



Post-Proceedings Support in a Family Drug and Alcohol Court

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Abstract

This article presents the findings from an evaluation of post-proceedings support (PPS) within Gloucestershire Family Drug and Alcohol Court (FDAC). PPS is offered to parents in the year immediately following a completed FDAC hearing. The article provides background on the formation and development of FDACs across England and FDAC evaluations, before detailing the specific delivery model in use in Gloucestershire. The evaluation that took place March 2020–July 2022 examined the delivery, effectiveness and impact of the support services provided to families after legal proceedings concerning child welfare due to parental substance misuse. Employing a mixed-methods approach, the study analysed quantitative data to assess outcomes such as parental cessation of substance misuse and family reunification, alongside qualitative insights through interviews exploring families' and professionals' perceptions and experiences. This evaluation sheds light on the strengths and limitations of this post-proceeding offer. It examines the extent to which the services can be said to contribute to sustainable recovery for parents and whether the model is transferable to other FDACs. It highlights the importance of continuing support for families and may provide 'conceptual' transferability and insights that will be relevant to other FDACs and beyond into children's and families' social work.

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Keywords: child protection, Family Drug and Alcohol Courts, post-proceedings support, problem-solving courts, recovery, substance and alcohol misuse

Accepted: April 2024

Background

Family Drug Courts began operating in the USA in the mid-1990s (Lloyd, 2015) modelled on the problem-solving courts (PSCs) established since the late 1980s (Boldt, 1998; Casey and Rottman, 2005; Centre of Justice Innovation (CJI), 2016). The evolution of PSCs was influenced by the concepts of therapeutic jurisprudence and restorative justice, both of which adopt non-adversarial and non-retributive approaches. The philosophy emphasises the role that self-determination plays in someone making positive behavioural changes to address the underlying reasons why they are in court whilst not conflicting with established norms of the legal system (Rottman and Casey, 1999; Wexler, 2001). King (2010) considers it a ‘collaboration’ between individuals and courts and other agencies to support change. PSCs are now in parts of Europe (Boone and Langbroek, 2018), Australia (Schaefer and Beriman, 2019), Canada (Slinger and Roesch, 2010) and New Zealand (Mills *et al.*, 2021). These form part of a vast literature reporting the work of PSCs in relation to drug and alcohol, domestic violence, mental health, indigenous sentencing and criminal behaviour and at the centre of these courts are specially trained judges guiding the process of rehabilitation. Amidst the literature evaluating the impact of PSCs, little attention has been paid to the support that those who graduate from them receive or to any services that provide this.

Specialist Domestic Violence Courts were the first PSCs to be introduced in the UK in 2006, quickly followed by the first Family Drug and Alcohol Court (FDAC) in London in 2008. The London FDAC was a three-year experiment initiated by District Judge Nicholas Crichton to address the increasing number of parents with drug and alcohol misuse problems who were appearing in his family court many of whom appeared regularly and experienced serial removal of children (see Harwin and Ryan, 2007). Gloucestershire FDAC was established in 2013, followed by Milton Keynes and Buckinghamshire’s FDAC in 2016. Gloucestershire was and continues to be distinct in that it is embedded in the local authority (LA) children’s social care (CSC) service and, from its inception, post-proceedings support (PPS) was embedded in its delivery model.

In 2015–2016, the second phase of the government’s Children’s Social Care Innovation Fund supported the establishment of seven FDACs

across England. In 2019, the government provided a £15 m to further expand the FDAC model. However, recently two FDACs have closed after their LAs withdrew funding. The closure of the only Welsh FDAC—Cardiff and Vale of Glamorgan—was announced in September 2023. Across England, fourteen FDAC teams currently (end 2023) operate in twenty-two courts covering thirty-five LAs (Centre for Justice Innovation, 2023), just under one-quarter of all LAs in England. With the exception of Gloucestershire, all FDACs are based on the London FDAC model and so do not include PPS. According to Harwin *et al.* (2018), this was to allow the model to be tested using a consistent delivery process. However, five of the fourteen FDACs responding to an invitation to contribute to our study in 2021 offered something that could be termed ‘PPS’ although it was substantially less than that in place in Gloucestershire.

Despite a common model, the composition of FDAC teams varies, but, in essence, they are multi-disciplinary teams of social workers and other practitioners with expertise in substance misuse treatment, mental health and domestic violence, working with a clinical lead and in partnership with a family court judge. Generally, the process around FDACs has not changed since their inception. Cases are considered for FDAC where substance/alcohol misuse is involved but not severe physical abuse or sexual abuse. At the first hearing, parents are offered the choice between engaging with the FDAC and continuing with the usual care proceedings. If the parents agree to enter the FDAC process, the case is adjourned whilst the FDAC team assesses the parents and develops a ‘trial for change’ programme, which is agreed at the next hearing. This programme, combining assessment, treatment and support, is designed to meet parents’ needs and give them the opportunity to address their problems within a timescale compatible with their child/children’s needs. All parents are allocated a FDAC keyworker and undertake regular drug and alcohol testing, and, in addition to the usual hearings attached to care proceedings, they attend court for ‘non-lawyer reviews’. There they meet with the Judge to review their progress and set goals with the FDAC keyworker, the child’s allocated social worker and the children’s Guardian, a court-appointed social worker from the Children and Family Court Advisory and Support Service (CAFCASS) who acts in the interests of the child.

