



Department
for Education

The New Orleans Intervention Model: Early Implementation in a London Borough

Evaluation report

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Contents

Introduction	4
Acknowledgements	5
Executive summary	6
Context	6
Evaluating the London Infant and Family Team (LIFT) service	7
The LIFT service	7
Assessing the proposal to conduct a Randomised Control Trial (RCT)	8
Recommendations from the qualitative research for the development of LIFT	9
Proposed methodology for evaluating the next stage of the LIFT	9
Action plan and progress to RCT	9
Structure of report	11
The New Orleans Intervention Model (NIM)	12
Background	12
The New Orleans Intervention Model in Tulane	12
The New Orleans Intervention Model in Scotland	14
Preparatory work in Croydon	15
Overview of the evaluation	17
The evaluation questions	17
The methodology and analysis: qualitative evaluation (Part 1)	17
Changes to the planned methodology	19
The methodology of the quantitative evaluation (Part 2)	19
Participants	19
Data collection	19
Action planning for the RCT (Part 2)	20
Findings Part 1	21
NIM in the context of the English children’s social care and justice system	21
Introducing LIFT into the London Borough of Croydon	21
Introducing LIFT in the English legal context	23
Key Findings	25
Lessons learnt on implementation	25
Views on the need for a service such as LIFT	29
Referrals in the first six months	30

The early cases	31
Reflections on LIFT from LIFT team members	32
Reflections on LIFT from other professionals	34
The possibility of conducting an RCT in the future	36
Rigorous alternatives to an RCT	39
Limitations of the Stage 1 evaluation	41
Implications and recommendations for policy and practice	43
Findings Part 2: Planning for implementation of the RCT April 2016 to January 2017	46
Introduction	46
Why does a randomised controlled trial seem to be the most appropriate research methodology to assess the effectiveness and cost- effectiveness of NIM?	46
Concern 1: Absence of a blueprint for conducting RCTs in the family justice area	49
Concern 2: Anxieties regarding randomisation of children in a social care context	51
Concern 3: Concerns about equity	52
Concern 4: No agreed level of what constitutes 'services as usual'	53
Concern 5: Rates of referral to LIFT have been low	54
Concern 6: Exclusion of target children with siblings over 5 years of age	55
Concern 7: Arrangements for analysis of data from a multi-site study	56
Concern 8: Difficulties communicating with key staff from children's social care	57
Discussion and next steps	59
Conclusions	61
Annex: Issues arising for the judiciary in the introduction of an RCT within family proceedings	62
Proposals for a modified RCT	62
References	65
Appendix A: GIFT, FACS and the RCT	72
Appendix B: Interview schedules	74
Interview schedule: LIFT staff	74
Interview schedule: Key stakeholders	76
Interview schedule: Judges in Croydon Family Court	78
Appendix C: Informants contributing to the qualitative evaluation	80
Appendix D: The process in Scotland	83
Appendix E: Legal flow chart	84

Introduction

The NSPCC introduced the New Orleans Intervention (LIFT) in Croydon and it has delivered this for over a year in collaboration with South London and Maudsley NHS Foundation Trust. The initiative brings a multidisciplinary team process, and a focus on infant mental health to assessments for young children in the care system. There is as yet, however, no evidence that the New Orleans Intervention is more effective than existing services. The same model in Glasgow has been the subject of a randomised controlled trial (RCT) since 2011 and the intention is to extend the RCT to include LIFT, if possible. This would strengthen the evaluation, as the service would be tested in different jurisdictions.

The Department of Education (DfE) funded the set-up and early delivery of the LIFT service through its Innovation Fund, and a requirement of this was that an external evaluation was undertaken. The external evaluation has been undertaken by two research teams at King's College London. One team (Mary Baginsky, Jo Moriarty and Jill Manthorpe) undertook qualitative research into the set-up and early delivery of the LIFT service and the feasibility of Croydon as the second RCT site. The fieldwork was completed by the end of March 2016. The other team (Dennis Ougrin and Kerry Middleton) focussed on quantitative data for the service and the local care system, as well as preparing for a possible RCT. Their contribution to this report covers the period up to January 2017.

The qualitative research generated a rich picture of the set-up and early delivery of the LIFT service and the findings are outlined in Part 1. In addition, it raised some key challenges to the viability of the LIFT service in Croydon joining the multi-site RCT. It was agreed that Dennis Ougrin and Kerry Middleton would develop an action plan to address the challenges and concerns that had been raised. This reporting has been structured to reflect the journey of this study: the first set of findings focuses on early implementation, and is based primarily on the qualitative research in Part 1; and the following section presents the action plan response generated to address the barriers and challenges to adopting an RCT in Croydon, and the progress of this, reported in Part 2. The report concludes with an annex provided by the District Family Judge for East London (Her Honour Judge Atkinson), which explains the judiciary's decision making about the LIFT service and the RCT design.

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Executive summary

Context

The New Orleans Intervention Model (NIM) is the name given to a service approach that provides intensive assessment and treatment for families of children aged 0-5 years in foster care, which informs recommendations to the court about adoption or permanent return to birth families. It was developed by Professor Charles Zeanah of Tulane University, Louisiana, United States (US), in the late 1990s. The intervention focuses on relational assessments by exploring the relationship between, for example, the child and mother, child and father, and child and foster carer. A multidisciplinary team undertakes attachment-based assessment and intervention work using structured clinical tools. The model has been adopted in various parts of the US, as well as in South Australia, but implementation has not always been consistent with the original model.

NIM has been part of the National Society for the Prevention of Cruelty to Children's (NSPCC's) services in Scotland since 2011, where it is known as the Glasgow Infant and Family Team (GIFT). This is subject to a randomised controlled trial (RCT) as part of the BeST? services trial / Evaluation of the New Orleans Intervention for Infant Mental Health led by Professor Helen Minnis of the University of Glasgow. The NSPCC successfully applied for funding to the Children's Social Care Innovation Programme (IP) – a programme of support run by the Department for Education (DfE) – to introduce the model into England for the first time and to evaluate its implementation. A pilot service was developed in the London Borough of Croydon, known as the London Infant and Family Team (LIFT), and it is this service which is the focus of this report.

The total number of looked after children in England has increased steadily over the last 8 years. There were 70,440 looked after children at 31 March 2016, an increase of 1% compared to 31 March 2015 and an increase of 5% compared to 2012. Over 800 of these are from the London Borough of Croydon, where the rate of LAC per 10,000 children in the population is the highest in London and one of the highest in the UK. However, it should be noted that the total includes over 400 unaccompanied asylum seeking LAC (Wilder and Dembour, 2015) almost of whom will be aged over 16. The overall population aged 0-19 in Croydon is also one of the highest in the country.

Being a LAC is linked with a range of adverse mental health, psychological and social outcomes (Luke et al., 2014, Sempik et al., 2008, Moriarty et al., 2016). There are no published results of services for babies and young LAC that have been tested in RCTs in the UK, although it is likely that some trials have included at least some LAC aged under 5 (for example, Carpenter et al., 2016, Robling et al., 2016). One of the key challenges to any RCT with this group is how to set up the process of randomisation before a final decision about a looked after child's placement has been made. This report describes some of the ethical, legal, and practical arrangements that need to be in place before this process can be achieved.

Evaluating the London Infant and Family Team (LIFT) service

A two part evaluation was commissioned to help NSPCC to implement the intervention in the London Borough of Croydon (LB Croydon). The first, based on 54 interviews undertaken in early 2016 with key stakeholders, considered Croydon's feasibility as the second site for the RCT being conducted in Glasgow and what was needed to develop the approach and methodology for a rigorous evaluation of the programme if an RCT was not possible. It also examines the initiative within the English social care and legal contexts.

The second, which ran until January 2017, investigated what data would need to be collected, and the arrangements for sharing data that would be needed to establish outcomes for all children and their families referred to LIFT. A comprehensive database was developed for the purpose of the evaluation by Dennis Ougrin and Kerry Middleton. The database covers sociodemographic, psychosocial and clinical data on all children and their families referred to LIFT. The database comprises 236 data points; 63 data of which collect information on sociodemographics, care journey details and levels of service contact, while the remainder record information about the mental health of children and birth parents (all potential assessments included).

Given the focus and timing of the evaluation, it was unable to establish whether NIM has made a difference to children and young people's outcomes, or those of their birth parents. Instead, one of the main themes of this report is the process of deciding how it might be possible to set up a system for obtaining this information. The report itself is divided into three parts. The first (pages 17-20) describes the context, and methods for the evaluation as a whole. The second (pages 21-43) presents the findings from the qualitative evaluation while the third (pages 46-60) summarises referrals made to the LIFT team, and presents progress towards establishing an RCT over the past 12 months.

The LIFT service

The NSPCC intended to start the LIFT service by June 2015 but this was not achievable within the timescales, given the level of professional expertise required. There were few referrals in the early months, so understaffing did not adversely affect delivery of the service. There were also delays in referrals from LB Croydon during the very early months of LIFT, although the reasons for this are not clear. At the time of the qualitative evaluation, through to March 2016, LIFT had capacity to conduct three assessments at any one time involving work with the child, birth parent(s) and foster carers. The intention was to have the capacity to undertake assessments with 5 or 6 parents simultaneously from May 2016. While a few issues still needed to be resolved, team members were very positive about the training they had received, as well as their experiences of working on the early cases. Benefits were beginning to emerge in the reports written by LIFT staff members as well as in feedback received from a Cafcass children's guardian.

LIFT currently comprises a child and adolescent psychiatrist, 2 senior psychologists, 2 clinical psychologists, 3 social workers and one family liaison worker, all of whom are provided with administrative support (70 hours a month). The majority of staff work in the service full-time (35 - 37.5 hours per week) and levels of experience in current professional roles range from 6 months to 31 years (mean: 10 years). All clinical team members received a total of 13 days training for their current roles (4 days - The New Orleans Intervention Model; 4 days - Circle of Security Interview; 2 days - Video Interaction Guidance; 2 days – Mentalisation; one day - Court Skills). The administrative team received 4 days of training on the model.

Between January 2016 and January 2017, there were 21 referrals of LAC to LIFT, which is in line with expectations. At the point of reporting (January 2017), 17 of the children referred had been discharged by LIFT, leaving 4 children in receipt of an ongoing service. The 17 families that had been discharged had received 96 days of LIFT input on average. Only 3 of the 21 children referred did not attend any LIFT face-to-face sessions; at the point of reporting (January 2017) the average number of sessions was 28.7 and LIFT had recorded an average of 14.1 phone calls per case. 14 of the 21 cases were closed early . Early closure occurred primarily due to the LIFT service decision not to intervene (3 cases); court decisions (4 cases); Local Authority decisions (2 cases), and family decisions (5 cases) . It was not possible to make direct comparisons with services as usual; however, social work practice is likely to be significantly less intensive than this level of contact and therefore the costs associated with LIFT are likely to be higher. A greater number of referrals is expected in subsequent years as the referral pathways become more established.

Assessing the proposal to conduct a Randomised Control Trial (RCT)

In the early phase of this evaluation, a number of challenges to using an RCT methodology were identified. At the time when the LIFT project was being established, contact was made with the judiciary in England. The President of the Family Division supported the establishment of the LIFT team and gave permission for LIFT cases to be exempt from the Public Law Outline (PLO) timetable. At the time, it was not considered that it would be feasible to conduct an RCT. The primary reason was that cases were already in proceedings, unlike in Scotland, and an RCT risked compromising the judicial function as the decision maker, guided at all times by the need to make a best interests decision in a timely manner. Other key stakeholders, including senior members of the local authority, were opposed to an RCT, considering it unethical to deny the service to families by privileging the evaluation method over the opportunity of an assessment by the LIFT team. A further impediment identified was the low number of referrals which would make it impossible to achieve the statistical power to detect differences between the randomised and control groups if Croydon was to be the sole English site.

Recommendations from the qualitative research for the development of LIFT

The qualitative research team concluded that the LIFT service and NIM in general have the potential to address some of the current challenges in Family Courts arising from a lack of analysis and evidence, which lead judges to express concerns about some plans that are presented to them. There are lessons to be learnt from the development of the LIFT service if it were decided to sustain the service in LB Croydon, or to replicate it in another authority in England, namely:

- ensure that adequate planning takes place and resources are agreed and made available, including for evaluation
- establish strong contacts with all relevant professionals and stakeholders to ensure they have sufficient awareness and understanding that LIFT is a mental health intervention for babies and young children
- decide on a robust evaluation methodology incorporating a cost study similar to that conducted in the evaluation of the Family Drug and Alcohol Court (Harwin et al., 2014)
- confirm research governance and data sharing processes are in place
- consider offering training based on the model to social workers and other professionals to support their assessment skills and engagement
- develop processes to learn from the findings of other studies conducted in the family justice arena.

Proposed methodology for evaluating the next stage of the LIFT

The challenges outlined above led the researchers undertaking the qualitative research to propose that alternative designs to an RCT be considered. In addition to the continued monitoring of the service and the longitudinal follow up of families involved, it concluded that a pragmatic clinical trial or quasi-experimental design could be considered if the service was to be extended to another authority in the future. Such designs are increasingly used for the evaluation of clinical and/or practice-based interventions where randomisation at an individual level is not possible or appropriate. So, while some families would still be offered the service and others would not, the randomisation would take place at an area, not an individual, level.

Action plan and progress to RCT

Responding to these proposals, the NSPCC, and the team from Glasgow and King's College London seeking to establish an RCT in Croydon, considered that, while the

findings from the qualitative research were very helpful in identifying key challenges to getting the RCT evaluation underway and in informing an action plan to address these, these challenges were not insurmountable..

Robust plans designed to overcome all potential barriers and objections uncovered during the qualitative phase of the evaluation have been developed. The plans were developed during a series of meetings and consultations organised by the King's College London and University of Glasgow research team, the LIFT service and the NSPCC, with senior representatives of the judiciary (including the President of the Family Division, Sir James Munby, and Her Honour Judge Atkinson, Designated Family Judge for East London), senior representatives of the London Borough of Croydon (Ian Lewis) and senior academics (Professor Sir Michael Rutter). These meetings and consultations took place from April 2016 onwards and have resulted in some progress in gaining support for the RCT of LIFT by all major stakeholders, including the judiciary and senior members of the Early Help and Children's Social Care Team. This process took a considerable amount of time which might be explained by the following two factors:

- there is no precedent for the implementation of a randomised trial within family proceedings in England. It is essential to set up a system that ensures that the role of the Judge is not compromised by the introduction of randomisation. The court has to be in control of the process because of its overarching obligation to consider the best interests of the child
- the time needed to establish a local operational framework for referrals to LIFT across the judiciary, children's social care, the NSPCC and the research team

Conducting an RCT will require administering a number of standardised measures to the children and their carers. The experience of clinical data collection by the LIFT team indicates that it is feasible to collect these measures. In addition, the number of referrals from the London Borough of Croydon is in line with the sample size calculations undertaken for the RCT proposal, and suggests that these aspects of an RCT are likely to be feasible.

Data sharing agreements between King's College London and the NSPCC are now completed (May 2017). Senior managers of LB Croydon and the local judiciary are supportive of an RCT in principle, and a multi-agency steering group is in place to oversee the project, with senior representatives from each of the partner organisations (LB Croydon, NSPCC, SLaM, the judiciary, University of Glasgow and King's College London). A detailed implementation plan for the RCT has not been approved, but planning is underway. Once completed, this plan will need to be approved formally by the President of the Family Division.

While LIFT appears to be a feasible model for LAC aged 0-5 living in Croydon, it is associated with high intensity of contact between the service and the families. This means that rigorous evaluation is required before any recommendations are made on wider implementation of the model. The remainder of this report outlines the challenges

involved both in implementing and evaluating LIFT. It ends by explaining the progress that has been made in setting up an RCT. However, the final protocol has yet to be agreed. As this would be the first RCT within family proceedings, it is essential to design one which is both viable and robust.

Structure of report

Details of the New Orleans Intervention model (NIM) follow in the next section. This includes a discussion both of the origins and development of the programme in the US as well as the subsequent delivery in Scotland which is being evaluated through a randomised controlled trial. An overview of the key questions and methodology for the evaluation are then provided. The findings are then presented in two parts, reflecting the structure and sequencing of the evaluation process:

- Part 1 covers the set-up and early implementation of the programme in Croydon until March 2016. It was undertaken by a research team from the Social Care Workforce Research Unit at King's College London and is largely qualitative in nature
- Part 2 reports on an action plan that was drawn up to address the concerns identified in the qualitative research about the viability of conducting a randomised controlled trial with this programme in Croydon. It was undertaken by a research team at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, and covers the period until January 2017

The report concludes with an annex provided by the District Family Judge for East London (Her Honour Judge Atkinson), which explains the judiciary's decision making about the LIFT service and the RCT design.

The bibliography and appendices relate to both parts of the evaluation.

The New Orleans Intervention Model (NIM)

Background

The National Society for the Prevention of Cruelty to Children (NSPCC) successfully applied to the Innovation Programme to fund both the introduction of the New Orleans Intervention Model (NIM) to England for the first time, and to evaluate its implementation. The service was developed in the London Borough of Croydon (LB Croydon) and is known as the London Infant and Family Team (LIFT). NIM has been a part of NSPCC's services in Scotland since 2011 where it is known as the Glasgow Infant and Family Team (GIFT). The development of NIM in Croydon drew on Glasgow's experiences of working with the model. Up to now, there has not been a robust evaluation of the model in any jurisdiction, although a randomised controlled trial (RCT) is underway in Glasgow, and it had been proposed to include Croydon in the trial as the second site (following an unsuccessful earlier attempt in another London Borough). This section provides an overview of NIM as it operates in Tulane, US, and explains how it operates and is being evaluated in Glasgow.

