October 2023 | **Report**

Pilot evaluation report

POST-PROCEEDINGS SUPPORT IN GLOUCESTERSHIRE'S FAMILY DRUG AND ALCOHOL COURT

Foundations
What Works Centre for Children & Families

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Acknowledgements

We want to acknowledge the support for this evaluation which was provided by Gloucestershire County Council's Turn Around for Children Services, who provided their time and shared their experiences on so many occasions. Similarly, those working in the FDAC court and partner agencies co-operated over the two and a half years of the evaluation.

The parents who participated contributed their experiences and the evaluation was the richer for these.

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Funding and competing interests

This rapid review was funded by What Works for Children's Social Care, which is now Foundations – What Works Centre for Children & Families. The authors declare no competing interests.

About Foundations – What Works Centre for Children & Families

Foundations is the national What Works Centre for Children & Families. Foundations researches and evaluates the effectiveness of family support services and interventions, and generates the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home and lead happier, healthier lives. Foundations was formed through the merger of What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF) in December 2022.

About the NIHR Health and Social Care Workforce, King's College London

The NIHR Health and Social Care Workforce (HSCWRU) is part of The Policy Institute at King's College London. It exists to develop research knowledge in the health and social care workforce field and to disseminate findings to policymakers, service providers, employers, and patient, service user and carer groups.

ACRONYMS AND ABBREVIATIONS

CAFCASS	Children and Family Court Advisory and Support Service
CAT	Cognitive analytic therapy
CGL	Change, Grow, Live (local drug and alcohol recovery service)
CiN	Child in Need
CRAFT	Community Reinforcement Approach and Family Training
DBT	Dialectical behavioural therapy
DFJ	Designated Family Judge
FDAC	Family Drug and Alcohol Courts
FGC	Family Group Conference
GAD-7	Generalised Anxiety Disorder Assessment
OT	Occupational therapist
PAWS	Post-acute withdrawal syndrome
PHQ-9	Patient Health Questionnaire
PPS	Post-proceeding support
SALT	Speech and Language Therapy
SGO	Special Guardianship Order
TACS	Turn Around for Children Service
TSQ	Trauma Screening Questionnaire
VIG	Video Interaction Guidance

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EXECUTIVE SUMMARY

Introduction

The study consisted of a pilot evaluation of Gloucestershire's Family Drug and Alcohol Court's post-proceedings support (PPS), which has been in place since 2013.

Gloucestershire's Family Drug and Alcohol Court (FDAC) and its PPS is delivered by the Turn Around for Children Service (TACS). TACS is a co-located, multi-agency service, managed by a children's social care manager. This service case manages children's permanency plans, which is a very different arrangement from those in place in other FDACs in England. It is jointly commissioned and funded by Gloucestershire County Council's children's services and public health nursing.

PPS is integrated into permanency planning for children and attached to a Supervision Order or, where a Special Guardianship Order (SGO) is in place, a Child in Need plan. Once parents are reunified with their children and moving towards successful graduation from FDAC, the FDAC team will recommend a 12-month Supervision Order. PPS is offered by the same team that delivers the FDAC, consisting of social workers, mental health practitioners, a psychiatrist, health visitors, speech and language therapists, an occupational therapist (OT), family support workers and an administrator. The team works with a local drug and alcohol recovery service and other community services. There are two FDAC judges.

Research questions

1. **Feasibility**
   - Is the PPS model acceptable to parents and professionals?
   - Is it appropriately resourced (including time)?
   - Was it implemented as intended and as set out in the logic model for its development?
2. **Evidence of promise**
   - Does PPS maintain or change parental behaviour as predicted in the logic model?
   - Did any combinations of services impact on outcomes?
   - What, if any, were the facilitators and barriers?
3. **Readiness for trial**
   - Will it be possible to replicate the model elsewhere, either in its current form or in an amended form?

To ensure the evaluation addressed the research questions, we examined whether:

- There were variations in the support offered to families and, if so, whether they were associated with different outcomes
- The current offer of PPS was considered to be the most effective model
- Families perceive the level and value of support offered as adequate

- Families who access the PPS offered by the FDAC/Gloucestershire partnership show improvements in outcomes, including reduced relapse and placement breakdown in the period after proceedings compared with national data
- There are suitable comparison groups which could be compared with PPS in future research
- It is possible to accurately cost the provision of PPS.

Methods

- The evaluation used a mixed-methods approach including interviews, observation and administrative data analysis. Data analysed included:

  a Interviews with members of the PPS/FDAC team, as well as with key professionals such as the psychiatrist and family judges in 2020, 2021 and 2022
  b Interviews with parents when they entered and concluded PPS
  c Interviews with professionals based in services and agencies working closely with the FDAC team
  d Recording of data on all families that had been through PPS from the outset
  e Estimating resourcing requirement of PPS
  f Observation of two informal reviews
  g Examination of any PPS in other FDACs and national FDAC data.

- Interview transcripts were analysed by hand using a reflexive thematic approach. Quantitative analysis consisted of only descriptive statistics, with national outcomes provided for context.

Key findings

- The PPS model in Gloucestershire fits well with the FDAC model in place, in terms of the intervention and population. It provides a substantial package of support for parents in the months after graduation from FDAC.
- It uses the same professional and administrative structures as FDAC, which helps to avoid duplication and reduce cost.
- It is very difficult to assess implementation as much of the period during which the evaluation was conducted coincided with the pandemic.
- It was well received by most parents and regarded as a valued and essential extension of FDAC by the professionals who engaged in the work.
- The logic model focuses on a reduction in both relapse and placement breakdown but, given what is known about the timescales around recovery, it is only possible to assess the success of PPS in the years that follow, which would require robust follow-up procedures alongside higher-quality data than were available.
- When compared with other research conducted on FDACs, families who successfully complete Gloucestershire's PPS appear to have positive outcomes. However, the small sample size, varying lengths of time since PPS completion, incomplete data and the impact of COVID-19 mean we were not able to answer our research question about evidence of promise.

- The majority of FDACs offer some ongoing support to parents who graduate from FDAC, usually for a three-month period, but there is nothing as structured or holistic as that in place in Gloucestershire.
- It was not possible for this evaluation to develop a manualised approach to PPS for two reasons:
    a The difficulty of transferring Gloucestershire's model of PPS to differently configured FDACs
    b There were only 26 cases entering PPS between its inception in 2013 and the end of June 2022. This is not a large enough sample to account for the variation in individual circumstances of families.
- Any future manualisation should focus on those areas that are consistent across most of the PPS: substance misuse, mental health, family/parenting support and Speech and Language Therapy.

Discussion

The fact that the evaluation took place over two and a half years provided the opportunity to have repeated contact with practitioners and parents and reach a deeper understanding of the initiative. It is evident from their accounts and from the research on addiction and recovery that PPS is an important adjunct to FDAC and, perhaps, should be an integral part of it.

However, one of the problems with transferability to other FDACs is the unique nature of Gloucestershire's offer. Although many other FDACs were offering some element of support during the early post-graduation months, they were drawing on smaller teams that lacked the multi-professional skill base present in Gloucestershire. While they would have welcomed more resources to bolster their offer, only a few would have considered a significant shift in the nature of their FDACs or have had the structures in place to be able to do this. This makes replication of the Gloucestershire model, at least in the short term, very unlikely.

Conclusions

Professionals involved with PPS were in no doubt that it was a vital part of the recovery process and most of the parents who were seen were very relieved that it was in place to provide the support they believed they needed after the intensity of the support they received while in FDAC.

It is unfortunate that the evaluation was significantly impacted by COVID-19 and, of greater longer-term importance, by the quality of local and national data that were available. If it were possible to improve the data quality, particularly on drug misuse after graduation, it would be feasible to examine the connections between elements of PPS or to design a quasi-experimental study to compare PPS in Gloucestershire with that in place in one other FDAC site.

It is important to recognise that, as helpful as PPS is to many parents, the nature of the recovery process means it will not be sufficient for all those graduating from FDAC.

INTRODUCTION

Family Drug and Alcohol Courts

Family Drug and Alcohol Courts (FDACs) offer an alternative to standard care proceedings involving parental drug or alcohol misuse, using a "problem-solving" approach to justice to support parents to reduce their misuse issues. The primary aim is to improve outcomes for children and families, ensuring that children can either live safely with parents at the end of care proceedings or, where reunification (defined as the legal order given for the child to return to live with the primary carer) is not possible, have the best chance for permanency and stability outside the family home. FDACs also aim to reduce the risk of families re-entering care proceedings at a later date.

An FDAC "trial for change" is an individualised programme of assessment, treatment and support involving:

- Giving parents opportunities to solve their problems
- Testing whether they can do that in a timescale compatible with their children's needs
- Using resources that FDAC can be sure of accessing quickly from the network of partner agencies or its own service.[1]

During FDAC proceedings the judge holds regular court reviews with parents but without lawyers, and an independent multi-disciplinary team provides treatment and support for parents to address problems such as poor mental health, domestic violence and financial difficulties.

Post-proceedings in context

The idea underpinning an intervention after FDAC proceedings have concluded is that it would be helpful to fill the gap identified in an earlier evaluation of FDACs. Harwin et al. (2018) reported on five-year outcomes for cases heard in FDACs and found that the first two years post-proceedings were the period of maximum risk to both sustained cessation and family reunification.

Although FDAC has better success rates in terms of family reunification and substance misuse cessation than those from standard family court proceedings, the evidence on FDAC relapses points to a need for post-proceedings support (PPS), which is not surprising given that post-acute withdrawal syndrome (PAWS) can last from six months to two years after someone has stopped using drugs or alcohol (De Soto et al., 1989).

[1] See https://www.familylaw.co.uk/news_and_comment/the-fdac-trial-for-change-combining-expert-assessment-and-intervention-during-proceedings

Before the abolition of FDAC National Unit in 2018,[2] its director, Dr Mike Shaw, a child and adolescent psychiatrist and co-director of the Unit, designed a two-year post-proceedings intervention. The *Post-Proceedings Handbook* (Centre for Justice Innovation, 2018) sets out the aims of PPS as:

1. To improve post-proceedings outcomes for children and families
2. To gain a better understanding of the problems that children and families experience post-proceedings.

The innovation was based on the theoretical model underpinning FDAC – that is, Prochaska and DiClimente's (1986) concept of the "Cycle of Change". This model proposes that the modification of addiction involves progression through five stages: pre-contemplation, contemplation, preparation, action and maintenance. According to the theory, individuals may go through these stages several times before reaching sustainable abstinence and recovery. In terms of PPS, it envisages that parents will attempt to maintain any change achieved during FDAC, but that there will be some lapses requiring a further "Cycle of Change" to achieve an equilibrium.

The model suggested by Shaw assumes two groups of parents:

- Group 1 parents: "Graduates" who have made enough progress with their problems for it to be "safe enough" to end the proceedings with the children remaining in their care
- Group 2 parents: Parents who have made some progress with their problems, but not enough to have their children returned by the end of proceedings.

The approach that was suggested included:

- Supplement, rather than replace, any available treatments
- Group treatments
- Group 1 families (graduates): treatments that would put more emphasis on "addressing traumatic drivers", "strengthening parent–child relationships" and "creating a child-centred lifestyle"
- Group 2 parents: addressing "controlling risky and damaging behaviours" and "addressing traumatic drivers"
- Responses to new problems that arise in the post-proceedings period
- Family planning as an essential element of any plan.

However, while there were elements of Shaw's model in the PPS model evaluated, it was not referred to by the professionals who were interviewed, which suggests that it was not a model that was driving the service.

[2] The FDAC National Unit (FDAC NU) was part of the Tavistock and Portman NHS Foundation Trust and was established in 2015 with a grant from the Department for Education's (DfE) Children's Social Care Innovation Programme and subsequently funded between 2016 and 2018 by the DfE and Ministry of Justice. It closed late in 2018 due to a lack of government funding. Its role in relation to FDACs passed to the Centre for Justice Innovation.

Supervision Orders and FDACs

Courts may issue a Supervision Order under section 31 of the Children Act 1989 if it is thought that a child is suffering or is likely to suffer significant harm. Supervision Orders are made at the conclusion of care proceedings to support maintenance or the reunification of families. They place the child under the supervision of the local authority (LA) and under section 35 of the Act impose a duty on the LA to "advise, assist and befriend" the child. They may last for one year, but may be extended yearly to a total of three years. They require a child to be supervised by children's social care, while still living in the family home or with a relative and may direct that a child receives specific services and that the parent ensures that the child accesses them.

Supervision Orders are therefore short-term court orders that enable children to remain or be reunited with their parents following care proceedings. However, their value continues to be a matter of debate. Harwin et al. (2019) found that Supervision Orders did not automatically attract the support they required. They reported feedback from CAFCASS guardians that the support provided during Supervision Orders following families' involvement in FDAC could be more widely applied, although this also varies considerably and, in some instances, was not known. However, the authors were not convinced that this suggestion would be feasible, given the pressure on children's services. In a later report Harwin and Golding(2022) recommended issuing guidance to support a national best practice framework for Supervision Orders to lead to greater consistency of support and oversight, not least over the number of families who return to court for further care proceedings (Masson et al., 2019) and the variation in their use between local authorities and Designated Family Judge (DFJ) areas in England (Harwin et al., 2019). These studies are part of the evidence base being constructed to examine the role of Supervision Orders in children's social care. However, they attracted very little attention in the recent review of children's social care (MacAlister, 2022).

Gloucestershire FDAC and PPS

FDAC team

Gloucestershire's FDAC and post-proceedings support is delivered by the Turn Around for Children Service (TACS). The children's permanency plans are case-managed by TACS, which is a co-located, multi-agency service, managed by a social work manager and jointly commissioned and funded by children's services and public health nursing. The team consists of:

- A service manager
- Two social workers – one of whom is an advanced practitioner
- Three mental health practitioners – two mental health nurses and an occupational therapist
- Two health visitors (both part-time)
- Two family support workers (both part-time and funded through a grant from the Department for Education)
- Two speech and language therapists (both part-time)

- An administrator
- A clinical lead (minimum 0.2 FTE)
- An adult psychiatrist (sessional).

The team works with a local drug and alcohol recovery service – Change, Grow, Live (CGL) – and other community services. It accepts referrals of families from across the county's localities and children of any age from birth onwards.

At the start of the evaluation there was one substantive FDAC judge and one who stood in for that judge when they were on leave, but in 2021 a second FDAC judge was appointed. In 2019 the Department for Education (DfE) provided additional funding for FDACs as part of the Supporting Families; Investing in Practice programme.[3] Before this additional funding, the Gloucestershire FDAC court sat every other Friday morning. The DfE funding allowed this to be extended to Friday afternoons, with the intention of enabling nine more families to be supported annually. It was anticipated that there would be more Supervision Orders/post-proceedings interventions than there were during this period. As this report details, COVID-19 had a significant impact on these numbers. The funding was also intended to be used to introduce family group conferencing into the post-proceedings model, but again COVID-19 restrictions impeded this plan.

While Gloucestershire's FDAC has fidelity with the evaluated FDAC model in relation to judicial processes and parent treatment interventions (Harwin et al., 2014), TACS is more closely integrated into children's services than any other FDAC. It is the only one where social workers in the team hold statutory responsibility for the cases in FDAC proceedings. It is also unique in having a significant level of input from health professionals. Since 2013, Gloucestershire County Council has offered a year-long post-proceedings support (PPS) programme following the conclusion of proceedings. This is integrated into permanency planning and attached to a Supervision Order[4] or, where a Special Guardianship Order (SGO) is in place, a Child in Need plan. In most instances, once a case is moving towards successful graduation and reunification the FDAC team will recommend a 12-month Supervision Order. Continuing the practice in place during FDAC, a social worker from TACS has responsibility for this order, which is jointly funded by partner agencies. If an SGO is established the team will provide support to the family or friend who has responsibility for the child(ren).

The cases of any children whose parents are engaged in FDAC are held by social workers in the FDAC team throughout the process, which is not the case in other FDACs. Until recently the social worker involved with a family through the FDAC proceedings stage would stay with them as they moved into post-proceedings, taking responsibility for the Supervision Order. While this provided consistency over the whole period, the pressure of combining new cases and post-proceedings cases became unmanageable, and the roles are now separate:

[3] https://www.gov.uk/government/news/15-million-investment-to-help-keep-families-safely-together
[4] If parents asked not to have a Supervision Order, they would not necessarily be excluded if the level of risk was judged not to warrant an order.

> "The post-proceedings period can be quite tricky, so having that established relationship with families where they might be frightened to tell you that they'd messed up, but where they are possibly less frightened because they really know you is helpful… But the flipside I suppose is that sometimes I think it is good to have a fresh pair of eyes." (Team member 4)

In recent years, and particularly since COVID-19, the number of parents with significant mental health problems was said to have risen considerably. A psychiatrist is attached to the team for one day a week and, in addition to diagnostic work, she provides prescriptions for mental health problems such as depression and anxiety, but not for addictions. She also provides clinical supervision for the nursing staff with whom she does joint clinic appointments. She would usually have fewer contacts with FDAC clients once proceedings conclude, probably seeing them every two or three months. However, the benefits of having an embedded psychiatrist are reported to continue into this stage. Many family members have continuing mental health difficulties and in these cases the psychiatrist is able both to continue treatment and to provide a link with a therapist, who may become involved if there were a major substance misuse relapse or a new or recurrent mental health disorder.

