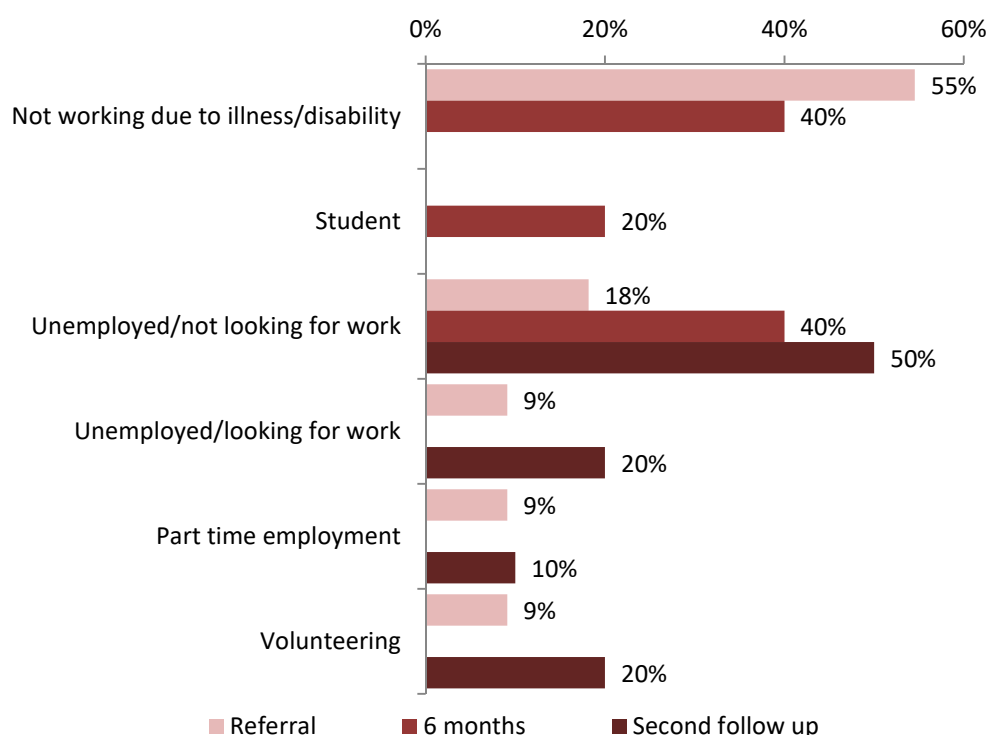
At referral 45% of the clients (n=10) were single and 45% (n=10) were living with a partner. At the six month follow up, 46% of clients (n=7) were married or living with a partner and 13% (n=2) were in a relationship. 4 of these women had positive and/or stable relationships with their (new) partners while 5 were in committed and stable relationships with the same partner.



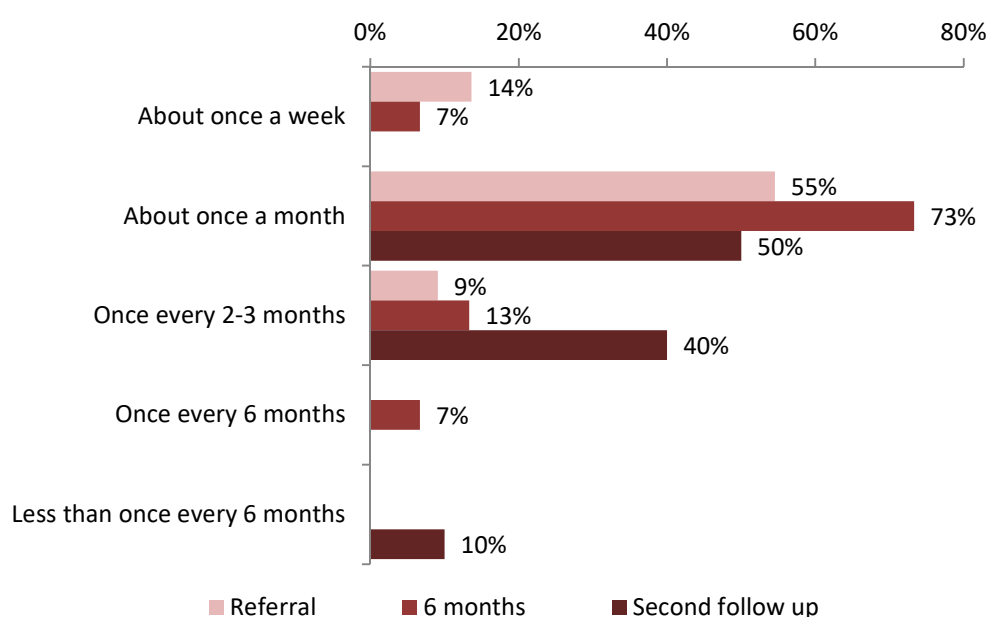
The majority of clients (n=20) at referral had stable accommodation, while all but 1 client (n=14) at the six month point were renting. The client who was sleeping on other people's floors/sofas at referral was renting at the six month point.



