Department for Education

Evaluation of Positive Choices in Calderdale for care experienced and other vulnerable young parents

Final Report

June 2020

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Acknowledgements

Researchers from the Institute of Public Care at Oxford Brookes University would like to offer our sincere thanks to all those who participated in this evaluation, in particular the young parents and Positive Choices staff members who offered their time so generously and without whose support this evaluation would not have been possible.

Key Messages

The **four key messages** from this study for sector leaders, commissioners and policy makers are that:

- Intensive programmes replicating Positive Choices aimed at very vulnerable first-time parents have the potential to significantly improve child to parent attachment and parenting skills, and to reduce risk factors for abuse and neglect. Where parents engage well, longer-term outcomes, such as parents' resilience, are more sustainable compared with those of parents accessing more traditional supports.
- However, intensive programmes like Positive Choices are likely also to identify unacceptable levels of risk to children at an earlier stage (understandably so given that the target participant group is known to be vulnerable or very vulnerable). Therefore, commissioners and service leaders might not expect to see a significant reduction in the number of children needing to come into care in the first 6-12 months of their life. The main (cost) benefit of programmes like Positive Choices would appear to be in reducing the incidence of subsequent (including repeat) referrals into social care services for parents who 'keep their babies' in the first months of life but whose care may begin to break down at a later stage.
- First time very vulnerable parents receiving Positive Choices-style support pre-birth (as opposed to only a children's social care services' pre-birth assessment) are more likely to respond positively compared with those who receive the same type of support at or post-birth. Around the time of a child's birth appears to be the worst time to commence support. This finding seems particularly important, as starting actual support pre-birth is not thought to be the norm currently in social care practice. More needs to be understood from other sites about the extent to which it is beneficial to start actual support earlier (during pregnancy), and, if it is, how to ensure this happens consistently in practice.
- Finally, it was envisaged originally that the Positive Choices Programme would be required mostly for first-time parents who are care experienced (looked after or care leavers). However, in practice, many young people who had experienced children's social care (for example, at least 1 Child Protection or Child in Need Plan) as a child but who did not come into care were also referred in for support. This latter group appear from the evidence in this study to be at least as vulnerable as their care experienced peers. The implications are that they should receive as much attention and support in transition to and during early adulthood, at the very least if and when they become a parent for the first time.

Executive Summary

Introduction

This evaluation explores the extent to which and how an innovative ‘Positive Choices’ Programme in Calderdale has supported very vulnerable including care experienced parents to care well for their baby or infant child.

The Positive Choices Programme and this study are important because, beyond having a trusted (and trustworthy) adult involved, not much is yet known about ‘what works’ in terms of the content and timing of effective support specifically for care experienced or otherwise very vulnerable young people who become pregnant. This is so, in spite of the fact that their children are known to be at significantly increased risk of requiring statutory (social work) support and coming into care.

The Project

Calderdale is a metropolitan borough council in West Yorkshire, of which Halifax is the main commercial, administrative and cultural centre. The overall population is around 210,000. Over a 3-year period, the project has worked with approximately 62 parents, aiming to improve outcomes for the whole family and enable the child(ren) to remain safely at home. The intervention model can be described as follows:

- Intensive.
- Systemic.
- Strengths-based (starting with individual and family strengths) including coming alongside the young parent in an empathetic, non-judgemental way.
- Relationship and evidence-based, including a strong element of workers ‘modelling’ and reinforcing (through positive praise) good parenting.
- Working in partnership (with the family and other agencies).
- Starting actual support (not just assessment) as early as possible in the pregnancy, otherwise as soon as possible after the child’s birth.
- A balance of structure (a structured programme of learning and development for the young person) and tailoring to the individual needs of families.
- Sticking with the young person even if their children comes into care.
- Encouraging young people to be confident in engaging with professionals and accessing lower tier supports in the longer term, rather than waiting for a crisis.

This evaluation

This evaluation is mixed method (combines quantitative and qualitative elements) and the analysis of findings draws upon: whole service population data; standardised outcomes measures; in-depth case file analysis (for families receiving support compared with a retrospective cohort receiving support prior to the establishment of Positive Choices) and interviews with parents, Positive Choices staff and broader stakeholders.

Where findings are described as significant, this means that they are statistically so.

Key findings and implications for practice

- The Programme has been working with an exceptionally vulnerable group of mostly first-time (prospective) parents including care leavers, looked after young people and young people who have had an involvement with children's social care as a child, many of whom also have a learning disability.
- The first-time parents who have experienced children's social care as a child but who did not come into care appear to be at least as vulnerable as their care experienced peers, including to known risks for child maltreatment (such as domestic abuse, substance misuse and poor mental health). Whilst looked after young people and care leavers generally have access to at least 1 professional support worker, their children's social care' experienced peers often do not.
- Positive Choices has enabled more vulnerable parents (including prospective parents and fathers) to receive tailored, intensive and structured support provided in 'sessions' with a named, consistent key worker. Sessions combine both therapeutic and 'educational' input (for example learning about a baby's brain development and how it is affected by exposure to regular or severe arguing).
- For parents engaging well with the Programme, there are well-triangulated indicators of strong or strengthened child attachment; understanding of (what constitutes) effective parenting; and positive life choices.
- In the short term, parents in both retrospective and Positive Choices cohorts 'kept their babies' in similar proportions (77% and 68% respectively). However, a much greater proportion of those receiving the Positive Choices support had clearly evidenced overall positive outcomes including improvements in their mental health; parenting choices; risk taking activities, including reduced involvement with domestic abuse or intense and frequent arguing in front of the child; and improved ability to manage behaviour when frustrated. These 'successful' Positive Choices parents had clearly made some major changes to their lifestyles and behaviours. This is particularly impressive as, compared with the retrospective cohort, the

Positive Choices cohort comprised many more parents whose behaviours were thought at the outset to present very high risks to their children.

- Whilst almost all of the Positive Choices parents whose outcomes were less positive had their child taken into care by the end of the intervention, within the retrospective (comparison) cohort only 10/17, 59% of the children of parents with less positive outcomes came into care. This finding suggests that intensive work at an early stage with parents who are known to be very vulnerable also has the potential to identify considerable risk (and the need for care) earlier.
- The most compelling indicator that Positive Choices interventions 'work' is that in the longer term, over periods of up to 3 years and an average of 19 months post-intervention, a significantly greater proportion (68%) of the Positive Choices children were able to remain living at home with parents without substantial including ongoing statutory support or plans, compared with only 37% of the retrospective cohort where outcomes could be ascertained (35% of the total). Although a full cost benefit analysis has not been possible to undertake within the context of Covid-19 related restrictions, evaluators estimate that the DfE investment of £440,000 over 3 years has resulted in actual and projected savings of at least £781,744 direct to the local authority.
- Parents involved with the Positive Choices Programme had a significantly better response when the work with them started pre-birth compared with when it started post birth (particularly unhelpful appears to be starting work at around time of the birth). The evidence in support of this finding comes from case file analysis as well as from standardised measures suggesting that the parents involved with the Programme pre-natally had a significantly better quality of interaction and spent significantly more time interacting with their baby compared with those who became involved at a later stage. This overall finding appears particularly important because, traditionally, children's social care services tend to commence actual support work after a child's birth, even where prospective parents are known to be vulnerable (although often a pre-birth assessment is undertaken at a pre-birth stage).
- Other risks for parents not having a positive response to the Programme appear to include: parental learning disability; the presence of very high level risks of abuse or neglect to the child at around the start of the Programme; and parents having had a childhood involvement with children's social care compared to being care-experienced.

  > "They think it's not going to happen (their own children coming into care)" (project worker)

- In summary, this study provides strong evidence in support of more consistent, widespread, and particularly pre-birth support of this nature for first-time parents

who are known to be (very) vulnerable. More needs to be learned about the significance of this support and how to ensure it is available more consistently. In the meantime, in support of replication by other sites, it is hoped that the evaluation report provides a clear indication of what worker attributes and activities support ‘real’ engagement and involvement of vulnerable parents in this kind of highly effective programme, including from the perspective of parents and staff involved in the Programme as well as from other stakeholders.

1. Introduction

Project context and the existing evidence base

This report presents findings from an independent evaluation of 'Positive Choices', a Calderdale Council innovation providing support primarily to care experienced young people who become pregnant for the first-time but also to other young (prospective) parents who are considered vulnerable. The innovation has been funded by the Department for Education (DfE) Children's Social Care Innovation Programme between 2017 and 2020.

The existing evidence base suggests that:

- Care experienced young people are significantly more likely than their peers to become pregnant early and to continue with the pregnancy, even when it is not planned. (Haydon, 2003; Dixon et al, 2006; Wade, 2008; Maxwell and Chase, 2008; Mendes, 2009; Dworsky and Courtney 2010; Matta Oshima et al, 2013; Botchway et al., 2014; Craine et al, 2014). Pregnant care leavers appear to be more closely connected with birth families (particularly mothers) compared to other care leavers (Dixon et al, 2006). Key factors thought to influence the rate of pregnancy amongst care leavers include: low educational attainment, poor mental health, sexual risk taking, domestic abuse and substance misuse. Protective factors are thought to include: remaining in care longer, having a flexible transition to independence and being supported by a trusted (and trust-worthy) named individual (Broadhurst and Mason, 2014). Knight et al (2006b) emphasize the emotional consequences of being in care and how this influences decisions around pregnancy and parenthood. This research team has characterized pregnant young care leavers as highly vulnerable emotionally, experiencing feelings of rejection (by birth families and/or the care system), loneliness, stigma, insecurity, social exclusion, and marginalization.
- Care experienced young people who become pregnant may experience considerable pressure from services to end the pregnancy but paradoxically not much pregnancy or parenting-specific support during it (Chase et al, 2006, Dixon et al, 2006). When the child is born, they may feel like they are 'under the microscope' to a greater extent than others, even other young parents (Chase et al, 2006). Beyond the 'trusted individual', not much is yet known about how best to support care experienced young people once they do become pregnant (Knight et al, 2006a, Fallon et al, 2015, Hyde and Jones, 2018), either pre or post birth.
- This is particularly striking because existing research suggests that babies and children of care experienced parents are at significantly increased risk of coming into care, continuing what has been described as an 'intergenerational cycle' of

abuse and care (Jackson and Smith, 2005 and Broadhurst et al, 2015). These same parents are highly likely to experience 'recurrent' care proceedings in due course in relation to any subsequent offspring (Broadhurst et al, 2014 and 2017). Substantial investment has recently been steered towards programmes designed to halt recurrent pregnancies or care proceedings once a first child has been taken into care, for example 'Pause' (McCracken et al, 2017).

- However, alongside this investment, Broadhurst et al, 2018 have also cast a spotlight on a growing trend of local authorities to issue care proceedings at or soon after the birth of a child to care leaver parent(s). This recent study has understandably raised concerns about what is described as a 'typically short window for pre-birth assessment' which means that prospective parents who are known to be vulnerable do not have enough opportunity to work purposefully on their parenting skills before the child is removed from their care.
- Experiences of vulnerable young parents who are not care experienced but who have nonetheless been the subject of at least 1 statutory (Child in Need or Child Protection) plan as a child are not as well explored in the research to date, although these 2 cohorts are likely to have had similar experiences including abuse or neglect and significant trauma (Broadhurst and Mason, 2014).

Project aims

Calderdale's Positive Choices Innovation Programme has sought to improve the quality of support and the evidence base for work with care experienced and otherwise vulnerable first-time parents by exploring a model of early, systemic, and evidence as well as trauma-informed intervention. The aims of the service are very clearly and consistently articulated by both key workers and local stakeholders working in the whole system of support to children and families:

> "Support parents to gain independence and lead them on a positive path. Reduce risk and social services' involvement. Give parents and child confidence and belief they can do things" (Positive Choices key worker, hereafter key worker)

Project eligibility and key activities

Eligibility for the service includes parents or prospective parents under 25 years who are care leavers, looked after young people or otherwise vulnerable and considered 'high risk' (mainly because of a history of involvement with children's social care).

Programme support is delivered over an extended intervention period, tapering off towards the end, by key workers with protected caseloads whose primary focus is to:

- Build trust and confidence with the young person.
- Reduce the risk factors (including individual and environmental) associated with negative parenting and child outcomes and increase family resilience.
- Promote child attachment and parent to child empathy and attunement.

The Programme also seeks to reduce further unplanned pregnancies, improve the personal and life choices of young people whether their child comes into care, and increase family overall resilience. Key aspects of the model are described by the service as:

- Systemic.
- Strengths-based (starting with individual and family strengths) including coming alongside the young parent in an empathetic, non-judgemental way.
- Relationship and evidence-based, including a strong element of 'modelling' and reinforcing (through positive praise) good parenting.
- Intensive, including to provide enough support and contact time with the young person to build trust and undertake an effective programme of work, but also to quickly identify any unacceptable deterioration in baby care.
- Working in partnership (with the family and other agencies).
- Starting actual support (not just assessment) as early as possible in the pregnancy, otherwise as soon as possible after the child's birth.
- A balance of structure (a structured programme of learning and development for the young person) and tailoring to the individual needs of families, for example of materials for a parent with learning disability or difficulty. A structured 8-week pre-birth programme is undertaken where possible.
- Sticking with the young person even if their children comes into care – at least up until the final care hearing (at which point they may be referred into another specialist service).
- Encouraging young people to be confident in engaging with professionals and accessing lower tier supports in the longer term, rather than waiting for a crisis.
- Being open to re-referrals of families to the project, where appropriate (in fact, no families had been so re-referred at the time of evaluation).