Similarly, because physical health has often been neglected when someone is addicted to substances, recovery from the physical damage caused may continue into post-proceedings and the psychiatrist continues be a point of contact and support if this is needed to negotiate access to health services. In addition to the psychiatrist, there are three full-time dual-diagnosis nurses across mental health and substance abuse, although one of these roles is now filled by an occupational therapist (OT). One of the mental health practitioners is the mental health lead, overseeing testing and linking with CGL by attending joint meetings and joint reviews. In addition to these tasks, the mental health practitioners see their role as both supporting parents with their mental health and engaging more in the community, by giving them the confidence to explore their interests:

> "I feel like I'm a broker, in a way; I find out about what this person wants to do and needs to do and what they could do, and then I enable it, I make it happen." (MH practitioner)

During the time the Supervision Order is in place the mental health/substance misuse practitioners will initially visit a family three times a week, as they had done during court proceedings, but with a pathway designed to gradually reduce the number of visits to ease the transition into universal services:

> "You would not let somebody go from intensive care to discharge… you need a step-down process so you're coaching them to rely on themselves. So by the time the end of the 12-month Supervision Order is approaching, they're only seeing us once or at most twice a week so they get used to reaching out to other people they can rely upon." (MH practitioner)

Another mental health nurse observed:

> "Although the bulk of the work will have been done before the Supervision Orders start, the links with mental health services allow us to do any therapeutic "finishing-off", making sure that people are feeling equipped to maintain their recovery, and perhaps know how to access occasional top-up interventions to manage anxiety, for example." (MH nurse)

The OT joined the team when it proved difficult to recruit to a part-time vacancy for a mental health practitioner, and the team thought that OT skills would complement their own while she also undertook general mental health practitioner duties.[5] But when a colleague went on maternity leave the OT extended her hours to take more responsibility for core aspects of the team's work, which meant that the mentoring work that she had intended to develop has not progressed.

A role that is unique to Gloucestershire's FDAC model is the health visitor (HV). All families in England receive five mandated universal health visiting contacts, from pregnancy to when their child starts school, but FDAC families receive more, with the nature of the service offered depending on the age of the child. Typically, where there is a young child, the health visitor will visit weekly at the start, then fortnightly, adopting a similar pattern to the clinical pathway described above. While most of their work is with children under 5 years of age, they do conduct initial health assessments with older children and liaise with other professionals where this is needed. By the end of the Supervision Order, health visitors are probably seeing families monthly to support the transition to a Universal Plus and a Partnership Plus service.[6] They do not carry anything like the number of cases that community-based health visitors do, which helps them to build a relationship with parents during FDAC, which continues into the PPS period and even beyond:

> "So, this one family finished FDAC and post-proceedings a long time ago and, although I don't have a big role, I am still there. When their baby was admitted to hospital the parents thought they were going to be asked if they had missed a medication because they once did when they were using, so it's very much a handholding, not a classic health visitor role." (HV practitioner)

As soon as the parents come into FDAC a speech and language therapist undertakes an assessment of their children with the intention of providing ongoing support for the child, the parents or the foster carers, and/or nursery school, and this continues into PPS. Although they do not work with parents, they support their colleagues to consider the language needs of parents and encourage them to consider parents' possible language and memory difficulties that may impede their access to information. The nurses and health visitors have a manager from within the NHS who covers

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[5] The OT has written about her role – see https://justiceinnovation.org/articles/expert-voice-isobel-johnson-occupational-therapist-gloucestershire-fdac

[6] These are the two most intensive levels of a four-level health visiting service. In Universal Plus, families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children. In Universal Partnership Plus, health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs (see https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/health-visiting-and-school-nursing-service-delivery-model)

practical arrangements around performance and development reviews, as well as holiday and sickness leave, while supervision of day-to-day work comes from within TACS. They also have access to external group safeguarding supervision through the NHS quarterly.

Family support workers described their role as helping families navigate problems that occur in their lives and, in so doing, relieve some pressures on social workers. As with health visitors, they carry smaller caseloads, which enables them to work intensively with families, challenge behaviours when necessary and, sometimes, work with perpetrators of domestic abuse:

> "From experience, in other circumstances our work is diluted and less impactful, much less successful. Whereas now, we've got the time to spend with these families, with the parents, with the children… and it's making a difference to be able to work with the children separately, and with the parents." (Family support worker)

The team are trained in Community Reinforcement Approach and Family Training (CRAFT) intervention.[7]

The post-proceedings plan

During the Supervision Order, children are usually also the subject of Child in Need (CiN) plans, and a social worker's contact over these is monthly. In the first three months of the plan multi-agency meetings occur every four weeks, chaired by the case-holding social worker, and then, if appropriate, the frequency is reduced to every six weeks. As with all Supervision Orders, the focus is on maintaining a safe environment for the child(ren), but it is also designed to support parents to continue to build their recovery capital. Progress is assessed around nine months and, if necessary, an extension may be requested.

The PPS Plan is based on the final assessment conducted by TACS and tailored to the needs of the family and child(ren). This is then agreed with lawyers, the judge and CAFCASS, with input from parents and guardians. It is written into the legal documents attached to the Supervision Order and signed by the parents and the judge who will conduct agreed informal reviews throughout. Parents' participation is voluntary, as there is no basis in law for post-proceedings work. However, the report is filed to all parties, including guardians and family solicitors. The informal reviews take place at three, six and nine months. At the expiry of the Supervision Order parents may have a final meeting with the judge if they so wish. The social worker writes a final care plan/document to close the case to children's social care. If the decision is taken to extend the Supervision Order, this involves an application to the court.

In addition to the informal reviews PPS covers:

[7] A scientifically based intervention designed to help concerned significant others (CSOs) to engage treatment-refusing substance abusers into treatment: https://www.robertjmeyersphd.com/craft.html

- A named keyworker who undertakes tasks such as case management, review and permanency planning. This is usually the same social worker who holds the child's case, but occasionally this could be a mental health practitioner
- The Supervision Order Pathway Plan, which sets out individual needs and is graduated so as to reduce in intensity over the months. It includes regular visits from the mental health/substance misuse practitioners and may include psychotherapeutic intervention such as dialectical behavioural therapy (DBT) or cognitive analytic therapy (CAT), provided by external practitioners. It is accompanied by an intervention plan for parents, which details their appointments with individual professionals and agencies
- Regular testing, which reduces to random testing by the end of the first three months
- Support for parenting and relationships including Video Interaction Guidance (VIG) or Speech and Language Therapy (SALT).

The PPS offer is permissive of relapse within reasonable boundaries, expecting that this may occur in some cases, and will offer support and not necessarily immediately escalate to child protection services. PPS is also offered for those where reunification does not happen, but responsibility for the children will be transferred to a social worker outside the TACS team. The team may also offer support to those who are looking after children who have not been reunified with their parents after FDAC, such as those who have been appointed under a Special Guardianship Order (SGO). We were also told of a case of one father who was being supported to prepare to take custody of a baby, with whom he had not previously had contact, whose mother had not graduated from FDAC.

Previous evaluation

Gloucestershire's PPS has not been evaluated previously. It was not clear to team members why Gloucestershire's FDAC had not been included in the national evaluation, but they thought it was because it did not match the standard model. With the benefit of hindsight this would appear to have been an omission, especially as during the discussions that took place in this present evaluation a few FDACs expressed a preference for Gloucestershire's model over their own.

In 2016/17 the London FDAC was awarded £30,000 by the David Isaacs Fund to provide post-proceedings therapeutic support. For several reasons it proved difficult to implement the planned intervention. An alternative model was applied, which involved referrals to a family therapist. The report on this initiative is available from the Centre for Justice Innovation.

Pilot context

Much of the evaluation was conducted while COVID-19 restrictions were in place during 2020 and 2021. This had an impact on the ability to examine fidelity to the model and on the evaluation of PPS more generally, as this report details.

Pilot evaluation

The elements of the evaluation were:

a A process evaluation
b The production of a manualised version of the intervention, which would lend itself to replication by other sites
c An assessment of how feasible it would be to run a larger impact evaluation at a later date.

The project's logic model is set out in full in Appendix A and in summary in Table 1 below.

Table 1. Summary of PPS logic model

Context	Interventions	Mechanisms	Outcomes
Embedded in Glos CSC since 2013 and, as with FDAC, delivered by the embedded team in Turn Around for Children's Services. This is a co-located multi-agency service trained in CRAFT[8] working in partnership with community services	Children's cases are held throughout FDAC and PPS by a social worker in TACS. The standard process is for a 12-month Supervision Order with an offer to parents of PPS, which is voluntary	Expectations are set out in a plan and parents are clear about the terms of that agreement and accept them, including the continuation of statutory social work	Build recovery capital though encouraging parents to: • Resolve their own problems • Improve situation re housing, education • Build family and other networks • Deal with challenges of parenthood
Children will be on various orders, the most common being a Supervision Order	The PPS is agreed on the basis of FDAC experiences and following discussions with judge, professionals, CAFCASS and parents	Relevant and appropriate interventions are delivered	More families maintain recovery and rates of relapse are reduced
Requirement for family group conferences	Informal review by judge at 3, 6 and 9 months, with a final meeting at 12 months	Progress is reviewed by judge and parents keen to access these reviews	Improved care of their children and development of skills to

[9] A scientifically based intervention designed to help concerned significant others (CSOs) to engage treatment-refusing substance abusers into treatment: https://www.robertjmeyersphd.com/craft.html

			support/manage behaviour[9]
FDAC judge and another judge to provide cover in courts, which take place every other Friday	Named keyworker – usually, but not always, the same social worker holding the child's case	Support to access community services while reducing time between contacts to build self-confidence	Reduced risk of further abuse and neglect
Reunification will have happened during FDAC	Clinical intervention responding to need – regular visits from mental health/substance abuse nurse and may include continuation of therapy, usually more intensive in early months, then reducing	Action taken if there is a relapse	Reduced placement breakdown
	Regular testing continues and from three months becomes random	Parents come to TACS if relapse occurs and TACS takes appropriate steps	Return to care proceedings is avoided
	Family group conferencing offer	Offer of support following PPS	Parents are positive about PPS
	Parents work with local substance misuse service, a recovery provider and supported to contact other services		Children have an opportunity to be involved through seeing the judge with a guardian and opportunities to feedback

[9] Given the scope of the evaluation plan and available resources, it was never intended that the evaluation would cover the views of children or that details of any developmental delays or the special needs of children would be collected or measurements used.

Research questions

The objectives for the evaluation identified in the protocol are detailed below with the research questions linked to each.

Feasibility

- Is the model acceptable to parents and professionals?
- Is it appropriately resourced (including time)?
- Was it implemented as intended and as set out in logic model?

Evidence of promise

- Does PPS maintain or change parental behaviour as predicted in the logic model?
- Did any combinations of services impact on outcomes?
- What, if any, were the facilitators and barriers?

Readiness for trial

- Will it be possible to replicate the model either in its current form or in an amended form?

To ensure the evaluation addressed the research questions, we examined whether:

- The current offer of post-proceedings support was considered to be the most effective model
- Families perceive the level and value of support offered to be adequate
- Families who access the post-proceedings support offered by the FDAC/Gloucestershire partnership show improvements in outcomes, including reduced relapse and placement breakdown in the period after proceedings, compared with national data
- There are suitable comparison groups that could be compared with those with post-proceedings support in future research
- It is possible to cost accurately the provision of post-proceedings support.

We also intended to examine:

- Any variations in the support offered to families and, if there were any, whether they were associated with different outcomes
- Fidelity of PPS to the model, but it became clear that the evaluation was also intended to define the model.

However, the evaluation started as the first COVID-related national lockdown was announced. The impact of the pandemic is discussed later in this report, but the conditions that were put in place as a result of the pandemic made the examination of both areas extremely challenging. The team's work was conducted very differently as many people worked from home, at least for some of the period, and some services in the community closed and moved elements of their intervention online.

Originally, we were asked to explore why families accepted or rejected the offer of ongoing support and if there were differences in the profile of families who accepted support and those who do not. However, as all parents who graduate from FDAC in Gloucestershire are offered PPS and none had refused an offer, there was no suitable internal comparison group.

The evaluation focused on TACS work with those parents who graduated from FDAC and entered PPS. The TACS team provides support to parents who have not graduated and to family members who have taken on the care of the children of FDAC parents who were not returned to them. While this is clearly valuable, it was not covered to any great extent within this evaluation.

Protocol and ethical review

The protocol was published in August 2020 by What Works for Children's Social Care at: https://whatworks-csc.org.uk/wp-content/uploads/KCL-FDAC-Post-Proceedings-Pilot-Protocol-August-2020.pdf

Ethical approval was provided by King's College London's Ethics Committee (Reference Number: HR-19/20-17824).

METHODS

Data collection

Before the evaluation commenced in May 2020, discussions had taken place between the principal investigator (PI) and the team manager where the elements of the evaluation were explained and a plan for recruiting participants and providing data was put in place. The intended elements of the evaluation, alongside any modifications and additions, are detailed below.

a) Interviews with members of the team, as well as with key professionals such as the psychiatrist and family judge

The team manager sent all these individuals the information sheets on the project and the relevant consent form. These were either returned to the evaluation team or consent was obtained and recorded before an interview began. All the individuals were interviewed in 2020, 2021 and 2022, with each interview lasting between 30 and 45 minutes.

While there was a high level of consistency across those who were interviewed, a few individuals were not seen on all occasions either because they were on maternity leave/sick leave or because they had joined the team after the evaluation had started. While several interviews with professionals were conducted face to face, the restrictions necessitated by COVID-19 meant that most interviews were conducted by a video conferencing programme or by telephone.

b) Focus groups with those working in services and agencies working closely with the FDAC team

Given the pandemic, it was not possible to organise these groups.

The team manager provided a list of key contacts in agencies that worked with TACS. The PI sent each an information sheet and explained the process around consent, as well as the practical arrangements for the interviews. A few agencies failed to respond and it proved harder to engage others.

Again, these interviews were conducted in the three years between 2020 and 2022. While some provided valuable data, those who were interviewed sometimes had a relatively low awareness or experience of PPS. Sometimes this was a result of a participant taking up a position during COVID-19 when, as is noted later, ways of working changed considerably.

c) Interviews with parents currently in PPS and those who did not graduate from FDAC

We intended to contact all parents who had entered PPS from May 2020 and exited by June 2022, conducting the interviews as they entered PPS and then again when it ended.

It was agreed that if any parent was experiencing a crisis or had re-entered proceedings, they would be excluded from the study. Before COVID-19, the intention had been to meet parents in court, describe the project, obtain their provisional agreement to participate and arrange a time for the first interview (T1), which would have usually taken place face to face, and at which point consent would have been obtained. Once the first lockdown was announced on 23 March 2020, home working and social distancing meant that the social worker working with these families explained the evaluation, provided them with an information sheet and obtained their permission to pass their contact details to the PI.

The PI then contacted those parents who had agreed for their details to be passed on. At this point one parent withdrew and several others said they wanted to be contacted later and were then uncontactable. A date to conduct the interview (T1) was arranged with those who were content to proceed. Consent to participate was gained before the interview started. The second interview (T2) took place at the end of PPS. The interviews with parents at T1 and T2 lasted between 20 and 40 minutes.

This report covers the impact of the pandemic on practice and the numbers of families entering FDAC and hence graduating to PPS. In the period of the evaluation (April 2020 until August 2022) only six families entered PPS; one was uncontactable and two chose not to participate in the evaluation, one of whom subsequently relapsed during PPS. It was fortunate that four parents who had completed PPS in previous years were identified by the team and approached to make sure that the questions prepared for the interviews with parents did cover the relevant areas. Three of the four agreed to participate. The fourth originally agreed but withdrew as the interview started. She said that while she was grateful that she had been in FDAC and PPS, she had made so much progress and started a new life, and did not want to be reminded of that time.[10] Although these interviews had originally been viewed as an opportunity to pilot the interview schedules, given that far fewer parents than expected were participating in the evaluation it was agreed to incorporate these data into the report.