The majority of clients (n=18) at referral were not working, either because they were unable to work (55%) or unemployed (27%). 40% of clients (n=6) at the six month point were unable to work while 40% (n=6) were unemployed and 20% were students (n=3). 3 clients had become students at the six month point (2 who had not been working because of disability/illness and 1 who had been volunteering) but the other 12 clients were still unable to work or unemployed.

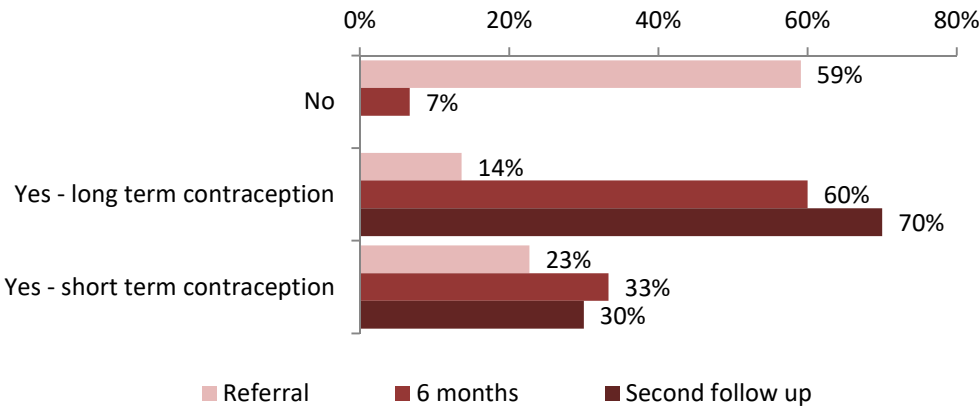


All clients (n=21) were registered with a GP at referral (except for 1 where this was unknown), and also those still engaged at six months (n=15). GP visits were of variable frequency among the group at both initial engagement and at the six month point.



59% of the group (n=13) were on medication for mental health problems at the start and this rose to 93% of the group (n=14) at the at six month follow up point.

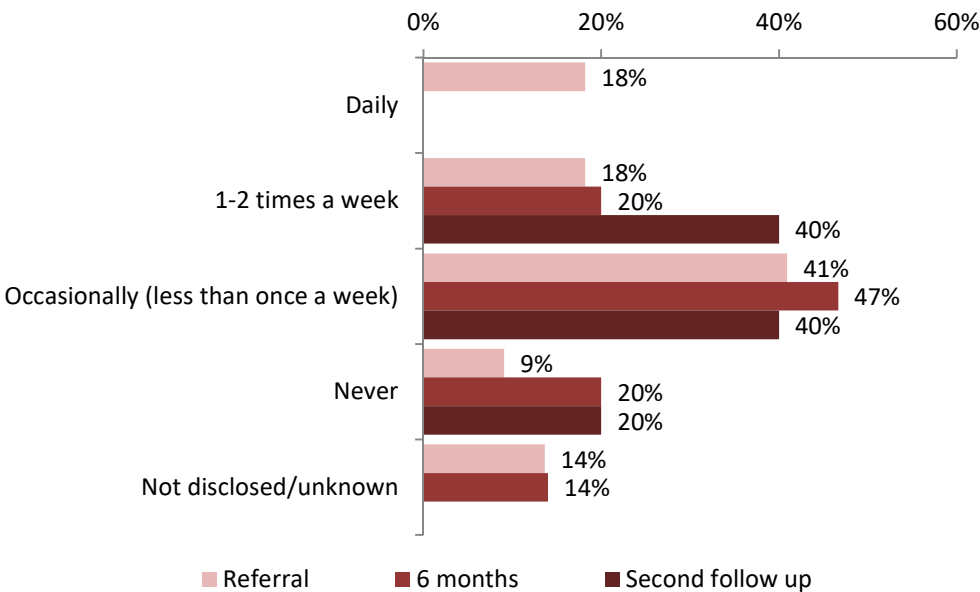
Only 37% of clients (n=8) were using contraception at the start of engagement. However, this increased to 93% of clients (n=14) at the six month point.