The New Orleans Intervention Model in Tulane

The New Orleans Intervention Model (NIM) is the name given to a service approach that provides intensive assessment and treatment for families of children from birth to 5 years in foster care, which informs recommendations to the court about adoption or permanent return to birth families. It was developed by Professor Charles Zeanah and a team at Tulane University, Louisiana, in the late 1990s. The intervention focuses on relational assessments, by exploring the relationship between, for example, the child and mother; child and father; and child and foster carer; and it may last for up to a year. The team is then in a position to make recommendations to a court about the best placement outcome for a child. The recommendation would generally either be to return a child to their birth parents or, where that is not considered appropriate, to allow the child to be adopted as early as possible (see Zeanah et al., 1997).

Following referral to the service, a multidisciplinary team of specialists in infant mental health and social care work with the families of children aged between six months and five years who have been abused and placed in foster care. NIM does not work with siblings over that age. The team uses structured interviews, observations and questionnaires to assess birth parents' mental health, parental relationship, and the problems and trauma they have faced. The intention is to improve the permanency decision-making process and allow the team to be in a position to make recommendations to a court about the best placement outcome for a child. Key to the assessment, which takes place over a ten week period, is whether the parent can recognise the neglect or abuse, and is capable of reflecting on its causes. The team assesses the child's development and attachment with each carer and birth parent. It

allows an assessment of the quality of the child's relationships and the extent of any change occurring over the course of the intervention. If the assessment indicates that the parent could, in time, look after the child, then the team provides tailored therapeutic support to address problems and strengthen the parent-child relationship. The assessment phase is more intensive than the intervention phase, where the treatment is tailored to respond to identified needs, and takes place over a period of around nine months.

The original project was set up and paid for by the court system in the State of Louisiana. Judges had recognised that cross-litigation and consequent delays were harmful to the children, as well as expensive. Courts use the assessments to reach a decision about placement. The team works in conjunction with the Court officers, as well as with the social workers holding responsibility for individual cases. Parents are mandated to take part and, while there is no question of anything being considered as confidential, this does not prevent later therapeutic work being done. In the view of someone who has observed the service in operation, who was interviewed as part of this present evaluation: 'From the mother's point of view the experience of someone being open and honest with them is a better basis for a therapeutic relationship than the offer of confidentiality.' Several informants in this present study referred to Professor Zeanah's belief, which is not evidenced but has clearly been influential, that no-one can tell whether a family should keep custody of their child at home until the family has been given a chance to change.

Professor Zeanah developed NIM in 1998. The data for the four years prior to and four years after the introduction of the intervention were analysed by Professor Zeanah and colleagues (see Zeanah et al., 2001). It emerged that, of the children in the study, there was an increase in the proportion adopted and, when children were returned to their birth families, there were fewer subsequent referrals for maltreatment, both for the reference child and any siblings. In the non-intervention group, 19 of the 145 (13.1%) children were confirmed to have suffered abuse in a subsequent incident, while this was the case for 4 of the 95 (4.2%) children in intervention group. A more recent seven year follow-up of children supported by the NIM found that their mental health was comparable to that of children who had not been abused (Robinson et al., 2012). However, neither an economic modelling nor a cost benefit analysis has been conducted.

The published evidence base of effective interventions for this group of families is currently very sparse. In an unpublished systematic review conducted by Minnis and colleagues, NIM was reported to be the only evidence-based programme found that used an infant mental health approach to improve the quality of permanent placement decisions so that children could experience appropriate nurturing care as early in life as possible. Another literature review by Carrey et al. (2014) found that current early childhood systems of care were not geared 'to respond to the complex needs of preschoolers at risk for mental health problems in a timely, coordinated, multidisciplinary, and comprehensive fashion' (p 2).

It is interesting to note that, despite the absence of a robust evaluation, NIM has been adopted in various parts of the US, as well as in South Australia. According to the Tulane Infant Team, at least in the US, this has not always been in ways consistent with the original model. So, for example, in Kentucky, one team adopted the NIM approach but only in respect of the way it conducted assessments. This team takes referrals from a large geographic area and concluded that while they could undertake NIM assessments, they could not go on to provide interventions. In New Mexico, there are several teams that are composed exclusively of social workers, whereas the other teams applying the model include a range of clinicians. It has also been used in Adelaide in South Australia by clinicians in the Women's and Children's Hospital.

The New Orleans Intervention Model in Scotland

The New Orleans Intervention Model (NIM) has been part of NSPCC's services in Scotland since 2011 where it is known as the Glasgow Infant and Family Team (GIFT).¹ In line with Professor Zeanah's model, GIFT conducts an assessment and, where deemed appropriate, an intervention with families whose children are aged between 6 and 60 months. There are usually about 20 or 30 cases (families) in touch with GIFT at any one time, with around a third in assessment and two-thirds in treatment. Families may be in contact with the service for up to a year, depending on the treatment phase.

Glasgow City Council also offers a service to a very similar group of families. The Family Assessment and Contact Service (FACS) was established by Glasgow Social Work Services in 2005 to address concerns about how effectively social workers are able to deal with the many demands made of them. The FACS was enhanced in 2011 in order to offer an improved level of consistency and expertise. It is a part of Families for Children, a registered agency for fostering and adoption for Glasgow Council. The FACS service works with families with children of all ages, including babies from birth – not from six months as in GIFT. It consists of a team of social workers who are experienced in conducting assessments to inform decisions about a child's future care by examining family functioning and making recommendations regarding placement outcomes for children within a three month period. The service is designed to assess a parent's capacity to empathise with their child and set aside their own needs in order to meet those of their children (see Donald and Jureidini, 2004). After an initial meeting, a FACS case is allocated to two workers. A social worker leads on the case and a social care worker assists with aspects such as the observation of contacts. The team meets with each family eight times over the three months, with each meeting usually lasting two hours. Families are asked to come in half an hour early to prepare and to wait behind for half an hour at the end to receive feedback.

¹ See Minnis et al., (2010) for further details of how the New Orleans work was translated for the Glasgow context.

There are two key differences between FACS and GIFT. FACS provides a detailed assessment but does not then go on to offer an intervention of any sort, whereas, if a GIFT assessment indicates that it would or could be beneficial to provide an intervention, the GIFT service will continue to work with that family. The second difference reflects a key philosophical difference between the two services. FACS staff said that their emphasis throughout the assessment is on how quickly a permanent placement can be secured for child. While they are conscious of the importance of supporting a child's mental health, it is not the focus of their work, whereas it is at the centre of GIFT's work.

An exploratory randomised control trial (RCT) investigating the effectiveness of the NIM in the Scottish context has been in place since 2010–2011 with FACS being the comparative business as usual arm of the trial (see Pritchett et al., 2015). Families are randomised to GIFT or to FACS.² The Chief Scientist Office³ of the Scottish Government Health Department funded the study known as the BeST? Services Trial: Effectiveness and cost-effectiveness of the New Orleans Intervention Model for Infant Mental Health. It included an element of economic modelling to explore the potential cost-effectiveness (see Turner-Halliday et al., 2016). The overall aim of the Glasgow study was to explore whether it would be possible to conduct an RCT and, if it proved possible to do so, to inform the design of a definitive RCT. In January 2015 amendments were made to the Chief Scientist Office's protocol, to enable the first hundred participants recruited to the trial to be included in the sample for the definitive trial as an internal pilot. The researchers have not released the data relating to the GIFT and FACS groups, arguing that to do so would jeopardise equipoise⁴ for the full study, referred to as the 'definitive' study. These data will, therefore, contribute to the definitive study and will not be reported until 2019, which means that researchers, analysts, funders and policy makers are not aware of the primary and secondary outcome data on the effectiveness measures that are being used. The definitive study will contain an economic analysis to calculate the incremental cost per improvement in child mental health and the incremental cost per quality-adjusted life-year (QALY) between GIFT and FACS. At the present time, data are not available from either side of the Atlantic on the cost per child of adopting this model.

Preparatory work in Croydon

Prior to the work described in this report, the University of Glasgow research team conducted a qualitative inquiry to gain a full picture of the current landscape of services,

² For further details of the randomisation process see Appendix A

³ The Chief Scientist Office is part of the Scottish Government's Health Directorates. Its stated mission is to support and increase the level of high-quality health research conducted in Scotland

⁴ 'Equipoise' means that there is genuine uncertainty in the expert medical community over whether a treatment will be beneficial. The principle of equipoise provides the ethical basis for medical research that involves assigning participants to different treatment arms of a trial. See Freedman, B. (1987) 'Equipoise and the ethics of clinical research'. *The New England Journal of Medicine*, 317, (3):141–145.

how NIM might fit into the current context, and where challenges might arise (Friedman-Levy 2015). The research was conducted for an MSc dissertation and was supervised intensively by the Glasgow trial research team. As part of this work, interviews were conducted with professionals in South London to determine how an RCT might be implemented within the landscape of on-going services. This research indicated that, despite predictable challenges, the buy-in of key stakeholders for an RCT could be achieved in South London; that there was an appropriate control intervention available and that it was generally feasible and ethical to recruit the families of maltreated children, and to randomly allocate them to NIM or the control intervention.

Overview of the evaluation

The evaluation questions

This evaluation of LIFT was commissioned to:

- determine the acceptability of the New Orleans Intervention Model (NIM) to key stakeholders in Croydon;
- make reference to the multi-site RCT of NIM in Scotland and provide information to support work to investigate the potential feasibility of an RCT of NIM in England.

The evaluation also considered how best to capture information about children's care journeys, permanency decisions, and mental health outcomes from services in LB Croydon, and to establish ways of collecting this information routinely. This work involved creating and refining a database, and identifying methods of routine data collection with respective teams.

The evaluation consisted of two parts. The first part involved a qualitative evaluation of the process of setting up the LIFT team, and considered what would be the best approach and methodology for a rigorous evaluation of the project if the planned RCT was not possible. The term 'feasibility study' is deliberately not used for this part of the evaluation to avoid any confusion with the feasibility study conducted as part of the Glasgow trial (see above).

Following delivery of the qualitative evaluation, the London based Principal Investigator of the BeST? Study in London (Dr Ougrin) also became responsible, from April 2016, for designing and implementing an action plan to address the challenges, identified through the qualitative research, in using the RCT impact evaluation design.

Because of its focus and timing, neither part of the evaluation was in a position to establish whether the NIM intervention has made a difference to children's outcomes or those of their birth parents.

An application for ethical approval for this evaluation was made to, and granted by, the West of Scotland Research Ethics Committee 3 (Pilot of the New Orleans Intervention Model in Croydon, REC Reference 15/WS/0179) as this present evaluation is linked to the Glasgow study, originally approved by this Committee in 2010.

The methodology and analysis: qualitative evaluation (Part 1)

The evaluation's initial methodology was agreed with the NSPCC and the Rees Centre on behalf of the Department for Education. The qualitative evaluation consisted of semi-structured interviews with 54 individuals, between December 2015 and early April 2016. Those interviewed worked in the agencies and organisations involved directly with NIM in

Glasgow and Croydon, as well as those with a direct and indirect interest in its operation. In most instances they were interviewed individually, but some were seen in a small group: for example, the three judges working in Croydon's Family Court were interviewed together. The vast majority of the interviews were face to face, but a few were conducted over the telephone, mainly for logistical reasons. Appendix B contains the interview schedule that was used with LIFT team members; the schedule used with key stakeholders and other informants, and the schedule used with the judges. In addition to the interviews undertaken, email exchanges took place with individuals with specific expertise in subject areas relevant to the initiative or its evaluation. Data were analysed using a modified version of the Framework Approach developed by Ritchie and Lewis (2003). All informants were given an assurance of confidentiality and, while a list of all those contributing their expertise and views is contained in Appendix C, no comment or observation is attributed, with one exception, where it is done with the permission of that person.

Those interviewed provided data in the following areas:

- staff in GIFT and FACS provided details of their respective services and of their role in the RCT. Many of these data have informed the early section of the report, where the different services in place in Glasgow and Croydon are described
- NSPCC staff at strategic and operational levels commented on the development, implementation and sustainability of LIFT
- staff in Child and Adolescent Psychiatry, University of Glasgow, described the RCT and their hopes for extending the trial to Croydon
- judges working in Croydon Family Court provided information on their early involvement with the service, and their initial experience of working with families in LIFT; other lawyers and legal academics shared their views on whether there was a need for such a service
- solicitors in local firms who had not yet represented families in LIFT discussed their views on the need for the service, and two solicitors who had clients in LIFT described their experiences
- staff in the local authority described their early contacts with the service and provided their opinions on its operation, and on the possibility of conducting an RCT
- strategic and operational staff in Cafcass, who had either been involved in early discussions about the establishment of the service, or were now working with families in LIFT, shared their experiences
- a range of academics discussed the role and experience of conducting RCTs in complex social interventions generally and in the socio-legal arena specifically. Other individuals provided their expert opinion on specific aspects of the initiative

Changes to the planned methodology

It is disappointing that it was not possible to have engaged more fully with staff working for the London Borough of Croydon. If a research governance process had been in place in the authority, this may have helped to facilitate a greater level of engagement, but other factors may also still have been at play. Early on in the process, senior and middle managers in the authority were interviewed and contributed valuable information and insights. The original intention had been to interview other informants based in relevant services, and to conduct focus groups with social workers and foster carers. It is regrettable that telephone and email contact with key people who could have facilitated this did not result in interviews that would be able to represent these views in this report.

When commissioning the evaluation, it was suggested that parents who would have been eligible for the service if it had been in place some six months earlier should be interviewed. However the evaluation team agreed with NSPCC not to pursue this as it would have required a line of questioning that would have been too hypothetical and potentially upsetting. It was also suggested that, in order to hear something from the families' perspectives, at least one of the families in the LIFT service and the relevant foster carer should be approached, in order to capture their thoughts about their involvement. While the evaluation team was concerned that this might interfere with the assessment, members of the LIFT team were happy for it to happen. In the absence of research governance procedures in the borough, the Director of Children's Services in Croydon also agreed that it would be acceptable to interview a parent and a foster carer. Unfortunately, the lack of response from relevant staff meant that approaches to the parent and foster carer could not be progressed. The team also intended to interview representatives of the local authority's legal team, the NHS Clinical Commissioning Group and the Child and Adolescent Mental Health Service (CAMHS) but these proved similarly difficult to arrange. Interviews with a wider range of professionals would also have facilitated an examination of the role and contribution of the project steering group and the operational subgroup established in early 2016.

The methodology of the quantitative evaluation (Part 2)

Participants

Participants were children (0–5 years old) resident in Croydon, referred for assessment and/or treatment by the LIFT team. There were no exclusion criteria based on diagnosis, comorbidity, gender or ethnicity. All of the first 21 children referred to LIFT between January 2016 and January 2017 were included in this aspect of the evaluation.

Data collection

Each encounter between the child, family and the LIFT service was logged into the NSPCC electronic case management and records system (Alpha). Using Alpha, the

number of encounters delivered by LIFT members was counted for each child and family for the duration of receiving LIFT or up to one year, whichever came first. The data collection was not blinded. Data on the LIFT service professionals' training in the NIM model was obtained from the LIFT service managers.

A comprehensive database was developed for the purpose of the evaluation. The database comprises 236 data points: 63 data points which collect information on sociodemographics, care journey details and levels of service contact, and the remaining on mental health information (all potential assessments included).

Action planning for the RCT (Part 2)

The barriers identified during the qualitative part of this evaluation were later considered through a series of meetings with key stakeholders (senior representatives of the judiciary; the London Borough of Croydon; academics; clinicians, and the NSPCC). During these meetings, the rationale for RCTs was discussed, methodology of previous RCTs, including those undertaken in the legal profession, was described, and the likely clinical, service, ethical and policy implications of RCTs were identified.

Findings Part 1

Mary Baginsky, Jo Moriarty and Jill Manthorpe

NIM in the context of the English children's social care and justice system

Introducing LIFT into the London Borough of Croydon

Data from the 2011 Census show that Croydon has the highest number of residents aged 0–19 years compared with all other London boroughs (26.9% of Croydon's total population). These data also show that the distribution of the 0–19 population is bimodal, with peaks at the pre-school ages between 0 and 4 years and between 14–17 years. The Index of Multiple Deprivation (IMD) 2010 evidences how Croydon became more deprived between 2004 and 2010, the north of the borough being generally more deprived than the south, sharing more of the characteristics of inner London. The low-income families local measure (HMRC) indicates that in Croydon just over 25 per cent of children under 16 years of age live in low income families. Croydon has the highest number of looked after children compared to all other London boroughs, and consistently has a higher number of Unaccompanied Asylum-Seeking Children (UASC) than any other local authority.⁵ At the end of March 2015 there were 845 LAC in Croydon, made up of 435 indigenous children as well as 410 UASC who, by definition and for most by age, would not be eligible for LIFT. As far as the under five population is concerned, a group with few, if any, UASC, of the 32 London boroughs, Croydon has one of the largest LAC populations in terms of numbers, but not as a proportion of the under five population. In 2015-16 a total of 70 LAC were aged under 5 (Department for Education, 2016a) representing 17 per cent of the non-UASC LAC population, This is in line with the majority of outer London local authorities, where the proportion falls between 13 and 17 per cent, with a few authorities having much higher and lower proportions. However, LB Croydon has a high number of children in foster care and a low number of adoptions. Croydon's records on the completion of care proceedings within the timescale were reported by all agencies taking part in this present evaluation to have been historically poor, with particular concerns expressed about the length and/or number of delays happening for children aged 0–5.

Most Innovation Programme (IP) projects were already in place by the time it was agreed to introduce the LIFT project into Croydon and funding was approved. Staff at LB Croydon worked with the NSPCC to design a model that would fit the local context.

⁵ The London Borough of Croydon hosts the London offices of the Border and Immigration Authority (the immigration service). This is where the great majority of asylum-seekers who are already in the country make their applications. Approximately 6 per cent of new applications by unaccompanied minors in the UK are made in Croydon.

