research in practice
Centre for Child & Family Justice Research
University of Essex
pause creating space for change
Nuffield Family Justice Observatory

Services for parents who have experienced recurrent care proceedings: Where are we now?

Findings from the mapping of locally developed services in England

Claire Mason, Centre for Child and Family Justice Research, Lancaster University

Julie Wilkinson, Research in Practice

Dartington
Trust

www.supportingparents.researchinpractice.org.uk

Acknowledgements

We would like to give sincere thanks to all the practitioners who gave their time to be part of this project. We know how busy you all are and without your generosity this project would not have been possible. We would also like to say particular thanks to Susannah Bowyer at Research in Practice and Mary Ryan for their very helpful comments on earlier drafts.

Contents

1. Introduction

Professionals working across the family justice system have long been aware that a number of parents repeatedly appear in care proceedings. Although this issue now commonly referred to as 'recurrent care proceedings' was well known at local practice level, prior to 2012 it had been given little attention in national policy or practice.

In 2012 Professor Pamela Cox, as part of an evaluation of one of the trailblazing services, aptly referred to this as a problem with no name (Cox, 2012). Pilot research work to examine the issue had also begun at Lancaster University. In the same year, Dr Mike Shaw and Sophie Kershaw, leads at the London Family Drug and Alcohol Court (FDAC) team, organised the first of two seminars. It was the frequent reappearance of parents before the family courts that had first driven the late Nicholas Crichton, then presiding district judge at the Central London Family Proceedings Court, to champion the establishment of FDAC in England in 2008.

These two seminars hosted by the Tavistock and Portman NHS Trust in 2012 brought together pioneers from practice, research and policy-making, including trailblazing services such as Positive Choices in Suffolk, Pause in Hackney, FDAC in London, Strengthening Families in Salford and a perinatal mental health service in Norfolk. Researchers from Lancaster and Essex Universities shared findings from their early research. Thus began the start of a national programme of work.

Over the last decade there has been significant development in the field. In 2014 a team, led by Professor Karen Broadhurst at The Centre for Child and Family Justice Research at Lancaster University, secured funding from the Nuffield Foundation and began a four-year national programme of research. The findings from this large-scale mixed methods study went on to provide important insights into both the size and scale of the issue in England and also the experiences of birth mothers caught up in this damaging cycle (Broadhurst et al., 2015, 2017,2018; Broadhurst & Mason, 2017, 2020; Mason et al., 2020).

In 2014 the Pause model, developed and piloted in Hackney and led by Sophie Humphries and Georgina Perry, received significant national investment from the first wave of the Department for Education (DfE) Children's Social Care Innovation Programme, enabling the establishment of a national organisation and the scaling-up and testing of the model in seven sites.

A second wave of funding followed and there are now Pause practices covering 35 local authorities in England. The Pause National Team supports the work of these practices and the development of new Pause practices. It offers an extensive learning and development programme for Pause teams and champions the work with women who have experienced recurrent care proceedings and wish to take a pause from pregnancy. In Wales, national investment by the Welsh Government has funded the 'Reflect' services that are currently offered across all local authorities in Wales.

Similarly, funding from the first wave of the DfE Innovation Programme in 2015 led to the development of the FDAC National Unit to support the development of FDACs across England, with match funding for four new FDACs and funding for further research into the longer-term outcomes for parents and children who had been through FDAC. Funding from the innovation programme was for one year only and over this time the National Unit supported the development of nine FDAC sites.

The follow-up research established that improved outcomes for parents and children who had been through FDAC were sustained at much higher levels than for parents and children in comparison cases (Harwin et al., 2016, 2018). The National Unit obtained further funding from the DfE over the next two years, enabling it to develop a training programme for new FDAC sites, a website, a set of standards for the FDAC model, a cost benefit analysis of FDAC and a data collection tool to be used in all FDAC sites to support ongoing evaluation.

When government funding for the FDAC National Unit came to an end in 2018, the FDAC national partnership then moved to sit within the Centre for Justice Innovation (CJI), funded by trusts and private funders. In 2019, CJI was invited to assist with a further allocation of money to new areas to develop FDACs, alongside a programme of research into the model organised by the What Works Centre.

The work of FDAC was particularly significant in its work with both mothers and fathers and the piloting of 'Early FDAC', an intensive pre-proceedings programme of support and intervention for parents who had experienced removal of one or more children from their care and were pregnant again (Shaw, 2020).

A growing body of evaluation evidence on locally developed services working with recurrent care experienced parents around the country has also made a significant contribution to the field, exploring theories of change, service activities and impact. The team at Essex University has been at the forefront of this work, having now completed evaluations of four local area services in England (Cox et al., 2017, 2020). Their recent publication (part of a **Special Edition in Societies** edited by Professor Pam Cox focusing on recurrent care) provided important learning drawn from across services.

DfE funding has also supported Salford's Strengthening Families to codify and evaluate their service, as part of a programme of work to 'scale and spread' innovative practice approaches across the Greater Manchester City Region.

The national Pause evaluation by the University of Sussex, Research in Practice and Ipsos Mori (Boddy et al., 2020) evidenced that:

- Long-term trauma-informed, relationship-based intervention provides an effective means of establishing positive changes in women's lives, meeting longstanding unmet health and welfare needs and addressing significant histories of trauma and adversity, including the loss of children into care and adoption.
- There are corresponding benefits through reductions in rates of infant care entry.
- The costs of intervention are offset by significant financial savings to the public purse.

A large-scale independent evaluation of this kind is out of reach of most recurrent care services. Nevertheless, these robust findings not only endorse the work of Pause but also speak to the value of this work more broadly.

In addition to these evaluations, research by the universities of East Anglia and Lancaster has now made evident the size, scale and experiences of fathers in recurrent care proceedings and drawn particular attention to the gender issues inherent in this field of practice (Bedston et al., 2019; Phillips et al., 2020, 2021).

Despite these developments in practice and the growing body of research evidence of the moral and financial imperatives for this work, parents who have experienced one or more sets of care proceedings face a postcode lottery. As this resource will outline, there are huge gaps in provision across the country. At the same time, practices that do exist are commonly under-resourced and the fact that their work operates in a service chasm between children's and adults' services provision adds to the insecurity of funding arrangements.

In 2019 a collaboration of organisations led by Research in Practice and Lancaster University secured funding from Public Health England and The Nuffield Family Justice Observatory for a twelve-month national project comprising two strands of work:

1) **Service mapping**
   Providing the first national overview of existing, specialist services for parents who had experienced recurrent care proceedings.

2) **Developing an online Community of Practice and open access website**
   Sharing learning and developing resources for practitioners working with parents who have had children removed from their care through court proceedings.

It is the first strand of this work, the service mapping, which is the focus of this resource.

2. Methodology

Mapping recurrent care services

Scope and aims of the work

The ‘mapping’ work which informed the report was carried out between October 2020 and March 2021. The aims of the work were to:

- Identify all services across England that were specifically working with parents who have experienced one or more sets of care proceedings.
- Collate basic information about these services and produce an online directory.
- Gain a more in-depth understanding of the range of services being offered and the similarities and differences between them.

As partners in this project, the Pause National Team shared information on their English practices and about other locally developed services known to them, which fed into this mapping work. Given the investment in the Pause national infrastructure and independent evaluation, significant knowledge is available on the Pause model and impact (see: **Pause – Creating Space for Change** and **Evaluation of Pause**). Thus, beyond geographic location, Pause services were not included in this mapping work.

Similarly, whilst some FDAC practitioners have joined the Community of Practice and their expertise in working with parents with complex trauma has been drawn upon significantly, given the distinct nature of FDAC as a court-based model, they were not included in the scope of the mapping work for this project.

Given the limitations of the funding, mapping was confined to services in England. However, it is important to note that Welsh colleagues have been core members of the Community of Practice and innovative developments in Wales have made an important contribution to the recurrent care knowledge base (see, for instance, the **Reflect evaluation report** and development of in-pregnancy intensive support services such as Baby in Mind in Bridgend and Baby and Me in Newport (**see here** for more information).

In the latter stages of the work, services that were either newly emergent, or which had not been identified through earlier outreach and subsequently became known to the team, were then included in the mapping.

Methodological approach

The mapping work was carried out using a mixed methods approach. **The mapping comprised the following:**

- **Survey**

  This was sent out to all organisations known to provide recurrent care services in England between August and December 2020. The list of services was generated by reviewing the Community of Practice membership, drawing on pre-established networks of the project team and knowledge from Pause National unit. Where no information about a recurrent service was available, follow-up work was undertaken.

  Emails were sent to all local authorities where no information was held. Where the local authority was a member of Research in Practice, this was followed up via the Research in Practice partners' link officers. For non-members, the team contacted the Directors of Children's Services.

- **Interviews**

  This initial scoping was followed by a series of interviews with managers and/or practitioners from 21 identified services. The interviews offered an opportunity to build on the basic information gathered through the stage one mapping work and glean a more in-depth understanding of the range and scope of services currently being provided to parents. The following research questions underpinned the interviews:

  - Why was the service established?
  - Where in the 'system' is the service located and which organisation delivers it?
  - Who does the service work with (i.e. referral criteria)?
  - What services are being provided?
  - How are the services being provided?

All interviews were carried out and recorded via Microsoft Teams. Thematic analysis was undertaken by the two researchers and themes checked for consistency.