2. Overview of the evaluation

Evaluation questions

This realistic (Pawson and Tilley, 1999), mixed method evaluation explores the following key questions:

Question One: Who has been referred into the Positive Choices Programme and to what extent do they appear to need an intensive support of this nature? To what extent can they be compared with a 'retrospective' cohort of parents and families with similar characteristics who were referred for support before the project commenced?
Question Two: To what extent have (prospective) parents and families referred into the Programme responded positively to the support including in relation to child to parent attachment, parenting skills and attunement, and reduced risk factors?
Question Three: To what extent are parents supported to care safely for their child(ren) so that the child(ren) can remain living at home, rather than come into care, both in the short and longer term?
Question Four: To what extent is it possible to place a value (including financial value) on the Programme?
Question Five: What supports effective implementation of a model like this and what are the key features for replication elsewhere?

Evaluation Activities

Data from the following sources and evaluation activities has been analysed:

Activity	Data Quantity	Detail
Secondary analysis of whole Programme activity and outcomes data	62 parents / 52 family 'units' involved in the Programme	These families referred into the Programme January 2017 to November 2019. Standardised measure data was available in relation to a considerable proportion (76%) of this cohort[1].
In-depth case file analysis of a sample of Positive Choices cases	36 key parents / 34 family units[2]	Conducted January 2018 to February 2020. This cohort represents a substantial sample (65%) of the overall cohort of families[3]

[1] It was difficult to establish a clear baseline using standardised measures, as key workers often needed to first establish a relationship with parents before inviting them to complete an initial questionnaire
[2] Where parents gave their express (informed) consent to participate in this way
[3] Including: 12/36 (33%) parents who were care leavers, 4/36 (11%) who were looked after children, and 20/36 (56%) who were considered vulnerable because of a significant previous involvement with children's Children's social care.

Activity	Data Quantity	Detail
Retrospective (comparative) case file analysis	48 vulnerable young parents and family units	Conducted September to October 2018. These parents were known to social services as vulnerable young people and had received a service before the Positive Choices Programme commenced[4]
Semi-structured interviews[5] with parents involved with Positive Choices.	13, most of whom (10) had already completed and the others almost completed an intervention[6]	Rolling through the evaluation. Researchers also attempted to involve young people who participated initially in a further interview, but they all chose not to do so, despite giving an initial indication that they would like to do so.
Semi-structured longitudinal interviews with Positive Choices workers and Professional Stakeholders	10 Positive Choices Key Workers and their managers or supervisors; 9 professional stakeholders[7]	These interviews took place in July 2018 and February 2020. A different manager or supervisor took part at each stage (total 2). A total of 8 Positive Choices key workers took part including 7 in July 2018 and 4 in February 2020 (of whom 3 had participated in the first July 2018 wave).

[4] This cohort included more care experienced young people (19/48 or 40% looked after young people and 15/54 or 31% care leavers) compared with the Positive Choices cohort (other vulnerable young people numbered 14/48 or 29%). The level of risk in the retrospective cohort was lower.
[5] Adapted for young people with a learning difficulty or disability in appropriate cases
[6] 4 parents described having been involved with the Programme whilst still pregnant (and for a while after the baby was born). The other 9 parents described having become involved at birth or when their child was a baby, infant or small child.
[7] With an involvement in the whole system of support to children and families locally including: children's social care and care leaver services; targeted youth support; health visiting; targeted midwifery services; CAMHS; council 'early help' and voluntary sector family support

3. Key findings

Who has been referred into the project and to what extent do they appear to need an intensive support of this nature?

Management information relating to the overall project suggests that a total of 52 family units including 62 parents (10 sets of couples) were recruited into the Positive Choices Programme between 2016 and 2019 by a range of professionals but mostly social workers or community health workers. Almost all these young people could be characterised as 'high need, high risk'. 87% were White British or another White ethnicity.

Demand for work pre or post birth

Much (approximately 50%) of the overall demand for Positive Choices has been to work with first-time prospective parents (pre-birth). However, a proportion of work has also been requested at around the birth of a child or subsequently, when the key child is an infant, as illustrated in the table below.

Table 1: Type of demand for Positive Choices in the overall and case file cohorts

Type of demand	Overall Cohort (family units)	Case file cohort
With first time parent(s) **pre-birth** (mostly between 1 and 5 months pre-birth)	50% (26/52)	50% (17/34)
With first time parent(s) **at around the time of birth**	23% (12/52)	26% (9/34)
With first time parent(s) **when the child is an infant** (between 6 months and 5 years post-birth)	17% (9/52%)	24% (9/34)
With parent(s) when **1 child is an infant and 1 pre-birth**	5/52 (10%)	0% (0)

Steadily more families have been referred to Positive Choices pre-birth, particularly during the final year of the funded Programme (2019-2020).

Demand by parent experience of care

Fifty percent of the overall cohort of young people recruited into the Positive Choice Programme so far have been care experienced (including 25/62, 40% care leavers and

6/62, 10% looked after young people). Fifty percent (31/62) of the young people were considered vulnerable for another reason including 19, 31% because they were known to children's social care services as a child. The case file cohort is representative of this same diversity: at the point of the pregnancy, just under one half (44%) were care experienced including (12/36, 33%) care leavers and (4/36, 11%) looked after young people. The majority (20/36, 56%) were considered vulnerable including with reference to their history of involvement with children's social care. The retrospective (comparator) cohort differed in that a greater proportion (71%) were care-experienced (including 31% care leavers and 40% looked after or recently looked after children).

Demand by key parent age and gender

Parents recruited into the Programme overall were aged between 15 and 26 years with most of the whole cohort (44/62, 71%) aged 17 to 22 years. Peak ages for referrals were 17 and 19 years and the mean (average) age was 19.13 years. Parents in the case file analysis sample, including mostly Mums (82%) but some Dads (18%) were similarly aged at referral into the service, with a mean (average) age of 19.5 years and mode (most common) of 19 years. In the retrospective (comparator) cohort, the young people were slightly younger on average (mean age of 18.53 years and mode of 16 years).

Demand by key parent learning disability or difficulty

A sizeable proportion (22/62, 35%) of the overall cohort of parents involved with Positive Choices are known to have a learning disability. Unlike in the retrospective (comparator) case file cohort where only 4/48, 8% are known to have a learning disability, a more sizeable proportion (10/36, 28%) of the parents in the Positive Choices case file analysis sample also have a known learning disability including 1 with a significant learning disability and 9 with a mild to moderate learning disability. Staff suspect that a further proportion of participating young parents have underlying learning difficulties that are not 'diagnosed' or easy to identify.

Demand by key parent experience of abuse and neglect as a child

Case file analysis[8] has provided insights into the childhood experiences of the care experienced and other vulnerable young parents, many of whom are known to have been subjected to abuse or neglect themselves as children, often in combination. These childhood experiences are explored in detail in Table 2 below:

[8] Both in the Positive Choices and Retrospective (Comparator) samples

Table 2: Parental experience of abuse or neglect in childhood: case file samples

Childhood Experience Abuse Type	Positive Choices case file sample		Retrospective (comparator) case file sample	
	Number	%	Number	%
Neglect	17/36	47%	21/48	44%
Physical abuse	14/36	39%	26/48	54%
Sexual abuse	14/36	39%	15/48	31%
Emotional abuse[9]	15/36	42%	14/48	29%

Demand by the nature of risk and resilience factors at the start of the intervention

The case file analysis also provided more in-depth information about the nature and level of risk(s) and resilience factors of relevance to child maltreatment at the point of initial involvement of the Positive Choices service. In both cohorts, the primary risk factors were domestic abuse, parental mental health problems, and parental substance misuse. Mental ill-health appeared to be more prevalent in the Positive Choices cohort whereas the prevalence, if not the degree of other factors was very similar.

Table 3: Risk factors in Positive Choices and retrospective family units

	Positive Choices case file cohort		Retrospective (comparator) cohort	
Risk Factor	**No.**	**%**	**No.**	**%**
Parental Mental Health Problems	22	65%	22	46%
Domestic Abuse or high levels of family conflict	26	76%	34	71%
Parental Substance Misuse	19	56%	26	54%
Housing Issues	11	32%	13	27%
Social Isolation	7	21%	6	13%
Parent actively offending	0	0%	5	10%
Parent at risk of sexual exploitation	3	9%	4	8%
Problems managing finances	3	9%	2	4%
Significant physical health needs	0	0%	1	2%

[9] largely through chronic exposure to domestic abuse

The whole cohort Positive Choices data (including both mothers and fathers) suggests similar levels of these risk factors, for example: 40/62, 65% noted to have risks posed by mental health problems, 41/62, 66% risks posed by domestic abuse, 26/62, 42% risks posed by substance misuse. A greater proportion (20/62, 32%) of the whole cohort were noted as being vulnerable because of sexual exploitation.

All 3 factors known to significantly increase risk when present in combination (domestic abuse, parental substance misuse and parent mental health problems (Cleaver et al, 2011)) were present in 12/34, 35% Positive Choices case file analysis family units compared with 11/48, 23% of the retrospective (comparator) cohort. In a further 12/34, 35% cases there were at least 2 out of 3 of these toxic trio issues present compared with 19/48, 40% of the comparator cohort.

Resilience factors were also documented in relation to the child and family in most (28/34, 82%) Positive Choices cases and in 35/43, 81% of comparator files in relation to which such information was available. The spectrum of resilience factors varied from case to case, with very few (6/34, 18%) Positive Choices cases having no such factors identified at the point of referral to the service. Resilience factors often included: supportive extended or substitute family; engagement with professionals; basic (child) care needs being met; or parent(s) preparing well for the baby's birth. Other less commonly identified resilience factors included: parents having some insight into their difficulties; or attending education, employment, or training.

Demand by risk(s) of abuse or neglect and level of family need

Data collected (see table 4 below) about the whole cohort of parents who were offered Positive Choices suggests that a very large proportion (55/62, 89%) were assessed as 'high risk' in relation to their child before the intervention started (2, 3% a medium risk and 5, 8% a low risk). Within the Positive Choices case file cohort, children's social work assessments leading to interventions with families identified specific risks of abuse or neglect in relation to 28/36, 78% parents, more so than in the retrospective (comparator) cohort (26/48, 54%). The nature of perceived risks of abuse were different both within the Positive Choices case file cohort and between it and retrospective case file cohort.

Table 4: Number and proportion of family units with children considered at risk of abuse or neglect in Positive Choices and comparator case file cohorts[10]

	Positive Choices cohort		Retrospective (comparator) cohort	
Specific Risks	**No.**	**%**	**No.**	**%**
Neglect	13/34	38%	13/48	27%
Physical Abuse	9/34	26%	10/48	21%
Sexual Abuse	5/34	15%	3/48	6%
Emotional Abuse	13/34	38%	11/48	23%

The overall level of need, as judged by the evaluators undertaking the case file analysis, was also quite different in the Positive Choices cohort compared with the retrospective (comparator) cohort of families accessing support in Calderdale before the Positive Choices Programme commenced, as illustrated in Table 5 below:

Table 5: Positive Choices and retrospective case file cohorts by level of need

	Positive Choices cohort		Retrospective (comparator) cohort	
Level of need	**No.**	**%**	**No.**	**%**
1. Universal needs	0	0%	5	11%
2. Some additional needs requiring targeted (early help) support	0	0%	3	6%
3. Multiple additional needs requiring coordinated (early help) support	2	6%	7	15%
4. Complex additional needs	3	9%	3	6%
5. Requires a statutory (social worker-led) plan i.e. Child in Need or Child Protection Plan	**29**	**85%**	**29**	**62%**

There was a far greater proportion of children who were considered certainly to require a statutory (social worker-led) plan for example a Child in Need or a Child Protection Plan in the Positive Choices compared with the retrospective cohort.

[10] Note: In a number of cases, risk of more than one form of abuse was identified

Positive Choices and Retrospective cohorts' similarities and differences summary

Key similarities	Key differences - Positive Choices cohort
Young people with similar overall experiences of abuse and neglect as children	Substantially more young people who have required children's social care as a child but are not care experienced
Young people of similar ages	More young people with learning disability
Young people with similar types of risk factors	More young people with mental health problems
Similar proportion with at least 1 known resilience factor at referral	More substantial overall risk levels including more requiring a social care-led plan for their own child

One hypothesis about the key difference (in overall risk levels) is that only the most vulnerable young (prospective) parents in Calderdale have been referred into the Positive Choices Programme. Another is that non-care, rather social services experienced parents exhibit riskier behaviours compared with those who are care-experienced, in part because of a lack of a trusted and trustworthy adult[11] in their adult lives, and they are more numerous in the live compared with the retrospective cohort.

To what extent have (prospective) parents responded positively to the Positive Choices Programme?

Management data suggests that families have been allocated a Positive Choices key worker very swiftly: many on the day of a local multi-disciplinary panel meeting to agree the referral (26%), or within a week of this (a further 36%). Other families were allocated between 1 and 7 weeks post-panel with the majority (82%) allocated within 3 weeks of the panel meeting. Almost all (59/61, 97%) parents[12] have engaged initially with the service.

Early engagement is perceived as an essential stage in the work, important to get right. It usually includes:

- An initial visit to explain the flexible support that can be offered and 'sell the benefits' of it.
- Getting to know the young person and what motivates them.
- Talking about the plan, if one is in place, to be clear about expectations.

[11] For example, a 'Pathways' (care leaver) advisor
[12] Where there was sufficient information upon which to make a judgement about participation

- Active non-judgemental listening, focusing on parent strengths as well as areas for support.
- Time to reflect and consider what parents want to change including using a 'timeline' approach

  ".. help them reflect on their own upbringing – how do they want things to be different .. how can we help them..?" (key worker)
- Use of 'vision statements' – how parents want their life and the child's life to be.