The effectiveness of FDACs in England

Until recently the evidence for FDAC in England was drawn from a series of evaluations conducted only on the London FDAC (Harwin *et al.*, 2014, 2016). The first report was based on a small comparative study forty-one FDAC cases (fifty-six children) and nineteen comparison cases

(twenty-six children) one-year post-FDAC treatment. There were indications that parents who had been through FDAC were more likely to have ceased using substances and/or alcohol and be reunited with their children. A later evaluation by the same team (Harwin *et al.*, 2016) was based on an analysis of data on ninety families referred to the London FDAC between 2008 and 2012 and 101 comparison families from LA without FDAC access. Whilst the authors recognise the drawbacks of a non-matched quasi-experimental study, there were some interesting findings which should be noted, although this summary does not adequately reflect what was a complex analytical process. The analysis focused on maternal substance misuse cessation and placement sustainability. The first two years after reunification presented the greatest risk in relation to both factors. Subsequently, the risk reduced but those who had been through FDAC and, as at the two-year timepoint, were more likely to have maintained cessation and retained their children.

A national evaluation of FDACs across England, conducted between 2020 and 2022, (Papaioannou *et al.*, 2023), was originally intended as an RCT. However, the restrictions on involving the family justice system in an experimental design, as encountered elsewhere (see Baginsky *et al.*, 2017), meant that it was reshaped as a quasi-experimental design. This evaluation was also limited by the failure to obtain data on non-FDAC cases from most of the LAs covered by the FDACs. The report details the constraints this created for the analysis and, in turn, for the findings. Nevertheless, they are worth noting. As with an earlier evaluation of a similar length (Harwin *et al.*, 2014), there were positive indications in relation to reunification, cessation of drug/alcohol misuse and fewer children taken into LA care amongst FDAC families. The evaluation was confined to the period up to the conclusion of proceedings so did not enable any element of longitudinal evaluation of comparative outcomes.

There are also large numbers of studies on similar courts in other jurisdictions, but relying on them to support FDACs in England has its limits. Despite Family Treatment Drug Courts having been in place in the USA since 1994 and increasingly adopted elsewhere, Fay and Eggins (2019) argue, with possible exception of reunification, the evidence on outcomes remains unclear. Similarly Green *et al.* (2009) found that different programme models appeared to produce different patterns. Consequently, findings could often be attributed to differences in methodological approaches and samples. This is important when interpreting research findings as well as the output from systematic reviews in this area, such as that by Ogonnaya and Keeney (2018) and meta-analyses, for example, Zhang *et al.* (2019). Whilst they are 'gold standard' summaries, the heterogeneity of the studies included reveals possibly important differences between them.

Whilst Zhang *et al.* (2019) analysed seventeen studies, all but one conducted in the USA found the reunification rate of these courts was

nearly twice that of the alternative. However, there was no difference between the two groups when it came to the risk of foster care re-entry or a report for suspected child maltreatment. The authors recommended providing post-court services to reduce the risk of failure. This is similar to the call made by [Harwin et al. \(2018\)](#) for ongoing support to be available for families after FDAC that recognised recovery was not a linear process and might require varying levels of support over a period of time. They referenced a US study by [Twomey et al. \(2010\)](#) that examined the experiences of pregnant mothers in the US equivalent of FDACs. Whilst that study had several limitations, the researchers found a marked level of deterioration between twelve and twenty-four months including in substance misuse which they said indicated the importance of meeting long-term needs. These studies highlight that whilst FDAC and equivalents are an important development in the family justice arena, they may not be enough to sustain the improvements.

Gloucestershire PPS

The Gloucestershire FDAC was established in 2013 and, excluding London, is the oldest in England. It is jointly funded by the LA and the National Health Service (NHS), both contributing staff and funding. It is located in the Turn Around for Children's Service (TACS), a multi-agency, co-located CSC service comprising social work, health visiting, family support, mental health service including psychiatry, substance misuse service, speech and language therapy (SALT) and occupational therapy (OT). There is a lead judge with another judge available to cover if necessary. It is managed by a social care manager, and the FDAC social worker is also the LA social worker holding statutory responsibility to safeguard and promote the welfare of the child. It is therefore distinct from other FDACs as it is embedded in the LA CSC. It does not, therefore, conform with the 'evaluated London FDAC model' which, according to [Harwin et al. \(2018\)](#), was the model which the 'new' FDACs were required to adopt to allow the efficacy of FDACs to be tested using a consistent delivery process. However, it is worth noting that whilst Gloucestershire FDAC was included in the national evaluation ([Papaioannou et al., 2023](#)) apart from acknowledging the distinct delivery model, no further account appears to have been taken of that difference.