[10] Another interview was conducted with grandparents who were caring for their grandchildren under a Special Guardianship Order (SGO) when their parents had relapsed during FDAC. The grandparents were supported through the initial period by the FDAC team, under the provisions to provide support even where parents had not graduated. Although the interview contributed to a deeper understanding of the work of TACS, as noted above the evaluation was confined to parents who had graduated.

d) Focus groups with parents who received PPS between 2013 and 2019

This would have allowed any parents who had been in FDAC PPS since its introduction in 2013 to attend a series of focus groups to allow them to reflect on their experiences of PPS and any benefits or detriments they identified. The TACS team would have sent a letter to their last known address to make them aware of the purpose of the evaluation, procedures and duration, as well as details of the team, and invite them to contribute to the evaluation, while stressing that participation was voluntary and setting out the timescale and arrangements for passing their contact details to the PI. However, when the TACS team investigated the relevant database, they found that it did not contain the details needed to contact these families. Even if it had been possible, it is unlikely that focus groups could have proceeded as planned because of social distancing requirements during COVID-19 and parental preferences.

e) Examination of case records of those receiving PPS between 2020 and 2022

Given the disruption caused by COVID-19, the decision was taken to collect data on all families that had been through PPS from the outset and these data were entered in an anonymised form by FDAC team members into a template provided by the evaluators. We used published data from the national FDAC database for the period 1 January–31 March 2022 to give context to the analysis of case data.

f) Data collection on team member time and activity

Our initial intention had been to provide PDAC team members with a time diary to collect data on the exact time spent with PPS families during a specified week in early 2022. Following discussions with the service manager, it was established that much of the work of PPS was front-loaded, with resource requirements much lower at the end than at the start of PPS. Due to the small number of families going through PPS at the time it was agreed that a time diary would not accurately capture team member activity. Instead, we provided a template to capture aggregate resource requirements to the service manager and business administrator, which linked to the supervision pathway plan for PPS and requested details of the salary levels of team members to use in producing unit costs.

g) Examination of documentation on PPS that is or has been in place in other FDACs

Given the difficulties encountered in collecting data for some of the elements, the PI suggested extending this element to include an exercise across all FDACs to understand which, if any, were offering any PPS and the nature of this support. Interviews were conducted with 13 FDACs in 2021 and each was contacted in 2022 to determine whether any changes had occurred over the subsequent 12 months.

In addition, the PI observed two informal reviews in front of a judge. In view of how few parents were in PPS, there were fewer opportunities to observe other hearings and it is unfortunate that the PI was not able to attend planned hearings in the first instance because of recent contact with someone with COVID-19 and in the second because of a rail strike.

Table 2. Data collected in this pilot evaluation

	Summer 2020 Timepoint 1	Summer 2021 Timepoint 2	Summer 2022 Timepoint 3
Interviews with families	6	5	2
Interviews with members of Turn Around for Children Service (TACS), psychiatrist and judges	8 individuals Manager was interviewed on three occasions	10 interviews – 11 individuals Manager was interviewed twice	10 interviews – 12 individuals
Interviews with professionals in other agencies	5	4	3
Interviews with FDAC managers across England	-	14	7*
Data from case notes of PPS families			26 cases
Data on FDAC resources			Based on typical PPS pathway

* These were discussions that followed an email sent to all FDACs to update data collected in 2021.

Data management and processing

A data management protocol was drawn up at the start of the project. The names and contact details of parents who agreed to participate were transferred to the PI by a secure and password-protected data transfer system. They were then stored in a secure folder on a King's College London (KCL) server that is backed up every night. That folder could only be accessed by the PI. All the parents who participated agreed that their contact details could be retained so the researcher could contact them in relation to future related research. The study data will be kept for ten years

after the report is finalised and contact details for participants for four years, after which times the data will be deleted. All documentation and interview schedules are available from the authors.

All recordings of interviews were transferred using a secure file transfer system operated by KCL to a very experienced transcriber who had signed a data-sharing agreement with KCL. Identifier codes were attached to the recordings sent to the transcriber and names and any other identifying references were removed from the transcriptions. The identifiers are only known to the PI and the spreadsheet where they are recorded is held in a separate, but also secure, folder. The recordings have now been deleted.

Analysis

Qualitative data analysis

The researchers drew on Ashworth's (1987) observation that the extent to which the findings are valid depends on the adequacy of description of the process. The interview transcripts from TACS members, stakeholders and parents were all analysed by hand rather than by an analytical programme, using a reflexive thematic approach, which is particularly suited to exploring people's experiences, views and perceptions (see Braun and Clarke, 2006). It allowed the identification of patterns through data familiarisation, data coding, theme development and revision. The first stage was for two researchers to read and open code each transcript in line with the areas explored in the interview schedule and then to move on to identify further themes and categories that emerged from the data. This is an iterative process conducted between researchers to verify, confirm, expand upon and qualify these elements. Validation was also tested through triangulation of data, in this case by collecting data from different sources and doing this at different time points. These different perspectives allowed the evaluators to gain a detailed understanding of different perspectives and experiences.

Quantitative data analysis

The anonymised template used for collection of the quantitative data on PPS cases was based on the existing data collection template provided by the Centre for Justice Innovation (CJI) as part of the National FDAC Database. We amended it to included additional information on PPS-specific data. Data on PPS families were cross-checked with both the Gloucestershire national FDAC submission and national FDAC data and any concerns were raised with the TACS business administrator to ensure accuracy.

Where possible, we used the same outcome analysis approach as the CJI for the National FDAC Database. Due to the small sample size, the impact of COVID-19 and the lack of any directly comparable data (as the outcomes of PPS would occur 12 months after the outcomes recorded by other FDACs), we have provided descriptive statistics only alongside national outcomes for context only.

Data on resource use were captured both in the template described above in relation to which services each parent had received, and directly from the TACS team in the form of a resource requirements template. This enabled us to estimate the number and type of interventions involved in a typical case, the staff involved and an estimate of the time spent. Data on staff salaries was not available so we used unit cost data from the Personal Social Services Research Unit (Jones and Burns, 2021) to provide an approximate cost of PPS provision per family.

The national FDAC database has only been reporting FDAC case data since the beginning of 2021, which would have resulted in a very small sample of PPS cases within Gloucestershire if the comparable time-period were to be used for PPS cases. As such, in the following sections we have provided figures for all PPS cases and, where appropriate, provided the comparable figure for context from the latest available national FDAC figures for 1 January–31 March 2022.

EVIDENCE

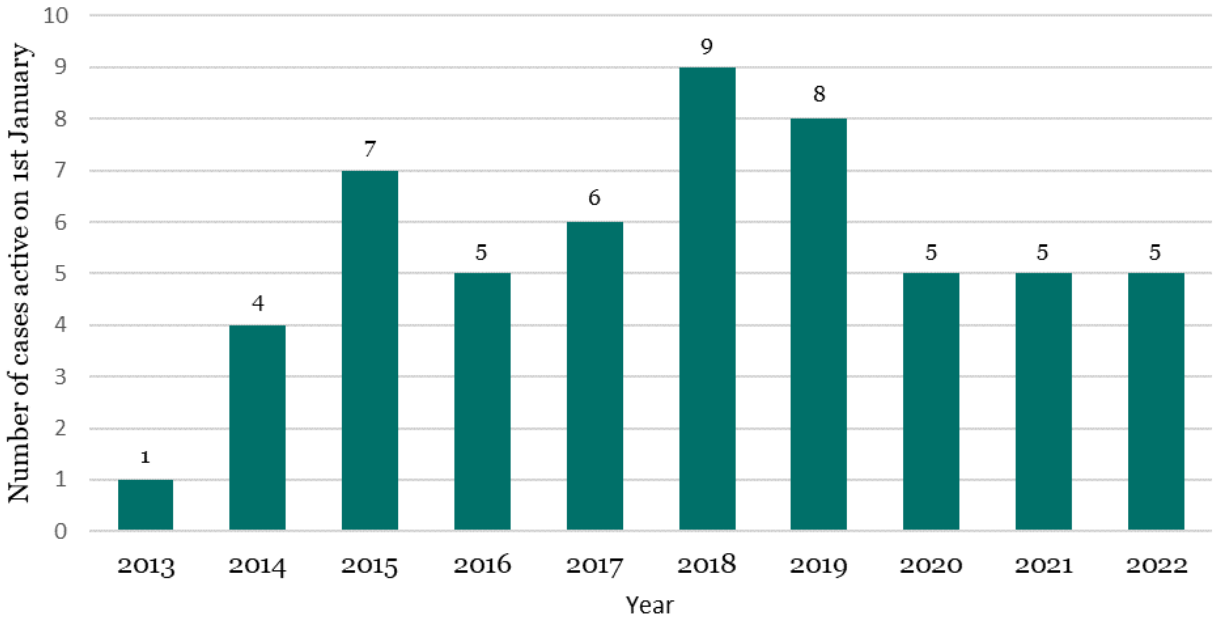
Case flow and family profiles

Case flow

The first PPS started in Gloucestershire in December 2013 (following the initial FDAC, which commenced in March of the same year) and up to the end of June 2022 there have been 26 FDAC cases that have entered PPS in Gloucestershire.[11] In the same period, there have been an additional five cases in which neither parent graduated from FDAC but some additional support was provided by the TACS team after FDAC had ended. These have not been included in any of the following figures.

There were five PPS cases in progress at the start of 2022, as shown in Figure 1. This is the highest number of active cases at the start of the year since 1 January 2018.

Figure 1. Gloucestershire's PPS cases in progress on 1 January each year



Since 2017, there were typically three to four PPS cases starting each year in Gloucestershire. This figure was slightly lower in 2020, when only two cases started, possibly due to the impact of

[11] In addition, there have been two cases starting PPS since the end of June 2022.

COVID-19. Since the start of 2021 to 1 July 2022, four cases have started PPS, as shown in Table 3, although this figure does not include two cases that have started PPS since the end of June 2022.

Table 3. Cases starting and ending Gloucestershire's PPS in 2013–June 2022

	PPS cases started in year	PPS cases ended in year	PPS cases ended successfully by at least one parent
2013	1	0	0
2014	3	0	0
2015	3	4	4
2016	2	3	3
2017	4	1	1
2018	4	3	3
2019	3	5	3
2020	2	4	4
2021	3	1	1
2022	1	5	3
Total	**26**	**26**	**22**

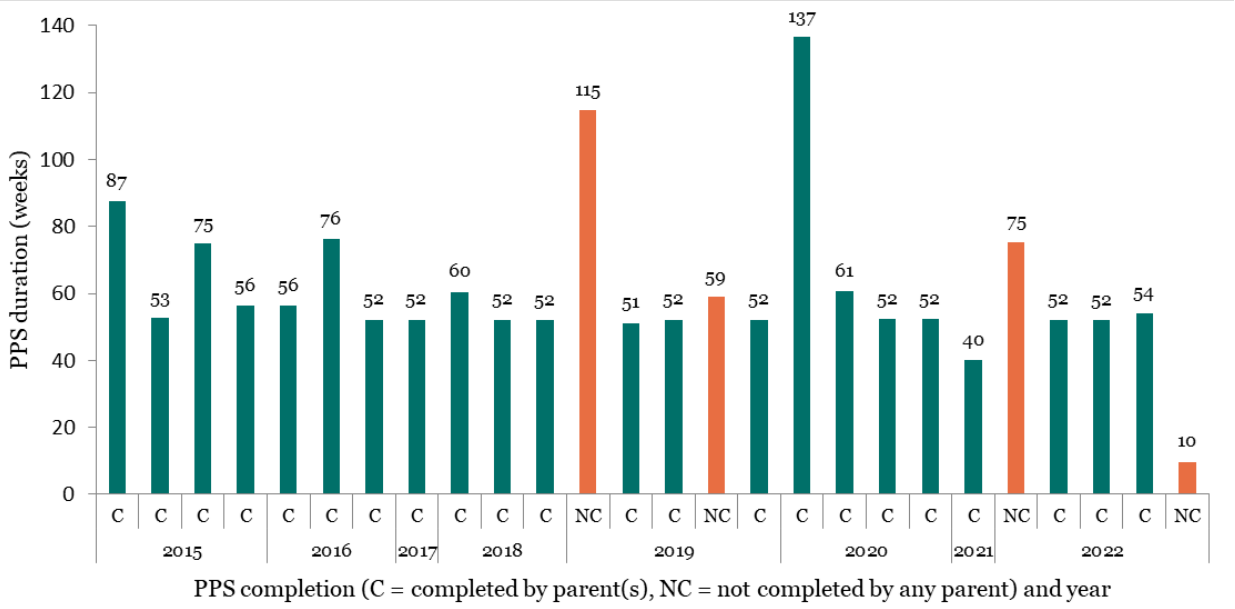
Of the 26 cases that have been in PPS, in 22 cases at least one parent completed it successfully. Only one case ended PPS in 2021; the timing of this would correspond to it being related to the

impacts of COVID-19. In the first half of 2022 five cases have ended PPS in Gloucestershire. More information on outcomes will be provided in the following section.

The mean average length of PPS was 61 weeks, although this was heavily skewed by a small number of cases, as shown by the median of 52 weeks (Figure 2). Of the 22 PPS cases in which at least one parent completed PPS, 17 (77%) were concluded in 52–56 weeks. When no parent (from a couple) successfully completed PPS, these cases tended to have longer durations, with one exception where PPS concluded very quickly. The average duration for these three cases was 83 weeks, representing the level of support that was in place to help parents recover from relapses in the hope of reaching recovery.

There were also a few instances where parents completing successfully were in PPS for much longer than the average. For example, in one instance parents graduated from FDAC and worked with TACS for the duration of the Supervision Order. When the Supervision Order expired both parents and TACS agreed to keep the case open during the parents' detox process. Following their detox, a final CiN meeting was scheduled with the intention of closing the case, by which time it was 15 months since they had graduated. But before this happened there were concerns about the child and it emerged that the parents had relapsed. The CiN plan remained in place and a plan was drawn up to support them back into abstinence, which they achieved quickly. The team withdrew support when the CiN plan after PPS had been in place for 137 weeks.

Figure 2. Duration of Gloucestershire's PPS cases by completion status and year



Demographic profile of parents

In the 26 PPS cases there were 45 parents involved in the process at the start of FDAC, 26 (58%) mothers and 19 (42%) fathers. Of these 45 parents, 37 graduated FDAC and started PPS. Failure to graduate from FDAC was higher among fathers than mothers, as shown in Table 4.

National FDAC data reported a similar proportion of women (57%) starting FDAC in 2022. Men made up a lower proportion (31%), probably due to gender being not known in 13% of cases.

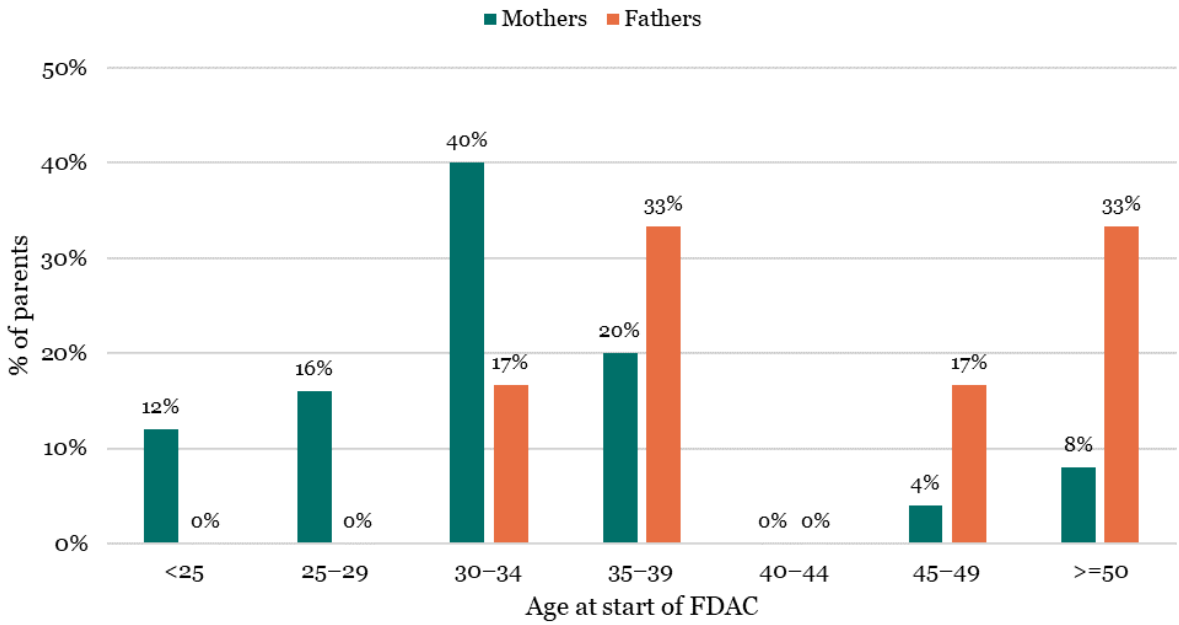
Table 4. Parents' involvement in Gloucestershire's PPS

	Starting FDAC	Did not graduate FDAC	Graduated FDAC and started PPS	Completed PPS successfully
Mothers	26	1	25	21
Fathers	19	7	12	10
Total	**45**	**8**	**37**	**31**

The demographic profile and circumstances of parents are provided for the 37 parents who graduated FDAC and started PPS.

The ages of parents in PPS at the first FDAC hearing ranged from 20 to 57 years, with an average of 36. The average age of mothers was 33 and of fathers 43. The distribution of parents by gender and age is provided in Figure 3.