During the initial engagement/assessment with Comma, advice on long-acting reversible contraceptives (LARC) was offered to 13 clients, of whom 7 had LARC put in place, 1 was considering her options and 5 refused the advice. (LARC was already in place for 3 women so no advice was needed and 3 other women relied on alternatives.)

Just 1 client was involved with probation services at referral to the service, but this client was no longer involved with the agency at the six month point.

27% of clients (n=6) revealed problems with alcohol use at initial engagement - almost all of these saying they drank daily. However, just 1 client said that it was a problem at the six month point. No one at the six month point said that they drank daily and just 3 clients said they drank 1-2 times per week.





23% of clients (n=5) revealed problems with drug use at initial engagement (cocaine for all plus marijuana for one). However, only 1 client said that they had a problem with drugs at the six month point. 9 clients (out of 19 for whom there was data) had been in treatment for alcohol or drug abuse prior to referral.

Table 5: client social context and wellbeing

	At referral		6 months	
	N	%	n	%
<b>Relationship Status</b>				
Single	10 (22)	45	5 (15)	33
Living with Partner/Married	10 (22)	45	7 (15)	46
<b>Housing status</b>				
Stable	20 (22)	91	14 (15)	93
Living with family	1 (22)	5	1 (15)	7
Unstable	1 (22)	5	0	0
<b>Employment status</b>				
Part time employed	2 (22)	9	0	0
Unable to Work	12 (22)	55	6 (15)	40
Unemployed	6 (22)	27	6 (15)	40
Student	0	0	3 (15)	20
Registered with a GP	21 (21)	100	15 (15)	100
<b>Frequency of GP visits</b>				
Once a week	3 (22)	14	1 (15)	7
Once a month	12 (22)	55	11 (15)	73
Once every 2-3 months	2 (22)	9	2 (15)	13
Once every 6 months	0	0	1 (15)	7
Unknown/undisclosed	5 (22)	23	0	0
Using medication for mental health issues	13 (21)	62	14 (15)	93
Using contraception	8 (21)	27	14 (15)	93
Planning a pregnancy			1 (14)	7
On probation or in contact with probation services	1 (22)	5	0 (15)	0
Problem with alcohol <sup>1</sup>	6 (21)	30	1 (14)	7
<b>Frequency of alcohol use</b>				
Daily	4 (21)	18	0 (13)	0
1-2 times a week	4 (21)	18	3 (13)	20
Occasionally	9 (21)	41	7 (13)	47
Never	2 (21)	9	3 (13)	20
Problem with recreational drugs <sup>2</sup>	5 (18)	28	1 (15)	7

<sup>1</sup> E.g. do they ever drink so much they can't remember things the next day? Do they get in trouble when drinking?

<sup>2</sup> E.g. do they use drugs regularly, does obtaining drugs get them in trouble? Do they take risks like injecting?

## Pregnancy and outcomes

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*Pregnancy:* just 2 clients were pregnant at the six month follow up stage, while 4 clients were planning to become pregnant.

Of the 2 pregnancies:

- 1 client, who became pregnant with her second child shortly after referral, had this child removed and soon after disengaged. She re-engaged following the set of proceedings which resulted in the removal of her second child and has engaged excellently since then, with the key worker feeling she has made significant progress.
- 1 client had a termination due to high risk health needs.