Gloucestershire is also distinct in having a one-year PPS programme, known as the Gloucestershire Supervision Order Care Pathway. This PPS programme is integrated into any LA Supervision Order or a Child in Need plan made in respect of a child. In the year following FDAC most children who are returned to their parents are the subjects of Supervision Orders which impose a duty on the LA to 'advise, assist and befriend' the child. Unlike a Care Order a Supervision Order does not

confer Parental Responsibility on the LA, but it may require a child to live in a specified place, undertake certain activities and report to a particular place at a set time. It also provides the opportunity to impose obligations on a responsible person if that person agrees to these. If, instead of being returned to a parent, a child is placed with a close family member or friend under a Special Guardianship Order the child is made the subject of a Child in Need plan. A PPS plan also is drawn up based on the assessment of a parent's progress through FDAC and designed to meet individual needs. It will include provision for regular visits from a social worker, as well as mental health/substance misuse practitioners. It may include psychotherapeutic interventions such as dialectical behavioural therapy (DBT) or cognitive analytic therapy (CAT), provided externally. There is regular testing for substances, as well as support for parenting and relationships including Video Interaction Guidance (VIG) and/or Speech and Language Therapy (SALT). The intention is that all interventions reduce over the year. The plan includes comments from the parent/s and from the Guardian. It is agreed with lawyers, the judge and CAFCASS, signed by the parent(s) and the judge and is attached to the Supervision Order or Care Plan. Parents are under no compulsion to take part and there is no statutory basis for PPS. A simplified version of the logic model for PPS is set out in [Table 1](#) (for full version see [Baginsky *et al.*, 2023](#)). At the end of the twelve-month period, the parents may choose to meet with the judge and, where things have gone well, the case will be closed to CSC. Alternatively, if it is decided to extend the Supervision Order, a court application must be made. The TACS team also provides support to parents who do not 'graduate' from FDAC, as well as to family members caring for children who are not returned to their parents, but this activity was not covered by this evaluation.

Although half of the thirteen FDACs in place in 2021 offered some element of PPS, there was nothing that matched the intensity of that provided in Gloucestershire. In light of [Harwin *et al.*'s \(2016\)](#) finding that the two years following conclusion of proceedings carried the highest risk, a closer examination of the support offered in Gloucestershire had the potential to make a substantial contribution to the body of FDAC knowledge which is the focus of the present article.

Impact of COVID-19 on PPS

In the early months of the pandemic, there was no substance testing, no face-to-face visits and no therapeutic work by the PPS staff. Families entering PPS would normally have met with a FDAC team member three times a week, but all contacts moved to video and telephone platforms. It emerged that only half of parents had computers, smart telephones or

Table 1. Summary of PPS logic model.

Context	Interventions	Mechanisms	Outcomes
Embedded in Glos CSC since 2013 and, as with FDAC, delivered by the embedded in Turn Around for Children's Services. This is a co-located multi-agency service trained in CRAFT ^a working in partnership with community services	Children's cases are held throughout FDAC and PPS by a social worker in TACS. The standard process is for a twelve-month Supervision Order with an offer to parents of PPS which is voluntary	Expectations are set out in a plan and parents are clear about the terms of that agreement and accept them, including the continuation of statutory social work	Build recovery capital through encouraging parents to: <ul style="list-style-type: none"> • resolve their own problems • improve situation re-housing, education • build family and other networks • deal with challenges of parenthood
Children will be on various orders, the most usual being a Supervision Order	The PPS is agreed on basis of FDAC experiences and following discussions with judge, professionals, Cafcass and parents	Relevant and appropriate interventions are delivered	More families maintain recovery and rates of relapse are reduced
Requirement for Family Group Conferences	Informal review by judge at three, six and nine months with a final meeting at twelve months Named keyworker usually, but not always, the same social worker holding the child's case	Progress is reviewed by judge and parents keen to access these reviews Support to access community services whilst reducing time between contacts to build self-confidence	Improved care of their children and development of skills to support/manage behaviour ^b Reduced risk of further abuse and neglect
FDAC judge and another judge to provide cover in courts which take place every other Friday Reunification will have happened during FDAC	Clinical intervention responding to need—regular visits from mental health/substance abuse nurse and may include continuation of therapy, usually more intensive in early months then reducing Regular testing continues and from three months becomes random Family Group Conferencing offer Parents work with local substance misuse service, a recovery provider and supported to contact other services	Action taken if there is a relapse	Reduced placement breakdown
		Parents come to TACS if relapse occurs and TACS takes appropriate steps Offer of support following PPS	Return to care proceedings is avoided Parents are positive about PPS Children have an opportunity to be involved through seeing the judge with a guardian and opportunities to feedback

^aAn intervention designed to help concerned significant others to engage treatment-refusing substance abusers into treatment: <https://www.robertjmeijersphd.com/craft.html>.

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

tablets to enable them to communicate with the team members and the court, so these were provided where necessary along with data packages and help to access meetings. But building and maintaining relationships proved much harder over video or telephone calls, aggravated by many technical and signal problems. Some team members thought that parents had been less invested in virtual meetings and in the virtual intervention plans that had been emailed to them. Practitioners expressed particular concerns about the cessation of substance testing as they believed it to be an important motivator for parents.

