



# Evaluation of **FAMILY DRUG AND ALCOHOL COURTS**

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What Works Centre for Children & Families

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# ABBREVIATIONS & ACRONYMS

|         |  |
|---------|--|
| ATT     | Average Treatment Effect on the Treated            |
| CAFCASS | Children Family Court Advisory and Support Service |
| CEM     | Coarsened Exact Matching                           |
| CI      | Confidence Interval                                |
| CIN     | Children in Need                                   |
| CJI     | Centre for Justice Innovation                      |
| DfE     | Department for Education                           |
| FDAC    | Family Drugs and Alcohol Court                     |
| ICC     | Intra-cluster Correlation                          |
| IE      | Impact Evaluation                                  |
| IPE     | Implementation and Process Evaluation              |
| LA      | Local Authority                                    |
| MDES    | Minimum Detectable Effect Size                     |
| NatCen  | The National Centre for Social Research            |
| PLO     | Public Law Outline                                 |
| RRR     | Relative Risk Ratio                                |
| RQ      | Research Question                                  |
| QED     | Quasi-Experimental Design                          |
| SATT    | Sample Average Treatment Effect on the Treated     |
| WWCSC   | What Works for Children's Social Care              |





# EXECUTIVE SUMMARY

# Introduction to the study

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

Previous research on the FDAC approach to care proceedings showed some promising results. Harwin et al.’s (2011) independent evaluation found that FDAC care proceedings are more likely than standard care proceedings to help parents stop misusing alcohol and substances and be reunified with their children. The follow-up evidence indicated that the achieved positive outcomes were sustained over time (Harwin et al., 2014; Harwin et al., 2016).

There are, however, a number of limitations in the existing evidence on FDAC’s effectiveness. Most of the evidence comes from the Harwin et al.’s (2011, 2014, 2016) evaluation that ran from 2008 and 2012, prior to the introduction of the Children and Families Act 2014,<sup>1</sup> which significantly altered how standard care proceedings operate (CJI, 2021). Their evaluation focused only on the London FDAC, the first to be set up. As FDAC has since been rolled out more widely to include 15 specialist FDAC teams, working in 22 courts and serving families in 36 local authorities, it is important to understand and assess whether the promising findings from London are observed in other areas of England.

This evaluation was commissioned to assess and understand the impact of FDAC using a counterfactual group, and to assess how FDAC has been implemented to date in England. The evaluation was commissioned by WWCS and was part of the Department for Education’s Supporting Families: Investing in Practice programme.

## Objectives of the study

The evaluation comprised two strands:

- An **impact evaluation** (IE), which aimed to quantify the impact of FDAC proceedings on reunification for children and families at the end of care proceedings compared to standard care proceedings (this was the primary outcome). The evaluation also aimed to test if parents who had been through the FDAC process as opposed to standard care proceedings were more likely to stop misusing substances (one of the secondary outcomes we assessed). It also investigated if there were any differences in the rate of contested final hearings (where it was not possible to reach an agreement between

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<sup>1</sup> See <https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

the caregiver and courts on what should happen) or the use of expert witnesses in proceedings (both of these were also secondary outcomes).

- An **implementation and process evaluation** (IPE), which aimed to assess a number of dimensions relating to how FDAC has been implemented and delivered, including participant experiences of delivering and receiving support through FDAC; variations in delivery across different FDACs, including facilitators and barriers to delivery and drivers of success; and comparisons between delivery of FDAC and standard care proceedings.

## Study design and sample

The initial plan was to assess the impact of FDAC using a randomised controlled trial (RCT). However, it was agreed by all parties that an RCT was not feasible in this context as the judiciary, the Department for Education and local FDAC teams highlighted the legal obstacles of randomly allocating families to different legal processes.<sup>2</sup> This meant the impact of FDAC was assessed through a quasi-experimental design (QED), using coarsened exact matching to generate a matched comparison group. It compared data on families in FDAC care proceedings drawn from 13 FDAC sites with similar families in standard care proceeding. Information from nine different local authorities (LAs) was used to construct the control groups. All these LAs have FDAC care proceedings operated within the area, except for Manchester (see the section on [Participant Selection](#) for details). In all cases (both FDAC and standard care proceedings), parental substance misuse was the key factor in the application for care proceedings.

IPE findings are based on 40 interviews that were undertaken with a broad range of stakeholders, including leads, support staff, members of the judiciary and parents from FDAC; as well as leads and members of the judiciary from non-FDACs. The interviews were completed across six FDAC sites with diversity across key characteristics (operational timeframe, caseload, number of local authorities served, geographic setting and types of cases) and four non-FDACs with the aim to enable comparisons to be drawn.

The cost analysis estimated the delivery costs of FDAC based on information provided by seven out of the 13 sites that were asked to supply cost data. It estimated the average annual cost per child by dividing the total annual costs by the number of children with primary carers who go through FDAC care proceedings.

The IPE fieldwork was completed from August to October 2021, while the cost evaluation and IE were finalised in December 2022.

## Results from the IE

It proved challenging to generate robust impact estimates with the available data. We were able to match on child and primary carer demographics, primary carer experiences of domestic abuse and their current misuse of drugs or alcohol. However, due to challenges

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<sup>2</sup> The most notable obstacle was the potential for non-FDAC families to appeal the outcomes of their case. Another obstacle was that families could legally challenge the random assignment process.



obtaining data, it was not possible to match on the following covariates that we know are very likely to be important: primary carer's mental health diagnoses, their severity of drug and alcohol misuse, and their stated motivation to abstain from alcohol and drug use. It is important to interpret the evaluation's results in this context and therefore to exercise caution when drawing conclusions about the causal impact of FDAC.

Bearing in mind the caveats noted above, the findings from this evaluation were indicative of positive (statistically significant) effects of FDAC on the outcomes of interest. We found:

- Children with a primary carer in FDAC care proceedings were more likely to be reunified with their primary carer at the end of the care proceeding in comparison to children with a primary carer in non-FDAC care proceedings (52.0% versus 12.5%).
- A higher proportion of FDAC than comparison parents had ceased to misuse drugs or alcohol by the end of the proceedings (33.6% versus 8.1%).
- The proportion of hearings being contested was lower for FDAC than standard care proceedings (4.2% versus 23.8%).
- A lower proportion of FDAC cases used external expert witness assessments compared with non-FDAC care proceedings (7.7% versus 96.1%).
- Children in FDAC sites had lower probability of being placed in LA care compared with non-FDAC care proceedings (28.6% versus 54.7%).

The positive outcomes for cases supported by FDAC is in line with the evidence on FDAC in the WWCS's Evidence Store and the literature base (e.g. Harwin et al., 2016; Zhang et al., 2019).

## Findings from the IPE

Overall, there was a strong sense that FDAC was meeting IPE participants' expectations. Comparing FDAC with the process for standard care proceedings, participants highlighted three inter-related benefits:

- A perception that FDAC was a more supportive process for parents, allowing them to demonstrate their ability to meet their child's needs – rather than feeling like a punitive process, participants spoke of FDAC feeling supportive at a crisis point helping them sustain chances that could lead to successful reunification outcomes.
- A perception that FDAC led to better outcomes – including reductions in drug/alcohol use, higher rates of reunification, increased insight and parenting skills (including for parents who were not ready for reunification at the end of proceedings), and lower rates of contested cases.
- A perception that FDAC achieved long-term cost savings – participants acknowledged that FDAC required investment upfront to provide intensive, wraparound support and supervision to parents, but felt it achieved savings later on.

Funding and resources allocated to FDACs were considered crucial to delivering the intensive package of support and court supervision, which in turn gave parents an opportunity to work on their health and personal development to achieve greater stability to care for their children.

Two key facilitators of perceived positive outcomes for families were:

1. The package of high-intensity, wraparound, multidisciplinary support FDAC provided: flexibly tailored for each individual, and coordinated by key workers, with whom parents can develop a trusted relationship.
2. The FDAC judges' role: leading and providing active oversight to the whole process; and having direct contact with parents, encouraging them to make and sustain changes.

Participants also identified challenges with implementing and delivering FDAC.

Challenges included some staff in multidisciplinary teams feeling like their views were not always heard; a perception among some staff that some FDACs lacked independence from local authorities; challenges around accessing some forms of support; and delays caused by COVID-19.

For example, some staff felt it was difficult to make their views heard where their discipline was a minority in a multiagency team.

## Results from the cost evaluation

Cost information is not collected consistently across FDAC sites, which meant there was large variation in the amount and types of costs reported across the FDAC sites. It was not possible to make meaningful comparisons between sites and we have low confidence in the average cost estimates generated.

## Research implications

The findings from the evaluation showed evidence that FDAC care proceedings have improved outcomes for children and families. This is in line with other research findings on FDACs.

While the evaluation is comprehensive and marks an important addition to the literature supporting a positive impact of FDAC on the intended outcomes, we acknowledge a number of limitations that should be addressed in future evaluations. It is crucial to:

- Improve data availability on the characteristics that are considered important for selection into FDAC (e.g. mental health diagnosis, severity of drug/alcohol misuse, stated motivation to reduce drug/alcohol misuse). This will greatly improve the impact evaluation design.
- Improve our understanding of the long-term outcomes of FDAC as this evaluation only captured the immediate effect of FDAC. A future follow-up analysis using similar impact evaluation design to the present study (i.e. with a matched comparison group) should be taken to explore the long-term impact of FDAC on the outcomes analysed in this evaluation. This would contribute to the small literature base which is suggestive of longer-term benefits of FDAC (Harwin et al., 2016).
- Robustly assess the economic value of FDAC, including assessment of the benefits of the achieved FDAC impacts.



# INTRODUCTION



# Project background

Family Drug and Alcohol Courts (FDACs) offer an alternative to standard care proceedings involving parental drug or alcohol misuse, using a “problem-solving” approach to justice to support parents to reduce their misuse issues.<sup>3</sup> The first UK FDAC was set up in London in 2008 as a three-year pilot funded by central government. Since then, the model has grown and, at the time of publication, there are 15 FDACs serving 36 local authorities in the UK.

The primary aim of FDAC is to improve outcomes for children and families, ensuring that children can either live safely with parents at the end of care proceedings or, where reunification is not possible, have the best chance for permanency and stability outside the family home. FDAC aims to stop parents from misusing alcohol and drugs, make the home environment safer, and reduce the risk of families entering care proceedings again in the future.

FDACs use a “problem-solving” approach to justice, whereby courts use their authority to help address the complex social issues that bring people before them (Harwin & Ryan, 2008; Roberts et al., 2017). FDACs seek to encourage parents to believe recovery and change are possible, and differ from standard care proceedings processes in providing the following support to families:

- Specially trained judges provide parents with regular supervision and support at fortnightly court reviews, which lawyers do not attend. These “non-lawyer reviews” are intended to facilitate judicial oversight of cases and effective working relationships between parents, judges and the team, allowing judges to develop better understanding of families’ needs and progress throughout proceedings.
- A specialist multidisciplinary team works closely with the courts and parents to provide intensive support to change and overcome their alcohol and drug misuse problems and other difficulties, such as underlying mental health issues or trauma from domestic abuse. Support is coordinated by dedicated key workers and might involve individual or group therapy, skills development, and referrals to appropriate treatment.

Though the FDAC model is similar across courts, there are some differences in implementation and delivery. For example, some sites provide pre-proceedings or post-proceedings support,<sup>4</sup> and some offer peer mentoring, where parents who have been through care proceedings and maintained their recovery support others through the FDAC process. Staffing also varies across sites; however, the core structure includes

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3 Care Proceedings are court proceedings which takes place where an application is made for a care order or supervision order in respect of a child (section 31 Children Act 1989). A local authority or authorised person may make the application to the court for the order, which would place the child in the care of a designated local authority. A court may only make a care or supervision order if it is satisfied that the child concerned is suffering, or is likely to suffer, significant harm; and that the harm, or likelihood of harm, is attributable to the care given to the child, or likely to be given to him if the order were not made, or the child being beyond parental control (section 31 Children Act 1989). It can take up to 26 weeks for a court to decide what should happen to the child and some complex cases can take longer.

4 Pre-proceedings support occurs prior to the local authority initiating care proceedings, in an attempt to avoid going to court. The structure for pre-proceedings FDAC support is similar to standard FDAC support. Post-proceedings support follows the final hearing after going through the FDAC process and may include a Supervision Order, ongoing support and treatment services, and substance testing.

substance misuse specialists, social workers, mental health specialists and a site lead. An overview of the delivery model is provided and discussed in detail in the [FDAC delivery](#) section of the IPE findings presented later in this report.

Since FDAC was first piloted, the Department for Education (DfE) has invested in increasing the number of FDACs across England. According to the Centre for Justice Innovation (CJI, 2022), 170 cases were completed in 2021/2022, involving 221 parents and 256 children.

## Previous evaluations

### FDAC evaluations in the UK

Early evidence about the effectiveness of FDAC showed that FDAC is a promising approach to helping parents overcome problems related to substance misuse. For example, Harwin et al. (2014) found that FDAC parents were more likely to stop misusing alcohol and substances by the end of proceedings and more likely to be reunified with their children relative to a parent in standard care proceedings. In a follow-up analysis, it was established that a higher proportion of mothers in FDAC continued to abstain from drugs or alcohol five years on, relative to comparison mothers. It also found that a significantly higher proportion of FDAC mothers than comparison mothers who had been reunified with their children at the end of proceedings experienced no disruption to family stability at a three-year follow-up (Harwin et al., 2016; Harwin et al., 2018).

Tunnard et al. (2016) undertook observations of hearings in FDAC courts and interviews with judges with the aim of understanding how the FDAC problem-solving approach is being implemented across new and longer-standing sites. The study found that FDACs are being rolled out successfully beyond the original London site, and that adherence to the practice and principles of FDAC's distinctive problem-solving approach is at the heart of what happens in court. Judges reported that positive outcomes such as increased likelihood of reunification, substance misuse cessation, and decreased likelihood of future child neglect and abuse, were due to the holistic approach taken by FDACs to provide wraparound support.

### International interventions on family courts

Two relevant systematic reviews of FDAC-like interventions in the United States found that Family Drug Treatment Courts (FDTCS) positively influence the likelihood that children are reunified with their families at the end of care proceedings (Ogbonnaya & Keeney, 2018; Zhang et al., 2019). Most of the studies included in their review used a quasi-experimental design by comparing families that received the intervention to a matched comparison group – a design similar to this evaluation. Consistent with prior literature that has highlighted the need to view reunification as an ongoing, long-term process (Harwin et al., 2018), most of the studies included an intervention focused on reunification as the primary outcome.



## Implications from previous evaluations

The existing body of evaluation studies on the impact of family courts interventions has yielded positive findings on family reunification (Zhang's et. al., 2019). Yet several international studies point out the difficulties of sustaining positive change for parents who struggle with problems related to substance misuse (Ogbonnaya & Keeney, 2018). Additionally, the existing evidence base on FDAC in England is limited. Much of the previous UK research focuses on the pan-London FDAC, the first site to be set up. The results from the London FDAC evaluation were promising but it is important to test if these results apply to the later expansion areas. There is also limited evidence about variation in effectiveness of FDAC across case types, including in relation to racial disparities and the experiences of fathers. The Centre for Justice Innovation conducted a review on FDACs' cost-effectiveness relative to non-FDAC care proceedings (CJI, 2021). Their findings showed that FDAC is a significantly less expensive way of hearing care proceedings than the standard approach. They argue that by avoiding lengthy legal disputes, FDAC provides local authorities and the Legal Aid Agency significant costs in relation to care proceedings.

Given the evidence gaps and the promising findings of earlier research, WWCSO commissioned NatCen to undertake a comprehensive evaluation of FDAC. The research design, described in detail in the following sections, was developed through an initial feasibility study. Key outputs of this were the FDAC logic model, provided in [Appendix A](#), and the theory of change, provided in [Appendix B](#).

## Overall design and research aims

The aim of this evaluation was to assess the overall effectiveness of FDAC across sites, exploring the implementation, delivery and impact of FDAC to date. The evaluation consisted of two strands: an impact evaluation (IE) assessing the impact of FDAC on child reunification, parental substance misuse, and other factors in comparison to standard care proceedings; and a qualitative implementation and process evaluation (IPE), which considered key facilitators and barriers to the implementation and delivery of FDAC, and the experiences of different groups.

The IE aimed to assess and understand:

- Whether children going through FDAC are more likely to become reunified with their parents at the end of care proceedings relative to children in non-FDAC care proceedings
- Whether parents going through FDAC are less likely to continue misusing alcohol or drugs by the end of care proceedings relative to parents in non-FDAC care proceedings
- Whether FDAC cases are more likely to be contested relative to non-FDAC care proceedings
- Whether expert witnesses are more likely to be consulted during FDAC relative to non-FDAC care proceedings.

There was initially a further research question to assess and understand the proportion of children reunified at the end of FDAC care proceedings that are still placed with their parent(s) three years after final court hearing, compared with the national average, which was removed during the project due to concerns that it wouldn't provide clear results.

The IPE aimed to understand and assess the following dimensions:

- FDAC delivery (including fidelity, reach and dosage) – how the programme has been implemented and delivered, whether and how it was delivered to the intended population, and the extent of support and contact this group received
- Quality of delivery – participant experiences of delivering and receiving support through FDAC
- Variations in FDAC delivery – a comparison of implementation and delivery issues across different FDACs, to understand facilitators and barriers, drivers of success and help to draw out learning
- Participant responsiveness – engagement with the FDAC aims, court proceedings, treatment services and other activities
- Ability to differentiate the programme from standard care proceedings – how implementation and delivery experiences differ from standard care proceedings.

## Ethical governance

NatCen's Research Ethics Committee granted approval for the IPE in December 2020. Approval from the Judicial Office to conduct interviews with judges and magistrates was granted in August 2021, with relevant District Family Judges formally notified prior to the start of any fieldwork.

## Study registration

The evaluation has been registered on the OSF platform and can be accessed at <https://osf.io/w7zac>.

## Data protection

Data Sharing Agreements were signed by the WWCS, CJI, NatCen, local authorities and FDAC sites, which set out the terms and conditions of accessing, managing and processing personal data.



# RESEARCH QUESTIONS

# Research questions

The IE sought to answer the following research questions (RQs):

- **RQ1** What is the impact of FDAC on the likelihood that children are reunified with their parents at the end of care proceedings relative to non-FDAC care proceedings as usual?
- **RQ2** What is the impact of FDAC on the likelihood that parents continue to misuse alcohol or drugs by the end of care proceedings relative to non-FDAC care proceedings as usual?
- **RQ3** What proportion of children reunified at the end of FDAC care proceedings are still placed with their parent(s) three years after final court hearing and how does this compare with the national average?
- **RQ4** What is the impact of FDAC on the likelihood of final care proceedings hearings being contested relative to non-FDAC care proceedings as usual?
- **RQ5** What is the impact of FDAC on the likelihood of expert witnesses being consulted during care proceedings relative to non-FDAC care proceedings as usual?
- **RQ6** What is the impact of FDAC on the placement of the child at the end of care proceedings relative to non-FDAC care proceedings as usual?

The IPE did not set out specific RQs. See the section on [Overall design and research aims](#) for the IPE's main aims.





# METHODS



In the following sections we outline the IE design, the approach we undertook to construct the treatment and control groups, we also describe in detail the outcomes of interest, the data sources, the sample size calculations, our approach to data management and our approach to the analysis.

Finally, we outline the IPE design and our approach to the cost evaluation.

## Impact Evaluation design

NatCen was originally commissioned to undertake a randomised controlled trial (RCT) to understand the effectiveness of FDAC. However, it was agreed by all parties that an RCT was not feasible in this context as the judiciary, the Department for Education and local FDAC teams highlighted the legal obstacles to randomly allocating families to different legal processes.<sup>5</sup>

WWCSC therefore asked NatCen to explore the feasibility of a difference-in-differences (DD) or alternative quasi-experimental design (QED), to estimate the effectiveness of FDAC. As a result of this work, it was decided to apply a QED, using coarsened exact matching (CEM) (Iacus et al., 2009) to control for selection to FDAC. CEM is a form of stratum matching that involves creating different bins by coarsening important covariates and then it performs exact matching on children/parents/cases in FDAC care proceedings (i.e. intervention group) with similar comparators in non-FDAC care proceedings (i.e. control group). Using matching techniques, we can control for important confounders that might otherwise result in unobserved confounding and lead to a biased estimate of the intervention effect on the important outcomes (see the section on [Matching](#) for details on CEM). However, matching can only control for observed characteristics. Selection bias associated with unobserved characteristics (such as parents' motivation to abstain from drug and alcohol use, or subjective decision-making by staff recruiting parents to FDAC) cannot be controlled for in this model. Furthermore, to implement CEM, we require data on the characteristics of parents and children in care proceedings cases that are likely to be associated with the outcome or selection into FDAC. Some characteristics that are considered important (e.g. severity of substance misuse) could not be taken into account due to data limitations (see the section on [Limitations related to the IPE](#) for more information).

[Table 3.1](#) presents the study design for the impact evaluation, including primary and secondary outcomes and measures used. The primary outcome – reunification – was defined as the legal order given for the child to return to live with the primary carer, derived from the placement of the child at the end of care proceedings. Details on outcome measures are included in relevant sections of this report.

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<sup>5</sup> Such as the potential for non-FDAC families to appeal the outcomes of their case.

Table 3.1. Study design

|                                      |                                     |   |
|--------------------------------------|-------------------------------------|---|
| <b>Study type and number of arms</b> |                                     | Quasi-experimental design: Coarsened exact matching   |
| <b>Unit of identification</b>        |                                     | Case, parent, and child   |
| <b>Matching variables</b>            |                                     | Parent demographics, Domestic violence, Alcohol or drug misuse, Child demographics, Case characteristics (see <a href="#">Table 3.6</a> ).  |
| <b>Primary outcome</b>               | <b>Variable</b>                     | Reunification (RQ1).  |
|                                      | <b>Measure (instrument, scale)</b>  | Binary indicator of whether the child is reunified with the primary carer. Derived from the FDAC site data collection tool (treatment group) or LA case management systems and case notes (control group).  |
| <b>Secondary outcomes</b>            | <b>Variables</b>                    | <ol style="list-style-type: none"> <li>1. Alcohol and drug misuse cessation (RQ2)</li> <li>2. Contested final hearing (RQ4)</li> <li>3. Use of expert witnesses (RQ5)</li> <li>4. Placement of the child (RQ6).</li> </ol>  |
|                                      | <b>Measures (instrument, scale)</b> | <p>Derived from the FDAC site data collection tool (treatment group) and LA case management systems and case notes (control group), including:</p> <ol style="list-style-type: none"> <li>1. Binary indicator of whether the parent's alcohol and/or drug misuse has ceased, derived from the parent's misuse records at the start/end of care proceedings.</li> <li>2. Binary indicator of whether the final hearing was contested.</li> <li>3. The use of expert witness derived from the use of specific expert witness: <ol style="list-style-type: none"> <li>a. Binary indicator of whether expert witnesses were used during care proceedings</li> <li>b. Count of the number of different types of expert witness.</li> </ol> </li> <li>4. Categorical indicator of whether the child is placed with their parents, living with another relative or in LA care at the end of the care proceedings, derived from the placement of the child at the end of care proceedings.</li> </ol> |

Note: The analysis of the effect of FDAC on long-term unification (RQ3) will be undertaken in summer 2023 and will be published in a separate addendum report.

# Participant selection

## Eligibility to FDAC (intervention group) and non-FDAC (control group)

Eligibility for study inclusion was defined as the following:

**FDAC group** (Intervention) – all cases that have been referred to an FDAC that were open between October 2019 and June 2022 and where a final hearing took place by October 2022 were considered eligible for inclusion in the study.

**Non-FDAC group** (Control) – any case that met the basic criteria for an FDAC referral and sits within an area covered by a local authority (LA) that has an FDAC but received non-FDAC care proceedings. The basic criteria for inclusion in FDAC are that care proceedings were issued and that there were concerns about parental alcohol or drug misuse as part of the care proceedings case. Note that Manchester was the only LA that provided data on non-FDAC care proceedings without an operating FDAC site in the area.<sup>6</sup> Details on the reasons for expanding the non-FDAC data collection to the Manchester LA is covered in the following section. Overall, to be eligible the non-FDAC case had to be open between October 2019 and June 2022 and have a final hearing take place by October 2022. Please see the [IPE](#) section for details on what non-FDC care proceedings look like.

As mentioned, the basic criterion for FDAC referral is that parental substance misuse (drugs or alcohol or both) is a key factor in the local authority's concerns about child(ren) within a care proceedings case. However, it is noted that the way cases were assigned (FDAC vs care proceedings as usual) varied between FDAC sites. Some FDAC sites have developed their own referral inclusion and exclusion criteria; however, the variation between sites has never been closely documented. There is therefore likely to be a degree of selection bias, with systematic differences between control and treatment participants. Please see the [FDAC protocol](#) (see the section on FDAC protocol – participants) for details on the variation between FDAC sites.

## Study sites

Participants for whom data was analysed as part of the impact evaluation were drawn from 13 FDAC sites (for the intervention group) and from nine LAs (for the control group). [Table 3.2](#) presents a full list of considered data sources by FDAC site and LA and the actual data sources used for the final analysis of the impact evaluation.

It should be stated here that the initial plan (see [FDAC protocol](#)) was to cover all 14 FDAC sites and the 31 LAs which were able to refer families into FDACs.<sup>7</sup> However, due to difficulties such as the COVID-19 pandemic and LAs resource constraints, we were only able to collect non-FDAC data from 12 LAs.<sup>8</sup> From these 12 LAs, only nine managed to provide us with the required outcome measure data for the impact analysis.

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<sup>6</sup> This decision was agreed in discussions with the client to include information from Manchester in the evaluation.

<sup>7</sup> Currently there are 15 FDAC teams serving families in 36 LAs (see <https://fdac.org.uk/current-fdacs/>). The discrepancy between the current sites and the original plan (i.e. 14 FDAC sites and 31 LAs) included: Cardiff and the Vale (launched in December 2021) and Wiltshire (launched in June 2022) and Somerset FDAC being closed.

<sup>8</sup> Data on non-FDAC cases came from LAs. Additional LAs were contacted to see if they could provide data for this evaluation because some LAs that were served by FDACs were not able to provide data. Manchester was the only LA that provided data on non-FDAC care proceedings without an operating FDAC site in the area. Please see the study protocol for details.

Further, one FDAC site did not manage to provide us with data within the timeframe of this evaluation, i.e. pan-London. We acknowledge that not including London sites in the final analysis has implications as these sites were the first FDAC sites in England and one of the largest. We made considerable efforts to request and obtain complete data from London. However, due to resource constraints within the London FDAC team, the provision of quality data was not feasible within the timeframe of this evaluation. It is noted that, with the limited London FDAC data we had available, we assessed the level of reunification (i.e. the primary outcome as defined later in the Primary outcome section) and found no significant differences between the London FDAC and other FDAC site samples.<sup>9</sup> The comparison of key variables between London and other FDAC sites is presented in [Appendix C](#).

We also acknowledge that not including information from all originally planned 31 eligible LAs in the control group could introduce a possible selection bias. To deal with imbalance between the intervention and control group we accounted for important characteristics that may influence the outcome. We also used multilevel modelling to account for between-site variation in outcomes. More details on matching and modelling are provided in the [Impact evaluation analysis](#) section.

**Table 3.2. FDAC sites and local authorities contacted for the IE and those which supplied data for IE**

| FDAC site (intervention group) | Local authority (control group) |
|--------------------------------|---------------------------------|
| Pan-Bedfordshire*              | Central Bedfordshire*           |
|                                | Luton                           |
|                                | Bedford                         |
| Birmingham and Solihull*       | Birmingham City*                |
|                                | Solihull                        |
| Coventry and Warwickshire*     | Coventry*                       |
|                                | Warwickshire*                   |
| East Sussex*                   | East Sussex                     |
| Gloucestershire*               | Gloucestershire                 |
| Kent*                          | Kent*                           |
| Leeds*                         | Leeds City Council              |

<sup>9</sup> The average reunification rate is 47% among other FDAC sites (n = 352) vs 55% in pan-London FDAC site (n = 65); p = 0.237; Effect Size (Hedge's g) = -0.16, 95% CI = [-0.42, 0.10].

| FDAC site (intervention group)                    | Local authority (control group)  |
|---|----------------------------------|
| London  | Bromley                          |
|   | Camden                           |
|   | Croydon                          |
|   | Kingston                         |
|   | Lambeth                          |
|   | Merton                           |
|   | Redbridge                        |
|   | Richmond                         |
|   | Sutton                           |
|   | Wandsworth                       |
| <b>Milton Keynes and Buckinghamshire*</b>         | Milton Keynes                    |
|   | Buckinghamshire                  |
| <b>Newcastle, Gateshead &amp; North Tyneside*</b> | Newcastle                        |
|   | Gateshead                        |
|   | North Tyneside                   |
| <b>Somerset*</b>                                  | Somerset                         |
| <b>Southampton*</b>                               | <b>Southampton City Council*</b> |
| <b>Stockport*</b>                                 | <b>Stockport*</b>                |
| <b>Walsall, Sandwell and Dudley*</b>              | Sandwell                         |
|   | Dudley                           |
|   | <b>Walsall*</b>                  |
| Not operating FDAC site                           | <b>Manchester*</b>               |

Note: text in bold (\*) indicates the data source used for impact evaluation.

## Outcome measures

### Primary outcome

The primary outcome of interest was a binary indicator of reunification immediately at the end of care proceedings (**RQ1**). It is noted that the primary outcome refers to short-term reunification while details on long-term reunification can be found below (in the section on **Further outcomes not analysed**). Reunification was defined as the legal order given for the child to return to live with the primary carer. Reunification was not achieved if the legal order given for the child was to live with another parent or family member who had not been the primary carer at the start of proceedings.



## Secondary outcomes

In addition to the primary outcome, three other secondary outcomes were captured as part of this study:

- First, parental alcohol and drug misuse cessation (RQ2): was defined as a binary indicator of whether the parent or primary carer stopped misusing drugs and/or alcohol at the end of care proceedings. Cessation was coded as one when an individual was misusing at the start of care proceedings but no longer misusing at the end of care proceedings, whereas zero indicates their continued misuse at the end of care proceedings. The parent must have had substance misuse issues at the start of care proceedings to be included in the analysis.
- Second, contested final hearing (RQ4): was defined as a binary indicator of whether the final hearing was contested, (i.e. not reaching agreement on what should happen), regardless of which party contested the hearing (where one indicates that the final hearing was contested and zero otherwise).
- Third, use of external expert witness during care proceedings (RQ5): was assessed using two different indicators:
  - First, based on a binary indicator where one indicates that there was at least one type of expert report/assessment being ordered during care proceedings and zero indicates that there was no expert report/assessment involved. The reports/assessments should be carried out by external experts, including psychological assessment, psychiatric assessment, non-residential parenting assessment, residential parenting assessment, independent social work assessment, forensic risk assessment, child's needs assessment, paediatric report and cognitive functioning assessment.
  - Alternatively, we looked at the count of the use of external expert witnesses during care proceedings. This indicator was defined as the number of different types of expert witnesses (i.e. reports/assessments) being consulted during care proceedings. It was constructed as a count variable based on the binary expert assessments variables drawn from the data collection templates (e.g. cognitive functioning assessment, psychiatric assessment, independent social work assessment).

## Additional outcome on child placement

As already mentioned, the primary aim of FDAC is to improve outcomes for children and families, ensuring that children can either live safely with parents at the end of care proceedings or, where reunification is not possible, have the best chance for permanency and stability outside the family home. In this sense, we conducted an additional analysis in relation to the placement of the child (RQ6). We constructed a categorical outcome variable that indicated whether the child is placed with their parents, living with another relative or in LA care at the end of the care proceedings, rather than as a strict binary outcome indicating whether cases resulted in reunification or not.

## Further outcomes not analysed

RQ3 was aimed at assessing and understanding the proportion of children reunified at the end of FDAC care proceedings that are still placed with their parent(s) three years after final court hearing, compared with the national average. This analysis required data obtained from the Children and Family Court Advisory and Support Service (Cafcass) and was meant to be published separately to the main report, later in 2023. Following a project review in Spring 2023, the decision was taken not to proceed with this follow-up analysis given that the outputs from this RQ would have been unlikely to generate clear or useful outputs, due to the fact that there was no plan to compare the FDAC outcomes with a counterfactual group.

## Data sources

The data used for matching and the evaluation of outcomes were collected from the following sources:

- The FDAC data collection tool was the source of data for FDAC (intervention) cases. The tool was developed and used by the CJI to collect data on FDAC cases. Data was available from 13 FDAC sites, operating within LAs. A full list of FDAC sites and the LAs where the data was drawn is provided in [Table 3.2](#). As mentioned above, London was not part of the final analysis of impact evaluation due to resource constraints in providing quality-assured data.
- LAs case management systems and case notes provided comparable data for non-FDAC cases.<sup>10</sup>

## Sample size

In June 2020, we conducted power calculations in Stata 17.1 based on the anticipated matched sample size, using formulae from Dong and Maynard (2013). Using the parameters set in the [Study Protocol](#),<sup>11</sup> we expected the evaluation would be powered to detect a relative risk ratio of 1.36 (or equivalent to a 9.1 percentage point difference) (Wishart et al., 2022:p.18). No power calculations were conducted for secondary analyses, but these would have lower power as the units of analyses were at the parent and case-level. However, as the intra-cluster correlation coefficient was relatively large for child-level analyses, the reduction in power would be relatively small.

At analysis stage we received data from FDAC (n = 380) and non-FDAC (n = 302). With the achieved sample and reunification rate (we updated our estimates of 25% to observed level of 22.5% for the control group),<sup>12</sup> the evaluation was powered to detect a relative risk ratio

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<sup>10</sup> LAs extracted comparable data based on a template developed by NatCen which aimed for comparable data collection. The template included detailed instructions and guidance for all key fields required to complete this evaluation. There was cell validation in order to minimise blank cells and ensure data comparability across LAs.