Interviewees

Table 1 shows the number of interviewees across the survey and interviews. A total of 14 individuals (from 13 organisations) responded to the survey. Follow-up interviews were conducted with nine of those who completed the survey. In addition, a further 12 interviews were conducted with practitioners from organisations that had not responded to the survey but were contacted directly by the team.

Table 1: Survey and interview responses

Interviewees	Number
Survey	14[1]
Survey interviewees interviewed	9
Additional interviews	12
Total number of interviews	**21**

---

[1] Two surveys were completed by two different people in the same local authority. These have not been included as separate counts in the subsequent analyses.

3. Findings

The findings presented below draw from the various elements of quantitative and qualitative data. Unless otherwise specified, detailed descriptions have primarily been drawn from the qualitative interview data.

Whilst quotes have been anonymised to protect practitioners' confidentiality, throughout the report a number of 'focus on practice' boxes have been included. These highlight particular aspects of the services.

Why were locally developed services established?

The interviews suggested many commonalities but also important differences driving the establishment of services. All interviewees described a growing imperative within their organisation to provide a service to 'break the cycle' of recurrent care proceedings as part of an overall need to reduce care proceedings being issued, and also to address the growing numbers of children entering care in England. When asked specifically about the drivers, interviewees described a range of local priorities that contributed to the development of the service.

> *One of the councillors read about Pause and wanted to do something. We set it up with [university], it was small scale as the funding came out of our budget. We went on a few visits to local authorities and had conversations with [neighbouring LA] about their service, keeping each other abreast of how we were developing the service. We set up a group with people from [neighbouring LAs] to exchange knowledge.*
>
> (Interview 12)

Most described an acute awareness of the economic costs associated with recurrent care proceedings, but also the clear moral imperative to break the damaging cycle. Some interviewees, particularly in services that had been in operation for some time, described how the narrative around the need for a service changed as knowledge from practice and research grew.

> *To start with it was a complete business model, we were a money saving project. The idea was it would cost £150,000 to fund the project but it would save the local authority money in the long-term. It came from social work but it also came from the performance board. It was part of an 'invest to save' agenda. We had accountants on board from the beginning and the model was very much around the idea that they would retrieve the data and demonstrate successful outcomes. We knew if we could divert three out of twenty of the families referred we would save money...*
> *The model was very driven by the performance data... It was also very heavily driven by adoption, siblings and the same woman's children being removed...It didn't come from a parent's rights perspective. It was more from adoption services and the focus on outcomes of children and concerns of the damage to children even before birth... Then the substance misuse service came on board and was a very powerful advocate for the experiences of women, mothers in recovery services.*
>
> (Interview 16)

Most interviewees noted an increasing awareness of the impact of leaving parents without any support after their child was permanently removed from their care by the court. The evidence for this need came from a range of sources. In some areas, data analysis provided powerful evidence of recurrence, although, for others, difficulties in accessing the relevant data to show the size and scale of local need continued to be an ongoing frustration.

Services that were set up post-2016 described their awareness of the developing field of research and practice-based knowledge and the influence this had in shaping their services. Research (Broadhurst et al., 2015; Cox et al., 2020) and subsequent work undertaken by **Research in Practice** were important drivers.

In a number of cases, interviewees described how they had first considered the Pause model before then deciding to develop their own local service. For the interviewees, the decision to develop the service locally was most commonly a combination of discomfort regarding the Pause model's requirement for women to agree (after an initial engagement period) to using long acting reversible contraception and the perceived high cost of the Pause model. That said, both initial data scoping and early conversations with the National Team at Pause and Pause practices had clearly been influential to local service design and scope.

Interviewees identified the significant role of one or more 'local champion' to the establishment of locally developed services. Champions came in many guises, including local practitioners from across the system who were able to identify the 'revolving door', and local judges who raised issues directly with local authority managers.

> *We looked at the number of women that had been through repeat proceedings – 70 per cent had had a repeat removal. One of the judges where the woman had had repeat removals said "Heads will roll if this woman comes back. What are you doing about it?" The operational manager asked to set it up. The drivers were a broader need for change - not just recurrent care practice - and particularly the judge championing it...*
>
> (Interview 17)

> *The service manager was particularly innovative and she and the manager of the parenting service had an oversight of the cases coming through... It became really evident that there were re-referrals that kept going back through the system in terms of parenting, early help, up and down the threshold constantly and repeat referrals and, within that, repeat removals of children, and they wanted to look at ways of potentially breaking that cycle. So the service manager gave the parenting manager permission to explore that and they started that work and it quickly became evident that it was a much bigger problem than first realised. They also found that the data showed that our authority was one of the worst in the area for repeat removals.*
>
> (Interview 2)

> *A former senior manager had been to a conference and wanted to do something as nothing was in place to support women who'd had children removed to reduce recurrent care proceedings... Data showed that women were having repeat removals. To break the cycle you need to step in and do something.*
>
> (Interview 19)

In all cases where the service was developed by the local authority, a strategic lead championing the cause proved critical. The portfolio of that manager within the local authority also appeared important in determining the future shape and location of the service.

Where are the services located and who is providing them?

Location and types of service available

Results from the mapping work indicate that, since the emergence of the early trailblazers such as Pause, Positive Choices, MPower, and Foundations, there has been a substantial increase in the number of services developed to support parents who have experienced one or more sets of care proceedings.

Table 2 shows the number and types of services provided across all local authorities in each region (excluding FDAC). Following significant DfE investment and the work of the Pause National Team, there are now 28 Pause projects operating in 35 local authorities in England.[2] In addition, the mapping work undertaken within this project has identified locally developed services covering a further 33 local authority areas, delivered by 29 providers, with a further five local services currently in development.

Table 2: Recurrent care services available in local authorities in each region (based on survey, interviews and email correspondence)[3]

Region	Total number of LAs in the region	Locally developed service/ in development	Pause service/in development	No service	Unknown
North East	12	0	7	3	2
North West	23	8	6	7	2
Yorkshire and Humber	15	5	4	3	3
East Midlands	10	1	2	3	4
West Midlands	14	6	1	2	5
East of England	11	4	0	4	3
London	33	8	8	12	5
South East	19	4	3	8	4
South West	15	2	4	7	2
Total	**152**	**38**[4]	**35**	**49**	**30**

Given the dearth of services a decade ago, these developments in services are to be celebrated. However, it is also important to note that in the majority of local authority areas there still appears to be no recurrent care service available. According to current data, there is no service of this kind in 49 local authority areas. Furthermore, due to non-response it was not possible to ascertain whether there was any service in a further 30 local authority areas.

---

[2] For further information on locations see: Where we work - Pause – Creating Space for Change

[3] For further information see: Services for parents who have experienced recurrent care proceedings

[4] Plus one additional service that was being delivered in three regions

Whilst FDAC is a particular and distinct approach to disrupting patterns of recurrent care proceedings, the expansion of FDAC is also important to note. There are now 14 specialist FDAC teams, working in 21 courts and serving families in 34 local authorities (see table 3).[5]

Table 3: FDAC services in local authorities in each region

Region	FDAC
North East	1
North West	1
Yorkshire and Humber	1
East Midlands	2
West Midlands	3
East of England	0
London	1
South East	3
South West	2
Total	**14**

Where in the local system are services located?

Of the 33 locally developed services that are currently operational, 24 had been developed by the local authority (in a minority of cases this had been joint funded with a partner from Health or Public Health) and the remaining nine by third sector organisations. Three of these third sector organisations delivered their service in more than one local authority area.

Based on the interview data, local authority based services are located broadly within Children and Family Services, although there is some divergence in terms of the service area. Examples of this include:

- Early help service
- Integrated health and social care service
- Intensive/specialist family support or assessment services (including edge of care)
- Special guardianship service.

---

[5] For further information on current FDAC teams see: **https://fdac.org.uk/current-fdacs**

The rationale for the location of the service varied but largely appeared to depend on the perspective and portfolio of the local champion driving the development.

Focus on practice: Location in the system

The **Time Programme** in Lincolnshire operates across Lincolnshire. There are four Time Workers based in the four localities. The team sits under the Head of Service and is managed by the Family Time and Family Group Conference Management Team. They are managed centrally by the practice supervisor who undertakes their case supervision. They also have monthly clinical supervision from a psychologist.

Strengthening Families in Salford is a discrete service, and is a key element of Salford's early help offer. Grown out of the parenting service, early help was its natural home. The decision to locate it in early help was also a recognition that many families who had experienced previous child removal felt distrust towards children's social care and a location in early help provided some important distance.

Hope project in the London Boroughs of Kingston and Richmond was originally developed as a post-adoption service for birth parents. Following the establishment of the Regional Adoption Agencies, a decision was made to move the service under the umbrella of the Special Guardianship Team. This decision was led by a desire to broaden the scope of the work to all parents who had had a child removed from their care through proceedings, regardless of the final legal order. It also preserved the separation from the Safeguarding and Court Teams, which workers deemed important.

The **Nest team** in Rochdale has adopted and adapted the Salford Strengthening Families model. The Nest model is co-located within both children's social care and early help. The Nest team social worker is the case-holder for the unborn baby and completes the pre-birth assessment in partnership with other members of the Nest team. The family support workers and the midwife in the Nest team also feed into the pre-birth assessment. The Nest team hold case responsibility for all cases unless the decision is to issue proceedings, then the case is transferred to the Child Protection/Court team following the completion of the pre-birth assessment.