It was hard to establish consistent approaches to work across the agencies and it quickly became apparent that some problems were more difficult to resolve remotely than in-person. Not only did agencies use different IT systems that did not communicate with each other, they also used different platforms for virtual meetings to which some agencies were not allowed access or entailed delays. Family courts in England had originally introduced the BT MeetMe system to support telephone hearings. Whilst this allowed the judge to check in with families, it could not replace face-to-face hearings which did not recommence until July 2020. Some partner agencies closed and the NHS professionals in the PPS team were deployed into frontline and community work during the early months of the pandemic. When they returned, the speech and language therapist (SALT) found the video connection pictures were of insufficient quality to read children's facial expressions and mouth movements. In general, we were told it was much more difficult over a video link to pick up on unspoken communication through body language and facial expressions. The local drug misuse service did not re-open until Spring 2022 and, even then, the only face-to-face work was with people who were alcohol or opiate dependent.

The evaluation

Outline of the methodology

This evaluation was a longitudinal study conducted between March 2020 (the national UK COVID-19 lockdown started then) and June 2022 (the pandemic was still ongoing but in decline). The logic model developed (Table 1) links inputs to outcomes of PPS to reach a better understanding of why the intervention might work.

The evaluation was designed to meet three objectives as set out in Box 1, and the elements of the evaluation are recorded in Box 2.

Grandparents caring for their grandchildren after parental relapse were also interviewed as they had been supported by the FDAC team, but the data in this article are confined to those collected from parents. In addition, one parent withdrew as the interview started. She said that

Box 1. Elements for testing each objective of the PSS
Feasibility: Is the model acceptable to parents and professionals? Is it funded appropriately? Is it implemented as intended?
Evidence of promise: Does PPS maintain or change parental behaviour? Did the way in which services were combined impact on outcomes? Were there facilitators and barriers?
Readiness for trial: Is the model replicable, that is, by other FDACs?

Box 2. Elements of the evaluation
<ul style="list-style-type: none"> ● Interviews with members of the PPS/FDAC team, as well as with key professionals at T1(2020, <i>n</i> = 8), T2 (2021, <i>n</i> = 10) and T3 (2022, <i>n</i> = 12) between April 2020 and July 2022 ● Interviews with parents when they entered and concluded PPS between March 2020 and August 2022 (T1 = 7 and T2 = 6) ● Interviews with professionals from services and agencies working closely with the FDAC team at T1 (2020, <i>n</i> = 5), T2 (2021, <i>n</i> = 4) and T3 (2022, <i>n</i> = 2) ● An examination of data on all families who had been through PPS from the start of PPS in 2014 (<i>n</i> = 26) ● An estimation of resourcing requirement of PPS by collecting data on aggregate resource requirements linked to an 'average' pathway plan for PPS ● Observations of informal reviews with consent of parents, FDAC judge and social workers ● An overview of any other PPS provided by other FDAC teams.

whilst she was grateful that she had been in FDAC and PPS, she had made so much progress, started a new life and did not want to be reminded of that time.

The study was funded by the then What Works for Children’s Social Care, now Foundations—What Works Centre for Children and Families. Ethical approval for the study was obtained from King’s College London’s Ethics Committee (HR-19/20–17824). All participants provided verbal (recorded) or written consent.

Impact of COVID-19 on the evaluation

The pandemic impacted on PPS operations and in turn on the evaluation. During the data collection period only six families entered PPS. Contact was then lost with one, and two declined to participate in the evaluation, including one who relapsed during PPS. However, the FDAC Team had asked four parents who had previously been in PPS if they would be willing to pilot the interview schedules with the researchers. Three agreed to participate. As far fewer parents entered PPS—or FDAC—during the evaluation period it was agreed to incorporate these

data into the evaluation. The researchers had intended to seek the consent of parents and the judge for a researcher to attend all the final FDAC hearings and then seek parents' permission to contact them to discuss participation further. This happened once, immediately before the pandemic.

It was also intended to conduct focus groups with parents who had been in PPS between 2013 and 2019. It emerged that the FDAC Team's database did not contain enough detail to enable them to send the information and gain consent. Similarly, to support the estimate of resource requirements the plan was for all FDAC team members to keep a diary for one week on their time spent with families in PPS. Primarily because of how few families were in PPS during this time and the different ways in which team members were engaging with families it was decided that this would not be generalisable to a post-pandemic world and so was not pursued.

Social distancing requirements also meant that, with a few exceptions, all interviews were conducted by telephone or on Microsoft Teams.

Analysis

Qualitative data were analysed using a reflexive thematic approach (see [Braun and Clarke, 2006](#)) that allowed patterns to emerge through familiarisation, coding and theme development of the three sets of transcripts from T1, T2 and T3. Initially, data were coded separately by two members of the team to capture anything relevant to the areas explored in the interviews then the codes were categorised into themes. Interviews from T1 were analysed before T2 interviews and similarly they were analysed before those of T3.

