Mothers At Risk of Repeat Removals

Pre-business case scoping and decisions to be made

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Decisions for JCB:

1. Are JCB committed to the delivery of a service in Southampton to support women who have children taken into care; to address their multiple needs, and reduce future children being taken into care?

2. If so, where would JCB like the funding for the service to come from? The options are as follows:

   A. Redirection of SCC - and potentially partner - funding to enable delivery of the service.

   B. Redirection of some FNP and SCC Children and Families resources (posts) under the current Section 75 framework.

   C. Another option as suggested and agreed by JCB.

3. Do JCB agree that we proceed with the development of a full business case, which is considered and approved by the Children's Multi-Agency Partnership Board, with prior input from Cabinet Members?

The rationale

1. Supporting mothers (and potentially fathers) to take more control of their lives, resolve their difficulties, and address the issues that led to their child/children being removed will lead to better overall health and wellbeing and related outcomes, less inequality and less spend on treating poor outcomes.

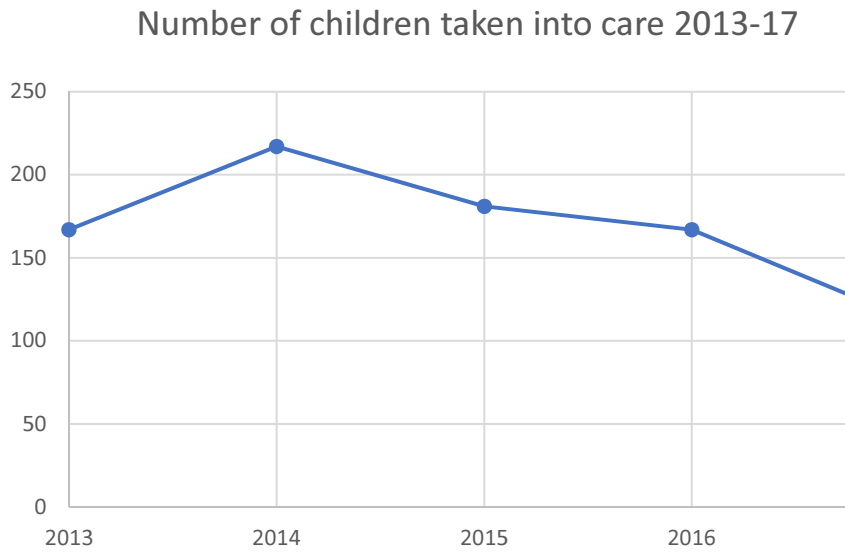
2. As the issues faced by many women are sufficiently entrenched, preventing further pregnancy during the time in which they are being supported, would increase the chance of a successful outcome for women whilst reducing the chance of them experiencing further attachment trauma.

3. This is a “cost avoidance” proposition. It will reduce avoidable long term pressure on Children’s LAC budget, and the associated additional spend of adult social care and NHS services on treating the fallout of unresolved cycles of family failure rooted in unresolved mental health issues, alcohol and substance addiction, domestic abuse and high levels of benefit dependency.