Once the final hearing has been held, and if baby is not reunited with parents, then parents can access support in Nest's adult only pathway (Pathway A). Following a positive pre-birth assessment, the Nest team remain involved with the family (Pathway C) in various arenas (Child in Need, Child Protection, Public Law Outline), where support is offered for up to five years[6]. The rationale for the decision was to ensure the dedicated Nest team held decision-making power given their specialist knowledge of the family.

---

[6] For full details regarding each of the pathways please see 'Focus on practice: Strengthening Families' on page 19.

Location within the local services system

Benefits and challenges

Interviewees discussed a number of benefits and challenges of the position of their service. Those running services in the third sector greatly valued their independence from statutory services and felt this aided parents' engagement. They also discussed the flexibility afforded to them through their position, in particular the ability to respond and adapt services quickly to meet identified needs. Strategic partnerships within the third sector were particularly valued and interviewees considered themselves to possess a good knowledge of, and connections with, other third sector services in their area.

> *Because our pilot has been funded through voluntary sector monies it has meant we have been able to be more flexible than if we were a commissioned service from the local authority. So we are able to trial new things as they arise.*
>
> (Interview 21)

Interviewees whose service was located within the local authorities' Children and Family Services valued the opportunity it provided to build close working relationships with other services, in particular social workers within safeguarding teams. Some also considered it an aid to information sharing. However, this also presented an ethical dilemma for some with respect to the confidentiality of information.

> *Because I sit in an office with a lot of the social workers that are allocated to the children of women I work with it is just so easy, they can just come over to my desk and tell me if they have some concerns… but this can lead to ethical dilemmas because the women know I sit with the social worker, so they can be worried about what I'm sharing - so I have to think really clearly about what I share with social workers and who is it benefitting, and is it necessary for protection for the child. I'm much more explicit now about getting permission from the women. If I was in a separate service I think that would be easier to manage.*
>
> (Interview 3)

The majority of services, with the exception of the few who were co-located with children's social care teams, shared frustrations regarding access to information from social workers. This was most keenly felt by services supporting parents in proceedings or in pre-birth assessment/pre-proceedings.

Receiving appropriate referrals and having influence over decision-making was a shared frustration across the board. Two interviewees spoke of 'hard-won battles' to change and influence the culture of social work teams. Relationships mattered and practitioners described the importance of relationships with individual social workers and the variation in practice and attitude, even where they were based within the same local authority. These attempts at forging links were made more difficult where there was a high turnover of social workers within children's social care.

> *It is really hit and miss, some social workers just don't get it… they don't have a good understanding of [service]… I think in the main that is like most local authorities due to the turnover of staff… you can go to all the team meetings and explain it to all those social workers and then they leave. We have seen some real changes in our pre-birth processes which has helped. We have an allocated social worker now within the [assessment team] and she picks up most of the pre-births and she really gets what we do. In those cases where that social worker has those cases it really makes a difference.*
>
> (Interview 2)

> *It's taken a long time to get referrals, it was a big challenge at the start of the project. Social workers were a bit suspicious at the start - they've done a lot of work up to proceedings stage and are thinking 'what can you do with this woman that we haven't been able to do'? As we've gone on and talked to social workers about success stories it's brought on referrals and we now get them regularly. They hadn't appreciated the importance of having that space, having that time without children for that intense support.*
>
> (Interview 6)

> *Getting referrals has been difficult, social workers' priority are the children and young people and they don't have the time to prioritise referrals to us and their relationship with parents. Social workers are that overloaded and the focus is on the child and their placement at end of proceedings and we just aren't a priority to them.*
>
> (Interview 21)

Case recording, confidentiality and information sharing

Where the recurrent care team shared the same IT system as social workers, interviewees described tensions about access to records and the limits to confidentiality. In particular, interviewees pointed out the concerns that recorded information might be used within care proceedings and the impact that this would have on their ability to build relationships with parents.

This had been mitigated in some services by clear decisions not to contribute to statutory assessments, and in others by establishing information sharing protocols and introducing 'one way' access, which meant that the children's case-holding social worker and manager could not access information about the parents on shared IT systems - but that practitioners within recurrent care services could still access important information or input into children's records.

> *At the start of the programme we recorded on [the children's social care system], but we found our notes were being used towards making decisions for contact and things. Clients choose to work with us on a voluntary basis. We quickly ensured our recording was confidential and not accessed by wider children's services. Only if clients become pregnant is information shared - they [parents] sign up to this.*
>
> (Interview 10)

> *When we set up we were under the [specialist assessment team] and were branded and called it [service name] because many of the woman we work with may have identified the [specialist assessment service] as being responsible for the loss of their children, so we wanted something that was quite separate but also so we could share in the resources. So we still use the [ICS system] but they can't access our recordings and our literature and files are separate. We are open and honest, but in the first instance, we want them to see us as separate.*
>
> (Interview 17)

Interviewees described how information sharing was carefully negotiated with the parent(s) in advance. Transparency and honesty were identified as being particularly important, understanding that without this the hard won trust and the key worker relationship could be at risk.

> *We are separate to social work teams - we need consent from parents to speak to social workers and share something really important. We wouldn't give a view around parenting capacity.*
>
> (Interview 14)

Whilst a very clear boundary was drawn in relation to information sharing in some services, in others there was more flexibility. Services understood that, given the intensity of their contact with parents, they were often best positioned to contribute information regarding the parent's progress. This was particularly important for services who worked with parents who were either still in proceedings or were pregnant and undergoing a pre-birth assessment. In these instances staff would commonly attend the core group, and in some instances legal gateway, meetings, providing information to social workers.

Given the intensive nature of their work with parents, practitioners often felt their knowledge of the parents was key. Information sharing worked both ways and, in some instances, interviewees did consider their expertise and knowledge was acknowledged and they were frequently called upon to provide consultancy or specialist advice to children's social workers. However, this took time and effort.

> *The team are experienced in this [pre-birth assessment] and social workers come to us for advice now. We are experts in this field and I don't think they could do it without us now. They didn't always, but now they do listen to us - we go to all core group meetings, strategy meetings, so we are aware of every single case.*
>
> (Interview 1)

Interviewees working with families who were currently in proceedings, or in the pre-birth period, were keenly aware of the possibility of being called to give evidence within care proceedings. Whilst to date this has been rare, practitioners shared some concerns about this happening and the impact this might have on their relationships with parents.

> *We don't do pre-birth assessments, but sometimes we have to provide a report for court. We're really clear to social workers what our role is and what we do. We don't do any assessment work.*
>
> (Interview 13)

Funding

The majority of services delivered by local authorities were funded directly by the local authority (with a minority also receiving funding through health or public health partnerships) and had been included in mainstream budgets. However, given pressures on public services and local authority budgets, all were aware of their vulnerability at a time of austerity and spending cuts. A minority of services delivered by local authorities had no specific funding stream and the sustainability of the service was quite precarious, or funding was being reduced with a resulting reduction in staff.

> *We're a small team. Because of the pandemic and local authorities having to review their spending there have been changes to funding. We started off last year with 4.5 frontline practitioners. From April we will be down to 2.5, in addition to my post. We're having to make hard spending decisions on who we work with.*
>
> (Interview 14)

Whilst most services were aware of the increasing need to grow their service in response to the identified need, some were actively in the process of expanding, based upon the success of the project.

> *We're funded by [local authority]. We've been awarded more money to expand. At the moment we only accept referrals from families known to [local authority], mostly from social workers working with the family where there's a plan for adoption or the post-adoption service. We've just put a report to the Chief Exec for a clinical supervisor to be part of the service... We're looking to be a commissioned service outside [local authority] in the future.*
>
> (Interview 8)

Funding for projects delivered by the third sector often relied on a range of sources, including funding from charitable trusts as well as commissioning directly from the local authority. For example, one third sector organisation discussed the following:

> *[It's a] puzzle of funding pots across different service areas. Some are locality based, a mixture of public health, and grants. We have a good income generation team [within the organisation] but we are very reliant on this internal team. Each project has its own funding arrangements but we also have a small central pot. I'd like to build that up so we could offer more consistency across all areas.*
>
> (Interview 11)

Who is receiving a service?

Gender

Many locally developed services initially developed with a focus specifically on working with women. However, increasingly, interviewees reported a growing understanding of the need to include the woman's partner in the work whether or not they were the father of her children.

A minority of services are now also offering a service to fathers in their own right, regardless of whether or not the mother is accessing the service (see table 4).

> *So when [recurrent care service] was first developed it was very much about working with women but then we started asking "Is there any reason that we are not working with men, why aren't we doing that?" So we then worked with couples, but we made it very clear that if we are working with a couple we are still supporting them individually, so we might have sessions together but they have to commit to seeing the worker separately. I definitely do think there is a gap there, fathers are really important. It is important for us to remember the part dads' play in recurrent care.*
>
> (Interview 21)

Table 4: Who services are working with (based on interviews)[7]

Who	Number
Women only.	2
Service for woman but also work with father of the child/ woman's current partner as part of work as a couple.	14
Service for mothers and fathers in their own right, regardless of whether or not they are a couple.	5

Practitioners with experience of working with fathers were acutely aware of the need for a service for fathers. Whilst aware of the similarities between the difficulties facing both parents, some awareness of the need for a gendered approach to the work was also evident.