<sup>11</sup> We anticipated a sample of 300 intervention children from 215 cases; We assumed clustering of children with parents with and ICC of 0.70, and no clustering withing LAs. Some other assumptions were: R-squared of 0.20 at level one and 0.10 at level two; A type one error rate of 0.05; Power of 0.80 (a type two error rate of 0.20); Two tailed significance testing. See the study protocol for more information.

<sup>12</sup> In the study protocol, we had assumed a reunification rate of 25% in the control group based on previous work (Harwin et al., 2018), while the received sample in December 2022 indicated that this rate would be around 22.5%.

of 1.53 (or equivalent to a 11.8 percentage point difference). The original and updated power calculations are presented in [Table 3.3](#). They show that we had slightly less statistical power than anticipated.

To maximise the likelihood of including all treatment cases (i.e. FDAC cases), we would have used a larger sample of control cases (i.e. non-FDAC cases) relative to the intervention group. Yet the achieved sample contained less non-FDAC cases/children than FDAC cases/children, owing largely to LAs' resource constraints in providing good-quality non-FDAC data. When applying CEM, we weighted observation to ensure that the number of intervention and matched-control observations within strata was the same. This allowed us to still be able to detect a sample average treatment effect on the treated (SATT<sup>13</sup>; see [Matching](#) section for details). More information on the sample size can also be found in the section on [Losses and exclusions](#) and in Figure 3.3 below.

**Table 3.3. Minimum detectable effect size calculation**

|  |               | Estimated MDES | Updated MDES |
|--|---------------|----------------|--------------|
| Relative risk ratio                              |               | 1.36           | 1.53         |
| Baseline/Endline correlations                    | Child         | 0.45           | 0.45         |
|  | Parent        | 0.32           | 0.32         |
| Intraclass correlations (ICCs)                   | Parent        | 0.70           | 0.70         |
|  | Social worker | 0.00           | 0.00         |
|  | Team          | 0.00           | 0.00         |
| Proportion of reunification in the control group |               | 0.25           | 0.22         |
| Alpha  |               | 0.05           | 0.05         |
| Power  |               | 0.80           | 0.80         |
| One-sided or two-sided?                          |               | 2              | 2            |
| Level of intervention clustering                 |               | Parent         | Parent       |
| Average cluster size (parent)                    |               | 1.40           | 1.40         |
| Sample size (children)                           | Intervention  | 300            | 380          |
|  | Control       | 300            | 302          |
|  | <b>Total</b>  | <b>600</b>     | <b>682</b>   |
| Sample size (cases)                              | Intervention  | 215            | 216          |
|  | Control       | 215            | 186          |
|  | <b>Total</b>  | <b>430</b>     | <b>402</b>   |

<sup>13</sup> SATT is the treatment effect averaged over only the subset of treated units for which good matches exist among available control units. The same change in causal effect notation is common in other methods for observational data, such as local average treatment effects (LATE) (Angrist & Imbens, 1995).

# Changes to the impact evaluation

Some elements of the evaluation design were changed as a result of data availability and due to the quality of the existing data. The changes are outlined in more detail in Table 3.4. We will cover the deviations and the implications in the relevant sections accordingly.

**Table 3.4. Deviations from the protocol**

| Impact evaluation | Dimension                         | Deviation summary  |         |                 |        |
|-------------------|-----------------------------------|--|---------|-----------------|--------|
|                   |                                   | Planned  |         | Current         |        |
|                   | Reduction in the treatment sample | FDAC sites = 14  | LA = 31 | FDAC sites = 13 | LA = 9 |
|                   | Matching approach                 | Deviation from planned matching due to common support, see <a href="#">Table 3.6</a> . The implication will also be covered in the <a href="#">Matching</a> section.   |         |                 |        |
|                   | Primary analysis                  | <ul style="list-style-type: none"> <li>Two-level instead of three-level model (i.e. children nested within primary carers/cases within sites) was used, accounting for only level-2 (site) and level-1 (child) random effect to avoid an overfitted model that may have poor power. See the <a href="#">Primary outcome analysis</a> section for details.</li> <li>Variables deleted due to collinearity: <ul style="list-style-type: none"> <li>a. primary carer's ethnicity</li> <li>b. primary carer's gender</li> </ul> </li> </ul> <p>These variables were not included in the primary analysis as they caused collinearity issues. For a full list of covariates included in the primary analysis, see <a href="#">Appendix F</a>.</p> |         |                 |        |
|                   | Secondary analysis                | The secondary analysis of cessation (RQ2) applied a two-level model instead of three-level model, accounting for only level-2 (site) and level-1 (parent) random effect to avoid an overfitted model that may have poor power.   |         |                 |        |
|                   | Additional analysis               | The additional analysis of placement (RQ6) applied a two-level model instead of three-level model, accounting for only level-2 (site) and level-1 (child) random effect to avoid an overfitted model that may have poor power.   |         |                 |        |
|                   | Longer-term analysis              | The exploratory analysis (RQ3) that was planned to assess whether reunification can be sustained over time has not been conducted as part of this report.  |         |                 |        |

## Data management

As outlined in the [Data sources](#) section above, we obtained data from the FDAC data collection template for intervention cases and for the non-FDAC participants and cases we used the local authority administrative data that was obtained using the data collection template prepared by NatGen. Although the FDAC data collection template collected thorough information, we were only able to use fields collected in both FDAC

and non-FDAC templates in matching and further analyses. We also needed to undertake additional steps (i.e. to derive new variables from the existing data) in order to harmonise FDAC and non-FDAC data. As part of this process, some of the variables in the FDAC data were recoded and we derived new variables (e.g. parental alcohol and drug misuse at the start of proceedings; substance misuse; severity of parental alcohol and drug misuse). Table 3.5 presents how we derived the new variables that allowed us to create harmonised FDAC and non-FDAC data. Please note that the full list of covariates used in the analysis is presented in [Table 3.6](#).

**Table 3.5. Harmonising FDAC and non-FDAC data**

| Derived variable to harmonise available data    | FDAC data   | Non-FDAC data   | How derived   |
|---|---|---|---|
| Primary carer for how many children             | N/A   | Number of children in household   | We derived a new parent-level variable from child-level data, counting how many children each parent cares for as primary carer, for both FDAC and non-FDAC groups.   |
| Primary carer – Age of youngest child cared for | N/A   | Age of youngest child in household                                      | We derived a new parent-level variable from child-level data, selecting the age of the youngest child the parent cares for as primary carer.  |
| Number of children in the case                  | N/A   | Number of children in household   | We derived a new case-level variable that was a count of the number of children in the case.  |
| Age of youngest child in the case               | N/A   | Age of youngest child in household                                      | We derived a new case-level variable, calculated from the age variable in the child-level data.   |
| Substance misuse type                           | Severity of parental alcohol misuse: High, Medium, Low, None, Unknown*<br>Severity of parental drug misuse: High, Medium, Low, None, Unknown* | Substance misuse type: Drugs; Alcohol; Drugs and Alcohol; None; Unknown | FDAC data was recoded to match non-FDAC data as follows:<br><br>1. If misusing at time of referral = “No”, we coded the substance misuse type as “None”<br><br>2. If misusing at time of referral = “Yes”, we checked parental alcohol misuse and drug misuse and categorised their substance misuse type as Drugs; Alcohol; Drugs and Alcohol; or Unknown<br><br>3. If misusing at time of referral = “Unknown”, we recoded the substance misuse type as Unknown |

\*This is based on clinical judgements on substance misuse severity where guidance for the FDAC data collection tool is provided in [Appendix D](#).



We collected information on the date of first and final hearing in proceedings for cases, along with date of issue. It is important to note that we excluded cases that were not closed before October 2022. Details on exclusions can be found in the [Losses and exclusions](#) section below.

The data contained pseudonymised identifiers at case-, parent- and child-level for us to identify sites of cases and further link observations across different levels. The use of pseudonymised identifiers ensured that no participants can be identified through the data that we received.

Once observations were cross-linked at different levels using pseudonymised identifiers, we then were able to use CEM to match intervention and control cases. The section below explains CEM further.

## Matching

The primary analysis estimated the impact of FDAC on reunification at the end of care proceedings based on the placement of the child. This approach sought to match children in FDAC care proceedings with similar children in non-FDAC care proceedings as usual. Implementing CEM required data for characteristics associated with selection into the intervention or the outcome at the start of care proceedings. CEM was conducted at the child-level using a set of characteristics considered important on influencing the primary outcome. Similar approaches were taken at the parent- and case-level dependent on the outcome of interest. [Table 3.6](#) presents variables involved in matching and analyses. Because of issues with “common support”,<sup>14</sup> we had to adjust how matching variables were coarsened, deviating from the study protocol. To ensure there are sufficient matched FDAC and non-FDAC cases, we adjusted some of the matching variables. This included collapsing categories of coarsened variables or altering bin sizes. The adjustments that were made are illustrated in [Table 3.6](#).

The CEM approach stratified the data on the basis of unique combinations of coarsened variables. For example, every parent in FDAC and non-FDAC care proceedings with the same combination of coarsened characteristics ended up in the same stratum (see [Table 3.6](#) for the matching strategy).

[Table 3.6](#) also outlines how specific variables were coarsened in matching. Variables were “coarsened” into binary or categorical variables (for example, if it was a continuous variable, such as the age of the child, the variable was re-categorised into age bands). As shown in [Table 3.5](#), some variables collected in FDAC sites were already collected categorically and did not require coarsening.

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<sup>14</sup> The assumption of common support means that FDAC and non-FDAC cases should be matched on key characteristics that would allow meaningful comparisons. However, the planned matching approach specified in the study protocol resulted in few matched FDAC and non-FDAC cases, making meaningful comparisons not feasible.

As shown in [Table 3.6](#), variables used in the analysis varied across the different outcome measures, with the primary outcome analysis containing the largest number of covariates. The covariates included date of case being issued, characteristics of the primary carer looking after the child of interest (e.g. demographics, substance misuse), parent characteristics aggregated to case level and demographic characteristics of the child of interest.

As mentioned above, the characteristics used for matching were associated with selection into the intervention or the outcome at the start of care proceedings. The logic of including a large number of covariates for matching was to identify the most similar intervention and control groups, based on important characteristics associated with the outcome. However, it is reiterated that the inclusion of all covariates specified in the study protocol caused issues with common support (i.e. more than 5% of intervention cases being lost), resulting in few matched cases available for analyses. To increase the number of matched cases while keeping as many covariates as possible in the matching, we followed the solution proposed in the protocol; i.e. to alter bin sizes for date/continuous variables (e.g. age) and collapse categories for categorical variables (e.g. experiences of domestic abuse). We further deleted covariates because of issues with common support (e.g. primary carer for how many children, the types of misuse). These adjustments might imply that the matched FDAC and non-FDAC cases was not “perfectly” identical with respect to certain important characteristics and a potential bias might therefore be introduced. However, as we also included the covariates (in their uncoarsened form) and CEM weighting in the analyses, we would still be able to provide a “doubly robust” estimation of causal effects for the matched sample. To be more specific, we would be able to detect the SATT.

Table 3.6. Variables for matching and analyses

| Characteristics  | Variable  | Type        | Planned coarsening strategy in matching  | Deviation from protocol in matching   |
|--|---|-------------|--|---|
| <b>Child-level outcome: reunification (primary outcome analysis)</b> |   |             |  |   |
| Case characteristics   | Date of issue   | Date        | Year and quarter   | Altering bin sizes. Coarsening years: 2019, 2020, 2021, 2022  |
| Parent characteristics   | Primary carer – Age                                   | Continuous  | Age bands: Less than 18 years old, 18–24, 25–34, 35–44, 45 or older  | Altering bin sizes. Coarsening age bands into five equal break-point groups: 16–29, 30–42, 43–55, 56–69, older than 69            |
|  | Primary carer – Gender                                | Categorical | No coarsening: Male, Female, Other, Unknown  | Unchanged   |
|  | Primary carer – Ethnicity                             | Categorical | No coarsening: White, Asian/Asian British, Black African/Black Caribbean/Black British, Mixed/multiple ethnic groups, other, unknown | Unchanged   |
|  | Primary carer for how many children                   | Continuous  | Bands: 0 (if not primary carer), 1, 2, 3 or more   | Deleted because of issues with common support   |
|  | Primary carer – Age of youngest child cared for       | Continuous  | Age bands: Less than 12 months old, 1, 2–3, 4–7, 8–11, 12–16   | Deleted because of issues with common support   |
|  | Primary carer – Past experience of domestic abuse     | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown                  |
|  | Primary carer – Currently experiencing domestic abuse | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown                  |
|  | Primary carer – Whether misusing at time of referral  | Categorical | No coarsening: Yes, No, Unknown  | Unchanged   |
|  | Primary carer – Substance misuse type                 | Categorical | No coarsening: Drugs; Alcohol; Drugs and Alcohol; None; Unknown  | Deleted because of issues with common support. Note the overarching variable – whether misusing at time of referral was unchanged |

| Characteristics  | Variable                      | Type        | Planned coarsening strategy in matching  | Deviation from protocol in matching  |
|--|-------------------------------|-------------|--|--|
| Parent characteristics aggregated to case level                                      | Number of parents in the case | Categorical | One, two, three or more  | Deleted because of issues with common support  |
| Child characteristics  | Age                           | Continuous  | Age bands: Less than 12 months old, 1, 2-3, 4-7, 8-11, 12-16   | Altering bin sizes. Coarsening age bands into five equal break-point groups: Less than 12 months old, 1-4, 5-8, 9-12, 13-16, |
|  | Gender                        | Categorical | No coarsening: Male, Female, Other, Unknown  | Unchanged  |
|  | Ethnicity                     | Categorical | No coarsening: White, Asian/Asian British, Black African/Black Caribbean/Black British, Mixed/multiple ethnic groups, Other, Unknown | Unchanged  |
| <b>Parent-level outcome: substance misuse cessation (secondary outcome analysis)</b> |                               |             |  |  |
| Case characteristics   | Date of issue                 | Date        | Year and quarter   | Altering bin sizes. Coarsening years: 2019, 2020, 2021, 2022   |

| Characteristics  | Variable  | Type        | Planned coarsening strategy in matching  | Deviation from protocol in matching  |
|--|---|-------------|--|--|
| Parent characteristics   | Age   | Continuous  | Age bands: Less than 18 years old, 18–24, 25–34, 35–44, 45 or older  | Altering bin sizes. Coarsening age bands into five equal break-point groups: 16–29, 30–42, 43–55, 56–69, older than 69 |
|  | Gender  | Categorical | No coarsening: Male, Female, Other, Unknown  | Unchanged  |
|  | Ethnicity                                       | Categorical | No coarsening: White, Asian/Asian British, Black African/Black Caribbean/Black British, Mixed/multiple ethnic groups, Other, Unknown | Unchanged  |
|  | Primary carer for how many children             | Continuous  | Bands: 0 (if not primary carer), 1, 2, 3 or more   | Deleted because of issues with common support  |
|  | Primary carer – Age of youngest child cared for | Continuous  | Age bands: Less than 12 months old, 1, 2–3, 4–7, 8–11, 12–16, N/A (if not primary carer)   | Deleted because of issues with common support  |
|  | Past experience of domestic abuse               | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown       |
|  | Currently experiencing domestic abuse           | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown       |
|  | Whether misusing at time of referral            | Categorical | No coarsening: Yes, No, Unknown  | Deleted because eligible parents all had substance misusing at time of referral  |
|  | Substance misuse type                           | Categorical | No coarsening: Drugs; Alcohol; Drugs and Alcohol; None; Unknown  | Unchanged  |
| <b>Case-level outcome: contested hearing, the use of expert witness (secondary outcome analysis)</b> |   |             |  |  |
| Case characteristics   | Date of issue                                   | Date        | Year and quarter   | Altering bin sizes. Coarsening years: 2019, 2020, 2021, 2022   |
| Parent characteristics aggregated to case level  | Number of parents in the case                   | Continuous  | Bands: 1, 2, 3 or more   | Deleted because of issues with common support  |

| Characteristics                                | Variable  | Type        | Planned coarsening strategy in matching  | Deviation from protocol in matching   |
|--|---|-------------|--|---|
| Parent characteristics                         | Primary carer – Age                                   | Continuous  | Age bands: Less than 18 years old, 18–24, 25–34, 35–44, 45 or older  | Altering bin sizes. Coarsening age bands into five equal break-point groups: 16–29, 30–42, 43–55, 56–69, older than 69            |
|  | Primary carer – Gender                                | Categorical | No coarsening: Male, Female, Other, Unknown  | Unchanged   |
|  | Primary carer – Ethnicity                             | Categorical | No coarsening: White, Asian/Asian British, Black African/Black Caribbean/Black British, Mixed/multiple ethnic groups, other, unknown | Unchanged   |
|  | Primary carer – Past experience of domestic abuse     | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown                  |
|  | Primary carer – Currently experiencing domestic abuse | Categorical | No coarsening: Yes – perpetrator, Yes – Victim, Yes – both, No, Unknown  | Collapsing categories. Coarsening into: Yes (including Yes – perpetrator, Yes – Victim, Yes – both), No, Unknown                  |
|  | Primary carer – Whether misusing at time of referral  | Categorical | No coarsening: Yes, No, Unknown  | Unchanged   |
|  | Primary carer – Substance misuse type                 | Categorical | No coarsening: Drugs; Alcohol; Drugs and Alcohol; None; Unknown  | Deleted because of issues with common support. Note the overarching variable – whether misusing at time of referral was unchanged |
| Child characteristics aggregated to case level | Number of children in the case                        | Continuous  | Bands: 1, 2, 3 or more   | Deleted because of issues with common support   |
|  | Age of youngest child in the case                     | Continuous  | Age bands: Less than 12 months old, 1, 2–3, 4–7, 8–11, 12–16   | Deleted because of issues with common support   |



Following the same logic, CEM was also conducted at both parent- and case-level to match similar parents and cases across FDAC and non-FDAC care proceedings.

Non-FDAC observations were weighted as follows (Iacus et al., 2012):

$$\frac{M_{\text{Control}}}{M_{\text{Treatment}}} \quad \frac{m_{\text{Treatment}}^s}{m_{\text{Control}}^s}$$

Where  $M_{\text{Control}}$  and  $M_{\text{Treatment}}$  denote the total number of matched units in the control and treatment group, respectively;  $m_{\text{Treatment}}^s$  and  $m_{\text{Control}}^s$  denote the number of control and treatment units in stratum  $s$ , respectively. These weights were used in the multilevel model, meaning that unmatched observations would be excluded from analyses.

The matching was conducted using the package `cem` in Stata 17.1 SE (Blackwell et al., 2009), which implements CEM as described by Iacus et al. (2009).

The numbers of matches, non-matches are reported in the [Losses and exclusions](#) section, along with the CONSORT flow diagram (see Figure 3.1).

## Impact evaluation analysis

### Preliminary analysis

The unit of analysis varied across outcomes. The primary outcome (reunification) was defined at the child-level, while the secondary outcomes were defined at either the parent-level (i.e. parental substance cessation) or case-level (i.e. contested hearing and the use of expert witnesses). Matching was implemented separately for outcomes at different units of analysis. Child-level outcomes included covariates about the child (such as age) and parent characteristics (mainly about primary carer's characteristics such as alcohol and drug misuse at baseline). See [Table 3.6](#) above for details, including parent-level outcomes and case-level outcomes.

Comparisons were made using the original uncoarsened covariates, with differences reported as Hedges'  $g$  effect sizes. In those cases where we observed an imbalance with an effect size of significantly greater than 0.05, we revised the matching specification by adjusting the coarsening of variables with an imbalance of greater than 0.05. The matching specification can be found in [Table 3.6](#), along with the adjustments.

We also used the multivariate L1 distance statistic before and after matching to describe the quality of the matching. This statistic measured the overall imbalance with respect to the joint distribution, including all interactions, of the covariates (Blackwell et al., 2009). The smaller L1, the less the imbalance across the covariates, with  $L1 = 0$  indicating perfect balance and  $L1 = 1$  complete separation across covariates. Note that the multivariate L1 statistic was computed by the multidimensional histogram that included all possible bin sizes of covariates (Iacus et al., 2012). The multivariate L1 statistic therefore was dependent on the scale of the input covariates (King et al., 2017). The covariate balance at all levels is

reported in the [Impact evaluation findings](#) section. The bin width used for each covariate at each level of analysis can be found in [Table 3.6](#).

## Primary outcome analysis

The primary outcome analysis was conducted on an intention-to-treat basis where the outcome was non-missing. A “doubly robust” estimation<sup>15</sup> of causal effects was estimated for the matched sample, applying the weights assigned during the matching, including a binary indicator of allocation to FDAC, while also including the uncoarsened matching covariates in the regression model, following Funk et al. (2011). The uncoarsened matching covariates included in the child-level regression model can be found in [Table 3.6](#). Note that the covariates primary carer’s ethnicity and primary carer’s gender were not included in the final primary analysis as they caused collinearity issues.

To account for the clustering of children within primary carers, cases and within sites, we used a multilevel logistic regression model. Instead of single-level regression models correcting for clustered standard errors, we applied multilevel modelling because multilevel models have more power and produce less biased standard errors (Hox et al., 2010).

The full model was as follows:

$$P(\text{Reunification}_{\text{ipcs}}) = \text{logit}^{-1}(\beta_0 + \beta_1 \text{Intervention}_{\text{ipcs}} + \beta_2 X_{\text{ipcs}} + u_{\text{pcs}} + u_{\text{cs}} + u_{\text{s}})$$

Where  $P(\text{Reunification}_{\text{ipcs}})$  is the probability of reunification. Children (i) are nested within primary carers (p), cases (c), and sites (s). The vector  $X_{\text{ipcs}}$  denotes the uncoarsened covariates. The random intercepts are represented as  $u_{\text{pcs}}$ ,  $u_{\text{cs}}$ ,  $u_{\text{s}}$ , respectively.

However, this three-level full model resulted in perfect prediction and overfitting issues because, when looking at the reunification variable, there was a significant overlap between primary carers and cases. When the primary carer variable had the score of one (i.e. reunification), so did the case variable. As a result, we decided to fit a two-level model for the primary analysis, only accounting for level-2 (site-level) and level-1 (child-level) random effects. This is marked as a deviation from the protocol in [Table 3.4](#).

The multilevel models described above were estimated using the `melogit` command in Stata. As mentioned in the [Matching](#) section above, we also applied CEM weighting to the model so that we would be able to detect the SAT. We also used `linktest` and `lrtest` command for post-estimation, ensuring model specifications and performance.

<sup>15</sup> A “doubly robust” estimation reduces the risk that the average treatment effect on the treated (ATT) was biased, provided that either the matching (modelling exposure to the intervention) or the regression model (describing the relationship between the dependent and independent variables) is well specified (for more information see Funk et al., 2011).

## Secondary outcomes analysis

The secondary analysis assessed the impact of FDAC on three outcomes:

- Parental alcohol and drug misuse cessation (RQ2)
- If the final hearing was contested (RQ4)
- Whether expert witnesses were used (and the total number of different types of expert witnesses were included) (RQ5).

Matching for these outcomes was conducted at the parent level for RQ2 and at the case level for RQ4 and RQ5 using the covariates outlined in [Table 3.6](#). A separate matching model was used to assess the impact on these outcomes to the primary analysis. Unlike the primary analysis, the unit of analysis for these outcomes was at parent (or case) level. We therefore matched similar parents (or cases) rather than children within cases.

The approach was consistent with the primary analysis, using the same user-written `cem` package in Stata 17.1. The numbers of matches, non-matches and covariate balance are reported in the [Impact evaluation findings](#) section below, in line with the primary analysis.

Each of these outcomes was analysed as binary variables with the unit of analysis at parent (or case) level. The sample for the analysis on cessation included only parents who had substance misuse issues at baseline. Covariates include in each analysis are also presented in [Table 3.6](#).<sup>16</sup> The models are:

1.  $P(\text{Cessation}_{\text{pcs}}) = \text{logit}^{-1} (\beta_0 + \beta_1 \text{Intervention}_{\text{pcs}} + \beta_2 X_{\text{pcs}} + u_{\text{cs}} + u_{\text{s}})$
2.  $P(\text{Contested}_{\text{cs}}) = \text{logit}^{-1} (\beta_0 + \beta_1 \text{Intervention}_{\text{cs}} + \beta_2 X_{\text{cs}} + u_{\text{s}})$
3.  $P(\text{Experts}_{\text{cs}}) = \text{logit}^{-1} (\beta_0 + \beta_1 \text{Intervention}_{\text{cs}} + \beta_2 X_{\text{cs}} + u_{\text{s}})$

The total number of different types of expert witness was otherwise analysed using a multilevel Poisson regression.<sup>17</sup> The model notation is as follows:

4.  $\text{ExpertTypes}_{\text{cs}} = \exp (\beta_0 + \beta_1 \text{Intervention}_{\text{cs}} + \beta_2 X_{\text{cs}} + u_{\text{s}})$

Where  $u_{\text{cs}}$  represents the random effects and were assumed to be normally distributed with 0 mean. The risk ratio was estimated using the `mepoisson` command in Stata.

Note that the final models of the secondary analyses were all two-level models, accounting for only level-2 (site-level) and level-1 (parent-/case-level) random effect.

## Exploratory analysis

An exploratory analysis that will aim to assess whether reunification can be sustained over time (**RQ3**) will be conducted in summer 2023 and reported in autumn 2023, upon access to the Children Family Court Advisory and Support Service (Cafcass) data.

<sup>16</sup> The parent-level model did not include parent's ethnicity while the case-level model did not include primary carer's gender as these covariates cause collinearity issues.

<sup>17</sup> We also used zero-inflated Poisson and negative binomial regression models to estimate the impact of intervention on the count of expert witnesses. The likelihood ratio tests showed that a Poisson regression model outperformed the other two models.

## Missing data analysis

The protocol specified that if more than 5% of cases were missing data on the primary outcome, then we would have considered conducting additional analysis and/or multiple imputation (see Wishart et. al., 2022). However, given a missing rate below the 5% threshold in our data for the primary analysis (4.5% among all eligible samples and 2% among matched samples), we did not conduct any additional analysis to handle missing data.

It is noted that CEM treated missingness as a separate value to match on. This way it retained more observations in the matching, resulting in higher power for some analyses. This means that:

- For the main analysis, cases with missing covariates were dropped – since the covariate was missing.
- For the sensitivity analysis which excluded covariates from the outcome model, observations with missing covariates were retained.

The extent of missingness by covariate can be found in Tables 5.5–5.7 which presents the imbalance check after matching.

## Sensitivity analysis

As a sensitivity analysis, we fitted a multilevel logistic regression model on the matched sample excluding the characteristics used in the matching in the regression model:

$$P(\text{Reunification}_{\text{ipcs}}) = \text{logit}^{-1} (\beta_0 + \beta_1 \text{Intervention}_{\text{ipcs}} + u_{\text{pcs}} + u_{\text{cs}} + u_s)$$

It was not possible to carry out the second sensitivity analysis as indicated in the study protocol. Specifically, the second sensitivity analysis entailed adjusting the cut-off points of the coarsening covariates for the matching. However, because of issues with “common support”, we had to adjust how matching variables were coarsened to ensure there are sufficient matched FDAC and non-FDAC cases for analyses. Thus, we adjusted some of the matching variables by collapsing categories of coarsened variables or altering bin sizes. These new adjusted bin sizes have become part of the primary impact analysis. A detailed account of all the adjustments that were made is illustrated in [Table 3.6](#).

## Additional analysis

We assessed the impact of FDAC on the placement of the child (RQ6), using a categorical outcome variable. This was assessed using a multilevel multinomial logistic regression.

$$P(\text{Placement}_{\text{ipcs}}) = \text{logit}^{-1} (\beta_0 + \beta_1 \text{Intervention}_{\text{ipcs}} + \beta_2 X_{\text{ipcs}} + u_{\text{pcs}} + u_{\text{cs}} + u_s)$$

The multilevel multinomial logistic model described above was estimated using the gsem command with mlogit option in Stata. Note that the final model of the additional analysis was a two-level model, accounting for only level-2 (site-level) and level-1 (child-level) random effect.

## Effect size – reporting relative risk ratios (RRRs)

For binary outcomes in this study, we reported the relative risk ratios (RRR), using the following formula:

$$\text{RRR} = \frac{P(\text{Reunified} \mid \text{FDAC}, X)}{P(\text{Reunified} \mid \text{non - FDAC}, X)}$$

Where the numerator is the probability of reunification for FDAC cases conditional on covariates (denoted  $X$  in the formula), and the denominator is the probability of reunification for non-FDAC cases conditional on the same set of covariates.

We calculated RRR as follows. First, we calculated the conditional probabilities from the fitted coefficients of the multilevel logistic regression models by holding the covariates constant at their means. Second, we then calculated relative risk ratios using the `nlcom` command in Stata, which returned the standard errors and confidence intervals of each ratio.

## Implementation and process evaluation

This section sets out the methodology of the qualitative implementation and process evaluation (IPE), which aimed to assess a number of dimensions relating to how FDAC has been implemented and delivered, including participant experiences of delivering and receiving support through FDAC; variations in delivery across different FDACs, including facilitators and barriers to delivery and drivers of success; and comparisons between delivery of FDAC and standard care proceedings.

The IPE involved in-depth interviews with participants from six FDAC sites and four non-FDAC sites. The aim was to provide explanations for the observed effects of FDAC, unpacking what works by identifying key facilitators and barriers and comparing with standard care proceedings. Prior to beginning fieldwork, ethical approval was obtained from the NatCen Research Ethics Committee and the Judicial Office to carry out interviews.

Recruitment for all participant groups was facilitated through gatekeepers at each site who liaised with potential participants. For all participant groups other than parents, the quotas were met. In total, 40 interviews were carried out with FDAC/local authority leads, support service leads, parents and judges. [Table 3.7](#) contains a breakdown of interviews completed and their target numbers by participant type.



**Table 3.7. Completed and target interview numbers**

| Participant group  | Completed | Target |
|--------------------|-----------|--------|
| FDAC leads         | 12        | 12     |
| Support staff      | 6         | 6      |
| Parents            | 8         | 12     |
| FDAC judiciary     | 6         | 6      |
| Non-FDAC leads     | 4         | 4      |
| Non-FDAC judiciary | 4         | 4      |

Though smaller than intended, the sample of parents achieved diversity across the range of primary and secondary sampling characteristics in relation to, for example, family composition, past experience of care proceedings, level of engagement with FDAC, gender, age and ethnicity.<sup>18</sup>

FDAC leads included three team managers, five specialist staff (in family support, substance misuse, recovery and mental health), three senior FDAC practitioners and one social worker. Support staff interviewed included three substance misuse workers, two domestic abuse specialists and one social worker. The parents interviewed included three men and five women between the ages of 30 and 51. Six parents were White British and two were mixed ethnicity, and parents had between one and five children in their care.

Interviews lasted approximately an hour and were conducted over Microsoft Teams or telephone. Topic guides were used flexibly by the interviewer to ensure key areas were covered across all interviews:

- For stakeholders and staff, interviews focused on commitment to and understanding of FDAC; views on whether the necessary processes and resources were in place; the skills and competencies of professionals to effectively deliver FDAC; the effectiveness of judicial oversight and partnership working; and views on parental engagement and experiences.
- For parents, interviews centred around understanding of and engagement with FDAC, experience of court proceedings and support, relationships with children, and views on fairness and impact.

All interviews were audio-recorded and transcribed verbatim. Interview data were managed and analysed using Framework, a systematic approach to case- and theme-based analysis of qualitative data (Ritchie et al., 2013).<sup>19</sup>

Observations of four court or service provider activities were also planned to provide further insight into how the FDAC model works in practice. However, it was not possible to conduct these observations within the agreed timeframe for the IPE.

<sup>18</sup> More information on methodological challenges and how these were overcome is detailed in the [Limitations related to the IPE](#) section.

<sup>19</sup> This is a matrix-based analytic method which enables both case- and theme-based analysis. It facilitates rigorous and transparent qualitative data management which is grounded in participants' accounts, views and experiences described in their own words.

## Cost evaluation

Costs were estimated based on the delivery costs of the intervention. Each FDAC site manager was asked to fill in a cost form covering costs incurred in the financial year 2020/21. Sites were asked to provide estimations on their setup (e.g. preparation costs, facilities, overheads) and delivery costs (e.g. salary costs, training and support costs, assessment and legal fees). A copy of the cost form can be found in [Appendix E](#).

The set-up costs were estimated only for sites that have launched since March 2020. Evaluation costs were estimated from the perspective of the LA on a per-child basis by dividing the total annual cost for the 2020/21 financial year (i.e. setup and delivery costs) by the number of children who went through FDAC care proceedings.



# DESCRIPTIVE ANALYSIS OF FDAC SITES

This chapter gives an overview of the FDAC sites included in the IE, drawing on data covering FDAC case numbers, and parent and child characteristics used in the impact analysis (relating to cases for which a final hearing had been completed by October 2022). This information relates to the research aim of understanding intervention fidelity, reach and dosage: whether and how the programme had been delivered to the intended population, and the extent of support and contact parents received.

Descriptive data was recorded by 13 FDAC sites over three years from October 2019 to June 2022. In total, 216 cases were completed by the end of this period. Of all 216 cases, 62% involved a single parent; 37% involved two parents; and 1% involved three parents. Most cases (59%) involved a single child, 21% involved two children, and a further 20% involved three or more children.

### Cases per FDAC site

As set out in Table 4.1, the number of FDAC cases per site ranges from nine to 38 in the data.