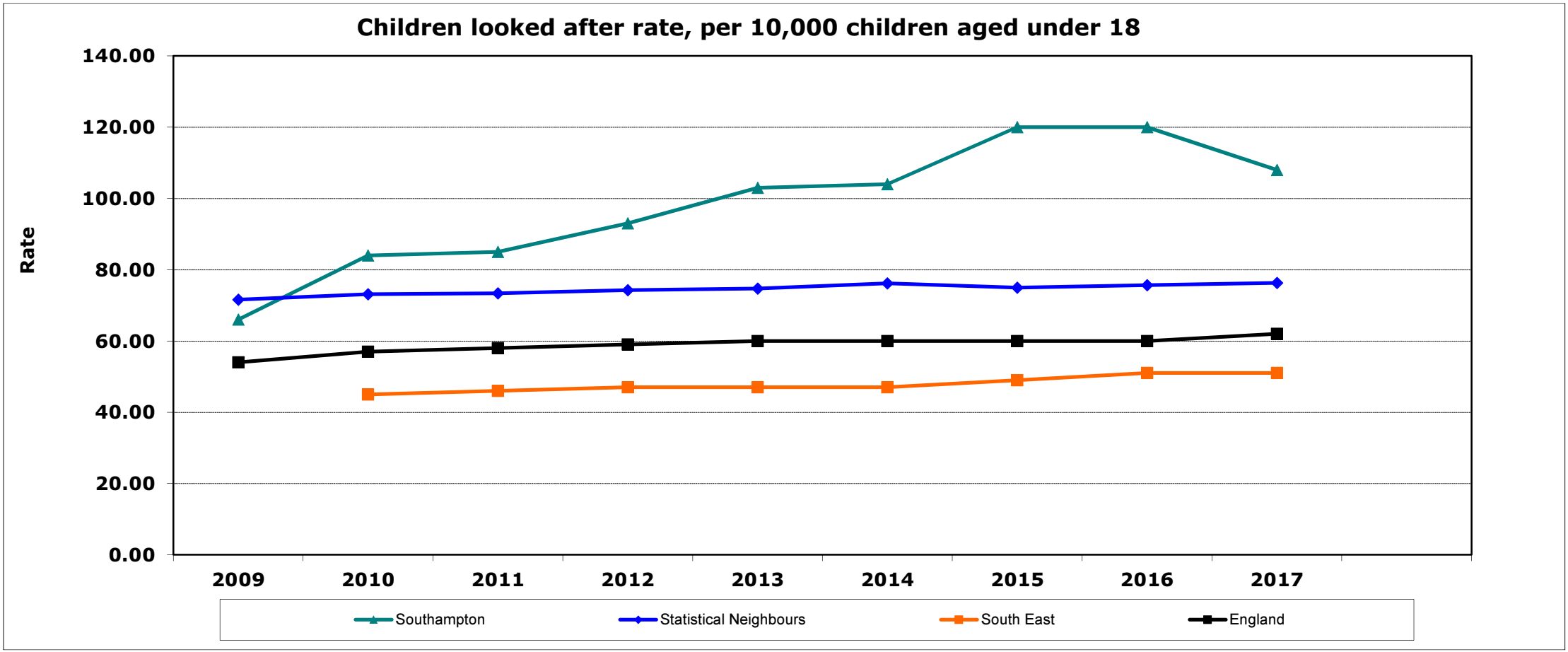
What the data tells us: CYP

- 2013-2017 **847 children and young people taken into care**.
- Number decreasing each year since 2014 in same five year period; from 217 in 2014 to 115 in 2017.
- **50% were taken into care before the age of 5 years** and 50% from 5-17 years.
- Of those CYP coded on the system (41% no code supplied and so excluded from calculation), **57% had some form of SEN status …**

- 39% have a special education need recorded;
- 10% have an Education, Health and Care Plan;
- 8% are coded as School Action or School Action Plus.



How we compare to other similar LA's



Source: Local Authority Interactive Tool

What the data tells us: Mothers

- 504 women gave birth to the 847 children taken into care during 2013-17.
- Of those 504 women **231 women had 2 or more children removed.** This is the group of women that we are (initially) particularly interested in.
- Of those 231 women who had a child/multiple children removed (at the same time) between 2013 and 2017, 66 of them went on to have a subsequent child/ren taken into care who were born more than 40 weeks after the previous child/ren removed. This suggests a **cohort of 66 women that would be an initial target group of women to work with** (as at end of 2017).

Tricky part… don't know who out of the 231 women will become the 66 that go onto have later born children taken into care!

Prioritising who receives the intervention

It would be most cost effective to target the following groups:

- **Younger women** – as can prevent more future LAC.

- **Those with a "new" second removal** (including those with older siblings removed at the same time), rather than women who are having their 3rd or 4th removal.

  - If target those with "new" second removals the cohort who go on to have later born children taken into care reduces from 66 to 37 mothers.

  - 8/37 (21.6%) of these mothers had a subsequent birth within 1 year of the second removal.

Would also want to prioritise based upon other factors; mother's needs, willingness of the mother to engage in the service, etc. A multi-agency partnership forum to make decisions about who to target for intervention required.

Presenting Issues – Learning from Bristol

60% have issues with **Drugs, Alcohol or both** – 37% in a national study*

68% have experienced **Domestic Violence** – 50% in a national study*

7% have diagnosed Learning Difficulties

13% are Care Leavers

36% have experienced a range of chronic **MH issues** – 38% in a national study*

16% have a criminal history

Research has identified several risk factors for having children removed. The most prevalent factors are unintended pregnancies at young ages; substance misuse; domestic violence; mental ill health; and learning disabilities. Risk increases with the increase in the number of risk factors – have a cumulative impact.

* Department for Education (2017). *Characteristics of children in need: 2016 to 2017.* Looks at 571,000 children subject to 646,120 care referrals.

Jade’s story

Jade began her engagement with Pause in early summer 2015, while in her early thirties. She had experienced 4 children removed from her care. Two were adopted, while 2 were in the care of a paternal grandmother.