> *We work with partners of women and men who are not with partners but have had children removed. The majority are couples. We might be working with men individually if they are no longer with their partner. We also work with partners of women even if they haven't lost a child.*
>
> (Interview 10)

> *We're continuing trying to work with fathers. We devised a six session programme - fathers like that better - they don't like talking about how they're feeling today. If they see they are working to a structure and plan they seem to engage better.*
>
> (Interview 13)

Interviewees also identified some important barriers to working with fathers, as outlined by this interviewee:

> *It has been hard getting dads into the service, some of that is about social work culture of prioritising and focusing on work with mothers...Like there is an expectation that women should separate from men if there are any issues of domestic abuse...Fathers are just sometimes seen as the cause of the problems rather than needing help in their own right.*
>
> (Interview 5)

---

[7] Data from the survey on who services worked with was insufficiently clear to include here.

Age

National research has shown that men and women who become parents as teenagers are more likely to experience recurrent care proceedings. Working with younger parents is therefore common across services. Whilst interviewees identified this cohort of parents as being particularly in need of support, they were also aware of the challenges of trying to successfully engage with them, particularly if the young parents were care-experienced themselves.

In an attempt to address this identified need, Leeds City Council made a decision to design their recurrent care service specifically for young parents under the age of 25.

Focus on practice: Futures, Leeds City Council

Futures is an intensive outreach service for young parents under the age of 25 who have experienced care proceedings and the subsequent removal of an infant (under 12 months).

It was set up in December 2017 with a defined remit of:

- Preventing repeat proceedings.
- Improving life circumstances of young parents who have experienced the loss of a child through care proceedings.
- Improving physical, emotional and mental health of young parents who have experienced, or are experiencing, care proceedings.

Futures is a small multi-disciplinary intensive outreach team consisting of 5.5 full-time posts. Practitioners hold small caseloads of no more than eight cases, enabling intensive contact with parents. It operates within the auspices of the Leeds Practice Model. Futures offers a range of interventions and activities, from very practical support to direct therapeutic work, depending on identified goals and individual needs.

Ethnicity

Interviewees noted that the majority of the parents they work with were from White British backgrounds, with few parents from Black, Asian and minority ethnic communities either being referred into or accessing the service. Interviewees commonly felt that the cohort of parents in their service did not reflect local demographics. However, when asked, few interviewees knew whether the ethnic backgrounds of parents accessing their services reflected the ethnic and cultural background of parents who had been party to care proceedings issued by the local authority.

This comparative data is an essential starting point if services are to identify, and subsequently address, barriers to parents from Black, Asian and minority ethnic communities. Interviewees from across the country identified this as an issue that needed exploring further.[8]

> *It's mostly white women. We've only had one referral for a South Asian woman. There's a large South Asian and Eastern European population in [local authority] and a high population of Irish travellers.*
> (Interview 3)

> *[We work with] parents from a range of cultural backgrounds. I would like to find out more about whether parents that get referred reflect the care proceedings population.*
> (Interview 14)

---

[8] A starting point for analysis of this issue is through the Child Welfare Inequalities App. This includes data on children looked after rates by ethnicity at a local authority level, which may be compared with local population data on ethnicity. See: **https://webb.shinyapps.io/cwip-app-v2/**

When are services working with parents? Timing of intervention

The majority of services focused on working with parents post-proceedings. Interviews suggest this focus was influenced by findings from national research and by the strong profile at a national level of the Pause post-proceedings model.

National research has clearly highlighted that short birth spacing is common for parents in recurrent care proceedings and, subsequently, very short intervals between the end of one set of care proceedings and the beginning of the next. Consequently, parents have very little time to access the necessary support and evidence sufficient change (Broadhurst et al., 2015, 2017, 2018; Cox et al., 2014).

Table 5: Timing of intervention (based on interviews)[9]

When	Number
Post-proceedings only.	8
Post-proceedings with 'light touch' before final decision.	7
Pre-birth, in-proceedings and post-proceedings.	6

Interestingly, a number of interviewees described the trialling of 'light touch' support services for parents during proceedings in situations when there is a high risk of the child being permanently separated from the parent's care. Whilst there was an understanding of the complications of working in proceedings and services moving 'upstream' in this way, there was also recognition that, once proceedings ended, many parents took such an emotional downturn that it was more difficult to engage them at that point. There was a hope that, by offering some initial support within proceedings, they may be able to form a trusting relationship with parents on which to build post-proceedings, maximising the chances of receiving support and preventing a quick subsequent pregnancy.

> *It's generally after the final decision [that we start working with them] but we were losing some clients as they would be pregnant again before we managed to work with them. So now we offer a light touch service prior to the final decision, which means we can access contraception for the client to prevent further pregnancy and start to develop a relationship.*
>
> (Interview 10)

> *I came in [as manager] and didn't understand why we weren't getting involved at an earlier point and supporting women who were in proceedings where they have had a previous child removed. What is the point of waiting, who benefits from that?...It's the difference between coming out of proceedings and feeling like you have worn a blindfold all the way through, compared to coming out with your eyes wide open having understood what has happened and then you already have someone alongside you who literally walks out of the court with you and says "OK, so what next, what are we going to do?", rather than waiting for six months to offer help.*
>
> (Interview 11)

---

[9] Data from the survey on the timing of intervention was insufficiently clear to include here.

Pre-birth programmes

A number of services that were originally set up to work with parents post-proceedings reported continuing to support parents if the woman became pregnant again. However, in addition to this adaptation to need, a number of locally developed recurrent care services have developed their service with a specific focus on working with parents who have experienced the removal of previous child(ren) from their care and are pregnant again.

Authorities such as Walsall, Salford, Tameside and Rochdale have recognised pregnancy as a key time for motivating change and have developed bespoke services for this cohort of parents[10], supporting them intensively through the pregnancy and post-natally, whether or not the baby stays in their care.

Focus on practice: Strengthening Families, Salford

Strengthening Families is an intensive early help service for parents - mothers and/or fathers - who have had at least one child removed from the family home and taken into care by the courts. Initially developed as a specialist pre-birth service for parents with experience of having a previous child removed from their care (Pathway B), the programme has grown and developed, and now provides support in three different ways at three different stages in parents' lives after court proceedings:

PATHWAY A: Post-proceedings early intervention and prevention.

PATHWAY B: Pre-birth pregnancy support and preparation for social work assessment.

PATHWAY C: Post-birth family support through to school readiness.

As well as providing direct intensive support to parents through key-worker relationships, the Strengthening Families team work in partnership with a wide range of service providers to access and coordinate the specialist help these vulnerable families need.

Following investment by the DfE, a development worker is supporting the spread of the model to other local authorities in the Greater Manchester area. Star in Tameside and Nest in Rochdale are both underpinned by the Strengthening Families model.

---

[10] Whilst Wales was not included in this mapping work, there has also been important innovation work in pre-birth support in Newport, Swansea and Bridgend.

Service length

Whilst most services had a defined period of intervention on paper (typically 18-24 months), in reality defining an end-point was complex and a more flexible approach deemed necessary. One reason for this was the time taken for initial engagement. Interviewees discussed the difficulties faced by some parents in accepting the offer of support and understood that building trusting relationships with parents often takes some time. Whilst they saw this as core to a trauma-informed approach, it inevitably made predicting the length of intervention more difficult and consequently impacted on caseload management.

Defining an end point was also complex. Interviewees frequently described a 'tapered service' where intensity of contact decreased slowly. Interviewees commonly stressed the importance of making sure there is no 'cliff-edge' when support ends. For most services, supporting parents to make links to community-based organisations and services was an important part of the 'ending work'. The need to keep the door open to parents should they require support, albeit in a much more limited way, was also recognised as important.

> *There is no set timescale, they [parents) do get a relationship with [the worker] because in [parents'] eyes they are the only ones who are there for them. But we do have to be careful that there isn't a reliance on the worker and we have to start pulling away and really build on those community resources.*
>
> (Interview 13)

> *On average I would say we work with women for about 18 months, sometimes shorter and sometimes longer. We will say we are a service for life, because although we will close, we offer a tapered service to every woman. As the support plan is being completed we will taper off our service but, even once we have closed, they all have our number and they will contact us if they need a bit of help – say, for example, with their letter-box contact or they have something they don't understand. We would much rather someone came back and asked us for help. We don't open them back up, but it's important to be there.*
>
> (Interview 17)

In some interviews the importance of having defined goals for the intervention and avoiding drift was emphasised:

> *We typically work with women for six to nine months. I think sometimes, though, there is some drift in the work they are doing, which isn't fine...What we don't want to do is just perpetually renewing and changing the goals once one set is achieved, because the reality is that for this client group there will always be goals that they need support with because they have lived a life of trauma and will always need support, but there comes a point when it is no longer healthy for us to be the ones doing it. We have to have an ending in mind from the beginning and make part of the goals the scaffolding of support they need to be able to move on from our service.*
>
> (Interview 11)

However, for others, the nuance of the work and the need to work at the parents' own pace made this much more challenging:

> *How do you define this work? In the end I think we are offering a service that says we will hold you in mind. We hold your experiences in mind. We know some of what has happened to you. We do that narrative work, helping them to transition from the then time to the now time without making judgements about how long that journey should take. I think it is a therapeutic service, defined by the women really. It is very nuanced.*
>
> (Interview 16)

What is being provided and how it is delivered: Service models and approaches

The survey responses and interviews have provided important insights into the development of local services and how they have evolved over time. Whilst, as discussed, there are important differences between services - what is provided, to whom and at what point - the qualitative interviews also suggest a shared set of core components (see table 6).

Table 6: Core components of recurrent care services

Core components
> Trauma-informed. > Recognition and acknowledgment of parents' loss and grief. > Relationship-based. > Therapeutic and practical support. > Assertive and flexible outreach work. > Person-centred and client led. > Sexual and reproductive health. > Developing healthy relationships.