**Table 4.1 Cases per FDAC site (from October 2019 to June 2022)**

| FDAC site                             | Cases      |
|---------------------------------------|------------|
| Birmingham & Solihull                 | 15         |
| Coventry                              | 12         |
| East Sussex                           | 16         |
| Gloucestershire                       | 12         |
| Kent                                  | 38         |
| Leeds                                 | 18         |
| Milton Keynes & Bucks                 | 21         |
| Newcastle, Gateshead & North Tyneside | 14         |
| Pan-Bedfordshire                      | 15         |
| Somerset                              | 17         |
| Southampton                           | 9          |
| Stockport                             | 11         |
| Walsall, Sandwell & Dudley            | 18         |
| <b>Total</b>                          | <b>216</b> |



## Parent characteristics

Data collected in this period relates to 219 parents/primary carers who had substance misuse issues at the start of care proceedings (see the [Secondary outcomes](#) section above). Two-thirds (69%) were female and 45% were between the ages of 25 and 34. The majority (90%) were White; 4% were Black African, Black Caribbean, or Black British; 3% were Asian or Asian British; and 2% were mixed or multiple ethnicities.

A high proportion of parents involved in FDAC care proceedings had some history of domestic abuse, with 48% reporting they had previously been a victim of domestic abuse, 16% reporting they had previously been a perpetrator, and 24% reporting they had previously been both a victim and a perpetrator. On starting FDAC proceedings, more than one-quarter (28%) were still victims of domestic abuse. As may be expected for a programme of this nature, a significant proportion of parents (82%) were recorded as misusing alcohol and/or different types of substances.<sup>20</sup> Disaggregating further, about 68% of parents were recorded as misusing drugs and alcohol; 17% as misusing drugs; and 13% as misusing alcohol. About half of the parents (47%) were prescribed mental health medication and about 13% of parents were engaged with the community mental health team at the start of care proceedings.

## Child characteristics

The FDAC site data included records relating to a total sample of 380 children. Of these, 24% were under one year old at the start of proceedings, 25% were between the ages of one and four, 28% were between five and nine years old, and 22% were between the ages of 10 and 16. Most (81%) children were White; 15% were mixed/multiple ethnicities; 1% were Black African, Black Caribbean, or Black British; 1% were Asian or Asian Other. In terms of child mental health, about 4% of children were recorded as having infant mental health or Child and Adolescent Mental Health Services (CAMHS) referral and around 9% of children had an Education, Health and Care Plan at the start of care proceedings.

## Support provided by FDAC sites

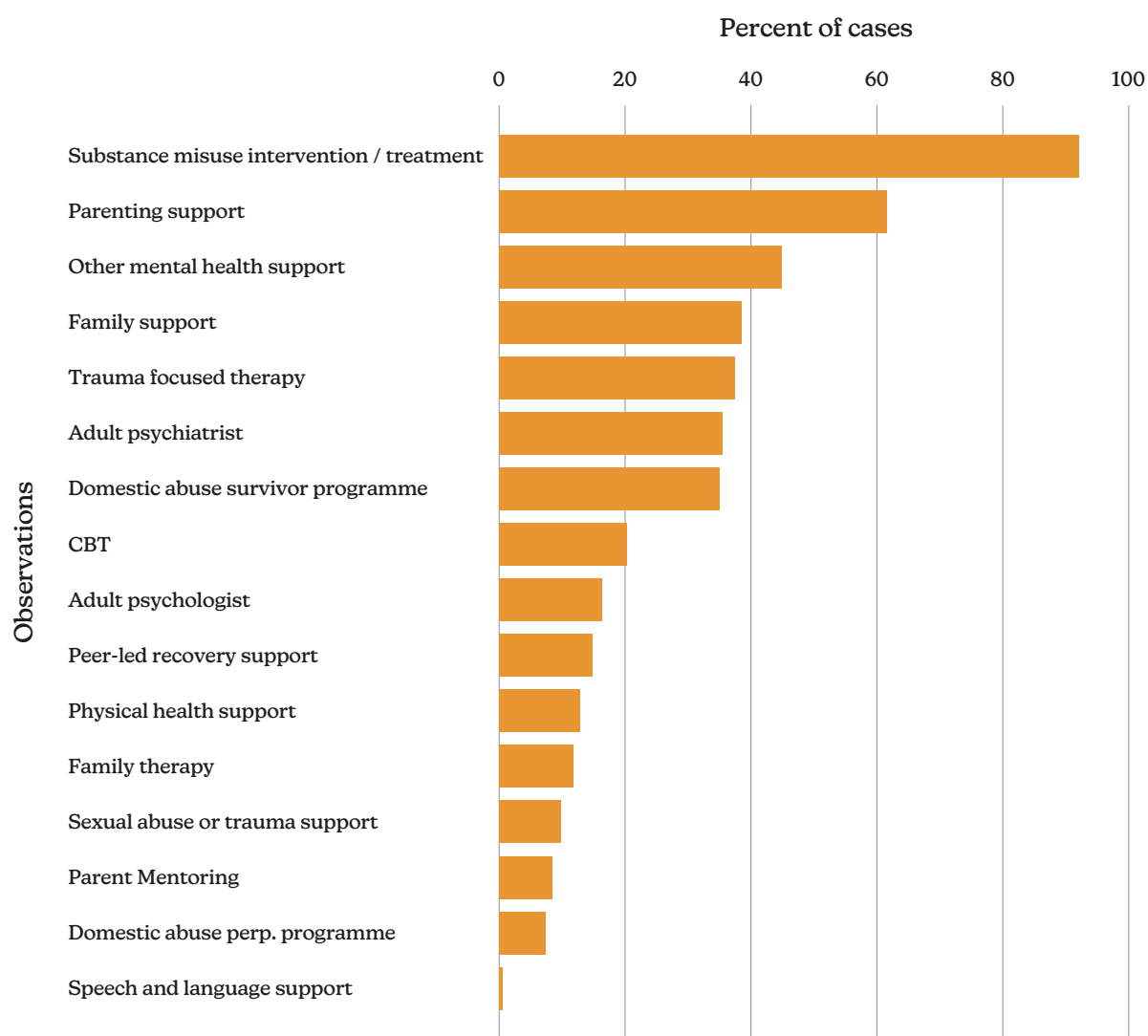
Data on support provided by FDAC sites was available for 219 parents who had substance misuse issues at the start of care proceedings (see the [Secondary outcomes](#) section). Almost all parents (92%) received substance misuse interventions or treatment (n = 203). The next most common types of support were parenting support (62%), other mental health support (45%) and family support (38%). This illustrates the wide range of support services available for parents going through FDAC. It also shows the range of support FDAC provides for issues such as mental health or trauma which may underlie and contribute to substance misuse. Figure 4.1 summarises the range of support provided.

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<sup>20</sup> Some FDACs have adapted their eligibility requirements to include cases where substance misuse is not a concern, for example some cases including domestic abuse or parents with cognitive difficulties who would benefit from the intensive model of FDAC.



Figure 4.1 Support provided to parents by FDAC sites<sup>21</sup>



Base: All parents in FDAC care proceedings with valid data (N=203, Missing=16).

<sup>21</sup> Percentages do not sum to 100% since parents can receive more than one intervention.



# IMPACT EVALUATION FINDINGS

## Losses and exclusions

For the intervention group, we received 431 cases covering 749 children from 13 FDAC sites; however, nearly 50% of the cases were not closed by October 2022,<sup>22</sup> and were therefore excluded (i.e. 215 cases or 369 children). Parents who did not meet the eligibility criteria<sup>23</sup> or were in a care proceeding that was not closed by October 2022 were also excluded from the analysis (i.e. 369 primary carers). For the control group, we received 186 cases covering 302 children and 349 primary carers from nine non-FDAC LAs. We excluded primary carers who did not meet the eligibility criteria (i.e. 69 primary carers).

**Figure 5.1** presents the overall numbers of cases, parents and children, excluded, matched and included in the final analysis by FDAC and non-FDAC sites. There were 300 children matched (FDAC n = 164; non-FDAC n = 136), with 264 children being included in the primary analysis (FDAC n = 142; non-FDAC n = 122). The discrepancy between the number of matched sample and analysed sample was because we excluded observations that had missing values for the outcome measures.

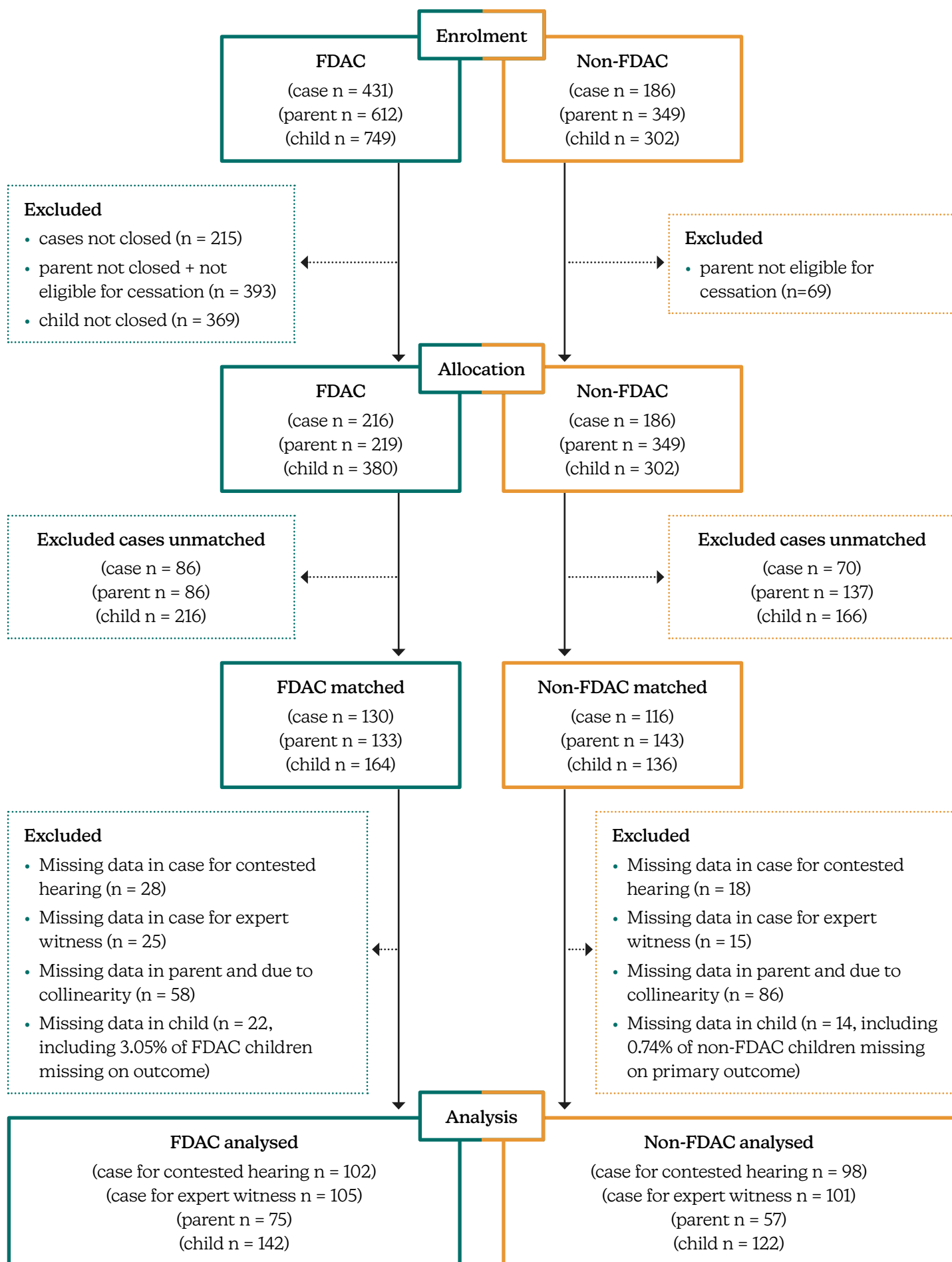
With regard to the primary analysis, as mentioned in the section on **Missing data analysis**, 4.55% of all eligible children were missing on the outcome of reunification while 2% of matched sample were missing.

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22 Based on the CJI's annual report for the 2021/22 year (CJI, 2022), the average FDAC case length was 43 weeks, which was longer than the usual 26-week timeframe in both FDAC and non-FDAC care proceedings. This may be because FDAC care proceedings are more likely to receive an extension, compared to non-FDAC cases (see the section on **FDAC delivery** for details). This reduced the sample size for the impact evaluation as many FDAC cases initiated in 2022 were not closed by October 2022.

23 To be eligible for the analysis of cessation, the parent must have substance misuse issues at the start of care proceeding (see the **Secondary outcomes** section). Although parts of the basic criteria for inclusion in FDAC are that there were concerns about parental alcohol or drug misuse as part of the care proceedings case, we could not be certain it was the case when the records of participants' substance misuse at the start of care proceedings were missing. These participants were thus not eligible for the analysis of cessation.

Figure 5.1 CONSORT flow diagram



## Preliminary analysis

**Tables 5.1–5.3** present covariates imbalance between the control and intervention groups before matching. We present the characteristics across the FDAC and non-FDAC group available on each respective variable using the sample of parents and children as analysed. We observed imbalance for the majority of the covariates used for the primary outcome analysis (see **Table 5.1**). Primary carers balance was assessed for age, gender, ethnicity, past domestic abuse and substance misuse at the start of the care proceedings. We observed that primary carers were older in FDAC sites (i.e. 2.28 years older), and there were more fathers or male primary carers in FDAC care proceedings (i.e. 9% in FDAC vs 5% in non-FDAC). Looking at ethnicity, we observed that there were fewer primary carers in FDAC from mixed/multiple ethnic groups (i.e. 5% in FDAC vs 10% in non-FDAC) or other ethnicity (i.e. 1% in FDAC and 5% in non-FDAC), and more primary carers were White (i.e. 90% in FDAC vs 79% in non-FDAC). Imbalance was observed across FDAC and non FDAC primary carers in terms of current domestic abuse (i.e. 49% of FDAC vs 75% of non-FDAC primary carers; ES=0.54, 95% CI= [0.37, 0.71]) and misusing substances at the time of referral to care proceedings (i.e. 72% of FDAC vs 90% of non-FDAC primary carers; ES=0.47, 95% CI= [0.31, 0.63]). This imbalance implied that primary carers in non-FDAC care proceedings were more likely than primary carers in FDAC proceedings to be experiencing domestic abuse (either as perpetrator or victim) and misusing at the time of referral to care proceedings.

At the child level, we observed imbalance in age and ethnicity. We observed that children were older in FDAC sites in comparison to children in non-FDAC (i.e. 0.77 years older on average). There were fewer children in FDAC from mixed or multiple ethnic groups (i.e. 16% in FDAC vs 25% in non-FDAC) or other ethnicity (i.e. 1% in FDAC and 3% in non-FDAC), and more children were White (i.e. 81% in FDAC vs 69% in non-FDAC).

Similar levels of high imbalance were also found for the secondary outcome analysis at the other two levels (see imbalance for the secondary outcome analysis at parent-level in Table 5.2 and case-level in Table 5.3). For example, FDAC parents were more likely to misuse both drugs and alcohol (69% of FDAC vs 56% of non-FDAC; ES = -0.26, 95% CI= [-0.44, -0.08]), but less likely to misuse drugs alone (18% of FDAC vs 30% of non-FDAC; ES =0.28, 95% CI= [0.11, 0.46]), compared to non-FDAC parents.



**Table 5.1. Imbalance check before matching – primary outcome analysis (RQ1 & RQ6)**

| Covariate   | Non-FDAC<br>group<br>mean (SD) | FDAC<br>group<br>mean (SD) | Un-std.<br>mean diff.<br>(SD) | p-value | Hedges' g<br>[95% CI]   | N (non-<br>FDAC,<br>FDAC) |
|---|--------------------------------|----------------------------|-------------------------------|---------|-------------------------|---------------------------|
| Year of issue – 2019  | 0.04<br>(0.20)                 | 0.04<br>(0.19)             | 0.01<br>(0.20)                | 0.68    | 0.03<br>[-0.12, -0.18]  | 682<br>(302, 380)         |
| Year of issue – 2020  | 0.33<br>(0.47)                 | 0.40<br>(0.49)             | -0.07<br>(0.48)               | 0.07    | -0.14<br>[-0.29, -0.01] | 682<br>(302, 380)         |
| Year of issue – 2021  | 0.54<br>(0.50)                 | 0.55<br>(0.50)             | -0.00<br>(0.50)               | 0.91    | -0.01<br>[-0.16, -0.14] | 682<br>(302, 380)         |
| Year of issue – 2022  | 0.08<br>(0.28)                 | 0.02<br>(0.13)             | 0.06<br>(0.21)                | 0.00    | 0.31<br>[0.16, -0.46]   | 682<br>(302, 380)         |
| Primary carer age<br>(in years)   | 32.23<br>(7.64)                | 34.51<br>(6.53)            | -2.28<br>(7.10)               | 0.00    | -0.33<br>[-0.48, -0.17] | 635<br>(266, 369)         |
| Primary carer<br>gender – Female  | 0.95<br>(0.21)                 | 0.91<br>(0.29)             | 0.05<br>(0.26)                | 0.03    | 0.17<br>[0.02, 0.33]    | 656<br>(277, 379)         |
| Primary carer<br>gender – Male  | 0.05<br>(0.21)                 | 0.09<br>(0.29)             | -0.05<br>(0.26)               | 0.03    | -0.17<br>[-0.33, -0.02] | 656<br>(277, 379)         |
| Primary carer<br>ethnicity – Asian/<br>Asian British                              | 0.04<br>(0.19)                 | 0.02<br>(0.13)             | 0.02<br>(0.16)                | 0.09    | 0.14<br>[-0.02, 0.29]   | 642<br>(267, 375)         |
| Primary carer<br>ethnicity – Black<br>African/Black<br>Caribbean/Black<br>British | 0.02<br>(0.15)                 | 0.03<br>(0.17)             | -0.01<br>(0.16)               | 0.59    | -0.04<br>[-0.20, 0.11]  | 642<br>(267, 375)         |
| Primary carer<br>ethnicity – Mixed/<br>multiple ethnic<br>groups                  | 0.10<br>(0.31)                 | 0.05<br>(0.21)             | 0.06<br>(0.26)                | 0.00    | 0.23<br>[0.08, 0.39]    | 642<br>(267, 375)         |
| Primary carer<br>ethnicity – Other  | 0.05<br>(0.22)                 | 0.01<br>(0.09)             | 0.04<br>(0.16)                | 0.00    | 0.26<br>[0.10, 0.42]    | 642<br>(267, 375)         |
| Primary carer<br>ethnicity – White  | 0.79<br>(0.41)                 | 0.90<br>(0.30)             | -0.11<br>(0.35)               | 0.00    | -0.33<br>[-0.49, -0.17] | 642<br>(267, 375)         |
| Primary carer – Past<br>domestic abuse  | 0.93<br>(0.25)                 | 0.92<br>(0.27)             | 0.01<br>(0.26)                | 0.75    | 0.03<br>[-0.13, 0.18]   | 628<br>(260, 368)         |
| Primary carer –<br>Current domestic<br>abuse                                      | 0.75<br>(0.43)                 | 0.49<br>(0.50)             | 0.26<br>(0.49)                | 0.00    | 0.54<br>[0.37, 0.71]    | 561<br>(221, 340)         |
| Primary carer<br>– Misusing at<br>the start of care<br>proceedings                | 0.90<br>(0.29)                 | 0.72<br>(0.45)             | 0.18<br>(0.40)                | 0.00    | 0.47<br>[0.31, 0.63]    | 638<br>(262, 376)         |
| Child age   | 4.62<br>(4.83)                 | 5.39<br>(4.69)             | -0.77<br>(4.76)               | 0.04    | -0.16<br>[-0.32, -0.01] | 659<br>(281, 378)         |

| Covariate  | Non-FDAC<br>group<br>mean (SD) | FDAC<br>group<br>mean (SD) | Un-std.<br>mean diff.<br>(SD) | p-value | Hedges' g<br>[95% CI]   | N (non-<br>FDAC,<br>FDAC) |
|--|--------------------------------|----------------------------|-------------------------------|---------|-------------------------|---------------------------|
| Child gender –<br>Female   | 0.45<br>(0.50)                 | 0.45<br>(0.50)             | -0.00<br>(0.50)               | 0.97    | -0.00<br>[-0.16, 0.15]  | 656<br>(276, 380)         |
| Child gender – Male  | 0.55<br>(0.50)                 | 0.55<br>(0.50)             | -0.00<br>(0.50)               | 0.96    | -0.00<br>[-0.16, 0.15]  | 656<br>(276, 380)         |
| Child gender -<br>Other  | 0.00<br>(0.06)                 | 0.00<br>(0.00)             | 0.00<br>(0.04)                | 0.24    | 0.09<br>[-0.06, 0.25]   | 656<br>(276, 380)         |
| Child ethnicity –<br>Asian/Asian British                               | 0.01<br>(0.12)                 | 0.01<br>(0.11)             | 0.00<br>(0.12)                | 0.87    | 0.01<br>[-0.14, 0.17]   | 650<br>(271, 379)         |
| Child ethnicity –<br>Black African/Black<br>Caribbean/Black<br>British | 0.02<br>(0.13)                 | 0.01<br>(0.10)             | 0.01<br>(0.12)                | 0.40    | 0.07<br>[-0.09, 0.22]   | 650<br>(271, 379)         |
| Child ethnicity –<br>Mixed/multiple<br>ethnic groups                   | 0.25<br>(0.43)                 | 0.16<br>(0.37)             | 0.09<br>(0.40)                | 0.00    | 0.23<br>[0.08, 0.39]    | 650<br>(271, 379)         |
| Child ethnicity –<br>Other   | 0.03<br>(0.17)                 | 0.01<br>(0.09)             | 0.02<br>(0.13)                | 0.04    | 0.17<br>[0.01, 0.32]    | 650<br>(271, 379)         |
| Child ethnicity –<br>White   | 0.69<br>(0.46)                 | 0.81<br>(0.39)             | -0.12<br>(0.43)               | 0.00    | -0.29<br>[-0.45, -0.13] | 650<br>(271, 379)         |

SD = standard deviation; Un-std. mean diff.= non-FDAC-FDAC unstandardised mean difference;  
CI = Confidence interval

Table 5.2. Imbalance check before matching – secondary outcome analysis at parent level (RQ2)

| Covariate   | Non-FDAC<br>group<br>mean (SD) | FDAC<br>group<br>mean (SD) | Un-std.<br>mean diff.<br>(SD) | p-value | Hedges' g<br>[95% CI]   | N (non-<br>FDAC,<br>FDAC) |
|---|--------------------------------|----------------------------|-------------------------------|---------|-------------------------|---------------------------|
| Year of issue – 2019  | 0.02<br>(0.13)                 | 0.02<br>(0.13)             | -0.00<br>(0.13)               | 0.97    | -0.00<br>[-0.18, 0.17]  | 499<br>(280, 219)         |
| Year of issue – 2020  | 0.31<br>(0.47)                 | 0.39<br>(0.49)             | -0.07<br>(0.48)               | 0.09    | -0.16<br>[-0.33, 0.02]  | 499<br>(280, 219)         |
| Year of issue – 2021  | 0.60<br>(0.49)                 | 0.59<br>(0.49)             | 0.01<br>(0.49)                | 0.87    | 0.01<br>[-0.16, 0.19]   | 499<br>(280, 219)         |
| Year of issue – 2022  | 0.07<br>(0.26)                 | 0.00<br>(0.07)             | 0.07<br>(0.20)                | 0.00    | 0.34<br>[0.16, 0.51]    | 499<br>(280, 219)         |
| Parent age  | 33.32<br>(8.56)                | 34.82<br>(6.72)            | -1.50<br>(7.83)               | 0.04    | -0.19<br>[-0.37, -0.01] | 487<br>(271, 216)         |
| Parent gender –<br>Female   | 0.57<br>(0.50)                 | 0.69<br>(0.46)             | -0.12<br>(0.48)               | 0.01    | -0.25<br>[-0.42, -0.07] | 499<br>(280, 219)         |
| Parent gender –<br>Male   | 0.42<br>(0.50)                 | 0.31<br>(0.46)             | 0.12<br>(0.48)                | 0.01    | 0.25<br>[0.07, 0.42]    | 499<br>(280, 219)         |
| Parent ethnicity –<br>Asian/Asian British   | 0.03<br>(0.16)                 | 0.03<br>(0.18)             | -0.01<br>(0.17)               | 0.68    | -0.04<br>[-0.22, 0.14]  | 484<br>(268, 216)         |
| Parent ethnicity –<br>Black African/Black<br>Caribbean/Black<br>British             | 0.04<br>(0.20)                 | 0.04<br>(0.19)             | 0.00<br>(0.19)                | 0.82    | 0.02<br>[-0.16, 0.20]   | 484<br>(268, 216)         |
| Parent ethnicity<br>– Mixed/multiple<br>ethnic groups                               | 0.07<br>(0.26)                 | 0.02<br>(0.15)             | 0.05<br>(0.22)                | 0.01    | 0.23<br>[0.05, 0.41]    | 484<br>(268, 216)         |
| Parent ethnicity –<br>Other   | 0.04<br>(0.20)                 | 0.00<br>(0.07)             | 0.04<br>(0.16)                | 0.01    | 0.23<br>[0.06, 0.41]    | 484<br>(268, 216)         |
| Parent ethnicity –<br>White   | 0.82<br>(0.39)                 | 0.90<br>(0.30)             | -0.09<br>(0.35)               | 0.01    | -0.24<br>[-0.42, -0.06] | 484<br>(268, 216)         |
| Parent past<br>domestic abuse   | 0.92<br>(0.27)                 | 0.89<br>(0.32)             | 0.03<br>(0.29)                | 0.25    | 0.11<br>[-0.08, 0.29]   | 471<br>(258, 213)         |
| Parent current<br>domestic abuse  | 0.79<br>(0.41)                 | 0.49<br>(0.50)             | 0.29<br>(0.48)                | 0.00    | 0.65<br>[0.45, 0.84]    | 417<br>(227, 190)         |
| Parent substance<br>misuse at the start<br>of care proceedings<br>– Alcohol         | 0.14<br>(0.35)                 | 0.13<br>(0.34)             | 0.01<br>(0.35)                | 0.86    | 0.02<br>[-0.16, 0.19]   | 493<br>(278, 215)         |
| Parent substance<br>misuse at the start<br>of care proceedings<br>– Drugs           | 0.30<br>(0.46)                 | 0.18<br>(0.38)             | 0.12<br>(0.43)                | 0.00    | 0.28<br>[0.11, 0.46]    | 493<br>(278, 215)         |
| Parent substance<br>misuse at the start<br>of care proceedings<br>– Drugs & Alcohol | 0.56<br>(0.50)                 | 0.69<br>(0.46)             | -0.13<br>(0.49)               | 0.00    | -0.26<br>[-0.44, -0.08] | 493<br>(278, 215)         |

SD = standard deviation; Un-std. mean diff.= non-FDAC–FDAC unstandardised mean difference ;  
CI = Confidence interval

**Table 5.3. Imbalance check before matching – secondary outcome analysis at case level (RQ4 & RQ5)**

| Covariate  | Non-FDAC group mean (SD) | FDAC group mean (SD) | Un-std. mean diff. (SD) | p-value | Hedges' g [95% CI]      | N (non-FDAC, FDAC) |
|--|--------------------------|----------------------|-------------------------|---------|-------------------------|--------------------|
| Year of issue – 2019   | 0.02<br>(0.15)           | 0.02<br>(0.15)       | -0.00<br>(0.15)         | 0.91    | -0.01<br>[-0.21, 0.18]  | 402<br>(186, 216)  |
| Year of issue – 2020   | 0.31<br>(0.46)           | 0.36<br>(0.48)       | -0.05<br>(0.47)         | 0.30    | -0.10<br>[-0.30, 0.09]  | 402<br>(186, 216)  |
| Year of issue – 2021   | 0.60<br>(0.49)           | 0.60<br>(0.49)       | -0.01<br>(0.49)         | 0.92    | -0.01<br>[-0.21, 0.19]  | 402<br>(186, 216)  |
| Year of issue – 2022   | 0.07<br>(0.26)           | 0.01<br>(0.12)       | 0.06<br>(0.20)          | 0.00    | 0.29<br>[0.09, 0.48]    | 402<br>(186, 216)  |
| Primary carer – Age  | 31.68<br>(7.58)          | 34.19<br>(6.72)      | -2.51<br>(7.21)         | 0.00    | -0.35<br>[-0.55, -0.15] | 382<br>(170, 212)  |
| Primary carer gender – Female  | 0.96<br>(0.20)           | 0.91<br>(0.28)       | 0.05<br>(0.25)          | 0.05    | 0.20<br>[-0.00, 0.40]   | 392<br>(177, 215)  |
| Primary carer gender – Male  | 0.04<br>(0.20)           | 0.09<br>(0.28)       | -0.05<br>(0.25)         | 0.05    | -0.20<br>[-0.40, 0.00]  | 392<br>(177, 215)  |
| Primary carer ethnicity – Asian/<br>Asian British                              | 0.02<br>(0.15)           | 0.01<br>(0.10)       | 0.01<br>(0.12)          | 0.27    | 0.11<br>[-0.09, 0.31]   | 382<br>(170, 212)  |
| Primary carer ethnicity – Black<br>African/Black<br>Caribbean/Black<br>British | 0.02<br>(0.15)           | 0.04<br>(0.19)       | -0.01<br>(0.17)         | 0.43    | -0.08<br>[-0.28, 0.12]  | 382<br>(170, 212)  |
| Primary carer ethnicity – Mixed/<br>multiple ethnic<br>groups                  | 0.09<br>(0.29)           | 0.05<br>(0.22)       | 0.04<br>(0.26)          | 0.11    | 0.16<br>[-0.04, 0.37]   | 382<br>(170, 212)  |
| Primary carer ethnicity – Other  | 0.04<br>(0.20)           | 0.00<br>(0.07)       | 0.04<br>(0.14)          | 0.01    | 0.26<br>[0.05, 0.46]    | 382<br>(170, 212)  |
| Primary carer ethnicity – White  | 0.82<br>(0.39)           | 0.90<br>(0.31)       | -0.08<br>(0.35)         | 0.03    | -0.23<br>[-0.43, -0.03] | 382<br>(170, 212)  |
| Primary carer – Past<br>domestic abuse   | 0.93<br>(0.25)           | 0.92<br>(0.27)       | 0.01<br>(0.26)          | 0.59    | 0.06<br>[-0.15, 0.26]   | 376<br>(166, 210)  |
| Primary carer –<br>Current domestic<br>abuse                                   | 0.76<br>(0.43)           | 0.43<br>(0.50)       | 0.33<br>(0.50)          | 0.00    | 0.71<br>[0.48, 0.93]    | 336<br>(144, 192)  |
| Primary carer<br>– Misusing at<br>the start of care<br>proceedings             | 0.93<br>(0.26)           | 0.74<br>(0.44)       | 0.19<br>(0.38)          | 0.00    | 0.52<br>[0.32, 0.73]    | 383<br>(171, 212)  |

SD = standard deviation; Un-std. mean diff.= non-FDAC–FDAC unstandardised mean difference;  
CI = Confidence interval

Tables 5.4–5.6 show imbalance checks after matching for the primary and secondary analysis. The results suggest that the CEM method was successful in maximising balance (between FDAC and non-FDAC groups on all matching covariates). For example, when looking at the covariates that were imbalanced in the primary outcome analysis (e.g. primary carer’s age, gender, ethnicity, past abuse, child’s age, ethnicity), we observe balance after matching (i.e. the difference between FDAC and non FDAC observations is close to zero). However, in an attempt to reduce imbalance, some of the observations did not remain in the analysed sample. A significant part of the sample was lost after matching for different levels of outcome measures: 382 out of 682 children (around 56%), 223 out of 499 parents (around 45%) and 156 out 402 cases (around 39%) were lost after matching (see [Figure 5.1](#) for losses and exclusion).

In the process of applying CEM, we also discovered that certain groups were no longer represented in our sample. For example, in the sample for the primary analysis, there were no longer male primary carers, in both the intervention (FDAC) and control (non-FDAC) group. Similarly, following matching, most ethnic groups were no longer included in the sample (99% of primary carers in FDAC and non-FDAC group were White). The demographic imbalance was to a great extent due to the observed variation in the original sample we received for analysis, and this was beyond the control of the quasi-experimental design.