1 client has had the youngest of her 3 children returned to her care following extensive work with Comma and children's social care. The child (who was in foster care) was returned home with a status of LAC at home, but the social worker has completed an assessment and is recommending to the court that this status is changed to Child Protection. Another client, who declined to share her data for the evaluation, also had a child returned to her care.

## Psychological measures

The evaluation includes a set of ‘validated’ questionnaires completed by clients at initial engagement and then at 6-month intervals. A questionnaire that has been ‘validated’ is one that has been developed over several years and has been tested, refined and used in various clinical and non-clinical populations which means that, as long as they are used unchanged, they are very useful for comparing clients’ scores with typical scores from similar or different populations. The questionnaires are completed by clients themselves on i-pads, although key workers are present to assist where necessary.

The questionnaires selected were ones that are considered relevant to the kinds of issues and problems the people using the service would be facing:

- Self-esteem: the *Rosenberg Self Esteem Scale* has 10 questions about self-esteem. There is a total possible score of 30 indicating high self-esteem. A score between 15 and 25 is considered ‘normal’.
- Grief: The *Adult Attitude to Grief Scale* has 9 questions about grief. The wording of some items was adapted slightly to refer specifically to the women’s’ grief about the loss of their child or children. The 9 questions are grouped into 3 aspects of grief: poor resilience, controlled and being overwhelmed
- Psychological wellbeing: the *CORE* has 34 questions which cover 4 areas of mental wellbeing: general wellbeing, problems, risk and functioning. The total score is also used to indicate ‘global psychological distress’
- Quality of life: the *Quality of Life Enjoyment and Satisfaction Short Form* has 16 questions about life satisfaction and enjoyment in different areas of daily functioning including work, home, leisure etc. The questionnaire has a minimum score of 14 and a maximum score of 70, and higher scores indicate better enjoyment and satisfaction with specific life domains.
- Interpersonal relating: the *Persons Relating to Others 3* has 48 questions about the way people relate to their friends, family and others. The measure has 8 dimensions which relate to the degree to which people are neutral, close or distant in their relationships with others. An overall score can give an indication of problems in interpersonal relating with a higher score indicating more problems.
- Trauma: the *PCL-C* is a questionnaire that is used to measure levels of trauma in a ‘civilian’ population (as opposed to veterans). It has 17 questions and a higher score indicates more symptoms of post-traumatic stress disorder.

Table 6 below shows the ‘clinical norm’ for each measure which gives the mean score on each scale from a comparable clinical group (taken from published research studies).

These provide a comparison point for the mean scores found in the group of women seen by Comma.

**Table 6: scores on psychological measures**

		Baseline		6 months			
	<b>Clinical norm (sample)</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Effect size</b>	<b>Number improved (CSC)</b>
Self-esteem	14.0 <sup>3</sup>	14.1	1.9	15.0	1.7	0.28	2(2)
Grief (poor resilience)	5.3	4.9	4.2	4.0	4.3	0.04	1(0)
Grief (over-controlled/denial)	8.0	8.9	3.7	8.8	3.7	0.19	0(0)
Grief (overwhelmed)	8.9	9.4	2.2	10.2	1.5	-0.21	0(0)
Psychological distress (overall)	1.85 <sup>4</sup>	1.9	0.5	1.7	0.3	0.38	2(0)
Psychological functioning	1.84	1.9	0.4	2.0	0.3	-0.20	0(0)
Psychological wellbeing	2.41	2.1	0.9	1.6	0.9	0.57	1(1)
Psychological problems	2.28	2.6	0.8	2.0	0.7	0.65	3(1)
Psychological risk	0.61	0.6	0.9	0.7	0.7	-0.15	1(1)
Trauma	62.3 <sup>5</sup>	63.4	7.8	55.3	10.9	0.88	3(1)
Interpersonal relating	60.1 <sup>6</sup>	56.6	13.9	56.3	11.3	-0.09	1(1)
Quality of life	55.7 <sup>7</sup>	38.3	9.9	38.5	7.1	-0.09	0(0)
Number of clients		7		6		6	

Overall, the baseline mean scores for previous recurrent care service evaluations relative to the clinical population comparators suggest that women in these services have high mental health support needs with considerable complexity and would be expected to meet the criteria for secondary care psychological treatment services. The mean scores for all measures in Comma were similar to the clinical means or, in the case of quality of life, considerably worse.