Trauma-informed, relationship-based practice

Across the interviews, practitioners showed an acute awareness of the parents' histories of trauma and the impact that had on both their parenting and their ability to engage with services. For many, this was core to their service design from the outset, whilst for others it has been part of their learning, developed both through their work with parents and through the growing evidence base from research and evaluation.

Whilst most services do not provide trauma therapy/interventions per se, interviewees generally described their services as 'trauma-informed' and that the relationships forged between parents and practitioners were fundamental to their work. For some, this was explicit - staff were trained and understanding of trauma was at the heart of their service. For most, however, this was achieved through the sensitive approach to the work with parents.

Interviewees emphasised services that focused on providing an opportunity for parents to experience a consistent, trusted, honest and respectful relationship with the practitioner. Some interviewees described this work as an opportunity to 'model' relationships, others referred to 're-parenting work'.

Whilst the language differed, what was common was the sense of providing a sense of security, working to achieve some stability. Integral to this was a need to move at the parents' own pace and working on their identified needs and goals.

> *A lot of parents want to talk from a position of not being shamed and judged. They also use the space to talk about things in the here and now that they're finding difficult. We meet the parent where they're at - sometimes there are very clear themes, for example around relationships, in others it's about how they're feeling.*
>
> (Interview 14)

> *The work is driven by the woman, not the referrer, it is about what that woman wants to achieve... in the early days it is about stabilisation and building the relationship and then it is about what they want, their aims and hopes.*
>
> (Interview 17)

For services working in the pre-birth period, a careful balance between working with parents' own identified needs, whilst being clear about the concerns of the local authority, required careful discussion and planning.

> *We really want to put parents at the centre of their own change, what they want to change and how they might, for example, want to manage their own behaviour differently. But, in doing that, we also need to help them understand how other professionals might view them and why they might have concerns. Like, for example, "You look and sound aggressive, and that concerns the social worker but I think you are scared. Let's look at that and think about it together."*
>
> (Interview 2)

Some interviewees described the system level challenges of working in a very different way with parents:

> *We have a lot of parents with drug and alcohol issues and when children are removed they often go off radar, things deteriorate, but the expectation of what needs to change is different within social work settings. The culture within social work is this is the pathway we want the parent to go down and there are implications if they don't. Whereas, for us, just holding them and allowing them to make their own choices is the important thing. Things such as they need to get mental health work, they need to get into substance misuse services, but then you speak to the parents and ask them if they want to get help and they say "No, I have no reason to at the moment." So there is no point trying to engage them in these services at that point. You just have to hold them and tolerate that.*
>
> (Interview 16)

Focus on practice: DAISY, Walsall - co-producing intervention plans

Launched by Walsall Children's Services in February 2021, the Daisy service is a new mentalisation and attachment-focused pre-birth and infant service. The DAISY programme is offered to parents from 12 weeks gestation for up to 26 weeks post-birth.

During the first phase of the programme, using a mentalisation-based assessment (The Adolescent Mentalisation Based Integrative Treatment - AMBIT), the key worker works with parents to co-produce an intervention plan. During these initial sessions, the key worker helps the parents to understand the social worker's concerns, alongside enabling parents to identify their own priorities for change.

Pat Crittenden's Dynamic Maturational Model process of narrative integration is used throughout this time to support parents to gain insights into their own behaviours and the trigger points that have led them to making unsafe choices, for themselves and their children. These sessions culminate in a co-produced formulation and detailed intervention plan. Clear milestones are agreed and the network required to support the change (professional and social) identified through the use of tools such as genograms and mapping.

Psychological interventions

Although the majority of services rely on referrals to mental health services for psychological interventions, a number of services have invested in staff training to enable them to provide these services in-house. This decision was driven by the difficulties involved with accessing appropriate mental health services for parents, as well as an understanding of the value of providing this work within the context of an existing trusted relationship.

Examples of therapeutic interventions offered by the service included Dialectic Behaviour Therapy (DBT), Eye Movement Desensitisation and Reprocessing (EMDR), or mentalisation-based approaches. The key to securing the investment in all these cases was senior managers who were prepared to champion the service and secure the necessary resources. In some cases this formed part of a broader organisational approach embedded across Children and Family Services teams.

Focus on practice: Psychological interventions

Foundations is a specialist recurrent care service in East Sussex, established in 2014 by a specialist nurse working within the council's specialist assessment team. Based on a key worker relational model, the service delivered by East Sussex Council offers a range of psycho-social interventions for childhood or adult trauma, anxiety, anger management and issues related to childhood attachment.

A decision was made to invest in staff training to deliver a range of psycho-social interventions in-house, as the team were aware of the difficulties that parents faced trying to access psychological interventions from adult mental health services. The team now offer Eye Movement Desensitisation and Reprocessing and narrative integration work based on Pat Crittenden's maturational model of attachment.

Breaking the Cycle is a therapeutically informed programme originally developed by the charity After Adoption as a post-adoption intervention and now adapted and delivered by Birmingham Children's Trust since 2019. Their approach is underpinned by Dyadic Developmental Psychotherapy (DDP). Theraplay is also used in parenting courses run by the team to support parents who have direct contact with their children or are considering having another child.

Key worker relationship

Core to being trauma- informed was an understanding that all intervention must be underpinned by a trusted relationship with either one worker, or a small identified team of workers. Building honest relationships with parents was seen as key across the services.

> *I think there is a very heavy emphasis now on work that is therapeutically informed, helping women make sense of their own life story… the primary thing we do now isn't signposting but it is establishing meaningful and equitable relationships and modelling what they look like, and then building on those to get to the work around goals.*
>
> (Interview 11)

Contact with key workers was frequent – typically several times a week - and through the vehicle of this relationship, parents were supported in a range of ways. Practical help was offered as part of a broader package of 'stabilisation work'. Supporting parents to reduce debt, find appropriate housing or improve their home conditions were identified as core components of the work with parents, who often face extreme financial challenges. This stabilisation work also placed an important focus on enabling access to other key services when required (for example, drugs and alcohol, mental health, sexual health, and domestic abuse services). Whilst the need to draw in other services was crucial, this was not signposting.

> *We offer direct therapeutic support to women within the service but we also act as a therapeutic link to other services - we don't just refer and hand them over, we walk with the mother through their journey.*
>
> (Interview 3)

The need for a tenacious and assertive approach to the work with parents was highlighted by the interviewees, particularly in the early stages of the work. This approach stemmed from an understanding that engagement took time and that, given the parents' difficult histories and often very negative perceptions of professionals, this work required a different approach. Engagement work was seen within the context of the parents' traumatic histories and trust was something that needed to be earned over time.

Peer support and group work

Whilst one-to-one support appears fundamental to all the services, a number of the interviewees also discussed how working in groups had become integral to their service offer. This took a variety of forms, and at different stages. Some had a specific 'psycho-educational' focus, such as ante-natal groups or parenting, while other groups provided a more informal opportunity for parents to forge new relationships within a safe space. The value of allowing exploration of their feelings and experiences through creative outlets was also greatly valued.

> *We started running groups after feedback from women. Every month was a different activity. But not many people were attending because they were working. The ones who attended came regularly - they really enjoyed having a safe space to talk to someone else who knows what they're going through, a safe space to chat.*
>
> (Interview 19)

An emphasis on 'being alongside' others who had lived experience of care proceedings and having a child removed from their care was felt to be important. Interviewees explained the benefits of such work to help with feelings of shame and stigma.

The importance of enabling parents to develop sustainable networks of support within family, friends and broader community services was highlighted as an important part of the work. In some services, peer-support groups had been developed and parents could continue to access these once they had left the service.

> *In [local authority] we're a family finding authority and model strengthening family relationships. We would work alongside them as long as is needed but, within that, we would be looking at building family networks and relationships, looking at mediation with extended family, so we could hopefully move it to a situation where the family is meeting each other's needs.*
>
> (Interview 6)

Focus on practice: Peer support groups

Comma and Cameo, Stockport Families

Cameo '*Come and Meet Each Other*' was established for women as part of the Comma service in Stockport. The Cameo group meets twice a month at the Women's Centre and other community venues such as parks, cafes, and on video. The group is facilitated by a worker at the Stockport Women's Centre seconded to Comma one day a week. The Cameo group provides a safe, welcoming and comfortable space for women to come together and share experiences. The group uses creative activities to facilitate discussion, self-expression and reflection. There are also opportunities for women to become peer mentors and offer support to newer members of the group.

Mothers Living Apart from Their Children, Women's Centre Kirklees

The Mothers Living Apart from their Children service is delivered by Kirklees Women's Centre, as part of their Mental Health and Wellbeing Service. Group work is core to the service and the 'Mothers Apart' group is supported by the service's facilitator. This peer group provides an important opportunity for women to meet to share experiences in a variety of ways. In addition, a 'Making Sense' group supported by peer mentors from the service provides a series of structured activities for women new to the service. The use of creative arts is an important aspect of the groups and has culminated in two books ***In Our Hearts*** and ***I had to Dig Deep***, in which women share their experiences through the use of artwork, stories and poetry.

One service was considering setting up group work for parents whose children have been removed and are currently in care proceedings.