**Table 5.4. Imbalance check after matching – primary outcome analysis (RQ1 & RQ6)**

| Covariate                                      | Weighted non-FDAC group mean (SD) | Weighted FDAC group mean (SD) | Un-std. mean diff. (SD) | p-value | Hedges’ g [95% CI]     | N (non-FDAC, FDAC) |
|--|-----------------------------------|-------------------------------|-------------------------|---------|------------------------|--------------------|
| Year of issue – 2019                           | 0.01<br>(0.11)                    | 0.01<br>(0.08)                | 0.01<br>(0.09)          | 0.59    | 0.06<br>[-0.16, 0.28]  | 300<br>(136, 164)  |
| Year of issue – 2020                           | 0.26<br>(0.44)                    | 0.27<br>(0.44)                | -0.01<br>(0.44)         | 0.91    | -0.01<br>[-0.23, 0.21] | 300<br>(136, 164)  |
| Year of issue – 2021                           | 0.68<br>(0.47)                    | 0.71<br>(0.46)                | -0.02<br>(0.46)         | 0.66    | -0.05<br>[-0.27, 0.17] | 300<br>(136, 164)  |
| Year of issue – 2022                           | 0.04<br>(0.20)                    | 0.02<br>(0.13)                | 0.02<br>(0.17)          | 0.23    | 0.14<br>[-0.08, 0.36]  | 300<br>(136, 164)  |
| Primary carer age                              | 33.48<br>(5.91)                   | 33.26<br>(5.29)               | 0.23<br>(5.58)          | 0.73    | 0.04<br>[-0.18, 0.26]  | 297<br>(135, 162)  |
| Primary carer gender – Female                  | 1.00<br>(0.00)                    | 1.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                      | 300<br>(136, 164)  |
| Primary carer gender – Male                    | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                      | 300<br>(136, 164)  |
| Primary carer ethnicity – Asian/ Asian British | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                      | 300<br>(136, 164)  |



| Covariate   | Weighted non-FDAC group mean (SD) | Weighted FDAC group mean (SD) | Un-std. mean diff. (SD) | p-value | Hedges' g [95% CI] | N (non-FDAC, FDAC) |
|---|-----------------------------------|-------------------------------|-------------------------|---------|--------------------|--------------------|
| Primary carer ethnicity – Black African/Black Caribbean/Black British | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Primary carer ethnicity – Mixed/multiple ethnic groups                | 0.01 (0.11)                       | 0.01 (0.11)                   | 0.00 (0.11)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Primary carer ethnicity – Other                                       | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Primary carer ethnicity – White                                       | 0.99 (0.11)                       | 0.99 (0.11)                   | 0.00 (0.11)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Primary carer – Past domestic abuse                                   | 0.94 (0.24)                       | 0.94 (0.24)                   | 0.00 (0.24)             | 1.00    | 0.00 [-0.22, 0.22] | 298 (135, 163)     |
| Primary carer – Current domestic abuse                                | 0.62 (0.49)                       | 0.62 (0.49)                   | 0.00 (0.49)             | 1.00    | 0.00 [-0.23, 0.23] | 272 (124, 148)     |
| Primary carer – Misusing at the start of care proceedings             | 0.90 (0.30)                       | 0.90 (0.30)                   | 0.00 (0.30)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Child age   | 4.27 (4.23)                       | 4.39 (4.04)                   | -0.12 (4.12)            | 0.79    | 0.03 [-0.25, 0.19] | 300 (136, 164)     |
| Child gender – Female   | 0.43 (0.50)                       | 0.43 (0.50)                   | 0.00 (0.50)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Child gender – Male   | 0.57 (0.50)                       | 0.57 (0.50)                   | 0.00 (0.50)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Child gender – Other  | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Child ethnicity – Asian/Asian British                                 | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Child ethnicity – Black African/Black Caribbean/Black British         | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Child ethnicity – Mixed/multiple ethnic groups                        | 0.02 (0.15)                       | 0.02 (0.15)                   | 0.00 (0.15)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |
| Child ethnicity – Other   | 0.00 (0.00)                       | 0.00 (0.00)                   | 0.00 (0.00)             | -       | -                  | 300 (136, 164)     |
| Child ethnicity – White   | 0.98 (0.15)                       | 0.98 (0.15)                   | 0.00 (0.15)             | 1.00    | 0.00 [-0.22, 0.22] | 300 (136, 164)     |

Note. CEM was able to match missing data as a separate category, resulting in N less than 300 for some variables where the imbalance check excluded missing values. The primary analysis otherwise included only matched and non-missing observations with the application of weighting (N = 264, non-FDAC n = 122, FDAC n = 142).

**Table 5.5. Imbalance check after matching – secondary outcome analysis at parent level (RQ2)**

| Covariate  | Weighted non-FDAC group mean (SD) | Weighted FDAC group mean (SD) | Un-std. mean diff. (SD) | p-value | Hedges' g [95% CI]    | N (non-FDAC, FDAC) |
|--|-----------------------------------|-------------------------------|-------------------------|---------|-----------------------|--------------------|
| Year of issue – 2019   | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 276<br>(143, 133)  |
| Year of issue – 2020   | 0.38<br>(0.49)                    | 0.38<br>(0.49)                | 0.00<br>(0.49)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Year of issue – 2021   | 0.62<br>(0.49)                    | 0.62<br>(0.49)                | 0.00<br>(0.49)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Year of issue – 2022   | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 276<br>(143, 133)  |
| Parent age   | 34.03<br>(6.58)                   | 33.36<br>(6.06)               | 0.67<br>(6.33)          | 0.38    | 0.11<br>[-0.12, 0.34] | 276<br>(143, 133)  |
| Parent gender – Female   | 0.74<br>(0.44)                    | 0.74<br>(0.44)                | 0.00<br>(0.44)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Parent gender – Male   | 0.26<br>(0.44)                    | 0.26<br>(0.44)                | 0.00<br>(0.44)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Parent ethnicity – Asian/Asian British                                     | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 274<br>(142, 132)  |
| Parent ethnicity – Black African/Black Caribbean/Black British             | 0.02<br>(0.12)                    | 0.02<br>(0.12)                | 0.00<br>(0.12)          | 1.00    | 0.00<br>[-0.23, 0.23] | 274<br>(142, 132)  |
| Parent ethnicity – Mixed/multiple ethnic groups                            | 0.01<br>(0.09)                    | 0.01<br>(0.09)                | 0.00<br>(0.09)          | 1.00    | 0.00<br>[-0.23, 0.23] | 274<br>(142, 132)  |
| Parent ethnicity – Other   | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 274<br>(142, 132)  |
| Parent ethnicity – White   | 0.98<br>(0.15)                    | 0.98<br>(0.15)                | 0.00<br>(0.15)          | 1.00    | 0.00<br>[-0.23, 0.23] | 274<br>(142, 132)  |
| Parent past domestic abuse   | 0.93<br>(0.25)                    | 0.93<br>(0.25)                | 0.00<br>(0.25)          | 1.00    | 0.00<br>[-0.23, 0.23] | 269<br>(139, 130)  |
| Parent current domestic abuse  | 0.70<br>(0.46)                    | 0.70<br>(0.46)                | 0.00<br>(0.46)          | 1.00    | 0.00<br>[-0.24, 0.24] | 246<br>(130, 116)  |
| Parent substance misuse at the start of care proceedings – Alcohol         | 0.11<br>(0.32)                    | 0.11<br>(0.32)                | 0.00<br>(0.32)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Parent substance misuse at the start of care proceedings – Drugs           | 0.11<br>(0.32)                    | 0.11<br>(0.32)                | 0.00<br>(0.32)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |
| Parent substance misuse at the start of care proceedings – Drugs & Alcohol | 0.77<br>(0.42)                    | 0.77<br>(0.42)                | 0.00<br>(0.42)          | 1.00    | 0.00<br>[-0.23, 0.23] | 276<br>(143, 133)  |

Note. CEM was able to match missing data as a separate category, resulting in N less than 276 for some variables where the imbalance check excluded missing values. The secondary outcome analysis at parent level otherwise included only matched and non-missing observations, excluded those caused collinearity and applied CEM weighting (N = 132, non-FDAC n = 57, FDAC n = 75).

**Table 5.6. Imbalance check after matching – secondary outcome analysis at case level (RQ4 & RQ5)**

| Covariate  | Weighted Non-FDAC group mean (SD) | Weighted FDAC group mean (SD) | Un-std. mean diff. (SD) | p-value | Hedges' g [95% CI]    | N (non-FDAC, FDAC) |
|--|-----------------------------------|-------------------------------|-------------------------|---------|-----------------------|--------------------|
| Year of issue – 2019   | 0.01<br>(0.09)                    | 0.01<br>(0.09)                | 0.00<br>(0.09)          | 1.00    | 0.00<br>[-0.24, 0.24] | 246<br>(116, 130)  |
| Year of issue – 2020   | 0.28<br>(0.45)                    | 0.28<br>(0.45)                | 0.00<br>(0.45)          | 1.00    | 0.00<br>[-0.24, 0.24] | 246<br>(116, 130)  |
| Year of issue – 2021   | 0.71<br>(0.46)                    | 0.71<br>(0.46)                | 0.00<br>(0.46)          | 1.00    | 0.00<br>[-0.24, 0.24] | 246<br>(116, 130)  |
| Year of issue – 2022   | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 246<br>(116, 130)  |
| Primary carer – Age  | 33.31<br>(5.87)                   | 33.17<br>(5.82)               | 0.13<br>(5.84)          | 0.86    | 0.02<br>[-0.22, 0.27] | 242<br>(114, 128)  |
| Primary carer gender – Female  | 1.00<br>(0.00)                    | 1.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 244<br>(115, 129)  |
| Primary carer gender – Male  | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 244<br>(115, 129)  |
| Primary carer ethnicity – Asian/<br>Asian British                              | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 242<br>(114, 128)  |
| Primary carer ethnicity – Black<br>African/Black<br>Caribbean/Black<br>British | 0.01<br>(0.09)                    | 0.01<br>(0.09)                | 0.00<br>(0.09)          | 1.00    | 0.00<br>[-0.25, 0.25] | 242<br>(114, 128)  |
| Primary carer ethnicity – Mixed/<br>multiple ethnic<br>groups                  | 0.02<br>(0.12)                    | 0.02<br>(0.12)                | 0.00<br>(0.12)          | 1.00    | 0.00<br>[-0.25, 0.25] | 242<br>(114, 128)  |
| Primary carer ethnicity – Other  | 0.00<br>(0.00)                    | 0.00<br>(0.00)                | 0.00<br>(0.00)          | -       | -                     | 242<br>(114, 128)  |
| Primary carer ethnicity – White  | 0.98<br>(0.15)                    | 0.98<br>(0.15)                | 0.00<br>(0.15)          | 1.00    | 0.00<br>[-0.25, 0.25] | 242<br>(114, 128)  |
| Primary carer – Past<br>domestic abuse   | 0.94<br>(0.24)                    | 0.94<br>(0.24)                | 0.00<br>(0.24)          | 1.00    | 0.00<br>[-0.25, 0.25] | 240<br>(112, 128)  |
| Primary carer –<br>Current domestic<br>abuse                                   | 0.53<br>(0.50)                    | 0.53<br>(0.50)                | 0.00<br>(0.50)          | 1.00    | 0.00<br>[-0.26, 0.26] | 216<br>(103, 113)  |
| Primary carer<br>–Misusing at<br>the start of care<br>proceedings              | 0.84<br>(0.36)                    | 0.84<br>(0.36)                | 0.00<br>(0.36)          | 1.00    | 0.00<br>[-0.25, 0.25] | 244<br>(115, 129)  |

Note. CEM is able to match missing data as a separate category. As a result, N was less than 246 for some covariates as the imbalance checks excluded missing values. Instead, the secondary outcome analysis at case level included only matched and non-missing observations and excluded those exhibiting collinearity (contested hearing N = 200, non-FDAC n = 98, FDAC n = 102; expert witness N = 206, non-FDAC n = 101, FDAC n = 105).

We also measured the quality of matching by examining the multivariate L1 distance statistic before and after matching. As explained in the Preliminary analysis section, the smaller L1, the less the imbalance across the covariates, with L1 = 0 indicating perfect balance and L1 = 1 complete separation across covariates. The L1 statistic after matching was computed by coarsening the data according to breaks as presented in [Table 3.6](#). Note that the multivariate L1 statistic was computed by the multidimensional histogram that included all possible bin sizes of covariates (Iacus et al., 2012). The multivariate L1 statistic therefore was dependent on the scale of the input covariates (King et al., 2017). We included a great number of covariates in the matching (particularly for the primary outcome), which increased the scale of all possible bin sizes, and therefore, the multivariate L1 statistic was likely to be high even with low level of imbalance observed across the covariates after CEM (see Tables 5.4–5.6). Nevertheless, Table 5.7 presents the multivariate L1 distance statistic before and after matching. The table shows a reduction in the multivariate L1 statistics across levels of matching, suggesting that a good matching solution was applied (Blackwell et al., 2009).

**Table 5.7. Multivariate L1 distance statistic before and after matching**

| Level of matching                          | Before matching | After matching |
|--|-----------------|----------------|
| Primary outcome analysis at child-level    | 0.86            | 0.79           |
| Secondary outcome analysis at parent-level | 0.65            | 0.46           |
| Secondary outcome analysis at case-level   | 0.61            | 0.34           |

## Primary analysis

We found that in our matched sample, while controlling for child and parental characteristics, a higher proportion of children undergoing FDAC were reunified or continued to live together with their primary carer compared to children with primary carers in non-FDAC care proceedings (52.0% versus 12.5%) (see [Table 5.8](#)).<sup>24</sup> The associated relative risk ratio (RRR) of the SATT for reunification is 4.15 (95% CI = [1.86, 9.24];  $p < .001$ ). The result suggests that reunification in FDAC is about four times more likely than in non-FDAC care proceedings. Taking these results together, we can conclude that children with primary carers in FDAC are more likely to be reunified with their primary carer at the end of care proceedings relative to children with primary carers in non-FDAC care proceedings.

This positive impact was robust to different specifications: running the model without any matching covariates (see the [Sensitivity analysis](#) below) and using a categorical instead of binary variable for placement at the end of the care proceedings (see the [Additional analysis](#) below).

<sup>24</sup> Multilevel models with the full list of covariates are presented in [Appendix F](#).

Table 5.8. Child reunification including full list of covariates

| Primary Outcome<br>– Child Reunification | FDAC group                                      | Non-FDAC group                                  | Effect size                                  |                                 |         |
|--|---|---|--|---------------------------------|---------|
|  | Proportion of reunification<br>(Standard error) | Proportion of reunification<br>(Standard error) | Total number of children<br>(FDAC, non-FDAC) | Relative risk ratio<br>[95% CI] | p-value |
|  | 52.0%<br>(0.08)                                 | 12.5%<br>(0.05)                                 | 264<br>(144, 122)                            | <b>4.15</b><br>[1.86, 9.24]     | <0.001  |

Notes: Full list of covariates along with the estimated coefficients can be found in Table F.1, [Appendix F](#).

## Sensitivity analysis

As described earlier, we replicated our primary outcome analysis with the full matched sample by excluding the characteristics used for matching from the regression model. Table 5.9 provides a summary of the analysis findings. The magnitude of the treatment effect is lower but remains statistically significant. The estimated effect was reduced to a risk ratio of 1.96 (95% CI: [1.21, 3.17];  $p < .005$ ). This indicates that children in FDAC sites are around two times more likely to be reunified in comparison to children in care proceedings as usual.

Table 5.9. Child reunification excluding covariates

| Primary Outcome<br>– Child Reunification<br>(no covariates) | FDAC group                                      | Non-FDAC group                                  | Effect size                                  |                                 |         |
|---|---|---|--|---------------------------------|---------|
|   | Proportion of reunification<br>(Standard error) | Proportion of reunification<br>(Standard error) | Total number of children<br>(FDAC, non-FDAC) | Relative risk ratio<br>[95% CI] | p-value |
|   | 39.9%<br>(0.06)                                 | 20.3%<br>(0.05)                                 | 294<br>(135, 159)                            | <b>1.96</b><br>[1.21, 3.17]     | <0.005  |

Notes: No covariates used in this model.

## Additional analysis

As an additional analysis, we estimated the difference between the proportion of children placed with their parent or primary carer and placed with another relative or family member between FDAC and non-FDAC care proceedings as well as the difference between the proportion of children placed with LA care between FDAC and non-FDAC care proceedings (**RQ 6**). The results are reported in [Table 5.10](#).

When comparing the proportion of children placed with primary carers (reference category) with the proportion of children placed within LA care between FDAC and non-FDAC sites, we find that children in FDAC sites had lower probability of being placed in LA care. The relative risk ratio associated with this difference in probabilities is 0.52 (95% CI: [0.33, 0.82];  $p < .005$ ). The results suggest that the likelihood of a child being placed with another relative or family member in the FDAC sample is lower than in the comparison sample; however, this was not statistically significant (RRR = 0.86; 95% CI = [0.50, 1.48];  $p = 0.595$ ).



Table 5.10. Child placement

| Outcome – Child placement    | Proportion of children placed with parent/primary carer (Standard error) | Proportion of children placed with another relative/family member (Standard error) | Proportion of children placed with LA care (Standard error) |
|------------------------------|--|--|---|
| FDAC group                   | 47.6%<br>(0.06)  | 23.8%<br>(0.06)  | 28.6%<br>(0.08)   |
| Non-FDAC group               | 17.7%<br>(0.04)  | 27.4%<br>(0.08)  | 54.7%<br>(0.10)   |
| Relative Risk Ratio [95% CI] | <b>2.69</b><br>[1.60, 4.51]  | <b>0.86</b><br>[0.50, 1.48]  | <b>0.52</b><br>[0.33, 0.82]                                 |
| p-value                      | <0.001   | 0.595  | <0.005  |

Notes: Full list of covariates along with the estimated coefficients can be found in Table F.2, [Appendix F](#).

## Secondary analysis

The updated study plan set out three different secondary outcome measure: parental alcohol and drug misuse cessation; contested final hearing; and use of external expert witness during care proceedings.

### Parental alcohol and drug misuse cessation (RQ2)

For the matched sample, we found that a higher proportion of parents in FDAC than parents in non-FDAC proceedings had ceased to misuse drugs or alcohol by the end of the proceedings (33.6% versus 8.11%). After controlling for matching covariates, the associated RRR<sup>25</sup> for this difference was 4.11 (95% CI = [1.68, 10.06];  $p < .001$ ; see Table 5.11). This indicates that parents in FDAC are four times more likely to stop misusing alcohol or drugs by the end of care proceedings relative to parents in non-FDAC care proceedings.

Table 5.11. Parent cessation including full list of covariates

| Secondary Outcome – Parent cessation | FDAC group                               | Non-FDAC group                           | Effect size                              |                              |         |
|--------------------------------------|--|--|--|------------------------------|---------|
|                                      | Proportion of cessation (Standard error) | Proportion of cessation (Standard error) | Total number of parents (FDAC, non-FDAC) | Relative risk ratio [95% CI] | p-value |
|                                      | 30.8%<br>(0.06)                          | 7.5%<br>(0.03)                           | 132<br>(74, 58)                          | <b>4.11</b><br>[1.68, 10.06] | <0.001  |

Notes: Full list of covariates along with the estimated coefficients can be found in Table F.3, [Appendix F](#).

<sup>25</sup> An RRR of 1.00 means that the likelihood of an outcome is the same in the two groups (treatment and control). An RRR that is less than 1.00 means that the likelihood is lower in the treatment group. An RRR that is greater than 1.00 means that the likelihood is increased in the treatment sample.

## Contested final hearing (RQ4)

For the contested final hearing outcome, we find that a lower proportion of case hearings were contested in FDAC than in non-FDAC care proceedings (4.2% versus 23.8%). The estimated RRR is 0.18 (95% CI = [0.06, 0.56];  $p = .003$ ). The associated RRR indicates that the likelihood of a hearing being contested in the FDAC sample is about 80% lower than in the comparison sample (see Table 5.12).

**Table 5.12. Contested case hearings including full list of covariates**

| Secondary Outcome – Contested case hearing | FDAC group  | Non-FDAC group                                    | Effect size                            |                              |         |
|--|---|---|--|------------------------------|---------|
|  | Proportion of contested hearings (Standard error) | Proportion of contested hearings (Standard error) | Total number of cases (FDAC, non-FDAC) | Relative risk ratio [95% CI] | p-value |
|  | 4.2% (0.02)                                       | 23.8% (0.09)                                      | 200 (102, 98)                          | <b>0.18</b> [0.06, 0.56]     | 0.003   |

Notes: Full list of covariates along with the estimated coefficients can be found in Table F.4, [Appendix F](#).

## Use of external expert witness during care proceedings (RQ5)

A lower proportion of FDAC cases used external expert witness assessments compared to non-FDAC care proceedings (7.7% versus 96.1%). The RRR of expert witness assessments is 0.07 (95% CI = [0.03, 0.24];  $p < .001$ ) showing that the likelihood of expert witnesses being consulted in FDAC cases is significantly lower than in non-FDAC cases (see Table 5.13).

**Table 5.13. External expert witness assessments including full list of covariates**

| Secondary Outcome – External expert witness assessment | FDAC group   | Non-FDAC group   | Effect size                            |                              |         |
|--|--|--|--|------------------------------|---------|
|  | Proportion of expert witness assessments used (Standard error) | Proportion of expert witness assessments used (Standard error) | Total number of cases (FDAC, non-FDAC) | Relative risk ratio [95% CI] | p-value |
|  | 7.7% (0.04)  | 96.1% (0.02)   | 206 (105, 101)                         | <b>0.08</b> [0.03, 0.24]     | <0.001  |

Notes: Full list of covariates along with the estimated coefficients can be found in Table F.5, [Appendix F](#).

The use of external expert witnesses was also recorded as a count variable (i.e. the total number of different witnesses used) and therefore a Poisson regression model was preferred. The RRR of the different types of external witness assessments is 0.07 (95% CI = [0.04, 0.14];  $p < .001$ ). The results suggest that on average FDAC cases used significantly fewer external expert witness assessments (0.16 witnesses per case) in comparison to standard care proceedings (2.19 witnesses per case) (see Table 5.14).

Table 5.14. Different types of expert witness assessments including full list of covariates

| Secondary Outcome<br>– Different types of expert witness assessments | FDAC group   | Non-FDAC group   | Effect size                            |                              |         |
|--|--|--|--|------------------------------|---------|
|  | Average number of external witnesses per case (Standard error) | Average number of external witnesses per case (Standard error) | Total number of cases (FDAC, non-FDAC) | Relative risk ratio [95% CI] | p-value |
|  | 0.16<br>(0.04)   | 2.19<br>(0.28)   | 206<br>(105, 101)                      | 0.07<br>[0.04, 0.14]         | <0.001  |

Notes: This outcome measure was defined as the number of different types of expert witnesses being consulted during care proceedings. It was constructed as a count variable based on the binary expert assessments variables drawn from the data collection templates (e.g. cognitive functioning assessment, psychiatric assessment, independent social work assessment).

## Missing data analysis

The missing primary outcome data does not exceed 5% of the intervention sample, and therefore, no imputation for missingness was carried out.



# IMPLEMENTATION AND PROCESS EVALUATION FINDINGS

This chapter sets out findings from the IPE, which used in-depth qualitative interviews to explore key facilitators and barriers to implementation and delivery of FDAC, and the experiences of different participant groups.

## Implementation and Process Evaluation

### FDAC sites overview

The IPE involved data collection with six FDAC sites and four non-FDAC sites. Among FDAC sites included in the study, sites varied in relation to how long they had been running, size of caseloads, and numbers of local authorities served. Eligibility criteria for referrals also varied. As previously noted by Tunnard et al. (2016), some FDACs had widened the core requirement beyond substance misuse alone, to include, for example, factors such as domestic abuse or cognitive difficulties without substance misuse. In these instances, our research found that eligibility decisions were made in relation to whether FDAC teams felt parents would benefit from intensive support (see the [FDAC delivery](#) section below for details).

Sites for the IPE were purposively selected to include a range of characteristics, and non-FDACs were sampled to facilitate comparability with the FDAC sites. Attributes of the final sample comprised the following:

- Sites served between one and three local authorities
- In terms of their geographic spread, three FDAC and three non-FDAC sites were based in urban areas, one of each were in rural locations, and the remaining two FDACs' settings were mixed (mainly urban with significant rural elements)
- The length of time FDACs had been established varied from under 12 months to eight years
- FDACs' annual caseloads ranged from seven to 40 cases
- Two FDACs sometimes accepted cases which did not have substance misuse as the primary concern.

## Set-up, implementation and governance

The FDACs sampled for inclusion in the IPE research had been operational for varying periods: some were well established, and others relatively new, using DfE funding to support set-up. This affected the extent to which participants from older sites were involved in or could recall issues of set-up and implementation. It is also important to note that experiences of setting up an FDAC will have differed over time: not least because of the COVID-19 pandemic, and more recent experiences will have been very different from those of FDACs set up at the start of the programme. Such differences are noted wherever possible throughout this section.



## Decision-making and application experiences

### Considerations for and against applying to set up an FDAC

Participants who had been involved in discussions about setting up an FDAC, or had heard about them, mentioned a range of considerations that can be classified in relation to three broad categories: perceived need, value and budget.

- **Need:** participants discussed a high prevalence of drug/alcohol misuse in care proceedings cases; low reunification rates achieved through standard processes; and high levels of recurrence among families experiencing these issues (echoing existing evidence such as CJI (2021)).<sup>26</sup> Some saw this as indicative that an alternative approach was needed to “break the cycle” and resolve issues more effectively.

Participants reported limited appetite in some local authority areas, however, related to a perception that standard care proceedings were sufficient. One view among non-FDAC participants was that support to which parents were referred during pre-proceedings should help them to make changes required for children to remain with them safely.

Financial viability was also a key consideration, and some participants recalled a concern among local authority stakeholders that demand would be insufficient for FDAC to achieve this for them.

**“Two of the local authorities ... were concerned as to whether or not they would generate enough FDAC cases to make it a viable financial option for them. ... that concern was probably misplaced because ... I could identify any number of cases that potentially would have been suitable for FDAC.” – FDAC judge**

- **Value/effectiveness:** participants recalled decision-making being influenced by evidence from other sites that had successfully implemented FDAC. This included information about reductions in expenditure relating to improved reunification outcomes, and shorter timeframes to complete care proceedings. These advantages were seen as underpinned by the opportunity FDAC offered for teams and the judiciary to gain greater insight into parents’ issues and underlying factors and to provide tailored support to address these effectively.

One view among non-FDAC participants was that FDAC might, however, be detrimental to families in repeating assessment and intervention work done during the Public Law Outline phase, and delaying the process for children to be fostered for adoption to achieve permanence where they could not be reunified with birth families.<sup>27</sup> Some expressed concerns about the sufficiency of the focus on the child throughout FDAC proceedings (chiming with some FDAC participants’ experiences

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<sup>26</sup> Previous research suggested that family reunification is particularly fragile in cases involving parental substance misuse in part because recovery is a lengthy and uncertain process. Many children end up in out-of-home care because parents are not able to overcome their substance misuse difficulties within care proceedings timeframes or sustain change over the longer term. Harwin et al.’s 2016 follow-up evaluation of FDAC, for example, showed that 25% of families in standard care proceedings were reunified (with children either remaining or returning home to the primary carer at the end of proceedings), compared with 37% of FDAC cases (Harwin, 2016).

<sup>27</sup> The Public Law Outline (PLO) is a practice direction applied once care proceedings have been issued.

of barriers to working in partnership with stakeholders who held similar views; discussed further in the **Governance and funding models** section).

- **Funding and resource:** As discussed below, DfE funding was fundamental to the successful set-up of some FDACs. In other areas, where local authorities juggled conflicting funding priorities and pressure to make savings, limited access to sufficient budget was a key barrier to implementation of FDAC – particularly once DfE match funding was no longer available. In some instances, planned FDAC provision was reduced due to limited budget; others were unsuccessful in grant funding applications and therefore could not proceed to set up an FDAC.

Related to this, some non-FDACs discussed a lack of staff resources. Social workers and the judiciary were felt to be overstretched already. Additionally, high staff turnover – and, therefore, limited numbers of experienced staff being available – was considered a potential barrier to effective implementation and delivery of a new, intensive programme of work.

### Application experiences

Participants who discussed the application process to set up an FDAC as part of the SFIP programme said that this required buy-in across agencies and, in some instances, between local authorities. Steering groups established to drive the application process included stakeholders such as local authority legal departments, children's services, finance, public health and Her Majesty's Courts and Tribunals Service (HMCTS). The aim was to ensure a consistent and coordinated approach which reflected the views and experience of key local partners involved in family justice and support.

Where local authorities sought to provide an FDAC jointly, the process to coordinate and plan effectively, accounting for differing funding priorities to agree a joint approach, was considered time-consuming. For some, it required more than a year of joint work to prepare and submit an application, and significant change to the commissioning group during that period could delay the process further. One view was that identifying and appointing an experienced project manager to lead on and push the FDAC application process forward worked well.

### Governance and funding models

The FDACs included in this research operated a range of different governance and funding models (see [Appendix H](#)). Key characteristics across sampled FDACs included:

- They had been commissioned either directly by local authorities, or through existing external service providers. Some participants discussed being situated within charitable organisations (for example, health and social care charities) or independent services that had been commissioned specifically to offer FDAC separate to the local authority.
- Staff contracting arrangements within these FDACs varied. They included, for example, a mix of direct appointments to FDAC teams, secondments from the local authority and specialist service teams, and contracts through partners commissioned to provide services to FDAC.

FDAC staff participants discussed receiving funding from local authorities, the Department for Education/Government, and partners such as the Police and Crime Commissioner.

### Governance models

FDAC participants who discussed strategic management arrangements mentioned steering and operational groups established at the initial planning stage to implement FDAC and provide ongoing oversight. Steering groups involved FDAC service managers working alongside commissioners and partner agencies, who reported on performance on an ongoing basis. One view was that these groups were instrumental in the set-up phase in engaging partners and designing operational and referral processes relevant to early stages of delivery.

Participants discussed three benefits and challenges relating to governance:

- Independence from the local authority/children's social services had a positive influence on how FDAC was perceived by parents and, therefore, on their engagement. FDAC's presentation as a separate entity was particularly beneficial where parents had not felt well supported going through standard care proceedings in the past. This echoes research by Tunnard et al. (2016), who found that independence was crucial at the start of some proceedings where parents were upset by the decision to bring proceedings.
- Where FDAC team members retained links to external services, they were also able to facilitate access to information held by those services about clients and facilitate rapid referrals (with access to support at greater pace than when referring externally). One view was that co-location within specialist services offered beneficial access to expertise and resources for FDAC to better support parents:

**"[T]hat independence from the local authority ... when you've got very resistant parents and they're thinking you're all the same, you're all the local authority. ... That has actually worked quite well. ... Also sitting within an organisation whose expertise is around substance misuse ... makes all the difference, because you've got so many resources that you can tap into to support parents as well." (FDAC staff)**

- Some participants suggested that, where colleagues were commissioned directly by the local authority, they were less likely to adopt a parent-centred stance, as a child-focused practice model was considered typical of children's services in standard care proceedings involving substance misuse. This could introduce a barrier to coordinated partnership working and effective support of parents. In addition, some staff participants were frustrated by inconsistencies they identified across the FDAC team and a sense that those more closely involved with children's services had greater influence on decisions at, for example, intervention planning stages.

**"It's too social worker-heavy ... it seems like they're working from a child social care model. ... there's no health visitors, there's no [domestic abuse worker] ... It's not very multidisciplinary for a multidisciplinary team. Essentially what's happened is they've opened up another child social**

care department. ... I think the local authority are too involved. [They] commission it, it's held in the local authority's offices, all of the social workers are from the local authority. They have too many fingers in it, and ... I feel like I have to shout very hard to get my voice heard." – FDAC staff

## Funding

Participants noted two key considerations related to funding: timeframes for which funding was available, and the level of provision to support a comprehensive service.

### Funding timeframes

Commitment to provision of ring-fenced resource for longer periods (beyond 12- or 18-month budgets) was felt to be beneficial in facilitating forward planning, security and staff retention. Funding commitments varied between local authorities, including some providing an FDAC jointly. In these instances, some local authorities had longer-term committed funding for their share of the provision, and others offered year-to-year funding, with less certainty over the longer term. One view was that ensuring continuity of funding over the medium to long term (five years, for example) would improve recruitment and retention of staff.

**"I think if these projects are to work ... to their best ability and seamlessly, then there needs to be certainty around what sort of funding streams are available and understanding that those funding streams will continue to be available". (FDAC judge)**

This echoes findings of previous research by Tunnard et al. (2016), who highlighted that a lack of secure funding for FDACs from one year to the next generated uncertainty and risk of under-resourcing the specialist team, reducing cover during staff absence and increasing staff burden, for example.

Participants from FDACs that had been in place for longer timeframes described two key facilitators of wider support for FDAC funding decisions: collation of evidence of impact, and the engagement and buy-in of senior stakeholders such as the judiciary.

### Level of funding

The level of funding to which FDACs had access was considered suitable or manageable for current provision, but participants (including staff and judiciary) noted that increased resource would enable teams to expand, recruit more specialist workers, and take on more cases, to the benefit of more families. One view was that their current provision was "just a starting point": participants felt that, if more resources were available, they would be able to meet demand for additional provision of FDAC support. In fact, securing additional funding in the life of their FDAC had enabled some sites that had been established for longer periods to continue and/or expand provision. Examples included increasing the number of FDAC court days that could be provided, or bringing specialists in areas such as domestic abuse or mental health into the team.

While there was clear appetite among some FDACs to expand, some participants highlighted the importance of considering all aspects of provision when thinking about potential growth. For example, the number of cases that could be taken on hinged on the

court's capacity and judicial availability. In some areas, these were already under pressure as a result of delays and backlog caused by COVID-19.

### Additional considerations

Participants discussed two additional barriers to implementation of FDAC that related to funding:

- **Competing priorities:** participants acknowledged that, though FDAC could achieve savings down the line, it was challenging for local authorities to ringfence funding for upfront costs of FDAC in the context of competing priorities (including pressure to achieve savings, provision for education, domestic abuse, secure placements, and to address issues such as county lines).
- Particularly where FDACs were reliant on external provision for specialist or ongoing support for parents, **the wider funding landscape** presented another barrier. FDAC staff highlighted that provision of such external services was limited, and those in place were often under-resourced, negatively affecting accessibility for parents.

**“Referring out to things that we can’t do [in-house], that can be massively frustrating because there just isn’t the resource there, really. ... there’s just less available to our clients in terms of support ... it can be really challenging to access things for them.” – FDAC staff**

## Implementation

### Early expectations

Staff participants (including members of the judiciary) across FDAC and non-FDAC sites had heard about FDAC from colleagues involved in the programme. Some attended presentations or training about FDAC prior to any direct involvement. Others had been involved prior to joining an FDAC team – for example, as social workers for parents whose cases went through FDAC.

Some of these participants reported that they were initially sceptical that the model would work. However, their views had shifted over time, informed and influenced by enthusiasm of other key stakeholders (such as members of the judiciary or strategic leads who had worked in or with other FDACs previously) and/or evidence of success in established FDACs. They hoped FDAC would both increase the number of families that were reunified at the end of proceedings and reduce rates of recurrence and future care proceedings being brought for these families.

Participants with more positive expectations anticipated FDAC offering something unique and involving a markedly different way of working from standard care proceedings. A number of anticipated impacts for parents, children and staff were discussed by FDAC staff in the interviews. For parents, it was expected that FDAC would involve more intensive work. One view was that FDAC incentivised change as it offered parents a “last chance” focusing on underlying issues rather than just symptoms and offering better access to holistic support with a supportive and problem-solving – rather than punitive – focus.