Many of the young people who participated in an interview for this evaluation described having been wary or weary of the 'helping professionals' before getting involved with a Positive Choices worker:

> "I was referred via the local authority. I've got social services in my life. They thought it would be really helpful. I wasn't sure" (parent)

Others described feeling isolated or lonely at the time and having personal 'issues' such as drinking or managing emotions. They also described feeling under-confident about themselves and/or about caring for a baby.

> "I'm used to being told I'm useless" (parent)

> "Being on your own can make your mental health deteriorate if you're holding it all in" (parent)

A very high proportion (32/36, 89%) of parents in the Positive Choices case file analysis cohort engaged well with and accepted the support offer in what was often described by project workers as an initial 'critical' 6 -12-month window. In only 1 case did the young parent decline all support. In the other 3 cases, the parent appeared to accept the support partially. This compares very favourably with the retrospective case file cohort within which there was evidence, including from running records and ongoing service reviews, of only 29/48, 60% young people engaging positively with the support on offer during this critical period. When asked how they or their worker overcame initial engagement concerns, parent interviewees described the things their worker did to connect positively with them:

> "She liked similar (TV) programmes for example about natural history. We found things in common" (parent)

or to provide practical support:

> "She would sort things out for us like finding information and explaining it well" (parent)

Some also mentioned how a joint introductory meeting (for example with the midwife or social worker, someone who was already involved) could be helpful.

Many parents went on to describe how ‘positively different’ it felt to work with a consistent Positive Choices worker including compared to other experiences with professionals:

> “She took time to know us better. We’d had a lot of services in our lives” (parent)

Worker attributes that were described by parent interviewees as being most valued in the initial stages of engagement were:

- Taking time to get to know one another.
- Being flexible for example about times and places to meet.
- Active listening to past histories, problems and concerns, providing an opportunity to reflect. It is interesting that many young people emphasised this as something they had not often or ever experienced previously.
- Being curious but not prying too quickly into personal life questions.
- Showing empathy and connecting in some way with the young person’s life story.
- Being approachable and non-judgemental.
- Being reassuring, supportive and positive.
- Being consistently and regularly there.
- Helping with practical things such as ‘forms and benefits’ or baby equipment.
- Accompanying the young person to meetings or baby groups.

Parent interviewee direct observations about these attributes included the following:

> “Reflected on what I didn’t want for my child that my mum did with me. Looked at my visions and aspirations for myself and my baby”

> “She didn’t ask me personal life questions unless I wanted to talk about them. But I have. I’ve got stuff to talk about, things that have happened to me in the past”

> “I felt able to tell (key worker name) about us having problems in our relationship”

> “They said I did really well at the first baby group I went to. I was nervous the first-time and she came with me the first few times, and then I went on my own”

Factors considered by workers to hinder the early engagement process include:

- Parents’ chaotic lives or ambivalence about having a child.
- An unplanned pregnancy.

- Parental mental ill-health.
- Parent wariness of the system, based on prior experience.

  "They are tired of being 'worked' and can feel that level of scrutiny and involvement will not stop" (key worker)
- Other professionals 'forgetting they are still young people' or 'telling them off' (key worker)
- The (unhelpful or unconstructive) views of family members or peers.
- Domestic abuse, substance misuse.
- Too many professionals involved already.

All the other professionals interviewed for this evaluation considered that Positive Choices workers engage very effectively with vulnerable young people and are highly skilled at this, not only at the start of the relationship but ongoing.

> "Young people will be more honest with key workers as they have a different relationship – the power imbalance is different (as the key worker isn't a social worker). The young person comes to trust the key worker" (stakeholder)

> "Engagement is brilliant – supportive and listen … build young person's confidence, provide encouragements, go when they say they will" (stakeholder)

Whole cohort data suggests parents were involved with the Programme for between 1 and 23 months (the mean length was 10 months and the mode 9 months). Within the case file analysis cohort, parents' engagement with the Programme was sustained for between 6 and 23 months (most between 8 and 14 months). The intensity of sessions for families varied between once to 3 times a week, often more frequent during an initial or intensive and risky phase of the work and less frequent or 'tapering' towards the end. These face to face sessions were often supplemented by outreach telephone calls or texts, additional meetings, and support to attend appointments.

To what extent were fathers engaged effectively?

Case file analysis suggests that fathers were engaged in the Programme in the majority (24/34, 70%) of cases, and in a robust way in 17/34, 50% cases. This is distinctly different to the retrospective (comparator) cohort within which only 9/48, 19% fathers were involved in any way with the support. Of the parents or couples interviewed:

- Generally, mothers thought that the baby's father had been involved quite to very well.
- Others commented that the baby's father had not been involved much or at all, in circumstances such as the father was living away or had separated.

Of those interviewees confirming that Dad had been involved, all described this involvement in very positive ways including with reference to worker flexibility and their involvement with the couple both together as well as individuals:

> "(key worker name) has always helped me with my mental health. I had a trauma a few years ago and was in a bad place. My mind set (now) has changed. Since she has been involved, she has supported me with this. I've done sessions on my own and also with (mother). This works for us" (father)

> "My partner was working but she (key worker) was flexible and worked around times he was working" (mother)

> "(key worker name) would make sure that, when he was home, he did things and would say it's his turn to do things. He is the bottle maker.." (mother)

How was positive parental involvement sustained?

The Positive Choices case file analysis evidenced high quality planning often combining a statutory (Child in Need or Child Protection) plan and more detailed intervention plan.

Highly structured, sessional work was evidenced in practice on all (100%) case files. This is again different to the retrospective (comparator) cohort in relation to which only approximately 50% included a structured, purposeful intervention in support of parenting, provided mostly by the Family Intervention Team (FIT) workers, and approximately half did not. In the retrospective cohort, most interventions were limited to social worker assessment and visiting (of the child) and/or care leaver support for the young person.

A very wide range of sessional support was undertaken by Positive Choices key workers and parents, including very typically[13]:

- Exploration of the significance of baby or child attachment and support for bonding.
- Work on domestic abuse including the impact of domestic abuse or arguing in front of babies and children, and broader work on couple and family relationships.
- Support for specific parent 'issues', most commonly substance misuse and/or emotional health and wellbeing but also personal hygiene and smoking cessation.
- Understanding risk to parents themselves, for example of (sexual) exploitation, and support to address this risk.

[13] More information about the tools used to support this work can be found at Appendix 3

- Educational support and practical modelling of basic baby routines and meeting baby needs including feeding, weaning, modelling, and supporting play time.
- Support for parents 'through' social services processes including emotional support but also ongoing explanations of statutory processes.
- Support for contact arrangements with other parents or family members.
- Practical support including in relation to finances, budgeting, and money management; to access appropriate housing; with home conditions (including to understand the impact of poor home conditions); and to access nurseries.
- Support for parents to gain self-esteem not only through emotional support but also achievements such as being able to organise effective contraception, or to access college or other educational or employment opportunities.
- Support for parents to reduce social isolation and access broader community (baby) groups.

In relation to 1:1 work with parents pre-birth, researchers noted a highly structured (often 8 week) pre-birth pathway programme with learning sessions on topics including: health in pregnancy; birth planning; preparing for baby; baby development; safe sleeping; breastfeeding; coping with crying; and learning about baby brain development. These 'baby learning' sessions were complemented by many or all the other forms of support listed above.

Key workers also coordinated the Positive Choices Programme and their own input with a range of agencies, listed at Appendix 4, and members of the extended family.

Parent interviewees placed a high value on this sessional work. Pre-birth, this included: baby brain development (and how it is affected by adverse home life including arguing), coping with crying, the importance of bonding including during pregnancy, breast feeding, learning about baby development and listening to their 'cues'. Post-birth, they valued some of the same and more including: baby care including 'baby brain', 'coping with crying', 'responding to baby cues'; practical support to undertake key baby care tasks; sustaining positive relationships with partners and family; exploring the impact of domestic abuse and/or frequent arguing on the baby and access to evidence-based programmes (such as the Freedom Programme) online; support to engage in frequent play and 'chat' with baby; support to attend meetings, parenting groups, or sexual health, substance misuse, housing or finance clinics; family group conferencing; practical help to access key items of equipment including through the local 'Mothershare' scheme; and support to manage one's own emotions or broader mental health.

As different parents explained:

> “She sits and speaks to us about things. She brings paperwork to each visit, sheets and quizzes. We’ve kept them all… a book of materials” (parent)
>
> “Just to make sure my mental health is OK. If I have problems, I should talk to people otherwise it will affect the baby. To give me motivation to get it sorted” (parent)
>
> “My Mum has also learned stuff. Things have changed since she had me!” (parent)

Parents of older infants and children also talked about getting help from their key worker with: bed or meal time routines; reward charts and other ways to support positive child behaviour at home; home conditions; getting support for the child in school; and toileting.

When asked ‘what was particularly helpful, if anything’, many parents expressed a view that ‘everything’ had been helpful.

> “It was all helpful – it changed my perspective about how to do everything right for my kids. Made me think about what it means to be a good Dad” (parent)

Other parents identified some aspects of the Programme that they felt had been particularly helpful including: the educational sessions relating to baby development (baby brain, mellow babies, baby cues); work on relationships, particularly the 1:1 work with the couple together; practical support including equipment and clothes; help with emotions and to access psychological support; having someone to talk to and encouragement; and support to access group-based programmes.

> “It’s getting us to go out more and do other things like playing with her to help her brain development” (parent)
>
> “(Learning) to put me and the kids first and not put others’ needs first” (parent)
>
> “Me and my partner didn’t want to go to group sessions, so it was good that the worker came to the house to do work with us together (for example the Freedom Programme)” (parent)

In describing how the support had been helpful, parents often mentioned the personal attributes of the key worker and their relationship as much as the sessional content. They talked about how different it felt to their experience of help from family members including their own parent(s):

> “The Programme is good but it’s (key worker name), the worker, who makes it great, the relationship with her. It’s all about the relationship” (parent)
>
> “I get on really well with (key worker name). It’s about how you do the job. She’s peaceful, doesn’t judge me. She just listens first, rather than telling” (parent)

> "You can tell for her it's more than just a job. She genuinely cares" (parent)
>
> "She knows what she's saying and says the right things. She's 10/10" (parent)
>
> "I enjoy my sessions. I find them quite therapeutic really. It's just (key worker X) as a person. If I talk to my Mum she will tell me (what she thinks I should do) straight away. X listens" (parent)

Worker attributes mentioned specifically by parent interviewees included: non-judgemental; fun; supportive; consistent; reassuring; and confidence-inspiring. Interviewees generally could not think of anything that would make the service better apart from in 2 cases where the parent thought that it could be improved either:

- by being more extended (in time); or
- by having more of an involvement of parents who had been through the same thing (and come out the other side).

All interviewees said that they would recommend the service to another person or to a friend and sometimes offered advice for other parents including:

> "This is the best thing we've ever done. Get the opportunity, take it. If it's not working, don't quit, give it time. We found it hard to trust professionals. Take time, work alongside" (parent)
>
> "It's a chance for a new relationship with a worker. I've always found it hard getting on with authorities. When people have been in care, there's a big trust issue… If you're struggling, they can help you. You learn new things" (parent)
>
> "They are easy to get along with, they don't judge, they are there to listen and help you through the hard times" (parent)

To what extent has positive parental engagement led to the development of positive parenting or positive child / parent attachment?

This question has been examined specifically through the lens of key indicators including: reduction in parent-related risks; child attachment and parent attunement; improvements in the understanding of parents about effective parenting methods; better parent life choices; and avoidance of a swift further pregnancy. Each are considered in turn below:

- **Reductions in parent-related risks.** Whole cohort data collected by the Programme and recorded through ongoing assessment and review suggests that parents involved in it have reducing level(s) of risk relating in particular to alcohol use, sexual exploitation, and housing. There have been reported reductions in

other areas of risk such as parental substance misuse or mental health, or domestic abuse, but these are less substantial.

Staff and stakeholders perceive the Programme to have had an impact on the reduction of risk factors overall including specifically through: identifying and agreeing risk factors with the young person; use of specific tools and programmes 1:1 (for example the Freedom Programme online); use of regular reviews so that young people can see the progress they are making; supporting young people to regulate their emotions; and use of Family Group Conferencing.

“A highly effective relationship-based model that helps young people to understand what risk looks like, as they have a distorted view of boundaries and acceptable and unacceptable levels of risk due to past experiences” (professional stakeholder)

Some stakeholders and key workers in interview suggested that the intensity of the Programme, including for example unannounced visits and the encouragement of parents to ‘open up’ to their key worker, means that risk(s) and any deterioration in baby care is spotted and acted upon earlier.

- **Child attachment and parent attunement**. Data from standardised measures relating to a sizeable (75%) proportion of the whole cohort of parents involved with the Programme suggest that the quality of attachment between even unborn children and their parents was high or very high, particularly where parents became involved with the Programme pre-birth. Detailed information about these scores can be found in the technical document (Appendix 7).

  In 21/31, 68% Positive Choices case files containing sufficient recorded information on the file to make a judgement, child attachment was noted to be sustained positively or improved as evidenced by: positive parent/child interactions; parent provision of stimulation for the child including through play; good eye contact; baby or infant responses; and observations of the infant being upset when Mum leaves the room. In all these cases, there was also strong evidence of parent attunement to their child’s needs. In 10/31, 32% cases, the child was not considered to be well attached to their (key) parent by the end of the intervention. In almost all cases, these were the children of parents who had engaged poorly or disengaged with the Programme. Many parent interviewees described from their perspective how the ‘bond’ with their child had improved including as a result of improved understanding of the baby needs, being encouraged to become more attuned to these needs, and specific attachment-related work with the key worker. Parent interviewees commented as follows:

  “Did work on attachment before and after the baby was born, things like talking to baby when she was in my belly” (parent)

".. with support from (key worker name) on things like how to hold baby, how to comfort her, reading her signs like knowing when she's upset" (parent)

"Interacting more, spending more time together" (parent)

"For example, the importance of connecting with the baby, to connect with her before she's born. I didn't know that (before). How important breast feeding is. I'm going to give it a try" (parent)

Positive Choices staff attributed the model's positive impact on parent attunement with the child to a range of sessional work focusing on: pre and post-birth bonding (incorporating Mellow Bumps or Babies materials); baby brain development; learning about the importance of bonding and play or talking with baby and exploring attachment 'opportunities' when feeding or bathing the baby; baby cues for example types of crying, signs of being tired or hungry. They also emphasised the importance of key worker modelling, for example of how to hold a baby, floor play or baby massage, followed by observation and positive reinforcement, and the involvement of fathers where possible.