> *We have been looking at group support and whether to open that up to parents in care proceedings, who haven't got their children with them but haven't had the final court hearing. Part of that was to try and capture that bit where it's difficult to talk about the service when they're in proceedings, and if you talk about it straight after proceedings they're quite upset and angry so it's not the best time. If we offered that we could offer them support in sharing their feelings at the group, and also it would be a way into the service if they needed it as they'd already know people who are part of the service.*
>
> (Interview 6)

Practitioners also pointed out the challenges of running groups and the need to ensure that they were offered at the right point. The need to take care in properly planning and supporting parents, both before and after the group, was mentioned by some of those interviewed. For others, the idea of running groups felt fraught with tension.

> *The view here is that this [key worker] relationship is for each woman with a person that is especially for them. For some it's the first time in their life they've had a relationship just focused on them. If we had a group - what does it feel like sharing the worker with other women on the programme? It might cause some anxiety around confidentiality.*
>
> (Interview 12)

Parenting and pre-parenting work

Whilst most services were primarily working post-proceedings with parents who no longer had children in their care, parenting work was still seen by some services as a core part of the offer. There was a recognition that some parents still had contact with children, either through supervised or unsupervised family time sessions, or because they were placed within the kin network and had been granted ongoing contact. In both instances, the services had quickly realised that parenting work was important to help ensure contact with children was as positive as possible for both the child and the parents.

> *Even if the children are not in the parents' care, we need to help that parent to still be the best parent that they can be…That might be through helping them write a letter, prepare for a face-to-face contact or work on their relationships with their families if they are caring for their children. This is so important to the parents' self-esteem as well as obviously better for the children longer-term. We also want to help parents hold onto the memories of their children. A lot of them talk about wanting to feel prepared for if one day they have contact with them again. The parenting doesn't go away, it is in everything we do really.*
>
> (Interview 2)

For those services working with parents who are currently pregnant, preparation for parenting formed a core part of their work. Practitioners understood that the shame and stigma associated with having previous children removed from their care made this work particularly sensitive, and adaptations were made to evidence-based parenting programmes to ensure they were tailored to the needs of this specific group. In most services this work was delivered as part of a group programme with follow-up one-to-one work. A focus on building attachment with the unborn child through psycho-educational input was key. Mentalisation explicitly underpinned the approach in some of these services.

Most services recognised the need for women to avoid short interval pregnancies and took an assertive outreach approach to contraception. However, some interviewees also discussed the need to acknowledge parents' desire to have further children and to help them prepare for that.

This pre-conception parenting work has been driven by the parents expressing the desire to have another child and their anxiety about the risk of experiencing another child being removed from their care. Whilst ethically challenging, the practitioners from these services described a moral imperative to respond.

Focus on practice: Pre-conception parenting work

Foundations in East Sussex use the Incredible Years parenting programme, but have adapted it specifically for parents in their service. It is primarily focused on forward planning but includes specific sessions aiming to promote reflection on past experiences of parenting.

Different Futures in Warwickshire has linked up with the parenting assessment team so that a pre-pregnancy assessment can be completed. Through this, parents can find out how much progress they've made and if they still need to make changes. The assessment helps them to make an informed decision about pregnancy at that specific time.

Comma in Stockport has used a family group conference model to help parents reflect on their own progress and get feedback from their own network of trusted family, friends and professionals to help them decide whether they are in the right place to try for another child. This approach puts parents at the heart of their own decision-making, whilst helping them to draw upon trusted networks of support. The local authority has also piloted a pre-conception assessment to help inform the parents' decision.

Evaluation and measuring outcomes

Given the funding and sustainability challenges faced by services, evidencing outcomes was a key concern for many. Whilst many used a range of goal-based outcomes, they were aware of external pressures to be able to evidence the cost saving benefits of their services.

> *We're using the Outcome Star - project workers felt they needed to be able to measure progress made and also have a forum for goals and make it very visual for clients so they could see progress. We use [software] - we can track all our data on women - how many women we're working with, how many are men, how many are accessing therapeutic services. We can provide information very quickly.*
>
> (Interview 10)

Four services had had an external evaluation led by the University of Essex, whilst a further five spoke of internal evaluations. Whilst all those who had received an external evaluation felt it was beneficial in terms of demonstrating impact and helping secure funding, the costs involved with an evaluation were noted as a barrier.

Even where there had been no formal evaluation, services were using a range of measures to demonstrate impact to senior managers. For example:

- anonymous surveys for clients to provide feedback on the service
- continuous monitoring of presenting issues
- how many take up the service
- progress towards goals
- pregnancy and outcomes following this
- access to partner agency services
- success stories
- cost savings.

Workforce conditions

Many services, particularly those that have been established for a number of years, recognised the importance of providing practitioners with the 'right conditions' for practice, and that this was in many respects as important as what was offered. The intensity and emotionally demanding nature of the work was clearly recognised by all those interviewed. However, the ability to create conditions that support practitioners differed across the services. As demands grow and budgets are threatened, there was a risk that, even where they did exist, these conditions could be compromised.

Caseloads and capacity

Keeping caseloads low was noted as important across the interviews. The typical number of cases appeared to be around eight to 12 per full-time worker. There was, however, an acknowledgement that different phases of the work required different levels of intensity of contact, and that this meant some flexibility was possible.

> *[We have] 20-30 cases. It's a lot, but when you look at the cohort they're not all engaging at the same time - sometimes they drop out and come back. It's about the relationship and trying to keep the momentum going.*
>
> (Interview 13)

Whilst there was a shared commitment to these approaches, it was also evident that, for some, the capacity of the service was a concern. Protecting caseloads posed a particular challenge because of limited resources, small teams and external demands, which placed managers and practitioners under considerable pressure. Balancing the need to protect the flexibility, reliability and availability of the worker to the parents with whom they worked, alongside meeting growing demand, was a challenge for some.

> *We have just made the decision to close our waiting list. My caseload should be about 10-12 and at the moment I'm carrying 24. So, one of my frustrations is that I can only really maintain women and am not doing any in-depth constructive work. We also have seven women on the waiting list.*
>
> (Interview 3)

Having smaller caseloads meant that some services had a waiting list, which was exacerbated by delays to care proceedings as a result of COVID-19. In some services, the ethical dilemma of putting parents on a waiting list was felt acutely. This was most keenly felt in teams involved with women who were currently pregnant. In an attempt to mitigate this, in one service they offered a 'consultancy' service to case-holding social workers where they were unable to work directly with the woman.

Other services had managed to avoid having a waiting list by utilising staff in other teams, or offering an arms-length service while waiting to work intensively with women/parents.

> *We've never had a waiting list. We really utilise services. If we're at capacity - we haven't been so far as we have other project workers to soak up that capacity. If we had a waiting list it completely defeats the purpose - people on the waiting list are very likely to get pregnant before anyone can pick them up. We have a sister service - birth family support. If we're struggling to manage capacity that service can offer emotional support. Some clients go through that service first and they refer on to us when they feel they are at a point to start working on issues, but they don't offer the same intensity.*
>
> (Interview 10)

In cases where the service was seen as a 'success' by the local authority, some practitioners described an increasing pressure to 'stretch' their service criteria. This caused concerns about 'diluting' the service because numbers became too high or because the specialist nature of the work was lost.

> *The tension is that because we are under scrutiny, because we are now being seen as a successful service and because we do offer a long-term service, we don't have the same flex in our capacity. They want us to widen our criteria to take on other families seen as high risk and 'work our magic'. So, they are asking us to take on families who are in proceedings and first time, high risk mothers. We are prepared to take on test cases but it is too early to widen it too much. We are under pressure, but if they want us to extend our criteria it can't be so vast that we are not doing what we do best.*
>
> (Interview 2)

The teams

Teams were commonly small (typically ranging from one to seven people, both full and part-time) and made up of staff with a variety of backgrounds and experiences. Interviewees suggested that staff teams with varied expertise were particularly helpful. For example, staff had been employed in a range of previous roles before joining the service: family support and parenting work, health visiting, domestic abuse, drugs and alcohol, play therapy, sexual and reproductive health services. In most cases this variety was seen as a huge asset and provided opportunities to both skill share within the team and also ensure parents' needs were matched with workers with the most appropriate skillset.

Some interviewees noted the lack of social work experience in their team. In some cases this was seen as a recruitment issue – often associated with the salary scales being too low to attract qualified social workers. However, most interviewees considered the values and qualities that workers brought to the role to be just as important as their professional backgrounds.

Most services had a dedicated team whose sole focus was to work with this group of parents. However, in some local authorities the team manager oversaw a number of services and, in a small number of instances, recurrent care work formed only part of the practitioner's job role, which presented some difficulties.

> *The team is small, there are competing demands and the workers have been really clear that [recurrent care project] work has to be something you can devote your time to. Whether it is half of your working week and then the other half of your week is split with the other tasks, there has to be some defined time that's just set aside for such a project like this. The work has just taken a hit really.*
> (Interview 15)

> *They do [recurrent care service] work alongside other work. Six workers work with two women at a time. Six zero hours staff also manage one to two women at a time in addition... We've extended to make it compulsory for all children and family workers to take at least one [parent who has experienced recurrent care proceedings].*
> (Interview 12)

Supervision and support

Supervision was highlighted as crucial for creating a space for reflection and for emotional containment to manage the intensive, therapeutic nature of the work. As well as individual and group professional supervision within the team, some services had recognised the need to offer clinical supervision to staff. In the minority of services who had invested in this, it was seen as hugely beneficial, providing a clinical lens to the work with parents and additional support for themselves as required.