Figure 3. Age of parents in Gloucestershire's PPS at the date of first FDAC hearing by gender



Ethnic background was only available for 22 of the 37 PPS parents, of whom 20 were from White British backgrounds with one Black/Black British parent and one parent of mixed ethnic background.

Parents' circumstances

At the start of FDAC, 27 of the 37 parents (73%) involved in PPS cases were known to have had previous involvement with children's social care (CSC) and 13 parents (35%) had previously had a child(ren) removed from their care.

National FDAC data show a lower percentage of parents starting FDAC in 2022 had previous contact with CSC (62%) and had previous children removed from their care (31%).

Twenty-nine of the 37 parents (78%) involved in PPS cases had at least one criminal conviction or caution at the start of FDAC.

National FDAC data show a lower percentage of parents starting FDAC in 2022 (56%) had at least one criminal conviction or caution.

Nearly two-thirds (25 of the 37) of parents involved in PPS cases lived in their own home, either as owner-occupier (three) or private tenant (seven) or in social housing (15). The remaining parents for whom data were available lived in supported accommodation (three) or with friends (two) or were homeless (three).

Parents' substance and alcohol misuse

Based on a combination of hair-strand testing and self-reporting, the most commonly misused substances at the start of FDAC by those parents in PPS were:

- Alcohol (78%)
- Cocaine (including crack) (73%)
- Cannabis (76%)
- Opiates (including both misuse of prescription opiates and heroin) (59%).

Thirty-six of the 37 parent (97%) had a history of substance misuse, with 34 (92%) reported as currently misusing at the start of FDAC.

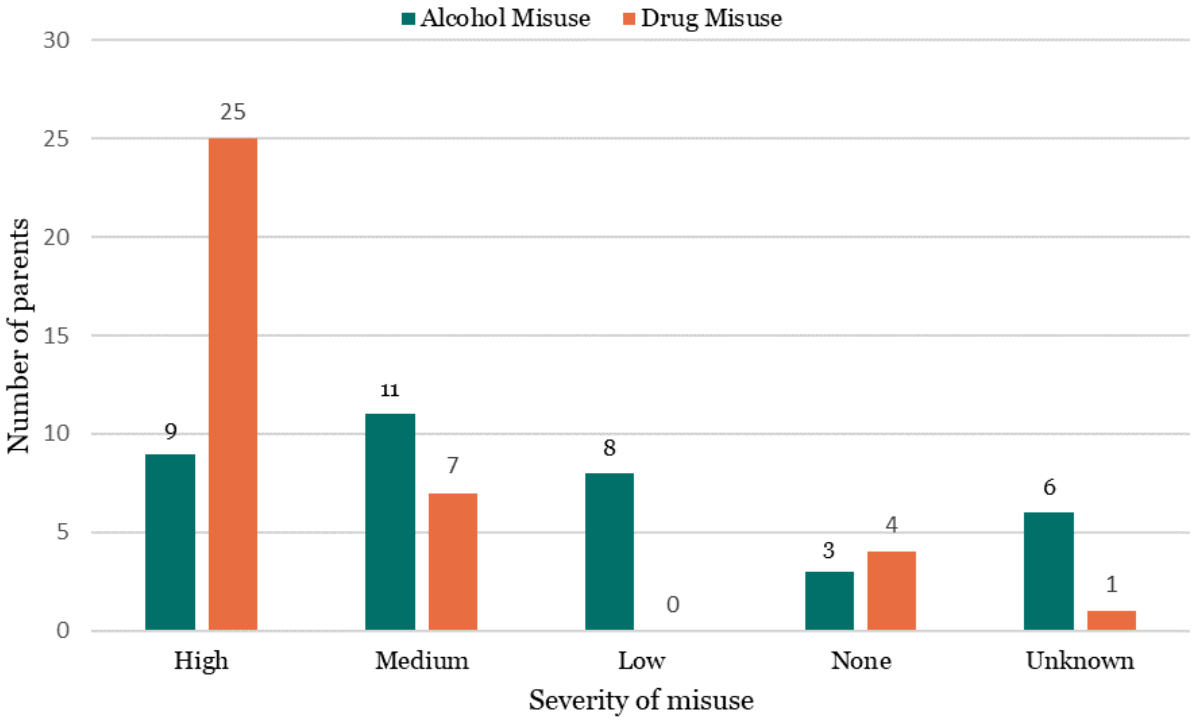
National FDAC data show a lower percentage of parents starting FDAC in 2022 (87%) had a history of substance misuse, with 66% reported as currently misusing at the start of FDAC.

Data on drug misuse severity indicated that 25 (69%) parents had been assessed at the start of FDAC as having "high" severity substance misuse and seven as "medium" severity; four did not have a substance misuse problem.

Data on alcohol misuse severity at the start of FDAC was available for 31 of the 37 parents in PPS cases, of whom nine (29%) parents had been assessed by TACS at the start of FDAC as having "high" severity alcohol misuse, eight were assessed as medium and 11 as low severity. Three parents did not have any reported alcohol misuse, as shown in Figure 4.

National FDAC data show a lower percentage of parents starting FDAC in 2022 (42%) had high severity drug misuse and a similar proportion (32%) had high severity alcohol misuse.

Figure 4. Severity of parents' alcohol and drug misuse at start of FDAC for those involved in Gloucestershire's PPS

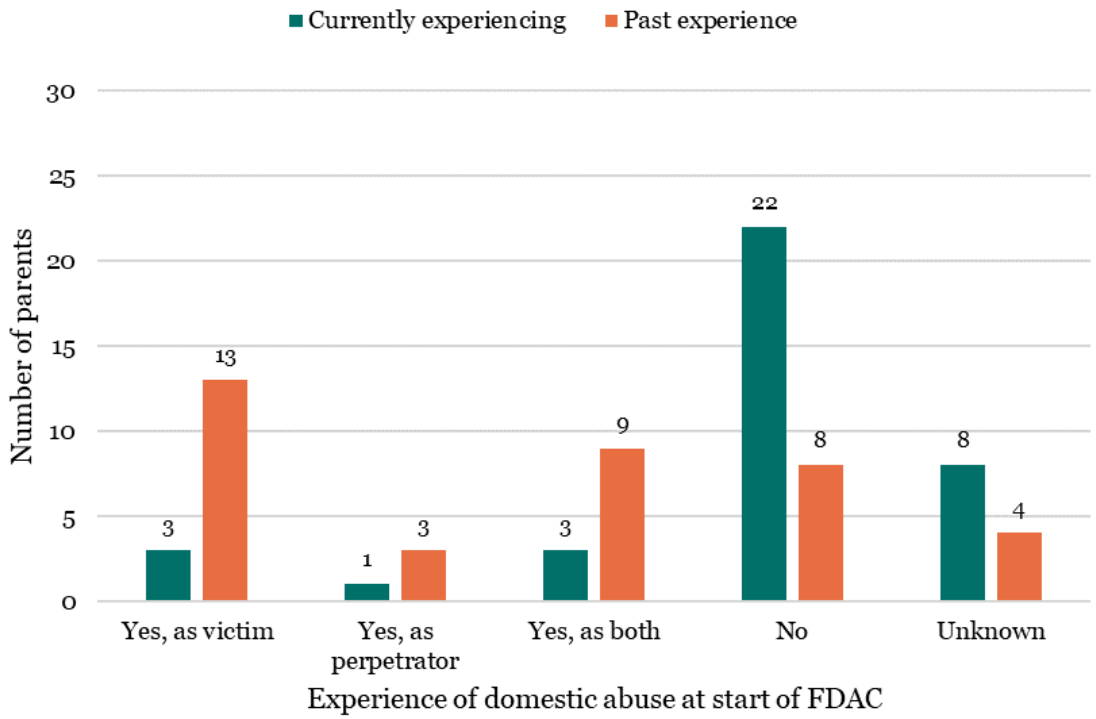


Domestic abuse

Twenty-five of the 37 parents (68%) involved in PPS cases were identified as having had some experience of domestic abuse, as either a perpetrator, victim or both. Seven were identified as currently experiencing domestic abuse at the start of FDAC, as shown in Figure 5.

National FDAC data show a higher percentage of parents starting FDAC in 2022 (89%) had some experience of domestic abuse, although this figure excludes not-knowns.

Figure 5. Parental experience of domestic abuse at start of FDAC for those involved in Gloucestershire's PPS



For the reasons explained earlier, comparisons with national FDAC should be treated with caution. However, the data on circumstances, and alcohol and substance misuse do indicate that the cases going into Gloucestershire PPS were no less severe or less complex than those in FDAC nationally.

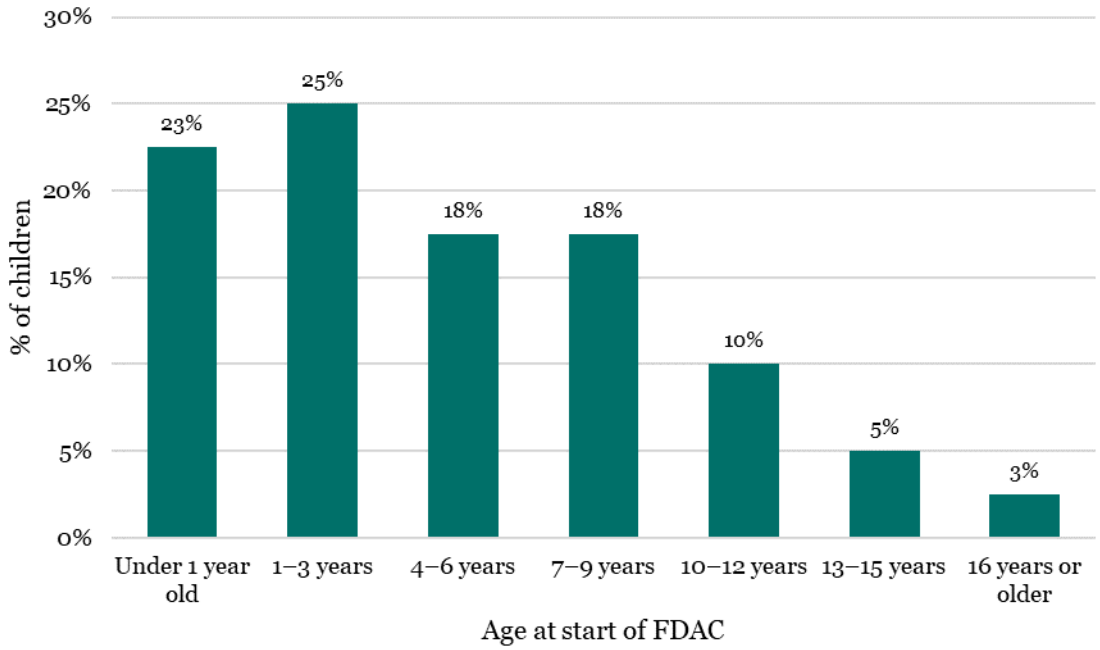
Demographic profile of children

The 26 PPS cases involved 40 children, with an average of 1.5 children per case.

National FDAC data had a similar average number of children in cases starting FDAC in 2022.

Twenty-one children (52%) were male and 19 (44%) were female. At the start of FDAC proceedings the average age of children whose parents went on to be involved in PPS was 5 years, and 12 (23%) were under 1 year, as shown in Figure 6.

Figure 6. Age of children in FDAC at the date of first hearing for those involved in Gloucestershire's PPS



National FDAC data had both a similar average child age profile and proportion of children under 1 year old (25%).

Children's circumstances

Reflecting the extent of parental prior contact with CSC, four children had previously been looked after while 34 children (85%) were the subject of an order at the commencement of proceedings. The most common orders were interim care orders (58%) and interim Supervision Orders (23%).

Similar proportions were observed in children in the national FDAC data, with 92% of children the subject of an order at the commencement of proceedings.

Of the 21 children old enough to attend school, ten had not attended school regularly and seven had an education, health and care (EHC) plan in place.

PPS outcomes

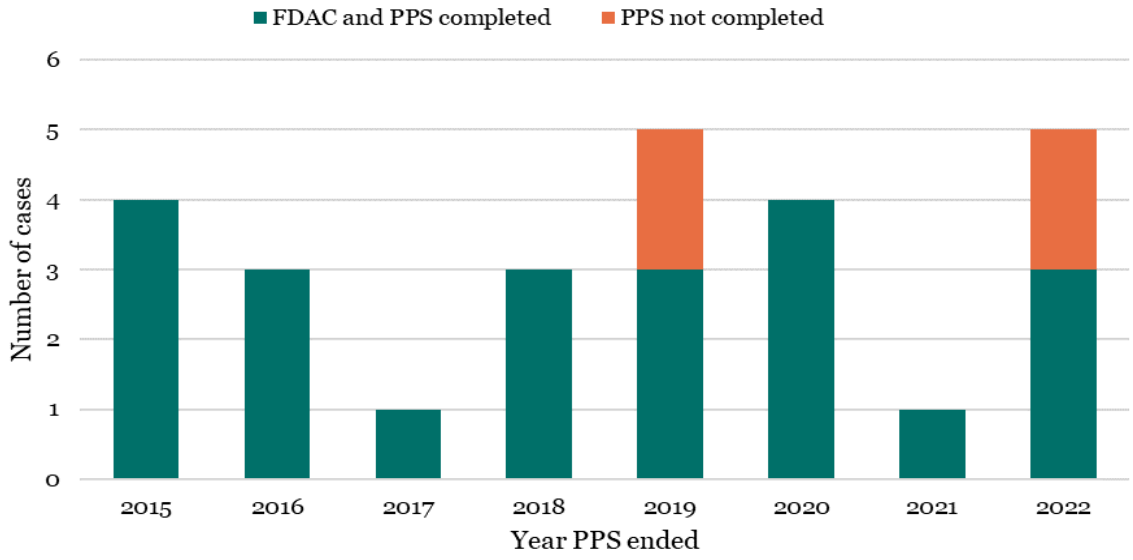
Is noted above, in 22 of the 26 cases at least one parent completed PPS, as shown in Table 5. In nine of the 11 cases in which a couple both graduated FDAC, both parents successfully completed PPS; in one, only one parent completed; and neither parent completed PPS in the remaining case.

In the eight cases where only one parent in a couple graduated from FDAC, seven went on to successfully complete PPS. Of the seven single mothers who graduated FDAC, five successfully completed PPS.

Table 5. Cases by FDAC graduation and PPS completion

	Two parents complete PPS	One parent completes PPS	No parent completes PPS
Couple entered FDAC, both graduated	9	1	1
Couple entered FDAC, father graduated	-	1	0
Couple entered FDAC, mother graduated	-	6	1
Single mother graduated FDAC	-	5	2
Total	**9**	**13**	**4**

Figure 7. Status of PPS completion by year



FDAC outcomes are typically assessed with reference to either reunification (the child living with one or both parents at the end of proceedings) or parental substance misuse (Harwin et al., 2014 and Harwin et al., 2016). In the national FDAC dataset this is done by comparing the child(ren)'s living situation and parental substance misuse at both the start and the end of FDAC. However, PPS cases would have to have successfully graduated from FDAC to have access to the PPS, so comparisons between start and end of FDAC may be of limited value.

In addition to outcomes at the start and end of FDAC, TACS provided data on the situation at the end of the PPS period, and data on whether there was a subsequent relapse or further involvement with CSC after PPS had concluded. As such, the data on PPS outcomes are provided in the following sections for all 26 cases involving PPS:

- Data comparing outcomes at start and end of FDAC and at the end of PPS
- Data examining subsequent relapse or further involvement with CSC following end of PPS.

Outcomes for parents

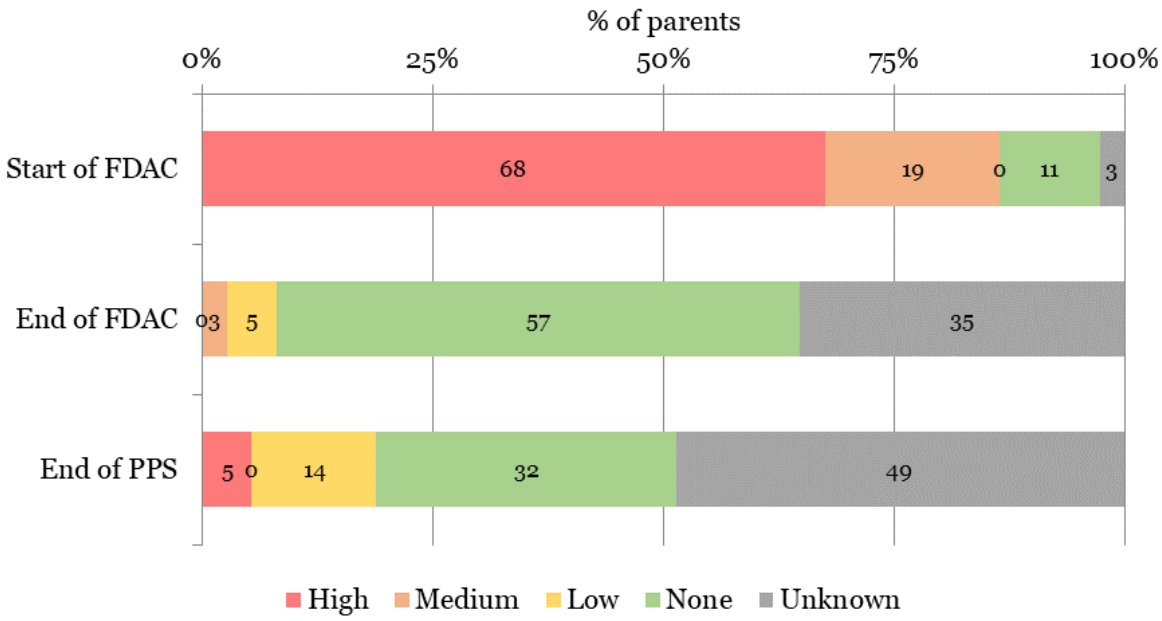
As previously discussed, at the start of FDAC, 25 of the 37 parents (68%) who went on to graduate FDAC had high severity drug misuse, with a further seven with medium severity.

