



**Intervening with pregnant women at risk of repeat care
proceedings: a realist and quasi-experimental evaluation of
the Startwell service in North East England**

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Ruth McGovern, Sally O'Keeffe, Emma Geijer Simpson,
Stephen McCarthy, William McGovern, Angela Bate.

SHORT SUMMARY

BACKGROUND

For the past two decades there has been a year-on-year increase in the number of children being taken into care, resulting in a 'care crisis' (Family Rights Group 2018). There is particular concern regarding the 24% of mothers who experience child removal and return as a respondent in successive care proceedings (Broadhurst, Alrouh et al. 2015) and the rising number of babies 'born into care' (Bilson and Bywaters 2020). There is an urgent need to understand how to interrupt the cycles of trauma and child removal experienced by mothers who are subject to repeat care proceedings.

AIM

This study aimed to evaluate the Startwell intervention provided by Barnardo's for pregnant mothers who have had one or more previous child(ren) removed from their care.

METHOD

The study employed a realist approach to service evaluation, using quasi-experimental and qualitative methods.

FINDINGS

Infants whose mothers received the Startwell intervention were more than twice as likely to be born into care than mothers in the comparison group who did not receive the Startwell intervention. However, infants whose mother received Startwell were less likely to be in care at 12 months than infants of mothers who were in the comparison group. Infants who were born into care were 10 times more likely to be in care at 12 months. However, the outcomes of infants who were born into care and received the Startwell intervention were better than those infants that were born into care and did not receive the Startwell intervention.

Within the challenging context of child protection, the Startwell practitioner provides a safe and trusting relationship, focusing upon the needs and experiences of mothers at risk of repeat care proceedings. This supports the challenging of behaviours and beliefs that are a risk to the infant. Where a decision is taken to remove the infant, that Startwell practitioner supports the mother to grieve her loss, enhancing her mental health and wellbeing.

CONCLUSION

The Startwell intervention provides non-adversarial relational-based support which is effective at increasing the reunification of infants who are born into care with their mothers.

EXECUTIVE SUMMARY

1 BACKGROUND

For the past two decades there has been a year-on-year increase in the number of children being taken into care, resulting in a 'care crisis' (Family Rights Group 2018). There is particular concern regarding the 24% of mothers who experience child removal and return as a respondent in successive care proceedings (Broadhurst, Alrouh et al. 2015) and the rising number of babies 'born into care' (Bilson and Bywaters 2020). The majority of mothers who have been subject to recurrent care proceedings have experienced structural disadvantage in multiple marginalities throughout their lives (Cox 2012). The removal of a child is itself traumatic and can compound the mother's difficulties and create an immediate psychosocial crisis [7]; whilst also having cumulative and enduring adverse impacts (Broadhurst and Mason 2017). There is an urgent need to understand how to interrupt the cycles of trauma and child removal experienced by mothers who are subject to repeat care proceedings.

1.1 STARTWELL INTERVENTION

In July 2020, Barnardo's North East piloted the Startwell service in Sunderland and then extended to five additional local authority areas in May 2022. The Startwell service provides an intensive relational intervention to pregnant mothers who have previously had one or more child removed from their care, and where there was a risk of care proceedings following the birth of their infant. Beginning at the earliest possible opportunity following pregnancy being confirmed, the intervention continues for around one-year, irrespective of whether the infant remains with the mother. If the infant is removed at birth, the Startwell practitioner will continue to offer support during proceedings and/or for the duration of this service. If the infant remains with mother or is returned to their care following a care placement, the Startwell practitioner continues to offer practical and emotional support and support engagement with services for at least three months or for the duration of the child protection plan.

2 RESEARCH AIM AND OBJECTIVES

This study aimed to evaluate the Startwell intervention provided by Barnardo's for pregnant mothers who have had one or more previous child(ren) removed from their care. The objectives of the evaluation were to:

- To estimate the effectiveness of the Startwell intervention at reducing the number of infants in care.
- Conduct a cost consequence analysis to assess return on investment based on the financial implications of the project offset by the reduction of children entering the care system.
- Derive explanatory evidence to describe what works in supporting mothers at risk of repeat care proceedings.

3 METHODS

The study employed a realist approach to service evaluation, using quasi-experimental and qualitative methods. The evaluation was conducted in the Startwell service provided by Barnardo's in six local authority areas in the North East of England.

3.1 QUASI-EXPERIMENTAL STUDY

The quasi-experimental study utilised routine data to compare the care status of infants born to mothers receiving the Startwell intervention to those receiving usual care, at birth (defined as the first 7 days of life), aged 6 months and 12 months.

3.2 COST ANALYSIS

The benefits of the intervention are provided in the number of children who avoided being in care aged twelve months. When including the costs of delivering the intervention, the benefits are provided as the cost per child who avoided being in care aged twelve months. The outputs from the outcome and cost analysis were used to inform a Return On Investment (ROI) model to estimate the cost per child who avoided being in care at twelve months of age when provided the intervention.

3.3 QUALITATIVE STUDY

We conducted interviews with mothers who were currently/had recently received the Startwell intervention, practitioners who referred mothers into the service and Startwell practitioners. Additionally, we conducted a focus group with Startwell practitioners to support theory refinement. Interviews and a focus group examined contextual factors (mother's characteristics/service provision

external to the Startwell intervention), mechanisms of change (a combination of resources offered by an intervention and the triggered response) and observable, measurable outcomes.

Data generated from the qualitative methods were analysed using a theory-driven approach. This consisted of explanatory statements (programme theories), which emerged from the data, were empirically tested with the findings of the quasi-experimental study. This analytical process resulted in refined theories which were iteratively examined. The programme theories were discussed and agreed with the project team and practice partners. This led to a consolidated account of how the intervention works, for whom, in which circumstances and why.