Jade had suffered sexual abuse as a child from a family member who lived locally. She had also experienced domestic violence in childhood and adulthood. Although she presented as confident, Jade explained that she had low self-esteem and was very insecure. She reported that she was struggling to manage the emotional impact of the loss of her children, was ‘constantly crying’, felt depressed, had no motivation, and was also affected by flashbacks related to previous experiences of abuse. Jade was facing issues with heroin and alcohol, and was using methadone but not accessing any other support. She described using substances as a coping mechanism.

Pause helped Jade to secure new, permanent housing, through a dedicated pathway arranged by Pause Board members. Jade stated this was the most important factor in helping her to achieve change, find stability, and escape drugs. Jade’s Practitioner helped her access treatment services for her substance misuse. Jade also started counselling, enrolled in college on catering and maths courses, and was doing ad-hoc voluntary work. Jade’s Practitioner helped her to successfully engage in group activities with other Pause women, took Jade on outings to the hairdresser and beautician, and provided practical support with buying household items, debt, and budgeting. Jade also significantly reduced her methadone use.

Jane’s feedback on Pause

I didn’t realise the impact domestic violence had on children until I did the Freedom Programme with Women’s Aid. I was heartbroken when my children were taken into care: it makes you feel like a s**t mother. When Amy called me from Pause, I was at the point of giving up, of killing myself. I was in a dark place, I felt like I was alone. Since I started working with Pause, I realise I’ve still got a chance.

I’ve got a new flat, a new job, and I’m doing training. I want to improve my life. Pause helped me get a cooker and a fridge freezer and I’ve got somewhere to bring my kids when we have contact. “Mummy’s little flat” – they love it.

Pause don’t threaten you – but if you’re taking the biscuit, they’ll tell you! I feel stronger now than I did before. Where I used to find meetings with social workers frustrating and upsetting, I can cope now. I feel confident in myself. And my mum’s really proud.

Evidence review

- 5/22 studies explored the effectiveness and cost effectiveness of LARC.

- 10/22 studies explored interventions for parents of children removed or at risk of removal:
  - 3 studies conducted in the UK, remaining from the US and Australia
  - Over 1200 participants
  - One was a systematic review of 12 studies, 2 included mothers, 8 included children and their families (including birth and foster families)
  - Gap in support for parents after a child is removed from their care, and need to address the risk factors that mean multiple children are removed.

- Includes an evaluation of the Pause programme.

Findings of the evidence review

- Quality of the evidence good to moderate.

- LARC effective and cost effective.

- Main outcomes for women:
  - Reduced rate of unplanned pregnancies
  - Improved psychological outcomes in parents e.g. confidence, self-worth, wellbeing
  - Improved outcomes in relation to risk factors e.g. domestic abuse, drug/alcohol use
  - High satisfaction with intervention

- Critical success factors:
  - Providing the intervention early (i.e. soon after a child removed from care).
  - Tailoring the support to woman's individual needs within a structure of a programme.
  - See "critical success factors" slide.

- Lack of research into long-term effects of interventions.

Pause (national model)

- Pause do not deliver the service. Operate in a similar way to a licensed programme.
- LA would need to deliver or commission the service whether buy into Pause or not.
- Key advantages to “buying into” the Pause model: using an evidence-based model, have access to Pause training and clinical supervision, intensive support (from the national and regional Pause team) with set up, delivery, monitoring and evaluation of the service.
- Key disadvantages: Limited flexibility to change the model to meet local needs, an expensive service if can’t utilise existing posts, according to other LA’s can feel like a “take over”.

Learning from Southampton stakeholders, Pause national team, and other areas that provide Pause*

All apply whether "buy into" Pause model or not…

- Build from what already have; use the strengths in the Southampton system.
- Intensive support over an 18 month period requires a devoted workforce, can't be an "add on".
- Needs to be a city-wide team, and have robust pathways and links with other services; for participating women and to ensure clinical supervision for professionals in team.
- A drawback of any service is that new posts are likely to be filled by existing social workers and substance misuse/domestic violence/MH services – so shifting resource and skills from one part of the system to another.
- No obvious community, voluntary or social enterprise (VCSE) sector provider in Southampton to deliver the service.
- Is some alignment between FNP and the Pause model i.e. Pay more to retain staff, case loads capped, strength-based approach, clinical supervision.