"Moments of insight, even if the smallest things – helping parents to develop insight (into) the importance of bonding" (key worker)

"Model how to do it: floor play, close contact between Mum and baby, responding to baby cues. Teach them what attachment is, this is how it feels" (key worker)

- **Improved parent understanding of effective parenting.** Parents were considered to have a good understanding of effective parenting in 22/33, 67% completed interventions in the Positive Choices case sample where there was enough information on the file to make this judgement. Parent interviewees were happy to describe some of the things they were doing differently as a result of the Programme:

  "Being there, putting him first" (parent)

  "You have to balance motherhood and a social life. I used to go out a lot. Now, I'm getting in on time, interacting with him (baby) more" (parent)

  Some also described having become (more) confident about parenting:

  "I have more confidence as a Mum to manage (baby's) tempers because I understand it better. I know his triggers" (parent)

  Most parent interviewees who thought the Programme did not have a major impact on their parenting considered that they were doing quite well with this

anyway before getting involved with Positive Choices. However, in 1 case, the parent described how she felt she needed to give her baby up for adoption

"..as baby's needs were too difficult for me to manage" (parent)

Positive Choices staff and stakeholders think the model helps young people to be better, safer parents including through: placing a strong emphasis on parenting skills and knowledge adapted to the child's age and stage of development; role modelling what it means to be a good parent; teaching how receptive a baby is (both pre- and postnatally); focusing on practical skills and routines; specific sessions focused on safety for example safe sleeping; coping with crying – how to stay calm when things get tricky; tailored work around domestic abuse and substance misuse including the impact on the baby and protecting oneself; starting this work early i.e. pre-birth where possible; and raising awareness that parents' own experience of being parented does not have to be repeated.

"Helps to stimulate learning, skills and confidence …helps young people to reflect upon their own experiences of being parented and how they might do it differently; helps with setting boundaries" (key worker)

- **Better parent life choices.** Parent interviewees described feeling confident or more confident in a range of different ways as a result of their involvement in the Programme, for example:
  - In their overall ability to cope

"I'm coping better. I don't stop what I need to do because of the stress. That's different to before. I feel confident about the future" (parent)

  - In their ability to parent well in the future

"I'm not confident in myself anyway but I do think I'm a good Mum" (parent)

  - About future employment prospects

"I've got a job and have been doing it for 14 weeks" (parent)

"..starting college in September" (parent)

Positive Choices staff and other stakeholders from a range of agencies consider that the service model can help parents to make better life choices in particular as a result of: a strong emphasis on building their confidence and self-belief; exploring their aspirations and helping to open doors where possible; active investigation of training and education options; having access to a dedicated employment advisor in the broader (FIT) team; being able to help the young person access childcare; providing advice about contraception and positive choices regarding further pregnancy.

"Focus is on supporting the young person as a parent as well as on baby – treat the young person as an individual in their own right, supporting young person to access services, encouraging Mum to get out of the house without baby without feeling guilty" (professional stakeholder)

- **Avoidance of further pregnancies.** 27/34, 79% of the Positive Choices case file cohort of mothers completing an involvement had no further pregnancies during the period of their involvement of up to 23 months. 7/34, 21% mothers had become pregnant again by the end of their involvement. This compares with 14/48, 29% becoming pregnant again over a similar time period in the retrospective (comparator) cohort.

To what extent have parents been supported to care safely for their child(ren) in the short and longer term?

The proportion of overall positive and overall negative outcomes was similar across the whole Positive Choices cohort (evidenced by management data provided by the Programme) and the case file analysis cohort. A full breakdown of the whole cohort outcomes data is provided in Appendix 6 to this report.

For a small proportion of families in both the overall sample and slightly smaller Positive Choices case file sample, it was not possible to be clear about the overall outcomes for the child(ren) and parents including because the intervention was not yet complete, or the parent(s) had disengaged (without adverse consequences) or moved to another area, or where the baby was still born.

Of the 35 family units in the whole Positive Choices cohort where outcomes could reasonably be ascertained, 21, 60% had an overall successful outcome including child(ren) remaining in the care of their parent(s) and 14, 40% largely unsuccessful outcomes including child(ren) being removed from the parent's care[14].

Of the 31 Positive Choices case file analysis cases (family units) where outcomes could reasonably be ascertained, these were considered by evaluators to be positive or very positive in almost the same proportion (19/31, 61%) of cases compared with mostly negative (in 12/31, 39% cases). In the positive outcome cases, not only did children remain living with and being cared for effectively by their natural parent(s) but parents

[14] This was approximately the same with respect to individual parents involved with the Programme in relation to which 25 were reported to have completed the programme successfully, 17 had their child removed, 2 declined participation but the child remained living with them, 2 moved to another area, and 1 had a child who was still born. Therefore, of the 42 who did engage, 25 (60%) were successful and 17 (40%) had their child removed.

were also often: taking control of their mental health and actively seeking help with their mental health; accessing community resources independently; distancing themselves from previously problematic friendship groups; recognising the impact of domestic abuse on themselves and their child, with the incidence of domestic abuse also reducing considerably or stopping; being able to manage their behaviours when frustrated; or continuing to accept support and to work with professionals in a collaborative and honest way. Parental substance misuse was often noted as having reduced considerably or stopped, more positive relationships were beginning to form between parents and their extended family, parents were exploring employment, education or training options or actively taking up these options, home conditions were improved and adequate or good, and there was positive household budget management.

In the retrospective (comparator) case file analysis cohort, the number and proportion of 'overall positive outcome' cases were considerably lower (15/48, 35%). Where outcomes were considered by evaluators to be positive in the retrospective cohort, it should be noted that families had often been provided with intensive family support services akin to Positive Choices, almost an early prototype of the service. Within the retrospective cohort there was also a greater proportion of 'outcome unknown' cases (15/48, 31%) as well as mostly negative cases (17/48, 35%) where little or no change had been made to negative lifestyle choices, young people continued to engage in inappropriate relationships, substance misuse and/or domestic abuse was still prevalent, sexual exploitation of the parent was continuing, parents were staying out for long periods of time with the baby, were moving home frequently, had poor financial management, were self-harming and were not seeking or accepting support. It is striking that, whilst most (11/12, 92%) of the 'negative outcome' families involved with Positive Choices had children taken into care, within the retrospective (comparison) cohort only 10/17, 59% of these children came into care.

Case Study

This case concerns a new mother aged 17 years at the birth of her first child. Mum was considered vulnerable because of her involvement with children's social care as a child. Positive Choices became involved from 4 months into the pregnancy (pre-birth). At that time, there were concerns about domestic abuse, parent mental health problems, parent substance misuse; and maternal grandmother's (negative) ongoing influence on Mum. A specific worry was that Mum would neglect this new-born child and a therefore Child Protection Plan was put in place.

Positive Choices was provided for 20 months, including weekly key worker sessions and additional support through phone calls and texts, and to attend children's social care meetings.

Sessions addressed several areas including: substance misuse; housing; practical parenting (e.g. nappy change and bathing); accessing benefits; registering with GP; contraception; mum's mental health; money management; weaning. Tools used

included: needs jigsaw, parenting theory sessions, cannabis use safety plan, coping with crying session. The parents had separated prior to the baby's birth and Dad did not want to be involved.
Early motivational conversations with the key worker supported Mum to take responsibility for her actions and to be pro-active in seeking the right equipment and support to care for the baby.
The child remained living with Mum by the end of the intervention and is considered well-attached. Consistently positive interactions were observed between parent and child, and Mum demonstrated a good understanding of what is good (enough) parenting. The baby was meeting all their developmental milestones, immunisations were up to date, Mum was interacting well with baby. By the end of the intervention, no risks were noted in relation to the child and Mum was engaging well with all professionals, receiving appropriate support from family members.

Other Positive Choices case studies can be found at Appendix 8.

Families in the Positive Choices cohort that had overall a positive outcome include:

- **Mostly parents who commenced working with the service pre-birth**.

  This is a striking finding. Within the whole cohort 'successful outcome' group, there were more parents who started the work pre-birth (15/25, 60%) compared with those starting the work at the time of their child's birth (5/25, 20%) or when the child(ren) was an infant (5/25, 20%). Within the slightly smaller Positive Choices case file cohort, the proportions are similar, as explored in Table 6 below:

Table 6: Timing of engagement for positive outcome Positive Choices case file cohort

Timing of engagement	Number	%
Pre-birth	12	63%
At birth	2	10.5%
In the first 6 months	0	0%
In the first 7-12 months	2	10.5%
When child aged 2-4 years	3	16%
Total	19	100%

  Within the whole cohort, 15/21, 71% relevant[15] parents who started the work pre-birth completed it successfully and 'kept their baby'. A relatively high proportion of parents starting work when their child was an infant were also successful

[15] Excluding those who had not yet completed an intervention or who could not complete an intervention for a reason such as still birth, or moved away from the area

(although the overall numbers are much smaller i.e. 5/7). A much lower proportion (5/14, 36%) of parents starting the work at birth were successful. These findings triangulate well with the more in-depth case file analysis outputs explored below.

Table 7: Timing of engagement with the Programme across different outcomes in the Positive Choices case file cohort

Timing of engagement	Number and % of Mostly Positive Outcomes	Number and % of Mostly Negative Outcomes
Pre-birth	12 (75%)	4 (25%)
At birth	2 (29%)	5 (71%)
In the first 12 months	2 (67%)	1 (33%)
Older child (2-4 years)	3 (60%)	2(40%)

These findings from case file analysis are supported by sub-cohort analyses of the Maternal Antenatal Attachment Scale (MAAS) and Maternal Post-Partum Attachment Scale (MPAS) standardised measure scores, indicators of the quality of attachment. The MAAS findings suggest that parents involved pre-natally have a significantly better quality of interaction and spend significantly more time interacting with their baby compared with those involved at a later stage. Both these findings are statistically significant. Post-natally, the (MPAS) indicators of attachment are also better for the group of parents involved pre-birth, but the effect size is only small to medium (not statistically significant in this case). More information about these scores can be found at Appendix 7.

Parent interviewees who considered the impact of the Programme to be positive were more likely to have become involved earlier, particularly pre-birth.

- **Slightly more care leavers** compared with other 'types' of Positive Choices clients. Within the whole cohort, a greater proportion (12/18, 67%) of care leaver key parents had a successful outcome compared with those who were still looked after (1/2, 50%) or those who were considered vulnerable because of a previous involvement with children's social care (8/15 or 53%). Within the case file analysis cohort of family units, the proportions are more pronounced, as illustrated in Table 8 below:

Table 8: Case File Positive Choices families with positive and negative outcomes by parent type

Young person type	Number and % with positive outcomes	Number with negative outcomes
Care leavers	9 (82%)	2 (18%)
Vulnerable because of involvement of children's social care	8 (50%	8 (50%)
Looked after young person	2 (50%)	2 (50%)

The features of the relevant[16] 17 parents with less positive outcomes within the whole cohort (management) data set include:

- A significant proportion of parents considered to be 'high risk' at the start of the intervention (16/17, 94%) including some (2) in relation to whom an older child had already been removed or 'given up' into care.
- A high proportion of parents with known learning disability (10/17, 59%).
- A greater proportion of parents who started working with the Programme at the birth of their child (9/17, 53%) compared with pre-birth (6/17, 35%) or when the child was an infant (2/17, 12%).
- A slightly higher proportion of the relevant looked after key parents (1/2, 50%[17]) or 'vulnerable' group (7/15, 47%) than care leavers (6/18, 33%).

The features of relevant 12 cases with less positive outcomes in the Positive Choices case file cohort are similar and include:

- A greater proportion of parents considered vulnerable because of a history of involvement with children's social care (8/12, 67%) compared with looked after (2/12, 17%) or a care leaver (2/12, 17%).
- A greater proportion of parents with mild to moderate learning difficulty (5/12, 42%).
- A greater proportion of families who began working with the service at the time of the birth (rather than pre-birth or when the child is older).

[16] Ibid
[17] Although the numbers are small

Table 9: Timing of engagement with the Programme for unsuccessful outcome families in the Positive Choices case file analysis sample

Timing of engagement	Number	%
Pre-birth	4	33%
At birth	5	42%
In the first 6 months	1	8%
In the first 7-12 months	0	
When child aged 18 months - 4 years	2	17%

Of these less successful Positive Choices cases examined in detail through case file analysis, almost all resulted in children coming into care or being looked after under another arrangement by a family member (in 11/12 cases). In the other case, there was a new Child Protection Plan as the child transferred to another local authority's responsibility when the parent moved. These cases were characterised by parent(s) not engaging in a meaningful way or stopping engaging in a meaningful way with the support on offer; continuing to abuse drugs or alcohol and/or to engage in domestic abuse; or continuing to associate with people who pose a risk to children. In many cases these young people's lives continued to be chaotic. Positive Choices staff consider the model to be less effective overall with parents where:

- There is an entrenched cycle of poor parenting (a pattern they experienced as a child).
- There is an entrenched pattern of domestic abuse or volatile relationships.
- The parents have not been able to engage in pre-birth work.
- The parents do not really believe there will be negative consequences of poor parenting (primarily those who haven't come into care themselves).