Previous use of questionnaire measures of maternal wellbeing in services relating to child removal have noted under-reporting of psychological symptoms by mothers at the start of intervention and an increase in psychological symptom reporting as the women

engage more with professionals and begin to trust them. It is therefore possible that things are even worse for these women than it appeared to be at baseline. Because there may be some under-reporting of symptoms and problems, we do not necessarily expect to see clinically significant improvements in all of these measures and may even see deterioration. However, a third of the sample improved on self-esteem and psychological distress overall; and half of the sample improved on psychological problems and trauma. These improvements were reliable statistically even if few of them moved the clients below the levels seen in clinical populations. Psychological need therefore remained high after 6 months.

## Brief case studies

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**Client A** was referred by a GP after having one previous pregnancy 10 years earlier resulting in removal and adoption. She was 33, volunteering at church, and renting. She had experienced physical, emotional and sexual abuse in childhood and had previously had an abusive partner. She was living with a different partner and long-term contraception was already in place. She was on medication for emotional problems. She had received community based treatment 9 years previously for use of amphetamines, but did not have a drug or alcohol problem at the time of referral. Her key worker felt that her main challenges were maintaining her mental health, accessing psychological therapies and accessing preparation to parenting support with no child in her care. Her main aims were to prepare for having another child by doing the required therapeutic work, improving her parenting ability, learning to maintain healthier relationships and avoiding the circumstances that led to her previous child being removed.

After 6 months, she was not working due to disability/illness. She was in a supportive loving relationship and engaged to be married, and both she and her partner were committed to accessing support. She was now using short-term contraception and planning a pregnancy. A Team around the Adult meeting had taken place which included input from a child social worker about the social work assessment process. She was still on medication for emotional problems. Over 6 months of engaging with Comma she reported clinically significant improvements in trauma symptoms as well as improvement in psychological problems, though her level of psychological need remained within the level of clinical need. She deteriorated in terms of risk, although this may represent more willingness to report risk. Other clinical areas saw no change over 6 months.

**Client B** was referred by her social worker and had had a child removed to the care of their maternal grandmother two years earlier as a result of domestic abuse and emotional abuse. She had experienced physical, emotional and sexual abuse in childhood, suffered the trauma of losing her father, and was bullied at school. She had also experienced partner abuse both within the last year and prior to that. She was 23, single, renting and not working because of disability/illness. She was not using contraception at referral so was advised about long-term contraceptives and was

considering options. She was not on any medication for emotional problems and did not have a drug or alcohol problem at the time of referral. Her key worker felt that her main challenges were her low self-esteem, confidence and mental ill health, and her vulnerability to unhealthy relationships. Her main aims were to prevent a recurrence of losing another child, to regain custody of and be a better parent for her child, to improve her mental health and go to college.

After 6 months, she was still not working. She was living with a partner but had experienced non-physical abuse within the previous 6 months. She was now using short-term contraception but not planning a pregnancy. She was now on medication for emotional problems and drugs (gas) were also a problem for her so she had been in drug treatment. Over 6 months of engaging with Comma, she reported little change in psychological measures and her scores indicated a deterioration in symptoms of trauma as well as poorer interpersonal relating and reduction in quality of life.

**Client C** had had two children removed to the care of their maternal grandmother ten years earlier. She had experienced serious sexual abuse when very young, and had experienced partner abuse both within the last year and prior to that including physical assaults resulting in brain injury. She was 33, single, renting and not working because of disability/illness. She was not using contraception at referral so was advised about long-term contraceptives. She was on medication for emotional problems. She was a regular user of cocaine and marijuana at the time of referral and was in community-based drug treatment. Her key worker felt that her main challenges were her physical and mental health. Her main aim was to get her children back and she hoped that the support from Comma would improve the chances of this happening.