Transcripts from T2 and T3 were coded based on codes developed from the T1 transcripts which helped to capture any change and develop questions specific to individuals based on earlier interviews. This was an iterative process where validation was also tested through triangulation of data against the different timepoints they were collected.

Data on families that had been entered on the anonymised template were analysed using the same outcome measures as the CJi for the National FDAC database. Due to the small sample size, concerns around data quality (which are addressed later in the article), the impact of COVID-19 and the lack of any directly comparable data (as the outcomes of PPS would occur 12 months after the outcomes recorded by other FDACs), we concluded that a descriptive approach was most suitable for the quantitative analysis.

Our initial intention had been to provide team members with a time diary to collect data on the exact time spent with PPS families during a specified week in early 2022. Following discussions with the service

manager, it was established that much of the work of PPS was front-loaded, with resource requirements much lower at the end than at the start of PPS. Due to the small number of families going through PPS at the time it was agreed that a time diary would not accurately capture team member activity. Instead, we provided a template to capture aggregate resource requirements to the service manager and business administrator, which linked to the supervision pathway plan for PPS. This data was combined with unit cost data from the Personal Social Services Research Unit (Jones and Burns, 2021) to provide an approximate cost of PPS provision per family. Due to limitations on space this is not presented here but is available in the full report (Baginsky et al., 2023).

Findings

Parents in PPS: profile and outcomes

Since 2013 when PPS was introduced into Gloucestershire, twenty-six cases had been in PPS, involving thirty-seven parents. We initially intended to examine any differences in the profile of families who accepted or rejected PPS. However, it emerged that all parents who had graduated from this FDAC were offered and accepted PPS. In twenty-two of the twenty-six cases at least one parent from each family completed it successfully. Their ages ranged from twenty to fifty-seven years (average age for mothers = thirty-three; for fathers = forty-three). In three-quarters of cases there had been prior involvement with CSC and in a third of them child(ren) had been removed from their parents. At the start of FDAC nearly three-quarters of parents had been assessed as having high severity substance misuse and nearly a third as having a similar level of alcohol abuse. Any comparison with national FDAC data needs to note that FDAC case data have only been reported since the beginning of 2021. That said, the cases in PPS appeared to be of a similar severity when they entered the FDAC process to that of the national profile.

Resourcing of PPS

The PSS support provided to families is understandably heavily front-loaded, with most work occurring in the first three months. Support is available throughout the twelve-month period but varies according to each family's needs. Data were provided on specific activities undertaken with parents during PPS. The most common was substance misuse intervention or treatment, which was recorded as being provided to at least one parent in all but one of the successfully completed cases. This was

followed by speech and language support for children (86%), and family/parenting support (82%). Around half the successfully completed cases also had other mental health support, peer-led recovery support, adult psychiatry, and physical health support.

Outcomes of PPS

Where available, data were collected about parents at the end of the PPS period in terms of the severity of misuse. There were insufficient data to examine change for half of this cohort of parents between the end of FDAC and the end of PPS. For those cases where they were available, drug misuse severity for thirteen parents stayed the same (in all but one staying as no misuse) and for five it increased, one going from no misuse to high severity, and for four cases no misuse to low severity. Similarly, eleven parents' alcohol misuse stayed the same (all but one staying as no misuse), whilst for eight severity increased from no misuse to low (2), medium (2) and high (4).

Of the twenty-two cases where at least one parent completed PPS, children were placed with the mother in 13, with the father in two, and with both parents in seven. When examined for subsequent involvement of CSC and a return to proceedings, most parents (24 of 31) had not relapsed. In six cases, one or more parent had subsequently relapsed—in one instance both parents having done so. Of the seven parents who had relapsed two did so more than five years after the end of PPS. The other relapses occurred within two years of the end of PPS and during 2020 and 2021, that is the pandemic. The professionals interviewed expressed little doubt that COVID-19 accounted for the increased number of relapses which started to emerge from August 2020 onwards. These were alongside increased severity of addictions and greater use of crack cocaine in combination with alcohol which seemed to increase resistance to change. Several professionals felt a contributory factor was the unavailability of community and universal services during the pandemic.

Existing evidence of substance misuse post-FDAC is currently limited to [Harwin *et al.* \(2018\)](#), who followed 140 London FDAC families and 100 standard proceedings families for up to five years after proceedings ended to examine the longer-term outcomes of FDAC compared with standard proceedings. They found the quality of data on substance misuse beyond three years after proceedings was not of sufficient quality to be of any analytic use. Collecting accurate evidence on a parent's substance misuse status is particularly problematic after proceedings have ended when the parent has no reason to submit to testing. Given the limited number of cases having completed PPS (22) and poor data quality on sustained cessation post-PPS, comparisons to the outcomes observed in [Harwin *et al.* \(2018\)](#) are provided for context only.