Based on existing data, the expectation was that there would be about 20 referrals to LIFT each year. As the authority initiates between 60 and 70 care proceedings annually, it was calculated that between 15 and 20 of these would be in relation to children aged 5 years or under. A typical scenario for a child under 60 months coming into contact with LIFT was that they would have been the subject of a child protection plan, and, as part of that plan, there would have been regular social work visits, and a specific piece of work might have been ordered before the local authority would have decided the case met the threshold for proceedings to be issued. A pre-proceedings letter would be sent to the parents, and a meeting would be set up to lay out concerns and define what parents must do.

Once the model by LB Croydon and the NSPCC was agreed, a meeting was held to describe the project to family judges working in the area. One judge became concerned about two aspects: that specific permission would be required from the President of the Family Division for LIFT to work outside the Public Law Outline's (PLO's) requirements; and that the President would also need to review the proposed plan to use an RCT to evaluate the project, as this was considered to be potentially discriminatory towards families not offered the service. NSPCC had planned to approach the President's office but before this could happen the concerns were escalated to him by the judge. After meeting the NSPCC representatives, the President of the Family Division accepted that siblings aged over five years would be excluded from the project and agreed to exempt cases in LIFT from the PLO's 26-week timetable and hence from the data reporting attached to that. Both decisions meant that the service was viable. It was decided that there would have to be a ten-week assessment to ensure that, where the assessment indicated a poor prognosis, the case could still be subject to the 26-week track and count in the statistics; on the other hand, if there was a good prognosis, the LIFT team could continue with the intervention and the case would fall out of the system.⁶ However, the President refused to support an experimental trial that might result in one family being allocated to a LIFT service while the next family received the local authority's business as usual (BAU) service.

By July 2015, LIFT had seconded staff from other NSPCC services, namely a team manager, three social workers and a family liaison worker (FLW). It took longer to appoint the clinical staff – three clinical psychologists (two grade 7 and one grade 8), a consultant clinical psychologist and a consultant psychiatrist. As part of the Innovation Fund commitment to the resourcing of LIFT, the DfE insisted that the LIFT service had to be up and working by October 2015, but by August the senior clinical staff were not in post. Soon after this the three clinical psychologists were appointed, but not the consultant psychologist or psychiatrist. Recruiting a consultant psychiatrist to a new post is a complicated process that takes months to complete. Eventually a consultant psychologist, already working for the local NHS mental health trust, South London and

⁶ Between May and October 2015 a specific care proceedings timetable was agreed with the judiciary.

Maudsley (SLaM), and a consultant psychiatrist, who had recently retired from the same Trust, offered their services on a part-time basis. All the psychologists and the consultants were employed by, and seconded from, SLaM to LIFT, although their salaries while on secondment were paid by the NSPCC. Ordering and organising the LIFT office space took time, but was relatively easy; making the final arrangements of the treatment spaces and confirming suitability of equipment took longer and had to wait for the clinicians to be in post. The full team was in position by October 2015 and only then did the service accept referrals. All clinical team members received a total of 13 days training for their current roles, covering NIM, Circle of Security interviewing, Video Interaction Guidance, mentalisation and court skills. Members of the administrative team also received four days of training on the model. From late summer 2016 onwards, the members of the LIFT team and other NSPCC staff held briefing sessions for groups of professionals working in the area who would come in contact with LIFT, and who would work with families being offered the service.

Introducing LIFT in the English legal context

LIFT is defined as a mental health intervention but it is one that is located within the English court system, so it is important to examine not only the context, but also the potential implications that arise. The feasibility study that was conducted in Glasgow has, of course, operated under Scottish law. Since 1971 in Scotland, children's hearings or panels, not courts, have held responsibility for dealing with most issues concerning children and young people under 16, and in some cases under 18, who commit offences or who are in need of care and protection. When introducing NIM into England, it was decided that LIFT would be available to families once care proceedings had been initiated, which placed it firmly in the English court arena in a way that is not the case with GIFT in Scotland. Cases in Glasgow are not the subjects of care proceedings and are dealt with by children's panels. The only role for a sheriff (equivalent of a judge in English courts) at this stage is to decide whether there is enough evidence to determine whether grounds have been established for the case to proceed, although the sheriff can later be called upon if individual decisions of the children's hearing are appealed (see Appendix D for further details).

In England, the primary statutory provisions governing children's proceedings are contained in the Children Act 1989, and the overriding principle that the Court must apply when making decisions concerning children is that 'the child's welfare shall be the paramount consideration'. This point is clearly reinforced in the annex to this report by the District Family Judge for East London, Her Honour Judge Atkinson. A further two pieces of legislation impact directly on the operation of LIFT. The Children and Families Act 2014 sets a 26-week time limit for proceedings relating to care and supervision, to ensure that decisions are made quickly and as early as possible in a child's life. In light of the legislative changes, revisions were made to the Public Law Outline (PLO), the key practice direction providing guidance on case management processes in public law cases. However, in its evidence to the Adoption Select Committee and the Justice Select

Committee on the Children and Families Bill, the judiciary made it clear that the timetable should be guided by welfare. While in a standard case it may be that this is achievable in 26 weeks, where this is not in the child's interest, it may take longer. In addition the Family Procedure Rules were amended to streamline proceedings in family courts by reducing the number of expert witnesses who are called to give evidence. In some areas a Court will no longer endorse an expert appointment unless there are essential elements of the case for which a local authority social worker does not have the expertise. However, alongside this, rulings in the Supreme Court and the Court of Appeal indicate that local authorities are now expected to provide the services to help families in care proceedings, and that a court should only endorse a care plan for adoption when every other option has been tried and tested (see *Re B* [2013] UKSC 33 and *Re W* [2013] EWCA Civ 1227). As Burman (2013) points out, the onus is now on the local authority to prove that all options and services have been explored before deciding that the order is proportionate.

Undoubtedly some children are left too long with abusive parents. If the damage they may have suffered is not sufficiently understood they may also experience significant problems later in their lives (see Selwyn et al., 2014). There is also evidence of the difficulties faced by adoptive parents of very damaged children (see Baginsky, 2012; Selwyn et al., 2014). However, children are also coming into care who, if effective support could be offered early enough, might be able to stay either in their birth families or in kinship care. Cases such as *Re B (A Child)* [2013] UKSC 33 and *Z-O'C (Children)* [2014] EWCA Civ 1808 have highlighted the need for local authorities to provide reasons why adoption outside of the birth family is necessary and the need for more rigorous assessment of parental capacity. Key to all this is the ability to carry out assessments that can be used confidently in making decisions that are in the best interests of the child. Although recent judgements may lead to change, at the present time, a standardised assessment for the benefit of the child, which can be used by the courts and social workers involved, is not generally available in England or, indeed, anywhere in the UK.⁷ Neither is there anything mandated in the courts that combines assessment and intervention.

⁷ A social work evidence template (SWET) has been produced by Association of Directors of Children's Services (ADCS) and Cafcass for use by English local authorities to submit an application for a care or supervision order, setting out the reasons for the application for a specific order in relation to a child.

Key Findings

Lessons learnt on implementation

Getting the service up and running

According to managers in the LIFT service, there was pressure to meet the timescales for the funding and reporting requirements that attach to the Innovation Programme. The original intention was to have the LIFT service in operation by June 2015, although it was quickly recognised that this would not be achievable. Delays were caused by recruitment timescales, particularly for senior clinicians, and by the negotiations that resulted when it became clear that the original RCT timetable would not be viable.

Most of the LIFT team pointed out that, in effect, the service was still technically understaffed, in terms of the days when the consultant psychologist and consultant psychiatrist were present, because the posts were part-time. This continued to be the position throughout the period when the qualitative research into the set-up and early delivery of the LIFT service was being carried out, although towards the end, a full-time consultant psychologist had been appointed and was about to start in late spring 2016.⁸ On one level, the understaffing was of little consequence because of the very few cases referred by spring 2016. However, some LIFT staff said that the temporary and part-time nature of some posts had introduced an element of instability, and that there had been occasions when they had had to take decisions they did not feel qualified to take. LIFT staff thought, in hindsight, that it would have been better to have followed the Glasgow GIFT model and appoint the senior clinicians first, although according to NSPCC, this could not have been arranged within the DfE timescale. Members of the LIFT team said that there were times when the service had lacked the level of leadership required on clinical issues; some informants speculated that the temporary and part-time nature of the senior posts had led them to feel an absence of clinical leadership, although this was reported to have been most acute in the early months.

It is also important to recognise some very practical challenges of bringing together employees from different agencies where there will be different terms and conditions of employment, as well as perceived (or actual) professional hierarchies. One practical example provided by managers involved the appointment of the Family Liaison Worker. The NSPCC has a set of job descriptions: each new appointment has to be matched against one of these. In New Orleans, FLWs have been lauded as the dream team, a view supported by the GIFT team in Glasgow. The FLWs are viewed as central to the

⁸ After the evaluation concluded, we were informed that the original appointee had not accepted the offer and the consultant psychologist post was filled by someone on a part-time (3.5 FTE) contract. By the end of the evaluation period it was not clear whether the post of consultant psychiatrist would be held by someone on a full time or part-time contract.

project because of the contacts made, and information picked up, when driving the families to and from appointments. A new job description was written for the FLW post in Croydon. There is no car parking available there and it was agreed that public transport would be used more frequently than in Glasgow or New Orleans.

By October 2015, although discussions had taken place with some services in the Croydon area, according to members of the LIFT team, very little time had been available to establish more formal relationships with mental health teams; drug and alcohol services; specialist personality disorder services, and domestic violence services. Good relationships with all of these were considered to be essential by LIFT staff for their service to function and this continued to be a priority during the present evaluation. While some briefings for key agencies and professionals did take place in the early months of the service, it was recognised by LIFT staff and others that more had been needed over a longer period of time and, although not at such an intense level, they needed to be a regular feature of the service. Over the year 2016–2017, discussions were underway regarding the proposed introduction of a Family Drug and Alcohol Court (FDAC) into Croydon’s judicial system, and many of the LIFT team commented that, prior to its introduction, it would be essential for both services to establish how they would work together.⁹

Making the plans work

The original intention was that the family’s social worker would liaise with their manager and the legal team in LB Croydon to suggest participation in LIFT, and this would then be followed by a meeting involving representatives of Croydon’s social care and legal teams, the parents and the parents’ solicitors. The purpose of such a meeting would be to describe the LIFT process and enable the parents to go away and make an informed decision about whether they wished to consent to the service or not. Not surprisingly, translating the plan into reality required some adjustments to be made. This is shown in Figure 1, which shows the referral pathways to LIFT, and in the flow chart in Appendix E.

Once proceedings are issued there may then be a delay of around three weeks before a court date becomes available. The expectation of court staff was that, by the first hearing, parents would have given their provisional consent to participate. This would have meant that, at the first hearing, if the judge had agreed that separation of parent and child was to occur, the case would have gone straight to LIFT and the assessment would have commenced. But the reality was different. According to social work managers in Croydon, it was necessary to change the planned sequence to recognise the fact that parents were so focused on being separated from their children, they either did not fully understand the project or they had not taken in information about it at all. Commenting on one early case, an interviewee noted that:

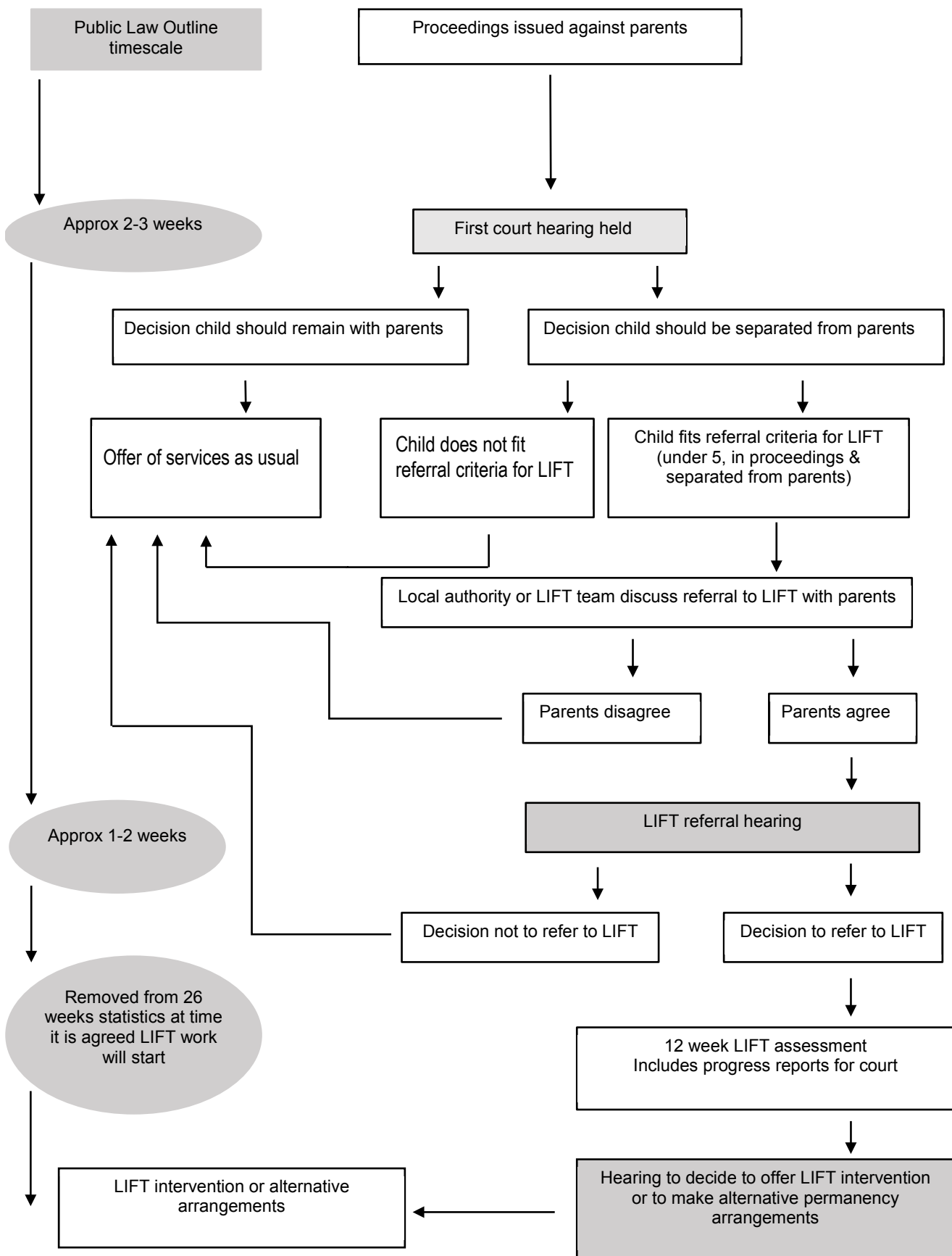
⁹ NSPCC and FDAC are in discussions at the time of writing about how both services will work together.

Because the first hearing was effectively ineffective, because the parents didn't know about LIFT, they didn't know the child had to be separately accommodated; there was a lack of knowledge, so we ended up having to put in an extra hearing. So, at the first hearing, a decision is taken in principle as to whether the children should be separated from their parent(s) and then, if they fit the criteria, parents are told that this is a potential LIFT case. It is only then that the meeting to seek informed consent takes place, followed by a LIFT referral hearing.

The intention is still to have a LIFT referral hearing around the fourth week into proceedings and then the decision meeting on the intervention stage at week 16. If the decision after the assessment stage is not to proceed with the intervention, it is expected that the case will adhere to the 26-week limit. This means that the authority will be planning for permanency in parallel with the intervention. The intention is that the assessments and reports on the intervention stage will provide sufficient evidence to meet the requirements of the Family Procedure Rules and Practice Directions which govern the procedures used in family courts in England and Wales.¹⁰ At the point at which the judges were interviewed for this evaluation (2016), no LIFT assessment had been completed so they could not comment further. But the process by which social care, NSPCC and the judiciary were able to work together to make the processes fit together reflects the level of commitment and goodwill on the part of all the agencies which was voiced by their representatives when interviewed. As Part 2 of the findings explains, the judiciary have since considered the process by which the courts can make the final decision about what should happen when a potential, qualifying family is selected to receive either the LIFT service or business as usual. This assessment is being made on the basis of the viability of an RCT in terms of its status as a court related intervention, not in terms of its methodology.

¹⁰ See <https://www.justice.gov.uk/courts/procedure-rules/family>

Figure 1: Referral pathways to LIFT



Views on the need for a service such as LIFT

If the PLO were followed meticulously, then the majority of the assessments should have happened prior to the decision to initiate proceedings, and the primary piece of evidence that the court should see should be the social work assessment that takes into account any previous assessments. According to informants in this present evaluation, it rarely happens in that way, and the feeling of those working in social care was that the Family Court did not have a sufficiently high level of trust in social work assessments. As one senior social work manager said:

I think that's partly the attitude of the court and partly the fact that our practice has not kept up with the expectations of the PLO process. There is still a lack of trust in social workers as the professionals undertaking their own assessments. And, to be fair, if I was a parent's solicitor, I would take exactly the same approach.