* Spoke to statistical neighbours Bristol, Derby, and Plymouth, and West Sussex

Critical success factors

- **Team of 5 people**. Critical for a good quality and robust service; ensures a good skill mix possible, ca loads can be capped, peer support and learning, cover when team members take annual (or sick) lea

- **Skill mix of the team** should include the following;

  - A Team leader that provides supervision, and access to clinical supervision.

  - **3 practitioners** with at least some experience from the following fields: social work, substan misuse, domestic violence and abuse, mental health. Would want at least one member of the team to be an experienced social worker with child protection experience (could be the Team Leader).

  - **Business and admin support**.

- **Paying practitioners** at a level equivalent to experienced social workers.

- **Cap on case-load** i.e. 8-10 cases per practitioner.

- **Tailoring** to the needs of each woman.

- **Branding** of the team (not seen as social workers).

- **Links with decision-making forums and services** in place.

Strengthening Long-Acting Reversible Contraception (LARC) advice and pathways

- Strengthen pathways between the NHS Solent Sexual Health Service (including Outreach Service) and other services i.e. LAC teams, substance misuse services, hostel staff.

- Upskill staff across the system to talk about LARC, promote time away from being pregnant, and refer to their GP or the Sexual Health Service i.e. social workers, substance misuse staff, domestic violence, pharmacy staff post prescribing of Emergency Hormonal Contraception.

- Train FNP health visitors and midwives to fit LARC.

- Review LARC in BPAS and ensure it as robust as would want it to be.

Cost avoidance according to national evaluation of Pause (McCracken et al.)

- For 125 women, estimated net savings of £1.2m to £2.1m per year after 18 months through avoided pregnancies and subsequent reduction in Looked After Children costs. Should see this as cost avoidance rather than savings.

- So, if 20 women participate in a local programme over an 18 month period (as recommended by Pause), the estimated cost avoidance after 18 months through avoided pregnancies and subsequent reduction in LAC costs is between £192,000 to £336,000 per year.

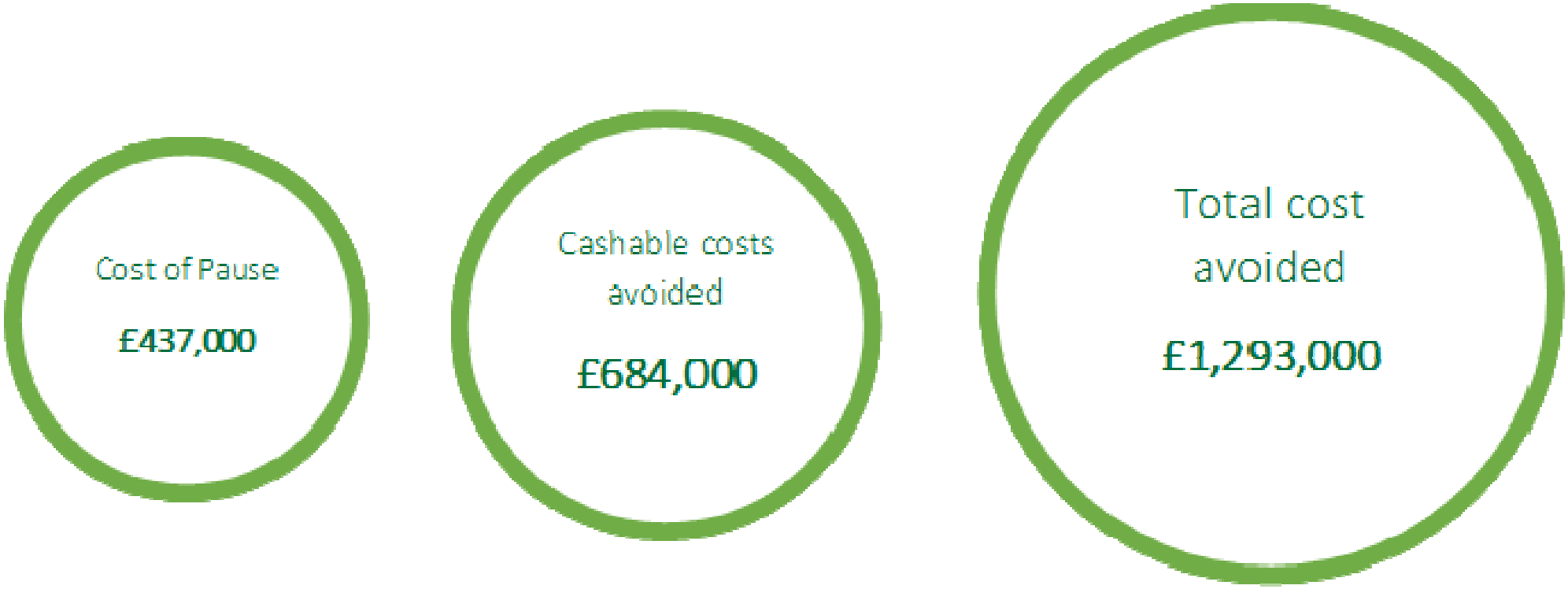
- Equates to 3-6 pregnancies avoided per year that would have subsequently been children that were taken into care.