**“I felt it was needed because a lot of parents are penalised for their substance misuse rather than being supported, and don’t have the fair chance to ... make positive change to their lives and be successful with jobs or parenting or anything. ... there’s underlying reasons that these parents do these things ... I think it’s a fairer way to go through court trial proceedings, giving understanding to the parent and giving them the chance to make the changes that are needed.” – FDAC staff**

Participants with more negative earlier views said their first impression of FDAC was that it asked too much of parents and one view was that it expected the best of parents at one of the worst times in their lives. In addition, some participants felt parents did not sufficiently understand the process. For example, parents would sometimes arrive at their first case management hearing asking when they would get their children back, which staff perceived as indicative of limited understanding. There was also a view that, because of its strengths-based parent-centred approach, FDAC would not sufficiently take the needs of the child into account and might risk returning children to family homes that were not safe (echoing Harwin et al. (2014), who reported a “continuing minority view” that a focus on parents leads to lack of attention on the child). Some FDAC staff and partners said that learning more about the approach – including, for example, collaboration between FDAC and social work teams – had resolved this concern for them. For others, however, it persisted; there was also acknowledgement that some external partners shared this negative perception of FDAC, which presented a barrier to effective partnership working with them.

**“There’s some social work teams who ... have really struggled to give the reins to us and ... trust that we’re not just coming in with a really positive stance and saying everything is great and perfect. We have had some difficulties ... and challenges with certain social workers around that”. – FDAC staff**

Early expectations and views of FDAC also focused on the anticipated roles and workloads of staff, which were perceived to be more intensive than in standard care proceedings. Some regarded it as a preferable way of working and described themselves and colleagues as optimistic and excited to have the opportunity to work more holistically and in depth. They anticipated that a multidisciplinary approach would offer access to a greater range of views and improved communication between partners, resulting in better-informed practice. Additionally, the judiciary and courts were seen as having a more active role in facilitating and motivating change. One view among the judiciary was that FDAC would enhance the role of the court because of judges’ direct communication with parents, frequency of involvement and active oversight of cases. Judges would see parents more than twice as many times and engage with them actively as a motivator of change, rather than reviewing and “rubber-stamping” local authority recommendations.

Some staff, however, described the prospect of working more intensively as somewhat daunting, particularly where they would be required to take on substantial new responsibilities (one example was key work involving formal assessment of parents, which was previously the responsibility of trained social workers). Based on what they had seen

of colleagues' work in other FDAC teams, for example, one view was that this way of working was likely to be overwhelming:

**“[T]hey literally seemed to be running around after these clients 24 hours a day. [Before I was involved] I used to think, ‘Oh my God, thank God I don’t have anything to do with FDAC!’” – FDAC staff**

## **Staff training and guidance**

Across participating FDACs, a wide range of training and resources were available to respond to different needs, roles and contexts. Three broad key categories of training, guidance and support were discussed: formal FDAC training for whole teams; role-specific training; and ad hoc learning and support. Each of these are discussed in detail below.

### **FDAC-specific, formal training**

Comprehensive three-day training and guidance for all team members (including the judiciary) was delivered by CJI, alongside experienced FDAC team managers and judges, and included a training programme that employed case study scenarios and roleplays, and written materials on the FDAC model, roles and processes.<sup>28</sup> Participants also mentioned expert presentations on topics such as domestic abuse, Foetal Alcohol Syndrome, and the role of FDAC partners including social workers, mentors, and peer support fellowships such as Alcoholics Anonymous. The quarterly practice-sharing forums convened by CJI, comprising a mix of presentations, group discussions, seminars and feedback, was a further learning opportunity for everyone involved in FDAC delivery.

Overall, participants found these training sessions helpful, as presentations were appropriately pitched and engaging, and discussion sessions facilitated useful information-sharing between colleagues. Participants valued the mix of training methods (including, for example, presentations, roleplays and discussion of case study scenarios), which appealed to a range of learning styles. Remote delivery, necessary for some during the pandemic, was considered a potential barrier to effectiveness; however, one view was that virtual delivery remained upbeat and effective.

Additionally, one view among judges was that bringing together whole teams (including members of the judiciary, social workers and specialists in, for example, mental health and other disciplines) in training sessions had two key benefits. One was the opportunity for team bonding, which helped to support onward collaborative work. The second was the opportunity to gain valuable insight and understanding of how other professions thought and operated. This was considered a rare opportunity for judges, to whom colleagues would typically defer in standard public law work. This echoes findings in previous research by Tunnard et al. (2016) on the importance of networking and ongoing training for FDAC judges.

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<sup>28</sup> The FDAC National Unit was created in April 2015 by the Tavistock and Portman NHS trust and adoption charity Coram, with support from the Department for Education's Children's Social Care Innovation Programme. The National Unit scaled up the FDAC intervention, supported nine FDAC sites, and closed in September 2018. The Centre for Justice Innovation (CJI) now provides national leadership to strengthen, expand and champion the FDAC approach, offering set-up advice and support, induction training and mentoring to FDACs.

### Role-specific training

Role-specific training, of which there was a mixture of in-house and outsourced provision, was also considered very important. Examples included targeted training on referrals, drug testing, writing court reports, motivational interviewing and understanding trauma. As Tunnard et al. (2016) have noted previously, training in motivational interviewing was particularly important for members of the judiciary, as non-lawyer reviews required them to engage with parents in a very different way than in standard proceedings. FDAC leads and support staff also considered practical tools and reference materials (such as help sheets on intervention planning, intervention timelines and parent workbooks) helpful to support their practice.

### Ad hoc learning and peer support

Participants described a range of ad hoc training and ongoing support, which included professional supervision and case management support as well as discussion and information-sharing with the wider FDAC team. This chimes with previous research by Harwin et al. (2011) which highlighted that reflective practice in regular supervision and team meetings were key elements of staff support in FDAC. Where they had joined FDAC at its inception, staff participants felt that a collaborative approach and range of relevant knowledge and experience within the multidisciplinary team supported “on the job” learning. Indeed, some participants who had not had access to FDAC-specific training sessions felt they had sufficient professional expertise and access to information via FDAC or other team colleagues.

FDAC staff and judges also appreciated opportunities to learn from the wider FDAC network. These included shadowing intervention planning meetings and court hearings in more established FDACs to learn from colleagues in equivalent roles, and gain experience and insight on particular processes (assessments and conduct of non-lawyer reviews, for example). At some sites, shadowing was a formal part of the induction programme.

Some participants also appreciated opportunities to consult their peers on specific issues. Access to a supportive peer network of FDAC practitioners was valued.

**“I’ve got good links ... if I need to ... ask a question [the manager] will come back to me and say ‘Yes, we tend to do it like this’. The whole FDAC community’s really supportive of each other.” – FDAC staff**

### Gaps and challenges in training

Participants in this research discussed four key gaps and challenges in relation to provision of training and guidance.

#### Availability and access

Access to formal training was relatively limited for some site and support leads – some said they had not had any FDAC-specific training, for example, or that this was limited to reading materials or a single briefing presentation. While some participants were content to learn from peers and colleagues, as described above, others would have valued more frequent formal training opportunities to ensure that key learning around the FDAC approach and delivery model aligned with the point at which they began delivery. Related to this, there was appetite for more regular information-sharing, which could help to

ensure FDAC practice was fully grounded in evidence around what works to achieve the best outcomes for families and the family justice system more broadly.

There were two key reasons that access to training was perceived to be limited. One was that the available sources changed over time: some FDACs were launched after the FDAC National Unit ceased training provision, for example, meaning that there was some confusion over where to access guidance and information for their team.<sup>29</sup> In other cases, individuals joined their FDAC after training had been provided to others. Where the schedule was misaligned with the start of participants' involvement with FDAC, some couldn't access training until they had been in post for some time, meaning they did not fully understand the delivery model at first.

**“I joined just as we were going live. So it's been learning as I go and picking up training as and when I can fit it in ... I've just had to – unfortunately, because of the way timing has worked I pick it up as I go along.” – FDAC staff**

As well as training delivery, it was important that written information and tools were provided to align with when staff started working with families. Some participants said they had received additional tools some weeks into delivery that they would have found useful earlier on and recommended that these be included in induction training packages to use from the outset.

### **Gaps in role-specific training**

Training needs varied in relation to specialism and experience, and some colleagues needed to “get up to speed” with theoretical models underpinning their team's practice or particular ways of working. Priority areas included training in court skills (including guidance around the level of detail and evidence to include in reports) and refresher training to help embed skills during delivery.

Examples of specific gaps in training/guidance relating to particular roles were:

- Training around assessment and writing court reports for staff who lacked experience of these skills in their work prior to FDAC (including, for example, family support and substance misuse specialists)
- Training for members of the judiciary around emotional resilience, to support them during and after delivering news of negative outcomes to parents, given the more involved and caring relationships developed during the intervention.

### **Communication**

Members of the judiciary suggested that existing training provision might be better advertised to encourage participation. One view was that it would be beneficial for information about training opportunities, including motivational interview training, to be disseminated more widely; one suggestion was that Judicial Office involvement in training provision might help to increase its profile.

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<sup>29</sup> It should be noted however that while some participants highlighted confusion over where to access training after the National Unit closed, the CJI provided the three-day induction training mentioned on page 58 which was available to all new FDAC sites and existing sites that expanded.

Additionally, one recommendation made by the judiciary was that an annual forum for FDAC colleagues to exchange experiences, ideas and good practice would be welcome – which suggests that not all judges were aware of the available networking opportunities (such as the National Judicial Forum) discussed by other participants. The appetite for ongoing networking and training opportunities echoes previous research evidence, such as Tunnard et al. (2016) mentioned above.

### COVID-19

Finally, the COVID-19 pandemic presented challenges in terms of the effectiveness of training. For example, some participants reported that the pandemic had introduced a month-long delay between their training and their site's launch, such that when the time came to put lessons into practice, it was no longer fresh in their minds and they had to learn as they went along.

## FDAC delivery

This section explores how FDAC worked in practice, bringing together data from parent, FDAC, and non-FDAC interviews. An overview of the delivery model is provided in [Appendix G](#) and is referenced throughout this section.

### Initial case assessment and allocation

#### FDAC eligibility

Site and support leads discussed three key criteria for parents to be referred to FDAC: they must present with either alcohol or substance misuse problems (except in some FDACs which also supported parents for whom domestic abuse was the primary issue); must indicate motivation to change this (for example, by engaging with a treatment provider or saying they want to change);<sup>30</sup> and the local authority must be issuing care proceedings.

Flexibility to take on a wide range of cases, and work in a way that best supported engagement, was highlighted as a key strength of FDAC compared with BAU. One example related to parents in relationships where domestic abuse allegations had previously been made. While the ongoing risk of domestic abuse was an important consideration in assessments of parents' motivation and readiness to engage, participants noted that in FDAC there was scope to work with such couples without requiring them to split, so that both parents could be supported to make changes.

FDACs were able to decline referrals on the basis of their team's capacity and/or assessments of parents' motivation to engage. Participants mentioned that exclusions could be made on the basis of parents' ability to engage where they had ongoing, active psychosis; very severe learning difficulties; or a high risk of domestic abuse, for example.

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<sup>30</sup> While 'motivation for change' was cited by FDAC staff as a decision-making factor regarding eligibility, guidance from the CJI states that assessments of motivation to change are not an element of the core FDAC model and training does not encourage FDAC teams to use motivational assessments in determining eligibility, given the growing evidence base which suggests that their value as predictors may be compromised by factors including the impact of trauma on behaviour, the trend towards socially desirable responding and the potential for implicit bias amongst assessors.



**“[W]e’ll take anyone who is ready to commit to abstinence and is able and willing to work with us. So there are some things that rule you out ... It’s a big process ... we’re asking them to do multiple things each day, and some parents just aren’t in that place.” – FDAC staff**

One view was that if parents were not ready for FDAC, there was a risk that the intensive process could perpetuate a cycle of negative experiences with support services.

**“Social care ... have to have a really good argument for us to want to take them on, because ... we don’t want to set somebody up to fail ... repeating a cycle of professionals working against families ... This is a hard process to go through ... so sometimes ... they’re not ready; they’re telling us they’re not ready. ... I’ve had it with a case recently ... I think we offered ... six assessment sessions and it just wasn’t working. So we take it into court and say, ‘This is where we’re at. She’s not ready. It’s got to go through standard care proceedings; she’s not in a place to do [FDAC].’” – FDAC staff**

## Referrals

Participants discussed three main referral routes into FDAC: from local authorities (via social workers or legal teams who were responsible for decisions about care proceedings); from colleagues working with families at the pre-proceedings stage (in partner agencies or wider services FDAC teams were situated within); and by parents’ lawyers or member of the judiciary when cases had already been brought to court.

FDACs aimed to instil a collaborative approach to support identification and referral of eligible cases, and it was important to encourage discussion. Some FDACs discussed potential cases prior to formal referral as standard – for example, in weekly meetings with local authorities to review and allocate cases where proceedings were about to be brought; or individually on an ad hoc basis. FDAC teams would consult social workers about parents’ understanding of issues and desire to be abstinent, and also provide information to give to families about what going through FDAC would involve. In some instances, information-gathering at the referral stage involved FDACs speaking directly to parents.

While there was evidence of effective collaboration around referrals, three interlinking challenges were identified with the process:

- Referral decision-making was not always transparent. For example, some participants questioned whether the process of determining eligibility was consistent or systematic across local authorities.
- Linked to this, some participants described initial reticence to refer to FDAC, which they related to variations in awareness and understanding of FDAC’s purpose and role, as well as around which cases would be eligible. This chimes with previous research evidence from FDAC judges, who felt that concerns among social workers, guardians and lawyers tended to decrease as they gained experience of and became accustomed to the FDAC model (Tunnard et al., 2016).
- Capacity to take on cases varied. Where it was limited, local authorities might more purposively select those parents they felt to have the best chance of success:



**“The local authorities ... because they only have, say, 15 spaces a year each ... may want to pick people who they feel have a better chance. So there is some picking of cases in the local authority. If they know they’ve got a lot of spaces, we’ll get pretty much anyone through. If they know they’ve maybe only got one [space] and they’ve got three or four families going into proceedings, they’ll weigh up and send us the person they think will do best.” – FDAC staff**

## **Onboarding: introduction, initial engagement, assessment and planning**

### **Early engagement**

Parents were made aware of FDAC prior to their contact with the team, through their social worker or at care proceedings information hearings in court.

Early engagement by FDAC teams involved them speaking to parents to talk through the process. Staff stressed that emphasis was placed on parents having a choice as to whether or not to engage with FDAC, and felt it was important that they were clear from the outset about the intensive work that would be involved. Parents appreciated clear, reassuring conversations with key workers and mentors at this stage. Parents said they agreed to go through the FDAC process for a number of reasons: because it offered intensive support and a collaborative approach, because it was different to things they had already tried, or because of evidence they were able to access relating to its effectiveness. The latter led them to believe it offered them the strongest chance of keeping their child.

**“[I]nstead of being a court case where you get your case heard one day and then ... they choose whether you’re fit enough to be a parent or not, like the normal courts, they said it would be spread over ... months and ... [t]hey’d see you every two weeks ... A normal court wouldn’t help you off the drink and drugs to keep your child. They’d just say, ‘Look, you’re obviously putting your drink and your drugs before your children, so bang, we’ll have your child off of you.’ FDAC is different. It gives you the maximum opportunity to do what you need to do to keep your child. It’s so much kinder.” – Parent**

Some FDACs completed pre-assessment screening prior to the assessment days to check parents’ suitability, with particular focus on their willingness and motivation to engage. Screening also explored parents’ understanding of the process and any barriers to change, and included baseline drug testing. Some FDACs had recently introduced pre-assessment screening across all cases to streamline the process and ensure that a lack of motivation would be picked up prior to the time-intensive full assessment.

Staff also described scheduling activities for parents to start as soon as possible after these initial discussions, with the aim of building momentum and supportive relationships from the earliest point.

### **Initial assessment**

FDAC teams completed full, formal initial assessments of parents (including the subsequent formulation of the intervention plan and agreement of this with parents and all other professionals) within two to four weeks. Initial assessments typically

involved team members meeting the parent for a full day of in-depth discussion of their experiences and issues, which sought to build on information provided in the court bundle. In terms of coverage, the assessment comprised:

- Substance misuse assessments – which included capturing baseline data on alcohol/drug use (using screening tools and blood or hair strand testing)
- Social work assessments – which included, for example, discussing childhood and family history; parenting and relationships; domestic abuse; physical and mental health
- Gauging parents' ability and motivation to engage, and discussion of parents' hopes and goals to feed into their intervention plans.

Programme documentation specifies that following the initial assessment day, the FDAC model requires the full FDAC multidisciplinary team to meet to formulate the outcomes of the assessment day to devise a bespoke intervention plan for the family (CJI, 2023). It is intended that the formulation of the plan follows a clinical model and is led by either the clinical lead or team manager. An intervention planning meeting should follow where the intervention plan is agreed with the parents, child's social worker and child's guardian before returning to court for a second case management hearing (CJI, 2023).

Staff participants described the initial FDAC assessment as holistic and comprehensive, gathering much more information at an early stage than in BAU. This echoes research by Harwin et al. (2011) which found that FDAC assessments uncovered a greater number of support needs – relating to substance misuse, mental health and domestic violence – than were identified by local authority care proceedings applications. It was regarded as a “tough” and intensive process due to the depth of coverage and time required of parents. Some parents felt that the assessment process was daunting and found it difficult as it explored sensitive topics in detail (including, for example, past drinking habits and experiences of trauma). They accepted, however, that this was necessary to work with parents in a meaningful and holistic way.

**“It was very intense. ... I met my key worker [and three other staff.] It was a very long day ... it did go on for about five hours ... We discussed everything from my past ... my family, my daughter, my drinking, my relationships ... my childhood, the lot. ... I knew it was something I had to do, so I forced myself to get ... through it all.” – Parent**

Staff and parent participants described three facilitators to this part of the process:

- The purpose of the initial assessment discussions was clearly explained, which parents said helped them to understand its value and alleviated their nerves.
- A relational, trauma-informed, flexible approach was taken from the outset – aiming to accommodate parents' needs, put them at ease, and move at a pace they could tolerate to support engagement. Examples included staff carrying out assessments at parents' homes when this would reduce their anxiety, and the assessment being attended by people parents already knew – such as a peer mentor – which parents said made them feel more comfortable.

**"It's kind of taking it on a case-by-case basis and looking at the individual's needs during that session. We've had some parents who have turned up and are really jittery, really overwhelmed with everything, so it's about just kind of taking small steps as much as possible." – FDAC staff)**

- Offering visits or other contact between this assessment and the sign-up hearing further supported relationship-building and engagement at this early point.

Two barriers to the initial assessment process were also identified:

- Difficulties accessing relevant information in a timely way. Where information from the local authority was provided late or referrals included insufficient detail, FDAC assessments lacked relevant background information. This could result in repetition and duplication of effort by both professionals and parents, as FDAC teams had to gather information that may previously have been provided to local authorities.
- Resistance by parents. Some parents described unwillingness to discuss past traumas, unsure how sharing this information would help; others were reluctant to reveal ongoing substance misuse, which could impact on their ability to effectively engage with support. There were, however, instances where parents who were initially reluctant to share information about drinking habits and past trauma had done so to their benefit.

**"I didn't understand, really, FDAC's need to probe into all different parts of my life ... But the more I talked to my support worker, the more she highlighted that, actually, the domestic violence is a trauma. Your dad passing away was a trauma ... those are actually the reasons for the drinking, so you sort those out and then you would, be able to continue not drinking. Otherwise you'll always resort back to it. It took me a bit of time to get my head around, but yes, it made sense." – Parent participant**

## **Intervention planning**

### **Formulating a plan**

For parents assessed as eligible for FDAC, the team next met to formulate a plan, which would guide onward support and goals throughout the FDAC process. (Plans would be discussed with parents in the intervention planning meeting as detailed below.) Staff felt that it was beneficial for colleagues across disciplines (such as substance misuse, mental health and domestic abuse specialisms) to be involved in developing parents' plans, to ensure that the intervention was appropriately targeted.

**"You don't want a process where everybody agrees, because then there's nobody questioning hypotheses, there's nobody thinking about it from a different angle. You want questions, don't you? That should be happening ... I would see it as a positive." – FDAC staff**

Involvement of families' social workers in the formulation meeting differed across FDACs. Some participants acknowledged that their involvement in the planning process was sometimes perceived as compromising the impartiality of the FDAC team and process.

This was because families' social workers were seen as representing local authority children's services, rather than sharing in FDAC's parent-centred, trauma-informed approach. However, to ensure a collaborative approach was taken, some FDACs decided to include social workers in the process and it was felt to support their buy-in and understanding of FDAC in general, as well as of the individual cases.

**"I was ... very keen that locality social workers played a really significant role ... actually the social worker is going to be the person who's involved with this family for the long term and it's not going to work if you don't bring the local authority with you. You've got to all work together, even if you disagree." – FDAC staff**

While there was appetite to involve a range of stakeholders in this part of the process, ensuring that views and perspectives were appropriately balanced was a key challenge. Where teams were weighted to a particular discipline or did not have a shared understanding of a parent-centred practice model, for example, some staff felt it was difficult to make their views heard and that the intervention would not be as effectively tailored as they hoped.

### **Intervention planning meetings (IPM)**

Following the development of the intervention plan, the programme documentation specifies that the team holds an intervention planning meeting (IPM). The purpose of the meeting is for the FDAC team to feedback findings from their assessment, to explain the proposed plan reached through formulation, and to agree the plan to be submitted to the court.

IPMs would typically involve the parent, FDAC team manager and practitioner, psychologist or clinical lead, and social worker. Some would also involve others such as the child's guardian and (if relevant) a treatment service care coordinator.

Participants had mixed views on the effectiveness of IPMs and surrounding processes. Some staff participants felt that parents had limited opportunity to input into assessment or intervention planning, which might impact on their subsequent engagement. Staff also noted that the goals identified within plans tended to be consistent across clients, which some saw as an indication that there was limited tailoring for individuals. An additional barrier was that some parents felt unable to contribute meaningfully to the process because of their drug use or circumstances at the time.

Other participants, however, saw the process as highly collaborative and supporting parents to lead their own change. For example, staff said parents were consulted to ensure they were happy with their plan, ensuring they felt listened to. Some parents said they felt able to give their opinion and have a say throughout the process; others said they had not themselves known what they needed, but felt fully involved as their key worker identified what they needed help with from the discussions they had together. Staff participants also noted that parents often identified the same broad goals as FDAC teams, agreed with the draft support plans, and were happy to accept support.

## Support provision

Outside of court, FDACs provided high-frequency, comprehensive, wraparound support from different specialists, assessing and responding to parents' needs in depth. Staff and parent participants described FDAC as a much more intensive process for parents than standard care proceedings, with multiple support appointments each week (consistent with previous research, such as Harwin et al. (2014)). One view among both staff and parents was that this “structured week” was important in developing parents' capacity, building momentum and keeping them on track.

**“Every day of the week for the first few months we had some sort of meeting or someone come and see us or something like that. There is always something going on every day for the first few months, but that helped me realise that in actual fact they are there to help me. They are there to make me succeed in the kindest of ways. They were pushing me to make me succeed in what I needed to do to keep my son.” – Parent**

The rest of this section discusses views and experiences of the various elements of the FDAC support offer, including specialist and key worker support, parent mentoring, drug testing, and support for children. Cross-cutting facilitators and barriers are considered towards the end.

### Specialist support, with key worker coordination

A key feature of FDAC was regular contact with a dedicated key worker from the FDAC multidisciplinary team, who provided 1:1 support as well as coordinating a range of provision from different services. This was very different from BAU, where parents were expected to manage appointments and engage in support by themselves, and some support could not be accessed within the 26-week timeframe of care proceedings. This difference is consistent with previous research on FDAC, including that of Harwin et al. (2011), for example, who found that parents accessed services more quickly and received more support.

In FDAC, 1:1 key worker support included them being:

- The primary point of contact for the parent, managing their case and coordinating support to make it easier for parents to access
- Available for support on a daily basis in addition to regular scheduled 1:1 sessions
- Directly responsible for intensive 1:1 support on relevant topics, such as mental health, domestic abuse, substance misuse, and parenting. Key workers also offered practical support (including home visits to assess and address living conditions issues, and help with benefits applications, for example). Staff described a structured programme of key work support, starting with substance reduction and steps to implement a routine which, once in place, could serve as the foundation enabling parents to address other issues
- The first port of call for other professionals. Typically, key workers would resolve issues between agencies; collate reports to non-lawyer reviews; and feed back to other FDAC team members. Related to this, a key difference from BAU was that FDAC



key workers were allowed to contact the child's social worker to discuss any issues, whereas in standard proceedings contact would have to be made through the local authority's legal department. Opportunities to engage directly could support more effective collaboration and streamline processes to minimise delays.

Parents' schedules of activities also included work with, as relevant, specialists in substance misuse, mental health, domestic abuse, and parenting. Staff participants emphasised the importance of effective team- and partnership working, including collaboration, timely communication and clear lines of responsibility.

### Parent mentoring

Peer support from parent mentors – individuals with direct experience of care proceedings and sustained recovery – was available in some FDACs. This support was considered beneficial, though some FDAC staff found its provision to be time- and resource-intensive as it was important to supervise and support mentors, for their own safety and comfort as well as those of parents they worked with. Mentors could:

- Offer guidance and help parents to navigate the process
- Encourage parents to engage and be honest with FDAC professionals
- Promote trust, lessen shame, and inspire hope as result of shared experience
- Work more flexibly than members of staff, including supporting parents out-of-hours.

In FDACs where mentoring was in place, parents valued support from somebody they could relate to (consistent with previous research by Harwin et al. (2011)). This was perceived to be particularly important in the context of adversarial past relationships with social services, which, at least at the start of the process, made parents less trusting of professionals.

**“I needed someone around me that was there as soon as I woke up, kind of thing – available to speak to and calm me down and, if need be, come and pick me up. That’s what he did. He did everything within his power to help me.” – Parent**

There was appetite among both staff and parents to introduce mentoring at sites where it was not yet in place. However, some participants highlighted that COVID-19 had been a barrier to implementing or extending peer mentoring services in their area.

### Drug testing

FDACs carried out drug testing much more frequently than in standard proceedings.<sup>31</sup> Similar to standard proceedings, hair strand and blood tests were completed at the beginning and end of FDAC proceedings, to establish hard evidence of the baseline and change over the course of the intervention. However, FDACs also frequently undertook additional voluntary testing measures, including breathalysers, mouth swabs and urine tests between these endpoints, both at key work sessions and at some unannounced visits to parents' homes. Some FDACs used additional tools such as alcohol-monitoring ankle bracelets to encourage abstinence.

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<sup>31</sup> Programme documentation highlights that when parents choose to sign up to FDAC at the second case management hearing they agree to regular, voluntary drug testing to occur.



Staff said that, rather than frequent testing being used as a punitive tool, its purpose was to gather supporting evidence of progress, enabling parents to demonstrate and prove their recovery. Parents reported that testing encouraged their openness and transparency; staff said it could facilitate challenging conversations with parents. It also helped parents to be accountable and focus on their substance misuse. Frequent testing enabled FDACs to understand and evidence any patterns and/or changes in parents' substance use over time. As such, staff noted that it could build a more accurate picture of a parent's substance misuse issues, helping to pinpoint stresses and triggers and target support where needed. In BAU, by comparison, testing was much more limited and used simply to assess whether or not parents were abstinent at key points in the process.

Practical considerations were a barrier to frequent testing for some. For example, the extent of monitoring that was possible was sometimes limited, particularly where the FDAC covered a large geographic and/or rural area, meaning staff would have to travel long distances to carry out unannounced home visits.

### Support for children

Some staff also discussed support for children, which was considered important in ensuring that the FDAC process took children's needs into account. This included meetings of professionals to understand children's needs and factor them into decision-making, and provision of information to children to help them understand the FDAC process and their families' experiences. Examples included tailored story books and information packs, and direct engagement between the judge and the child (supported by their guardian and social worker). Some FDACs also provided access to family therapy later in the FDAC process to support families as whole.

### Facilitators/key elements of support provision

Three interlinking supportive factors were discussed in relation to provision of support within FDAC: its intensiveness; relationship-building; and flexibility.

#### 1. Intensive, in-depth support from specialists to address underlying issues

Rather than focusing narrowly on immediate needs alone, FDAC supported parents to address underlying issues, looking in depth at reasons behind their substance misuse. Participants across groups saw FDAC as offering the opportunity to effect change at a fundamental level through holistic, in-depth assessment and issue-focused intervention support, which focused on the parent rather than solely on their child. One view among parents was that this contrasted starkly with standard care proceedings, where social services were sometimes felt to deprioritise parents in favour of the child's needs, or to require them to achieve results without appropriate support to address issues.<sup>32</sup>

The high frequency of appointments over the intervention timeframe was seen by both staff and parent participants as giving parents an opportunity to address longstanding issues, and staff also said that smaller caseloads enabled them to engage in depth in trauma-informed work which was not possible in the BAU context. Specialist

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<sup>32</sup> This finding links to Harwin and Golding's (2022) findings on care proceedings in their recent study: <https://www.cfj-lancaster.org.uk/projects/parental-experiences-of-care-proceedings-supervision-orders-and-care-orders-at-home>

providers could also work more intensively and longer with parents than in standard care proceedings, where they would typically be asked by local authorities to conduct more targeted assessments to answer specific questions, and might do a time-limited intervention with client on a specific issue to minimise risk, rather than assessing and responding to their issues in the round.

A key difference between FDAC and BAU was that it offered a wider range of expertise within or accessible to the multidisciplinary team, provided in a holistic way. Parents suggested that provision of support in combination was particularly effective in motivating and supporting their recovery.

**“It was a good set up, the bracelet on my ankle, the one-to-one meeting with my mentor, all those things together and with the drug and alcohol testing. All of that together forced recovery.” – Parent**

In addition, FDAC teams could offer access to a range of support and resources that social workers might not be able to – including, for example, family therapists and psychotherapists. As a result, one view was that FDAC was better able to identify issues such as trauma, including post-traumatic stress (PTSD).

Finally, the multidisciplinary approach also meant FDAC professionals did not have to wait for court hearings and formal applications for expert intervention to be accessible – staff participants said it was therefore quicker to secure assessments and referrals. In some instances, access was facilitated by partnerships with, or co-location within a wider service offering specialist provision. Examples included video interaction guidance on parenting, a range of psychological therapy specialisms (such as cognitive analytic therapy, psychological support and psychiatrists); family therapy; learning difficulty specialists; domestic abuse and sexual risk specialists.

## **2. Relationships, openness and transparency**

Developing strong, supportive relationships was a key focus of the FDAC approach. Parents described key workers’ support, in particular, as integral to their understanding and experience of the process; this was very different to their experiences in standard care proceedings which were perceived as more adversarial.

**“She’s my key worker but she’s like my friend. She’s got so much time for me ... Words can’t describe it. Her support has been brilliant. I’ve got through all this with her support.” – Parent**

Participants across staff and parent groups discussed the importance of having dedicated contacts and being able to get in touch with the team at any time. As outlined below, key workers worked flexibly to accommodate parents’ needs as much as possible. Developing strong and collaborative relationships enabled key workers to encourage and, where necessary, challenge parents to support them to engage productively).

**“[My key worker] knew how to turn the pressure on as well. If I wasn’t doing something right, she would tell me, so it wasn’t like it was all roses all the time. If I hadn’t done something, then I would know about it ... everybody**

**needs that push every now and again just to get them on the straight and narrow, and say, ‘Well, come on, you missed that last week. You’ve got to do it this week.’” – Parent**

This chimes with previous research which has highlighted the value parents placed on practical and emotional support provided by FDAC, including motivation supported by experienced workers who knew how to help them regain responsibility and overcome difficulties (Harwin et al., 2014).

### **3. Flexible, individualised approach**

Previous research has noted that FDAC offered parents an individualised package of care (Harwin et al., 2011). In this study, staff talked about tailoring FDAC support, taking a “holistic and fluid” approach to accommodate individual needs and ensure the intensity of work was geared to what parents were able to tolerate. In so doing, they sought to balance activities so that parents were supported and engaged but did not “feel like they’re in a bootcamp”. FDAC teams acknowledged the importance of offering some flexibility. This included assisting parents to continue to engage with support they were already accessing, rather than requiring them to engage with specific services offering similar activities relating to abstinence or domestic abuse, for example. Examples included domestic abuse support provided by local charities, peer support on abstinence, and residential rehabilitation facilities.

**“Sometimes we’ve got parents that come in and they’re already working with [a charity] around domestic abuse. We don’t stop that work: we ask the parent to continue, and then we pick up the reflective conversations around what they’ve learned and what difference that actually makes around their parenting.” – FDAC staff**

In addition, if parents felt unable to do something, the team would also offer equivalent support in a different way.

**“If I did have any problems with the [other] meetings, or I wasn’t understanding something, then I could reflect with [my key worker] about doing something else, or about cutting it out.” – Parent**

Some staff also discussed using a staged process to build support for parents up over time. At the start, for example, contact was initially limited to sessions with the dedicated key worker, focusing on supporting parents to establish a routine and manage reductions in their substance use, giving them time to develop trust. Additional specialist support on issues such as trauma, domestic abuse, and parenting skills was typically introduced later into the process when parents had greater awareness of and engagement with it.

**“Once they’re stable ... we then think about what else they need. So do they need counselling? Do they need specific trauma work, domestic abuse work, perpetrator or criminality-type work? Once they’re settled, that’s when we’ll start bringing other people in. So they’ll have their key worker all the way through ... doing drug and alcohol testing, writing the court reports. Then they’ll have extra people come in.” – FDAC staff**

Where parents had particular attachment issues and benefitted from contact with fewer members of staff, some FDACs would limit their direct contact to the key worker alone, with specialists contributing remotely. This could include training the key worker in specific relevant issues and helping to plan sessions.

Some staff also discussed practical ways in which support could be offered more flexibly to better engage parents and help to build trust. These included, for example, offering evening appointments to facilitate parents' access to support, as well as creative approaches such as meeting outdoors, exercising together, and offering fidget tools and colouring to help parents concentrate in support sessions.