4 FINDINGS

4.1 QUASI-EXPERIMENTAL STUDY FINDINGS

The quasi-experimental study included data from 159 infants/mothers; n=79 received the Startwell intervention; n=80 received usual care. The main findings were:

- Infants whose mothers received the Startwell intervention were more than twice as likely to be born into care (defined as entering care within first 7 days of life) than mothers in the comparison group who did not receive the Startwell intervention and this difference is statistically significant ($p=0.019$). Infants whose mothers were referred to the Startwell intervention more than twelve weeks before their birth are also more likely to be born into care and this is also statistically significant ($p=0.044$).
- Infants whose mothers received the Startwell intervention were less likely to be in care at 6 months, all other factors being equal. However, this was not statistically significant.
- Infants whose mothers received the Startwell intervention were less likely to be in care at 12 months, all other factors being equal. This was statistically significant ($p=0.049$).
- Overall, infants born into care were ten times more likely to be in care at 12 months compared to those who were not taken into care at birth. This difference is statistically significant.
- Infants who were born into care and who received the Startwell intervention had comparatively better outcomes than infants who were born into care and whose mothers did not receive the Startwell intervention. Infants in the Startwell group were almost 4 times as likely to be in care at 12 months, whilst infants who had been born into care and whose mothers were in the comparison group and who did not receive the Startwell intervention were 15 times more likely to be in care at 12 months than those who were not born into care and

did not receive the Startwell intervention. Those that received the Startwell intervention and were born into care were almost 4 times as likely to be in care at twelve months as those that did not receive the Startwell intervention and were not born into care. These differences were found to be statistically significant.

4.2 COST AND CONSEQUENCE

The Return-on-Investment shows the cost per infant avoiding being in care aged 12 months was £48,132.77.

4.3 QUALITATIVE STUDY FINDINGS

The qualitative study recruited a total of 39 participants, consisting of n= 10 referring practitioners (n=9 social workers; n= midwife), Startwell practitioners, service manager and administrator (n=11), mothers who have received the Startwell intervention (n=17) and a partner (n=1).

Within the challenging context of child protection, the Startwell practitioner provided **non-adversarial support focused upon the mothers needs and experiences**. By separating functions of support from safeguarding, the mother was able to develop a **trusting relationship with the practitioner, which becomes the necessary context for all other intervention work**. When a mother shared a safe and open relationship with their Startwell practitioner, they were often more able to **ask for help if experiencing difficulties, avoid deterioration in their circumstances and be challenged by the Startwell practitioner to change behaviours or beliefs** that were considered a risk to the infant. This was most important when **supporting a mother to be reunified with their infant**. When a decision is taken to remove an infant from the mother's care, the Startwell practitioner supported mothers' continued involvement in activities which may **facilitate her to begin to process her grief**. Such support maybe a necessary component of interventions to enhance the mental health and welling of mothers and **interrupt the cycle of recurrent care proceedings**.

5 CONCLUSION

This evaluation has found that the Startwell intervention provides non-adversarial relational-based support which is effective at increasing the reunification of infants who are born into care with their mothers.

DETAILED REPORT

1 BACKGROUND

In the past two decades there has been a year-on-year increase in the number of children who have entered care in England, resulting in a 'care crisis' (Family Rights Group 2018). In March 2023, there were 83,840 children in the care of a local authority in England; with the North East having the highest proportion of looked after children in the country (113 per 10,000 children compared 71 per 10,000 children nationally) (Department for Education 2023). There is particular concern regarding the 24% of mothers who experience child removal and return as a respondent in successive care proceedings (Broadhurst, Alrouh et al. 2015) and the rising number of 'babies being born into care' (Bilson and Bywaters 2020). The majority of the mothers who experience recurrent care proceedings have experienced multiple disadvantages throughout their lives (Cox 2012). They are often considerably younger at the time of their first birth than both the general population of mothers and those mothers that experience a single care proceeding (Broadhurst and Mason 2017). Many have experienced adversity in their childhoods which led to them becoming looked after themselves as children and are typically exposed to additional risk factors in their adult life, such as domestic violence, substance use and mental health problems (Broadhurst, Mason et al. 2017).

The need to protect children from harm is unquestioned. However, the removal of a child can compound the mother's vulnerability creating both an immediate psychosocial crisis (Broadhurst and Mason 2020); whilst also having an accumulative and enduring adverse impact (Broadhurst and Mason 2017). The enormity of the recovery challenge following the removal of a child is increasingly recognised (Broadhurst and Mason 2020), alongside a growing acknowledgment of the moral and economic imperative to support the mental health and wellbeing of mothers who have experienced care proceedings and also to affect change in order to prevent recurrence (Broadhurst and Mason 2013). Over the past decade there has been a rapid growth in services for mothers at risk of recurrent care proceedings. However, there remains a paucity of evidence for interventions to support the mental health and wellbeing of these mothers (Easter, De Backer et al. 2022) both as a means of supporting the mother in her own right and to prevent future care proceedings (Cox, McPherson et al. 2020).

1.1 THE STARTWELL INTERVENTION

In July 2020, Barnardo's North East piloted the Startwell service in Sunderland and then extended to five additional local authority areas in May 22. The Startwell service provides intervention to

pregnant mothers who have previously had one or more child removed from their care, and where there was a risk of care proceedings following the birth of their infant. The service provides an integrated, intensive, and systemic model of support based on assertive outreach, relationship-based practice, systemic practice, attachment theory, trauma, grief and loss, strength-based practice and evidence informed interventions. The Startwell intervention is anticipated to help set in place strong foundations on which mothers can build a more positive future for themselves and keep their infant safe by understanding and consistently being able to prioritise their needs. They provide practical support to attend and engage with a wide range of health and social care services in the community, to ensure appropriate antenatal care and support is accessed and services are provided in response to the mother's health needs. To deliver this intense model of work, practitioners hold a small case load (a maximum of 10 per full-time worker), allowing for strong relationships and trust to be built with each mother.

The Startwell intervention is intended to begin at the earliest possible opportunity following pregnancy being confirmed although in many cases mothers are referred in a late stage of pregnancy. The intervention continues for around one-year, irrespective of whether the infant remains with the mother. If the infant is removed at birth, the Startwell practitioner will continue to offer support during proceedings and/or for the duration of this service. If the infant remains with their mother or is returned to their care following a care placement, the Startwell practitioner continues to offer practical and emotional support and support engagement with services for at least three months or for the duration of this child protection plan.

2 RESEARCH AIM AND OBJECTIVES

This study aimed to evaluate the Startwell intervention provided by Barnardo's for pregnant mothers who have had one or more previous child(ren) removed from their care. The objectives of the evaluation were to:

- Estimate the effectiveness of the Startwell intervention at reducing the number of infants in care.
- Conduct a cost consequence analysis to assess return on investment based on the financial implications of the project offset by the reduction of children entering the care system.
- Derive explanatory evidence to describe what works in supporting mothers at risk of repeat care proceedings.

3 METHODS

The study employed a theory-driven approach to service evaluation, using quasi-experimental and qualitative methods. This approach seeks to understand not only whether an intervention works, but what it is about the intervention that works, for whom, in what circumstances and why. It acknowledges that interventions take place within complex social systems and is therefore well suited to studying interventions, such as the Startwell intervention, with complex and potentially multiple pathways from implementation to impact.