This view was confirmed in interviews with solicitors working in Croydon. There were several references to the abilities of experienced social workers to provide reliable assessments, but too often they encountered what were, in their view, inadequate ones written by inexperienced, and often very newly qualified, social workers. As a result, and despite the changes described above designed to reduce the use of expert witnesses, there continues to be a great deal of reliance on expert assessments, usually commissioned as spot purchases from independent psychiatrists, psychologists and social workers. This contributed to a lack of consistency in the services for families which were described on more than one occasion as being 'random' and 'variable' in nature. It was evident that, amongst solicitors and judges, some of the appeal of LIFT lay in the fact that it appears to introduce a level of consistency, while also offering a therapeutic intervention in appropriate cases. Depending on how the service is funded in future, some informants in all the agencies thought there was also the potential to save money on reports from experts that were seen to be nothing like as detailed, or based on such thorough assessments, as the LIFT team claims their reports will be. Significantly, LIFT staff members were unsure about whether the judiciary regarded LIFT as independent, nor were they convinced that the judges did not expect LIFT to provide an overall forensic view of a case, as one LIFT clinician reported:

What we're providing is, from our perspective, and from the partial information that we have, our best shot, okay, because there is a real difference and I've already felt pressure to provide an overall expert view, okay, and it's not quite what we're doing.

Referrals in the first six months

Croydon initiates between 60 and 70 care proceedings in a year, with between 15 and 20 being for children aged under 5 years. However, in the first six months of the service, between 1 November 2015 and 31 March 2016, only four cases had been successfully referred to LIFT and one assessment had been completed.¹¹ The data collected for the quantitative element of the evaluation found that, between these dates, there were a further 11 other potential cases where, at least for some, a decision to commence care proceedings was pending.¹² While it is unclear why so few cases were referred, the number of referrals was not giving rise to much concern amongst LIFT team members as it enabled those involved to test the model in practice, without the pressures which may occur when the service is operating at near, or full, capacity. The staffing in place during the evaluation period meant LIFT could deal with three cases at any one time going through its assessment process, but the intention was that it would have the capacity to assess five or six simultaneously from May 2016. However, discussions were taking pace at this time within the NSPCC about the possibility of extending the LIFT service to other authorities and these may have been motivated in part by the small number of referrals received from Croydon. If it had been possible to interview social workers working with families who could potentially access LIFT, it might have been possible to understand what, if any, blocks stood in the way of referral. For example, in initial interviews with managers, reference was made to difficulties that could arise if the parent concerned also had children who were over five years of age and therefore outside the remit of LIFT.

An effort was being made by the LIFT team to increase the referral rate by contacting, and making further presentations to, solicitors in Croydon and by making weekly visits to the relevant team in Croydon Children's Services to answer any questions and address any concerns. This was seen to be particularly important in light of the departure of a manager in Children's Services who was to have identified potential LIFT cases. A concern expressed by some members of the LIFT team was that social workers and other professionals lacked sufficient understanding of how LIFT worked and what it involved. Senior managers interviewed at the end of 2015 and in early 2016 appeared to have a very good knowledge of LIFT, so it was not clear why this had not apparently percolated down to other staff. Apart from their concerns about the RCT and how to manage the exclusion of siblings aged over five years, Croydon senior managers had been very enthusiastic about the initiative when interviewed.

According to reports from informants to this study, including those working in LB Croydon, the threshold for initiating court proceedings for the interim removal of a child from their parents has risen in recent years. This does not mean the safeguarding

¹¹ It is important to remember that referrals are made following a court decision, the first of which was made in January 2016. The case had been identified in October 2015. Two inquiries were being considered, one of which translated into a referral in April 2016.

¹² Three Police Protection Orders and eight Section 20s

threshold has changed, rather that other ways are being explored to safeguard children, particularly babies. At the same time, financial considerations have also come into play. The significant changes to legal aid funding for parents involved in care proceedings have ended funding for placements in family assessment centres. These usually cost between £32,000 and £60,000 for a standard three-month period, compared with £500–£600 per week for a parent and child placement in a foster carer’s home, which equates to between £6,500–7,800 over an equivalent 13 week period. As a result there has been a dramatic rise in mother and child, or parent and child, foster placements in the last 18 months in England. In addition to the cost factor that applied to these expensive assessments, the belief was also expressed by several informants that a much better relationship between the parent and child could be developed within the setting of a foster placement. It was reported by some informants that these developments meant that the court was more frequently exploring how to manage risk without interim removal and this may have resulted in fewer than expected referrals to LIFT. This is an indication of how the changing context operates at many levels in the safeguarding of children.

The early cases

The first referral was a newborn child. This baby would not be included in Professor Zeanah’s practice. His team had originally worked with children from the age of six months or over, although informants reported that he has broadened this by working with some three month old babies. In this case, the baby had been removed from its parents at birth after being exposed to drugs and alcohol prenatally and, if it had gone home, potentially would have been in a violent and unpredictable environment. The mother was on a programme that required her to stay clean of illicit substances, street drugs and alcohol. The father was no longer involved in the LIFT project. The Croydon team worked with Professor Zeanah to adapt the model for this particular child. The team decided that the baby needed to be 12 weeks old by week four of the assessment, to allow a specific procedure to be used. By the time LIFT began the assessment the baby was approaching this three months stage and it was possible to conduct the necessary assessment, with consultation from Professor Zeanah, while social care practitioners continued with parallel planning for permanency. There was a five-week review to provide the judges with evidence of the mother’s engagement. Reviews of this nature are part of the agreement between the project and the Court. The timescales meant that there was little flexibility in terms of dropped appointments, and this was made very clear to the mother. At the same time as work on the evaluation was coming to an end, the assessment had been completed and provided to the Court. As explained earlier, the evaluation team did not have the opportunity to interview parents, foster carers (or other carers) or local authority social workers working with this case, or any other. However, one very experienced Cafcass children’s guardian commented on their contact with LIFT for one of the families with whom LIFT was working: ‘I was in awe of them, actually in terms of developmental understanding of that child, and that must give it the best chance.’ After receiving the report, this guardian wrote to say: ‘I have (now) received and

read the LIFT assessment report. I think it is a succinct, high quality document which reflects excellent assessment work’.

Two other cases were at a much earlier stage in terms of proceedings. One involved a mother with learning difficulties, where the maternal grandmother was the special guardian. There was a great deal of antagonism between the two but the same Cafcass guardian quoted above said:

If you can have a child in this world, whether the primary carer is the mother or grandmother, and that child grows up loved, knowing that the mother and the grandmother love the child, that the mother has cognitive limitations that have led to all of those other things, that’s a tremendous win for that child. If I’m really honest, I think, in the business as usual system, the chances of that being the outcome would have been small.

The other case involved a child who had been physically abused so severely that criminal proceedings against the parent were a possibility. It was reported that the mother did not acknowledge any responsibility. This raised an interesting issue for a service that is based on participants being able to acknowledge the difficulties and move on. Several informants questioned the inclusion of this case, but the legal and clinical opinion that had been sought was that the assessment was offered to all those cases that fit the criteria – that is, inter alia where a child has been separated and is under 60 months. A member of the LIFT team said:

The decision might have been taken not to work with cases where finding of fact or criminal hearings are taking place, just because of the complexity of it all, but that decision hasn’t been made at this time and we are able to do that, and I know they do that in Glasgow as well.

Reflections on LIFT from LIFT team members

All team members were very positive about the training they had already received on the method, as well as that which was planned. They had just begun to translate this training into practice with the early referrals to the project. In March 2016 they thought that timescales around the assessment process were ‘just about okay’ but that they would need to be tested over time. However, as no case had reached the intervention stage, they did not know how much additional work would be needed, and whether it would be possible to produce the shift (among parents) that was required, even in the extended timescale. This team member summed up the uncertainties:

If the assessment was sufficiently positive to move to the intervention stage, indicating that things are indicating something positive and stating our reasons why we might require a further three months. And then my understanding is, if there is a reunification, we possibly can get another three months to support the

reunification towards the end of the work, so, altogether, that could be almost a year.

The benefits they attached to the NIM model and to the way of working emerged in the feedback received from LIFT staff members. The value of working as a team when dealing with the level of complexity of the referred cases was greatly appreciated. It stood in contrast to what staff said they had either experienced or observed as individual psychologists or social workers, when conducting parenting assessments on their own:

I know myself that you can't be objective all of the time; you get pulled into different things, so I think it's really good having the team there, watching behind the screen what you're doing or watching clips back, you get to watch back what's happened, so I think you get a really good thorough assessment that's fair.

The following comments from two members of the LIFT team encapsulate the amount of work that had been involved in establishing the service:

It was challenging times...It took a bit of time for people to work out who was responsible for different things and that could feel quite confusing for me, in terms of who do I report to for different parts, so that was all quite complicated, but I feel like we're now really settling as a team, which is then a shame because our psychologist and psychiatrist aren't permanent members of staff, so there'll be changes again as we go forward.

We've got the rooms, we've got the mirrors, we've got the cameras, we've been able to buy all the toys, we've been able to have the training, so all the different assessment and interventions which, in order for the whole team to be on the same page, I think that's been really, really helpful. So it feels that a lot of that has been really good. There's been still some trial and error, I suppose, in it all, but that's been very valuable, I think.

There were comments on what were seen to be unrealistic timescales around the establishment of the service and which were judged to have created uncertainty and a degree of demoralisation, insecurity and instability. The absence of clinicians at an earlier stage had meant that some members of staff felt they had not been able to make key decisions – and possibly made the wrong ones about practical matters. In some respects, this was echoed in comments about the days – or parts of days – when senior clinicians were not present. And, as noted above, LIFT staff members were uncertain about judges' expectations of their reports in relation to both their independence and scope. Nevertheless, by the time the evaluation was concluding, the team appeared to be coming together, despite some underlying problems that still needed to be addressed.

The clinicians on the LIFT team expressed their hope that it would be possible to evaluate the service using an RCT, usually asserting that RCTs represent the gold standard for evidence about what works in medicine. However, it was also recognised

that even if judicial opposition to an RCT was overcome, given the current low number of referrals, the RCT would have to be something for the future. As the evaluation drew to a conclusion in March 2016, LIFT team members were still trying to determine the exact numbers of cases being dealt with by GIFT, which has a similar, but not identical, staff resource to LIFT. They wanted to know how many cases a year GIFT was managing in terms of assessment and in terms of treatment. The belief was that LIFT could not function at the same volume, because LIFT was on a learning curve, as they had not yet reached the intervention stage with any family. They were conscious that there would be a great deal of learning as this proceeded, and that would take time and have implications initially for the number of cases with which they could deal.

Despite the teething problems, participants from the LIFT team spoke about the value of having had the New Orleans Intervention Model translated for this side of the Atlantic in Glasgow, and being able to draw on their experience in establishing LIFT within the English context, as well as the direct support offered by Professor Zeanah, who provided consultation by video link. These early cases also provided the opportunity to work with the judges dealing with LIFT cases to establish and test the reporting arrangements in place to review cases during the assessment stage.

Reflections on LIFT from other professionals

While informants outside LIFT were interested in the role LIFT could play in keeping the relationship going between the parents and child for as long as possible until evidence emerged to suggest permanency was more likely to be achieved by reunification or separation, they also speculated about other areas where the LIFT project could potentially make a contribution. Some were interested to see whether involvement in the LIFT project might have a positive impact on repairing relationships with children who were currently subjects of proceedings but who would be returned home to their parents' care. They were curious as to whether the approach might also prevent repeat entries into care, as well as ascertaining whether involvement in LIFT improves the bonding and attachment of the child to their existing carer, which could then be transferred to any subsequent adopter or special guardian. This was considered to be particularly important, given the trend of increasing numbers of special guardianship orders where children are placed with members of their extended families. As in so many other authorities in England, there is a high number of child care proceedings and repeat applications which involve families where domestic violence, drug and alcohol misuse, and mental health problems are present, singularly or in combination. One participant explained:

It is very rare to have an application of a first time mother or parent...We're talking about multiple applications and mothers who have been in care and products of that particular system...And I think where I expect, as I understand, the project has some value is helping the parent to have a very clear insight, I would expect, in relation to their situation, the attachment with their children and maybe what

were some of the precipitating factors in relation to previous removal. So, at least, there could be an intervention that was aimed at achieving something different.

Almost as much emphasis was placed on the role LIFT could potentially play in addressing repeat pregnancies amongst women who had had their children taken away: a subject that has attracted great deal of attention (see Broadhurst et al., 2014; Broadhurst et al., 2015).

The other aspect of LIFT which dominated discussion in the present evaluation was the belief that combining a rigorous assessment and, where appropriate, an intervention, should lead to more confidence in the decision being made. Once again it should be remembered that LIFT is a comprehensive mental health intervention with babies and children under five years of age. It is aimed at improving placement permanency decisions for maltreated children by keeping its focus on the child. In discussions that took place during this present evaluation outside LIFT or mental health services, the mental health aspect was not raised. Instead the emphasis was on LIFT's potential role in addressing the increasing pressures of rising numbers of referrals, cases and proceedings. This led social work managers and others to contemplate what the service could offer beyond direct work with children and families, and whether aspects of LIFT could be embedded in social work practice:

There absolutely must be [a more general role] and if that's part of anybody's thinking, that one could graft on a LIFT team to do pieces of work, as well as the actual model, that would be, in my view, fantastic.

While the service was valued, the different contexts of statutory and voluntary sectors led some to think how much more could be achieved if social workers were trained in the skills needed to work in LIFT, which they would potentially then be able to use with families. However, it was usually added that this would only work if social workers were then working with a reduced caseload. However, informants who worked with the local authority made observations on practices and processes in the authority that they described as variable, and ranging from excellent to very poor. The fear was expressed that involvement with LIFT could mask the existing problems that the authority appeared to have in keeping to the 26-week timetable and that, as a result, too many cases would be passed over to LIFT. Given the low number of referrals made to LIFT, this concern did not appear to be justified, at least during the initial months.

Despite the expected birth pangs that surround a new service, senior managers in the local authority were very enthusiastic about the initiative. They viewed the LIFT service as having the potential to address some of the current challenges in Family Courts which arise because of a lack of analysis and evidence which lead judges to express concerns

about some plans that are presented to them.¹³ Within the context of permanency planning in England for children for whom there are serious concerns about their family's care, the London Infant and Family Team (LIFT) initiative was seen by these managers, and others in the child protection world, as very interesting and of value. It was viewed as holding the potential to address some of the controversy in the area of adoption and special guardianship.

The possibility of conducting an RCT in the future

In examining the question of whether or not it would be possible to involve LIFT in an RCT, evidence was drawn from literature, as well as from discussions with experts in the field of RCTs, law and social care with some informants having expertise across all three fields.

It is important to make best use of important contextual factors when considering the next stages for the LIFT evaluation. The first is that, while there are very few examples of RCTs in the English social care arena, they do exist.¹⁴ However, most of those that have been conducted in child welfare have been evaluations of parenting programmes for foster carers (for example, Macdonald and Turner, 2005); parents (for example, Hutchings et al., 2007), and adoptive parents (for example, Rushton et al., 2010) and appear to be pragmatic rather than pure. Recently the evaluation of a service designed by the NSPCC for children aged 4 to 17 years who have been sexually abused adopted a pragmatic randomised trial with a waiting list control (Carpenter et al., 2016).

The evaluation of the Multi-dimensional Treatment Foster Care (MTFC) (Biehal et al., 2012) was funded by the then Department of Children, Schools and Families (now Department for Education) and illustrates the many challenges that an RCT in this arena can face. For example, the authors described the 'somewhat messier reality of using an RCT to evaluate a highly complex social intervention delivered by 18 diverse LAs (local authorities)' (page 3). Ultimately, 12 of the 18 LAs did not take part in this RCT.

While more RCTs are beginning to emerge in the field of social care, they are entirely absent in the English family law area. Although the trial is of an infant mental health approach to assessment and intervention for maltreated infants in foster care, the fact is that it is located during the time when families are in court proceedings. This distinguishes it from other RCTs of psychosocial interventions for vulnerable children - for example, that conducted on the Family Nurse Partnership (Robling et al, 2016) - and places it in the socio-legal and family law arenas. The Family Drug and Alcohol Court (FDAC) pilot is possibly the nearest the family justice system has got to an experimental

¹³ Report in The Guardian on 18 November 2012, '[Adoption process is being rushed by councils, say judges.](#)'

¹⁴ See Dixon et al. (2014)

evaluation of services (see Harwin et al., 2014). The evaluation team did not conduct an RCT but they did have a comparator group. This group included cases that met the criteria but where parents did not consent, and other cases where parents agreed to participate but FDAC did not have sufficient capacity to accommodate them.

The NIM intervention is being undertaken in a site (Croydon) which is subject to a very different legal context to the one operating in Scotland, where GIFT is based, and where an RCT is being conducted. The differences between the English and Scottish legal systems, combined with the fact that GIFT is not offered during proceedings, made it possible to conduct an RCT in Glasgow. It is also worth noting that, according to the Tulane Infant Team, an RCT has not been conducted there for a similar reason that appears to make it unacceptable in England, namely that it would not gain the approval of the courts.

Previous attempts have shown it is essential to get relevant organisations on side before embarking on an RCT (see, for example, Dixon et al., 2014). The LIFT project operates at the boundaries of mental health, social care and the judiciary, so it is difficult to understand why the key differences in family law processes between the English and Scottish legal systems, and the possible implications for the cases that would be included, were not explored at an initial stage. However, the outcome is unlikely to have been different. Once the decision had been made to locate the LIFT project in the proceedings stage, then randomisation would have to be done when the case reached court. So, if there were two cases suitable for LIFT, one would be allocated to LIFT and one to usual services. From the outset, while welcoming the LIFT service, the judiciary expressed misgivings about this approach. The belief is that randomisation in this context may well be unlawful and discriminatory under English and European law. If the opinion of the bench changed and judges approved an RCT, there would still be the possibility that appeals would follow.