### Challenges of delivering support provision

Four key challenges were discussed in relation to support provision. They comprised parents' ability to engage, access to services, available resources and COVID-19, as described below.

- **Parents' ability to engage:** While the intensive support offered by FDAC was perceived to be beneficial for some parents, there was concern among some staff participants that this level of activity was too much for others who might previously have been leading very chaotic lives. Some parents agreed they had found the process overwhelming and intrusive. Looking back on their experience, however, some said they had realised this level of activity was necessary for them to make and maintain changes.

**“When I was doing it, I thought it was ... too much pressure, too much stress whilst trying to give up something that I'd been used to for 30 years of my life. But looking back on it from now, I have had to go through a lot of stress and a lot of stuff clean and I think ... they put enough pressure on you, not to break you, but to make you stable in life so you can cope with the stuff later on that's going to come to you in life.”**

**– Parent**

- **Access to partner/external services:** Where specialist support could not be provided in-house, limited availability of external services was a key barrier to providing the wraparound support that some parents needed. Housing and mental health provision were highlighted as examples. Staff noted, for example, that the crossover between substance misuse and mental health could make accessing services difficult – either because services would determine the individual was not stable enough to take part in therapy, or because there was a requirement for them to be “in crisis” to access services. Partners also felt that FDAC added pressure to recovery services by requiring high-intensity work, which was not always feasible for them.
- **Capacity:** One view among FDAC staff was that delivery of intensive, high-frequency support (including intervention planning activities and frequent non-lawyer review meetings, described in more detail below) could be challenging in terms of staff time and capacity. Some reported that full-time administrative support was necessary to manage linking with courts, filing reports, and data reporting.

- **Changes relating to COVID-19:** Participants suggested that it was beneficial in terms of accessibility for FDACs to offer telephone/online support to parents during the pandemic. However, one view was that it was sometimes more difficult to engage parents in support when meetings were not in person. Where COVID-19 restrictions required staff to work remotely with parents, some felt this had reduced parents' engagement, commitment and sense of being supported, with knock-on impacts on the effectiveness of intervention activities.

**“A couple of the parents have said ... there wasn't the same ... relationship intensity there. It was just like a check-in, ‘How are you doing?’ Where [when] they've actually got to get up and go to the clinic and have their actual face-to-face appointment ... they found that more beneficial.” – FDAC staff**

One way in which FDACs had sought to overcome this was to offer to meet parents outdoors for walks, runs, or swims as a way of maintaining their productive and supportive relationships.<sup>33</sup>

## **In-court support provision**

### **Non-lawyer reviews**

Parents' progress was regularly recorded in reports discussed with the parents and specially trained judge at fortnightly non-lawyer reviews. These were typically 30-minute meetings in court, providing an update on progress over the preceding two weeks, discussing any issues that had arisen, and agreeing achievable goals – for parents and professionals – for the next fortnight. As previous research has highlighted, the regular engagement with a dedicated and specially trained judge throughout the process was a key difference between FDAC and standard care proceedings, in which the judge would not usually see parents between their case management and issue resolution hearings at either end of proceedings (Harwin et al., 2014). This section discusses three key features of the non-lawyer reviews in turn.

#### **1. A forum for collaboration**

Non-lawyer review meetings functioned as a forum for collaboration between key parties involved in the case (including partner agencies, local authorities and children's guardians), which could streamline the process to agree actions to support the parent. This chimes with previous research by Tunnard et al. (2016), which identified that the regular reviews ensured everyone involved could keep up to date with progress throughout the case. FDAC staff felt it was important to involve the child's social worker to feed in updates on children, which helped ensure focus on children's needs as well as those of the parents. Some FDACs also invited the child's guardian and, if appropriate, extended family members, allowing them to have a voice in proceedings. One view was that offering remote access during COVID had improved guardians' attendance: this was important, as they represented the child's interest and non-attendance could lead to delays or misunderstandings.

<sup>33</sup> Some FDACs had since returned to face-to-face contact in COVID-compliant office settings; others continued to provide reduced face-to-face provision.



## 2. The judge's central role

Judges had more active oversight of, and contributed to, parents' progress in two ways:

- They were able to marshal support to resolve anything that was seen to get in the way of parents' recovery. Examples included judges writing to external providers to influence them to resolve challenges around support referrals.
- As an independent authority, judges could instil a different level of encouragement and motivation, lending weight to messaging from the wider FDAC team:

**“[Parents] tend to sit up and take notice a little bit more ... it's really quite helpful for us around challenging difficult or inappropriate behaviours.”  
(FDAC staff)**

Establishing a direct, constructive relationship with their dedicated and specially trained judge was highlighted as a key element of parents' FDAC experience (echoing previous findings of, for example, Harwin et al. (2011; 2018) and Tunnard et al. (2016)). This gave parents a greater sense of agency and helped them to understand the process, expectations and, ultimately, the judge's decisions about their case. In contrast, the BAU process involved parents engaging through lawyers, and was seen by some as less humane and more intimidating, with more limited attention to parents' understanding.

## 3. Frequency of reviews

Some participants felt that the frequency of the reviews was beneficial, echoing findings of previous research (Harwin et al., 2011; Tunnard et al., 2016). They provided a helpful mechanism by which the effort and progress parents made could be both evidenced and recognised and, by setting clear and achievable expectations over short timeframes, helped to maintain momentum and commitment. Parents appreciated that any issues could be quickly dealt with:

**“What's really nice is, because it's every two weeks, what's not going so well is nipped in the bud before the next two weeks ... it's always moving [forward].” – Parent**

A contrasting view was that they were too frequent: two weeks was considered insufficient time for parents to achieve substantial change, making the resource-intensive process repetitive. Staff also noted that it could be difficult for parents to accommodate in-person attendance due to travel and childcare arrangements, which might present a barrier to engagement.

### Effectiveness of non-lawyer reviews

Altogether, this approach was felt to be beneficial for parents. The reviews were positive and encouraging in nature, and one view among staff was that this was beneficial to maintaining parents' engagement. Though appearing before the court still caused some nervousness, parents felt part of a collaborative process, finding the reviews to be supportive rather than adversarial.

**“I didn't worry about the [meetings] in court because she made it feel**



so comfortable by saying, ‘Right, we need to take into consideration what’s going on in their lives. They are being torn apart. He’s away from his partner. They’re in an FDAC court fighting for their child.’ She made other professionals see that. She also constantly reminded all the other professionals about the good things that we’d done, not just the bad.”

– Parent

Some parents said they appreciated the regular, formal opportunity to reflect on and show their own progress, as well as to raise directly any issues which needed to be resolved. Examples included judges supporting parents to visit children and requiring social workers to cover travel costs to enable parents to attend support service courses.

**“I think they’re brilliant because it’s giving you your own voice and you can voice your concerns, and anything ... say, ‘Look, this is going wrong’, or, ‘This isn’t working for me’, and he’d actually listen to you and he’d talk to you like a human being.”** – Parent

Some staff participants questioned the perceived leniency of the court, however, feeling that at times it might have been beneficial to give parents “a bit of a telling off” rather than focusing so much on commending them for what they had done well.

Judges also had greater insight into the family’s functioning, needs and progress as a result of seeing them much more often than during standard proceedings, and engaging directly on an ongoing basis. FDAC participants said this gave the judiciary more insight into parents’ thinking than could be provided by the social worker’s parenting assessment in standard care proceedings, facilitating more informed decision-making. This chimes with previous research by Harwin et al. (2014), which found that coupling support provision with the courts’ close monitoring of progress provided a fair test of parents’ capacity to change throughout FDAC.

## Offboarding and post-intervention support

Towards the end of the trial for change, participants explained that FDAC teams reviewed the intervention plan to recommend an extension or outcome. If not seeking an extension, FDACs would then schedule an Issues Resolution Hearing and prepare a written Review Parenting Assessment providing evidence of the progress and change parents had made and the rationale for the decision about their case. Parents and social workers would be notified of the recommendation at this stage.

### Extensions

Staff participants noted that, while 26 weeks was the usual length of care proceedings in both FDAC and standard practice, it was common for FDAC cases to be extended at least once.<sup>34</sup> This contrasted with resistance to extensions in BAU, where they were often considered detrimental in terms of prolonging timeframes for children to achieve permanence and, as such, were discouraged. Despite this, one view was that standard proceedings often went over the 26-week limit due to resource issues in local authorities,

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<sup>34</sup> Based on the CJI’s annual report for the 2021/22 year (CJI, 2022), the average FDAC case length was 43 weeks.

CAFCASS, and court services. Some staff perceived this as a missed opportunity to extend support for families who may have needed extra time to evidence positive outcomes.

FDACs could request extensions from Week 18 if it was not possible at that stage to reach either a positive or negative recommendation. This included, for example, where parents were progressing but more work was needed before it could be concluded that children would be safe in their care. Extensions were also given to support reunification processes, ensuring that parents were supported while children settled into the home.<sup>35</sup>

Staff and parent participants valued this greater flexibility, which could enable parents to fully engage in support and complete work to achieve changes that were not considered feasible in a shorter timeframe. Additional time to work on themselves was regarded by some parents as a “brilliant” opportunity, and one view was that extensions were necessary, as it would not have been realistic to completely give up drugs in a shorter timeframe.

Parents also reported receiving extensions to accommodate reunification. Some initially perceived extensions negatively but understood the purpose of allowing more time to cement change and avoid returning to court at a later date, once key workers explained this to them.

## Hearings

The FDAC Issues Resolution Hearing involved the parent, FDAC and all professionals supporting the parent. At the hearing, the parenting assessment and aftercare plan was discussed, identifying further action or evidence needed before the final hearing to avoid it being contested.

The final hearing was attended by the judge and FDAC team who had worked with the family. The decision made by the judge was informed by reports filed during the 26 weeks of care proceedings, and a final hair strand test. Staff participants identified the process to pull together the range of evidence used at this stage as challenging in some instances. In terms of their capacity, for example, having only one week to submit their final report could be difficult for staff, compared with the four weeks allocated for this in standard proceedings. The process could also be delayed by additional external assessments that were required (including, for example, cognitive assessments).

Participants noted that the decision given in the final hearing was usually in line with what everyone was expecting, due to their active involvement in transparent discussions throughout the process. Two outcomes were possible at this stage:

- **If the outcome was successful return of children to the family**, a “graduation” ceremony would be held after the final hearing, celebrating what the parent had achieved. Children were invited; the parent was presented with a certificate and card; and the judge usually brought a cake and gift for the child. This was very well received by parents, who considered it demonstrative of personal investment:

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<sup>35</sup> Project documentation states that if the proceedings are extended, Non-Lawyer Reviews, key work sessions, Review Reports and Review Intervention Planning Meetings continue. An extension also requires a further Review Parenting Assessment.

**“We were sat in the court eating cake and biscuits and sweets and crisps. It was like having a little party in court. ... There was me, my partner, my baby, my mentor and the three from [FDAC] and the social worker ... they all praised me as much as possible ... sat there eating cake and having a laugh and a joke and saying, ‘You’ve done it.’ The judge even bought ... my boy a couple of presents, a couple of books ... and a card ... It was really nice.” – Parent**

- **If the case outcome was not positive, and children could not be safely returned to the family,** the final hearing set out what contact would look like for the parent and where the child would be placed, drawing on all available evidence. The team would then focus on engaging the parent in more formal interventions to support their welfare to keep them as stable as possible. This could include, for example, referrals to services for parents who have had children removed, aiming to prevent removal of any additional children in future.

FDACs that had reached this stage of delivery described the much lower proportion of contested final cases as a key difference between FDAC and BAU, and anticipated this saved resources, time and money. Staff and parents felt that parents had a better understanding of the authorities’ concerns and decision-making throughout the process, as a result of insight they gained from the intensive support and open, transparent discussions at the regular non-lawyer reviews. Staff said that understanding the process and knowing they were given a fair chance helped parents to accept its outcome – including, for example, accepting non-reunification outcomes where they recognised that they were not able to meet their child’s needs within their timescale (echoing previous findings by Harwin et al. (2014)). Some staff, however, felt that the range of professional agencies’ views were not always fully considered or balanced at the final formulation stage, and that the decision was imposed upon them:

**“This ... goes back to the dynamics of the team and being too heavily involved with [the] local authority. I’ve had heated discussions as a substance misuse worker in the final formulation where I’ve thought parents should have an extension and I was heavily outweighed by the social workers, and I just felt like my voice wasn’t being heard.” – FDAC staff**

Staff also noted that, while fewer parents contested negative outcomes, it could be challenging to keep them engaged in the end stages of FDAC support. Knowing the recommendation was negative could destabilise parents and lead them to abruptly disengage from FDAC support because they felt betrayed. To prepare for this, some staff participants discussed plans to introduce an additional meeting with parents before the final meeting to prepare them for the outcome and discuss next steps.

### **Post-intervention support**

FDAC participants were keen to ensure continuity of care post-intervention (echoing findings of previous research by Harwin et al. (2014)). Staff described working to taper direct provision of support gradually after the final hearing and referring to other services for ongoing support if needed. The nature and duration of ongoing support varied across

their sites – staff discussed provision lasting between four weeks and two years depended on whether or not reunification was recommended, to support parents’ different needs, as outlined below:

- **If reunified**, parents would usually be subject to a 12-month supervision order by the local authority.<sup>36</sup> FDAC staff described lower intensity key work being carried out alongside this in the early stages, to complete any outstanding work and help parents to prepare for and settle into reunification. Support from the FDAC team would then gradually taper off as parents moved on to other services outside FDAC.
- **For those whose children were not returned to their care**, FDACs would refer to community or local authority services for support (examples included mental health and grief counselling services). Some staff said that parents would be retained on the FDAC caseload until referrals were accepted, which was broadly welcomed. One view was that FDACs were better able to support parents who were not reunified as they were less likely to be perceived as part of the agency that had removed children from their care (typically the local authority). The opportunity to continue support was regarded as a key difference from standard care proceedings, where participants said support was generally not available to parents if they were not reunified with children.

Whatever the recommended outcome, staff participants felt it was important to offer continuity of support to parents, and flexibility to continue key working in some form was valued.

**“With one parent, I was still doing the key work sessions ... we looked at that reducing after the final hearing, but there was still unfinished work that we needed to do ... to tie things together. That was really important that we were flexible with that.” – FDAC staff**

Some staff participants also discussed having a more flexible “open door” policy for parents after proceedings concluded. For example, some FDACs actively encouraged parents to let them know how things were going, while others left the option open for parents to get in contact should they feel the need. Offering aftercare was seen as important, but also identified as a challenge in terms of resourcing for teams, for whom a flexible and open-ended approach stretched resources even further. Staff also noted that bringing intensive support to a close was an important element of parents developing independence.

**“It is one thing that we’ve found difficult ... because we didn’t have enough ... bodies really to continue to provide long-term aftercare support. ... It’s also a balance ... for the parent then to be able to stand on their own two feet with the continued support. We’re not there as a long-term agency ... Having said that ... if they want to message us, they could still do that ... It does depend [on the individual], but we would never just ... leave them. Because it’s such a short period of time that they’ve had to make the changes, it’s about making sure they’ve got that continued support.” – FDAC staff**

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<sup>36</sup> A supervision order gives the local authority the legal power monitor the child’s needs and progress while the child lives at home or somewhere else. For further information see: <https://www.citizensadvice.org.uk/family/children-and-young-people/protecting-children/court-orders-to-protect-children/child-abuse-supervision-orders>

Parents welcomed continued support with workers with whom they had developed supportive relationships, while recognising that the intensive programme would come to a close. Given the pressure on resource, ensuring this shared understanding of tapering down of support could be particularly important.

A key challenge at this stage related to gaps in available support for onward referral and support post-FDAC. Staff participants highlighted that this was particularly the case in relation to housing; domestic abuse support for perpetrators and male victims; and longer-term therapeutic support.

## Perceived impacts

This section explores the perceived impacts and outcomes of FDAC on parents, their children, FDAC staff and judiciary, support services and the wider family justice system. The range of influencing factors underpinning these perceived impacts are discussed throughout, and comparisons with care proceedings as usual are drawn wherever possible.

Staff and parent participants described a range of positive impacts for everyone involved in, or affected by, FDAC. This section explores each of these in turn.

## Perceived impacts of FDAC on parents

Ultimately, and importantly given the focus of FDAC, participants felt that FDAC resulted in higher reunification rates for parents and children, and increased parents' chances of sustained recovery in comparison to care proceedings as usual. These quantifiable outcomes chime with previous research which identified positive outcomes such as increased likelihood of reunification, substance misuse cessation, and decreased likelihood of future child neglect and abuse (Harwin et al., 2016; Harwin et al., 2018; Tunnard et al., 2016).

Participants described a range of interconnected outcomes for parents supported by FDAC, which fell into three broad categories: individual wellbeing; skills development; and parenting and relationships. Participants also discussed a range of shorter-term outcomes related to experiences of the care proceedings process and longer-term outcomes resulting from changes made during the FDAC process, which are explored below.

### Parents' wellbeing

Three key wellbeing outcomes were discussed by participants across the staff and parent groups, relating broadly to the perceived impacts of FDAC on parents' use of drugs and alcohol, their emotional wellbeing and material wellbeing.

#### Managing drug and alcohol use

Managing reductions in consumption of alcohol and substance misuse was a fundamental aim of the FDAC process. Participants across the staff, judge, and parent groups considered FDAC to offer parents the best chances of achieving this, as previous



research has suggested (Harwin et al., 2014). This was because of the holistic approach to assessment and intervention planning; coordinated provision of intensive, wraparound support; the focus on working transparently with parents by developing supportive, trusting relationships to encourage and enable change; and more frequent testing to evidence progress. Parent participants explicitly attributed their recovery to the combination of support that was offered. This echoes Tunnard et al. (2016), who found that provision of holistic support to address problems underlying parents' substance misuse (including mental health and domestic abuse) contributed to FDAC's positive outcomes, including reunification, reductions in substance misuse, and decreased likelihood of further neglect or abuse of children in future.

Staff noted that recovery was not always possible within the intervention's timescales, particularly where alcohol and substance misuse were longstanding and ingrained issues for parents. As such, FDAC's greater flexibility to facilitate extensions (where, for example, parents were progressing towards but had not yet attained the sustained changes required for children to be returned safely to their care) was considered an important facilitator of this key outcome. One view among parents was that it would not have been feasible for them to attain and embed their abstinence without extensions to the intervention from the 18-week review point.

### Material wellbeing

Participants also discussed outcomes relating to parents' material wellbeing, including access to benefits, accommodation, and improvements to their physical environment. These resulted from, for example, key workers supporting parents to prepare relevant applications or forms, or visiting homes to help organise the physical environment. Staff also discussed supporting parents leaving abusive relationships to access shelters or other appropriate accommodation, for example.

**“They helped me get my house ... they helped me set up benefits ... I had a support worker come round the other day and help me fill out a council tax exemption form so I’m now exempt from paying council tax.” – Parent**

Managing these basic needs was important for three main reasons, as it helped to:

- Address and remove barriers to engagement in or progress with the intervention programme – this could include, for example, the risk that a parent might return to an abusive relationship in order to access accommodation or money from a partner
- Demonstrate to parents that their needs were taken seriously and that it was important to help them resolve things which might hinder their onward engagement with the programme or progress with recovery
- Build parents' stability and security, which would be crucial for them to safely care for their children and meet their needs in the future.

### Emotional wellbeing

Participants identified a range of outcomes for parents that related to their emotional wellbeing. These included improvements to mental health, linked to being able to access relevant psychological support; as well as improvements to their self-image, sense



of purpose and confidence. These outcomes were linked to parents' insight into and understanding of root causes and influencing factors underpinning substance misuse and parenting issues, as well as their achievements over the course of the FDAC intervention.

The non-lawyer review process was an important facilitator of these impacts. All participant groups said that parents' direct involvement in the process, and the consistent encouragement from FDAC professionals including the dedicated and specially trained judge, was important in motivating their continuing effort, belief in themselves, and hope for the future. The non-lawyer reviews also gave parents a voice; consistently supported them to focus on short-term, achievable goals each fortnight; and to reflect on and recognise their achievements as well as outstanding issues to be addressed. Focus on progress helped to give parents a sense of accomplishment and increase belief that they could achieve changes required to stop misusing drugs and alcohol and improve their lives.

## Parenting and relationships

FDAC was perceived to have two key impacts in terms of parenting, relating to reunification and the quality of parent-child relationships. Participants also identified impacts relating to parents having healthier relationships more broadly, including with partners, friends and family members.

### Parent-child relationships

FDAC staff, judges and parents shared the view that reunification outcomes were more common in FDAC than in standard proceedings, as previous research has found (Harwin et al., 2014; Harwin et al., 2016).

Greater accessibility of support for a broader range of issues, including trauma and domestic abuse, were important facilitators to parents being able to develop key skills and evidence progress to enable children to be returned to their care. However, parents' eligibility for FDAC also hinged on their motivation to change, meaning that those who were less likely to achieve reunification were perhaps more likely to go through standard proceedings.

FDAC was also seen to influence improvements in relationships between parents and children, regardless of reunification outcomes, for two key reasons:

- **Demonstrating commitment:** seeing their parent engage and progress in FDAC was felt to demonstrate clearly to children that their parent was committed to looking after them and wanted them in their care. The hard work parents had to put into the process, to engage with support and evidence change with the end goal of achieving reunification outcomes where possible was testament to this. This, in itself, could have a powerful influence on the relationship, as parents progressed from prioritising their own needs to focusing on the family.

Staff and parents described children being kept informed throughout, with social workers and guardians feeding back updates from the non-lawyer review meetings as well as direct updates from parents. Children appreciated and were proud of parents'

efforts and achievements. In some instances, participants described the changes they saw in parents as positively influencing other children's willingness to re-engage with parents from whom they had previously been separated (including, for example, older children removed earlier on through other care proceedings processes).

Even where reunification was not achieved, participants felt that family relationships benefited from the insight children had into the effort their parents had gone to through the FDAC process in hopes of reunification. This seemed to make it clear that the child was important to them and that they wanted to retain a relationship with them.

- **Increased insight, understanding, and parenting skills:** participants felt that the intensive, specialist support accessed through FDAC enhanced people's skills in relation to their parenting. Participants identified improvements in parents' ability to meet their children's needs, understand the impacts of their behaviour on their children and develop coping strategies to deal with challenging situations. Building these parenting skills was a core aim of FDAC: ensuring parents were able to understand, prioritise, and safely meet their child's needs was essential if reunification was to be achievable. Support included parenting courses, observations and/or video reviews of interactions between parents and children, all of which focused on developing their parenting skills and equipping them to care safely and effectively for children in the future.

**"[Previously] I thought, 'Well, I am a good parent. Okay, I drink, but I always make sure they've got uniforms; I always make sure they're clean and tidy; I always make sure they have food on the table' ... but when you do the parent programme, you actually think, 'Well, no, I'm not a good parent, because I'm not putting their needs before mine'. So that really opened my eyes." – Parent**

Where recovery was not possible within the child's timeframe and reunification was not supported, FDAC staff felt that parents were nonetheless better able to play a role in the child's life – within care plan restrictions – as a result of the insight and understanding they had gained around the child's needs and parenting techniques. Examples of impacts for parents who did not achieve reunification included them managing to maintain sobriety for contacts with their child. Improvements in parents' insight and skills was also considered important in helping to ensure they would be better equipped to parent again in future, to avoid returning to care proceedings for other offspring.

**"It makes them focus on their priorities and on their children and ... even where their children have been removed from their care ... demonstrating that they can live a lifestyle as if their children were with them." – FDAC judge**

## Other relationships

Judges and parents mentioned that going through FDAC helped parents to manage other relationships in their lives in three main ways:

- **Recognising problematic relationships:** FDAC supported parents to recognise, disclose, leave and recover from unhealthy relationships (involving domestic abuse, for example). This was facilitated by the in-depth assessment process; open, supportive communication between parents and key workers; and specialist intervention support around issues such as domestic abuse and trauma. Through this work, parents described gaining new understanding of their experiences in past and current relationships, including recognising abusive behaviours for the first time. In addition, some were empowered to disclose abuse for the first time and others were encouraged and assisted to leave abusive relationships, with support to, for example, access alternative accommodation and develop skills and strategies to set and maintain boundaries in their relationships going forward.
- **Managing existing relationships:** FDAC contributed to improvements to parents' relationships more broadly – including with their family, for example – by giving them insight into patterns of behaviour, needs and issues of others, and skills to manage challenges and points of potential conflict, which might previously have influenced drug-taking or alcohol consumption because they triggered negative emotions. Greater insight into their own trauma, triggers and helpful coping strategies supported parents to set and maintain boundaries to engage in these relationships in healthier ways.
- **Recovering damaged relationships:** FDAC also supported parents to rebuild relationships (often with close family members) that had been damaged as a result of their substance misuse, which could help to provide security and informal support in their day-to-day lives.

**“I went nearly five months without speaking to my mum. Then with [the FDAC team’s] polite pushing, we’ve now got a brilliant relationship again.” – Parent**

## Skills development

Through intensive work with key workers and specialists, parents developed insight and understanding of their issues, including underlying factors influencing their past behaviour, their own role in their experiences, and healthier coping strategies. As such, a key perceived impact of FDAC was building parents' capacity to manage issues including abstinence, parenting and wellbeing better in future. Participants across FDAC staff and parent groups described this as having a beneficial impact on parents' view of themselves, as they were supported to understand and take ownership of their role in past experiences with a constructive focus on doing things differently, rather than simply apportioning blame.

**“We’ve had ... good ... open, honest discussions around some pretty hefty subjects ... not looking at pointing the finger of blame, but looking at my role within, for example, the breakdown of [my] marriage; my role in certain**

**situations that ... escalated to police being called on that one occasion ... taking quite a lot of ownership of stuff as well as looking at the wider impact of your behaviours and actions and words on those around you – most relevantly [the] two children...” – Parent**

## **Shorter-term outcomes**

In addition to the outcomes detailed earlier in this section, which centre on parents being able to better manage their own health and relationships, the research identified a range of shorter-term outcomes related to parents’ experiences of care proceedings. In general, FDAC helped parents to feel involved and listened to and, as a result, they were better able to understand and accept decisions that were made throughout the care proceedings process. This is consistent with existing evidence (including Harwin et al., 2018; Tunnard et al., 2016).

### **Feeling supported, listened to and involved**

Coordination of support by FDAC key workers reduced barriers to accessing services that parents required, enabling parents to engage with support from the earliest point, building momentum and facilitating their progress. Consistency of contact via dedicated teams also reduced the burden on parents in terms of retraumatising repetition of their story.

**“Parents and their children don’t have to keep being assessed by different services; it happens in-house. I think that that makes it easier for parents and their children, so they hopefully don’t feel like they’re having to keep telling their story over and over again, because that’s really traumatising.” – FDAC staff**

The strengths-based, relational and collaborative approach, with a positive focus on accomplishment and achievable goals, also gave parents a greater sense of agency.

**“[T]hey feel included in the process. It’s not done to them; it’s done with them.” – FDAC staff**

Key workers and parent mentors were thought to be key to process and some parents described them like friends rather than adversaries. As a result, some parents discussed feeling able to disclose traumatic experiences for the first time, including experiences of domestic abuse, for example. Direct, supportive and encouraging relationships with judges also influenced parents’ engagement with support, their perception of the fairness of the process, and understanding and acceptance of final recommendations.

**“Having the ... consistent judge all the way through ... meeting with the parents every two weeks ... that experience of forming that relationship with someone that they have perceived to [have ...] so much control ... over their life, is really, really helpful to them. I think that, in itself, shifts ... that attitude towards professionals and the concerns that we have.” – FDAC staff**

## Understanding of process and decision-making

Parents had a much clearer understanding of the care proceedings process, local authorities' causes for concern, and ultimately the rationale for decisions that were made about their case. This came as a result of open discussion throughout the process and in non-lawyer reviews, as Tunnard et al. (2016) have previously highlighted, as well as the insights parents gained through specialist support. This influenced increased acceptance of final outcomes, which staff said should come as no surprise.

**“She knows that baby’s going to be adopted now. She knows that it’s not safe for baby to be returned. She knows that she can’t make the changes ... it’s still a good outcome because she understands that, she acknowledges that.” – FDAC staff**

## Perception of fairness

Consistent with previous research by Tunnard et al. (2016), staff also felt that parents had greater opportunity to evidence change in FDAC than in standard care proceedings in the following ways:

- The frequency of contact and drug testing throughout the FDAC process better enabled parents to demonstrate progress over time, which could be challenging in more arm’s-length standard care proceedings processes.
- Regularly reviewing and recognising progress served as a powerful motivator of continued efforts for some parents, and helped to feed into more informed decision-making at the end of the process, all of which contributed to greater confidence in the process being fair. This is consistent with previous research by Tunnard et al. (2016), in which judges reported that parents including those whose children were not returned to their care nonetheless felt they were dealt with fairly throughout the process.

## Longer-term outcomes

In the longer term, staff felt that FDAC reduced relapse and returns to care proceedings – parents were better able to sustain change, due to insight, understanding, and coping strategies they gained throughout the process, as well as ongoing support accessed at the end of care proceedings. This echoes the findings of previous research as highlighted throughout this report (including, for example, Harwin et al., 2014).

Tangential impacts of FDAC on parents’ longer-term ambitions and prospects included:

- Longer-term involvement with FDAC as parent mentors, desiring to “give back” and support other parents through the process. Parents talked about the positive influence that parent mentors had on their own FDAC journeys and lives more broadly. In some instances, becoming a parent mentor contributed to parents’ onward career progression, as parents moved from volunteering as parent mentors into paid employment.
- Progressing from FDAC to attend college or university. Staff participants felt that FDAC had contributed to parents’ skills development, sense of purpose and self-

belief, enabling them to take these opportunities, which they may not have done previously:

**“She went from barely being able to write a text to ... doing a few college courses ... building up her confidence ... she’s just finished her first year [of a] social work degree and really attributes it to that FDAC process.” – FDAC staff**

## Perceived impacts of FDAC on children

FDAC was also perceived to improve children’s experiences both during and after care proceedings, in terms of their understanding of the process, their parents’ issues and the efforts being made to resolve them; separation and reunification of families; and improved relationships and living arrangements over the longer term.

### Insight and understanding

Staff felt that open communication between the dedicated FDAC judge and children, as well as provision of age-appropriate written materials (such as story books) helped children to understand the range of their parents’ issues. It also enabled them to understand what parents were attempting to do to address their issues, and improved children’s knowledge both of the FDAC process and how it worked to support both parents’ and children’s needs. Previous research has also highlighted enhanced understanding as a key outcome for children (Tunnard et al. (2016)).

One view among FDAC participants was that seeing their parents engage with the process on a regular basis contributed to children’s understanding that parents were making an effort to change negative behaviours, which could support them to feel cared for. Direct inclusion of children in, for example, “graduation” celebrations after final hearings contributed to their understanding of the effort to which parents had gone with the aim of keeping the family together.

Even if reunification outcomes were not possible, some participants felt that the involvement of children in the process, seeing their parent’s efforts and progress, could be a positive outcome for a child. This could help alleviate worry about their parents’ state and support children’s wellbeing more generally.

**“Just seeing that they’re doing well in themselves, that is a successful outcome for a child.” – FDAC staff**

### Reduced separation of families

Avoiding separation during and after care proceedings, where safe to keep families together, was considered beneficial for both parent and child in minimising disruption and trauma – including babies’ bonding and attachment to their parent. This could happen either during or after care proceedings had completed:



- In instances where it was considered safe, it was perceived as beneficial for some children to stay living with parents during FDAC proceedings. One view among parents who had been able to keep their child with them while going through FDAC was that this would not have been possible in standard care proceedings. Reasons for this included, for example, parents being able to access residential recovery units with their child, which might not have been accessible outside FDAC.
- Some parents whose children had been removed at the start of care proceedings before reunification believed that their time apart was shorter in FDAC than it would have been in standard care proceedings. This related to the perception that FDAC timescales were more concise than the timelines for standard care proceedings, as recommendations could be made at 18 weeks. Parents also felt that they might not have been able to sustain changes to their drug and alcohol use without the intensive support provided by FDAC, meaning that reunification would not have been possible at all.
- Related to this, all participants identified higher rates of reunification as a key outcome of FDAC. One view among staff was that flexibility to offer extensions was key to supporting more families to achieve reunification:

**“[W]e’ve definitely had parents who have been reunified with their children who wouldn’t have been in standard care proceedings. Because of course with FDAC ... you’re able to ... recommend that care proceedings are extended ... You’re essentially able to buy some parents and their children a bit more time, when time is needed.” – FDAC staff**

A contrasting view among some non-FDAC participants, however, was that FDAC processes took longer than standard care proceedings and delayed the timeline for children to achieve permanence in settled homes, particularly where reunification was not ultimately possible.

## **Experiences after proceedings**

One view among staff and parents was that parents were better equipped to meet their children’s needs after going through FDAC, as a result of the insights and skills they had gained in relation to managing addiction issues, trauma, and relationships. Some participants suggested that parents’ commitment throughout the process enhanced their motivation to continue their efforts to achieve or maintain abstinence and prioritise their children – whether or not reunification was achieved.

**“I’ve learned that my daughter is more important to me than that drink. That’s what I’ve learned. I’ve worked so hard to get her home I’m not going to have one drink just to lose her again.” – Parent**

Parents’ ability to better manage other relationships – such as re-establishing connections with their wider family, or setting boundaries to ensure they did not fall back into previous unhealthy or abusive relationship patterns – was also thought to affect children’s experiences after care proceedings. Changes in parents’ practical circumstances – in

relation to, for example, access to accommodation and benefits (as outlined earlier in the section) – had a similar impact.

Where reunification was not recommended, one view was that children could achieve permanence and live safely elsewhere more quickly through FDAC. This related to the perception that FDAC timescales were more concise than those for care proceedings as usual, where staff identified that resource and capacity issues at the final stages often introduced delays.