After 6 months, she was still not working. She had been in a relationship for around eight months but not living with her partner and there was no evidence of domestic abuse: she described her partner as caring and protective but not controlling or abusive. She was now using long-term contraception and not planning a pregnancy. She was still on medication for emotional problems but drugs were no longer a problem for her and she was no longer receiving treatment. After 6 months of engaging with Comma, her questionnaire scores indicated clinically significant improvements in self-esteem and trauma symptoms. However, her scores indicated a deterioration in terms of being overwhelmed by grief, overall psychological distress and specifically psychological functioning.

#### **Client D**

was referred by the Prevention Alliance and had had 2 children relinquished to their father's care following domestic abuse, unstable mental health, neglect and alcohol misuse. She was 46, not working because of disability/illness, renting and in debt. She had an abusive and neglectful childhood with experience of domestic abuse between her mother and her mother's partners, alcohol misuse by her mother and the poor mental health of her mother. She had experienced financial, physical and sexual abuse from a

number of partners in the past and within the last year: the use of alcohol by both parties had often led to violence and conflict. She was separated and not using contraception so advice on long-term contraception was given and this was put in place. She was on medication for emotional problems. She had received alcohol detox treatment in the past, but did not have a drug or alcohol problem at the time of referral. Her key worker felt that her main challenges were her “chaotic” lifestyle and the risky circle of people she mixed with, poor mental health and undiagnosed cognitive difficulties. Her main aims were to have someone to talk to, to feel less lonely and fill her day, to sort out her debt, and to meet other people who have been through the same thing.

After 6 months, she was still not working. She was dating casually but in an insecure relationship with joint binge drinking and some domestic abuse. She was still using long-term contraception and not planning a pregnancy. She was still on medication for emotional problems. There was little change indicated by the psychological measures except her self-esteem saw a clinically significant improvement. After 12 months her questionnaire scores indicated clinically significant improvements in overall psychological distress, psychological problems, trauma symptoms and quality of life.

**Client E** was referred by a nurse practitioner and social worker after having a baby removed from her care two years earlier due to domestic abuse plus poor mental health and parental emotional instability. She had experienced emotional abuse in childhood and had been in care, and had experienced non-physical partner abuse within the last year. She was 19, single, renting and unemployed/looking for work. She was not using contraception at referral so was advised about long-term contraceptives. She was on medication for emotional problems. She was a cocaine user (leading to risky behaviours) at the time of referral but was not receiving treatment. Her key worker felt that her main challenges were her unstable mental health, debt and finances, and conflict with her ex-partner. Her main aim was to receive support to access mental health treatment and improve her mental health, help to manage her debts and to *“improve my life so that I can be a good parent to my daughter”*.

After 6 months, she was still not working. She was living with a new partner who was described as supportive with no known history of domestic abuse and a supportive and welcoming family. She was now using long-term contraception and not planning a pregnancy. She was still on medication for emotional problems but drugs were no longer a problem for her. Her questionnaire scores showed clinically significant improvements in interpersonal relating and psychological risk. There were also improvements (though her scores remained within the level of clinical need) in trauma symptoms, psychological problems, overall psychological distress and grief in terms of resilience. Her scores on control of grief had deteriorated.

**Client F** had had one child previously removed through care proceedings a year earlier. She had experienced physical and emotional abuse in childhood and had been in care. She had experienced physical, emotional and sexual partner abuse both within the last

year and prior to that. She was 33, single, renting and not working due to disability/illness. She was using short-term contraception at referral. She was not on medication for emotional problems. Drugs and alcohol were not a problem for her. Her key worker felt that her main challenge was resuming a relationship with her ex-partner.

After 6 months, she was a student and still single. She was now using long-term contraception and not planning a pregnancy. She was still on medication for emotional problems. on psychological measures indicated clinically significant improvements in psychological wellbeing; as well as improvements (though remaining in the level of clinical need) in overall psychological distress and psychological problems. She appeared to have deteriorated in terms of trauma symptoms, interpersonal relating and grief (both overwhelmed and low resilience).



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