  "They think it's not going to happen (their own children coming into care)" (key worker)
- Their emotional needs are not being met, so they seek out attention from inappropriate sources.
- There is hidden substance misuse or domestic abuse.
- For any other reason, they are not motivated, for example if they did not really want the baby.

Key workers have emphasised in interview how non-care experienced parents may be more vulnerable or their children may be at greater risk of coming into care because they

"*..don't see anything wrong with where they are as parents when they see their upbringing as being okay"* (key worker).

What has been the impact of the Programme on the number of children coming into care?

Given the high level of risk and need within families referred to the Positive Choices service, it is likely that a proportion of children will come into care by the end of the intervention.

The management data collected by the Programme itself suggests that in 14/35, 40% relevant completed cases (family units), the child(ren) of the family were being cared for away from natural parents by the end of the intervention compared with 21/35, 60% overall family units completing the Programme successfully.

Of the children included in the Positive Choices case file analysis sample:

- 11/34, 32% had come into care during or by the end of the intervention.
- 23/34, 68% had not come into care during the period of the intervention or, despite coming into care (technically i.e. with a Care Order), continued to be cared for successfully by their parent.

This is approximately the same proportion as those in the retrospective (comparator) case file analysis cohort wherein 11/48, 23% did come into care and 37/48, 77% did not come into care. However, it must be remembered that these cohorts are considered different in one important way: the level of risk (to the child) was considered considerably higher at referral in the Positive Choices cohort compared with the retrospective (comparator) cohort.

What has been the sustainability of positive family outcomes beyond the end of the intervention period?

The case files of Positive Choices families that had closed with children remaining with parents (19 in total) were reviewed at March 2020, at which point the cases had been closed for between 3 and 38 months (with a mean or average duration of 19 months). The findings were startling. Only 5/19, 26% children had been re-referred to children's social care and in only 3 of these cases did the referral lead to an assessment. Other findings include:

- No subsequent Child Protection or Child in Need plans have so far been required in relation to any of the cases.
- None of the children or parents in these 19 cases have been re-referred to Positive Choices.
- No children have come into care since case closure in any of these 19 cases.

These longer-term outcomes (for parents engaging successfully with the Programme) are much better than those for children in the retrospective cohort who did not come into care during or by the end of the intervention (37 in total). By the time of the case file analysis between 0 and 81 months (with an average of 25 months) after case closure, it was not possible to ascertain the whereabouts or circumstances of 2 children and their parents (they had moved away from the area). 4 more children were no longer living with the key natural parent (bringing the overall total of those coming into care to 15/46 or 33% of those where outcomes could be ascertained). 7 more were the subject of ongoing active social services' concern under either a Child Protection or a Child in Need Plan and 7 were the renewed focus of concern in the form of social services' referral(s) or assessments and/or were receiving targeted support from prevention teams. Overall, of the original 46 children in the retrospective (comparative) case file cohort where longer term outcomes could be ascertained, only 17, 37% were still living with their natural parent(s) with no active social services' arranged support, far fewer than in the Positive Choices cohort (23/34 or 68%).

A chi-squared N-1 test was performed in relation to these findings. The proportion of Positive Choices parents keeping their babies and remaining free of the need for social services support was significantly different to the children and families in the retrospective sample (X^2 (1, N=80) = 7.45, $p < 0.01$). Based on the odds ratio, the odds of parents keeping their babies and not experiencing further involvement with social services were 3.57 higher if they had Positive Choices intervention.

Potential challenges to the sustainability of positive outcomes were described by parent interviewees as including: ongoing mental health struggles; staying away from alcohol or drugs; going to meetings with 'professionals' alone; going out to parent and toddler groups alone; being able to consistently manage child routines and behaviour; and managing money.

> "It's hard to stay off the alcohol" (parent)
>
> "Some ups and downs because of my mental health" (parent)

Many professional stakeholders consider a critical strength of the Programme to be its ability to make families more resilient in the longer term, including through:

- Building young person confidence and giving them the tools to do their own risk assessments and to problem solve.
- Encouraging them to attend group-based parenting support alone.
- Encouraging them to ask for help without being judged.

  "Strong focus on building life skills…prepare them for key worker stepping away" (stakeholder)

"Opportunity to mature a bit and learn how to access services" (stakeholder)

To what extent is it possible to place a financial value on the Programme?

In order to fully explore the financial value of the Programme, it would be important to look not only the proportions of children supported to remain safely at home with parents, who come into care or who need further statutory support after a Positive Choices intervention (including compared with a retrospective cohort), but also:

- The unit costs (per family) of delivering the service, including the 'real' costs of the service, for example incorporating organisational overheads.
- Trends in whole cohort demand, for example the extent to which the number of infants becoming looked after in Calderdale decreased over the time the Programme has been in place.

Unfortunately, neither of these data items are currently available to evaluators owing to the Council's need to focus its efforts on supporting families during the Covid-19 pandemic. What can be said, in the absence of this information, is that there are likely financial savings attributable to the 68% Positive Choices case file cohort children remaining successfully at home with natural parents without the need for further statutory support in the medium to longer term compared with only 37% of those in the retrospective cohort without such an intervention, as shown in Table 10.

Table 10: Percentage medium-term[18] outcomes for Positive Choices and retrospective case file analysis cohorts

Medium term outcome	Positive Choices cohort	Retrospective cohort
Child became looked after in the short to medium term	32%	33%
Child / family required an additional, significant intervention in the medium term	0%	30%
Family did not require any further intervention	68%	37%

[18] Short to medium term references by the end of an intervention and a follow up period of up to 3 years (average of 19 months) post-intervention

We note that not all the children from the retrospective cohort who required further statutory support became looked after in the medium term: many were the ongoing subject of a further Child in Need, Child Protection or Targeted Prevention Plan. However, based on all the evidence available on the case files, evaluators estimate that approximately one third of this group still remaining at home but with further statutory interventions in the medium term were likely to go on to become looked after, including as a result of the (accumulation of) statutory plans and little change in home conditions.

In Calderdale, 54 family units worked with Positive Choices over a period of slightly less than 3 years. A conservative estimate of projected savings from the service over this period is calculated by evaluators to be in the region of £781,744 accruable to local authority children's social care services alone[19]. This is calculated as follows:

- Without Positive Choices, in a cohort size of 54, 30% need at least one further intervention, giving you 16 children. Based on the evidence from case files, evaluators estimate that each of these children will require an average 1.5 further interventions, with each intervention lasting approximately 1 year. A conservative estimate of the cost of a Child in Need or Child Protection intervention of a 1-year duration (based mostly on social work case management costs) is £3,402[20] [21]. Therefore, the total social work costs saved in relation to these further interventions alone are calculated as follows: 16 x 1.5 x £3,402 = £81,648.
- Without Positive Choices, evaluators also project that some at least of the 30% (16) families who remained together in the short to medium term but who required additional interventions including child protection plans relatively soon after the first (at least a third of the 16, or 10% of the total) will need to come into care as a result of the further child protection concerns. 10% of an overall 3-year Positive Choices referral cohort of approximately 54 children would mean that an additional 5.4 children would be likely to come into care without the service). On the basis of an average period of being looked after of 2.21 years[22] and an average cost per

[19] There may be other benefits accruable for example to the Police and health services through reductions in domestic abuse incidents
[20] Source: New Economy Manchester Unit Cost Database (2019) https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/
[21] There are no costs within this estimate relating to actual support interventions e.g. family support services
[22] Based on the average duration of a period of care for children who ceased to be looked after in the year 2018-2019 (808 days) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/850306/Children_looked_after_in_England_2019_Text.pdf

year of being looked after of £58,664[23], the savings can be calculated as follows: 2.21 x 5.4 x 58,664 = £700,096.

- **Therefore, a conservative estimate of the total projected savings are £781,744 across a 3-year period of delivery, these savings accruable directly to local authority social care services rather than to other organisations.**
- Greater savings might also accrue to a local authority able to generate even more referrals of vulnerable (first-time) parents early in their pregnancy.

Although evaluators are not able to undertake a full cost benefit analysis (based on the full costs of the Positive Choices Programme) we do know that the DfE funding for the 3-year period was £444,000. The projected savings are almost double this figure, suggesting, at the very least, that the costs of the service start up, delivery and development are very likely to have been recouped and more through this Programme.

What has supported effective implementation of the Positive Choices model and what are the key features for replication elsewhere?

Apart from the key practice features already mentioned in this report (see page 6, including intensive, strengths-based, systemic, relationship based, a balance of structured and flexibility within the learning programme, therapeutic support), other critical features described by those working within the model and those experiencing it locally include:

Internal supports

- Key workers and their manager or supervisor who are highly qualified, experienced and trained in the key aspects of the role (See Appendix 5 for more details).
- Regular informal and formal 1:1 supervision and group-based supervision.
- A 'buddy' system that ensures that a named co-worker who has met the family can take over when the key worker is on leave or unavailable for any reason.

[23] Source: New Economy Manchester Unit Cost Database (2019) https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/

Broader including external supports

All staff interviewed for the evaluation said they believed that the success of Positive Choices depended very much on the embedding of that service within a broader targeted early help (Family Intervention Team (FIT)) offer locally. The reasons given for this included in particular: that the broader FIT service protected but also reinforced the ethos and overall ways of working of Positive Choices, making it easier to keep the shape of the offer; and that it provided access to broader including specialist advice and support, for example Family Group Conferencing, expertise in working with fathers, and access to group parenting programmes.

> "Really strong sense of being a team and support to each other" (key worker)

Key workers also considered that it is very important the Programme utilises a 'Team around the Family' approach, working closely together with other agencies and services in a coordinated way.

> "Need to coordinate the engagement of professionals so as not to overwhelm young people but also make sure there is regular support" (key worker)
>
> "Have to be mindful what other professionals are doing so don't duplicate" (key worker)

Most staff considered that, once the model was embedded, it became relatively easy to get other required services involved apart from more specialist services such as CAMHS and drug and alcohol services. Mental health services are perceived to be a key service gap, especially for 17 to 18-year olds, as the transition from CAMHS to adult mental health services is not always smooth and can be difficult to navigate for young people.

If setting this kind of service up elsewhere, Positive Choices staff and stakeholders would recommend:

- Keeping the model 'as is' including low very manageable caseloads, a dedicated 'pod' or unit, regular supervision and pod-based opportunities for group reflection, not having waiting lists, systemic focus, early years training, focus on pre-birth work, structured sessional work using evidence based materials, use of standardised and other measures to explore need giving young people coping strategies, and allowing young people time to tell their story.
- Supporting the referral of prospective parents at a very early stage i.e. as soon as the pregnancy is known, not having to wait until 20 weeks and allocating quickly.
- Ensuring that there is positive support from senior leaders, protecting the model as it was intended to be delivered.

- That it is important to be able to undertake weekend visits as it is a time of vulnerability as other support services are generally closed.
- Drawing on the Mellow Bumps or Babies parenting programme.
- Familiarising parents with a group-based programme where possible whilst continuing to provide 1:1 support to them, this to promote sustainability of parental access to support and their overall resilience.

The things they would change or adapt include the following:

- Including an element of peer mentoring (particularly as part of the step-down process for young parents into more mainstream support, a key element of the support 'tapering' process) as originally envisaged for the Programme.
- Being able to create more opportunities for group work with parents – the service has recently commenced a parenting group into which Positive Choices parents are consistently referred. The first part of the group programme looks at the benefits of play and stimulation and later group sessions focus on other aspects of the 'Mellow Babies' Programme including parental mental health, weaning, child development, finances and so on.
- Adding in accommodation support akin to a mother and baby unit within which parents can be taught skills and observations undertaken (for some).
- Considering including in the referral criteria parents who have already had a child removed from their care.

> "We're always looking for ways to develop further in Calderdale: we're not complacent" (Manager, 2020)

Summary key findings on 7 practice features and 7 outcomes

Improvements in family support practice with very vulnerable first-time parents have clearly resulted from the implementation of 'Positive Choices' in Calderdale. These developments in practice were mainly evidenced through the sampling (of case files) and interviews with key workers, stakeholders, and parents. These were evidenced in relation to 3 out of the '7 practice features[24]' reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (Sebba et al, 2017):

Features of practice	Findings from this evaluation
Systemic approaches to social work practice	• Although this evaluation has not explored systemic social work(er) practice, it has explored this in relation to family support (key worker) practice where families have a statutory (Child in Need or Child Protection) Plan. • Systemic practice was considered by Positive Choices staff and broader stakeholders to be a core feature of effective practice with first time parents (both mothers and fathers), alongside: intensive; strengths-based; relationship-based; including a strong element of 'modelling' and reinforcing good parenting; starting actual support as early as possible in pregnancy; having a structured (evidence-based) programme alongside broader tailored, flexible support.
High intensity and consistency of practitioner	• This positively evaluated Positive Choices model includes at its core the commencement of intensive working by one consistent key worker as early as possible in pregnancy for very vulnerable first-time parents. • The intensity of work with the parent(s) often tapers towards the end of an intervention on average of 10 months. • The intensity of sessions for families varies between once to 3 times a week, often more frequent during an initial or intensive and risky phase of the work and less frequent or 'tapering' towards the end. These face to face sessions were often supplemented by outreach telephone calls or texts, additional meetings, and support to attend appointments.
Having a whole family focus	• This successfully evaluated Positive Choices model has included a strong focus on the very vulnerable parent(s) in the context of their whole family.