## Perceived impacts on professionals

Three main impacts were identified for FDAC team members, including members of the judiciary, relating to development of skills and expertise; effectiveness of working practice; and wellbeing. Each are described in turn below.

### Skills and expertise

FDAC staff, including members of the judiciary, reported developing new skills and expertise through their involvement with the programme. For FDAC staff and support leads, this included working more collaboratively across disciplines where specialists had previously been accustomed to working in silos; knowledge-sharing across the multidisciplinary team; and developing a broader range of specialist skills (enabling them to contribute to assessments, prepare reports and evidence for court, and/or deliver specialist support in key work sessions).

**“Within FDAC ... you learn a lot because you have to. It’s a different way of working ... from the perspective of a social worker. It’s a different way of working; the reports that you’re writing are different. The way that you’re working with parents is different, and you have to almost invest in that relationship that you build with the client ... supporting them along their journey.” – FDAC staff**

FDAC judges also reported that the intensive and relational approach to working with parents required them to develop new skills to directly motivate and engage them, together with more typical responsibilities to oversee decision-making for their case. Motivational interviewing and increased multidisciplinary collaboration were key differences between FDAC and standard proceedings when it came to judges’ involvement. Participants reported a range of available training to support judges to obtain and develop these new skills. (The use of motivational interviewing has also been highlighted by Tunnard et al. (2016), who highlighted its importance for judges in facilitating parents to develop confidence and take on responsibility for finding solutions to their problems.)

## More effective practice

Staff and judges felt they had better insight and understanding of parents' individual needs as a result of multidisciplinary involvement in assessment and planning, regular contact with parents, and the opportunity to dig into issues in depth. Staff said this was not possible in the context of standard proceedings, where caseloads were typically higher and there was less frequent contact.

Having the time and capacity to consider parents' issues and needs with a holistic focus gave staff clearer oversight of progress and outcomes and a sense of satisfaction that, at the end of proceedings, they had done everything they could to support parents.

**“You get to know the parent ... work with the parent, you get that time and that space where you're focusing on the problem[s] with the parent and addressing them ... [whereas in] business as usual ... with high caseloads ... you're just kind of going through the numbers.” – FDAC staff**

## Staff wellbeing

A number of impacts identified by staff participants related to staff wellbeing:

- Staff and judges had mixed views on FDAC's impact in terms of **workloads and capacity**. Some staff reported that their caseload was lower and more manageable than in standard care proceedings. Others, however, reported that managing intensive engagement with parents, coordinating their schedule of support, delivering frequent reports to support non-lawyer review hearings, and attending the range of meetings was challenging to accommodate. Some participants reported feeling overwhelmed and emotionally drained at times, linked to the intensity of their work with parents. This chimes with findings of previous research by Harwin et al. (2011), which identified team capacity and potential burnout resulting from intensive work on complex cases as ongoing challenges.
- **Collaboration and support** across the multidisciplinary team was considered to reduce the decision-making burden on some FDAC team members. Some participants preferred this way of working, feeling more supported than in previous roles where they had worked in silos. By contrast, however, some staff felt that multidisciplinary approaches were not successfully implemented, and reported frustration and dissatisfaction as a result of their sense that other disciplines' perspectives carried more weight in formulations of plans and outcomes.
- **Emotional investment:** As previously identified by Tunnard et al. (2016), one view among members of the judiciary was that their greater involvement in parents' cases through frequent, direct contact in non-lawyer reviews made them more emotionally invested in cases. This could introduce additional emotional burden when the outcomes they had to deliver did not go in parents' favour. Provision of resilience training was considered beneficial for members of the judiciary where this had been available.

# Perceived impacts on the family justice system

Impacts on the wider family justice system fell into two categories, relating to cost and applications to wider practice, each of which are described below.

## Costs

One view among FDAC and non-FDAC staff and members of the judiciary was that FDAC was a costly and resource intensive approach compared to standard care proceedings models. This related to costs associated with its implementation (that some local authorities considered the up-front cost of an FDAC team as too great an initial cost). It also relates to costs associated with delivery, due to the intensive and frequent support provided to parents throughout the proceedings. For example, FDAC required more frequent judicial involvement in the fortnightly non-lawyer review meetings, whereas in standard care proceedings, judges would typically only be involved in a handful of hearings. Additionally, one view was that particular elements of specialist support provision provided through FDAC – such as some forms of psychological support – were costly to arrange as part of the intervention. Standard care proceedings and problem-solving courts did not offer the same range of specialist support for this reason. Findings of previous research by Harwin et al. (2014) and CJI (2021) provide a contrasting view on the day-to-day costs associated with FDAC, indicating savings per family throughout proceedings.

While participants in this research acknowledged some higher costs, there was a strong sense, particularly among FDAC staff, that FDAC could achieve considerable savings in comparison to standard care proceedings (echoing the previous research cited above). These related to reduced rates of return to later care proceedings, as well as reductions in costs for other relevant services including, for example, fostering and mental health interventions. Savings accrued in the short term, (for example, during proceedings) specifically relate to the savings made as a result of the lower proportion of contested cases. Participants related these key outcomes to FDAC's holistic approach, which was felt to assess and address a broader range of needs than was the case in care proceedings as usual. Additionally, FDAC was considered to facilitate sustainable change over the long term, as parents had developed skills and insight to address underlying issues, recognise patterns and risks, and deploy healthier coping strategies. These allowed them to better manage their relationships and parenting going forward, avoiding costly future care proceedings and reducing the need for additional intervention by, for example, social care or criminal justice down the line. This chimes with, for example, the findings of Harwin et al. (2016) that lower proportions of FDAC cases returned to care proceedings within a five-year period.

## Reflections on wider practice

Positive experiences of FDAC prompted some staff to consider how individuals in other court proceedings or jurisdictions – such as those involved in youth justice proceedings – could better be engaged and supported in court hearings. Participants reported that members of the judiciary had begun to deploy similar approaches in a broader range

of settings – for example, speaking directly to individuals rather than their solicitors in hearings where both were present. Consistent with previous research (Tunnard et al., 2016), members of the judiciary also felt it important to explore opportunities to expand this way of working into a broader range of settings where it might be beneficial.

**“I think it is ... impacting on the approach that I adopt in other jurisdictions ... and I would like to pursue that ... idea of a problem-solving model in other proceedings; youth proceedings in particular.” – FDAC judge.**

## Learning points for future roll out of the FDAC model

Drawing on findings from themes discussed in the IPE, we have identified five learning points which could be used to inform further roll out and sustainment of the FDAC model.

- 1. The implementation and set-up stage is crucial to getting a sustainable FDAC model in place.** In the early stages, stakeholders should think about how to best to collaborate and ensure agreements are in place to support partnership working. This has worked particularly well in areas where set-up has been led by an experienced project manager.
- 2. Effective lines of communication and strong partnerships need to be in place throughout FDAC set-up and delivery.** All parties need to have a good understanding of how FDAC works, be clear on their (and others’) roles and responsibilities, and have appropriate channels for communication to support information sharing and multiagency working. Similar recommendations are highlighted in previous research (Tunnard et al., 2016, Harwin et al., 2011).
- 3. FDACs need to be properly funded and resourced over a sustained period of time to ensure ways of working can be embedded locally.** Funding should also help to establish and support the delivery of required wraparound provisions, including referrals to local services at the end of the formal FDAC process. This echoes previous research, including for example the recommendation from Harwin et al. (2016) that local health and adult social care services could contribute to FDAC team funding to support a sustainable and joined-up approach.
- 4. Staff development and training should be ongoing, reflecting new learning and evidence where necessary.** This should include opportunities to learn from other sites and access best practice forums, helping staff to be reflective of their practice and deliver a consistent service. Previous research has also emphasised the value of ongoing training and networking opportunities (Tunnard et al., 2016).
- 5. Data on FDAC should be routinely shared within and between FDACs to support understanding of progress and success.** There was an appetite among some staff to understand more about the evidence base to ensure practice is fully grounded in understanding what works and help to achieve the best outcomes for families and the family justice system more broadly.





# COST EVALUATION FINDINGS



The estimates of the costs associated with running FDAC are based on the information provided in the cost form from seven FDAC sites. Across the 2020/21 financial year, these FDAC sites had cases involving a total of 204 children. In reviewing the cost information received, we observed that there was no consistent way in which FDAC sites were collecting cost information. In addition, there were gaps in the information provided on the different types of costs across the FDAC sites. We ran into several different issues. Specifically, some of the FDAC sites did not report running costs at all arguing that FDAC is an additional function to another permanent team within LA. This implies that FDAC site leads could not provide an accurate estimate of the relevant staff costs. We caveat the findings around this cost evaluation by noting that the cost data received is of poor quality and that there are inconsistencies in how FDAC sites reported their costs.

With those caveats in mind, we decided to simply present the cost figures as received. The average cost per child across the FDAC sites that supplied data was £17,737. There was wide variation in this figure across sites, ranging between £636 and £56,555. The costs at either end of the range likely reflect under-reporting due to difficulties identifying FDAC specific costs at the lower end, and unused staff capacity at the higher end. Future efforts to collect cost data will require clearer guidance on the precise costs to include and how to gather them.

In [Table 7.1](#) we clarify how many sites provided information for the different cost categories included in the cost form. The variation in costs can be further explained by how long each FDAC site had been running. For example, four sites were launched in 2020 and had set-up costs associated with this, while the remaining had only the running costs to report. An implication of this is that some sites reported only a couple of cases, while others which are in a more mature state reported more than 20. This variation in the total number of cases has important implications to the average cost per child we report in this evaluation. To obtain the average cost per child for each site, we divided the total cost incurred per site (both the set-up and running costs) by the total number of children that went through FDAC in the 2020/21 financial year.

Table 7.1 reports the different types of cost. In total, four sites reported set-up costs in the 2020/21 financial year, ranging between £3,000 and £97,805. Regarding running costs, a few sites expressed difficulties in distinguishing between costs incurred as part of FDAC and costs incurred as part of a more permanent fixture within the LA structure. Those FDAC sites indicated that they are part of a much bigger team which has multiple other functions, so it is challenging to distinguish which costs relate to FDAC. In future, more support will be required to help sites identify relevant costs.

**Table 7.1. Cost of delivering FDAC for the 2020/21 financial year**

| Item                                 | Type of cost  | Average cost across sites | Average cost per child | Number of sites that provided data for each category |
|--------------------------------------|---------------|---------------------------|------------------------|--|
| Preparation costs                    | Set-up costs  | £21,913                   | £498                   | 3  |
| Facilities, equipment and materials  | Set-up costs  | £5,376                    | £308                   | 1  |
| Staff salary                         | Running costs | £195,670                  | £959                   | 6  |
| Maintenance, equipment and materials | Running costs | £8,144                    | £64                    | 3  |
| Training & support                   | Running costs | £2,600                    | £20                    | 3  |
| Assessment and legal fees            | Running costs | £9,088                    | £55                    | 3  |
| Other*                               | Running costs | £26,737                   | £164                   | 3  |

\* Includes costs such as travel and subsistence costs, overheads and other programme inputs.



# CONCLUSION AND DISCUSSION

# Impact Evaluation findings

This evaluation aimed to assess the impact of the FDAC model on a range of child and parent outcomes using a quasi-experimental design, as a randomised controlled trial was not possible.<sup>37</sup> More specifically, the evaluation applied coarsened exact matching to try and construct a suitable comparison group for comparing outcomes with the FDAC group (see **IE design** section for more information on the design). Our findings support the conclusion that outcomes are better among families in the FDAC group compared to the comparison group. However, there were two major limitations to our ability to construct a convincingly suitable comparison group and this means caution should be exercised when interpreting the impact estimates presented here. We describe the limitations before describing the impact estimates.

First, there is a high risk of confounding. This means that there may be important differences between the FDAC and comparison group at baseline that could be driving the differences in outcomes we found.

One reason for concern about confounding is due to missing characteristics that we believe could have been important for group selection in this study. These were primary carers' mental health diagnoses, which were collected by LAs but deemed too labour intensive to extract, severity of drug/alcohol misuse, which were only collected by a minority of LAs and also deemed too labour intensive to extract, and their stated motivation to cease their substance misuse, which is unlikely to be recorded in a consistent and usable way at present. The results might have been influenced by some of these factors that could have determined whether a parent was referred to FDAC. For example, it is possible the reported results are upwardly biased (i.e. an overly optimistic estimate) as the IPE findings indicated that parents who were more motivated to attempt abstinence were selected into the FDAC group.

A second concern about confounding comes from the important differences observed between the two groups before matching, which made it difficult to find matches for all FDAC cases. For example, primary carers in the FDAC group were less likely to experience domestic abuse and to misuse drugs/alcohol than families in the control group. We were able to find matches for some of the sample, which bolsters the internal validity of the impact estimates, but a significant proportion of observations were not analysed (over half for some analyses), which limits the generalisability of our findings and weakens the external validity of the impact estimates. One important limitation to note was that the final matched sample was almost exclusively of White (99%), female caregivers.

While discussing generalisability, it is worthy to note that this evaluation did not include information for all FDAC sites or all LAs that were eligible for inclusion. For example, care proceedings from the London FDAC were excluded from this evaluation due to FDAC resource constraints in providing quality data. For the same reasons, only 12 out of 31 eligible LAs for the study agreed to provide data for the evaluation. This means that

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<sup>37</sup> The choice of study design was a result of assessment on the best impact evaluation option. The rationale behind it is presented in the **IE design** section, while its limitations are discussed in the **Limitations** section. Briefly, the "effects" can be interpreted in a causal way under the (strong) assumption that all relevant controls are included in the specifications that both influence treatment status and the outcome variables.

there may be unobserved differences between care proceedings that were included in the evaluation and the rest that were eligible but did not supply data.

Evidence from the primary outcome analysis suggests that children with a primary carer in FDAC proceedings were four times more likely to be reunified with their primary carer in comparison to children with a primary carer in non-FDAC care proceedings. The positive effect found for the primary outcome analysis was robust to different specifications. However, the size of the effect did reduce in our sensitivity analyses pointing to our findings possibly being an overestimate or upper bound of effect.

Further, the evaluation also found that parents in FDAC were four times more likely to stop misusing alcohol or drugs by the end of care proceedings relative to parents in non-FDAC care proceedings. The secondary outcome analysis also established that the likelihood of a hearing being contested in the FDAC sample was about 80% lower than in the comparison sample. Another finding was that the likelihood of expert witnesses being consulted in FDAC cases was about 90% lower than in non-FDAC ones. Relatedly, on average FDAC cases used a lower number of different types of external expert witness assessments (0.16 types of external expert per case on average) in comparison to standard care proceedings (2.19 types of external expert per case).

The findings from the qualitative IPE analysis reinforce the IE evidence. It is important to note that the IPE data collection was undertaken before the IE data was collected and analysed. Overall, staff, judges and parents who were interviewed as part of the IPE corroborate the impact findings. Many success stories were spoken about, which existed on a spectrum of parents completely abstaining from alcohol and substances and being reunified with their child, to parents reducing their exposure to alcohol and substances and accepting that they were not able to safely care for their child within a safe and appropriate timeframe. Evidence from the interviews suggested that reunification was more common in FDAC, and the length of separation was shorter compared to standard care proceedings. Interviews with participants also suggested that parents in FDAC sites had a better chance in ceasing substance misuse as it held parents accountable. Staff also noted that more frequent testing of substance misuse in FDAC in comparison to standard care proceedings allowed them to target support, if needed.

## Implementation and Process Evaluation findings

Three important, inter-related benefits of FDAC were highlighted by participants when compared with standard care proceedings. Combined, these appear to contribute to a fairer, more cost-effective system with better outcomes for parents and families.

**Higher rates of reunification:** FDAC was thought to offer parents a better chance to evidence change across a range of indicators including substance misuse and parenting skills, to enable them to be safely reunified with their children. There was also hope that parents who were not able to achieve reunification outcomes would now be able to recognise the needs of their children above their own, accept that they might not be able to care for them and avoid instances of subsequent children being removed from their



care. This reflects indications of previous research on FDAC (Harwin et al., 2014, 2016 and 2018).

**Cost savings:** Participants acknowledged that FDAC required investment upfront to provide intensive, wraparound support and supervision to parents. Enhanced support provision was implemented with the aim of achieving savings later on by reducing numbers of children placed in costly care arrangements, as well as continuing support needs for parents. The case for offering comprehensive support in children's social care is well documented and chimes with previous research on FDAC, which indicates that the higher rates of reunification and fewer contested hearings can have cost savings later down the line (Harwin et al., 2011).

**A more supportive and gentle process:** Across participant groups, it was felt that FDAC gave parents a fair opportunity to demonstrate their ability to take care of their child's needs. Rather than feeling like a punitive process, participants spoke of FDAC feeling supportive at a crisis point or time of acute need, enabling them to make and sustain changes that could lead to successful reunification outcomes. This chimes with previous research on FDAC (Harwin et al., 2014, 2018).

Key features of the **unique package of support** provided through FDAC, thought to contribute to positive outcomes for families, included:

- Intense wraparound support, which begins immediately when parents sign up to the programme and extends beyond duration of FDAC
- Flexibility and tailoring to meet each individual parent's needs and circumstances in the round (including, for example, support with finances and housing)
- Consistency of support which is led and coordinated by a key worker with whom each parent can develop a trusted relationship
- Multidisciplinary professionals within the FDAC team and effective brokering of additional external support where required
- Inclusion of peer support in some areas, which was perceived as an additional motivator for parents.

Key features of the **judge-led supervision** provided through FDAC and thought to contribute to positive outcomes for families included:

- The unique role of judges to lead and provide oversight to the whole process, alongside encouraging parents to make and sustain changes
- The collection of a broad range of evidence to make effective decisions about what is appropriate and safe for families during care proceedings
- The authority of the judge to address concerns of parents (for example, in relation to visitation) and ensure appropriate support is in place.

Other facilitators perceived to enable parents and provide FDAC teams and courts with the evidence needed to ascertain whether children can live with parents safely, included:

- **The problem-solving and non-adversarial approach and ethos of FDAC**, which has a focus on relationship-building, openness and transparency and is beneficial in supporting engagement with parents
- **Independence of the FDAC team from local authority social work teams**, which supported parents' engagement with and trust of the programme
- **Effective partnership working**, within and across teams and local stakeholders, including for example liaising with social work teams through multiagency meetings
- **The timing of the FDAC offer**, which was thought to be a "powerful moment to intervene". Some participants explained that FDAC comes at a time when children are about to be removed and that the urgency of the situation can be a real motivator for change
- **The focus on parents' voices and choices** which can instil a sense of fairness and accountability and can support them to feel empowered to change.

### Key challenges

Challenges with implementing and delivering FDAC were also identified by participants and were perceived to affect the extent to which positive impacts were experienced and achieved in some areas. In general, those FDACs that were newer and less well established sometimes experienced challenges to a greater degree, as systems and processes were less well established. Key challenges identified throughout the report included:

- **Difficulties working across teams with different specialisms and priorities.** For example, some staff felt it was difficult to make their views heard where their discipline was in the minority in a multiagency team. Establishing a shared theoretical model of practice and clear lines of responsibility was therefore important.
- **A perception that FDAC lacked independence from local authorities.** Findings from this research suggest that parents were more likely to engage with FDAC if they thought support was framed as being completely separated from the local authority. Therefore, models that include more traditional social worker roles in the team or have confusing lines of responsibility back to the local authority can make processes less appealing for some parents.
- **A view that FDAC prioritised the needs of parents above children.** FDAC was viewed by some participants as being overly focused on the parents, and, therefore, not adequately focused on the child (as previously highlighted by Harwin et al. (2014)). Strong partnerships between social work teams, guardians and the courts were key to ensuring the child's needs were kept front and centre of the process and some FDACs offered support directly to children and families, which was thought to be helpful.
- **Gaps in the support offer.** In some areas, more specialised services (including domestic abuse support tailored to male victims and perpetrators, and longer-term therapeutic services, for example) were not as readily available for parents to access. Linked to this, though FDACs made efforts to refer families on to other support at the end of the programme, it was acknowledged that local services may not have the capacity to continue to deliver intensive onward support, which might mean that some families relapsed later down the line.

- **COVID-19, which caused delays and limited face-to-face contact in some areas.**  
Where FDACs were not able to operate “in-person”, there were concerns that parents might not be getting the support or supervision they needed to make and sustain long-term change. COVID-19 also impacted on the timings for some newer FDACs setting up and the ability of some sites to fill staff vacancies.

In addition to these challenges, there was a sense among some participants that the FDAC model of support and supervision does not work as well for some parents, due to the complex nature of their substance misuse issues and related challenges. In particular, the 16-week time period allocated for the “trial to change” was not perceived to be long enough to work with those with more ingrained substance misuse habits, making reunification an unachievable outcome for some families.

In contrast to this, the eligibility criteria for accepting parents onto FDAC – in that they needed to show that they were motivated to change within the allocated timeframe – was thought to limit the possibility of parents coming onto the programme who were not expected to be able to achieve reunification outcomes.

### **Limitations related to the IPE**

The findings from the IPE build upon evidence provided only by those judges, staff and parents that engaged in the interviews. We cannot rule out the possibility that those participants that engaged with the interviews have had more positive views on FDAC.

During the IPE fieldwork timeframe, concurrent activities were being carried out for the IE and other, separate evaluations of FDACs.<sup>38</sup> This made it more challenging to establish a clear, shared understanding about the evaluation’s requirements as well as to manage research burden for FDAC staff across all areas. Approval from the Judicial Office, required for members of the judiciary to be interviewed, took significantly longer than expected, posing challenges to the initial timeline.

Variations in both FDAC and non-FDAC models resulted in concerns around anonymity for some sites that would be identifiable from certain details. Care has been taken to ensure such details are not included in this report.

It was not possible to include as many parents who had experienced FDAC in the research as intended. This was for three reasons: some FDACs had been set up relatively recently and, as such, had limited pools of parents who would be suitable; some parents were relatively early on in their engagement with FDAC, receiving intensive support, and it was not considered appropriate to ask them to take part in an interview in addition; and some proved hard to contact. To mitigate this, we carried out additional parent interviews at sites with larger cohorts of suitable parents. We also used multiple avenues to contact parents – including by phone, email and through support workers.

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<sup>38</sup> This includes a peer mentoring evaluation by King’s College London, an evaluation of post-proceedings support by the University of Sussex, and an evaluation of engagement with FDAC using behavioural insights by the Centre for Evidence Implementation. Additionally, many FDAC sites have their own evaluations ongoing.

## Cost evaluation

The cost evaluation provides a description of the costs associated with FDAC, but only draws on information from a small sample (7 out of the 15 FDAC sites). It is important to note there were many gaps in the information supplied in the cost form. We also observed that there is no consistent way in collecting cost information across FDAC sites, and that made it difficult for us to compile and compare the information on costs. As a result, we are not confident that the costs captured in this report are an accurate portrayal and further work will be required to gain a better understanding of costs associated with an FDAC case versus standard care proceedings. We provide a brief comparison of the costs we gathered with standard care proceedings below, but please note the preliminary and exploratory nature of this.

The average cost per child associated with running FDAC for the 2020/21 financial year was calculated to be £17,737. This figure varied across sites, ranging between £636 and £56,555. We expect that this huge variation is likely due to under-reporting owing to difficulties identifying FDAC specific costs at the lower end, and unused staff capacity at the higher end.

According to CJI's (2021) business report,<sup>39</sup> the average cost for a care proceedings case in England is **£32,440**. The lower cost per child in FDAC cases corroborates previous findings by Harwin et al. (2018), and likely reflects the lower proportion of contested cases and reduced rates of return to later care proceedings, as well as reductions in costs for other relevant services including, for example, fostering and mental health interventions. In addition, it likely reflects lower costs associated with the number of external expert witness assessments requested in FDAC cases relative to standard care proceedings.

## Research implications

We recommend that a future evaluation of FDAC should carefully consider and plan in the following points.

- **Collect rich data to improve the process for matching:** The IE provides new evidence that FDAC results in higher reunification rates of children with their parents. To increase confidence in these findings, data should be collected on key confounders. These include parental mental health and alcohol/drug misuse severity which were collected through CJI's FDAC data collection tool but not consistently collected by the local authorities through non-FDAC care proceedings. It is also important to more fully understand the selection process into FDAC vs non-FDAC care proceedings, such as the role of parental motivation to abstain from drugs and alcohol. This may take the form of a standalone piece of research but would be especially important for informing future data collection on potential confounders related to selection.

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<sup>39</sup> See <https://justiceinnovation.org/sites/default/files/media/document/2021/Family%20Drug%20and%20Alcohol%20Courts%20%28FDAC%29-Business%20case.pdf>

- **Expand the study population:** The London FDACs were not included in this evaluation as originally planned. Expanding the study population to London in future would increase diversity in the sample (e.g. in ethnicity) and improve the generalisability of findings. Furthermore, Manchester was the only LA that was not linked to an FDAC site. A future evaluation could also consider recruiting a pool of LAs like Manchester to provide data that weren't able to refer into FDACs at all. Doing so in future would likely eliminate some concerns around selection bias; however, this would also require access to data on confounders such as participants' motivation to abstain.
- **Assessment of long-term impact of FDAC:** A future study that can construct a comparison group with matching or similar approach should be taken to explore the long-term impacts of FDAC on the outcomes analysed in this evaluation.
- **Value for money evaluation:** Future research could undertake a comprehensive value for money evaluation of FDAC, including assessment of the benefits of the achieved FDAC impacts (e.g. monetise the benefits associated with the higher rates of reunification and fewer contested hearings). A comprehensive VfM analysis would use a representative sample and a valid comparison group.





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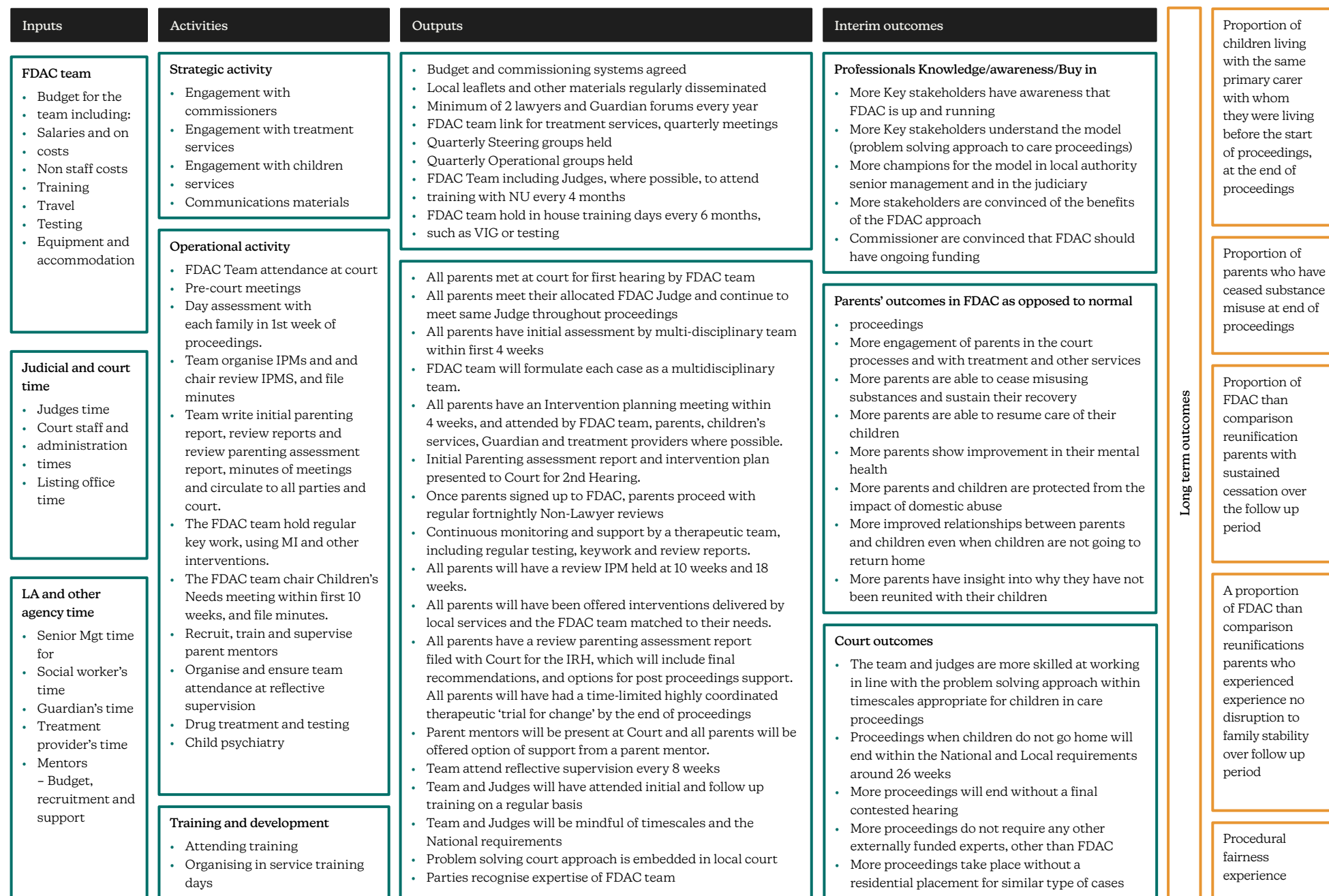
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# APPENDICES