By the end of FDAC, 21 parents (57%) were assessed as having no drug misuse at all by the TACS team, while none had high severity, one had medium severity and two had low severity drug misuse. The drug misuse severity for a further 13 parents was not known, but 11 of these parents were separately reported as being abstinent from substance misuse, suggesting the figure for those parents with no drug misuse at all is higher than reported in the available TACS data.

By the end of PPS, the number of parents with no reported drug misuse had fallen to 12, although the data on drug misuse severity at the end of PPS was not available for nearly half of the parents, as shown in Figure 8. The number of parents with some level of reporting misuse (low, medium or high) had increased from three at the end of FDAC to seven at the end of PPS.

Data on substance use was only available for one of the six parents not completing PPS and that parent had "high severity" drug misuse.

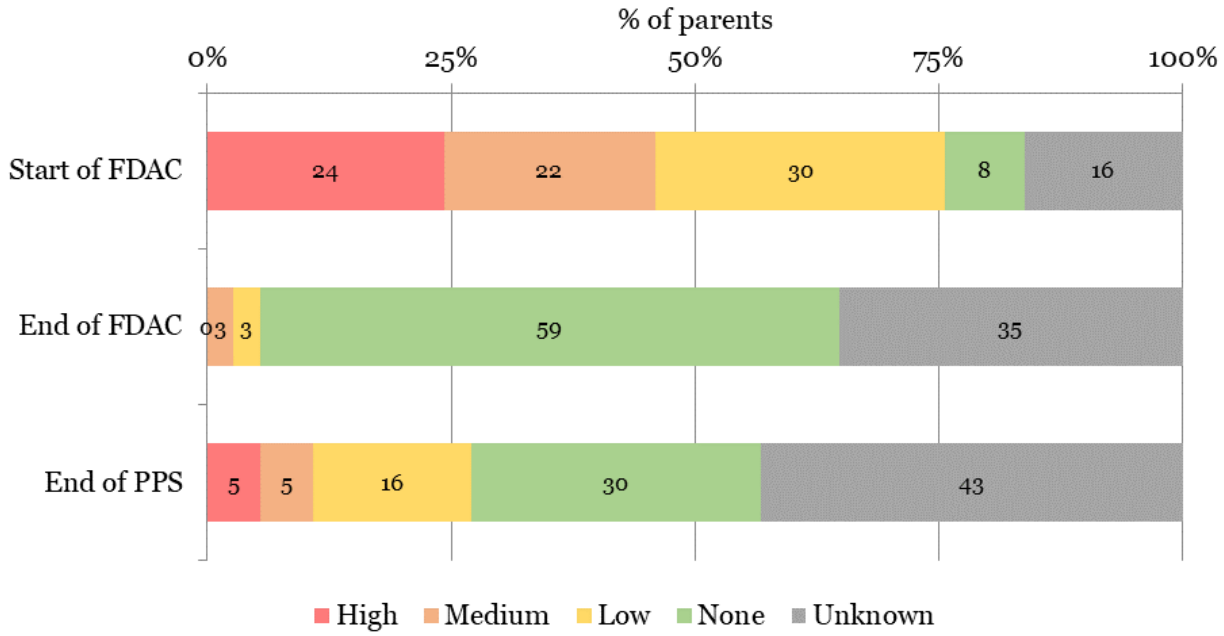
Figure 8. Parents' drug misuse severity at start of FDAC, end of FDAC and end of PPS for parents who graduated FDAC



At the start of FDAC, nine of the 37 parents (24%) who subsequently graduated from FDAC had high severity alcohol misuse. By the end of FDAC, 22 parents (59%) were reported as having no alcohol misuse at all, as shown in Figure 9. Again, alcohol misuse severity was not known for 13 parents, of whom 11 were separately reported as abstinent.

By the end of PPS, the number of parents reported as having no alcohol misuse had fallen to 11 (30%), although again the data on alcohol misuse severity at the end of PPS was not available for 16 parents.

Figure 9. Parents' alcohol misuse severity at start of FDAC, end of FDAC and end of PPS for parents who graduated FDAC



Overall, between the end of FDAC and the end of PPS, there were not enough data to determine direction of change for 51% of parents about drug misuse and 49% of parents about alcohol misuse. Where data were available at both end of FDAC and end of PPS, 13 parents' drug misuse severity stayed the same (in all but one case staying as no misuse) and five parents' drug misuse increased (in one case from no misuse to high severity and in four cases from no misuse to low severity). Similarly 11 parents' alcohol misuse stayed the same (in all but one case staying as no misuse) and eight parents' alcohol misuse severity increased from no misuse to low (two), medium (two) and high severity (four).

Outcomes for children

Legal outcomes for FDAC cases are tracked per child, because it is possible for different legal outcomes to occur for different children within the same family.

As previously stated, there were 26 PPS cases that had ended as at 1 July 2022 involving 40 children. At the start of FDAC 18 of these 40 children were living with the parent who was caring for them before proceedings, while 14 children were in residential or foster care.

Table 6. Living arrangements of children in PPS cases at start and end of FDAC and end of PPS

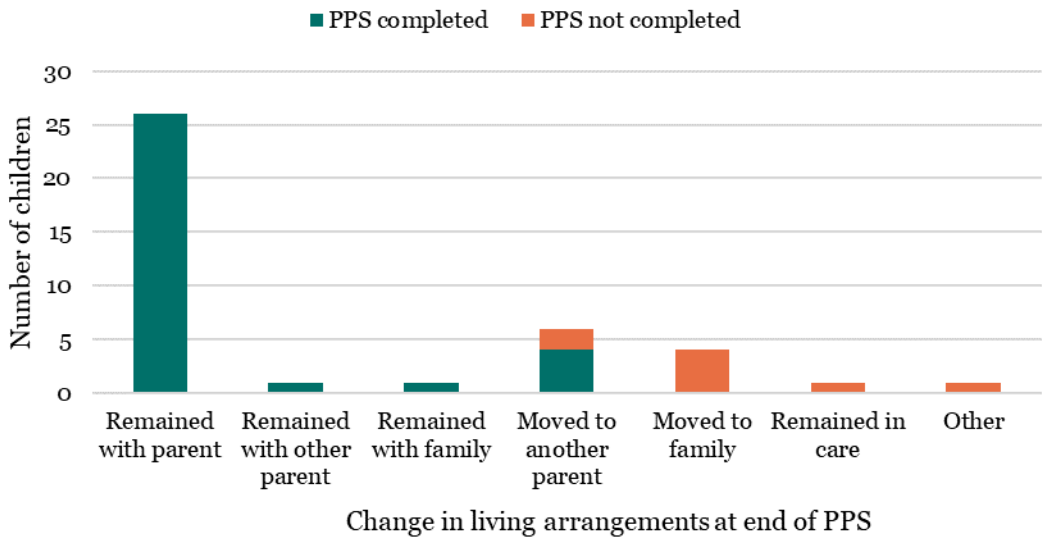
	Start of FDAC	End of FDAC	End of PPS
With parent who was caring for them before proceedings	18	37	26
With another parent	1	1	7
With non-parent family	5	1	5
In care (residential/foster/shared)	14	1	1
Other	2	0	1*
Base	40	40	40

* Supported living.

By the end of FDAC, 37 children (93%) were living with the parent who was caring for them before proceedings, two were with another parent or family member and one remained in residential care, as shown in Table 6. By the end of PPS, 26 children (65%) were living with the parent they were living with before the case entered proceedings, and a further 12 were placed with their other parent or a non-parent family member. All of the children in families for which PPS was successfully completed were placed with a parent or non-parent family member at the end of PPS.

None of the eight children in the four cases not successfully completing PPS stayed with the parent they were living with before the case entered proceedings, as shown in Figure 10. Where they were moved from the parent, all were placed with a parent or non-parent family member.

Figure 10. Change in living arrangements between the end of FDAC and end of PPS



Outcomes after PPS had been successfully completed

Harwin et al. (2018) followed 140 London FDAC families and 100 standard proceedings families for up to five years after proceedings ended to examine the longer-term outcomes of FDAC compared with standard proceedings. They found a significantly higher proportion of FDAC mothers were estimated to sustain cessation over the five-year follow-up when compared with a comparison group from standard proceedings (58% versus 24%). They also used maternal relapse, placement change and return to court as a single composite measure to serve as a proxy for family stability and found a significantly higher proportion of FDAC mothers who had been reunited with their children at the end of proceedings were estimated to experience no disruption to family stability at three-year[12] follow-up (51% versus 22%) compared with standard proceedings.

In Gloucestershire there were a total of 22 cases in which at least one parent completed PPS. Within these cases 32 parents had graduated FDAC and 31 completed PPS (with the father in one couple not completing PPS), as shown in Table 7. The four cases in which PPS was not completed involved five parents (four of them mothers).

[12] The proxy for family stability could only assess impact over three years because thereafter there was a lack of available information.

Table 7. Circumstances of parents successfully completing Gloucestershire's PPS

	Cases in which PPS completed	Parents graduated FDAC	Mothers completing PPS	Fathers completing PPS
Couple complete FDAC and PPS	9	18	9	9
Couple entered FDAC, one parent completes PPS	8	9	7	1
Single mother completes FDAC and PPS	5	5	5	0
Total	**22**	**32**	**21**	**10**

In all 22 successful PPS cases the child(ren) was reunified with parent(s), as shown in Table 8; in 13 cases children were placed only with the mother, in two only with the father and in seven with both mother and father.

Table 8. Reunification of children with parents following successful completion of Gloucestershire's PPS

	Reunified with both parents	Reunified with father	Reunified with mother	Total cases
Couple complete FDAC and PPS	7	1	1	9
Couple entered FDAC, one parent completes PPS		1	7	8
Single mother completes FDAC and PPS			5	5
Total	**7**	**2**	**13**	**22**

We have analysed the case records of these 22 cases for evidence of subsequent relapse by the 31 parents who successfully completed PPS, subsequent involvement of CSC and a return to proceedings.

In total, six of the 22 cases (27%) had evidence of subsequent relapses by one or more parents following the completion of PPS, as shown in Table 9. A total of seven of the 31 parents relapsed, with one case involving the relapse of both mother and father, meaning most (77%) parents had sustained cessation after PPS had concluded. Of those who did relapse, two parents relapsed more than five years after PPS had concluded while five parents relapsed within two years of PPS concluding. Five of the seven relapses occurred in the years 2020 and 2021.

To make the sustained cessation figure more comparable with the 58% figure for FDAC produced in Harwin et al. (2018), we would need to examine only "reunified" mothers over a five-year period. Only eight cases in Gloucestershire involved a mother who had completed PPS more than five years ago and in none of the cases was there evidence of relapse within five years of having done so. Subsequently two mothers had relapsed but this happened beyond the five-year period.

In total, four of the 22 cases had subsequent placement change; in two the child(ren) were placed with grandparents and in the other two the children were placed into residential/foster care following a parental relapse. This means that 18 of the 22 cases (82%) have so far maintained reunification (the length of time for this will vary depending on how recently the PPS concluded). In addition to the four cases that resulted in placement change, one case resulted in a return to court for a Child Protection Order. This means that 23% of successful PPSs had a return to court, which compares with the three-year figure for FDAC of 34% (Harwin et al., 2018).

Table 9. Summary of family disruption following successful completion of Gloucestershire's PPS

	Total cases	Parental relapse	Return to court	Placement change	Subsequent involvement with social care
Couple complete FDAC and PPS	9	3	2	1	6
Couple entered FDAC, one parent completes PPS	8	1	1	1	1
Single mother completes FDAC and PPS	5	2	2	2	3
Total	**22**	**6**	**5**	**4**	**10**

Following the same method as Harwin et al. (2018) we can create a proxy for family stability which looks at any cases that had maternal relapse, placement change and/or return to court within three years of PPS ending. Comparing family stability could be done within three years of FDAC ending (which would incorporate the year of PPS support and the following two years) or within three years of PPS ending. We concluded that the comparison made more sense if it was three years after PPS support had ended because the evaluation was more interested in whether PPS made reunification more likely and relapse less likely in the longer term, rather than whether parents were less likely to relapse while in PPS.

Only 12 of the successfully completed PPS cases had occurred three or more years ago. Of these, only one case had any disruption within the three years following the end of PPS. Three more of the cases showed some disruption to family stability but not within three years of PPS ending. This means 66% of PPS cases with a reunified mother showed no disruption to family stability at all compared with the three-year figure for FDAC of 51% (Harwin et al., 2018). It is important to note the limitation of this comparison due to the very small sample of cases involved.

We also collected information on whether the reunified families had any subsequent involvement with CSC. This goes beyond the placement change or court proceedings used above. Ten of the 22 families (45%) had some recorded involvement with CSC, which would include the five that resulted in a return to court. Of the five cases that did not involve a return to court, three were an

early help assessment that resulted in no further action with the parent (therapy support was provided for a child in one cases).

PPS services, resources and costs

The support provided to families through PPS is understandably heavily front-loaded, with most work occurring with families in the first three months. Support is available throughout the 12-month period and will vary according to each family's particular needs. As such, any breakdown of what a *typical* PPS intervention would involve should be treated as indicative only. This also meant that any attempt to collect a diary of staff time would be impacted by the stage of PPS of the current pool of families. This approach was also made impossible due to the timing and impact of COVID-19, which limited the number of cases and changed how the PPS functioned during that time.

The expected treatment pathway plan used by the TACS team is provided in Figure 11. This was provided by the TACS team with estimates of the time spent on each intervention. We have used this, along with information gathered from the interviews and case data, to estimate the time spent on each activity during PPS. We have then combined this with standard unit costs for equivalent banded staff to give an estimation of cost.[13]

Data were provided on whether specific activities had been undertaken with parents during PPS. In the 22 cases that had concluded PPS successfully, data were collected on the activities undertaken with the 37 parents who had successfully graduated FDAC.

The most common activity undertaken with parents was substance misuse intervention or treatment, which was provided to at least one parent in all but one (95%) of the successfully completed cases, as shown in Table 10. This was followed by speech and language support for children (86%), and family/parenting support (82%). Around half of all successfully completed cases also had other mental health support, peer-led recovery support, adult psychiatrist and physical health support.

The most frequent "other" activities listed were Video Interaction Guidance (VIG) (four cases), housing support (four cases) and child/teen counselling (three cases).

Figure 11. Typical treatment pathway plan

Week 1–4

- Stay Well Plan covering both mental health and substance misuse, with a focus on maintaining abstinence and wellness
- A formulation which is shared and agreed with parents
- Substance misuse intervention weekly (or as clinically indicated) (TACS, CGL)

[13] Data on TACS team staff salaries was requested but was not available by the time of publication.

- Testing three times each week – TACS or CGL
- Weekly group attendance at CGL
- Mental health intervention fortnightly combined with testing

Week 5–12

- Testing reduced to fortnightly – TACS or CGL
- Substance misuse intervention weekly (or as clinically indicated) (TACS, CGL)
- Mental health intervention fortnightly, combined with testing
- Testing reduced to twice a week
- Weekly group attendance at CGL

Week 13–20

- Substance misuse intervention as needed (TACS, CGL)
- Mental health intervention every three weeks
- CGL contact as needed
- Testing reduced to once a week – TACS or CGL

Week 21–28

- Substance misuse intervention as needed (TACS, CGL)
- Mental health intervention as needed
- CGL contact as needed
- Testing reduced to fortnightly – TACS or CGL

From week 29 to end

- Hair-strand test at the start of the last three months (from about week 36)
- Testing reduced to monthly – TACS or CGL
- Substance misuse intervention as needed (TACS, CGL)
- Mental health intervention as needed
- CGL contact as needed
- Repeat PHQ, GAD and TSQ at end
- Final appointment with clinical psychiatrist

There will also typically be four court appearances during the PPS. The allocated social worker will prepare and file the court reports to update the judge every three months during the Supervision Order period.

They will also do the statutory visits etc. as required for the children and work with the parents to support as required.

There are also CRAFT workshops available for the parents to help them reach a better understanding of addiction – two of the TACS team run these approximately every six weeks and they last one hour.