The researchers leading the Scottish RCT have argued that, in the absence of knowledge about the relative benefits of each service, randomisation would be equitable. However, the New Orleans Intervention Model is described as a theory-based, evidence-driven way of working, requiring a high level of skill, operating in a context where services as usual are widely considered to be variable in terms of consistency, performance and resources. This means there is, at least, an apparent level of inequality that might lead the average member of the public to assume that LIFT represented an enhancement over the standard offer. This view was clearly shared by the solicitors who worked in Croydon. In addition to any legal challenge that might be made, the methodology itself would compound the problem highlighted by Lord Justice Ryder in *Re W* (2013) where families were offered very different services, meaning that there is no agreed level of services as usual. It may be that, in any evaluation design, it will not be possible to offer families identical services, but it is important that they are offered services that at least appear to be equitable.

It is crucial to recognise that it was not only the judiciary who opposed an RCT at this stage. Senior managers in Croydon, and some LIFT staff, expressed their view that it would be unethical, not least because they claimed that services as usual did not involve similar levels of input. The absence of a robust alternative, such as Glasgow has with FACS, led some participants in the Croydon area to conclude, as the President of the Family Division had done a year earlier, that it would be inappropriate and inequitable to conduct an RCT in the LB Croydon. One senior manager said they could not condone it going ahead without an equivalent service in place, and the resources were not available to establish one:

If we had an RCT we shall not be able to access or employ any of that knowledge until 2019. We might also know that it would be best for a child but we'd have to deny the service if the dice fell the other way. We'd be prioritising the research project, and that's very uncomfortable. I think it's more than uncomfortable; I think it's wrong.

A key driver to conduct a pure RCT in the case of LIFT is the view that most new NHS health interventions have to be ratified by the National Institute for Health and Care Excellence (NICE) and, in order for this to occur, there has to have been at least one RCT demonstrating its effectiveness. While the LIFT intervention includes health components, it includes others as well. It may be time to engage with NICE on the matters that have arisen around this RCT, as well as to continue the links already made with the Nuffield Foundation, which is working with Lancaster University and the Alliance for Useful Evidence to establish the scope and delivery of a new Family Justice Observatory. The Observatory is intended to address the dearth of empirical research evidence in this area for policy-makers and practitioners, disseminate what does exist, and explore the implications for practice and decision-making.¹⁵

There are, however, also methodological considerations. The argument for conducting an RCT is that, without one, there is the danger of over- or under-estimating the effectiveness of an intervention or failing to identify harm amidst claims of benefit. But this requires a calculation to be made of the statistical power of the trial to detect effectiveness. A trial with very low statistical power may not be worth pursuing (see Wittes, 2002). The service is very new and it is widely recognised that it is necessary for services to become established before an evaluation is able to measure effectiveness (see Kerr et al., 2010). In terms of conducting an RCT, much depends on the number of eligible families being referred to the service, and the pace at which they increase as the service becomes more established. The sample has to be of a size that would give a reasonable level of certainty in relation to any effect, so it has to be large enough to demonstrate statistical significance. The two-site trial (that includes the existing Scottish

¹⁵ This follows the recommendation in the Family Justice Review (Norgrove, 2011) for a coordinated and system-wide approach to research and evaluation, supported by a dedicated research budget - see [Towards a family justice observatory](#) and Rodgers et al. (2015).

site and plans to include Croydon and other areas of London) will need to take care not to claim comparability between the datasets, given the contextual variations, let alone if any suggestion were made that data from the two countries could be merged at any point.

If it did prove possible in the future to conduct an RCT in London, data from two or more sites would obviously provide a higher level of evidence than those emerging from one site (Glasgow). However, it is essential to address concerns raised by professionals, including lawyers, in relation to claims of discrimination against families not involved in LIFT, before embarking on the challenges of recruiting new sites and developing relationships with different NHS services and with other family courts. The following issues need to be addressed in the absence of a blueprint for conducting RCTs in the family justice area which means that time is required for continued discussions with key partners and stakeholders:

- the opposition from the judiciary and senior members of the local authority focused on concerns about equity which will need to be addressed and relationships sustained. This might be through the roll out of a series of events designed to introduce the pilot to lawyers working in the Croydon Court, social workers and Cafcass This was missing from the early stages of the LIFT service
- methodological issues, including the stage in the project's development at which it is acceptable to conduct an RCT, the number of cases being referred, and the arrangements and agreements in place between London and Glasgow researchers on the use of data emerging from the two sites, need to be recorded and monitored

Rigorous alternatives to an RCT

It is clear that any evaluation of LIFT would fall within the Medical Research Council's guidance on the evaluation of complex interventions (see Craig et al., 2012, Evans et al., 2015, Moore et al., 2015). While the guidance recommends that randomisation should always be considered for assessing effectiveness, it goes on to say:

Developing, piloting, evaluating, reporting and implementing a complex intervention can be a lengthy process. All of the stages are important, and too strong a focus on the main evaluation, to the neglect of adequate development and piloting work, or proper consideration of the practical issues of implementation, will result in weaker interventions, that are harder to evaluate, less likely to be implemented and less likely to be worth implementing. (p. 4)

The conclusion at this point in the research was that an RCT might be feasible in the future, but in the meantime, it was essential to apply a robust methodology that followed a staged approach to the project, as recommended by the Medical Research Council. This may take place alongside continuing work to determine at what point, if any, an RCT

would become feasible (see Hind et al., 2014). It is vital that the evaluation of the next stage incorporates both qualitative and quantitative methods. There is a variety of ways in which these may be combined to improve the trustworthiness of each, and this could be achieved in a multi-method approach. The end result must be a design that contributes to evidence of the effectiveness of the model in the English context, and which reflects the complexity of the intervention and the situation in which it operates, as well as an analysis of resources required to establish and sustain the service. As the Glasgow study shows, it takes time to accumulate robust evidence. Any evaluation of LIFT will make a significant contribution to that which already exists from the work of the Tulane Infant Team, alongside that which will emerge from Glasgow. Together, these works will inform what has been called 'the evidence jigsaw' (Clayton et al., 2011). The findings and knowledge from the Scottish and English experiences could then be brought together in the most responsible way possible.

If it proves impossible to conduct a pure RCT in the future, other, well-established methodologies could make significant contributions (Priebe and Slade, 2001). As noted above, pragmatic clinical trials or quasi-experimental designs, are increasingly used for the evaluation of clinical and/or practice-based interventions where randomisation at an individual level is not possible or appropriate. Waiting list designs, matched case designs, cluster randomisation designs and stepped wedge designs offer possible alternatives when the realities of legal or judicial requirements make pure random assignment impossible (James Bell Associates, 2013; Woods and Russell, 2014). All of these designs have been discussed with the NSPCC with the suggestion that, if a quasi-experimental design had to be adopted, and if, at any point, another authority was interested in adopting LIFT, a variant of the stepped wedge design would be the most appropriate. Other designs would give rise to similar problems to those encountered in transferring the Scottish RCT design to London and into the English court system. While a waiting list was used on the evaluation of Letting the Future In (Carpenter et al., 2016) the timescales that apply to the PLO mean it would not be feasible to adopt it. The stepped-wedge cluster design includes an initial period in which no clusters (areas) are exposed to the intervention, then, at regular intervals (the steps) one cluster crosses from the control to the intervention under evaluation. Data collection continues throughout the study so that each cluster contributes observations under both control and intervention observation periods. The intervention is already operating in Croydon, but it would be possible to modify the methodology to allow comparison to be made with a new authority intending to adopt the service in the future. It would provide a stronger methodological rigour than a pre and post study, because it would be possible to control the rollout, and to include elements of randomisation that reduce bias (Handley et al., 2011). So while some families would still be offered the service, and others would not, the randomisation would take place on the basis of living in different authorities. This is similar to the situation that existed in the evaluation of the Family Drug and Alcohol Court (FDAC) (Harwin et al., 2014). The methodology followed up all families referred to FDAC at the Inner London Family Proceedings Court by the three FDAC pilot authorities. All cases in which parental substance misuse was a key factor in the local authority application for

care proceedings were listed to be heard in FDAC. The evaluation team compared these cases with a sample of families referred to the Inner London Family Proceedings Court because of parental substance misuse by three other (non-FDAC) local authorities. Whatever the shape of the evaluation in the future, it will be essential to continue with the existing, detailed data collection system that has been developed already.

Limitations of the Stage 1 evaluation

This evaluation was commissioned to report on lessons learnt on implementation of the innovative services - including early expectations and perceptions of the fit between the intervention and multiple systems (legal, health, social care) and the degree to which the intervention is acceptable to key stakeholders - as well as to inform the decision on whether or not it is possible to conduct an RCT in the future.

The methodology adopted enabled these questions to be addressed. However, while the report has explored the lessons for future rollout, there have been challenges in reaching a clear understanding of the fit between the intervention and other services. Despite a good level of engagement with children's social care in the early stage of the evaluation, this was not sustained. Difficulties over communication, and access to key informants, proved to be a problem. Whatever approach is taken to the future evaluation of LIFT, it is essential to gain a commitment that the local authority will support and participate in all aspects of the study. To this end, it will be necessary to have the appropriate research governance processes in place and to appoint someone as the one link in the local authority who has sufficient seniority to make decisions in key areas. The absence of such a person meant it was not possible to conduct planned elements of the current evaluation. The difficulties in communicating with those who would have been able to facilitate contact means that it was not possible to look in detail at the decision making process on the cases referred to LIFT, or to judge social care's reaction to early cases that have been assessed by the service. Although there was a significant level of input from a member of the CAMHS team in a neighbouring authority, the many attempts to engage with the CAMHS service in Croydon proved unsuccessful (which may indicate high levels of demand for their services). Judges in the family court, and members of local solicitor firms, did, however, engage with the project throughout and, despite concerns about the idea of conducting an RCT, were positive about the contribution which LIFT would be able to make. The timing of the data collection meant it was not possible to cover their reactions to the outcomes of early LIFT cases. Nevertheless, this report has examined the fit between the service and Government's policy aimed at speeding up the adoption process, and improving the life chances of those children waiting in care, as well as how it has the potential to address concerns expressed by judges over the quality of assessments.

In any future evaluation, it would be essential to have opportunities to interview parents, carers and professionals involved in the project, in order to understand their experiences. There are also key decisions relating to referrals and progression that would need to be

explored and which would require the co-operation of the local authority. Early on in the project, concerns were expressed about the exclusion of target children with siblings who were over 5 years of age. It is important to understand how this concern is being managed and whether, for example, it is having any impact on referrals that might otherwise be considered to be appropriate for LIFT. While there is recent research indicating the problems that can arise in trying to keep sibling groups together (Rushton et al., 2010; Saunders and Selwyn, 2011), it is a contested area, and keeping sibling groups together continues to be a strong priority in many authorities.

The timing of the evaluation meant that the LIFT staff group was in the process of forming, and members of the group were still exploring ways of working, both collectively and individually. Thus it was not possible to collect their reflections on the impact of operationalising the service and the extent to which the support and supervision in place met their needs.

There are other key questions that will need to be considered in the future that could not be addressed by this evaluation, given the early stage of the service's development. These include whether the extended multidisciplinary assessment offers more reliable information for the courts and enables better outcomes for children in terms of earlier intervention. It was also not possible to assess the pilot's replicability and sustainability. It will only be possible to judge these elements when LIFT is operating at full, or near full, capacity and when the local authority and courts have had experience of working with the model. At the moment, it is a free service to the local authority, but as only a handful of cases had accessed LIFT by the end of the evaluation, it was a very expensive service in terms of the actual cost overall. In addition there has not yet been an assessment of the call on public funds that may be needed - for example, in terms of additional meetings and hearings. In April 2016 the project was granted additional Innovation Programme funding; any future evaluation must build economic models on the basis of the willingness of the NSPCC and/or local authorities to fund the service.

Implications and recommendations for policy and practice

We stand on the cusp of history. 22 April 2014 marks the largest reform of the family justice system any of us have seen or will see in our professional lifetimes. On 22 April 2014 almost all the relevant provisions of the Crime and Courts Act 2013 and the Children and Families Act 2014 come into force. On 22 April 2014 the Family Court comes into existence and the Family Proceedings Court passes into history. On 22 April 2014 we see the implementation of the final version of the revised PLO in public law cases and the implementation in private law cases of the Child Arrangements Programme. Taken as a whole, these reforms amount to a revolution. Central to this revolution has been – has had to be – a fundamental change in the cultures of the family courts. (President of the Family Division, Views from the Presidents' Chambers' newsletter, April 2014)

There are lessons to learn from the early development of the LIFT project between October 2015 and March 2016. Some apply to the establishment of any new service; some are specific to the introduction of a multidisciplinary service designed to engage with a range of agencies, and others to the current changes in the family justice system. If the decision were taken to replicate the LIFT service in another authority in England or elsewhere, it would be important to establish a realistic timetable and make allowance for the fact that new interventions often take longer to become established than their originators expect. The development team in NSPCC's central office played a key role in establishing the service, but with hindsight it would have been helpful for there to have been closer liaison, from the outset, between development managers and those who would be charged with delivering the initiative. Operational staff were largely absent from early discussions, when it would have been helpful to have had someone present with a strong connection to practice and experience of the time needed to set up a service. This may also have avoided the early deployment of some staff, who were largely responsible for determining their own work activities until the clinicians were appointed. This leads to a strong recommendation that, in future, clinicians are appointed before any other team members.

At various points in the present evaluation, references were made to the contact that had been established with staff in the court team within the Children's Service Directorate in Croydon, and how this contact had subsequently declined. Participants recognised that there needed to be more engagement with the team initiating proceedings, and members of the LIFT team were taking steps to address this over the coming months. It was suggested that one way to improve engagement would be to offer relevant training to social workers. While making time for this was seen to be a challenge, both in terms of the social workers and LIFT team, it is perhaps something that could be developed when resources and capacity allow.

One issue emerged in discussions with LIFT staff members which does require a resolution. Some of those interviewed were concerned that judges expected LIFT to provide an expert view equivalent to the experts that had often been appointed. But if LIFT is not providing an expert view in their assessments it is, perhaps, unclear what they are providing, so it is important to resolve any misunderstandings – perceived or actual – as soon as possible.

The absence of very early engagement with the courts seems to have been a missed opportunity. Given the central role of courts in this project, it would have been advisable to engage the judiciary at the highest level at the point when the project was being discussed. Instead, the initial approach was made to the then District Family Judge (DFJ) before discussions took place with the President of the Family Division. The Family Court and Alcohol Court (FDAC) has shown that it is possible to do things in a very different way (Harwin et al., 2014) and this is now (2017) being introduced into Croydon. It will be important to continue the contacts now established to plan the relationship between FDAC and LIFT, so that each evolves with reference to each other.

If, in the future, there are constraints on the extent to which LIFT may be replicated in other authorities, it might be possible to use the expertise that exists in the team to explore alternative ways in which aspects of the model might be applied, and to look at examples of how this has happened in the US and elsewhere. The task would be to identify any elements of the model that could be adapted for use where it is not possible to embed the whole.

The announcement in April 2016 that the LIFT project had been granted additional Innovation Programme funding should be seen alongside another significant parallel development. In March 2016 the government announced plans to change the law to allow more children to be adopted as part of a wide-ranging four-year strategy set out in *Adoption: A Vision for Change* (Department for Education, 2016b). In light of judicial concerns over the parenting assessments received, and the judgements that have been made on the responsibilities of local authorities to take all steps to ensure a care plan for adoption is progressed only when every other option has been applied, LIFT has the potential to make a significant contribution. The strategy and the plans for proposed legislation also set out goals for more babies to be placed with foster parents who may want to adopt them permanently, which fits with the approach in place in Tulane.

The quotation at the start of this section illustrates the extent to which the family justice system is evolving and the pace at which this is happening. It does not, however, include all the changes that have taken place, and omits the significant development of the Family Drug and Alcohol Courts (FDAC). The final report of the Family Justice Review (FJR) (Norgrove, 2011) drew attention to a number of issues that are directly related to this present evaluation, and the need for more robust evidence of what is effective. LIFT must be seen as part of this evolution and it is vital that early lessons from the service can be used to contribute to this debate, on the understanding that final conclusions

about the service have yet to be drawn. At a time when the government is introducing legislation as a consequence of the difficulties faced in assessing children and their parents and carers and deciding on the right route to permanence for them (House of Lords, 2016) this evaluation is especially timely. The achievements to date should not be underestimated, not least in relation to the courts. The judiciary has accepted that siblings aged over 5 years are excluded from the project and where an intervention follows from an assessment the case will not have to meet the PLO timescales. A reporting process has also been established which allows a judge to review the progress of a case referred to the service. It is with this in mind that the following recommendations are made:

- ensure that the LIFT team is sufficiently resourced to deliver the service in Croydon, and, if the service delivery/evaluation design involves working with an additional local authority, that adequate planning and resources are agreed and applied
- continue to work to establish strong contacts with all relevant professionals and stakeholders and make sure they have sufficient awareness and understanding of LIFT, particularly in relation to the distinct element of LIFT as a mental health intervention for babies and young children
- decide on a robust evaluation methodology as soon as possible, using quantitative and qualitative methods, and incorporating a cost study similar to that conducted in the evaluation of the Family Drug and Alcohol Court (Harwin et al., 2014). The evaluation should include a review of the criteria used to refer cases to LIFT; an examination of decision making on the referrals; an analysis of costs of establishing and running the service, alongside the development of a template for analysing the costs and potential benefits. It is imperative that the evaluation model is in line with the court process. Otherwise, there is a risk that not enough referrals will be made to the LIFT service.
- obtain a commitment from any authority where LIFT operates, or might be introduced, that the necessary support will be provided to allow the initiative to be fully evaluated, and that appropriate research governance and data sharing processes will be maintained or established
- consider offering training, in the form of continued professional development, based on the model to social workers and other professionals, to support their assessment skills as well as their engagement. Develop processes to learn from the findings of studies conducted in the family justice arena in relation to similar groups targeted by LIFT, specifically evaluations of Cafcass Plus projects (for example, Broadhurst et al., 2013 and Holt et al., 2013) as well as those that might emerge from reports or evaluations of the New Orleans Intervention Model in other countries

Findings Part 2: Planning for implementation of the RCT April 2016 to January 2017

Dennis Ougrin and Kerry Middleton

Introduction

This section updates some of the material considered in Part 1 to explain the process by which agreement in principle was reached on conducting an RCT comparing the LIFT service with business as usual in Croydon. The final protocol has yet to be agreed, but this section aims to show the current state of thinking in terms of a response to the concerns outlined in Part 1, pending agreement about the final protocol.