[24] The seventh area, group case discussion, was assumed to be taking place but not examined in any detail for this evaluation

Features of practice	Findings from this evaluation
	• The key worker not only works, where possible, with both parents (fathers as well as mothers), but also seeks to engage broader family support for the parent(s) and the Programme itself, also to help parents navigate family relationships successfully, albeit with the safety and wellbeing of the baby or child as the priority. • Fathers were engaged in support much more successfully by Positive Choices (in between 50% and 70% cases) compared with services working with very vulnerable first-time parents before (19%). • Parents interviewed for this evaluation often commented on how well key workers engaged with mothers, fathers, and all members of the family.

Improvements in outcomes for children and families were mainly evidenced through case file analysis and secondary analysis of whole cohort data including as follows:

Outcomes	Findings from this evaluation
Greater stability for children	• Far fewer children with Positive Choices intervention needed ongoing social care interventions after the initial one concluded, compared with those who received a similar service before Positive Choices started.
Reduced risk for children	• The Programme has been working with an exceptionally vulnerable group of mostly first-time (prospective) parents including care leavers, looked after young people and young people who have had an involvement with children's social care as a child, many of whom also have a learning disability. • In the short term, parents in both retrospective and Positive Choices cohorts 'kept their babies' in similar proportions (77% and 68% respectively). However, a much greater proportion of those receiving the Positive Choices support had clearly evidenced overall positive outcomes including improvements in their mental health; parenting choices; risk taking activities, including reduced involvement with domestic abuse or intense and frequent arguing in front of the child; and improved ability to manage behaviour when frustrated. These 'successful' Positive Choices parents had clearly made some major changes to their lifestyles and behaviours. This is particularly impressive as, compared with the retrospective cohort, the Positive Choices cohort comprised many more parents whose

Outcomes	Findings from this evaluation
	behaviours were thought at the outset to present very high risks to their children
Increased wellbeing and resilience for children and families	• For parents engaging well with the Programme, there are well-triangulated indicators of strong or strengthened child attachment; understanding of (what constitutes) effective parenting; and positive life choices. • Parents involved in the Programme had a much better response when work started pre-birth compared with when it started post-birth (particularly unhelpful appears to be starting work around the time of birth). • Other risks for parents not having a positive response to the Programme include: parental learning disability; the presence of very high level risks of abuse or neglect to the child around the start of the Programme; and parents having had a childhood involvement with children's social care compared to being care experienced.
Reduced days spent in care	• Whilst all (100%) of the Positive Choices parents whose outcomes were less positive had their child taken into care by the end of the intervention, within the retrospective cohort, only 59% came into care. This suggests that intensive work at an early stage with parents who are known to be very vulnerable also has the potential to identify significant risk (and the need for care) earlier. • However, in the longer term, a far greater proportion (68%) of the Positive Choices children have been able to remain living at home with parents without a further intervention compared with only 35% of the retrospective group. • Evaluators have estimated that, without Positive Choices, a proportion of the children requiring these additional interventions (approximately 10% of an overall referred cohort) would need to come into care, this in addition to those who require care because of unacceptably high levels of risk to the child detected during the period of initial intervention.
Better value for money	• Conservative projected savings in the region of £781,744 across a 3-year period of delivery have been calculated from an investment of £444,000 over the same time period.

Strengths and Limitations of the Evaluation

The key strengths of this evaluation are that the findings have been drawn from a range of sources (they are well-triangulated, particularly across whole and sample cohorts) and the data quality is mostly excellent.

Participation levels in the evaluation amongst young parents and staff has been relatively high.

Key study limitations are:

- That the retrospective (comparison) cohort was not quite the same as the Positive Choices (sample) cohort, as mentioned earlier, and this has limited very accurate comparisons.
- The design of the evaluation meant that, with regard to standardised measure data, it could only establish correlation between variables of interest, not causal relationships. Lack of a control group for this dataset means that positive outcomes could have occurred by chance.
- With regard to the standardised measure data, a further limitation is that there was insufficient information (for example from several questionnaire 'scores' administered sequentially) to explore the extent to which interventions improved attachment over time. It should be acknowledged with this in mind that, with parent cohorts like these, it is problematic to establish a 'true' baseline because it is difficult and sometimes unhelpful to engage parents in such questionnaires before a relationship with the worker (and therefore early work) has been established.
- Because of the extreme demands placed at very short notice on Calderdale Council as a result of the Covid-19 pandemic, it has not been possible to ascertain either the extent to which the Programme has had an impact on the number of younger infants or children becoming looked after over time or a full cost benefit analysis. It is hoped that these can be explored in due course with the Service.

Lessons and Implications

This study suggests that:

- **More actual support should consistently be provided pre-birth** for (first-time) parents who are known to be vulnerable. This does not happen currently in many parts of the UK and would constitute a major shift in social work and support practice. More also needs to be learned about how social workers and other key professionals may be encouraged more consistently to refer vulnerable parents into services like Positive Choices both in Calderdale and in other sites for support as well as (pre-birth) assessment.
- **The Positive Choices model would appear from all the evidence to present a highly effective way of working to improve outcomes** for (first-time) vulnerable parents and this study describes some of the key factors for those who may wish to replicate the model. Other sites should expect to see gains in terms of: improved child / parent attachment; parental understanding of what constitutes effective parenting; positive life choices of the young person; reduced risk factors for abuse and neglect; and improved rates of infants remaining in the care of their natural parent(s) in the longer term. They should also be prepared for the likelihood that rates of infants coming into care from these cohorts will not reduce significantly in the short term (by the end of an intervention period), rather in the medium to longer term.
- **More tailored support should be provided to young people who have experienced abuse or neglect (and often a Child Protection or Child in Need Plan) as a child but who did not come into care**, including in relation to their parenting but also to promote more positive life chances. As a group, they appear from this study to be at least as vulnerable as those who are care experienced.
- **More should be learned** from studies like this one, including from ongoing work in Calderdale, about both the potential of pre-birth work with vulnerable first-time parents and how best to support non-care but social care experienced young people (not only in pregnancy but also in their transition to adulthood more broadly).

Appendix 1: Positive Choices Logic Model

The project Logic Model which has informed the evaluation is re-produced below:

Inputs	Outputs	Desired short-term outcomes	Desired longer-term outcomes
Trained family support workers delivering a 'behaviour change model' intervention for 'high risk' young parents including in particular: young people in care or care leavers when a viable pregnancy is confirmed Team members supported by the overall 'pod' and supervising manager Service embedded in a broader experienced Family Intervention Team providing a range of targeted supports to families	1:1 strengths-based, therapeutic key worker support including evidence-based parenting (e.g. mellow bumps) and other interventions for mothers and fathers Peer mentoring Multi-agency support for the whole family, tailored to their needs (a team around the family arrangement) Ongoing work with the young person even if the child is removed from their care	Reduced risk factors for poor parenting, both parent (e.g. domestic abuse, substance misuse, mental health problems) and environmental (e.g. poor housing, insufficient income, social isolation, poor community supports) Increased resilience factors, both parent and environmental Improved understanding of effective parenting of infants Good parent - child attachment, attunement, empathy and responsiveness during the perinatal period	Better outcomes for children of the family e.g. health, attachment, cognitive, social Reduced number of children of vulnerable parents (including looked after young people and care leavers) coming into care or with a child in need / child protection plan Reduced further unplanned pregnancies to the parent(s) involved in the Programme Where the child(ren) do need to come into care, improved personal and life choices of the parents subsequently Whole system change to provide more acceptable and effective support for vulnerable young families Scheme capable of being transferred successfully to other local areas

Appendix 2: Positive Choices Overall Cohort Basic Characteristics

Table 11: Parent referred into Positive Choices Programme by year (2016-2019)

Year	Number referred	% referred
2016	6	13%
2017	24	39%
2018	18	29%
2019	12	19%
All years (total)	60	100%

Table 12: Number of family units by type of intervention: pre-birth, at birth or other

Type	Single Parents	Couples	Total number and % of family units
Pre-birth	21	5	26 (50%)
Pre-birth (for one child) + other infant child of the family	4	1	5 (10%)
At or around the birth	9	3	12 (23%)
Post-birth (infant child)	8	1	9 (17%)
All types of timing	42	10	52 (100%)

Table 13: Age of parents at referral into Positive Choices (2016 to 2019)

Age	Number of (key) parents	% (key) parents
15	1	2%
16	5	8%
17	11	18%
18	9	14%
19	12	19%
20	8	13%
21	7	11%
22	5	8%
23	1	2%
24	2	3%
26	1	2%
Total	62	100%

Table 14: Positive Choices participants by gender

Participant Gender	Number	Proportion
Female	51	82%
Male	11	18%
Total participants	62	100%

Table 15: Positive Choices participants' ethnicity

Ethnicity type	Number	Proportion
White British / Irish / other White background	54	87%
Mixed White British and Black African / Black Caribbean / other mixed	4	6.5%
Asian or White / Asian mixed	4	6.5%
All ethnicity	62	100%

Appendix 3: Tools and Approaches used by Positive Choices Workers

Key tools and materials used by the key workers in their work with young people include:

- ‘Baby Brain (Development)’ materials
- ‘Coping with crying’ materials
- ‘Baby cues’ materials
- ‘Safe sleeping’ materials
- (The importance of) interactive play
- Adult wellbeing (tool)
- Attachment tools for example ‘You and your baby’ (highly visual materials)
- Needs Jigsaw
- Risk assessment tools such as the Safe Lives’ domestic abuse (DASH / CAADA DASH) risk assessment tools
- Neglect Toolkit
- Standardised measures relating to attachment (pre- and post-birth)
- Materials relating to evidence-based parenting programmes for example: Mellow Parenting or Mellow Babies and Strengthening Families (also the ‘Change Programme’ for parents with learning needs)
- The Freedom Programme (online materials relating to domestic abuse) and other materials to promote healthy relationships
- Tools relating to child sexual exploitation
- Budgeting tool
- Baby Massage
- Baby Yoga

Appendix 4: Agencies and people with whom the service has coordinated support for parents

- Social workers and Pathways Advisors relating to Public Law Outline (PLO) or care proceedings.
- Community health professionals and sexual health clinics.
- Voluntary organisations providing practical support, for example Mothershare; Noah's Ark; Smartmove; those offering charitable donations.
- Food banks.
- Specialist services, particularly CAMHS; community mental health services; perinatal mental health team; Women's Centre; substance misuse agencies.
- Family Group Conferencing Services and group-based parenting programmes.
- Housing Services.
- Benefits Agencies, employment advisory and Citizens Advice Bureau.
- The broader family unit including the parents' own parents and/or grandparents (extended family).
- Positive Choices 2 (a Calderdale programme for women whose children have been removed from their care).
- Community-based play services.
- Probation Service.

Appendix 5: Key Internal Supports for the Positive Choices Model

The key workers are all experienced to very experienced with:

- Core qualifications including relevant degrees and/or level 3-5 NVQ in a relevant subject area.
- Between 2 and 12 years' experience working in a similar role including with young adults and families who are vulnerable.

The key workers are all highly trained and confident in their role, including many who have completed or are embarking on a systemic family practice training. Core training modules include: safeguarding; evidence-based parenting programmes such as Mellow Parenting or Babies and/or Strengthening Families; domestic abuse and parent conflict; substance misuse; mental health; neglect; child sexual exploitation (CSE); baby massage and baby yoga; (support for) 'Caring Dads'; Parenting Assessment Manual (PAMS) assessments for parents with learning disability.

The supervising manager has approximately 15 years' experience. They line manage the key workers and provide supervision. They also attend the Early Intervention and Domestic Abuse panels locally (to receive referrals and discuss cases).

Staff consistently describe receiving:

- Regular 1:1 formal supervision on a monthly basis.
- Regular group-based supervision (pod supervision) on a monthly basis – providing an opportunity to discuss challenging cases and share resources and approaches.
- Daily, more informal 'open door' support from the team and team manager.
- A 'buddy' system that ensures that a named co-worker who has met the family can take over when the key worker is on leave or unavailable for any reason.

Many believe this is very helpful. They explained:

> "Keeps you on track and focused" (key worker)
>
> "Keeps me resilient and confident – when hitting barriers and questioning my own confidence. I can talk it through with others, look at other options and it can pick you up, help to re-focus" (key worker)

Appendix 6: Whole Cohort Outcomes Data

Proportion of Overall Successful Parents

In 1 case it was not clear whether the parent had engaged or completed the Programme. In another 14 cases, the parent(s) had engaged but the Programme was still underway, not yet due to complete. **Of the remaining 47 cases**, Table 16 below explores the outcomes:

Table 16:Outcomes by participants completing a programme

Outcome	Number of participants	Percentage of participants (approx.)
Completed programme successfully	25	53%
Child no longer living with the parent	17	36%
Family declined participation, child remaining with them	2	4%
Family moved	2	4%
Child still born	1	2%
Total	47	99%

Of those parents that engaged initially at least (42 in total), 60% (25/42) completed the Programme successfully, their children remaining with them. In 40% cases (17/42) the child was removed from their parents' care.

Proportion of overall successful family units

In 1 case it was not clear whether the parent had engaged or completed the Programme. In another 11 cases, the parent(s) had engaged but the Programme was still underway, not yet due to complete. Of the remaining 40 cases:

Table 17: Number and percentage of overall successful compared with other types of outcomes for Positive Choices family units

Outcome	Number of family units	% of family units
Successful completion	21	52.5%
Child no longer living with parent	14	35%
Family declined participation, child remaining with them	2	5%
Family moved	2	5%
Still birth	1	2.5%
Total	40	100%

Leaving aside those parents who declined involvement at the start, could not be involved or could not care for their child (due to still birth), the total number of family units that had an opportunity for a successful outcome was 35. Of these, 21/35 (60%) completed the Programme successfully whereas 14/35 or 40% had a child removed.

Appendix 7: Standardised Measures Analysis Technical Document

Evaluators analysed the standardised measure data collected from Positive Choices service users (parents) during the latter 2-year period of the Programme, including:

- The Maternal Antenatal Attachment Scale (Condon, 1993) known as MAAS.
- The Maternal Postnatal Attachment Scale (Condon and Corkindale, 1998) known as MPAS.