This evaluation was approved on 8th September 2022 by the Faculty of Medical Sciences Research Ethics Committee, part of Newcastle University's Research Ethics Committee (reference: 2359/24340). This committee contains members who are internal to the Faculty. This study was reviewed by members of the committee, who must provide impartial advice and avoid significant conflicts of interests. Additional ethical review was secured from Barnardo's Research Ethics Committee.

3.1 QUASI-EXPERIMENTAL STUDY

A comparative-cohort study was conducted to estimate the effectiveness of the Startwell intervention. A formal sample size calculation for the quasi-experimental study was not conducted. The sample for the intervention group consisted of all pregnant mothers who had received the Startwell intervention and given birth between July 2020 and December 2023. The comparison group was all pregnant mothers residing in a neighbouring local authority; who were subject to a child protection plan; who had given birth during the same period; and had one or more previous care proceeding. The comparison site provided standard in-house child protection intervention, based upon the signs of safety model (Turnell and Edwards 1999).

The quasi-experimental study utilised routine data to compare the care status of infants born to mothers receiving the Startwell intervention to those receiving usual care, at birth (defined as the first 7 days of life), aged 6 months and 12 months.

We utilised routinely collected data, consisting of:

- Age of mother
- Date of registration
- Ethnicity

- Gestation of infant at start of intervention
- Category of abuse
- IMD (rank and decile)
- Date of any care entry within first 12 months of infant life
- Date at which episode(s) of care ended within first 12 months of infant life

We assessed the impact of the Startwell intervention by comparing the outcomes in the group of mothers who received Startwell to the outcomes in the group of mothers residing in a local authority where the Startwell service was not available. The outcomes were examined were the probability of:

- The infant being born into care.
- The infant being in care at 6 months.

The infant being in care at 12 months.

3.2 COST ANALYSIS

Within this analysis, the benefits of the intervention are provided in the number of children who avoided being in care aged twelve months. It is recognised that there may be other benefits resulting from the intervention that were not able to be captured by this analysis. When including the costs of delivering the intervention, the benefits are provided as the cost per child who avoided being in care aged twelve months. The outputs from the outcome and cost analysis were used to inform a Return On Investment (ROI) model to estimate the cost per child who avoided being in care at twelve months of age when provided the intervention.

3.3 QUALITATIVE STUDY

We conducted interviews with mothers who were currently/had recently received the Startwell intervention, practitioners who referred mothers into the service and Startwell practitioners. Additionally, we conducted a focus group with Startwell practitioners to support refinement of our understanding.

To achieve recruitment to the study, the researchers attended a Startwell team meeting to explain the study and invite participation. Startwell practitioners were recruited via the Service Manager. Both referring practitioners and mothers were recruited through Startwell practitioners, who informed the

potential participants about the evaluation and requested consent to share contact details with the research team. Researchers then contacted potential participants to provide the participation information sheet and explain the evaluation. Written informed consent was obtained and interviews/focus groups were scheduled at a time convenient for participants.

The interviews and focus group examined contextual factors (mother's characteristics/service provision external to the Startwell intervention), mechanisms of change (a combination of resources offered by an intervention and the triggered response) and observable, measurable outcomes. Researchers followed a topic guide, which was iteratively refined and informed by on-going data analysis. Interviews were conducted by telephone, Microsoft Teams or in-person, depending on participant preference.

3.3.1 ELIGIBILITY CRITERIA

The eligibility criteria to participate in the qualitative study were:

- Mothers who had accessed the Startwell service in the North East of England.
- Startwell practitioners who had delivered the intervention to mothers.
- Practitioners (e.g. social workers) who had referred mothers to the Startwell service.

Exclusion criteria were:

- Mothers were excluded if they were unable to give informed consent or if they were in acute mental health distress, as determined by the assessment of the Startwell practitioner.

3.3.2 QUALITATIVE DATA ANALYSIS

Data generated from the qualitative methods were analysed using a realist framework, whereby explanatory statements (programme theories in the form of Context-Mechanism-Outcome configurations) emerged from the data inductively, were empirically tested with the findings of the quasi-experimental study, and then served as the unit of analysis for further transcripts in an iterative process. The configurations were discussed and agreed with the project team and practice partners. This led to a consolidated account of how the intervention works (or not), for whom, in which circumstances and why.

4 FINDINGS

4.1 QUASI-EXPERIMENTAL STUDY FINDINGS

The quasi-experimental study included data from 159 infant-mother dyads; n=79 received the Startwell intervention; n=80 received usual care. The age of mothers across the sample ranged from 19-45 years (mean age 30.27 years), the majority of the sample were White UK (87.9% of all where ethnicity is recorded) and lived in areas of high deprivation (78.6% lived in an area amongst the 20% most deprived). Most infants in the cohort were subject to a child protection plan due to neglect.

Table 1: Demographics.

		Control		Intervention	
		n	%	N	%
N		80	100	79	100
Mothers age	< 21yrs	4	5	1	1.27
	21-30yrs	47	58.75	38	48.10
	31-40yrs	24	30	36	45.57
	40yrs+	5	6.25	4	5.06
	Missing	0	0	0	0
Ethnicity	White UK	71	88.75	75	94.93
	Other	9	11.25	4	5.06
	Missing	0	0	0	0
Cat. Abuse/Neglect at Entry	Neglect	54	67.5	60	75.95
	Emotional	17	21.25	6	7.59
	Physical	7	8.75	2	2.53
	Sexual	2	2.5	0	0
	Missing	0	0	11	13.92
IMD Decile	1	48	60	43	54.43
	2	18	22.5	16	20.25
	3 +	14	17.5	13	16.46
	Missing	0	0	7	8.86
Registered more than or equal to 12 weeks before birth	No	37	46.25	36	45.57
	Yes	43	53.75	41	51.9
	Missing	0	0	2	2.53
Born into Care	No	48	60	26	32.91
	Yes	32	40	39	49.37
	Missing	0	0	14	17.72
Care aged 6 months	No	40	50	22	27.85
	Yes	37	46.25	28	35.44
	NA*	3	3.75	14	17.72
	Missing**	0	0	15	18.99

	No	42	52.5	30	37.97
	Yes	32	40	16	20.25
	NA*	6	7.5	18	22.78
Care aged 12 months	Missing**	0	0	15	18.99

* NA refers to infants who have not yet reached this age; ** missing data is where the outcome is not known typically because the service does not have contact with the mother

4.1.1 Born into care

Infants whose mothers received the Startwell intervention were more than twice as likely to be born into care (defined as entering care within the first 7 days of life) than mother who did not receive the Startwell intervention and this is statistically significant ($p=0.019$). Infants whose mothers were referred to the Startwell intervention more than twelve weeks before their birth are also more likely to be born into care and this is also statistically significant ($p=0.044$) (see appendix; table 2 for further details).