Harwin *et al.* (2018) found a significantly higher proportion of FDAC mothers were estimated to sustain cessation over the five-year follow-up when compared with a comparison group from standard proceedings (58 per cent versus 24 per cent). Only eight PSS cases involved a mother who had been 'reunified' with their child/children over a five-year period and none had relapsed within five years of completion, although two relapsed beyond the five-year period. Harwin *et al.* (2018) also used maternal relapse, placement change and return to court to develop a single composite measure taken as a proxy for family stability. A significantly higher proportion of FDAC mothers compared with the comparison group, who had been reunited with their children at the end of proceedings, was estimated to have maintained family stability (51 per cent versus 22 per cent) at three-year follow-up.

Examining family stability post-PPS could be done within three years of FDAC ending (which would incorporate the year of PPS support and the following two years) or within three years of PPS ending. We concluded that the comparison made more sense if it was three years after PPS support had ended as the evaluation was more interested in whether PPS made reunification more likely and relapse less likely in the longer term, rather than whether parents were less likely to relapse whilst in PPS. Only twelve of the successfully completed PPS cases had occurred three or more years ago. Of these, eight showed no disruption to family stability. (See Table 2)

Professionals' views on PPS

The FDAC Team members and associated professionals interviewed had not worked in another FDAC so could not compare the Gloucestershire model with others. They thought that by having a team based in CSC and co-located with, and funded by, the NHS reduced duplication and

Table 2. Summary of figures for sustained cessation and reunification after PPS completed.

Summary	All		PPS ended more than three years ago	
	<i>n</i>	%	<i>n</i>	%
Total cases in which PPS completed	22	–	12	–
Couple complete FDAC and PPS	9	41	5	42
Couple entered FDAC, one parent completes PPS	8	36	5	42
Single mother completes FDAC and PPS	5	23	2	17
Occurred after PPS:				
No disruption to family stability	15	68	8	67
Maintained reunification	18	82	10	83
Parental Relapse	6	27	3	25
Return to Court	5	23	3	25
Subsequent involvement with social care	10	45	7	58

made communication much easier than it would be with an external team. It also decreased the number of professionals with whom parents had to maintain contact. Until recently, the same social worker worked with a family through FDAC and PPS, but, partly to manage the pressures on social workers, this work had been separated. Whilst some thought that this could disrupt established relationships with families, it was also seen as an advantage in introducing fresh perspectives.

We found health visitors, mental health workers and family support workers offered more intensive interventions than they could offer in the community because of their small caseloads. This was part of the whole package that was considered very important for families who had faced the trauma of potentially losing their child/children, sometimes after many years of chaotic and inconsistent parenting. With their children back in the family home, parents had to learn to nurture them in a very different milieu, where drugs and alcohol did not play a part. But, having said that, professionals acknowledged that whilst parents may sustain abstinence during the recovery process, it was still early in the recovery journey. As such, PPS was designed to respond quickly to any relapse whilst also helping parents reduce their dependence on professionals.

Parents' views on PPS

As noted, few parents participated in this evaluation. Moreover, their views on PSS and FDAC often coalesced as one experience. With one exception, all were very positive about their time on PPS, not least because they had not felt ready to manage on their own when they graduated from FDAC. Some believed reunification with their child/children or maintaining reunification had been possible because of PPS. Whilst they acknowledged the part that all PPS professionals had played in helping them return to normalised parenting, most singled out the judge as providing a combination of support and challenge. Not surprisingly, there were those who would have preferred fewer visits and less frequent testing as they moved into the next phase of their lives.

Addressing the evaluation's objectives

Feasibility

Overall the model of PPS in Gloucestershire was acceptable to parents, FDAC Team professionals and others working alongside them. However, it was difficult to engage community-based professionals because many lacked awareness of PPS as distinct from FDAC and others

were uncontactable during the pandemic. Those who were interviewed considered it to be appropriately resourced. Having an embedded psychiatrist in the FDAC enabled diagnostic work and treatment to continue in PPS, similarly the presence of OT and mental health workers gave access to their expertise which may not be so available in other FDACs.

Implementation of PPS was difficult to assess given the pandemic context. Much PPS work was conducted virtually during the first year and beyond. Community support services closed for a long period and when reopened many moved on-line. Thus the evaluation was unable to capture PPS implementation in the form it had been intended.

Evidence of promise

The logic model (Table 1) focused on a reduction in both relapse and placement breakdown. Evidence against hypothesised outcomes is summarised in Table 3. However, we could not measure the following outcomes:

- ‘Building of recovery capital’ by PPS: it would only be possible to assess the success of PPS in the years that follow. Whilst we could do this in part, it would require higher quality of data than were available.
- ‘Improved care of their children’: this would have required pre- and post-measurement.
- ‘Parents develop skills to support/manage behaviour of children’: whilst it was not possible to assess this element, parents reported feeling supported by TACS over the care of their children.