As discussed earlier, a Randomised Controlled Trial (RCT) of NIM has been ongoing since 2011 in Glasgow. In this RCT, outcomes for children worked with by NIM are compared to outcomes for children assessed by the local social work services, the Family Assessment and Contact Service (FACS), run by a highly specialised team of social workers. As part of this RCT, all 0-5 year old children who come into care due to suspected abuse or neglect, and whose parents and foster carers consent to participation, are randomly allocated to NIM or FACS. The child undergoes an assessment just after coming into care, one year later and then at 2.5 years, using a variety of measures evaluating mental health, developmental and attachment functioning.

A substantial amount of qualitative work has been undertaken as part of the RCT in Glasgow. This revealed both perceived benefits and challenges of introducing a mental health model into work with maltreated children in Scotland, and helped delineate aspects of NIM's implementation and delivery, clarifying relationships between NIM and key stakeholders. With the RCT continuing in Glasgow, the research team aims to expand it to part of South London. The addition of one or more sites in South London will allow the research team to expand the evidence base regarding interventions for the youngest LAC in both English and Scottish contexts, thus increasing generalisability of the findings.

Why does a randomised controlled trial seem to be the most appropriate research methodology to assess the effectiveness and cost- effectiveness of NIM?

NIM was evaluated in the US in a context where there is very little childcare social work. It has never been compared with social work and, in Louisiana, it is more likely to be NIM or nothing. Across England, services for children coming into care are responding to the requirements of the Family Justice Review and, if these enhanced children's services turn out to be as good as NIM, they are likely to be even more cost-effective.

Unless an innovative service has been rigorously tested, it is impossible to be certain that it doesn't have unintended harmful effects. Two examples are the Cambridge-Somerville Trial and the Scared Straight interventions (Petrosino et al, 2003). The Cambridge-Somerville Trial was a particularly well-conducted study: starting in 1939 with a group of more than 500 juvenile delinquents, participants were randomly allocated to either a range of services (including counselling, academic tutoring, medical and psychiatric attention, referrals to YMCA, Boy Scouts, summer camps and community programmes) or to simply checking in at regular intervals. Almost all, 94% of the participants, were followed up 30 years later and, surprisingly, more of those who had had the counselling and other services had committed criminal acts. As noted here by the trial chief investigator 'a larger proportion of criminals from the treatment group went on to commit additional crimes than their counterparts in the control group' (McCord, 1978, p.286). Another apparently positive intervention, Scared Straight, which introduced juvenile delinquents to adults who had already been convicted of crimes, was shown to be harmful across nine studies, as the author of a meta-analysis of nine studies concluded '...programs such as Scared Straight increase delinquency relative to doing nothing at all to similar youths' (Petrosino, 2003, p.58).

The reason randomisation is a useful research method – especially in complex settings – is that if enough individuals are randomised, all complexities – both known and unknown – will be balanced out. This should result in two groups that are identical except for the new intervention. It is helpful to imagine a large lecture theatre with students streaming in with groups of their friends. If, at the entrance, a coin is tossed so that students are randomly allocated to sit on one or other side of the central aisle, those friendship groups will be spread evenly across the two sides of the lecture theatre. If more than 100 students are allocated randomly to each group, then all sorts of factors will be evenly spread and there will be a very similar number, on each side, of students who have blue eyes, have a parent with an alcohol problem etc. In the BeST? trial, the aim is eventually to randomly allocate around 500 children to receive NIM or social work across all the sites, including the 180+ children already recruited from Glasgow and new recruits from Glasgow and South London. This should balance complex factors such as the number of large sibling groups, the number of asylum-seeking families, the proportion of families in which parent used cocaine, etc.

The potential to use alternative, non-RCT, study designs was explored in detail by the BeST? trial research team, and has been subject to international peer review by experts in complex interventions methodology. In particular, according to the study statistician, Dr McConnachie (individual communication), an individually randomised design is by far the most efficient. In Part 1, it was suggested that a stepped wedge or random cluster design could be considered in the future, should an RCT not prove to be possible. In Dr McConnachie's view, a stepped wedge design is not currently feasible for the evaluation of NIM. This approach is suitable for those interventions already approved for implementation. The evaluation is then done by introducing the intervention in a random

order over the sites. The stepped wedge design could only work if all outcomes are collected via routine data, because the outcomes for all sites are needed simultaneously, throughout the trial phase. As routine data collection is not currently consistent with the quality required for a rigorous evaluation, individual consent and follow-up for every family would be required – again, at all sites for the duration of the trial – which would almost certainly not be feasible, in the view of the trial team. A cluster RCT, and a stepped wedge, both require a large number of sites, because it is the site that is the unit of analysis. The sample size would need to be inflated, often quite considerably, due to clustering of outcomes. One of the original ideas for BeST? was to divide Glasgow into two geographical halves, one of which would receive the NIM service, the other to standard care, but, following a discussion, it was decided this would not be a valid approach.

RCT technology has improved a lot over the last ten years, especially since the publication of the MRC Complex Interventions Framework (Craig et al., 2008). Interventions within trials no longer have to be rigidly manualised, but they are expected to be well described and, before a trial even starts, extensive exploratory work is done to ensure that the new intervention fits the local context. Qualitative work is done throughout the trial so that whatever the outcome, we can get a good understanding of why an intervention worked or didn't work.

This has also been the experience of the Big Lottery funded Realising Ambition programme in which five RCTs in social care were funded:

Big Lottery took the bold step of investing in four real-world RCTs as part of Realising Ambition. Not because we or others think that RCTs are the only or even best method of evaluation in all circumstances: we don't. But because when it comes to testing the impact of an intervention on outcomes they do a good job of helping us to attribute cause by filtering out other possible explanations for any impact observed. (Young Foundation 2017)

Key tasks identified by this programme, in order for RCTs to be successful, include getting buy in (usually involving intense multi-agency consultation); getting the right size of trial (usually larger numbers than stakeholders initially expect) and thinking about both likely benefits and possible adverse effects of new interventions. They also highlighted some crucial areas of focus in RCTs, including recruitment and retention, model fidelity and avoiding contamination.

The qualitative work – both that included above in Part 1, and the earlier qualitative work (Friedman-Levy 2015) – was essential to gain an understanding of the child welfare practices that exist within LB Croydon, and identifying how the work of the LIFT service has begun to function within this context. This has been an important means of supporting the implementation of the proposed RCT. The sections below summarise some of the concerns raised in the qualitative evaluation of early implementation of the

LIFT service up to March 2016, along with the work that was conducted up to January 2017 to begin to address these issues. Suggestions of strategies and action points for ongoing evaluation are provided.

Concern 1: Absence of a blueprint for conducting RCTs in the family justice area

There are no existing examples of implementing a randomised trial within family proceedings in England. The Stage 1 report highlighted differences between the Scottish and English legal systems, which meant that the trial protocol in Scotland could not be directly transferred to proceedings in England. In her annex to this report, Her Honour Judge Atkinson has considered the factors that have informed decisions by the judiciary about whether and how best to proceed with an RCT in the English legal context.

Response

Although there are no examples of implementing a randomised trial within family proceedings, there are existing studies that can inform the development of an RCT within family proceedings, although neither involve looked after children, and one took place over 30 years ago in a very different legal context. Berg and colleagues (1978) randomly allocated juveniles who were failing to attend school into those whose cases were adjourned and those who received supervision. More recently, an RCT design in which two groups of patients discharged from psychiatric hospitals received the same levels of clinical treatment but for differing lengths of time was used by Burns and colleagues (2013) to test the use of Community Treatment Orders. This work required coordinating a complex multi-agency network, and required significant planning with Judges in order for the randomisation to work within the court framework in a way that accorded with legal practices. Gathering research evidence in highly complex systems is challenging, but the technology of RCTs has developed to address this. As noted above, the Medical Research Council's Guidelines for the Evaluation of Complex Interventions Framework (Craig et al., 2008) provides a useful frame for formulating, and then conducting, RCTs that we consider to be potentially applicable in highly complex settings such as the Family Justice System.

While there is indeed no blueprint for the intended RCT, the need for one has been articulated by the National Institute for Health and Care Excellence (NICE). NICE is a non-departmental public body that provides national guidance to improve health and social care. It produces evidence-based guidance and advice for health, public health and social care practitioners and develops quality standards and performance metrics for those providing and commissioning health and social care services. Specifically, when developing its Public Health Guideline (PH 28) on looked after children and young people, it recommended that research should:

...develop robust methods for evaluating services for looked after children and young people by working with multidisciplinary research specialists in health,

social care, and economic evaluation ... Explore barriers to conducting controlled studies (for example, concerns about random allocation of looked after children and young people) and making recommendations to reduce these obstacles. It should produce clear guidance about when it would be considered unethical, unnecessary, inappropriate, impossible or inadequate to randomly allocate participants (NICE 2010).

Subsequently, the NICE Guideline's on children's attachment in Care (NG 26) made recommendations for research on children with attachment difficulties that state:

Attachment-focused interventions targeting adoptive parents, carers and children and young people are scarce ... A randomised controlled trial should also be carried out to compare the clinical and cost effectiveness of an attachment based intervention to promote secure attachment in children and young people who have been, or are at risk of being, maltreated, with usual care (NICE 2015).

Actions:

- Provide information and ongoing opportunities for discussion with key partners and stakeholders regarding the Medical Research Council's Guidelines for the Evaluation of Complex Interventions Framework, the position of NICE and the Department of Health as regards RCTs and learning from previous RCTs that appear to have relevance to the family justice system. Since data collection for Part 1 of the findings in this report was completed, there have been several meetings between the research team and senior members of the Judiciary in order for the research team to fully understand the challenges inherent in randomising within the Family Court. These included meetings with Sir James Munby, President of the Family Division, with Charles Geekie QC (a local barrister independent of the RCT but willing to discuss challenges) and several meetings with Her Honour Judge Atkinson, designated family Judge for the East London Family Court. We have also held what we hope will be the first multi-agency steering group for the RCT, if it is able to go ahead. Chaired by Her Honour Judge Atkinson, this involves the other East London Family Court Judges, and representation from Croydon Social Work Services, the NSPCC, King's College London and the University of Glasgow. Her Honour Judge Atkinson has reflected on the factors that have informed the judiciary's decision-making about the fit of the RCT design within care proceedings in an annex at the end of this report.
- Continue consultation with the Department for Education, Department of Health (e.g. through the Nuffield Family Justice Observatory), NICE and the Health Research Authority regarding the proposed RCT. Since data collection for the qualitative study reported above in Part 1 was completed, there has been consultation with these organisations, including a Roundtable Event hosted by the Department of Health in June 2016, to discuss the role of evidence in family justice which included a discussion about RCTs in that sector. This was attended

by academics, including some of the authors of the present report, and representatives from voluntary organisations working with vulnerable families; representatives from children's social services, and representatives from the Department of Education.

Concern 2: Anxieties regarding randomisation of children in a social care context

When the Stage 1 interviews took place, senior social work managers, and some LIFT staff, had expressed anxiety regarding the randomisation of children in a social care context. The anxieties were informed by a sense that services as usual did not involve similar levels of input to the LIFT intervention.

Response

After an extensive consultation process following completion of the Stage 1 evaluation, most senior representatives of children and family early intervention and children's social care of the London Borough of Croydon are now generally in favour of facilitating the RCT, in our view. The BeST? trial research team have now joined the project's steering group, which includes senior management representatives of LB Croydon. In the context of an RCT, this group would consider, and address, any ethical challenges highlighted by the process evaluation work. This will assist in finalising the trial protocol.

Despite the recent growth of interest in, and significance of, evidence-based practice in social work, relatively few RCTs have been conducted in children's social care. Solomon et al (2009, p.14) point to possible constraints on the development of evidence based practice from this:

Social work has not reached the point of designating specific social work practices as [evidence based practice]. One of the primary reasons is the shortage of available evidence, particularly empirical evidence from RCTs. The caution here is that if social work researchers do not engage in RCT investigations, (evidence based practices) may not be developed for social work interventions, nor will social workers contribute to the broader arena of (evidence based practice) for psychosocial interventions.

A challenge faced in social work, and many other human services, from using evidence to inform practice decisions arises from the complexity inherent in their work, that decisions have to be taken to address the particular circumstances in each case: 'It is not a simple application of population-level evidence to individuals' (ibid.).

In addition, the people they are working with are likely to be highly vulnerable and experiencing high levels of stress and distress. This informs an ethical dimension to the concern, namely that it is not acceptable to withdraw, or fail to offer, a service that could benefit them. In such a circumstance, it can feel to the practitioner as if there is a tension

between their practice ethics and research ethics. Solomon et al. (2009) suggest that, while this is experienced commonly, the tensions can be reconciled. They refer to the ethical principles for research and RCTs outlined by the Belmont report in The National Commission (1979) as a way of achieving this: respect, beneficence and justice. Randomisation can be justified meaningfully where there is genuine uncertainty about the effectiveness of the intervention that is being tested, and hence it has been important to explore the notion of equipoise with local stakeholders in Croydon, and to continue this process.

There appears to be no evidence that a higher intensity of input to children, even using infant mental health techniques, is better than the input offered by social work services. In the Glasgow feasibility RCT (Turner-Halliday et al., under review), the qualitative process data showed equivalent levels of enthusiasm for, and concern about, both the New Orleans Intervention Model (NIM) and the social work model. In Croydon, the most recent inspections rated children's services as 'satisfactory' for the overall effectiveness of its safeguarding and LAC services (OFSTED and CQC 2012) and as 'good' for the overall effectiveness of adoption services (OFSTED 2013).

It is suggested that concerns about the ethical consequences of an RCT are best met by a system in which the courts are the final arbiter about who receives LIFT and who receives services as usual, once the randomisation process has taken place. The court has the overarching obligation to consider the best interests of the child, and both parents and professionals need to know that, in some cases, the court could decide to pull the child out of the trial on a welfare basis. It will be made clear to families in recruiting them to the trial, that the services they are being offered are equitable, in our judgement. We argue that this is the case, since we have no evidence that NIM is better than social work services as usual. We have ethical approvals for our consenting process.

Concern 3: Concerns about equity

Participants in the Stage 1 evaluation were concerned that there would be concerns about equity, as LIFT appeared to represent an improvement on business as usual services. Anxieties about equity fuelled opposition and concerns from the judiciary and senior managers in the local authority to the RCT.

Response

Sir James Munby has expressed concern about the way the involvement of independent experts in judicial proceedings can slow things down and cause drift and that, in many cases, social work expertise is sufficient (Munby, 2014). In our discussions with him, as more information was provided on the nature and value of RCTs, he has welcomed the potential for the RCT guiding the judiciary as to the kind of expertise that may be helpful in making the challenging decisions about children's permanent placement.

There are some examples of services offering a higher level of input to children and young people being harmful or not having an effect. Examples include:

- The Scared Straight studies in which young offenders were introduced to adults with a criminal history. A recent meta-analysis showed that these interventions were harmful (Petrosino et al., 2003).
- Group therapy for adolescents who self-harmed was shown to be ineffective (Hazell et al., 2009).
- The Cambridge Somerville Trial in which young offenders were offered medical care, school tutoring and counselling. Over a thirty year follow-up of more than 90 per cent of the cohort, more crimes had been committed by those who had the more intensive interventions (Dishion et al., 1999).
- The Fluid Expansion As a Supportive Therapy (FEAST) trial of fluid boluses for young children experiencing shock in African hospitals. The trial was stopped before completion because of a higher death rate due to fluid bolus treatment, even though this is the standard treatment for shock in the West. The Medical Research Council (2013) has made a video about this, which is available online.

Actions:

- Provide information and opportunity for discussion with key partners and stakeholders regarding previous RCTs in vulnerable populations and complex settings and the potential for negative or little effect findings to emerge. This may apply even with apparently obviously helpful interventions of higher intensity
- Continue our consultation with the Department of Education, Department of Health (for example, through the Nuffield Observatory), NICE and the Health Research Authority regarding the evaluation.

Concern 4: No agreed level of what constitutes ‘services as usual’

The Stage 1 evaluation highlighted that, unlike Glasgow where FACS is a well established business as usual service, the level and type of services allocated to families in Croydon appear to be very variable.

Response

By definition, usual services are the services that these families would receive if they did not get the NIM intervention. Usual services will be described in a detailed process evaluation and will be reconsidered at operational meetings by the BeST? services trial team. The fact that ‘usual services’ will inevitably vary across the UK sites will be an advantage, in our view, especially if NIM is found to be cost-effective across these different contexts: however, this does have implications for analysis and reporting in terms of there being no consistent treatment as usual.

Actions:

- Continue liaison with local stakeholders about our genuine uncertainty as regards the relative cost-effectiveness of NIM and services as usual.
- Between-site differences will be taken into account during the statistical analysis of the trial data.

Concern 5: Rates of referral to LIFT have been low

The Stage 1 evaluation noted the low number of referrals that had been made to the LIFT team in the early months after the LIFT service was established.

Response

It is acknowledged that rates of referral from the local authority were low initially. This may have been partly explained by staff changes within the care planning and permanency planning teams which meant that establishing consistent contact and promoting the LIFT service within standard care was difficult. This included the departure, in February 2016, of the care proceedings manager who was previously the primary point of liaison for referrals. As a result, there appeared to be a lack of clarity from local authority staff on the nature of the LIFT service, and what might constitute a suitable referral. In addition, reservations from local authority staff may also be attributable to the additional workload associated with making a LIFT referral.