4.1.2 Care at 6 months of age

Infants whose mothers received the Startwell intervention were less likely to be in care at 6 months than those who did not, all other factors being equal. However, this difference was not found to be statistically significant (see appendix; table 3 for further details).

4.1.3 Care at 12 months of age

Those infants whose mother received Startwell were less likely to be in care at 12 months and this was statistically significant (see appendix; table 4 for further details).

Overall, infants who were taken into care at birth were over ten times more likely to be in care at 12 months compared to those who were not taken into care at birth. As infants whose mothers received the Startwell intervention were more likely to be born into care than those infants whose mothers did not receive the intervention, we conducted analysis which accounted for this difference in the groups. Firstly, we considered the outcomes of infants who did not receive the Startwell intervention. We found that the infants whose mothers did not receive the Startwell intervention

and were born into care were almost 15 times more likely to be in care at 12 months and were not born into care. Secondly, we compared this to the outcome of infants whose mothers had received the Startwell intervention and found comparatively better care outcomes. We found that infants who were born into care were almost 4 times as likely to be in care at twelve months as those that did not receive the Startwell intervention and **were not born into care**. These differences were all found to be statistically significant (see appendix; table 6 for further details).

4.1.2 Days spent in care in the first 12 months

Infants whose mothers received the Startwell intervention, on average, spend slightly more days in care in their first 12 months than those children whose mothers did not receive the Startwell intervention. This may be explained by earlier care entry. However, this was a very small difference (0.5 days) and was not found to be statistically significant (see appendix; table 7 for further details).

4.2 COST AND CONSEQUENCE

Table 8 below shows the expected outcomes of 100 'baseline' infants. A 'baseline' infant is an infant who was subject to a child protection plan for neglect, resident in a postcode in the most deprived IMD decile and was not known to the service more than 12 weeks pre-birth. If mothers of these 100 'baseline' infants received the Startwell intervention, there would be 21.29 more children taken into care at birth. However, at the age of 12 months, there would be 4.71 less infants in care (see appendix; table 8 for further details).

Although more infants whose mother received the Startwell intervention are taken into care at birth than infants whose mothers did not, the average number of days spend in care in the first 12 months did not differ between the groups (see table 6). Therefore, it is unlikely that there are additional care costs for this cohort compared to the non-Startwell cohort.

The cost of delivering the Startwell service for 2 years across 6 local authority areas was £577,593.23. The Return-on-Investment tool provides the cost per infant avoiding being in care at 12 months, if the Startwell intervention is provided. For the cohort who received the intervention in this analysis, the model estimates that, without Startwell, there would be 28 children in care aged 12 months, compared to the actual number of 16 children who were in care. This means the cost per infant avoiding being in care aged 12 months was £48,132.77. For the cohort who did not

receive the intervention, providing Startwell would have led to an estimated 6 children avoiding being in care aged twelve months, leading to a cost per child who avoided care of £97,769.37.

5. QUALITATIVE STUDY FINDINGS

The qualitative study recruited a total of 39 participants, consisting of n= 10 referring practitioners (n=9 social workers; n=1 midwife), Startwell practitioners, service manager and administrator (n=11), mothers who have received the Startwell intervention (n=17) and a partner (n=1). Most data were gathered in one-to-one interviews (n=31). We also conducted 1 focus group with the Startwell team which consisted of practitioners, service manager and administrator (n=8 participants). Findings from the quasi-experimental study were examined iteratively with the analysis of the qualitative data, to inform the development and refinement of our explanations for how the Startwell intervention works (or not) for who and in what circumstance and why. Findings are presented below under three themes (or programme theories): i) focusing upon the needs and experiences of the mother; ii) safely challenging behaviour and beliefs and iii) grief and loss. Due to the composition of the Startwell Team (which included one male practitioner and one Service Manager), we do not report on the gender or specific role of the Startwell team member when providing verbatim quotation. This action was taken to maintain confidentiality.

5.1 Focusing upon the needs and experiences of the mother

Participants highlighted throughout the interviews that in situations of child protection concern, the primary focus of services is typically upon safeguarding the child. Whilst the necessity of prioritising child welfare was unquestioned, the interdependence between supporting the mother and the infant were at times overlooked in a system that prioritised child welfare. This often led to the needs of the mother being largely unconsidered and unsupported.

The welfare of the child is paramount, but the welfare of the child is dependent on what's going on for the parent. And that often gets ignored` (Startwell practitioner, interview)

The focus upon safeguarding the infant resulted in the framing of the needs of mothers as risks *she* posed to her baby. Mothers reported they felt blamed for the difficulties they had encountered throughout their lives, and repeatedly discussed situations wherein they believed they were largely

unsupported by services. Mothers often perceived this as evidence of services being adversarial and hostile towards them. This created a context for intervention wherein the mother was highly defensive and mistrusting of services. For example, mothers reported feeling unable to openly discuss the difficulties they were experiencing, to ask for help, or to speak up if they were unsure what was expected of them. This was particularly evident in mothers who had experienced multiple care proceedings.

The way the system is, it's like they'd rather try to prove why you're not a good parent rather than put things into place like, "We're going to do this to help you (mother, 6 children removed from her care).

Social workers, Startwell practitioners and mothers alike acknowledged the importance of separating the support for mothers from the requirements to assess and take action to safeguard the infant. It was suggested that attempting to support the mother whilst safeguarding the infant within a highly pressurised process would ultimately lead to the needs of mothers being deprioritised. In addition, a separation of support and safeguarding functions was considered necessary to overcome high levels of defensive behaviours often exhibited by mothers experiencing the threat of infant removal. When support was entangled with safeguarding, mothers typically resisted intervention, resulting in nonadherence to the plan. When disentangled however, mothers experienced lower levels of threat and could engage with the actions identified within the child protection plan.

Sometimes they [mothers] want someone who's going to be on their side or they feel that you're on their side and I think you can do that up to a point, but then eventually, you can't be on their side, 'cos you're effectively like, working in the best interests of the child...and I think that's a bit of a hard square to circle sometimes, because then they feel like you're not kind of...you're not trying to support them maybe as much as they'd want you to (male social worker).