> *We have psychologists within our teams - they will meet workers every six weeks for clinical supervision and are also available for workers if they've got a case they are struggling with...They do a lot of trauma-informed training.*
> (Interview 1)

The opportunity to meet with others doing similar work was also noted. Even where services were small, interviewees pointed to the presence of a strong team culture with a shared value base. An identity as a service that set them apart from others, particularly if based within Children and Family Services, was also a common feature. All the services interviewed except one had their own name, carefully chosen to reflect the ethos of their approach.

The benefits of co-work, where two members of the team are allocated to each parent, were also highlighted in some teams, and offered opportunities to bring different skills and balance the intensity of the work. However, this was sometimes challenging and could potentially undermine the consistency and reliability of the relationship.

The risk of isolation in this work was evident, particularly for small services based within Children and Family Services. Making time for support was seen as difficult alongside the pressures of the day-to-day work. The support offered by the Community of Practice that was set up as part of this project was valued by those who were members.

> *I love it, it supports us to think and learn, and we can take our anxieties there...Having emotional support is helpful so you're not isolated. [A difficulty is] I sometimes can't spare the time. It's a dilemma in which one to go to. The message board between sessions is helpful.*
> (Interview 3)

Partnership working

Services recognised the need for the key worker to help parents navigate their way through the broader health and social care system, and access support for the range of issues they so commonly needed support with. Services also recognised the benefits of establishing strong professional relationships with partner agencies. However, depending on the local context, the level of success in accessing services varied.

Accessing adult mental health services was identified as particularly challenging, with practitioners themselves finding the system difficult to navigate. Interviewees often felt a high level of frustration that parents rarely met the criteria, despite their very obvious needs. Sometimes this was because of complexities where parents had both substance misuse and mental health difficulties, which led to both services declining help because they required the other problem to be resolved before any treatment could be offered.

Similarly, diagnoses such as borderline or emotionally unstable personality disorder became barriers to accessing services. In other instances, specific recommended psychological treatments were either not available or had significant waiting lists.

> *Mental health and housing are a real struggle. There is no interface with adult mental services, so you go as an outsider. The setup is so complex and you lose contacts - I don't know how to navigate it, so women don't have a chance. Services are also short-term and the funding goes. Housing challenges are similar. You need a main person and a relationship. There is no named person, no phone number - you have to go through the web. The mental health threshold is so high. There is inequality in perinatal and infant mental health services - you can only access the service if you have a child with you.*
>
> (Interview 3)

As described in the previous quote, housing was also noted as a challenge in many areas. Geography appeared a key factor, with those based in London and the south east finding this particularly challenging. Whilst some interviewees described building good relationships with housing services, issues such as universal credit, lack of housing stock and the bedroom tax all contributed significant challenges.

Sexual health services

Sexual and reproductive health, and developing healthy relationships, was described as a core component of services for women (and men). Whilst only a condition of service in one of the locally developed services, an assertive outreach approach to reproductive health was taken by most and this was seen as core to the work. In some cases, it was the ethical dilemmas associated with conditionality within the Pause model that had led to decisions to develop their own service, although interviewees noted the importance of strongly promoting parental engagement in reproductive health services.

For some this engagement was a key outcome measure for the service. The emphasis was on a sensitive approach to this element of the work and acknowledgement that this had to come after a relationship had been formed. For some practitioners, the sensitivity around this work had been particularly challenging.

> *It wasn't a condition of service and we felt very uncomfortable about getting involved in decisions around contraception. No one said what we would do with them, but contraception was seen as a key starting point because people assumed that if you had had one baby removed you had to not get pregnant to avoid another baby being removed. It wasn't a condition of service, but it was strongly indicated, and we had the sexual health commissioner on the steering group from the beginning. We developed a priority pathway route to sexual health services from the beginning. I think the journey regarding contraception is a really important one in this. It's really profound because it is so difficult to talk about with women who've lost their children. There's all sorts of power and authority and control issues in the mix. It being a conditional element of any service is extraordinary, but [they are] really savvy at working out what services want you to say and do in order to get their service, so they are very aware that if a figure in authority says they want you to have contraception, there are complications and outcomes if you don't. So it's been a really, really fundamental element of the journey. Can they risk saying no? When women do say no, they do risk being judged as reckless and irresponsible.*
>
> (Interview 16)

Allowing control and choice over sexual and reproductive health was seen as crucial for many interviewees, and a need to show sensitivity to this area of practice was key.

> *We will talk about contraceptive choices and status and if the woman declines contraception we will work with her to think about potential consequences of that choice, and try to help her think about why she doesn't want to do that. But it's complicated and we have to be really careful to respect the woman's choice. One woman said to me "My body is the only thing I've got control over and I will decide when and where I will access contraception", and that was a really striking conversation that I had with her. We did agree that every time I met with her I would bring it up in conversation and we did have that conversation but on her terms, and sometimes she didn't want to talk about it at all and I respected that. Then, one session months later, she came to me and said "Look at my arm" and she had had the depo injection. And when I asked her she said I've had it because I had given her the space to talk about it, but not put her under any pressure to get it or made to feel bad about her decisions. She said "People have been pushing me around all my life and this is something I want to be in control of."*
>
> (Interview 3)

Beyond the ethical considerations, the relationship with, and pathways into, sexual health services were key to supporting women to get advice around, and take up the offer of, using contraception. Interviewees were generally positive about their relationship with sexual health services, and highlighted the importance of their flexibility and adaptability to women's needs, for example going to meet the women in cafes or at home and arranging appointments at short notice.

> *[Sexual health nurse in LA]. It's an assertive outreach approach - she will see them anywhere... at short notice, same day if possible, anytime, anywhere. If someone is ambivalent, when we're out with them we'll just pop by the clinic. I usually tell [nurse] we're going to be out with the person and ask her to keep a couple of hours clinic based so we can pop in. Contraception and sexual health are at the core, but not a condition of service. The women we work with have so little choice, they've been controlled all their life, and it's their bodies. Contraception doesn't suit all women. We strongly encourage it but want people to make their own decision rather than force it. Most accept LARC [Long Acting Reversible Contraception] - those that don't usually accept short-acting contraception.*
>
> (Interview 17)

> *We have an amazing relationship with the sexual health team, they will come out and do home visits with us. We had one woman who cancelled seven times to have a coil fitted and, in the end, the worker said "How about I come out to the house and give her the injection until she is ready to have the coil fitted?" They are just so flexible. We are able to talk to them beforehand - some of the women have felt really triggered by filling out the forms, so now they give them to us prior and we can fill in a lot of that information in a safe space in advance and then go with them to the appointment, and they don't have to talk about things they find triggering.*
>
> (Interview 21)

One service also discussed the importance of contraception for men and their responsibilities around this.

> *We get signed consent to say they [men] understand their responsibility. We've all been trained to do pregnancy testing and condom distribution. The work involves talking to them about their responsibility within relationships.*
>
> (Interview 10)

Although the majority of services had a good relationship with sexual health services, the level of flexibility and prioritisation afforded to the parents did vary. For some, the challenges were stark:

> *Sexual health services are not as flexible as we want...they're not very adaptable processes. I don't feel we have a strong relationship. We've tried but results vary in different areas. I think it is about the way services are set up that stops this. We've attempted to get a priority pathway but it's just not forthcoming.*
>
> (Interview 11)

4. Summary of key findings

Nearly a decade on from the early research and service development on recurrent care, the first national mapping of services in England has been completed and, through survey responses and follow-up interviews, a significant amount has been learnt about locally developed recurrent care services in England. The following is a summary of the key findings based on this qualitative data:

1) Increased service coverage, more locally developed services - but still significant gaps

This mapping work has made visible the scale of services specifically developed to work with parents who have experienced one or more sets of care proceedings in England. For the first time, it's possible to see the spread of services and identify significant gaps in current provision. In particular, this work has shown the growth in locally developed services across England.

In addition to the 28 Pause practices covering 35 local authorities and the 14 FDACs, the data collected shows recurrent care services are operating in 33 local authorities across the country. These services are delivered by 29 organisations. A further five local authorities have reported that a service is currently under development in their area. Most of these services are based within Children and Family Services within local authority structures. However, there is a significant contribution from the third sector.

2) Identity and ethos of services appear more important than their location within the system

Most recurrent care services are based within local authority Children and Family Services, but in different parts of the system - within early help, children's social care, targeted interventions and special guardianship teams. A significant number are also run by third sector organisation. In all cases, interviewees identified significant benefits and challenges to their location. It is hard, then, to conclude that there is a 'right place' to locate these services.

Independence and separation from the local authority as a whole, and children's social care in particular, may help initial engagement with parents who have experienced care proceedings, but may make it harder to access information and influence decision-making. In contrast, being inside the local authority may allow easier access to internal data and other key professionals within children's social care. However, it may also lead to ethical dilemmas in respect to confidentiality and information-sharing, and may not afford the same degree of flexibility as in the third sector.

Wherever the services are based, practitioners strive to provide a service that 'feels different' to parents. Service identity, ethos and culture is conveyed through the carefully chosen and symbolic names of the different services.