We were unable to assess whether the way in which services were combined influenced outcomes because of pandemic-related changes. Harwin *et al.* (2016) proposed that the complexity of FDAC interventions necessitated a future larger study to unpick the relative contribution of its different components. This applies similarly to PPS. To have confidence in any assessment of replicability the evaluation of any initiative that consists of different components must be able to assess if they produce consistent outcomes (Graham and Birchmore-Timney, 1989). The elements of the PPS offer are adapted to meet the needs of parents. Whilst most will access substance misuse interventions, and testing and mental health interventions are provided to the majority of those in PPS, a range of other support is tailored to individual needs such as ongoing SALT, health advice, family/parenting support, access to the psychiatrist and to therapeutic and SALT interventions for children. When compared with other research conducted on FDACs, families who successfully completed Gloucestershire’s PPS appeared to have positive

Table 3. Evidence of logic model outcomes.

Outcome	Evidence
Building of recovery capital More families maintain recovery	It was not possible to assess this element Eight of twelve PPS cases with family reunification showed no disruption to family stability at all over three or more years
Families experience of support is positive	Overall parents' experience of PPS was positive
Reduced rates of relapse	77% of thirty-one parents had sustained cessation after PPS had concluded
Improved care of their children Parents develop skills to support/manage behaviour of children	It was not possible to assess this element It was not possible to assess this element but felt supported by TACS over care of their children
Reduced risk of further abuse and neglect	Abuse and neglect are very difficult to evidence. Ten of the twenty-two families (45 per cent) had some recorded involvement with CSC following PPS ending. Of these, five resulted in a return to court and three were an early help assessment that resulted in NFA with the parent.
Reduced placement breakdown	Eighteen successfully completed PPS cases (82 per cent) maintained reunification after the end of PPS (the length of time for this will vary depending on how recently the PPS concluded).
Benefits for child development and outcomes	The child-specific offer, especially continued speech and language therapy and counselling, provides benefits, but it was not possible to measure these within the evaluation
Return to court proceedings is avoided	Continued contact and support via PPS means team can intervene early where there is a relapse and take action which might stop return to proceedings

outcomes. However, due to the small sample size, varying lengths of time since PPS completion, incomplete data and the impact of COVID-19 mean, we were not able to answer our research question about evidence of promise. The twenty-six cases in PPS between 2013 and the end of June 2022 did not constitute a large enough sample to allow for the variation in offer or parental circumstance. Similarly, we could not identify facilitators and barriers to service delivery because of the pandemic-related changes.

Readiness for trial

Any manualisation of PPS would focus on its component parts which for the reasons stated above were difficult to assess and currently make it impossible to develop a PSS manualised approach. But had it been possible, it would be hard to map how it could be introduced into another FDAC because of the distinctive way in which the Gloucestershire

model is integrated into CSC. Other FDACs are independent of CSC or have a lighter-touch relationship with it. Some FDACs provide some form of PPS such as conducting informal reviews and continuing a testing programme during a Supervision Order, but the same breadth and intensity of support around recovery and targeted support that were available in Gloucestershire were not available elsewhere. Whilst there are lessons for other FDACs from Gloucestershire's PPS, it is difficult to see how transferability or replicability would be possible without a substantial redesign of the evaluated FDAC model (Harwin *et al.*, 2014) and, from discussions with other FDACs, there was little interest in doing so.

Study strengths and limitations

The evaluation lasted thirty months, and most professionals were interviewed at least three times, other than the few who joined or left the TACS whilst the evaluation was running. Parents were also interviewed at the start and end of PPS. The time available and the repeated contact with individuals enabled the researchers to reach a deeper understanding of PPS.

The most visible limitation was its juxtaposition with the pandemic. Not only did services change, the intensity of work with families was reduced which made it impossible to evaluate some key elements. As discussed above, the number of parents interviewed was fewer than expected because of the reduced number graduating from FDAC during the pandemic. Contacting parents was sometimes a protracted process, not least because with some changed their telephone number between T1 and T2. Even though most parents were interviewed twice, we believe that overall the interviews were not as penetrating as they could have been if trust had been established by face-to-face interaction and the researcher had then been able to judge how best to approach sensitive areas. Whilst most interviews with professionals were conducted online this did not appear to lower the quality of the interactions or the data obtained.

Although the interruption to some services was relatively short, ways of working changed considerably with more hybrid and remote working becoming the norm during the evaluation. The backlog of cases entering CSC had consequences for the assessment of possible cases for FDAC. Many professionals considered that problematic alcohol and substance misuse had increased and this was reflected in the dropout rate from FDAC which was reported to be at higher levels. Consequently, fewer parents graduated and entered PPS and thus there were fewer parents to approach to take part in this evaluation.

Although comparisons with outcomes from FDACs from other research seem positive, several limitations must be considered. The relatively small number of cases that had gone through PPS over the years, combined with the less than ideal quality of the data available, posed severe limitations on the evaluation. The impact of the pandemic also means that comparisons must be treated as indicative and possibly of limited value. We were also aware that it was impossible to identify relapses if parents were not engaging with services, and, although this is a common problem across FDACs, without comparable data following graduation it is difficult to assess the impact of PPS. It is also worth noting that we had access only to cases involved in PPS and, as such, we did not have the data available to calculate the actual FDAC drop-out rate in these, or previous, years.