Like tag-teaming, so you have the social workers who have all the statutory responsibility... to the woman's viewpoint it's heavy-handed because they're the ones that are doing all the legal interventions around the children, they're doing the parent assessments, they're telling

the woman what it is that they need to do to be able to keep the children. We can, kind of, tag team that so we can support the woman, help them to understand why children's services are saying the things that they're saying, help them to recognise what it is about their behaviours that they might need to change and why they might need to change them... (Startwell practitioner, focus group)

Without the burden of assessing safeguarding risk, the Startwell practitioner can focus upon the needs of the mother, asking 'what *happened* to you', rather than 'what is *wrong* with you?' This trauma-informed approach was experienced by mothers as compassionate and empathetic. This resulted in mothers feeling understood and their experiences validated, which gradually contributed to the mother lowering her defences and engaging with the service.

It's about when there's a barrier breaking the barrier down slowly; it's not about hitting it with a bulldozer, it's about right this barrier's in place for a reason, and respecting that enough and building up trust, I think, I think a lot of these women feel very, very let down... when I first met her, after an hour I could feel there was, there was a significant wall between us and I sat there for another hour and that hour, an hour extra made a massive difference cos she said I was the first person to properly listen to her. And, and I said 'I hear you', because that, you know they've got so many awful emotions and it's what they do with them. (Startwell practitioner, focus group)

She [Startwell practitioner] listens to us, she doesn't judge us and she understands like, sometimes where I'm coming from, about how like social workers were wrong in the past and she understood that and... She lets me tell the full story; she doesn't like, let us just tell her little bits and bobs; she lets us tell her the full story about what's happened and things (mother, baby currently in her care, three previous children removed for her care).

Most participants reflected that mothers were guarded when discussing their circumstances with other professionals involved in the child protection plan (who they were typically mistrusting of) and would often choose to withhold or falsify information during interactions. Conversely, the focus the Startwell practitioner has upon the mother's needs and experiences led open and honest conversations about their situation. Mothers felt reassured that the information they shared would

not be met with judgements about their character, abilities or prejudice. Moreover, Startwell practitioners were able to support mothers to attend antenatal appointments or access services in response to their own health needs, such as drug and alcohol services or mental health treatment; services the mothers would have typically remained hidden from. This led to increased visibility of the mothers, their needs and ultimately the risk that may be present. As such, the involvement of Startwell practitioners was at times considered to be beneficial to accurate assessment of risk, and therefore the safeguarding of the infant.

Because we [social workers] do have really difficult conversations with people and we do have to make plans that are really difficult for parents to accept and to acknowledge the risks. So, the Startwell workers have been that bridge. They're really good at being that bridge and that sort of scaffolding maybe to support parents in ways that we aren't necessarily able to do. They can have- They have really, really good conversations with parents, because there isn't that professional barrier. Whereas, there is with [social work] practitioners, so to speak. So, it's not that they get information and then they grass on them, or anything like that, but it's more around sometimes if parents aren't being truthful with us, they may be truthful with their worker. Or they can say, "Well, I can speak to you, but I can't speak to her" (female social worker).

Startwell practitioners provided bespoke, women-centred care, within the context of a consistent relationship. This care was both dependent upon the relationship first being present and reinforcing of it. The provision of each occasion of support in response to a need, along with the variability of needs the Startwell practitioner provided support for was regularly highlighted by mothers and practitioners. In particular, mothers highlighted that the Startwell practitioner was reliable and have genuine concern for the mother's wellbeing; characteristics that they cited as proof that the Startwell practitioners were *for* and not *against* the mother.

But just having someone to take me, heavily pregnant, with my swollen ankles and what have you, sitting in the car as much as- my appointments could be an hour, two hours long and she would sit there and be there, waiting for me, when I came out. I just thought that was a beautiful thing to do for someone, just having that little bit of support there, as much as it

meant absolutely nothing to her. It was just, "I'm just sitting in my car," but it meant the absolute world to me at the time (mother, baby in her care, two previous children removed).

You don't feel alone, you feel supported and... Yes, it's like a nice feeling, it helps you feel a little bit stronger. There've been times when I've thought, "This is just so hard." They'll give you a boost and... Yes, so it just makes you feel a lot stronger. They, kind of like, give you a bit of strength (mother, six children removed from her care).

Meeting someone who I can finally trust, and 100% trust, you know. There's no reason to have that niggle in the back of my head where you're like, "Oh, I should really trust her this much?" I've just got 100% trust. I think everything else I've touched on, to be honest. But trust is a big thing for me, so, allowing someone access into my life...She's done everything and more she could, while supporting me and [son]. So, I'm eternally grateful for the service (mother, one infant reunified, two children in care).

5.2 Safely challenging behaviour and beliefs

The development of a trusting relationship between the mother and the Startwell practitioner provided a haven of safety for the mother during times when she felt under threat. This safe and trusting relationship is a necessary context for all other intervention work and often spanned the entirety of the mother's child protection journey. When a mother shared a safe and open relationship with their Startwell practitioner, they were often more able to ask for help if experiencing difficulties. This resulted in timely support for a presenting issue as well as the avoidance of further deterioration of their situation. For example, mothers described being able to disclose an episode of substance use to their practitioner and therefore being supported to quickly return to abstinence, or telling the practitioner that they were suffering from anxiety and being supported to attend appointments they may have otherwise failed to attend. Such difficulties were typically hidden from other professionals involved in the child protection plan, for fear they would be used as evidence of their deficit parenting.

In many instances, this support was not sufficient to prevent care entry altogether. Typically, these mothers had particularly high levels of need, and at times it was reported that mothers were referred to the Startwell service when there was no expectation that they could retain the care of their infant. Instead, mothers were referred with the intention of supporting attendance at health

and social care services, I an effort to reduce the risk to the infant until such time as the infant was born and could be taken into care. When an infant was taken into care, the mother often experienced this to be an act of adversary where they were being 'blamed for their pasts' or 'things done to them'. Social workers (and other child protection care team members) were often criticised by mothers for their lack of understanding or consideration for how these experiences contributed to the difficulties experienced currently by the mother. As a result, mothers often disengaged from these services following a decision to remove an infant and often entered a period of psychosocial crisis. However, the Startwell practitioner was able to maintain the mother's engagement in support following removal. Having focused upon the needs and experiences of mothers however, Startwell practitioners were thought to understand what had *happened* to mothers and therefore, *why* they behaved in particular ways, or held certain beliefs. This provided the optimum context for mothers whose infants had entered care to be supported through the initial crisis and then work towards reunification.