Table 10. Activities undertaken with parents in successfully completed PPS

Activity	Cases in which at least one parent received support	% of successful PPS cases
Substance misuse intervention/treatment	21	95%
Speech and language support	19	86%
Family/parenting support	18	82%
Other mental health support	13	59%
Physical health support	11	50%
Peer-led recovery support	11	50%
Adult psychiatrist	10	45%
CBT	4	18%
Family therapy	4	18%
Domestic abuse survivor programme	4	18%
Adult psychologist	3	14%
Parent mentoring	2	9%
Trauma-focused therapy	1	5%
Sexual abuse or trauma support	1	5%
Any other support	19	86%

Combining the data on the most frequent activities undertaken with the typical treatment pathway allowed us to identify which support was provided to most families. To arrive at typical costs we therefore included substance misuse and mental health interventions, group work, speech and

language support (SALT), health visitor (HV) support, family/parenting support and clinical psychiatrist support.

Where the TACS team were not able to provide an estimate of the time spent on a particular intervention, we have used the proportion of families receiving the intervention as a proxy for resource allocation compared with the time spent on mental health interventions (on the basis that this was the most consistent element throughout PPS and as it reduced so other resource requirements would likely reduce). We also included time spent on management/peer support and administration. With no other available data we estimated this equated to half the time spent on mental health interventions.

We estimate that the cost to the local authority of providing PPS in a typical FDAC case is approximately £6,270, with a breakdown of costs by activity provided in Table 11. This does not include any statutory work that is required with the families, which would be done by the social worker, including statutory visits to the children, organising the Supervision Order Review Meetings (SORM) meetings etc. This is because this is not unique to PPS and would form part of the provision in any standard proceedings.

It also does not include court costs. Previous research (Harwin et al., 2011) suggested the cost of providing 15 FDAC court hearings (excluding FDAC team costs) was £1,465, so it would be reasonable to expect the informal court hearings – usually four at three-month intervals – to cost in the region of an additional £400, meaning the overall cost of provision would just under £6,700 per family for a successful PPS case.

Table 11. Indicative costs of typical PPS activity

Activity	Time spent per PPS (hours)	Staff involved	Indicative costs (£)
Mental health interventions/testing	21	OT or MHN 50/50	819
Substance misuse interventions	15	CL or SOW (CGL) 50/50	675
Group work	12	CGL	231
Family/parent support	17	SOW	430
Clinical psychiatrist support	10	CP	620
Health visitor support	11	HV	368
Speech and Language Therapy	18	SALT	744
Report preparation	8	CL & SW	888
Court appearances (TACS team)	4	CL & SW	444
Management/peer support	10.5	SM	683
Admin	10.5	BA	368
Total			**6,270**

Details of the unit costs and assumptions behind the costing are provided in Appendix B. This is intended as indicative only and we have tried to be clear about the assumptions and limitations of this costing exercise.

Professional views on Gloucestershire's model of post-proceedings support

Team members had not worked in other FDACs to be able to compare the Gloucestershire model with the standard approach, but there were many references to the benefits of FDAC – and PPS – being located within TACS, not least because they were able to access all the information they required on children and families. It was suggested that the model had originally been introduced to minimise the duplication of staffing, but it became the preferred model because it allowed the team to be in control of decisions as they did not have to liaise with a LA social worker, it speeded up communication and reduced barriers to multi-agency working. It allowed the FDAC team to make all the decisions and as a result intervene more swiftly because they did not have to wait to talk to the LA social worker. Similarly, parents had far fewer professionals with whom they had to maintain contact.

These specific arrangements were thought not only to support PPS but probably to reduce the incidence of neglect of children. However, this was very difficult to evidence. There was a shared and strongly held view that the six-month FDAC proceedings was not sufficiently long to allow parents to feel confident about their recovery, although it is worth noting that the typical length of FDAC proceedings was around 47 weeks. The Public Law Outline (2014) and the Children and Families Act 2014 impose a 26-week time limit for the completion of care and supervision proceedings, but somebody can be in recovery for far longer than that, and even far beyond the PPS period (see, for example, Leshner, 1997). The fact that the Supervision Order was held by the FDAC team made it possible for the two timescales to come closer together.

Professionals pointed to the number of parents who went through FDAC who had been exposed to traumatic experiences and linked this with their substance abuse and dependence. Research indicates a strong relationship between adverse childhood experiences and subsequent substance use and poor mental health outcomes, particularly post-traumatic stress disorders (PTSD) (see, for example, Wu et al., 2010). Many of the adults who went into FDAC were said to be suffering from PTSD and other co-morbidities, so it was unrealistic to expect that these could be addressed in the relatively short FDAC period. The main goal during FDAC proceedings was to achieve abstinence. Although any mental health problems might be identified and therapy and/or medication provided, it was seen as important not to overwhelm parents with too many interventions at the same time. The post-proceedings period was viewed as additional "recovery time" that allowed a period of consolidation, prevention and treatment.

Many of these parents will have been involved in the child protection process for years and all will have faced the possibility of the permanent removal of their children. During their time in FDAC they will often have examined and synthesised experiences that have not been confronted before, while addressing substance and alcohol dependency and abstinence. It was suggested that even if someone might reach and maintain abstinence during the care proceedings, that would still be considered quite early in the recovery process and it was only realistic to recognise that relapses happen after proceedings. Sometimes the changes made during the FDAC proceedings occur

because parents feel compelled to make progress, but they are not necessarily full invested in their own recovery. The longer they have to internalise those changes the longer they have to see improvements in their lives. Where PPS had gone well, it was said that parents had reached a deeper understanding of how they had to be proactive in maintaining that situation after the team had stepped down:

> "By the time they have successfully come through FDAC and graduated into a new relationship with us under supervision, we would be hoping to have imparted the basic principles of self-awareness and some insight into how trauma may have played a role in their situation… it should create a wider and more flexible therapeutic space to look at their identity, where they feel they've come from, consolidate the journey and give them more tools." (Team member C)

Alongside the role of PPS in helping parents consolidate progress and become more self-sufficient, was the opportunity it gave the team to deal with any relapse promptly, while monitoring the children and attempting to minimise any impact on them. Without a structure, it was suggested that more of these cases would go back into proceedings.

> "It's quite usual for parents to have a lapse and for that to happen in the post-proceedings period." (Team member P)

> "What the Supervision Order does is to allow us to prevent some of that stuff happening in the first place or be there to pick up the pieces if it's a short period, or a blip situation and help them get back on track and provide that additional monitoring and work. We can take action because assessments have been done, it's been through proceedings, we need an alternative permanency plan now, and we have all that information at our fingertips because we've carried on doing the work." (Team member U)

It also allowed team members to work with parents to complete what was described as more low-level work, such as working on promoting healthier lifestyles which could not take priority during care proceedings. Similarly, team members were able to help parents adjust to parenting in a very different way now that they were not using drugs and/or alcohol:

> "They have got to think about how to parent their children, because it will be different. It will feel different for them, and it will feel different for their children. So I think the Supervision Order and our support is really important to help them embed their recovery." (Team member F)

The introduction of a programme for perpetrators as part of a suite of programmes to address domestic abuse was widely welcomed. Previously it had been difficult to find a place with an appropriate external provider because the demand for such places was very high. Again, it was said that it would be too overwhelming to offer this during the FDAC proceedings, even though that period was essential in preparing parents to engage during post-proceedings. The ten-week, one-

to-one programme that is used was developed by Swift, a specialist family service in East Sussex County Council:

> "I just think it's really important that we have that year to be able to do those heavier interventions, the more intensive programmes, because during that first three months they're not ready for some of the interventions that we could give them, and we've got to do it at the right time so that we can take it in and then use it." (Team member Q)

Professionals' views on the impact of COVID-19

The start of the evaluation coincided with the early days of the COVID-19 pandemic and it is important to appreciate its impact not only on the evaluation, not least because fewer families entered FDAC, and hence post-proceedings, during this period, but also on the way PPS (and FDAC) operated. This section deals not only with the practical arrangements that were put in place to allow work to continue, but also with the perceptions of those professionals who were interviewed on the impact on families, addictions and commitment to the process.[14]

The FDAC team worked hard on recovery plans with its partners, but it proved impossible to get everybody to agree to operate in the same way. Agencies used and approved different platforms for virtual meetings, which hindered work in the early stages of the pandemic. Family courts in England quickly introduced the BT MeetMe system, a telephone service for telephone hearings. This allowed the FDAC judge to check in, reassure parents that they were still being listened to and, to some extent, continue coaching. It was described as "being kept alive but not really functioning". Eventually hearings moved to Skype and face-to-face hearings recommenced in July 2020. Agencies already used different IT systems that did not communicate with each another and, although it had been easier to resolve any difficulties when everyone was in the office, it was more difficult when they were working remotely. They also had different guidelines over personal protective equipment (PPE) and the circumstances when home visits could be made.

At the outset, around half of parents had computers, smartphones or tablets that allowed them to engage with court virtually. Where families did not have computers or an internet connection, the team bought them smartphones and provided all families with data packages. The team members also coached and supported parents on how to use the equipment and access meetings. Nevertheless, some problems remained. It was said to be much more difficult over a video link to pick up on unspoken communication through body language and facial expressions. However, professionals who were interviewed thought that while people might have been disadvantaged because communication was more difficult virtually, they had not been disadvantaged in terms of decision-making.

[14] The Centre for Justice Innovation (CJI) issued a practice briefing on FDACs and COVID-19 (CJI, 2020).

Normally families entering PPS would see someone from the FDAC team three times a week but during the first lockdown, in addition to all contacts moving to video and telephone platforms, there were other changes. Partner agencies closed and the health professionals in the team moved into frontline and community work during the early months of the pandemic. The speech and language therapist struggled to work through a video connection because the pictures were not of sufficient quality to read children's facial expressions and mouth movements. Face-to-face conversations between the different professionals that usually happened in the office or in court were said to have taken on a different shape when they were over a telephone or video, and in some cases they were not happening at all.

In the early months there was no testing for substances, no face-to-face visits and no therapeutic work. The inability to test was seen to be particularly important, even for post-proceedings, because it is viewed as a strong motivator for parents. Virtual intervention plans were developed and emailed to families, but it proved more difficult to get them to respond. Relationship-building with parents and children was harder over a WhatsApp video or telephone call with numerous technical and signal issues. Some team members thought that there had been parents who had been less invested in virtual meetings, and that others may have found it hard to engage because of their lack of technical confidence.

One of the most significant consequences was the reduced service offered by the local drug service over a considerable period. Even when the doors opened again there was very limited face-to-face work, and it was only meeting with people who were alcohol- or opiate-dependent. Although virtual group work was conducted, team members who were interviewed did not think this had been sufficient for FDAC parents.

As the year continued, the services in FDAC evolved. So, for example, a smart, mobile portable breathalyser was used and one of the nurses visited parents wearing PPE to do hair-strand testing. Although it was said to have been easier to manage through the second and third lockdowns, there were ongoing disruptions into the summer of 2022, mainly attributed to many lawyers continuing to work remotely and drug services not having returned to normal.

Among those interviewed there was little doubt that COVID-19 had accelerated relapses, with an increase beginning to emerge from August 2020 but becoming more evident by summer 2021 and continuing into 2022. This is supported by the fact that five of the seven relapses that occurred after successful conclusion of PPS, occurred in the years 2021 and 2022. There was also a marked increase in the chronicity of addictions. In part this was said to have been aggravated by the continued closure of treatment services which, in turn, meant intensive programmes were not available and the response to a relapse was not nearly as swift as normal. There had also been a noticeable shift in the pattern of addictions. There was a national rise in alcohol-induced illnesses during this time (Bantounou, 2022), which was reflected in the cases in Gloucestershire's FDAC, alongside the reported increasing chronicity and greater use of crack and alcohol mixes that were said to make people particularly resistant to change.

Possibly as a consequence, there was an increased level of non-completion of FDAC and more relapses within the post-proceedings phase. In 2018, four cases graduated from FDAC to PPS, all of

which resulted in reunification; in 2019 this had reduced to three, and in 2020 to two. Of these five graduating, only three resulted in long-term reunification. There had been more cases involving babies than ever before, none of whom had successfully completed the trial for change. Most had involved maternal alcohol misuse, often with consequent harm to the babies that had been born. Some parents in FDAC had also returned to using drugs and even become entrenched in their use, possibly because help had not been given quickly enough to stem that harm. And this pattern was said to be continuing into the post-COVID-19 period, with parents falling out of FDAC during the trial for change and returning to normal proceedings. There were said to be more instances of disguised compliance and fake tests, where people provided samples from non-using friends and contacts:

> "We talked in the team meeting last week about this trend where people refuse to do things now, and people aren't so willingly being co-operative. I do wonder if that's part of the pandemic, where we were forced to do things we didn't want to do." (Team member P)

One team member viewed this, in part, as a reflection of the changes in society in general, where people have been thrown back on their own resources and where expectations have shifted:

> "I was just having a general conversation with a social worker in another team yesterday. She is really unhappy that she's going to have to come back to the office for three days a week because she wants to work at home. So why would parents who have been essentially left, you know… somewhat left to get on with it, not also be pushing back to those changes that society are now expecting of them?" (Team member V)

There were also relapses at the end of their post-proceedings work, which were still attributed to the reduced level of support that was available during COVID-19 and afterwards, including the services in the community, which played a significant role in the recovery process:

> "The intensity of engagement has been rocked by the COVID-19 crisis and as a consequence there's been a slight unravelling around the edges of that engagement, and this is reflected in some of the post-proceedings contacts. Obviously, the engagement within proceedings had been reduced, so the engagement post-proceedings has also been affected." (Team member B)

One of the strengths of FDAC and PPS was seen to be the skills in the team that gradually gave parents the confidence to access universal services, but this had been undermined during the pandemic:

> "Having a link worker outside our team, in one of the services, who can say, I'm there for you when they need more support because of confidence. Often, their understanding of what is available is not very good, they definitely need more support to access universal services because they feel judged, and they feel that they can't do it. But those services are rapidly disappearing or raising their thresholds." (Team member D)

In addition to fewer parents completing FDAC, there were also fewer families being offered that route through proceedings. Team members suggested that because local authority lawyers were struggling with excessive workloads, it was proving difficult to get cases ready for court and more cases were being put into pre-proceedings and, as a consequence, more complex cases were entering FDAC, which then failed to complete and returned to standard proceedings. This was described by one participant in these terms:

> "It feels like everything's stuck, like we've entered into a slow-motion kind of scenario where everybody's travelling more slowly because of the amount of work they have." (Team member B)

But the fact that fewer parents were entering FDAC was also attributed to the impact of the increased pressures on the social care workforce, which meant that perhaps families who may be appropriate for FDAC were not being identified:

> "I wonder then if the social workers are thinking "I should have a conversation with FDAC" and not getting round to it. So it is left until the last minute until a lawyer says "oh, haven't you guys have thought about FDAC here", and then we're all scrambling around a little bit." (Team member D)

However, there was also the reverse impression expressed, that some people had graduated from FDAC because they had been able to convince professionals they were stable as a result of so many contacts being virtual.

The problems encountered by Gloucestershire were not confined to that FDAC. The evaluators had heard similar accounts from other FDACs across England in the interviews conducted to explore the extent to which post-proceedings work was being undertaken, as reported below.

Parents' views on Gloucestershire's model of post-proceedings support

Apart from testing, social work contact and appointments with the psychiatrist, it was usually difficult for parents to distinguish between the services they had received specifically during PPS compared and those received during FDAC proceedings, so accounts tended not to differentiate between proceedings and post-proceedings. However, there were very positive references to the ways in which the FDAC team had worked with them throughout and how they had been able to build on this relationship during PPS:

> "We know we are lucky to have had the chance. It was the hardest thing I've ever done in my life. I see parents that have had their kids taken off them, but we got this chance to turn our lives around. The fact that the team stayed with us after we had graduated gave us the confidence to know we could make it. (Mother T)

> "It kept me on my toes because I had people that were still involved. It would be easy to get to the point where court proceedings are finished and go, right, let's get on with the rest of my life, but what does that look like for some people? Some people go back to using or just slip back into their old ways quite quickly, whereas I feel, with the support I had afterwards, that enabled me to cement my changes." (Father D)

With only one exception, all the parents who were interviewed referred to the importance of PPS because they did not feel ready to manage without that support at the end of post-proceedings. One mother who had several children, most of whom had been removed from her care over the years, but whose youngest child had been returned to her at the end of FDAC, attributed the fact that she had been able to keep the child to PPS. She said she had developed a very close relationship with the health visitor during the PPS period and had learnt so much about child development and parenting from her. She had asked for her to continue to support her after PPS as she was now pregnant and wanted that same level of support with a new-born. In another family, a father reflected on the tensions that can occur after proceedings when children return home and they have to learn to live as a family again. In his case the relationship with his partner broke down, but because he was in PPS he said he had been able to access support to get him through this period:

> "Without their support I think I could have been drawn back into a battle with her [the ex-partner]... They basically worked as a mediator at times, and also as an authority figure. I struggled with communication with my ex-partner, as I had done during the relationship, so with the breakdown it was very helpful that they were there to support me and put things across in an authoritative manner to my ex-partner." (Father R)

There was one area over which all the parents seen agreed and that was their contact with the judge in the informal reviews. They frequently referred to those contacts during FDAC and the role the judge played in steering them to a successful conclusion through a mixture of challenge and support. They valued the opportunity to maintain that contact and even to demonstrate their continued progress:

> "I think this was an important part of my journey. I held onto the judge's words during the FDAC period. I felt I was important to him – I didn't want to let him down – and then I wanted to show that the belief in me had been right." (Parent 2)

> "During FDAC there were times when I felt embarrassed to be there. I suppose something in me didn't think I deserved his faith in me. As time went on I was proud to come through the other side and then show him I had changed, and I was keeping up the progress." (Parent 4)

However, not everything about PPS was viewed positively. Amid the otherwise overwhelmingly positive responses, there were a few negative comments that should be noted. Two were as applicable to FDAC as PPS. One was the point made by two fathers who regretted that all those

working in TACS were women and who thought that the presence of a male would help fathers to be more engaged. The other was that despite the many complimentary comments about the professionals with whom they had worked in FDAC and PPS, there was a small number of parents who had not related to, or even liked, individuals with whom they worked. There were also instances where one parent had developed a good relationship with a team member but their partner had not. Given the intensity of the work undertaken at this time, it was evident that these underlying feelings could be a barrier to engagement, but parents had been reluctant to make them known in case it had negative consequences for their progression.