Further standardised measure data was collected from some fathers (the Paternal Antenatal Attachment Scale or PAAS (Condon, 2015)) but there were insufficient numbers completing this measure to justify analysis for the purposes of this report.

A total of 33 mothers completed the MAAS and 26 parents (mostly mothers but some (2) fathers) completed the MPAS when their child was an infant.

- 26 mothers completed a MAAS questionnaire only
- 13 mothers completed a MAAS and MPAS questionnaire
- 8 parents (including 2 fathers) completed a MPAS questionnaire only

Therefore, 47 (or 76%) of the 62 parents recorded as having had an involvement with Positive Choices completed at least 1 of these questionnaires. Cross-analyses of the questionnaire data with management information recording the extent to which parents had ‘successfully completed’ their Positive Choices intervention suggests that the cohort of 47 completing at least 1 questionnaire were not ‘cherry picked’ in any way in that they comprised a variety of ‘successful completers’, ‘unsuccessful completers’ and ‘unknown outcome as yet’.

The MAAS was completed by first-time parents who had been involved with the Programme for approximately 6 weeks in a majority (18/33) of cases and a smaller but sizeable proportion (12/33) of mothers completed questionnaires that were administered by their social worker(s) as part of a pre-birth assessment rather than as part of an actual intervention. In 3/33 cases, the MAAS was administered in relation to non-first-time parents who became involved with the project pre-natally.

The MPAS was completed by parents (mostly mothers) at approximately 6 weeks into the intervention. It was also reviewed in some cases after 3 and 6 months but these scores were less consistent and therefore discounted for the purposes of this evaluation.

Analyses of the MAAS and MPAS data have been undertaken in relation to the whole cohort of parents completing questionnaires as well as in relation to a key emerging hypothesis for the study, namely that parents involved pre-birth may respond better than those becoming involved post-birth. In a small number (less than 5%) of cases where

there were 1 or 2 missing values in the questionnaire results, Positive Choices cohort mean values have been imputed to them.

Maternal Antenatal Attachment Scale (MAAS) Whole Cohort Results

The MAAS (Condon, 1993) consists of 19 items divided over 2 sub-scales: 'quality of attachment' (11 items) and 'time spent in attachment mode' (8 items). The first subscale represents the quality of the mother's affective experiences towards the foetus (feelings of closeness and tenderness versus feelings of distance and irritation). The second subscale represents the intensity of preoccupation with the foetus in terms of time spent thinking about, talking to and palpating the foetus. All items are scored on a 5-point scale. The minimum (lowest) score for the Total MAAS is 19 and the maximum (highest) is 95. The scores for subscales range from 11 to 50 and 8 to 40. High scores reflect a positive quality of attachment and a high intensity of preoccupation with the foetus.

The whole cohort (of mothers completing MAAS) scores are explored in Table 18 below:

Table 18: MAAS subscale statistics for all Positive Choices mothers completing a questionnaire

Scale Examined	No. questionnaires	Mean (SD) score	Range of scores
MAAS Overall Score	33	80.67 (10.31)	57 - 95
MAAS Quality of Attachment Score	33	39.90 (7.05)	27 - 50
MAAS Time spent in Attachment Score	33	32.50 (4.76)	22 - 40

If the lowest possible total MAAS score is 19 and highest possible score is 95 then the mean total MAAS score of 80.67 is towards the upper end of the MAAS total score range. Similarly, if 11 is the lowest possible MAAS quality of attachment score and 50 the highest then the mean MAAS Quality of Attachment score of 39.90 is towards the upper end of the MAAS Quality of Attachment score range. For Time Spent in Attachment Mode, the average score was 32.50 out of a possible maximum MAAS time spent in attachment score of 40, again towards the upper end of the score range. On average, all 3 MAAS subscale results indicate that the sample overall possessed a very positive quality of attachment and a very high intensity of preoccupation with the foetus antenatally.

Maternal Postnatal Attachment Scale (MPAS) Whole Cohort Analyses

MPAS was developed as a self-report measure to assess mother-to-infant bonding in an infant's first year of life. The theoretical framework on which the questionnaire is based is like that used for the antenatal bonding scale (MAAS). In a similar fashion to the MAAS, many of the statements ask for a response based on the mother's experience in the last fortnight. Each item has a range of 2 to 5 options reflecting the frequency with which such an experience occurs. An adjustment to allow for the different number of response categories per item is required before summing the items to obtain the MPAS total score. A higher score on the MPAS indicates higher quality of maternal attachment. The possible range of MPAS total scores is 19-95. The MPAS is also divided over 3 subscales, indicating "quality of attachment", "absence of hostility" and "pleasure in interaction". 'Quality of attachment' consists of 9 items; 'pleasure in interaction' consists of 5 items; 'absence of hostility' 5 items. The scores for each of the subscales are determined using the average of each of the items from that subscale, providing a range of scores for each subscale between 1 and 5. Higher scores indicate higher quality of maternal attachment.

Table 19: Median values and SIQRs for the 3 MPAS subscales for all Positive Choices parents completing a questionnaire

MPAS scales	No. parents	MPAS1		MPAS2		MPAS3	
		Median (SIQR)	Range	Median (SIQR)	Range	Median (SIQR)	Range
Total Score	26	87(4)	73-95	81(7)	67-94	88(3.5)	85-90
Quality of Attachment	26	42(3)	28-45	41(3.5)	32-45	42(2.5)	38-45
Absence of hostility	26	22(3.5)	11-25	18(3)	15-25	23(1.5)	21-25
Pleasure in interaction	26	23(2)	20-25	23(2)	15-25	23(1.5)	20-25

The average MPAS total score over the 3 data collection points was 87 (out of a possible 19-95 range), with an average Quality of Attachment score of 42 (out of a possible 9-45), average Absence of Hostility score of 22 (out of a possible 5-25) and average Pleasure in Interaction score of 23 (out of a possible 5-25). This suggests that the quality of attachment in this sample of service users was high.

Analyses of MAAS and MPAS scores by timing of commencement of Positive Choices involvement (pre- or post-birth)

The group of service users who started working with the service during a most recent pregnancy but who already had at least 1 infant child was small (n.3) and therefore excluded from the analysis.

Table 20: Number of parents completing MAAS and MPAS by timing of intervention commencement

Group	MAAS	MPAS	Total
Pre-birth starters	18	12	30
Post birth starters	12	14	26
Pre and post birth parents	3	3	6
Total	33	29	62

Pre-birth group MAAS Scores

18 of the mothers receiving an intervention pre-birth completed a MAAS approximately 6 weeks following initial contact with the service. MAAS total scores for this group ranged from 57-95 with a mean of 81.56 (SD=11.91). The possible range of total MAAS scores is 19-95 and therefore the mean total MAAS score for the sample of service users receiving an intervention pre-birth is near the upper end of the range of possible scores.

Scores for the Quality of Attachment subscale of the MAAS ranged from 30 to 50 with a median of 43.28 (SD=6.81). The Quality of Attachment subscale scores of the MAAS can range from 11-50 and therefore the mean score for the sample of service users receiving an intervention pre-birth is close to the upper end of the range of possible scores.

Scores for Time Spent in Attachment Mode subscale of the MAAS ranged from 24 to 40 with a median of 34.06 (SD=4.96). The Time Spent in Attachment Mode subscale scores of the MAAS can range from 8-40 and therefore the mean score for the sample of service users receiving an intervention pre-birth is close to the upper end of the range of scores.

These measures of antenatal maternal attachment can be interpreted as service users receiving an intervention pre-birth possessed a very positive quality of attachment and a very high intensity of preoccupation with the foetus antenatally.

Pre-birth group MPAS scores

12 (40%) first-time mothers starting an intervention pre-birth completed a MPAS. MPAS total scores ranged from 81-95 with a mean of 82.64 (SD=9.91). The possible range of total MPAS scores is 19-95 and therefore the mean total MPAS score for the sample of service users receiving an intervention pre-birth is near the upper end of the range of possible scores.

Scores for the Quality of Attachment subscale of the MPAS ranged from 39 to 45 with a mean of 39.97 (SD=5.70). The mean score for the sample of service users receiving an intervention pre-birth is close to the upper end of the range of possible scores for the Quality of Attachment subscale.

Scores for the Absence of Hostility subscale of the MPAS ranged from 17 to 25 with a mean of 20.00 (SD=3.98). The mean score for the sample of service users receiving an intervention pre-birth is close to the upper end of the range of possible scores for the Absence of hostility subscale.

Scores for the Pleasure in Interaction subscale of the MPAS ranged from 20 to 25 with a median of 22.83 (SD=1.90). The mean score for the sample of service users receiving an intervention pre-birth is close to the upper end of the range of possible scores for the Pleasure in Interaction subscale.

After birth group MAAS scores

MAAS total scores ranged from 67-91 with a mean of 81.56 (SD=11.91). The possible range of total MAAS scores is 19-95 and therefore the mean total MAAS score for the sample of service users receiving an intervention after birth is near the upper end of the range of possible scores.

Scores for the Quality of Attachment subscale of the MAAS ranged from 30 to 50 with a mean of 43.28 (SD=6.81). The Quality of Attachment subscale scores of the MAAS can range from 11-50 and therefore the mean score for the sample of service users receiving an intervention after birth is close to the upper end of the range of possible scores.

Scores for Time Spent in Attachment Mode subscale of the MAAS ranged from 27 to 40 with a mean of 34.06 (SD=4.96). The Time Spent in Attachment Mode subscale scores of the MAAS can range from 8-40 and therefore the mean score for the sample of service users receiving an intervention after birth is close to the upper end of the range of scores.

These measures of antenatal maternal attachment can be interpreted as service users about to receive a post-birth intervention already possessing a relatively positive quality of attachment and a very high intensity of preoccupation with the foetus antenatally.

These scores may have been affected by both the timing of its administration i.e. during a pre-natal assessment and administrator type (largely social worker).

MPAS for the service users receiving an intervention after birth

MPAS total scores ranged from 62-90 with a mean of 76.9 (SD=6.0). The possible range of total MPAS scores is 19-95 and therefore the mean total MPAS score for the sample of service users receiving an intervention pre-birth is near the upper end of the range of possible scores.

Scores for the Quality of Attachment subscale of the MPAS ranged from 35 to 49 with a mean of 38.6 (SD=3.6). The possible range of Quality of Attachment subscale scores is 9-45 and therefore the mean total MPAS score for the sample of service users receiving an intervention after birth is near the upper end of the range of possible scores.

Scores for the Absence of hostility subscale of the MPAS ranged from 17 to 24 with a mean of 20.3 (SD=1.7). The possible range Absence of hostility subscale scores is 5-25 and therefore the mean Absence of hostility subscale for the sample of service users receiving an intervention after birth is near the upper end of the range of possible scores.

Scores for the Pleasure in Interaction subscale of the MPAS ranged from 14 to 25 with a mean of 21.8 (SD=2.2). The possible range of Pleasure in Interaction subscale scores is 5-25 and therefore the median Pleasure in Interaction subscale for the sample of service users receiving an intervention after birth is near the upper end of the range of possible scores.

Table 21: A comparison of pre and post birth starter participant MAAS Scores

MAAS (sub) scale	Group	Number	Mean	SD	Standard error mean
MAAS total score	Intervention pre-birth	18	81.56	11.91	2.81
	Intervention after birth	12	79.33	7.61	2.20
MAAS Quality of interaction score	Intervention pre-birth	18	43.29	6.81	1.60
	Intervention after birth	12	34.83	3.59	1.04

MAAS (sub) scale	Group	Number	Mean	SD	Standard error mean
MAAS Time spent in interaction	Intervention pre-birth	18	34.06	4.96	1.17
	Intervention after birth	12	30.17	3.43	.99

Comparison of means between the Intervention pre-birth and Intervention after birth groups showed that on average:

1. Service users had higher MAAS total scores when they received an intervention pre-birth (Mean=81.56, SE=2.8) than where the intervention started after the birth of their child (Mean 79.33, SE=2.20). This difference was not statistically significant t(28)= .57, p>.05. This represented a small size effect r= .11.
2. Service users had higher MAAS Quality of interaction scores when they had an intervention pre-birth (Mean=43.29, SE=1.60) than intervention after birth (Mean 34.83, SE=1.04). This difference was statistically significant t(28)= 3.93, p< .01. This represented a large size effect r= .60.
3. Service users had higher MAAS Time spent in interaction scores when they had an intervention pre-birth (Mean=34.06, SE=1.17) than intervention after birth (Mean 30.17, SE= .99). This difference was statistically significant t(28)= 2.36, p< .05. This represented a medium size effect r= .41.

Table 22: A comparison of pre and post birth starter participant MPAS scores

MPAS (sub) scale	Group	Number	Mean	SD	Standard Error Mean
MPAS total score	Intervention pre-birth	12	81.86	10.00	3.02
	Intervention after birth	14	77.35	7.09	1.90
MPAS Quality of interaction score	Intervention pre-birth	12	39.64	5.86	1.77
	Intervention after birth	14	38.86	4.11	1.10

MPAS (sub) scale	Group	Number	Mean	SD	Standard Error Mean
MPAS Absence of Hostility score	Intervention pre-birth	12	20.27	4.05	1.22
	Intervention after birth	14	20.21	1.97	.53
MPAS Pleasure in Interaction	Intervention pre-birth	12	22.73	1.95	.59
	Intervention after birth	14	21.74	2.60	.70

Comparison of means between the Intervention pre-birth and Intervention after birth groups showed that on average:

1. Service users had higher MPAS total scores when they had an intervention pre-birth (Mean=81.86, SE=3.02) than intervention after birth (Mean 77.35, SE=1.90). This difference was not statistically significant t(24)= 1.58, p>.05. However, this represented a medium size effect r= .31.
2. Service users had higher MPAS Quality of interaction scores when they had an intervention pre-birth (Mean=39.64, SE=1.77) than intervention after birth (Mean 38.86, SE=1.10). This difference was not statistically significant t(24)= .58, p> 05. This represented a small size effect r= .11.
3. Service users had higher MPAS Absence of Hostility score scores when they had an intervention pre-birth (Mean=20.27, SE=1.22) than intervention after birth (Mean 20.21, SE= .53). This difference was not statistically significant t(24)= -.18, p> .05. This represented a very small size effect r= .04.
4. Service users had higher MPAS Pleasure in Interaction score scores when they had an intervention pre-birth (Mean=22.73, SE= .59) than intervention after birth (Mean 21.74, SE= .70). This difference was not statistically significant t(24)= 1.20, p> .05. This represented a small size effect r= .22.