3) Services share a set of core components

Whilst the services differ in size, scope and resourcing, interviewees identified a set of components they consider core to their service. These are a combination of what is delivered and the way in which the service is delivered.

a) Trauma-informed and recognition of loss and grief

Interviewees recognise that attempts to cope with complex trauma, loss and grief, underpin many of the parents' presenting problems. Whilst the knowledge, skills and resources to offer appropriate psychological interventions within the service itself vary, an understanding of the impact of these experiences on the day-to-day lives of parents is shared.

b) Relationship-based

The work is relational - a respectful, honest and consistent relationship with one or more members of the team is crucial. Typically, interviewees described this relationship as the vehicle for delivering interventions.

c) Therapeutic and practical support

Whilst most services describe their relationships with parents as ‘therapeutic’, a need for practical work is also central. Poverty, poor quality and insecure housing, and debt are pervasive and there is a focus on meeting basic needs in order to help achieve more stability.

d) Assertive and flexible outreach approach

Whilst some services try to deliver much of their work in-house, others rely heavily on other agencies to access appropriate services. This is not signposting; rather, the need for an assertive and flexible outreach approach is recognised. These components were shared in the aspirations and design of services. However, interviews suggest that the extent to which they are consistently evident in practice is affected by both working conditions and resourcing (see below).

e) Person-centred and client-led

The work is person-centred and client-led. Interviewees spoke of the importance of co-produced goals and plans that respect the person’s history and that work to agreed goals at the parent’s own pace. Shared goals were also important when the parent’s case was also ‘open’ to children’s social care teams (for example, in pre-birth assessment).

f) Sexual and reproductive health

Whilst individual perspectives, timings and approaches may differ, a focus on sexual and reproductive health is a core part of all services. In some services this explicitly included pre-conception work.

g) Modelling and developing healthy relationships

The relationship between the worker and the parent provides an opportunity to model a healthy, consistent and ‘boundaried’ relationship. This may be the first time the parent has experienced this and it acts as an important starting point to reflect on their experiences of other relationships.

4) Developing effective pathways into partner services is essential but challenging

Interviewees were candid about the challenges faced by parents trying to navigate complex health and social care systems. The offer from adult mental health services for the parents with whom these services work was a cause of particular concern. Waiting lists, thresholds and specific service criteria were all acting as significant barriers.

The need for strong relationships with other services, such as housing and reproductive health services, was also noted. Where possible, priority pathways were sought, with varying degrees of success.

5) Services have important differences

Although sharing some core components, services also have important differences that have been highlighted throughout this resource:

a) Who the service works with.

Whilst many services initially focused on women, services are increasingly working with couples and a small number are now working with fathers in their own right. There are concerns that the services may not be effectively reaching families from Black, Asian and minority ethnic communities who have experienced recurrent care proceedings. More analysis of local area data is required in order to verify this, and action is required to better understand and address the potential barriers for families from minoritised ethnic communities.

b) What they offer.

Although there are core components to the services, there are also differences. For example, pre-conception work for parents considering having another child, parenting work for parents who still have contact with their child and peer group support.

c) When the service works with parents.

The services work with parents at different points in their lives after their children have been removed from their care. Whilst many locally developed services were initially influenced by early trailblazer services, they have evolved and changed as they learnt from their work with parents.

Some services now work with parents during a subsequent pregnancy, helping to address issues and keep the baby in their care; others have begun to support parents through a subsequent set of care proceedings. The majority work specifically with parents post- proceedings when the decision has been made by the court and the child is no longer in their care.

Some services are now working at multiple points in the parent's journey. The local context and levels of available funding also played an important part in shaping the service. For example, services are now working further 'upstream' and offering support to parents through proceedings, in pregnancy and working with men as well as women, either as couples or parents in their own right.

6) Protecting working conditions is important

Interviewees recognised the unpredictability and emotionally intensive nature of the work and identified a series of working conditions necessary to ensure practitioners were able to sustain the work. Low caseloads, robust supervision arrangements and peer support were identified as important.

The extent to which these conditions were protected in reality varied. Whilst some interviewees described low caseloads and access to clinical supervision, a felt lack of support, adequate training and supervision was evident in others. Teams are small, and in some services practitioners are lone workers or doing the work alongside other roles. Worker burnout and turnover are likely if these conditions are not protected.

7) The work is hard to define and the impact hard to measure

Whilst services understood the importance of showing and measuring impact, they also remained concerned that, in the current context, many of their ‘soft outcomes’, though of great significance to the parents and their families, are both hard to measure and may not be sufficient to satisfy commissioners and funders. Interviewees suggested that some of the current outcome measures belied the nuance and complexity of the work. External evaluations were considered helpful, but hard to fund within already limited budgets.

8) Sustainability and funding are key challenges for this work

Despite the growth in the last decade, services are still relatively few in number, and the majority of them are small in scale. Whilst the interviews painted a very diverse set of funding levels and arrangements, all services felt to some extent under threat, particularly in the context of cuts to spending and austerity measures.

Even where services were being expanded, pressures to ‘stretch’ the service by broadening criteria, reducing periods of intervention or increasing caseloads were causes for concern and threatened the ethos and values some services felt essential to their approach.

5. References

Bedston, S., Philip, G., Youansamouth, L., Clifton, J., Broadhurst, K., Brandon, M., & Hu, Y. (2019). Linked lives: Gender, family relations and recurrent care proceedings in England. *Children and Youth Services Review, 105*, 104392. https://doi.org/10.1016/j.childyouth.2019.104392

Boddy, J., Bowyer, S., Godar, R., Hale, C., Kearney, J., Preston, O., Wheeler, B. & Wilkinson, J. (2020). *Evaluation of Pause*. Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932816/Pause_-_Sussex.pdf

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: Raising the profile of women who are vulnerable to successive, compulsory removals of their children – a plea for preventative action. *Journal of Social Welfare and Family Law, 35*(3), 291-304. https://doi.org/10.1080/09649069.2013.805061

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., & Kershaw, S. (2015). Connecting events in time to identify a hidden population: Birth mothers and their children in recurrent care proceedings in England. *The British Journal of Social Work, 45*(8), 2241-2260. https://doi.org/10.1093/bjsw/bcv130

Broadhurst, K., & Mason, C. (2017). Birth parents and the collateral consequences of court-ordered child removal: Towards a comprehensive framework. *International Journal of Law, Policy and the Family, 31*(1), 41-59. https://doi.org/10.1093/lawfam/ebw013

Broadhurst, K.E., Mason, C.S., & Webb, S. (2018). Birth Mothers Returning to Court: Can a Developmental Trauma Lens Inform Practice with Women at Risk of Repeat Removal of Infants and Children? In Shaw, M., & Bailey, S. (eds), *Justice for Children and Families: A Developmental Perspective, 59-67*. Cambridge University Press.

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work, 19*(1), 15-37. https://doi.org/10.1177/1473325019893412

Cox, P. (2012). Marginalized mothers, reproductive autonomy, and 'repeat losses to care'. *Journal of Law and Society, 39*(4), 541-561. https://doi.org/10.1111/j.1467-6478.2012.00599.x

Cox, P., Barratt, C., Blumenfeld, F., Rahemtulla, Z., Taggart, D., & Turton, J. (2017). Reducing recurrent care proceedings: Initial evidence from new interventions. *Journal of social welfare and family law, 39*(3), 332-349. https://doi.org/10.1080/09649069.2017.1345083

Cox, P., McPherson, S., Mason, C., Ryan, M., & Baxter, V. (2020). Reducing recurrent care proceedings: Building a local evidence base in England. *Societies, 10*(4), 88. https://doi.org/10.3390/soc10040088

Harwin, J.E., Alrouh, B., Ryan, M., McQuarrie, T.J., Golding, L.F., Broadhurst, K.E., Tunnard, J., & Swift, S. (2016). *After FDAC: outcomes 5 years later Final Report*. Department for Education. FDAC_FINAL_REPORT_2016.pdf (lancs.ac.uk)

Harwin, J., Alrouh, B., Broadhurst, K., McQuarrie, T., Golding, L., & Ryan, M. (2018). Child and parent outcomes in the London Family Drug and Alcohol Court five years on: Building on international evidence. *International journal of law, policy and the family, 32*(2), 140-169. https://doi.org/10.1093/lawfam/eby006

Mason, C., Taggart, D., & Broadhurst, K. (2020). Parental Non-Engagement within Child Protection Services - How Can Understandings of Complex Trauma and Epistemic Trust Help? *Societies, 10*(4), 93. https://doi.org/10.3390/soc10040093

Philip, G., Youansamouth, L., Bedston, S., Broadhurst, K., Hu, Y., Clifton, J., & Brandon, M. (2020). "I Had No Hope, I Had No Help at All": Insights from a First Study of Fathers and Recurrent Care Proceedings. *Societies, 10*(4), 89. https://doi.org/10.3390/soc10040089

Philip, G., Bedston, S., Youansamouth, L., Clifton, J., Broadhurst, K., Brandon, M., & Hu, Y. (2021). *'Up Against It': Understanding Fathers' Repeat Appearance in Local Authority Care Proceedings (Full Project Report).*

Shaw, M. (2021). A Proof-of-Concept Pilot for an Intervention with Pregnant Mothers Who Have Had Children Removed by the State: The 'Early Family Drug and Alcohol Court Model'. *Societies, 11*(1), 8. http://dx.doi.org/10.3390/soc11010008

Research in Practice
The Granary Dartington Hall
Totnes Devon TQ9 6EE

tel 01803 867692
email ask@researchinpractice.org.uk

Authors: Claire Mason, Centre for Child and Family Justice Research, Lancaster University, and Julie Wilkinson, Research in Practice

Research in Practice is a programme of
The Dartington Hall Trust which is a company
limited by guarantee and a registered charity.
Company No. 1485560 Charity No. 279756 VAT No. 402196875

Registered Office:
The Elmhirst Centre, Dartington Hall, Totnes TQ9 6EL

www.researchinpractice.org.uk