While all parents viewed graduation as an enormous achievement, there was a divide between those who welcomed PPS unreservedly, wanting support through the next phase in their life in any shape, and those who, while not wishing to be left to fend for themselves entirely, wanted more space than PPS offered. Members of this group thought that the process had gone on too long and that the testing and visiting regime could have stopped earlier.

However, only one mother was entirely negative about the PPS experience. She had been using alcohol excessively and as a result her child had been taken into care. She had found the period in FDAC very difficult, not least because she was very concerned about her child and the quality of the foster care placement, which she said had only added to her determination to reach abstinence as soon as she could manage it. Nevertheless, she attributed her recovery to the mental health support and therapy she had received during proceedings and the confidence she had drawn from her encounters with the judge. Overall she did not think she could have succeeded without FDAC. But once she had achieved abstinence and had graduated from FDAC she resented what she viewed as the continued interference in her life. She held a professional job, to which she had returned. While she recognised that children's social care would have to monitor the welfare of her child, she specifically objected to the continuation of testing and challenged why she could not be trusted to manage her recovery through her continued involvement with CGL, as well as with AA and SMART.[15] She found it particularly difficult to accept testing when, during COVID-19, it was by a member of the team, which, she said, had been undertaken in a more intrusive way than previously.

> "[Names a professional] would always say, when I'm drinking on a scale of nought to ten, for parenting, she's nought, she's rubbish, and I agreed with her. But as a parent when she's not drinking, she scores ten plus every single time. I hadn't been drinking for months and I had very good recovery, my whole mental state had changed… post-proceedings work wasn't necessary. To have people trying to advise me on parenting, when everyone, without exception, will tell you I'm a bloody good parent, is a waste of their time and an intrusion into mine." (Parent 3)

[15] SMART stands for Self-Management and Recovery Training. It is a community programme of peer support groups that help people recover from addictive behaviours.

She said that there had been little direct work with other members of the team during PPS, although they had kept in touch with her. She was, however, complimentary about the work done by one of the social workers with her child. It is interesting that one of the other FDACs offering some PPS reported an almost identical account of their experiences with a mother who was also in a high-status professional job who had entered FDAC as a result of abusing alcohol.

Post-proceedings support in other FDACs

Table 12 summaries the post-proceedings activities in FDACs around England.

Table 12. Post-proceedings in other FDACs

FDAC	Post-proceedings support offered
Birmingham	Three-to-six-month post-FDAC support and community intervention plan that is filed with the final assessment. Offer includes keyworker contact once per month for the first three months and random testing, continued access to AA meetings and CA Cocaine Anonymous meetings alongside peer-led coffee morning and craft group.
Black Country	No post-proceedings offer.
Coventry	A three-month post-proceedings. Some level of weekly contact and ongoing testing for three months. The keyworker remains the same. Assessment at the end of three months to see what improvements had been made, whether there was stability from the end of the final report to three months of reunification.
East Sussex	Support is offered for at least three months post proceedings, and often much longer. It is provided by the same person who supported them through FDAC and involves testing – at first weekly and then reducing to fortnightly. It is written into any plan that is in place – i.e. Supervision Order or Family Support Plan. There is also an "open door" policy, which means they can return to the team if they feel like they need support in the future. Where reunification has not been possible, support is offered by a separate multi-disciplinary team set up to work with women to try and reduce the numbers of repeat care proceedings.
Kent	Offer described as after-care, not post-proceedings support, and includes regular coffee mornings to maintain contact between the team and parents.

Leeds	An informal three months of after-care.
London	No formal offer of PPS. However, keyworkers maintain their relationship with those parents who have been identified as needing after-care.
Milton Keynes and Buckinghamshire	Once a month check-in at the very least and monthly unannounced testing.
Newcastle, Gateshead and North Tyneside	No post-proceedings offer.
Pan Beds	Post-proceedings offer described as a "soft exit" lasting on average 12 weeks but could extend to six months depending on the level of need. It includes keyworker gradually reducing the frequency of contact and offering continuing access to any therapeutic services they have been receiving.
Somerset	No post-proceedings offer.
Southampton	Any parent who graduates from FDAC has an offer of 12-month post-FDAC support from a social worker (keyworker) and a family engagement worker.
Stockport	Intention is to have a post-recovery worker.
Wiltshire (started July 2022)	Not planning to introduce PPS but looking at plans for families coming out of FDAC and putting formalised pathway agreements into place with partner agencies, and linking with family keyworkers in safeguarding teams etc.

The reason many FDACs had introduced some post-proceeding support was primarily to provide support to parents following the intensity of FDAC proceedings. The months in FDAC were often described as dealing only with the "tip of the iceberg" as far as trauma is concerned, which was why some staff in FDACs, such as in this one, continued to offer therapy beyond the final hearing:

> "We offer something called narrative exposure therapy because it works very well for people with multiple traumas, and I've got a very strong view that if you start trauma therapy, what you can't do is just cut people off just because the

> proceedings have happened to end. We will finish it, even if FDAC is finished, and this has allowed me to see what can be done after the end of FDAC, continuing one-to-one therapy with a parent around trauma. You just don't have time to do that within the FDAC and it's often one of these remaining needs and there's nowhere else to go for it because there's hardly any trauma services out there. We have also sometimes offered couple or systemic work, because you throw children back into a home, there's no support because they're not LAC (Looked After Children) or SGO, they get nothing, and they're just expected to get on with it." (FDAC C)

It was generally agreed that the "usual" support families received while on a care order or Supervision Order cannot be compared with that available during FDAC. One FDAC manager reflected that social workers were being asked to work with parents, some of whom were so psycho-dynamically complex that they would challenge experienced psychologists and therapists, but support from those professionals was not available.

As in Gloucestershire, continuing to work with parents after they have successfully completed FDAC was viewed as a way of providing support for the transition into community services after the intensity of FDAC. One of those interviewed drew a parallel with the period following a residential parenting assessment, where the likelihood of breakdown is high because the parents were back in their own communities. There were frequent references to families yearning for continued support because they were worried how they would react when it came to an end. Many families were also said to welcome the continuation of testing where this was offered:

> "… a lot of them are worried that testing will stop. So, a lot of them are miffed if you say I'm not testing you three times a week, it's only once a week, they worry about that. So that's one element that we've never really had any difficulties with, surprisingly." (FDAC X)

While a number of FDACs continued to test during the post-proceedings period, there was at least one that did not. They viewed testing as part of proceedings and were unsure what they would do about a positive test once FDAC had concluded.

FDAC staff also recognised that families may not be ready to start engaging with other services immediately after graduating and that an element of coaching and hand holding was important. Similarly, concerns focused on children being returned to their parents' care often triggered anxieties based on their previous experiences. It was clear that all FDACs – those with and those without post-proceedings provision – appreciated its importance. There was the sense that the effort put into the FDAC period was jeopardised by not having something that followed on:

> "Sometimes cases that look so secure, and you think, they've done great, and then three months later mum has started drinking again and the local authority have gone for an emergency removal. So there's a sense that we lose our investment by not having something afterwards. Obviously, some cases are going to break

> down, but I think when they break down in that first 12 months there's a feeling that we have not done enough." (FDAC M)

In a few cases the support that was put in was also extended to families where children had not been returned and would be experiencing loss and trauma:

> "We made that decision as a team – we don't get paid for it. I don't think we'd ever be able to evidence it, but we've had cases where parents following proceedings, whether it's been a negative or positive, have had moments of crisis, or they've had issues in terms of new partners, relationships, and having that support, having the people around who've made those decisions and understanding and can talk it through has definitely helped." (FDAC H)

Gloucestershire was not alone in commenting on the increasing complexity of cases they had faced during the pandemic and beyond. At the time of the interviews (summer 2021), most said that the outcomes were continuing to be poor, driven not only by the pandemic but also as a consequence of virtual working:

> "People struggled with virtual engagement, while the complexities of their difficulties in terms of their mental health, domestic abuse and obviously their substance misuse, particularly around alcohol, had really intensified. I think, the average over the years that we've been running at is 40% reunification, but it really dropped so we were really at 31%, so that was a significant reduction." (FDAC S)

Staff in two FDACs thought that it would be helpful if they could follow the Gloucestershire model and take responsibility for post-FDAC Supervision Orders, although neither had the capacity to be able to take on additional work. However, one suggested that the LA might want to look at repositioning responsibility for Supervision Orders and support the FDAC to take them on, given that the numbers would be comparatively small. It was thought that this would help address the fact that many LAs do not have appropriate provision for children on Supervision Orders:

> "There is no one to work with them on what's it like being back home, what their worries are, getting the parents to talk to the children, support repair conversations. FDAC does focus a lot on the parents because we're trying to get the parents as far as we can, but for me I often say, the journey of recovery for the children often starts when FDAC ends, and who is there supporting them?" (FDAC Q)

While the type of post-proceedings work that was undertaken varied, there was a consensus over three areas that should be the minimal level of support provided for parents after FDAC:

- Some form of support that was in place for a minimum of three to six months after the conclusion of proceedings
- Continued access to therapeutic interventions for up to two years
- Ongoing advice and support on how to access appropriate services.

FINDINGS

Evidence of feasibility

Is the model acceptable to parents and professionals?

The PPS model in Gloucestershire fits well with the FDAC model in place there, in terms of the intervention and population. It was well received by most parents and regarded as a valued and essential extension of FDAC by the professionals who engaged in the work. However, one parent expressed concern with the level of intrusion involved in continued testing throughout PPS.

Possibly because of COVID-19, numerous attempts to involve some professionals based outside TACS had proved futile, and although some community agencies did participate in this study each year there was a very low awareness of PPS and the representatives interviewed were not able to differentiate between FDAC and PPS.

Is it appropriately resourced (including time)?

Gloucestershire's FDAC and PPS are delivered by the Turn Around for Children Service (TACS). The team consists of seven full-time and six part-time staff and works with a local drug and alcohol recovery service – Change, Grow, Live (CGL) – and other community services.

PPS is able to use the same professional and administrative structures as FDAC, which helps to avoid duplication and reduce cost. It provides a substantial package of support for parents in the months after graduation from FDAC, which gradually reduces to give parents the opportunity to access services while professional support is still in place while establishing independence.

A broad range of activities was undertaken with families, with the majority receiving substance misuse interventions, mental health interventions, speech and language support for children, family/parenting support and physical health support. The team identified value in being able to work on more low-level work such as working on promoting healthier lifestyles, which could not take priority during care proceedings.

Until recently the social worker involved with a family through the FDAC proceedings stage would stay with them as they moved into PPS, taking responsibility for the Supervision Order. The workload this involved became unmanageable and these roles have now been separated.

The team benefits from having an embedded psychiatrist, which allows diagnostic work and treatment to continue in PPS while also providing clinical supervision for the nursing staff. An occupational therapist (OT) was brought into the team to add complementary skills while also undertaking general mental health practitioner duties. Due to the maternity leave of a colleague, the OT has had to take more responsibility for core aspects of the team's work, which meant that the intended mentoring work has not progressed.

Within the constraints of conducting the evaluation through the pandemic, it appears that the Gloucestershire model of PPS is adequately resourced.

Was it implemented as intended and as set out in the logic model?

It is very difficult to assess implementation because much of the period during which the evaluation was conducted coincided with the pandemic. Implementation of PPS was adapted to allow for social distancing, which meant that, after an initial pause, many interventions moved to a virtual platform. Some of the support services in the community were closed for a long period and when they reopened many of the groups and sessions were conducted online, even up to June 2022. In addition, fewer cases than would normally have entered PPS did so, and those that did enter PPS faced additional challenges, which impacted rates of relapse. The pandemic meant that implementation was not therefore undertaken as intended and the model was therefore unable to be followed precisely.

Evidence of promise

Does PPS maintain or change parental behaviour as predicted in the logic model?

Although there is a large body of empirical data on the short-term effectiveness over one to two years of treatments for drug and alcohol abuse, it is also known that recovery is a long-term process and gains may be short-lived. The logic model focuses on a reduction in both relapse and placement breakdown, but it is only possible to assess the success of PPS in the years that follow, which would require robust follow-up procedure alongside a higher quality of data than were available.

The logic model set out the steps from inputs to outcomes of PPS to understand the causal logic underlying the intervention to reach a better understanding of why the intervention does or does not work. It identified inputs in terms of human and other resources provided, outputs or activities and the intended outcomes. We have summarised the evidence of the expected outcomes in Table 13 below.

We have provided the overall figures for sustained cessation and reunification after PPS in Table 13. It should be noted that although comparisons that were made with FDAC, drawing on other research, look broadly positive, the small sample size, varying lengths of time since PPS completion, incomplete data and the impact of COVID-19 mean that any comparisons should be treated as indicative only and, while positive, are of limited value.

Table 13. Evidence of logic model outcomes

Outcome	Evidence
Building of recovery capital	The methodology and context of the evaluation did not provide sufficient data to allow this to be evaluated.
More families maintain recovery	66% of (12) PPS cases with a reunified mother showed no disruption to family stability at all over three or more years compared with the three-year figure for FDAC of 51% (Harwin et al., 2018)
Families' experience of PPS support is positive	Overall parents' experience of PPS was positive It was not possible to assess the level of, or satisfaction with, children's involvement in the PPS process
Reduced rates of relapse	77% of parents had sustained cessation after PPS had concluded. Only eight cases involved a mother who had completed PPS more than five years ago. In none of the cases was there evidence of relapse within five years of having done so, although subsequently two mothers had relapsed beyond the five-year period. This compares with 58% maternal sustained cessation over five years in FDAC (Harwin et al,. 2018)
Improved care of their children	It was not possible to assess this element
Parents develop skills to support /manage behaviour of children	It was not possible to assess this element but families felt supported by TACS over care of their children [Parents considered that the child-specific offer, especially continued Speech and Language Therapy and counselling, provided benefits but it was not possible to measure these within the evaluation.]
Reduced risk of further abuse and neglect	Abuse and neglect are very difficult to evidence. Ten of the 22 families (45%) had some recorded involvement with CSC following PPS ending. Of these, five resulted in a return to court and three were an early help assessment that resulted in NFA with the parent
Reduced placement breakdown	18 successfully completed PPS cases (82%) maintained reunification after the end of PPS (the length of time for this will vary depending on how recently the PPS concluded)

Return to court proceedings is avoided	Continued contact and support via PPS means team can intervene early where there is a relapse and take action, which might stop return to proceedings. 23% of successful PPS had a return to court, which compares with the three-year figure for FDAC of 34% (Harwin et al., 2018)

Did any combinations of services impact on outcomes?

It was not possible to assess the effectiveness of varying combinations of services for several reasons. It would be unsafe to draw any conclusions from the data obtained when the delivery of PPS had been adapted so substantially to respond to the measures taken during the pandemic. Neither was it possible to assess this from the data available from the TACS team on the different services that were available and accessed.

What, if any, were the facilitators and barriers?

The willingness of most parents and many professionals to engage in this work enabled the evaluators to reach a balanced view on the potential value of PPS. However, COVID-19 had a major impact on the delivery of PPS, and consequently on both the number of families seen during the evaluation period and (potentially) on the number of relapses experienced during that time.

Alongside the relatively small number of cases that have been through PPS in Gloucestershire over nine years, the biggest barrier to achieving a firmer basis for drawing conclusions about the efficacy of PPS has been the quality of data available. The ability to identify accurately relapses where parents are not actively engaging with the service makes longer-term outcomes difficult to assess, although this is not a problem unique to PPS. A lack of comparable outcome data following graduation in other FDACs makes it difficult to assess the true impact of PPS.