Conclusions

Measurement of service user attachment in the evaluation indicates that the sample was strongly bonded to their infants, with scores at the higher end of the MAAS and MPAS scale at the time the instruments were completed. Some service users only completed a MAAS (26), some only a MPAS (8) and some (13) completed both. It was hypothesised

that both the MAAS and MPAS scores of the service users starting their Positive Choices intervention pre-birth would be higher than those starting the work after the birth of their child.

Findings offer some support for the hypothesis. All subscale totals were greater for the group of service users who received intervention before birth compared to those service users who had intervention after birth of their child. However, only 2 subscales of the MAAS showed a statistically significant difference: quality of attachment and time spent in attachment. The quality of attachment subscale was associated with a large effect size indicating that the finding is important. We might tentatively conclude that intervention before birth for the service users was influential in improving the quality of attachment between carers and their children. This is important as evidence from the literature on child attachment suggests that it is a powerful predictor of their social and emotional outcomes (Lyons 1996; Lyons 2008).

Ideally, further work would be undertaken in Calderdale and in other similar sites to explore these findings with a greater sample of service users. In the meantime, the findings need to be treated with caution. Firstly, the design of the evaluation was such that it could only establish correlation between variables of interest, not causal relationships. Lack of a control group means that findings could have occurred by chance. A further limitation is that there was insufficient information in this study to explore the extent to which interventions improved attachment over time. It should be acknowledged with this in mind that, with parent cohorts like these, it is problematic to establish a ‘true’ baseline because it is difficult and sometimes unhelpful to engage parents in such questionnaires before a relationship with the worker (and therefore early work) has been established.

Appendix 8: Case Studies

Case Study 1

This case concerns a care leaver aged 19 at the birth of her second child. Mum had experienced sexual abuse and neglect as a child and had been looked after for 4 years. An older child of the family had already been taken into care.

Positive Choices became involved 2 months prior to the child's birth when there were concerns about domestic abuse, parental substance misuse and parent mental health problems. However, Mum was expressing a commitment to care for this second child. The service was involved for 12 months including twice weekly sessions with Mum plus support to attend meetings and additional calls and texts.

In the first month of involvement, Mum did not engage with the Service but then her reluctance was overcome with tailored support from the key worker.

The focus for key worker sessions included: housing, impact of domestic abuse, safe sleeping, feeding, finances and benefit entitlement, parent and baby groups in the community, routines, employment, relationships, weaning, college, child health. Direct work included: DASH, maternal attachment assessment, coping with crying (DVD) and activities, substance misuse assessment, adult wellbeing assessment, impact of domestic abuse work, Freedom Programme online, play and sensory sessions.

Dad engaged in the impact of domestic abuse activities and undertook a Freedom Programme online. There was very good liaison with community health and children's social care.

The child has not come into care but has continued to require a Child in Need Support Plan for the duration of the intervention.

A single assessment undertaken towards the end of the intervention indicated that a secure attachment had been observed between mum and baby - baby smiles in response to mum's presence, baby smiles in response to stimulation and looks around when parents leave the room. There was evidence that Mum speaks warmly to baby and offers cuddles, and baby appears happy and offers Mum smiles in return. Mum was evidencing an understanding of good (enough) parenting and had taken steps to protect her baby from her own mental ill-health. There was also evidence of a good standard of housing, both parents actively engaging in domestic abuse work. Mum was considering college, both parents were engaging with professional support

Case Study 2

This case involves a new mother who experienced significant involvement with children's social care as a child because of physical and sexual abuse, but who did not come into care. She was 20 years old at the time of the birth of her first child.

At the time of the referral to Positive Choices, 3 months before the child was born, there were concerns about domestic abuse between this Mum and her partner, high levels of family conflict, and parent mental health problems. However, Mum's partner

was supportive of the pregnancy as were paternal grandparents. Mum was well engaged with ante-natal services.

The family engaged with Positive Choices for 14 months based on approximately once weekly sessions and additional support to attend appointments, also general therapeutic support. The sessions were structured to provide educational input in relation to baby preparation and early childcare and to address Mum's mental health issues and couple arguments or violence. Dad was fully engaged and participated in many of the sessions. Mum was also fully engaged in the Programme and appeared to actively accept and respond to advice. The work was undertaken at the parents' pace and support was provided to help each to develop their own strategies and confidence.

The child is now well attached to parents with evidence of consistent positive interaction and parental responses to child cues. The home conditions have been consistently good. No statutory plan or further pregnancy has happened during the intervention period. Mum and Dad are accessing community services and activities.

Case Study 3

This case concerns a care leaver aged 23 years at the birth of her second child. Mum had experienced neglect, physical abuse and sexual abuse as a child and had been looked after for 11 years. The Positive Choices Service became involved 4 months pre-birth.

At the start of the Positive Choices intervention, there were concerns about domestic abuse, parent substance misuse and the death of an older child. Specific concerns related to Mum's ability to protect her child from physical abuse. Mum was accepting support from grandparents and from professionals. Work commenced very quickly after referral under an Interim Care Order granted to protect this child from harm and continued for a 7-month period.

The intervention involved both Mum and Dad and included sessional work relating to home conditions, substance misuse, attachment, financial support, preparation for birth of new baby, emotional support relating to the death of the previous child and through contact with new baby. A range of tools were used including: attachment resources, needs jigsaw, substance misuse assessment tool, reduce the risk tool, adult wellbeing tool. However, because of the fractious relationship between Mum and Dad, these sessions did not always involve them both together.

The child was looked after from birth. Although the child was removed from Mum's care, she worked hard to become attuned to her child's needs during contact. The risks of abuse and neglect (through exposure to domestic abuse and parent substance misuse) remained at the end of the intervention. However, Mum had attended all contact sessions and developed a bond with the child. Mum did not become pregnant during the intervention period. During intervention, Mum also ended the relationship with child's father due to domestic abuse incidents and moved off cigarettes and onto e-cigarettes to reduce risks to child. Post intervention, Mum is actively engaging with support from social care services, including for contact, and recent records show that she can take the child out during supervised contact sessions.

Case Study 4

This case concerns a new mother aged 17 years at the birth of her first child. Mum was considered vulnerable because of her involvement with children's social care as a child. Positive Choices became involved from 4 months into the pregnancy (pre-birth). At that time, there were concerns about domestic abuse, parent mental health problems, parent substance misuse; and maternal grandmother's (negative) ongoing influence on Mum. A specific worry was that Mum would neglect this new-born child and a therefore Child Protection Plan was put in place.

Positive Choices was provided for 20 months, including weekly key worker sessions and additional support through phone calls and texts, and to attend children's social care meetings.

Sessions addressed several areas including: substance misuse; housing; practical parenting (e.g. nappy change and bathing); accessing benefits; registering with GP; contraception; mum's mental health; money management; weaning. Tools used included: needs jigsaw, parenting theory sessions, cannabis use safety plan, coping with crying session. The parents had separated prior to the baby's birth and Dad did not want to be involved.

Early motivational conversations with the key worker supported Mum to take responsibility for her actions and to be pro-active in seeking the right equipment and support to care for the baby.

The child remained living with Mum by the end of the intervention and is considered well-attached. Consistently positive interactions were observed between parent and child, and Mum demonstrated a good understanding of what is good (enough) parenting. The baby was meeting all their developmental milestones, immunisations we up to date, Mum was interacting well with baby. By the end of the intervention, no risks were noted in relation to the child and Mum was engaging well with all professionals, receiving appropriate support from family members.

Case Study 5

This case concerns a care leaver Mum aged 15 years at the time of her child's birth, 5 years prior to the involvement of the Positive Choices Service. Mum had experienced physical and sexual abuse as a child and had been looked after for 8 years. At the point of the service becoming involved, the child had challenging behaviour and Mum mental health problems. Support was available, particularly from Mum's former foster carer who was also the primary carer for the child for a part of each week. Positive Choices was provided for 18 months, based on weekly key worker sessions and other outreach visits and telephone calls or texts. Support was provided both to Mum and her former foster carer. Home visits and outreach sessions were provided to support: sleep and routines, adult supervision of the child, mum's mental health, and the child's school arrangements. There was also a Family Group Conference and CAMHS involvement with Mum. Mum has been largely very accepting of and engaged with the support.

This child has not required a statutory plan during the period of Positive Choices intervention, nor has Mum become pregnant again. Some progress has been noted in relation to the child's behaviour and he has attended school more regularly, but there are still some problems. Mum is reported to have grown in confidence as a parent and her mental health is reported to have improved.

Case Study 6

This case concerns Mum aged 25 and a care leaver at the time of the birth of her first child. Mum is considered vulnerable because of her Asperger's Syndrome which affects her memory and sleeping patterns and impacts on her communications with others. Mum also experienced neglect as a child and was in care for 2 years.

The concerns at the time the Positive Choices Service became involved 1 month before the birth were: domestic abuse; parent mental health problems; parent substance misuse and parent learning disability combined with a specific concern in relation to potential emotional abuse. However, both parents had engaged well with the social work assessment.

The service has been involved for 13 months with structured sessions with parents conducted on approximately a twice weekly basis plus support to attend meetings and appointments and supportive texts and calls.

The key family issues that have been addressed include: home conditions, employment, impact of domestic abuse and relationships, emotional health and wellbeing, accessing benefits, substance misuse, managing finances, accessing nursery, support with child protection process. Tools used by the key worker include: genogram, maternal postnatal attachment scale, substance misuse assessment, DV impact worksheets, anxiety and depression score, reduce the risk tool, healthy and unhealthy relationship tick tool, dreams and aspirations tool; positives work; baby development stages; triggers work, baby milestones checklist; pros and cons of relationships, income and expenditure forms, development wheel.

Mum and Dad have both been fully involved although, for some time after domestic abuse incidents, they separated. The worker continued to engage with Dad and, when the couple reunited, joint sessions began again. They completed activities such as dreams and aspirations tool, maternal postnatal attachment scale.

The worker's approach has been very clearly strengths-based with a lot of positive reinforcement. The worker clearly listens and responds to what both Mum and Dad are saying. Additional services accessed include: liaison with midwife and health visitor, Mellow babies' group and baby massage, charity funding for holiday, domestic abuse support through Women's Centre, childcare grants, substance misuse support service, mental health assessments, nursery, sexual health clinic.

The child has not come into care for the duration of the intervention although the statutory plan changed from Child in Need to Child Protection around the time of the domestic abuse escalation. There is evidence that the child is well attached to both parents and there are good maternal responses to baby needs, provision of emotional warmth and affection and stimulation, good eye contact. Mum demonstrates an understanding of good (enough) parenting including in relation to safeguarding and routines. The baby appears to be thriving.

Mum has reduced her substance misuse, secured regular employment, and is working with baby's father to address relationship strains.

However, at the end of the intervention, there remained some albeit lower level risks to the baby's wellbeing in the event of a flare up of domestic abuse, parental mental ill-health, or substance misuse.

Case Study 7

This case concerns Mum, a care leaver aged 19 years at the time of her first child's birth. Mum had experienced neglect as a child and, as a result, had been looked after for 9 years.

The Positive Choices Service became involved 3 months before the baby's birth. Concerns at the point of referral were: housing difficulties, Mum's unstable living arrangements, vulnerability to being exploited, lack of consistent engagement with support and mum's vulnerability and risk of further exploitation. However, Mum was living with her former foster carer's mother and was well supported; had sought advice and support from the CAB on managing finances and was saving for the baby's arrival; proactive in engaging with all appointments; and had changed friendship circles in recognition of the risks of the previous friendship circle to herself and the baby.

The Service was involved for 8 months. Key worker sessions were provided on a mostly weekly basis. Advice and support was provided in relation to: preparing for labour; benefits entitlements; CSE; breastfeeding and bottle feeding; a number of structured activities completed: maternal ante-natal attachment scale; adult wellbeing score; early years tracker unborn; safer sleep for babies; dreams and aspirations; expectant and new parents checklist; breastfeeding support. There was plentiful positive reinforcement and encouragement from the key worker.

Mum attended her ante-natal classes and engaged positively and proactively throughout the Programme.

Dad was not involved.

By the end of the intervention, there was evidence that Mum and baby had formed a strong attachment and that Mum was caring well for the baby, providing stimulation and positive interactions whilst continuing to live with her foster carer's mother.

Mum demonstrated an understanding of good (enough) parenting including: picking up on baby's cues (when baby is tired; how she cries for different things; the way baby moves). Mum was observed as being very attentive to the baby, able to recognise when the child is upset and maybe hungry, unwell or in need of a nappy change. By the end of the intervention, Mum and baby were attending a baby massage group. Mum was accessing all appropriate benefits and had completed training with Homestart in order to start volunteering with them. She was actively looking for new accommodation for herself and the baby.

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Reference: RR1042

ISBN: 978-1-83870-131-4

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