- Further potential cost avoidance from reductions in levels of domestic violence*, harmful alcohol use**, and Class A drugs** after 18 months for a local programme are between £100,500-£117,000, though these estimates should be treated with caution.

*Estimated using Pause records of self reported incidents and estimated of annual repeat incidents. Cannot be proven that reductions the result of the Pause programme.

** Estimated using Pause records of self reported outcomes and cost avoidance estimates. Cannot be proven that reductions the result of the Pause programme.

nancial impact of the pause in pregnancy in relation to a ause Practice in the North



Cost avoidance (local analysis)

Dependent on birth rate of mothers at risk of repeat removals, and which women engage in service (and hence number pregnancies avoided).

Scenario 1: Prioritise women who have had 1 or 2 removals and are thought to be at high risk of having another child and subsequent removal; younger women (aged 18-30 years).

Scenario 2: Prioritise women who have had 2 removals and are thought to be at high risk of having another child and subsequent removal; women of any age.

Resourcing options

Option A: Redirection of SCC - and potentially partner - funding to enable delivery of the service for a fixed period.

Scenario 1: Service as suggested by Pause (buying into the national Pause programme).

- **£450k** for an **18 month period** as costed by the Pause national team (approx. £303k staffing costs, £89k programme costs, £57k local costs).
- The actual cost is dependent on the delivery model. The preferred delivery model is a SCC service or SCC/NHS Solent service delivered under the Section 75 agreement, in which case many of the "local" costs (HR, IT equipment etc.) would be absorbed within SCC's (and potentially NHS Solent's) current overhead charges. The maximum we could potentially reduce costs to by deducting some overhead costs and using a combination of the midpoint and lowest suggested grades for posts is around £405k (using Pause's costing template). However this is dependent on grades as agreed with Pause. If the service is delivered by an external provider would need to add at least some of the overhead costs back in.
- Of the 450k, £40,875 goes directly to Pause over an 18 month period (for membership and training).

* If opt for Option A scenario 1, recommend buying into Pause for an 18 month period but leaving the option open to continue the service without buying into Pause after the 18 month period.

Scenario 2: Service as suggested by Pause but delivered as a bespoke service. Approx £346k

- Taken out Pause membership fee and reduced women's resource by 50%.
- Assumes the service is delivered by SCC or under the Section 75 agreement with NHS Solent and so "local" costs have been reduced. If delivered by an external provider would need to add at least some of these costs back in.

Option A continued…

Strengths of Option A, scenario 1: Able to utilise the money more freely to employ people with the right skill mix and experience (i.e. rather than shifting existing posts), not detracting from an existing service, strengths of buying into Pause as highlighted in slide 13 (i.e. buying into an evidence based model).

Risks of Option A, scenario 1: Funding available for a fixed time period and so risk that further funding not available or sustained longer-term, risks of buying into Pause as highlighted in slide 13.

Resourcing options

B. Redirection of some FNP and SCC Children and Families resources to deliver the service under the current Section 75 framework.

i.e. 2 x 0.8 FNP Nurses (Grade 7).

1 x Family Engagement Worker.

1 x Senior Social Worker. Requires backfill.

The above headcount and skill mix informed by the Pause model.

Service delivered under joint Solent and SCC management.

Strengths: Sustainable way of resourcing the new service, building from what's already in place, Solent has strong links with key services and clinical supervision already embedded, alignment with relevant SCC teams.

Risks: Possible limitations as to when can redeploy FNP nurses (terms of the FNP licence being explored).

Recommendations:

1. That JCB commit to the delivery of a service in Southampton to support women who have children taken into care; to address their multiple needs and reduce future children being taken into care.

2. That JCB support the following resourcing option:

   Option A, scenario 1. Redirection of SCC - and potentially partner - funding to enable delivery of the service for a fixed period of time.

   Recommend buying into Pause for an 18 month period but leaving the option open to continue the service without buying into Pause after the 18 month period.

3. That JCB agree that we proceed with the development of a full business case, which is considered and approved by the Children's Multi-Agency Partnership Board, with prior input from Cabinet Members.