The only way it was going to change [baby return to mothers care] was if mum would engage with really intensive therapeutic work, and if that was going to be within this child's timeframe and if she began that work. Would she then be safe to have her child back in her care whilst she began that work? Now, that onus and the responsibility for that work being undertaken was on Mum. So, we knew she needed that additional support, no matter which way this case ended (female social worker).

If it wasn't for [Startwell practitioner] helping me through it, I wouldn't- because social services were involved because of domestic violence and drug abuse, I think I would've relapsed, with the amount of stress it would've caused, if I'd tried to do it on my own, but she really helped me (mother, one infant reunified, four children in care).

I do whatever, deal with whatever comes along really because my, the women I work with, they just seem to have a multitude of things happens along the way, and, and it's about keeping them on the tracks a bit, because I think they will be easily derailed (Startwell practitioner, interview).

Startwell practitioners were able to communicate 'difficult to hear' messages in a manner that many mothers were willing to accept. Mothers reported that they perceived a sense of hope for themselves and were encouraged by the Startwell practitioner who they perceived 'wanted them to succeed' and believed in their ability to do so. Consequently, they were well positioned to challenge the behaviours or beliefs of mothers, which were considered to pose a risk to the safety of the infant. Whilst challenging conversations of this nature may be difficult for other practitioners to conduct, the consistency of the supportive relationship throughout the process and the frequency of contact enabled repeat discussion, and the opportunity for deepening reflection by the mother.

I think it was she had plenty of time to listen to me, to listen to how I felt. And when she would listen, she would not only listen to what I was saying, but she would challenge what I was saying, to get other things out of me about how I felt, why I felt like that. Was there anything different that I could have done that would have made me feel different? There was so much challenge from her, that gave her so many angles for me to open up to in ways that I never thought I would be able to (mother, five children in care)

We talked a lot about relationships. I didn't realise that they were abusive, you get used to anything and I'd seen a lot growing up. I wouldn't put up with it now. I know what to look for and I have the voices on my shoulders watching out for signs (mother, 3 children in care).

I describe my job as, I feel, being a good parent. Because you do, you nurture, you support, you listen, all the rest of it. You advocate, but you can also kick them up the bum when they need it as well. So, that's where the honesty comes in (Startwell practitioner, focus group).

Not all mothers were able to respond positively to these challenges from the Startwell practitioner. Whilst the safety of the relationship enabled honest conversations to occur, some of the mothers struggled to comprehend the risks that were highlighted to them. Typically, the mothers who the Startwell intervention did *not* 'work' for, where mothers who continued to struggle to understand safeguarding processes and concerns after explanation from the Startwell practitioner. These mothers often had mild or moderate learning disabilities, demonstrated lower levels of reflective functioning, and were reluctant or unable to accept that their past behaviours and risks were relevant to the current child protection plan. They often lacked positive social support (for example

supportive friends or family) and therefore the personal and social resources to facilitate change, making the scale of change appear unachievable to them. These mothers were most likely to continue to demonstrate behaviours or beliefs that were deemed a risk and were therefore, least likely to retain the care of their baby or be reunified following a period of care.

What we know is that they can't make good decisions, they are very vulnerable, we know statistically, to get back in another relationship that is violent. And so we have to prepare them and do that same level of work and often it's kind of that 'that was the past' and that is the bit of the work that they maybe don't engage with as much, they think it's a bit more superficial, erm just because they think it that that was in the past, and I think most cases I've had, mums who are with violent partners have gone on to be with another violent partner in the future, I don't know how these people seem to find them, but they do. And it just kind of preparing them and give them the toolkit for what to look for, show them how to do Claire's Law, and I think sometimes it kind of goes in one ear and out the other (female social worker).

4.4 Grief and loss

The removal of a child, particularly in the early days of life is a highly distressing experience for mothers. The grief and loss experienced by mothers was highlighted throughout the interviews. It was recognised that whilst the experience of loss in these circumstances is largely unavoidable, the process itself was thought to be very difficult for mothers and often served to reinforce their trauma throughout. These processes often necessarily included in-depth discussion about their parenting deficits, risk-taking behaviours and previous traumatic experiences, and as such served to induce feels of shame, stigma and distress.

I think when you talk to [mothers], it just feels like it was something just done to them – they didn't have a voice that, nobody cared, nobody valued them, nobody cared about them nobody recognized that for them losing this baby was going to be like the end of the world, and if it felt like that to them, they felt like that and that they didn't want to live anymore (Startwell Worker, interview).

Mothers reported that they had felt very alone and isolated during previous care proceedings and often contrasted these experiences to the valued support they were receiving currently from the Startwell practitioner. There was evidence of practical and emotional barriers to providing and/or accessing support during and after care proceedings, particularly in situations where permanency is achieved through adoption. Many of the services that had been involved during pregnancy, or whilst the infant was in the care of the mother, may no longer have a legitimate role and are therefore withdrawn. Conversely, mothers themselves may withdraw from services, particularly in circumstances where relationships are negatively affected, or where mothers hold these professionals responsible for the decision to remove the infant.

She [social worker] just dumped uz. You can't expect to take a baby off somebody whose carried that baby for 9 months and then just dump her (mother, five children in care).

Normally when you kind of say right your baby's not coming home, this is the plan, we get no engagement, no phone calls are answered, they don't come to meetings anymore... normally I know I wouldn't probably see her again, even if I tried (female social worker).

Infant removal is clearly a difficult and distressing experience for all involved parties and whilst social workers were unwavering regarding the importance of safeguarding infants from harm, the impact upon the mother was widely recognised. The Startwell service was distinct from other services in that the legitimacy of involvement with the mothers remained irrespective of the care status of the infant. Moreover, the strength of the relationship between the Startwell practitioner and the mother endured, with most mothers continuing to engage throughout. The Startwell intervention was therefore thought to be a critical source of support to reduce the trauma for mothers where a decision had been taken to place the infant in care. Further, the knowledge that the Startwell practitioner would be supporting the mother during the process appeared to go some way towards mitigating the emotional impact which the care proceedings may have upon social workers.

In cases where children have been removed and they're in foster care. You do worry about mums, their mental health and their wellbeing, and how they're feeling. It's not a nice thing to have to do. Or if you've had to remove a baby from the hospital, you know that worker is there to pick up the pieces sometimes for a couple of days and the fallout of that. You know

that they're going to have that support, which is nice. It's nice to know that, because we physically can't do it (female social worker).