Discussion

The focus of this evaluation was on the PPS offered by one FDAC which, itself, adopted a different model to the one in place across England. In that respect, it is possible to argue that it was never feasible to assess whether it was transferable to other FDACs. The demand for this evaluation must, in part, have come from a desire to know what might work to improve outcomes for families that have graduated from FDAC. At present, very little is known about those outcomes. Earlier research on one FDAC pointed to the highest risk to reunification and cessation occurred in the two years following the conclusion of proceedings so anything that could reduce that risk would be welcome.

This evaluation helped identify what was working. Overall the majority of parents appreciated the opportunity to be able to continue to access support after FDAC. They valued the professionals with whom they worked and, in particular the contacts they had with the judge. There was also an economic advantage in the TACS model in that it used the same professionals and structures as FDAC which also provided continuity for parents. There may also be lessons more widely for Supervision Orders and the level of support that they should attract beyond FDAC given [Harwin *et al.*'s \(2019\)](#) findings on the inadequacy of the support currently provided for families on Supervision Orders. In all the interviews with professionals, no one questioned the importance of providing support for those who have graduated from FDAC, recognising the challenges involved in recovery. However, Gloucestershire's PPS depends on the continued involvement of the multi-agency FDAC team, allowing a very structured front-weighted service, which brings into question the direct transferability of the model. Given the distinctiveness of the FDAC model, it would not be possible to transition the PPS format more widely when other FDACs are supported by smaller teams lacking the breadth

of the multi-professional input that is available in Gloucestershire. In light of the financial pressures on LAs that were leading to some FDACs closing and others existing on short-term funding at the time of the evaluation it would seem unlikely that there would be an interest in adopting the model.

Although the evaluation did not establish the effectiveness of the PPS model in place in Gloucestershire, it provided a road map on what could be provided irrespective of the FDAC model that was in place. Having said that, an earlier step perhaps should have been to evaluate the impact of that model—that is one that is embedded in CSC—compared with the others, which are either independent of, or located in, other LA departments. It may also have provided an opportunity to assess if a model more intimately embedded in CSC provided additional buffering against a harsh economic climate that has seen some FDACs close or face short-term funding uncertainties.

Whilst the evaluation of the model was long overdue, so is a dedicated evaluation of PPS offered by some other FDACs. This evaluation also captured details on what was in place elsewhere alongside the response of those working in them to the Gloucestershire's offer (as reported in Baginsky *et al.*, 2023). Although they did not have the appetite to adopt that approach, either because they viewed it as firmly located within Gloucestershire distinct FDAC model or because of the resource implications, much of what they described pointed to the need for their initiatives to be examined further.

The Parliamentary Office of Science and Technology (POST) report (Mentzou and Mutebi, 2023) was published after the Ministry of Justice launched three Intensive Supervision Courts (ISC) in June 2023 as part of the government's ten-year Drug Strategy (Ministry of Justice, 2020). Whilst the authors of the POST report welcomed these courts, they pointed to the limited evidence base for PSCs in the UK because of 'inconsistent implementation and evaluation'. Our own evaluation was hindered not only by the pandemic but also by the limits to the quality of longitudinal data that were available. As noted above, other evaluations have been similarly hindered.

However, the specifics of the model and the potential for replication should not be allowed to detract from the strengths of PPS as revealed in this evaluation. Not only does it provide a bridge from FDAC into future recovery for parents, the adoption of a holistic approach to the family recognises the centrality of the child and the importance of providing support to them. It has long been acknowledged that support plays a vital part in sustaining recovery for individuals with substance use disorders (see, e.g., Borelli *et al.*, 2017) with the chances of better recovery outcomes and a decreased chance of prolonged relapse (Wasserman *et al.*, 2001; Dobkin *et al.*, 2002). The importance of encouraging people to take ownership and responsibility for their recovery (Leamy *et al.*,

2011; Best *et al.*, 2018) is part of the underpinning philosophy of Gloucestershire's PPS, but this takes time. The main goal during FDAC is to achieve abstinence but many of the parents had other long-standing problems which compounded the challenges they faced, so it would be unrealistic to expect that these could be addressed in the relatively short FDAC period. PPS was viewed by parents and professionals alike as additional 'recovery time' to allow for consolidation, prevention and treatment.

Conclusion

PPS is a 'bridge' in what can be a long-term process, frequently requiring multiple episodes of treatment. Expectations of PPS should recognise that even its additional post-FDAC support will be insufficient for some parents. Although the evaluation did not find the empirical evidence necessary to conclusively prove the effectiveness of the PPS model in Gloucestershire it clearly made a valuable contribution to the majority of parents interviewed. Whilst it may not be directly transferable to other FDACs, the philosophy and ethos which underpin the work of the PPS team may provide 'conceptual' transferability and insights that will be relevant to other FDACs and beyond into children's and families' social work.

Funding

The project was funded by What Works for Children Social Care, but the views expressed are those of the authors.

Conflict of interest statement. None declared.

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British Journal of Social Work, 2024, 54, 2336–2357

<https://doi.org/10.1093/bjsw/bcae057>

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