Readiness for trial and future research

Will it be possible to replicate the model either in its current form or in an amended form?

The PPS offer in Gloucestershire has consistent elements and interventions that are adapted to meet the needs of parents, in terms of both the offer and their intensity. Substance misuse interventions, testing and mental health interventions are provided to the majority of those in PPS. But the TACS in Gloucestershire also offers a range of other support that is specifically tailored to the needs of the family, such as ongoing Speech and Language Therapy, health advice, family/parenting support, continued access to the psychiatrist and therapeutic support.. While the range of support offered to families is likely to be part of the reason that PPS is viewed positively by

parents, it makes it difficult to identify the most effective elements of the PPS without a more intensive, longitudinal study of individuals.

While any potential manualisation should focus on those areas consistent across most of the PPS – substance misuse, mental health, family/parenting support and SALT – it is not possible to develop a manualised approach to PPS at the present time, even if it were possible to envisage how it might be transferred to very differently configured FDACs. This is, of itself, problematic. Discussions with other FDACs provided information on what many were offering after proceedings had concluded, but the discussions also identified the division that exists between a model that is integrated into CSC, as in Gloucestershire, and those that have been introduced by FDACs that are either independent of or less integrated into CSC. As the research showed, there was nothing to stop other FDACs requiring parents to return for informal reviews or testing during the Supervision Order. However, they did not have access to the continuing network of targeted support that is in place in Gloucestershire around recovery and the provision of holistic support for families.

We have indicated above that in Gloucestershire it was difficult to identify the specific contribution to families of the different components as PPS responds to need, but it was able to draw on a wider range of professional and community support than was in place elsewhere. So, while it is hoped that other FDACs may learn from Gloucestershire and similarly that Gloucestershire will follow the development of PPS around the country, it would prove difficult to transfer the model that has been evaluated without substantial remodelling the "usual" FDAC model. It is also worth noting that there was little appetite among those working in other FDACs in this study to follow that path. In this sense the context is a key limiting factor on transferability.

DISCUSSION

Discussion of findings

One of the strengths of the evaluation was that the interviews were conducted over two and half years. Although it proved more difficult to reach some parents, as well as those in some partner agencies, the repeated engagement with those most closely involved in providing the elements of PPS showed how committed they all were to PPS and to maintaining the support despite the difficulties encountered through this period.

This study highlights that there is a need for ongoing support for families after they graduate from FDAC, which has already been identified in a previous FDAC evaluation (Harwin et al., 2016 and 2018). Professionals working with families were convinced that there were parents who had graduated from FDAC and who were continuing to live with their children who would have returned to proceedings without the opportunity to consolidate their progress and be supported through relapses that occurred in the months following their graduation. It was widely acknowledged that post-FDAC relapses were not uncommon and the skills of those working in TACS could be harnessed to manage these and judge the most appropriate response, while encouraging parents to take control of their own recovery process. Borelli et al. (2017) demonstrate the importance of societal support in maintaining recovery. PPS was tailored to empower them to take control of their lives and know where to access services in the community and beyond when contact with the TACS team had ended.

The impact of COVID-19 on the operation of FDAC, PPS and this evaluation must not be underestimated. While the interruption of services was relatively short, agencies working in the community took a long time to return to anything like normal. There were also backlogs of cases to be processed in CSC, which interrupted the assessment of possible cases for FDAC. But, in addition, the nature of the problematic alcohol and substance misuse was also said to have become more severe and, as a result, the dropout rate from FDAC was higher than it had been so fewer parents graduated and entered PPS and, as a result, there were fewer parents to approach to take part in the evaluation.

The parents who were interviewed were generally very positive about their experiences in PPS. They recognised that they had needed additional support in the post-FDAC period and were grateful that this was available from professionals with whom they were familiar and flexible enough to respond to their needs and those of their families. They also appreciated the ongoing contact with the FDAC judges who had provided support, challenge and validation. There was, however, a minority who expressed dissatisfaction with specific aspects such as continued testing or with the length of time the team stayed in contact. The few who wanted a shorter period of PPS believed that there was a point where contact with TACS served little purpose. While they were no longer dependent on alcohol and/or substances, their long-term recovery relied on accessing

community-based services rather than the specialist support they had received in FDAC and immediately after graduation.

It came as a surprise to discover how many other FDACs were offering PPS even though none were as extensive as that in place in Gloucestershire. While there were some looking to expand their PPS offer, most were providing the support within the existing resources of the FDAC team and recognised that they were unlikely to be in a position to establish anything comparable to the Gloucestershire PPS, given its unique structure. This uniqueness arises from the fact that it is a co-located, multi-agency service, managed by a social work service manager and jointly commissioned and funded by children's services and public health nursing.

Harwin et al. (2018) found that the available data on sustained cessation beyond three years after proceedings was not of sufficient quality to be of any analytic use. This problem is also evident in the reporting from the national FDAC database, where the quantity of known substance misuse severity is far lower at the end than the start of FDAC (as would be expected due to loss of contact with parents). This is an inherent problem with collecting data on substance misuse, but it would be particularly problematic to collect accurate evidence on a parent's substance misuse status three years after proceedings have ended when the parent has no reason to submit to testing. Even where a parent has a reason to submit to testing, the recorded data is still of questionable quality. Data on the severity of drug and alcohol misuse at both the end of FDAC and the end of PPS were missing (at one or other or both points) for half of the parents entering PPS in Gloucestershire. It is likely any evaluation of FDAC or PPS will face similar data quality issues.

For the reasons explained at various points in this report the findings do not provide sufficient empirical evidence of the effectiveness of the PPS model in place in Gloucestershire or of its potential to transfer to other FDACs, given the uniqueness of the offer. However, this should not minimise its valuable contribution to families who have received PPS over the years. While it does not provide sufficient evidence for "direct transferability", it probably provides sufficient evidence for "conceptual" transferability as well as insights that will be relevant to other FDACs. The specifics of the model and the potential for replication should not be allowed to detract from the strengths of PPS. It provides a bridge from FDAC into future recovery for parents, and by adopting a holistic approach to the family it recognises the centrality of the child and the importance of providing support for them. However, it is a "bridge" and it is known that recovery from addictions is a long-term process, frequently requiring multiple episodes of treatment. Expectations of PPS should recognise that even the additional post-FDAC support it provides will not be sufficient for some parents.

Limitations

While the evaluation has provided valuable insights, it also had limitations. As far as families were concerned the impact of COVID-19 meant that we were not able to speak to as many families as planned. While this allowed a more detailed examination of individuals' experiences, the low overall number of cases involved in this unique approach to PPS ruled out a more robust statistical approach. It certainly was not a large enough sample to allow for the variation in individual

circumstances that will be found across families. It was also not clear that families going through PPS five years ago had the same experience as those going through it between 2020 and 2022.

There were also problems accessing some data around resources and costs. This impacted the costing work in particular, where the planned method had already been adjusted due to COVID-19. External unit costs had to be used because internal salary costs were unavailable.

The Centre for Justice Innovation (CJI) only started to collect standardised data to populate the national FDAC database from January 2021. As a result, the level of missing information in the national outcomes data record made accurate comparisons difficult. Due to the very nature of PPS, it only involves cases in which parents have successfully graduated FDAC. The logic model focuses on a reduction in both relapse and placement breakdown, but the true measure of the success of PPS can only be seen in the years after PPS has completed. Comparing the outcomes of FDAC graduates from other FDACs 12 months after graduation with those at the end of PPS would be the equivalent of comparing outcomes between parents who are receiving ongoing help with those who are not. Ideally the outcomes of families receiving PPS would be examined one to three years after PPS has ended, with those one to three years after graduating FDAC. The challenge here would be the accessibility to, and quality of, the data.

It is also important to consider the logic model that underpinned the evaluation has been tested and the response reported. With hindsight it is possible to see how neither the model nor the methodology allowed a thorough consideration of related but independent processes or of the combination of interventions and mechanisms that were most or least successful. The logic model described the implementation logic in linking interventions, mechanisms and outcomes but it did not account for *differences* in implementation, practices or context. Writing specifically about the challenges of evaluating activities designed to promote a healthier way of living, Cox (2000) has suggested a simple implementation path may not be the most appropriate approach to adopt where interventions involve multiple, inter-related elements and where the relationships between these elements and behaviour change "are complex and ill-defined" (p119). As a result, while the evaluation has produced much that is valuable, it has not dealt with PPS's underlying complexity. Clearly COVID-19 sent a bolt through expectations of the way in which PPS would be offered, but even in a normal, non-pandemic world there was not the opportunity to assess what Yin (2013) calls the "arrows… the flow of transitional or causal conditions, showing or explaining how one event might actually lead to another event" (p 324). The omission increases the danger of wrongly assigning causation in a complex multifaceted intervention.

Conclusions

The evidence collected on the PPS programme in place in Gloucestershire shows that it is well-resourced and is appreciated by parents and professionals alike. It provides a substantial package of support for parents in the months after graduation from FDAC, which is similar to that provided during FDAC but is reduced gradually to give parents the opportunity to access targeted and universal services while professional support is still in place. In all the conversations that took place during the evaluation, nobody questioned the importance of providing support for those who

have graduated from FDAC, recognising the challenges involved in recovery. This is reflected in the number of FDACs that have introduced some form of post-FDAC support. However, while Gloucestershire PPS's dependence on the multi-agency FDAC team's continued involvement into PPS allows a very structured front-weighted service, it brings into question the direct transferability of the model and underlines the need for a service in all FDACs that is a "bridge" between treatment for past addictions and living an intervention-free life.

There are two main recommendations emerging from the study. One relates to the importance of improving the quality of the data collected on those accessing FDAC and PPS. The other is covered in more detail in the following section and rests on the importance of designing an evaluation model that builds on this study and is able to measure the causal connections.

Work is being undertaken by the CJI to improve the consistency and comparability of nationally collected FDAC data. However, the problem remains that the longer a parent has been involved in FDAC/PPS the more likely that their recorded drug misuse status is not known (or at least not consistently recorded). Longer-term outcomes, including around family stability and further involvement with CSC, are not currently consistently recorded and would need additional work to define a coherent collection methodology.

Directions for future research

A future study of Gloucestershire's PPS should begin with a logic model that includes both a focus on causation and complexity and one which is informed by this study. It should support the examination of the connections between elements of PPS by identifying the metrics and data required, the evidence relating to the connections between these in implementation paths and the causal mechanisms that might explain how these connections occur, which might lead to desired outcomes. The elements of the design would have to be developed but as a minimum would contain pre and post testing of behaviours and attitudes, engagement, observations and shadowing, data on the nature and timings of interventions, participant interviews and focus groups over the duration of the programme, and repeated interviews with key informants in TACS and beyond. It would need to be underpinned by better data about staffing deployment and costs. Ideally, the data collection processes would be supported by an embedded evaluator. It is possible to see how the logic model would then become a theoretical model for the intervention and recommendations for the resources that would be needed to sustain it.

An alternative approach would be a comparative study of Gloucestershire's model of PPS and that in place in an FDAC, committed to providing a structured approach to PPS that went beyond limited support and contact. However, while it would be possible to arrive at a quasi-experimental design, underpinned by the components described in the previous paragraph, it would be difficult to align the individual interventions studied, given the uniqueness of Gloucestershire's offer. It would, therefore, be important to pay particular attention to which aspects of the intervention process should be assessed by which data collection method.

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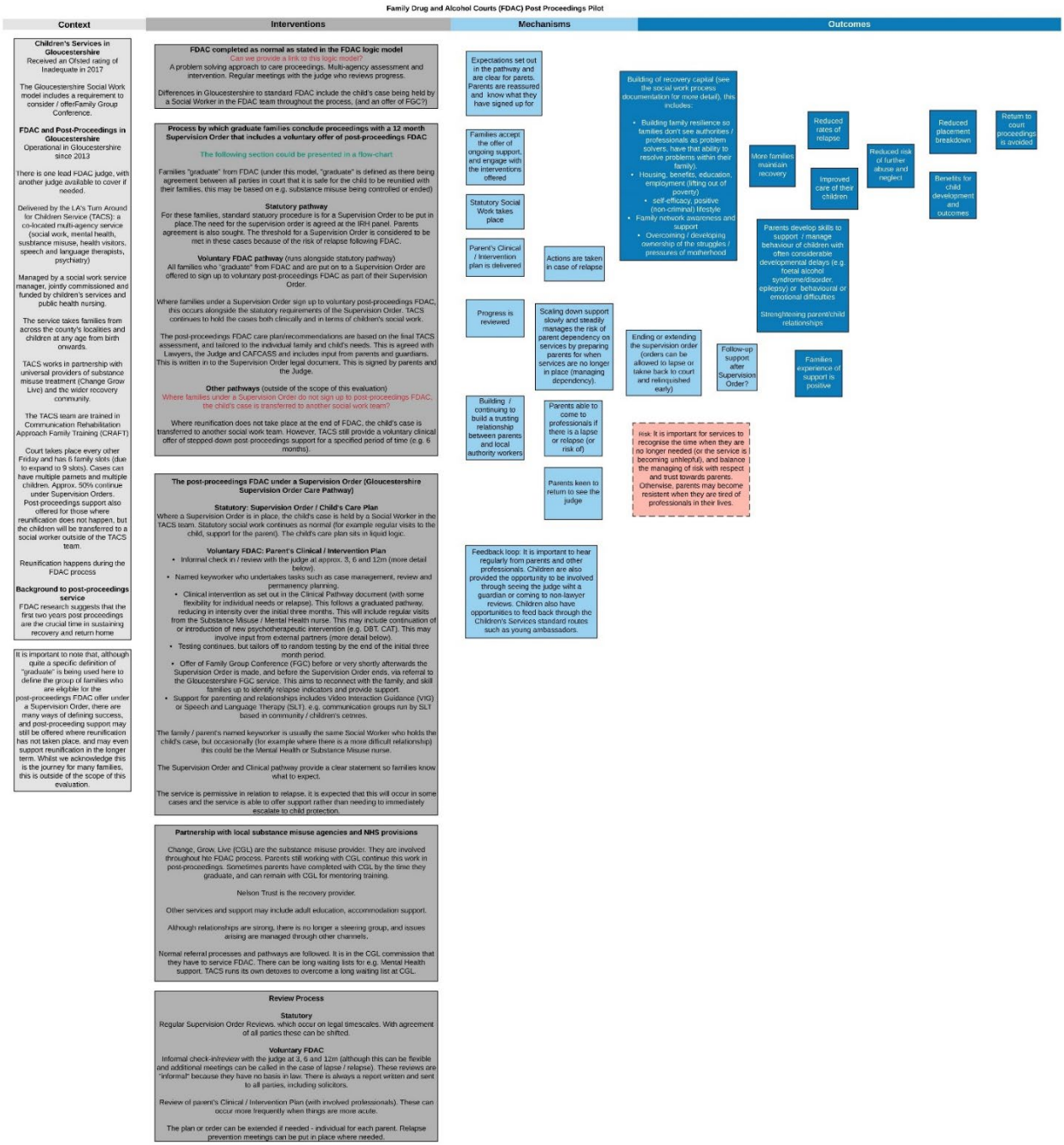
APPENDICES

Appendix A: Revised logic model



Appendix B: Additional tables

Table 14. Costing assumptions

Period	Assumption
Week 1–4	Average 3 MH/SM interventions/testing per week
Week 5–12	Average 2.5 MH/SM interventions/testing per week
Week 13–20	1 SM intervention, 3 MH interventions in period
Week 21–28	1 SM intervention, 3 MH interventions in period
Week 29–end	SM intervention, 6 MH interventions in period, 1 hour testing at week 36
General assumptions	Each intervention is assumed to last one hour
	Typical PPS assumed to last 52 weeks
	There will typically be four court appearances during the PPS. The allocated social worker will prepare and file the court reports to update the judge every three months during the Supervision Order period
	Management/peer support and administration are estimated to require 50% of the time spent on MH interventions throughout PPS. This is on the basis that MH are most consistent resource requirement and as this reduces so would need for management and admin support. This is a proxy due to no available data
	SALT, health visitor support, family/parenting support and clinical psychiatrist: calculated proportion of families reportedly receiving by the time spent on mental health interventions. This is a proxy due to no available data

Table 15. Unit cost estimates for all PPS staff

Role	Unit cost (£ per hour)	Unit cost equivalent role
Clinical lead	65	Professional staff, Band 7
Service manager	65	Professional staff, Band 7
Occupational therapist	47	Community occupational therapist
Business administrator	35	Professional staff, Band 4
Support and outreach worker	25	Support and outreach worker
Mental health nurse	33	Professional staff, Band 4
Social worker	46	Social worker (children's services)
Clinical psychiatrist	65	Professional staff, Band 7
Health visitor	35	Professional staff, Band 4
Speech and Language Therapist	41	Professional staff, Band 5
Group work	231*	12 behavioural activation sessions delivered by a non-specialist

* This is the total cost for 12 sessions of group work.