LIFT members have been proactive in addressing these issues. Continued attempts have been made to promote the LIFT service by attending weekly drop-ins within standard care services to answer queries. LIFT members are also providing presentations to standard care services in order to continually update new staff. Other efforts made to engage staff members include inviting social workers to visit the LIFT service. Most recently, a new care proceedings manager has been appointed (October 2016). All of these measures have led to a substantial increase in the number of referrals. As reported above, between January 2016 and January 2017, there were 21 referrals of LAC to LIFT, which is in line with expectations. At the point of reporting (January 2017), 17 of the children referred had been discharged by LIFT. These families had received 96 days of LIFT input, on average. Of the 21 children referred, 18 had attended at least one face-to-face session; at the point of reporting (January 2017) the average number of sessions was 28.7, and LIFT had recorded an average of 14.1 phone calls per case. 14 cases were closed early. Early closure occurred primarily due to the LIFT service decision not to intervene (3 cases); court decisions (4 cases); Local Authority decisions (2 cases), and family decisions (5 cases). These early discharges provide valuable data on the way the NIM intervention may perform in a real life environment in parts of South London. In good quality RCTs, statistical analyses are performed on all randomised participants, irrespective of whether or not they completed the interventions studied. This approach, called Intention To Treat analysis, ensures any effects found are not exaggerated, and it improves both the generalisability and the applicability of the findings.

If LIFT becomes part of the RCT, an NIHR funded research team would include a trial recruitment coordinator who would contribute to ensuring a steady flow of referrals. This would be a social worker whose role would be to identify eligible referrals from all the children coming into care in Croydon; ensure randomisation occurs, and approach eligible families for consent. This has been extremely successful in Glasgow, and very few eligible children appear to have been overlooked. This role will be subject to agreement by the local project steering group.

In order to reach our target number of families participating in the UK RCT (500 in total across all sites), we have estimated that we need to recruit 4 families per month in South London (2 randomised to LIFT, 2 randomised to services as usual). Given the current referral rate, this would require expanding the RCT beyond Croydon. The number of eligible families that can be randomised in South London is only bound by the capacity of LIFT to take referrals, and this has been carefully modelled in the Glasgow Infant and Family Team (GIFT).

Actions:

- LIFT to continue to build communication links, and promote the LIFT service within LB Croydon.
- Conduct parallel planning with neighbouring local authorities and key stakeholders in those areas to prepare the ground for the possible expansion of the RCT to achieve the target recruitment rate in South London. This work will require close liaison with the relevant personnel, and learning from the evaluation.

Concern 6: Exclusion of target children with siblings over 5 years of age

Participants in the Stage 1 evaluation suggested that keeping sibling groups together continues to be a strong priority in many authorities such as LB Croydon. This had generated a concern that the RCT would make this problematic, because different children would be seen by different teams, or some of the sibling group would not be seen at all.

Response

The fact that a family with children aged both over and under age 5 is randomised to LIFT does not imply different placement or permanency outcomes for the siblings. Where sibling groups include a child over age 5, the Glasgow Infant and Family Team has dealt with this on a case by case basis. The same approach will be used in South London.

The direct work used in the NIM model is designed for children under age 5: however, the detailed report on family functioning that is produced by NIM is likely to be highly relevant for older children, even though any direct work with the older sibling would not usually be conducted by LIFT. Child and Adolescent Mental Health Services (CAMHS)

are more available for children over the age of 5 than for pre-school children, and there is theoretically no reason why younger children should not have direct work from LIFT while an older child in the same family that requires it receives direct input from CAMHS. However, the pressures on CAMHS are not under-estimated and there is no guarantee that children over 5 will get such a service.

Guidelines for social workers around working with families with older siblings have been developed by GIFT and, in November 2016, were shared with LIFT, who will continue to develop these to ensure they are as useful in the South London context, if it is decided to go wider than LB Croydon.

Actions:

- Maintain close liaison between the LIFT team, Croydon Children's Services, the GIFT team and Glasgow Social Work Services, in order to ensure that systems around these sibling groups are set up appropriately.
- Continue to share practice experience between GIFT and LIFT with families with older siblings and in other circumstances.

Concern 7: Arrangements for analysis of data from a multi-site study

The Stage 1 evaluation noted the differences between Glasgow and Croydon in terms of the legal system, population demographics, and the range and type of services offered between the two sites. A concern was expressed about the implications for the use of data arising from this being a multi-site study.

Response

It is true that some RCTs report significant inter-site differences. However, inter-site differences are not necessarily a problem. They might reflect real-life differences in practice. In this case, having both Scottish and English research sites may improve generalisability of the findings. Appropriate statistical approaches will be used.

Research assessments are designed to be identical in all study sites involved in the multi-centre RCT, and we already have ethical approval for this.

We have drafted research agreements between the various partners. These must be signed off before the site in Croydon, and sites across parts of South London, can open for recruitment.

Actions:

- Continue to work towards opening a South London RCT site with Croydon as the lead authority

Concern 8: Difficulties communicating with key staff from children's social care

Some adaptations had to be made to the Stage 1 evaluation when it proved impossible to arrange interviews with some parts of Children's Social Care and the CAMHS service in Croydon. The number of children referred to LIFT appeared to be lower than the number of eligible families, and some participants questioned whether this had arisen because some members of some social work teams dealing with potentially eligible families were unfamiliar with the LIFT service and the research.

Response

Difficulties in communication is a key issue in most trials. It is especially pertinent to the evaluation of NIM, an intervention with multiple stakeholders. Standard social care also typically involves multiagency and multidisciplinary work, which makes communication a challenge.

There have been several meetings and phone-calls in the latter half of 2016 and in 2017 between Mr Lewis, Director of Children and Family Social Work in LB Croydon, Mr Forde from the NSPCC (funder of the LIFT service), and Professor Minnis, Chief Investigator of the multi-centre RCT. These have allowed detailed discussions to take place about how the RCT would work in Croydon and other areas of South London, and have continued during meetings with Mr Lewis, Mr Forde, Professor Minnis and Her Honour Judge Atkinson at the East London Family Court.

In the 2015 South London feasibility work, we interviewed key informants from Children's Services and relevant health services (Friedman-Levy 2015). We have learned, from this work and from our Glasgow feasibility work, that communication with key stakeholders is crucial at every stage of the study.

It has been helpful that, in Glasgow, a Steering Group, chaired by Glasgow's Chief Social Worker and involving senior social work managers, the NHS, the NSPCC and the University, has met regularly. We hope to replicate this in South London.

In addition, the BeST? trial research team members have joined the London project steering group, which is likely to facilitate communication and troubleshooting where there are challenges with access to informants.

Actions:

- Liaise with multi-agency partners in South London – particularly Mr Lewis and Her Honour Judge Atkinson – in order to develop the most efficient and effective multi-agency governance structure to oversee a South London RCT site.
- There has been progress with finalising data sharing agreements between the NSPCC, KCL and LB Croydon.

- Liaise with, and learn from, Glasgow city council about effective research governance arrangements that can be shared with LB Croydon through this project.

Discussion and next steps

Three main areas are discussed below:

- LIFT appears to be a generally feasible model for looked after children aged 0-5 living in Croydon
- LIFT is associated with high intensity of contact
- despite several reservations, there appears to be good progress to commencing an RCT evaluation of NIM in LB Croydon.

In the pilot study that used all referred cases, both the numbers and the intensity of work were in line with what was expected. Although lacking a control group, the process variables revealed significant intensity of input from professionals, delivered by LIFT. Given the differences in characteristics of child and family service users, and the nature of the LIFT intervention, comparisons of the process variables between LIFT and other programmes, including services as usual, should be made cautiously.

The number of children referred to LIFT (21 between January 2016 and January 2017) was in line with expectations. A greater number of referrals is expected in the subsequent years as the referral pathways become clearer. The number of referrals is in line with the sample size calculations undertaken for the RCT, and suggest that the RCT is likely to be feasible. We found that, out of the 17 children referred and discharged by LIFT, families received 96 days of LIFT contact, on average. Of the 18 children that have had at least one face-to-face session, the average number of sessions was 28.7 and 14.1 phone calls. We did not have access to direct comparisons with services as usual: however, social work practice is likely to be significantly less intensive, and therefore the costs associated with LIFT are likely to be high. In LIFT, duration and intensity of contact varied widely and these factors are not likely to be indicators of quality. A substantial number of cases were closed early. This is an important indicator, consistent with the real life, pragmatic trial design. The intensity of the interventions is an important variable in any trial. Harm can result from both over-servicing and under-servicing patients and families (Furman and Jackson 2002). Further research is needed to explore the efficacy of LIFT. In particular, a very long-term evaluation is required, taking into account wider societal costs. While many LAC do well, LAC are at an increased risk of a number of adverse outcomes, including suicide and self-harm; physical and mental health disorders, and criminal activity. For example, a study on the cost of care for young offenders found that antisocial young people use fewer services in the community, thus appearing to incur less cost (Barrett et al., 2006). However, the concurrent cost of their criminal activity overshadowed this, showing that they had difficulties when not engaged with the healthcare system. Similar consideration will apply to the costs associated with suicide, loss of productivity, and certain physical and psychiatric disorders.

As discussed above, plans are being designed to overcome all potential barriers and objections uncovered during the qualitative phase of the evaluation. It is worth noting

that, from the second half of 2016 onwards, progress is being made in gaining approval for the RCT by all major stakeholders, including the judiciary and the senior social workers. The challenges of conducting an RCT in the socio-legal context are not unique to Croydon and have been discussed in detail by Greiner and Matthews (2016). These authors have examined the possible reasons why the US legal profession, in contrast to the US medical profession, has been reluctant to adopt the use of the RCT as a knowledge-generating tool. The studies they analysed were 'field experiments conducted for the purpose of obtaining knowledge in which randomization replaces a decision that would otherwise have been made by a member of the US legal profession' (Greiner and Matthews, 2016, p.295). Their findings are strikingly similar to the obstacles and objections uncovered by this service evaluation, partly reflecting constraints in social care sectors in relation to RCTs. Greiner and Matthews (2016) found that, despite significant philosophical and practical obstacles, the number of RCTs that have involved the legal profession is growing, with over 50 RCTs published to date.

Rigorous evaluation of LIFT will require administering a number of quantitative measures to the children and their carers. Alongside this quantitative measurement, detailed qualitative and quantitative process evaluation will be needed throughout the trial. Qualitative aspects of this work will need to include focus groups and/or individual interviews with social workers, foster carers, birth parents and legal professionals associated with the trial, as well as focus groups and interviews with the LIFT team and professionals involved in delivering social work services as usual. Quantitative process evaluation work will need to include ongoing careful monitoring of the way families move through the services, as well as recording of the number of hours and type of input (and by whom) that families receive in each arm of trial. This will enable health economic analysis to examine cost-effectiveness of LIFT as compared to services as usual. Together, this process evaluation work could provide a detailed description of the context surrounding the trial, and explore the functioning of the services being compared, so that, whatever the quantitative outcome of the study, we may have a better understanding of the interventions and how they functioned in the contexts in which they were delivered.

The process described above has highlighted an evolving journey towards the decision on the most rigorous and scientifically sound design for NIM evaluation. This journey has also highlighted how unusual RCTs are at the intersection of the legal, health, social professions. The journey is an exciting one. It provides learning for other researchers who might design RCTs in this field in the future.

Conclusions

LIFT appears to be a feasible service for LAC in Croydon, but probably not in LB Croydon alone. A robust impact evaluation would need a larger sample size than from this one London borough. Rigorous evaluation of LIFT is required before any recommendations are made about wider implementation of the model. Several barriers to both implementing LIFT, and evaluating LIFT in an RCT, uncovered by the qualitative part of this evaluation have been successfully tackled, but this is a changing service environment and further challenges are to be anticipated. While the number of referrals, and the intensity of input, are in line with those expected, the number of early dropouts is an important variable with implications for the delivery of NIM services. The initial objections and barriers uncovered by the qualitative research are being addressed. The LIFT evaluation team remains hopeful of securing the support of the key stakeholders to undertake an RCT of the NIM model in Croydon and wider areas of South London.

Annex: Issues arising for the judiciary in the introduction of an RCT within family proceedings

It is the responsibility of the Designated Family Judge (DFJ) for East London to lead the delivery of fair and efficient family justice across the East London Family Designated area. East London Family Court has the highest volume of public law and private law children cases across London. Within that area, there are 10 separate issuing local authorities, one of which is the London Borough of Croydon. Croydon is one of the biggest issuing authorities in the East.

In keeping with the President's commitment to support any appropriate alternative means to deliver proper outcomes for children, the President and DFJ supported the introduction of the NIM model in Croydon (LIFT). The President gave his permission to remove LIFT cases from the 26-week timetable, as he had done with Family Drug and Alcohol Court cases.

From the outset the NSPCC was very keen to introduce the study through a randomised controlled trial (RCT). The judiciary, supported by the President, initially opposed the introduction of an RCT for the following reasons:

- lack of informed consent. The original plan was that randomisation would take place on issue; the family would be unaware that they had been randomly assigned to services as usual or LIFT
- concern that pre-proceedings services in Croydon was so poor that there was an immediately attractive argument that anyone not being given access to the multi-disciplinary team would have a legitimate complaint that they were not being treated fairly
- most significantly, a concern that random selection of the means by which a family is assessed might curtail the Judge in the exercise of his/her duty to make a fully considered welfare decision about the child

Accordingly, the feasibility study was approved as a qualitative piece of research without the RCT. The President has been clear throughout that, without the agreement of the judiciary and, in particular, the DFJ, there could be no RCT. However, following further requests that continued consideration should be given to the possibility of an RCT, the DFJ was tasked with exploring how, if at all, an RCT could be accommodated within the legal process.

Proposals for a modified RCT

To understand the original hurdles to the RCT, there needs to be an understanding of the legal process in England and Wales and the role of the Judge in that process. This is very different to Scotland where an RCT on the NIM model is already in place.

The moment the local authority issues proceedings in relation to a child, the Judge is fixed with a statutory responsibility to make decisions only in the best interests of that child. This is best demonstrated by the fact that, even if the local authority wishes to withdraw its proceedings, it needs the permission of the court before it can do so. That permission is only given if a welfare analysis supports withdrawal as being in the best interests of the child.

The principle that the child's welfare is paramount guides all decisions during the process, including the gathering of evidence for the essential welfare determination. Further, since April 2014 there has been a time imperative imposed upon that decision making, reminding us that delay is contrary to the welfare of children, and requiring that we manage a case so that the welfare decision is made within 26 weeks.

Dealing with each of the original obstacles in turn:

Informed consent

The proposal has been modified to enable parents to make an informed choice as to whether they are part of the trial or not.

A rethink about what amounts to BAU

On reflection, the Judges thought that the concern about the lack of pre-proceedings work within Croydon was not an issue, because BAU within the context of care proceedings was not simply the ordinary services provided in Croydon, but rather the services that the court orders must be provided in order for it to make its welfare decision. In the family justice system, BAU is a rigorously managed application within which evidence is gathered so as to enable the court to make welfare decisions about a child's future within 26 weeks. If Croydon falls short in its pre-proceedings work, then judicial case management will make up that shortfall by ensuring that proper assessments are carried out to inform decision making. So, in fact, the judicial role could be seen as ensuring the BAU is up to the standard necessary to produce the necessary evidence for a welfare determination. It is assumed that the multi-disciplinary assessment produced by LIFT will provide that evidence, and, by that means, there could not be any legitimate argument that there was in-built discrimination against those proceeding along the standard care proceedings route.

Compromising the judicial role

The key issue that remains is not compromising the judicial role.

There is no precedent for the implementation of a randomised trial within family proceedings. Nevertheless, if it can be achieved, the Judiciary is very keen to support the RCT and we have offered our commitment to finding a way to implement an RCT in this research trial. As DFJ, I am in the process of working on a model which guarantees the Judge is able to override the study in order to take welfare decisions for a child and

ensures that there is no curtailment of the judicial role. That is a work in progress but indications are favourable.

Her Honour Judge Carol Atkinson

Designated Family Judge for East London

28 June 2017

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Appendix A: GIFT, FACS and the RCT

In the feasibility study, the names of all families in Glasgow with a child aged six months to five years entering foster care were referred to the trial by social workers. Parents were contacted by very experienced social workers who provided information and an explanation of the study; answered any questions, and asked them if they would agree to participate in the study. The randomisation protocol took place at this point. If the parent consented to take part in the research they would then be randomised to FACS or GIFT. A sub-study (Welch et al., 2016) within the feasibility study explored what parents understood about the study. The findings indicated that many families found it difficult to understand that participation in the trial process was separate from the processes surrounding the entry of their children into care. The researchers, therefore, recommended randomisation before consent. The original timing was also found to lead to delays of up to eight weeks. As a result, randomisation has been repositioned to take place at the start of the process.

This means that when a child is accommodated by Families for Children (Glasgow City Council) the research team is notified and the case is randomised to FACS or to GIFT. If parents do not consent to take part in the trial, they can still engage with FACS or GIFT, whereas previously they would only have been able to work with FACS. The change has implications for the work GIFT is expected to undertake and, for the first time, in early 2016 a longer waiting list has emerged¹⁶:

The reality is we've had an increase roughly from two referrals a month to five referrals a month under the new randomisation, so we're swamped and we've been developing strategies to try to manage that in a fair and equitable fashion.
(Member of the GIFT team)

At the time of the present evaluation's visit to the Glasgow research team (February 2016) it was not yet known how many families would consent to the service but not to taking part the research, and how many would consent to both. There were families who had waited several months to engage with GIFT. This was leading to concerns amongst professionals working alongside GIFT both about the model's sustainability and how the problem of possible delay would be resolved. In circumstances where a child had been waiting for three months, GIFT team members have started to arrange consultations with social work colleagues to see if it is possible to apply what is described as 'a GIFT perspective', prior to the assessment commencing.