I think it's reducing the trauma. Because the women are going through the process by themselves, because usually the other agencies have left them because it's focused around the child, and there hasn't been anybody to support the woman through that. Or go along with her, or sitting beside somebody whilst they're dealing with it, or talking it through, talking about how they felt about it. So, hopefully, it's reducing some of that trauma. It's hand-holding through the whole process. (Startwell practitioner, focus group)

Participants reflected that when an infant is subject to care proceedings, mothers often feel that their identity as a mother is not recognised; that their grief and loss is somehow not valid. This may lead to disfranchised grief wherein mothers feel inhibited from grieving due to the sense of shame and blame surrounding their loss. The Startwell practitioner was thought to play a particularly important role in supporting the mother with her loss. The mother was most likely to find comfort in this relationship and feel able to engage with activities which may facilitate her to begin to process her grief. For example, supporting mothers to spend time with their infant after birth was considered critical in responding compassionately to the grief the mother was experiencing at that time.

[the Startwell practitioner] was the one who actually went and supervised some of her family time at hospital when she'd given birth and she was really appreciative of that, erm, and it's just someone that she felt comfortable, who was able to always see that in a really difficult time in her life, when the baby was sadly not going to be staying with the young mother. But yeah, she was really thankful; that [Startwell practitioner] was able to be there and support her in that tough time (female social worker).

Startwell practitioners supported mothers in tasks that maintained their identity as a mother beyond the decision to remove the infant. Specific examples included mothers attending meetings discussing care arrangements and contributing details about the pregnancy and birth to life story books so that the child's own sense of their identity maybe supported. Involvement in these

activities were considered important for the child and helpful in enabling the mother to recognise that care was necessary and begin to reconstruct their parenting identity in the face of care entry.

For some, you know, the babies won't go home, but at least if they can be engaged in that process and have their voice heard and have their say, it may not be the outcome that they really want to happen, but it means that in years to come, if that child as well does look at their records they'll see that mam's attended that meeting or gone to that contact. I think for me, that's another big part of it, you know, I have worked family support, I've worked with kids. I've worked with women that have been in the care system and, you know, wanted to request their records, social care records, and hearing that their mam didn't want them and wouldn't attend the contact wouldn't do this wouldn't do that - that has had huge implications on them. (Startwell practitioner, interview)

For her [mother] to come back in and sit in front of me and do a life story book for her son, knowing that he's with adoptive parents...because of that [Startwell intervention] package of support. So, yes, it's not the outcome she wanted. It was the outcome the local authority recommended. But actually with the support that she was offered, she was able to see that she wasn't able to make the change required to keep her son safe. I don't think that would've been as well received had she not had the support from her Startwell worker (female social worker)

Participants reflected that involving mothers in this way gives mothers an opportunity to provide a level of care to their child. This may serve as acknowledgement of the significance of their role as the mother of the infant, and therefore the significance of their loss. Moreover, the mothers may be supported to prioritise their infants needs in the situation resulting in the mother feeling they had 'done the right thing for their infant' and therefore counteract feelings of guilt. In doing so, mothers may reconceptualise their grief as having meaning, even benefit, and begin a gradual process of mourning and acclimation to their loss.

One of the things that really got me was when a woman would tell you they understand that it was better for the baby not to be with them, that they knew they couldn't look after them at the moment. Your heart broke for the woman and all the things going on for her, but then still wanting to be the best mum and recognising what was best for baby. One of the most emotional was a woman who went to court and decided to withdraw her appeal against the

adoption, even the judge was tearful as she explained that she thought it was in the child's best interests. She was broken afterwards, but we were able to keep working with her and 'hold' her while she went through the grief. (Startwell practitioner, interview)

5 CONCLUSION

This evaluation has found that the Startwell intervention is effective at increasing the reunification of infants who are born into care with their mothers. Within the challenging context of child protection, the Startwell practitioner provides non-adversarial support focused upon the needs and experiences of mothers. Our findings suggest that approaches which separate supportive functions from safeguarding functions within the child protection plan may best enable mothers to experience the level of safety and trust necessary for them to accept and address identified risk. Within the current evaluation, the functions of support have been provided by Barnardo's, a charity external to the local authority. As the local authority holds responsibility for assessing child protection risk and recommending child protection measures (including care entry) and Barnardo's provides support to the mother, a clear separation is achieved. This is an approach that has been provided in other service models addressing sensitive issues within in the context of child protection (Harwin, Alrouh et al. 2014, McCracken, Priest et al. 2017, Cox, McPherson et al. 2020, Rodger, Allan et al. 2020). More recently, a number of local authorities in the UK are beginning to bring such services 'in-house', seeking to provide additional and targeted support for pregnant women at risk of repeat care proceedings. These specialist pre-birth child protection teams often include social workers and family support workers, which may offer an opportunity for some separation of functions. However, it is unclear whether the findings of 'what works' in the Startwell intervention would transfer fully into local authority provided interventions. Further evaluation of these services would enable refinement of this programme theory to inform service optimisation for pregnant mothers at risk of care proceedings and their infants.

The findings of our quasi-experimental study show that infants whose mothers received the Startwell intervention were over twice as likely to be born into care. There are two probable explanations for this that are supported by our empirical findings. One explanation is that the mothers who receive the Startwell services are not comparable to mothers who do not receive the intervention. This quasi-experimental study utilised routinely gathered data which included relatively minimal information on sample socio-demographic characteristics. Whilst the mothers

appeared similar in terms of age, ethnicity and IMD ranking, other influential characteristics may have differed. For example, we do not have information relating to the number of previous care proceedings each mother has been subject to, nor the spacing of these care proceedings. Should mothers in the Startwell intervention group have experienced a greater number of previous care proceedings to the mothers in the comparison group or shorter spacing, this would suggest a greater recovery challenge. Referring practitioners may have purposively selected mothers with higher need to refer into the Startwell service, and therefore, referral into the service maybe predictive of care entry.

An alternative explanation for infants of mothers who received the Startwell intervention being at increased odds of being born into care is that the child protection care teams in these cases may be more be better informed about risks. This explanation is supported by our qualitative findings which show that mothers are more likely to be honest about their circumstances with Startwell practitioners who they perceive will 'listen without prejudice' and our quantitative findings showing that being involved in the Startwell service for more than 12 weeks pre-birth (affording trust to develop), is associated with increase likelihood of an infant being born into care. The growing concern about the number of infants being born into care, particularly in the North East of England (Broadhurst, Alrouh et al. 2018, Bilson and Bywaters 2020), has resulted in an increased policy and practice focus upon preventing care entry. The programme theory developed during this evaluation suggests that the higher rates of infants being born into care maybe indicative of a system which is better able to safeguard children, whilst also supporting mothers to work towards reunification by 12 months post birth. Future research focusing upon longer-term care outcomes along with longitudinal research examining the care trajectories of infants born to mothers at risk of/subject to repeat care proceedings are necessary to better understand how to address this complex issue.