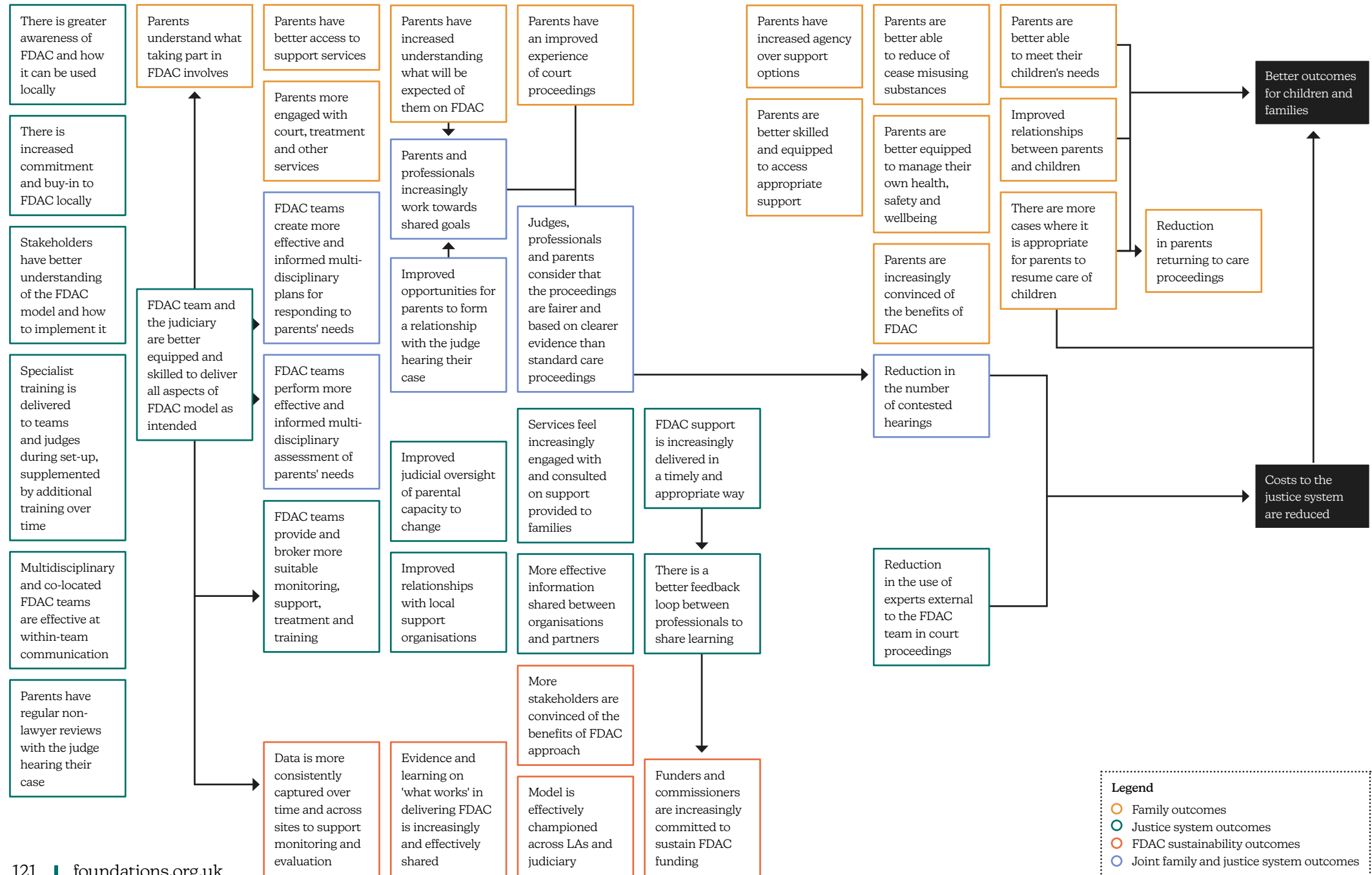


## Appendix A: FDAC logic model





## Appendix B: FDAC theory of change



## Appendix C: Key variables between London FDAC and other FDAC sites for primary analysis

| Variables   | Other FDAC<br>group mean<br>(SD) | London FDAC<br>mean<br>(SD) | Un-std. mean<br>diff.<br>(SD) | p-value      | Hedges' g<br>[95% CI]   | N<br>(Other FDAC,<br>London) |
|---|----------------------------------|-----------------------------|-------------------------------|--------------|-------------------------|------------------------------|
| Primary outcome – reunification   | 0.47<br>(0.5)                    | 0.55<br>(0.5)               | -0.08<br>(0.50)               | 0.237        | -0.16<br>[-0.42, 0.10]  | 417<br>(352, 65)             |
| Year of issue – 2019  | 0.04<br>0.19                     | 0.11<br>(0.31)              | -0.07<br>(0.21)               | <b>0.011</b> | -0.33<br>[-0.57, -0.08] | 453<br>(380, 73)             |
| Year of issue – 2020  | 0.4<br>0.49                      | 0.68<br>(0.47)              | -0.28<br>(0.50)               | <b>0.000</b> | -0.58<br>[-0.82, -0.33] | 453<br>(380, 73)             |
| Year of issue – 2021  | 0.55<br>0.5                      | 0.21<br>(0.41)              | 0.34<br>(0.49)                | <b>0.000</b> | 0.70<br>[0.45, 0.95]    | 453<br>(380, 73)             |
| Year of issue – 2022  | 0.02<br>0.13                     | 0<br>0                      | 0.02<br>(0.12)                | 0.190        | 0.17<br>[-0.08, 0.41]   | 453<br>(380, 73)             |
| Primary carer age (in years)  | 34.51<br>6.53                    | 36.08<br>(6.27)             | -1.57<br>(6.49)               | 0.052        | -0.24<br>[-0.48, 0.00]  | 448<br>(369, 79)             |
| Primary carer gender – Female   | 0.91<br>0.29                     | 0.99<br>(0.11)              | -0.08<br>(0.27)               | <b>0.016</b> | -0.30<br>[-0.54, -0.06] | 458<br>(369, 79)             |
| Primary carer gender – Male   | 0.09<br>0.29                     | 0.01<br>(0.11)              | 0.08<br>(0.27)                | <b>0.016</b> | 0.30<br>[0.06, 0.54]    | 458<br>(369, 79)             |
| Primary carer ethnicity –<br>Asian/Asian British                          | 0.02<br>0.13                     | 0.05<br>(0.22)              | -0.03<br>(0.15)               | 0.110        | -0.20<br>[-0.44, 0.04]  | 451<br>(375, 76)             |
| Primary carer ethnicity – Black African/<br>Black Caribbean/Black British | 0.03<br>0.17                     | 0.09<br>(0.29)              | -0.06<br>(0.20)               | <b>0.015</b> | -0.31<br>[-0.55, -0.07] | 451<br>(375, 76)             |
| Primary carer ethnicity –<br>Mixed/multiple ethnic groups                 | 0.05<br>0.21                     | 0.05<br>(0.22)              | 0<br>(0.21)                   | 1.000        | 0.00<br>[-0.24, 0.24]   | 451<br>(375, 76)             |
| Primary carer ethnicity – Other   | 0.01<br>0.09                     | 0.04<br>(0.2)               | -0.03<br>(0.12)               | <b>0.040</b> | -0.26<br>[-0.50, -0.02] | 451<br>(375, 76)             |

| Variables  | Other FDAC<br>group mean<br>(SD) | London FDAC<br>mean<br>(SD) | Un-std. mean<br>diff.<br>(SD) | p-value      | Hedges' g<br>[95% CI]   | N<br>(Other FDAC,<br>London) |
|--|----------------------------------|-----------------------------|-------------------------------|--------------|-------------------------|------------------------------|
| Primary carer ethnicity – White                                  | 0.9<br>0.3                       | 0.76<br>(0.43)              | 0.14<br>(0.33)                | <b>0.001</b> | 0.43<br>[0.19, 0.67]    | 451<br>(375, 76)             |
| Primary carer -<br>Past domestic abuse                           | 0.92<br>0.27                     | 1<br>0                      | -0.08<br>(0.27)               | 0.469        | -0.30<br>[-1.09, 0.49]  | 374<br>(368, 6)              |
| Primary carer –<br>Current domestic abuse                        | 0.49<br>0.5                      | 0<br>0                      | 0.49<br>(0.50)                | <b>0.017</b> | 0.99<br>[0.20, 1.78]    | 346<br>(340, 6)              |
| Primary carer – Misusing at the<br>start of care proceedings     | 0.72<br>0.45                     | 0.5<br>(0.53)               | 0.22<br>(0.45)                | 0.174        | 0.49<br>[-0.20, 1.17]   | 384<br>(376, 8)              |
| Child age  | 5.39<br>4.69                     | 7.72<br>(4.44)              | -2.33<br>(4.65)               | <b>0.000</b> | -0.50<br>[-0.74, -0.26] | 457<br>(378, 79)             |
| Child gender – Female  | 0.45<br>0.5                      | 0.57<br>(0.5)               | -0.12<br>(0.50)               | 0.053        | -0.24<br>[-0.48, 0.00]  | 459<br>(380, 79)             |
| Child gender – Male  | 0.55<br>0.5                      | 0.43<br>(0.5)               | 0.12<br>(0.50)                | 0.053        | 0.24<br>[0.00, 0.48]    | 459<br>(380, 79)             |
| Child ethnicity – Asian/Asian British                            | 0.01<br>0.11                     | 0.04<br>(0.2)               | -0.03<br>(0.13)               | 0.069        | -0.23<br>[-0.48, 0.01]  | 452<br>(379, 73)             |
| Child ethnicity – Black African/Black<br>Caribbean/Black British | 0.01<br>0.1                      | 0.11<br>(0.31)              | -0.1<br>(0.15)                | <b>0.000</b> | -0.65<br>[-0.90, -0.40] | 452<br>(379, 73)             |
| Child ethnicity – Mixed/multiple<br>ethnic groups                | 0.16<br>0.37                     | 0.19<br>(0.4)               | -0.03<br>(0.37)               | 0.532        | -0.08<br>[-0.32, 0.16]  | 452<br>(379, 73)             |
| Child ethnicity – Other  | 0.01<br>0.09                     | 0.03<br>(0.16)              | -0.02<br>(0.10)               | 0.135        | -0.19<br>[-0.44, 0.05]  | 452<br>(379, 73)             |
| Child ethnicity – White  | 0.81<br>0.39                     | 0.63<br>(0.49)              | 0.18<br>(0.41)                | <b>0.001</b> | 0.44<br>[0.20, 0.69]    | 452<br>(379, 73)             |

Note 1. Data on other FDAC sites was drawn from the datasets before matching with local authority data.

2. Due to resource constraints, London data is incomplete, leading to some small cells in key covariates (e.g. domestic abuse, substance misuse). Therefore, the comparison between London and other FDAC site clients should be treated with caution.

## Appendix D: FDAC data collection tool: Guidance for clinical judgements on substance misuse severity

| Severity | Drug misuse   | Alcohol misuse   |
|----------|---|--|
| None     | Not using any drugs   | Not using alcohol  |
| Low      | <ul style="list-style-type: none"> <li>• Low level cannabis use</li> <li>• Use of prescription drugs (Zopiclone, diazepam, co-codamol)</li> </ul>   | Non-harmful/non-problematic alcohol use, at or below the recommended level (no more than 14 units per week)  |
| Medium   | Social/recreational drug use including club drugs and legal highs   | <ul style="list-style-type: none"> <li>• Social drinking with history of harmful non-physically dependent use</li> <li>• Social drinking where there is a history of physically dependent use</li> </ul> |
| High     | <ul style="list-style-type: none"> <li>• Intravenous drug use</li> <li>• Chaotic drug use (homelessness, crime, pre-occupation with drug use dominating lifestyle, chaotic relationships, sex work)</li> <li>• Poly-substance misuse of illegal drugs (more than one substance)</li> <li>• Poly-substance misuse including misuse of prescribed drugs (more than one substance)</li> <li>• Poly-substance misuse including misuse of legal highs</li> <li>• High level cannabis use, daily multiple use</li> <li>• Misusing prescribed drugs (obtaining without a prescription; overuse)</li> </ul> | Physically dependent alcohol use   |

## Appendix E: Cost form

### FDAC costs template 2020/2021

[What Works for Children's Social Care](#) has commissioned [NatCen Social Research](#) to conduct a national evaluation of Family Drug and Alcohol Courts (FDACs).

Part of this national evaluation is a **cost evaluation**. We would like to discover

- (1) the costs of setting up the FDAC in your local authority (LA) and
- (2) the costs needed to run your FDAC for a year.

This will help us to better understand the resources needed to scale-up FDAC provision.

To help us with this evaluation, we would like you to complete this short form please, by 23 September 2022.

No individual FDAC will be identifiable in our reporting. We are primarily interested in estimating average setup costs and costs per child.

If you have any questions about this form, or need more time to complete it, please email us at [fdac@natcen.ac.uk](mailto:fdac@natcen.ac.uk).

Many thanks for your work on this!

#### Site information

|  |  |
|--|--|
| FDAC site name   |  |
| FDAC site launched on (Month / Year)   |  |
| Total number of children involved in cases that commenced financial year 2020/2021 |  |
| Name of person completing form   |  |
| Role   |  |
| Email address  |  |

1

### Setup costs of FDAC in your LA

This section asks about one-off implementation costs, related to the setup of FDACs in your LA. Setup costs refer to the costs occurring before point at which you were able to accept cases to FDAC. We are focusing on setup costs for sites that launched on March 2020 or after. If your site launched before March 2020, please write "N/A" in the "Total setup cost" row.

Below are examples of possible setup related costs. If not applicable to your site, write 0 in the cost column or delete the row. Add rows where necessary. You can also use notes to add further information.

| Example category<br>(delete or expand<br>as needed) | Example item                       | Total item<br>cost (£) | Notes<br>(optional – please add<br>anything that can help us<br>contextualise the figure in<br>our reporting e.g. specify<br>how many people took<br>part in the initial training,<br>or how many new IT<br>devices you bought) |
|---|------------------------------------|------------------------|---|
| Preparation costs                                   | Initial setup meeting              |                        |   |
|   | Consultancy costs                  |                        |   |
|   | Initial recruitment                |                        |   |
|   | Other (please specify)             |                        |   |
| Facilities, equipment and materials                 | Office space                       |                        |   |
|   | Equipment (including IT equipment) |                        |   |
|   | Other (please specify)             |                        |   |
| Training  | Initial training for staff         |                        |   |
| Overheads   | Overheads                          |                        |   |
| Other   | (please specify)                   |                        |   |
| <b>Total setup costs</b>                            |                                    |                        |   |

2



### Delivery costs – financial year 2020/2021

These are the regular costs, including staff costs, related to the delivery of FDACs in your LA. Delivery costs refer to the costs occurring from the point at which you were able to accept cases to FDAC. Please specify the total annual costs for 2020/21.

Below are examples of possible delivery related costs. If a category is not applicable, write 0 in the cost column or delete the row. Add rows where necessary or use notes to add further information about costs. If you are unsure to which category the recurring cost belongs, please add the cost as "other".

| Example category (delete or expand as needed) | Example item   | Total item cost (£) | Notes (optional – please add anything that can help us contextualise the figure in our reporting e.g. number of staff, and annual salary per type) |
|---|--|---------------------|--|
| Maintenance, equipment and materials          | Office space   |                     |  |
|   | Equipment (including IT equipment)   |                     |  |
|   | Booking external venues  |                     |  |
|   | Other (please specify)   |                     |  |
| Salary costs (including NI and pension)       | Specify type and number of staff and type of contract (e.g. full-time and part-time) |                     |  |
|   | Specify type and number of staff and type of contract (e.g. full-time and part-time) |                     |  |
|   | Specify type and number of staff and type of contract (e.g. full-time and part-time) |                     |  |
|   | Specify type and number of staff   |                     |  |
|   |  |                     |  |

3

|                              |   |  |  |
|------------------------------|---|--|--|
|                              | and type of contract (e.g. full-time and part-time) |  |  |
| Training and support         | Training of staff                                   |  |  |
|                              | Consultancy costs                                   |  |  |
|                              | Other (please specify)                              |  |  |
| Assessment and legal fees    | Clinical assessment                                 |  |  |
|                              | Drug testing  |  |  |
|                              | Special guardianship order costs                    |  |  |
|                              | Legal costs   |  |  |
|                              | Parent mentor costs                                 |  |  |
| Travel and subsistence costs | T & S for families                                  |  |  |
|                              | T & S for staff                                     |  |  |
|                              | T & S for other stakeholders                        |  |  |
| Overheads                    | Overheads   |  |  |
| Other programme inputs       | (please specify)                                    |  |  |
| <b>Total running costs</b>   |   |  |  |

Thank you very much for your work on this – we really appreciate it!

## Appendix F: Primary analysis full model (including covariate coefficients)

Table F.1. Primary analysis full model

| Variables  |                     | Coefficient | Std. err. | z     | P> z  | 95% CI |       |
|--|---------------------|-------------|-----------|-------|-------|--------|-------|
| Intervention (yes)   |                     | 2.46***     | 0.66      | 3.72  | 0.000 | 1.16   | 3.75  |
| Date of issue (Year and quarter)                               |                     | -0.01       | 0.10      | -0.07 | 0.943 | -0.20  | 0.19  |
| Primary carer – Age  |                     | 0.00        | 0.04      | 0.09  | 0.929 | -0.07  | 0.08  |
| Primary carer for how many children                            |                     | 0.32        | 0.17      | 1.82  | 0.068 | -0.02  | 0.66  |
| Primary carer – Age of youngest child cared for                |                     | -0.01       | 0.10      | -0.06 | 0.955 | -0.20  | 0.19  |
| Primary carer –<br>Past experience<br>of domestic abuse        | No (reference)      | -           | -         | -     | -     | -      | -     |
|  | Yes, As Both        | -2.11*      | 0.92      | -2.3  | 0.022 | -3.92  | -0.31 |
|  | Yes, As Perpetrator | 0.00        | (empty)   |       |       |        |       |
|  | Yes, As Victim      | -0.46       | 0.79      | -0.59 | 0.557 | -2.01  | 1.08  |
| Primary carer –<br>Currently<br>experiencing<br>domestic abuse | No (reference)      | -           | -         | -     | -     | -      | -     |
|  | Yes, As Both        | 1.05        | 0.77      | 1.36  | 0.175 | -0.47  | 2.56  |
|  | Yes, As Perpetrator | 1.28        | 1.77      | 0.72  | 0.47  | -2.20  | 4.75  |
|  | Yes, As Victim      | 1.46**      | 0.51      | 2.86  | 0.004 | 0.46   | 2.45  |
| Primary carer –<br>Whether misusing<br>at time of referral     | No (reference)      | -           | -         | -     | -     | -      | -     |
|  | Yes                 | -1.40       | 0.99      | -1.42 | 0.155 | -3.34  | 0.53  |
| Primary carer -<br>Substance<br>misuse type                    | No (reference)      | -           | -         | -     | -     | -      | -     |
|  | Alcohol             | -0.87       | 1.35      | -0.64 | 0.519 | -3.52  | 1.78  |
|  | Drugs               | -2.04       | 1.33      | -1.53 | 0.125 | -4.65  | 0.57  |
|  | Drugs & Alcohol     | -2.23       | 1.28      | -1.74 | 0.082 | -4.75  | 0.28  |

| Variables                     |                              | Coefficient | Std. err. | z     | P> z  | 95% CI |       |
|-------------------------------|------------------------------|-------------|-----------|-------|-------|--------|-------|
| Number of parents in the case |                              | 0.55        | 0.44      | 1.24  | 0.215 | -0.32  | 1.41  |
| Age                           |                              | -0.01       | 0.08      | -0.17 | 0.863 | -0.16  | 0.13  |
| Gender                        | Male                         | 0.30        | 0.37      | 0.82  | 0.41  | -0.42  | 1.02  |
| Ethnicity                     | White (reference)            | -           | -         | -     | -     | -      | -     |
|                               | Mixed/multiple ethnic groups | -0.90       | 1.29      | -0.7  | 0.486 | -3.41  | 1.62  |
| Constant term                 |                              | 0.60        | 24.64     | 0.02  | 0.981 | -47.70 | 48.89 |
| Site                          |                              |             |           |       |       |        |       |
| var(_cons)                    |                              | 1.25        | 0.81      |       |       | 0.35   | 4.46  |

Notes: Std. err. = Standard error, CI = Confidence interval, Significance thresholds = \*\*\* p < .001, \*\* p < .01, \* p < .05.

Table F.2. Additional analysis – Outcome: Child placement

| Variables   | (1)   | (2)  | (3)                   |
|---|---|--|-----------------------|
|   | Placed with primary carer<br>(Reference category) | Placed with another<br>relative or family member | Placed within LA care |
| Intervention (yes)  | -   | -1.00**  | -2.05***              |
| Std. err  |   | (0.46)   | (0.57)                |
| 95% CI  |   | [-1.89, -0.10]                                   | [-3.17, -0.93]        |
| Date of issue (Year and quarter)                            | -   | 0.01   | 0.01                  |
| Std. err  |   | (0.10)   | (0.10)                |
| 95% CI  |   | [-0.18, 0.21]                                    | [-0.19, 0.20]         |
| Primary carer – Age   | -   | -0.11***   | 0.04                  |
| Std. err  |   | (0.04)   | (0.04)                |
| 95% CI  |   | [-0.18, -0.03]                                   | [-0.04, 0.11]         |
| Primary carer for how many children                         | -   | -0.11  | -0.18                 |
| Std. err  |   | (0.18)   | (0.17)                |
| 95% CI  |   | [-0.46, 0.25]                                    | [-0.52, 0.16]         |
| Primary carer – Age of youngest child cared for             | -   | -0.02  | -0.23**               |
| Std. err  |   | (0.10)   | (0.11)                |
| 95% CI  |   | [-0.22, 0.18]                                    | [-0.44, -0.03]        |
| Primary carer – Past experience of domestic abuse (yes)     | -   | 1.35   | 0.32                  |
| Std. err  |   | (0.86)   | (0.73)                |
| 95% CI  |   | [-0.34, 3.04]                                    | [-1.11, 1.76]         |
| Primary carer – Currently experiencing domestic abuse (yes) | -   | -1.21***   | -1.12**               |
| Std. err  |   | (0.45)   | (0.50)                |
| 95% CI  |   | [-2.09, -0.33]                                   | [-2.10, -0.14]        |
| Primary carer – Whether misusing at time of referral (yes)  | -   | 1.67**   | 3.99***               |
| Std. err  |   | (0.65)   | (0.94)                |

| Variables                     | (1)   | (2)  | (3)                   |
|-------------------------------|---|--|-----------------------|
|                               | Placed with primary carer<br>(Reference category) | Placed with another<br>relative or family member | Placed within LA care |
| 95% CI                        |   | [0.39, 2.95]                                     | [2.15, 5.82]          |
| Number of parents in the case | -   | -0.84**  | -0.20                 |
| Std. err                      |   | (0.40)   | (0.47)                |
| 95% CI                        |   | [-1.62, -0.06]                                   | [-1.12, 0.71]         |
| Child age                     | -   | 0.05   | 0.09                  |
| Std. err                      |   | (0.08)   | (0.08)                |
| 95% CI                        |   | [-0.11, 0.20]                                    | [-0.07, 0.26]         |
| Ethnicity (White)             | -   | -1.36  | -1.42                 |
| Std. err                      |   | (1.36)   | (1.38)                |
| 95% CI                        |   | [-4.04, 1.31]                                    | [-4.13, 1.28]         |
| Constant                      | -   | 0.89   | -2.87                 |
| Std. err                      |   | (24.78)  | (25.00)               |
| 95% CI                        |   | [-47.69, 49.46]                                  | [-51.86, 46.13]       |
| (M1[site])                    | -   | 1  | -2.03                 |
| Std. err                      |   | (constrained)                                    | (1.30)                |
| 95% CI                        | -   | -  | [-4.59, 0.53]         |
| Observations                  | 263   |  |                       |

Notes: Standard errors in parentheses, Confidence Intervals in brackets, \*\*\* p <0.01, \*\* p <0.05, \* p <0.1.



Table F.3. Secondary analysis – Outcome: Parental alcohol and drug misuse cessation

| Variables   |                 | Coefficient | Std. err. | z     | P> z  | 95% CI |       |
|---|-----------------|-------------|-----------|-------|-------|--------|-------|
| Intervention (yes)  |                 | 1.71***     | 0.52      | 3.26  | 0.001 | 0.67   | 2.73  |
| Date of issue (Year and quarter)                            |                 | -0.01       | 0.13      | -0.07 | 0.929 | -0.25  | 0.23  |
| Primary carer – Age   |                 | -0.04       | 0.04      | 0.09  | 0.407 | -0.12  | 0.48  |
| Primary carer – Gender (female)                             |                 | -0.27       | 1.20      | -0.23 | 0.820 | -2.63  | 2.08  |
| Primary carer – Ethnicity                                   |                 | -           | -         | -     | -     | -      | -     |
| Primary carer for how many children                         |                 | 0.03        | 0.07      | 0.44  | 0.663 | -0.33  | 0.51  |
| Primary carer – Age of youngest child cared for             |                 | 0.03        | 0.07      | 0.46  | 0.648 | -0.10  | 0.16  |
| Primary carer – Past experience of domestic abuse (yes)     |                 | -1.06       | 0.87      | -1.22 | 0.222 | -2.78  | 0.64  |
| Primary carer – Currently experiencing domestic abuse (yes) |                 | 0.44        | 0.64      | 0.68  | 0.494 | -0.81  | 1.69  |
| Primary carer –<br>Substance<br>misuse type                 | No (reference)  | -           | -         | -     | -     | -      | -     |
|   | Alcohol         | -           | -         | -     | -     | -      | -     |
|   | Drugs           | -1.60       | 1.05      | -1.52 | 0.129 | -3.67  | 0.47  |
|   | Drugs & Alcohol | -1.30       | 0.62      | -2.10 | 0.035 | -2.52  | -0.09 |
| Constant term   |                 | 2.99        | 31.00     | 0.10  | 0.923 | -57.76 | 63.76 |
| Observations  |                 | 132         |           |       |       |        |       |

Notes: Std. err. = Standard error, CI = Confidence interval, Significance thresholds = \*\*\* p < .001, \*\* p < .01, \* p < .05.

Table F.4. Secondary analysis – Outcome: Contested final hearing

| Variables   |                              | Coefficient | Std. err. | z     | P> z  | 95% CI |       |
|---|------------------------------|-------------|-----------|-------|-------|--------|-------|
| Intervention (yes)                                    |                              | -2.18***    | 0.80      | -2.74 | 0.006 | -3.73  | -0.62 |
| Date of issue (Year and quarter)                      |                              | 0.01        | 0.14      | 0.09  | 0.928 | -0.27  | 0.30  |
| Primary carer – Age                                   |                              | -0.06       | 0.04      | -1.29 | 0.197 | -0.14  | 0.03  |
| Number of parents in the case                         |                              | 0.58        | 0.60      | 0.95  | 0.340 | -0.61  | 1.78  |
| Primary carer – Ethnicity                             | Mixed/multiple ethnic groups | -3.44       | 2.60      | -1.32 | 0.186 | -8.54  | 1.65  |
|   | White                        | -2.58       | 1.75      | -1.48 | 0.139 | -6.00  | 0.84  |
| Primary carer – Past experience of domestic abuse     | Yes, As Both                 | 1.83        | 1.65      | 1.11  | 0.266 | -1.40  | 5.05  |
|   | Yes, As Perpetrator          | -           | -         | -     | -     | -      | -     |
|   | Yes, As Victim               | 1.24        | 1.48      | 0.84  | 0.403 | -1.67  | 4.16  |
| Primary carer – Currently experiencing domestic abuse | Yes, As Both                 | 0.86        | 1.00      | 0.85  | 0.394 | -1.11  | 2.83  |
|   | Yes, As Perpetrator          | 0.27        | 2.00      | 0.14  | 0.89  | -3.63  | 4.19  |
|   | Yes, As Victim               | 0.69        | 0.65      | 1.04  | 0.296 | -0.60  | 1.98  |
| Primary carer – Substance misuse type                 | Drugs                        | -0.38       | 0.90      | -0.42 | 0.673 | -2.14  | 1.38  |
|   | Drugs & Alcohol              | -0.62       | 0.70      | -0.89 | 0.374 | -2.00  | 0.75  |
|   | None                         | -3.38***    | 1.44      | -2.35 | 0.019 | -6.20  | -0.56 |
| Number of children in the case                        |                              | 0.07        | 0.23      | 0.31  | 0.759 | -0.39  | 0.53  |
| Age of youngest child in the case                     |                              | -0.09       | 0.09      | -1.01 | 0.313 | -0.28  | 0.09  |
| Constant term   |                              | -1.81       | 35.77     | -0.05 | 0.960 | -71.93 | 68.30 |
| var(_cons)  |                              | 1.07        | 1.08      |       |       | 0.15   | 7.70  |
| Sites   |                              | 14          |           |       |       |        |       |
| Observations  |                              | 200         |           |       |       |        |       |

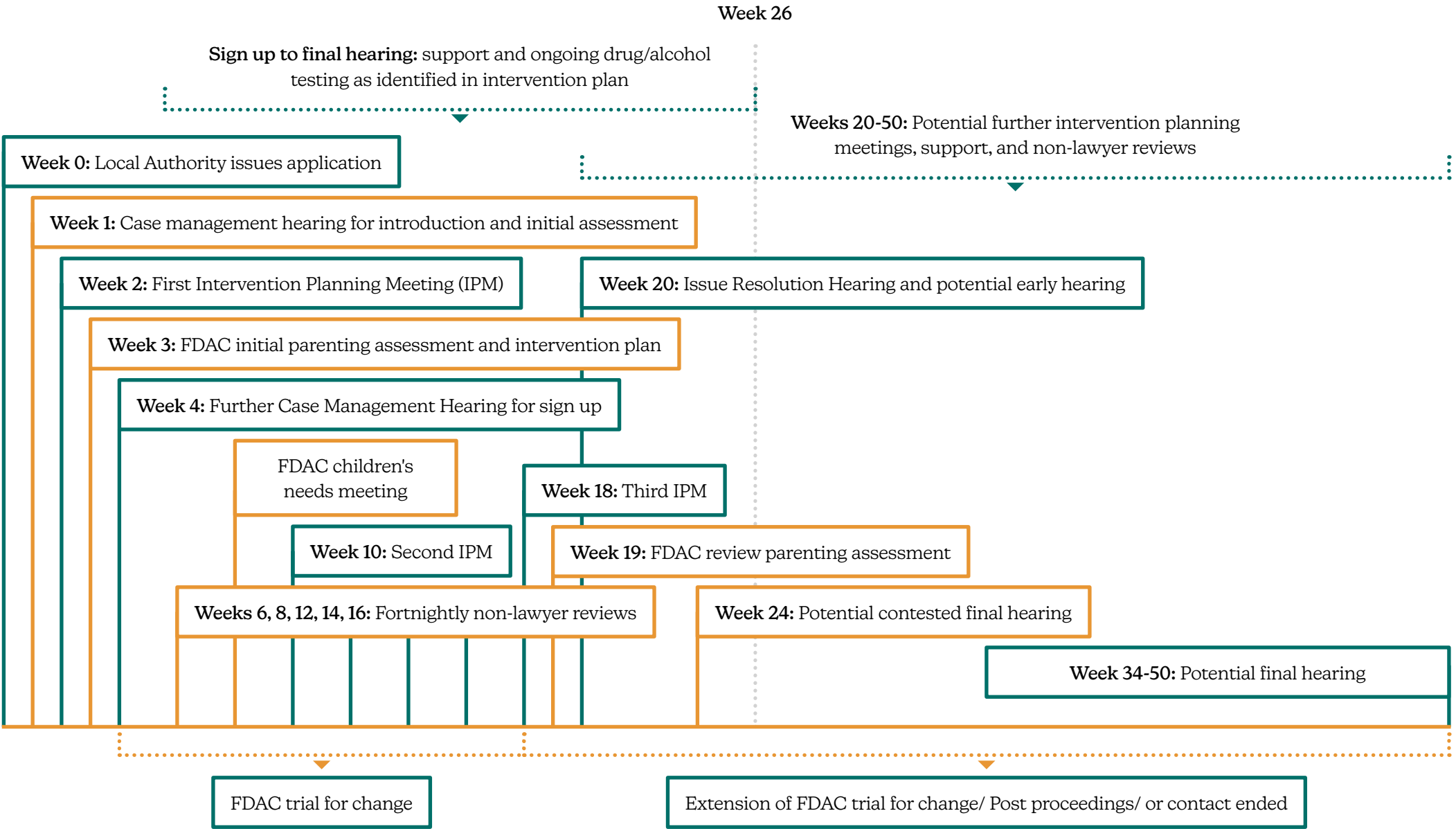
Notes: Std. err. = Standard error, CI = Confidence interval, Significance thresholds = \*\*\* p < .001, \*\* p < .01, \* p < .05.

Table F.5. Secondary analysis – Outcome: External expert witness

| Variables   |                              | Coefficient | Std. err. | z     | P> z  | 95% CI |       |
|---|------------------------------|-------------|-----------|-------|-------|--------|-------|
| Intervention (yes)                                    |                              | -6.38***    | 1.11      | -5.72 | 0.000 | -8.56  | -4.19 |
| Date of issue (Year and quarter)                      |                              | 0.01        | 0.18      | 0.04  | 0.968 | -0.36  | 0.38  |
| Primary carer – Age                                   |                              | -0.16**     | 0.07      | -2.26 | 0.024 | -0.29  | -0.02 |
| Number of parents in the case                         |                              | 0.02        | 0.67      | 0.03  | 0.978 | -1.30  | 1.33  |
| Primary carer – Ethnicity                             | Mixed/multiple ethnic groups | -0.03       | 4.60      | -0.01 | 0.995 | -9.03  | 8.97  |
|   | White                        | -0.015      | 3.32      | -0.04 | 0.964 | -6.66  | 6.36  |
| Primary carer – Past experience of domestic abuse     | Yes, As Both                 | 0.51        | 1.43      | 0.36  | 0.721 | -2.29  | 3.31  |
|   | Yes, As Perpetrator          | -           | -         | -     | -     | -      | -     |
|   | Yes, As Victim               | 0.89        | 1.29      | 0.69  | 0.49  | -1.63  | 3.34  |
| Primary carer – Currently experiencing domestic abuse | Yes, As Both                 | 0.74        | 1.05      | 0.71  | 0.479 | -1.31  | 2.80  |
|   | Yes, As Perpetrator          | -2.98       | 3.81      | -0.78 | 0.434 | -10.47 | 4.50  |
|   | Yes, As Victim               | -1.73**     | 0.83      | -2.08 | 0.038 | -3.36  | -0.01 |
| Primary carer – Whether misusing at time of referral  | Drugs                        | -2.55**     | 1.29      | -1.98 | 0.05  | -5.07  | -0.03 |
|   | Drugs & Alcohol              | 0.16        | 0.91      | 0.18  | 0.860 | -1.62  | 1.94  |
|   | None                         | -2.32       | 1.69      | -1.37 | 0.171 | -5.64  | 1.00  |
| Number of children in the case                        |                              | 0.35        | 0.26      | 1.35  | 0.177 | -0.15  | 0.85  |
| Age of youngest child in the case                     |                              | 0.02        | 0.09      | 0.21  | 0.836 | -0.17  | 0.21  |
| Constant term   |                              | 6.91        | 46.55     | 0.15  | 0.88  | -84.33 | 98.16 |
| var(_cons)  |                              | 0.82        | 0.85      |       |       | .10    | 6.38  |
| Sites   |                              | 14          |           |       |       |        |       |
| Observations  |                              | 206         |           |       |       |        |       |

Notes: Std. err. = Standard error, CI = Confidence interval, Significance thresholds = \*\*\* p < .001, \*\* p < .01, \* p < .05.

Appendix G: Delivery model



\* Diagram adapted from CJI (2023)

## Appendix H: FDAC sites' commissioning structure

| LAs that can refer families to linked FDACs | FDAC site                    | FDAC site commissioning structure  |
|---|------------------------------|--|
| Bedford                                     | Pan-Bedford FDAC             | FDAC is within the LAs but separate to CSC<br>(FDAC team sits within the independent reviewing service of the lead LA)   |
| Central Bedfordshire                        |                              |  |
| Luton                                       |                              |  |
| Birmingham City                             | Birmingham FDAC              | FDAC is within the LAs but separate to CSC<br>(FDAC team sits within the independent reviewing service of the lead LA)   |
| Solihull                                    |                              |  |
| Coventry                                    | Coventry FDAC                | FDAC sits within the LA but the team is separate to children's services  |
| Warwickshire                                |                              |  |
| East Sussex                                 | East Sussex                  | A specialist assessment team within the LA   |
| Gloucestershire                             | Gloucestershire              | FDAC team is not independent from children's services and sits within the care proceedings team. They are case holders of the children as well as working with parents |
| Kent  | Kent                         | FDAC team sits within the LA but the team is separate to children's services   |
| Leeds City                                  | Leeds                        | FDAC is contracted out to Barca (a not-for-profit organisation)  |
| Croydon                                     | Pan-London FDAC              | FDAC is contracted out by the consortium of LAs to the Tavistock and Portman NHS Trust   |
| Sutton                                      |                              |  |
| Bromley                                     |                              |  |
| Camden                                      |                              |  |
| Kingston                                    |                              |  |
| Lambeth                                     |                              |  |
| Richmond                                    |                              |  |
| Wandsworth                                  |                              |  |
| Redbridge                                   |                              |  |
| Buckinghamshire                             | Milton Keynes and Bucks FDAC | FDAC is within the LAs but separate to CSC<br>(FDAC team sits within the independent reviewing service of the lead LA)   |
| Milton Keynes                               |                              |  |

| LAs that can refer families to linked FDACs | FDAC site          | FDAC site commissioning structure  |
|---|--------------------|--|
| Newcastle<br>Gateshead<br>North Tyneside    | North-East FDAC    | FDAC is within the LAs but separate to CSC<br>(FDAC team sits within the independent reviewing service of the lead LA) |
| Somerset                                    | Somerset           | FDAC is within the LAs but separate to CSC<br>(FDAC team sits within the independent reviewing service of the lead LA) |
| Southampton City                            | Southampton        | A specialist assessment team within the LA   |
| Stockport                                   | Stockport          | FDAC team sits within the LA but the team is separate to children's services   |
| Sandwell<br>Dudley<br>Walsall               | Black Country FDAC | FDAC is contracted out by the consortium of LAs to Change Grow Live (CGL), a charity                                   |











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