Several informants thought that the expectations of the GIFT project had been raised too quickly and were now too high. Some considered the service's credibility would soon be questioned if the GIFT team could not find a way to meet demand. In an attempt to avoid

¹⁶ Over time, a waiting list developed for GIFT anyway, compared with FACS, because of the longer time with which the GIFT team is involved with families.

this happening, what was described as a Catch 22 situation had developed. The offer of a consultation on some cases has raised the possibility that the team might not be involved in every case that is randomised to GIFT. One GIFT team member described the solution which had been adopted:

So it's an interesting time. So we don't know how it's working yet and we may try it out and decide it's not the best idea we've had, but I think we definitely need to be actively trying something because the waiting time. We've projected that if we're resourced to see two cases a month and we're getting five in, even if one or two of those don't come off a month, our projection is that our waiting list will grow and grow, so we really do have to do something.

If families are being dropped at this stage, not because they have made a choice, but because of the limited capacity of the team, it was expected to lead to questions over the research process and fidelity to the randomisation protocol:

Sometimes we have been in the position of not being able to offer treatment when, if there wasn't the capacity issue, I think we might have, and that's one of the things that I find most uncomfortable about it in terms of the rigour of the model and applying the model.

All the GIFT team members who were interviewed in this present evaluation were very enthusiastic and committed to the model. They recognised the importance of the trial in contributing to evidence of whether the model survived the Atlantic crossing. Nevertheless, some informants inside and outside GIFT saw the trial itself as a potential constraint that placed limitations on how the model was used. For example, a number of references were made to assessments conducted by the FACS where the families concerned might benefit from the type of intervention offered by GIFT, but the trial meant this was not possible.

Appendix B: Interview schedules

Interview schedule: LIFT staff

1. What do you consider to be the key components of NIM and how these are being translated into practice locally?
2. Reflecting on the ways NIM has been introduced, are there things that:
 - have been particularly helpful/gone well?
 - have made the introduction more difficult?
 - could have been better if done differently?

3. In your experience, how do the NSPCC delivery team and local authority LAC team fit together?

(Prompt, if not covered, for meetings/informal contacts/coordination; location; priorities and any strategic objectives.)

4. Overall, do the arrangements work? If not how could they be improved?
5. Which would you say are the main agencies involved with NIM? And what about any other agencies – can you tell me which they are and how they are involved?
(Explore what is meant by ‘involvement’; any systems in place to facilitate intra and inter agency work re NIM; ways in which involvement could be improved or broadened; any agencies/services that should be involved but are not at present and vice versa.)

6. You said that you thought the key aims and aspects were (...) Do you consider this reflects how things are at the moment? If not, how does it differ?

7. How, if at all, do you think NIM fits in with the government’s plans for adoption reform, e.g. the move to regional adoption agencies?

8. It has been suggested that an RCT will be conducted in relation to NIM? Do you think this is:

- acceptable?
- feasible?

(Feasibility and acceptability are separated here – may merge in interview but still vital to discuss them both.)

(Explore the reasons for response; conditions that could make it hard to do such research; views on the acceptability of any objections to RCT; any implications for

the continuation of NIM if an RCT is not conducted; views on alternative if an RCT not feasible/possible or practicable.)

9. If an RCT is conducted, some families not receiving NIM will be offered services as usual. What would this involve?

(Check for services for birth parents; foster carers; 0–5s in care; cross agency services.)

(Looking for an explanation of what families have been offered pre-NIM and how, if at all, this would be different from a services as usual offer in the future – need to be clear about the components of services as usual.)

10. What if anything have you learnt from what is happening in:

- the USA
- Glasgow
- elsewhere?

11. Between now and the end of March 2016, what do you consider to be the key steps that need to be taken in relation to:

- the development of NIM in Croydon and by whom
- embedding the service in Croydon
- the development of a robust evaluation?

12. How do parents get approached to take part in the service?

13. Are there any services available for them to consider when they are approached on i) consent ii) anything else?

14. Have you read, seen or heard anything about NIM that you found particularly helpful in explaining the model (e.g. journal article, website, report?)

(Please check: Has the interviewee worked with the 0–5 age group before? Does s/he know of any 0–5 therapeutic services for under 5 year olds? Check for any information on areas with good provision.)

Interview schedule: Key stakeholders

1. Would you explain to me how you became aware of the NIM model and the work that NSPCC are doing to test it?

(Make sure these areas are addressed: key individuals involved at that stage; how processes were explained; your initial reactions to the proposal; others' initial reactions to the proposal; any contact with/information from (whom/which sources and how?))

2. What do you consider to be the key components of NIM and how these are being translated into practice locally?
3. When NIM was first explained to you, what did you understand to be:
 - a. the key aims (for organisation, children, birth parents, foster parents, etc);
 - b. key aspects of the NIM project?

4. What do you recall about the ways NIM was introduced into Croydon?

(Clarify timings and processes for each step.)

5. On a practical level, in your experience how do the NSPCC delivery team and local authority LAC team fit together?

(Prompt: meetings/informal contacts/coordination; location; priorities and any strategic objectives; overall – do the arrangements work? If not, how could they be improved?)

6. Have you read, seen or heard anything about NIM that you found particularly helpful in explaining the model (for example, journal article, website, report?)

7. Thinking back over how NIM has been introduced, are there things that:

- have been particularly helpful/gone well?
- have made the introduction more difficult?
- could have been better if done differently?

8. Which would you say are the *main* agencies involved with NIM? And what about any other agencies – can you tell me which they are and how they are involved?

(Explore: what is meant by 'involvement'; any systems in place to facilitate intra and inter agency work re NIM; ways in which involvement could be improved/broadened; any agencies/services that should be involved but are not at present and vice versa.)

9. You said that you thought the key aims and aspects were (...) Do you consider this reflects how things are at the moment? If not, how does it differ?
10. Up to this point, how has Croydon approached the question of permanency decisions – from the perspective of i) the local authority ii) the judiciary?
 - a) In what way(s), if any, do you think the introduction of NIM would represent an improvement?
 - b) Do you have any concerns about the introduction of NIM?
11. How, if at all, do you think NIM fits in with the government's plans for adoption reform – for example the move to regional adoption agencies?
12. How important is the evaluation to your decision making? Are you able to provide any examples of implementing evidence-based practice in Croydon's social care services (adult or children)?

Where appropriate ask:

Has it been suggested that an RCT will be conducted (explain using showcard) in relation to NIM?

(If YES or NO, ask why thinks will/will not be feasible?)

(Explore: the reasons for response; conditions that could make it hard to do such research; any implications for the continuation of NIM if an RCT is not conducted; views on alternative if an RCT not feasible/possible or practicable.)

(If YES or NO, ask why thinks will/will not be acceptable)

(Explore: the reasons for response; conditions that could challenge acceptability.)

If an RCT is conducted, some families not receiving NIM will be offered services as usual. What would this involve?

15. Looking for an explanation of what families have been offered pre-NIM and how, if at all, this would be different from a services as usual offer in the future – need to be clear about the components of services as usual.
16. Between now and the end of March 2016, what do you consider to be the key steps that need to be taken in relation to: the development of NIM? (and by whom); the development of a robust evaluation?

Interview schedule: Judges in Croydon Family Court

1. Can we start by asking you about the key problems and challenges with which you are faced in situations where permanency decisions are being made about looked after children?
2. How did you become aware of the LIFT initiative prior to its introduction? Were you involved in any negotiations prior to its being set up?
3. What were your views on the need for such a service at the time negotiations started? (Prompt for views on quality of assessments, delays in reports, local council procedures/policies)
4. In your opinion, what are the most important aspects of the model for you? How important is the quality and/or timeliness of the reports? How does access to advice and treatment for birth parents or foster carers compare with what is usually provided?
5. Have your views changed since the team has become operational? What are the reasons for this?
6. Can I just check about your expectations about the role played by children's social care in helping you reach decisions about permanency? What is the fit between mental health and social care? Is it important to you that the LIFT team is multidisciplinary?
7. How would you describe relationships between the judiciary and the local authority in relation to permanency decisions for children?
8. Do you have any experience of working with an authority where there is a similar service? Any similarities and differences between that (these) experiences and this model?
9. We know about the timescales introduced by PLO. How does LIFT fit with these? Is the time allowed to complete the assessment too long, too short or about right? Do you have any views on the balance between the assessment and intervention phases?
10. What, if anything, is going well with LIFT at the moment? Is anything in need of improvement? How does it compare with the 'usual service' children, birth parents and foster carers might receive?
11. In the long term, do you see this as a service that could be available to all parents, or should it be offered to a select group? If so, how should these parents be selected?

12. What do you think would be the best method to evaluate a service such as this?
(Views on RCT or comparison within Croydon or in Croydon plus another local authority?)

Appendix C: Informants contributing to the qualitative evaluation

Interviewee	Role
Jenni Ashmead	GIFT Consultant Psychiatrist
Her Honour Judge Atkinson	Designated family judge for the East London Family Court
Nick Axford	Senior Researcher and Head of What Works at the Dartington Social Research Unit
Robin Balbernie	Clinical Director, Parent Infant Partnership UK
Chantelle Barker	Duncan Lewis Solicitors, Croydon
Jane Barlow	Professor of Public Health, University of Warwick
Nina Biehal	Professor of Social Work, Department of Social Policy and Social Work, University of York
Johnny Boorman	LIFT Principal Clinical Psychologist
Kevin Brown	FACS Service Manager
Richard Church	Consultant Psychiatrist and CAMHS lead for Lambeth
Melanie Claxton	LIFT Clinical Psychologist
Jessica Colaiaco	LIFT Team Manager
Lee Cormack	Senior Solicitor, Glasgow Council
Nicola Cosgrave	LIFT Consultant Clinical Psychologist
Richard Cotmore	Head of Evaluation, NSPCC
Nicholas Crichton	Resident District Judge at the Inner London Family Proceedings Court from April 1997 until 2014.
Jessica Cundy	Development Manager Programme Manager
Julia Donaldson	GIFT Consultant Clinical Psychologist
Aileen Downey	Circuit Judge, South Eastern Circuit, based at Croydon County Court
Helen Entwistle	LIFT Social Worker
Jude Eyre	Senior Strategy Analyst at NSPCC.
Matt Forde	Head of National Services, NSPCC Scotland
Rachel Green	Case Progression Care Proceedings Manager, Croydon
Brian Jacobs	LIFT Consultant Psychiatrist

Interviewee	Role
Karen Lacey	Croydon Drop In
Ian Lewis	Director of Children's Services, Croydon
Ian Luke-Macauley	Senior Service Manager, Cafcass
Debbie MacCormack	Strategic Manager, Early Intervention and Family Support Service, Croydon
Lynn McMahon	Senior Project Manager, Mental Health and Wellbeing, University of Glasgow
Kathryn Major	District Judge, South Eastern Circuit, based at Croydon County Court
Sherry Malik	Director of Children's Services, NSPCC
Judith Masson	Professor of Socio-Legal Studies, University of Bristol
Julia Mayes	Programme Manager, NSPCC
Susanne Miller	Chief Social Work Officer, Glasgow
Helen Minnis	Professor of Child and Adolescent Psychiatry, University of Glasgow
Louise Nankivell	LIFT Clinical Psychologist
Barry O'Sullivan	LIFT Social Worker
Maria Orme	Solicitor, Atkins Hope Solicitors
Laura Porter	Clan Child Law Ltd
Siobhan Pritchard	Duncan Lewis Solicitors, Croydon
Anna Rickards	Head of Practice and Learning, Pause
Petrina Roberts	Duncan Lewis Solicitors, Croydon
Kelly Rodd	Solicitor, Atkins Hope Solicitors
Liana Sanzone	LIFT Social Worker
Sue Schofield	NSPCC Service Manager Croydon
Helen Thomson	Children's Guardian, Cafcass
Hugh Thornbery	Chief Executive, Adoption UK
Alison Timpson	FACS Social Worker
Wendy Tomlinson	LAC Service Delivery Manager, Croydon

Interviewee	Role
David Torgerson	Director of the York Trials Unit, University of York
Emily Waddington	LIFT Family Liaison Worker
Karen Walker	Duncan Lewis Solicitors, Croydon
Harriet Ward	Professor of Child and Family Research - Research Professor, University of Loughborough
Karen Ward	Children's Development Manager, Croydon
Charles Zeanah	Sellars-Polchow Professor of Psychiatry and Professor of Clinical Pediatrics, and Vice-Chair for Child and Adolescent Psychiatry, Tulane University

Appendix D: The process in Scotland

Once a child protection order (CPO) is granted, the grounds for referral are drawn up and put to the parents at a children's hearing on the eighth working day CPO. The CPO comes to an end at this children's hearing. The children's hearing can grant an interim compulsory supervision order at this time, which can secure a child in a place of safety.

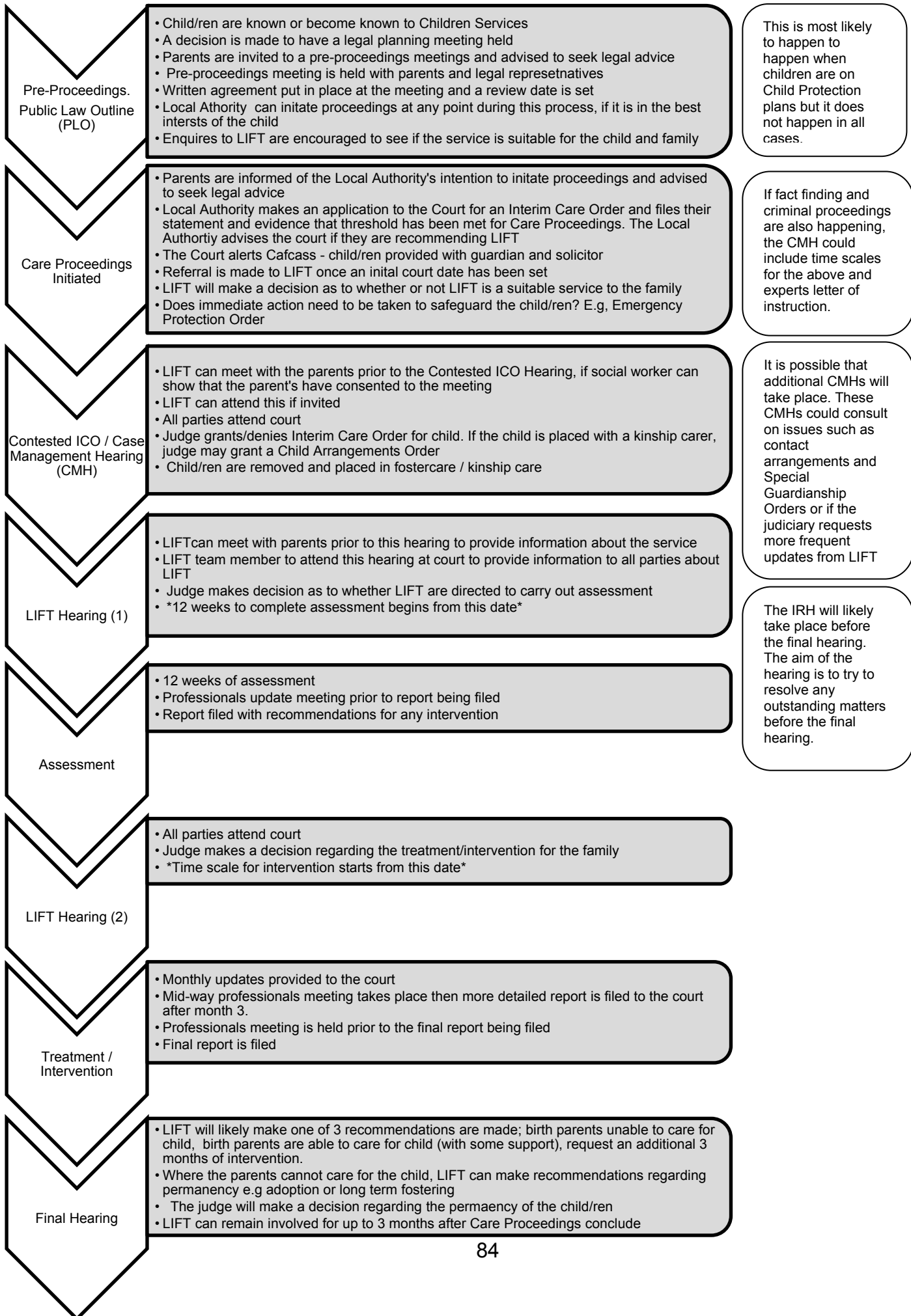
If there is no CPO, but only a referral to the children's hearing, the grounds for referral are drawn up and put to the parents. With a CPO in place everything is done much faster, but the steps are the same. The children's hearing can grant an interim compulsory supervision order at this time, which can secure a child in a place of safety.

If the grounds are denied, or not understood, then they are sent to the sheriff for proof. The sheriff will hear evidence and will decide if the grounds for referral are established. If no grounds are established, the matter ends there and then. If there are grounds established, then the matter is sent back to the children's hearing to decide whether there should be a compulsory supervision order put in place.

The only role of the sheriff at this stage is to decide whether there is enough evidence to decide whether grounds are established. The sheriff can later be called upon, if individual decisions of the children's hearing are appealed. When dealing with the appeal, the sheriff can send it back to the children's hearing for disposal, or can substitute his or her own decision in.

The children's hearing does not have the power to compel a parent through a compulsory supervision order. Measures attached to these orders can only compel the child to do something or can require the implementing authority to do something. This is different from the judicial power that a sheriff or judge can wield.

Appendix E: Legal flow chart





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