Our evaluation has highlighted the moral imperative of supporting mothers whose infants achieve permanency through adoption. It was evident within our evaluation that mothers often felt isolated and alone during this time. Services are typically withdrawn, or the relationship between the mother and the service breaks down resulting in the disengagement of mothers. In situations where the mother perceived that their relationship with their infant is not recognised, her loss is not acknowledged, and the mother herself is not valued, she may be at increased risk of developing disfranchised grief (Doka 2002), and create an even more challenging context for future pregnancy. Ambiguous loss due to physical separation (Boss 2016) and where the separation is seen to be in the best interests of the child (Baum and Negbi 2013), may interrupt the grieving process (Doka 2002). The support provided by the Startwell practitioner resulted in the continued involvement of mothers in processes and activities relating to the care of their infant as they transitioned into care. This

involvement may facilitate sense-making (where mothers make sense of why their infant was removed), meaning reconstruction (where the mothers are able to reconstruct care as being 'good' for their infant), and reorganise their identity as a mother. Loss-orientated and restoration-orientated coping of this kind, has been found to facilitate adaptive grief in parents bereaved by death (Stevenson, Achille et al. 2017). Intensive, relational-based support for mothers who have experienced repeat care proceedings may therefore be a necessary component of interventions to enhance the mental health and welling of mothers and interrupt recurrent care proceedings.

5.1 Strengths and limitations

To our knowledge, the current service evaluation is the first to utilise routinely collected data to evaluate the care outcomes of infants born to mothers who have received an intensive intervention to prevent repeat care proceedings. We have further strengthened the evaluation with realist logic, well suited to examining the complexity within interventions which are likely to have different effects, in different contexts. The evaluation does have a number of limitations however. Our data collection was limited by the relatively short implementation window and restricted capacity of the service. As such, our sample is small and therefore vulnerable to type 1 and type 11 errors. We were able to access care status within the first 12 months of life however children may have continued to be in care/re-entered care beyond this timepoint. In particular, care entry in the comparison group was often later and on-going at 12 month post-birth and therefore the duration of care in this group was often beyond our follow-up period. As our cost consequence analysis is based upon total number of days in care during first 12 months of life, the delay in care entry observed in the comparison group is likely to have skewed costs. Our qualitative study engaged mothers who had avoided care, experienced reunification following a period of care and whose children had been removed and were not reunified. Whilst this is likely to have supported a wider range of experiences of Startwell to be captured, our recruitment strategy was not able to recruit mothers who were referred to Startwell but did not engage.

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7 Appendix

Table 2: Logistic regression on being born into care.

Coefficients		Odds ratio	Confidence Interval	p value
Category of abuse	Neglect (baseline)	1.000	-	-
	Emotional	0.454	0.164 to 1.258	0.129
	Physical	2.015	0.472 to 8.611	0.344
	Sexual	3.240	0.165 to 63.322	0.438
IMD Decile	1 (baseline)	1.000	-	-
	2	0.429	0.168 to 1.091	0.076
	3+	1.888	0.756 to 4.717	0.174
Known more than 12 weeks before birth		2.090	1.020 to 4.283	0.044
Startwell		2.409	1.157 to 5.014	0.019
Constant		0.498	0.244 to 1.016	0.055

Table 3: Logistic regression on being in care at 6 months of age.

		Odds ratio	Confidence Interval	p value
Category of abuse	Neglect (baseline)	1	-	-
	Emotional	1.232	0.326 to 4.663	0.758
	Physical	0.18	0.019 to 1.667	0.131
	Sexual	0.546	0.014 to 21.772	0.748
IMD Decile	1 (baseline)	1	-	-
	2	1.116	0.292 to 4.270	0.873
	3+	1.387	0.368 to 5.220	0.629
Known more than 12 weeks before birth		0.213	0.062 to 0.734	0.014
Born into care		69.269	17.410 to 275.600	0
Startwell intervention		0.503	0.158 to 1.601	0.245
Constant		0.427	0.162 to 1.125	0.085

Table 4: Logistic regression on being in care at 12 months of age.

Coefficients		Odds ratio	Confidence Interval	p value
Category of abuse	Neglect (baseline)	1.000	-	-
	Emotional	0.739	0.240 to 2.281	0.599
	Physical	0.380	0.064 to 2.257	0.287
	Sexual	1 (empty)	-	-
IMD Decile	1 (baseline)	1.000	-	-
	2	1.048	0.326 to 3.361	0.938
	3+	0.757	0.257 to 2.229	0.613
Known more than 12 weeks before birth		0.615	0.251 to 1.506	0.287
Born into care		10.685	3.963 to 28.806	0.000
Startwell		0.377	0.143 to 0.994	0.049
Constant		0.420	0.173 to 1.022	0.056

Table 5: Logistic regression on being in care at 12 months, with Startwell and being born into care as a combined coefficient.

Coefficients		Odds ratio	Confidence Interval	p value
Category of abuse	Neglect (baseline)	1.000	-	-
	Emotional	0.758	0.242 to 2.379	0.635
	Physical	0.340	0.054 to 2.154	0.252
	Sexual	1 (empty)	-	-
IMD Decile	1 (baseline)	1.000	-	-
	2	0.984	0.303 to 3.198	0.978
	3+	0.758	0.255 to 2.254	0.618
Known more than 12 weeks before birth		0.600	0.243 to 1.480	0.267
Startwell and born into care	No Startwell, not born in care (baseline)	1.000	-	-
	No Startwell, born in care	14.820	4.325 to 50.784	0.000
	Startwell, not born in care	0.670	0.155 to 2.905	0.593
	Startwell, born in care	3.951	1.293 to 12.014	0.016
Constant		0.377	0.148 to 0.958	0.040

Table 7: Days spent in care in the first 12 months

	Usual Care	Startwell
Mean	167.01	167.53
S.D.	166.49	152.84
Median	151	169
IQR	0 to 365	0 to 365
t-test (p-value)	0.9864	

Table 8: Expect outcomes of 100 'baseline' children

	Usual Care		Startwell		Difference in numbers in care*
	In Care	Not in Care	In Care	Not in Care	
In care at Birth (number of children)	33.25	66.75	54.54	45.46	-21.29
In care at 12 months (number of children)	46.47	53.53	41.77	58.23	4.71

*the difference is calculated as number in care in usual care minus the numbers in care for the Startwell intervention