

Calderdale Council

Evaluation of Positive Choices 2020-2021

Report

August 2021

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Executive Summary

This evaluation report from the Institute of Public Care at Oxford Brookes University explores the nature, quality and impact of an innovative, intensive support service for vulnerable (prospective) parents in the Calderdale area of West Yorkshire in the years 2020-2021. It follows on from an initial evaluation report (Burch et al, 2020) of the same service in the first 3 years from 2017-2020.

Findings are drawn from a mixed method study including: analysis of whole cohort pseudo-anonymised administrative data and standardised measure data; case file sampling; and interviews with parents involved in the Programme as well as Positive Choices staff members and broader stakeholders. These evaluation activities mirror almost exactly those undertaken for the initial evaluation.

Second stage findings may have been affected by the period(s) of Covid restrictions that have characterised the period 2020-2021.

Key findings include:

In relation to referral criteria for and referral patterns into Positive Choices

- Demand has continued strongly into and for the Positive Choices Programme. By May 2021, over 70 families had been referred into the service across a 4-year period (2017-2020), between 18 and 24 per 12-year period.
- The Programme appears to all those working within and to stakeholders engaging with it to have developed to become very embedded and confident including about which families may benefit and how best to provide support.
- The referral criteria have changed slightly in the most recent 12-month period. Whereas mostly first-time parents (care experienced young people or young people thought to be vulnerable because of their own childhood involvement with children's social care) were referred into the Programme originally, referral criteria have been developed further to include parents with a child already removed from their care. This adaptation has meant that the average age of participants is slightly higher, and staff and stakeholders believe that this cohort of parents is very welcome but can bring additional challenges including greater parental resistance to being involved in the first instance.
- Another key change in referral patterns has been that a greater proportion of parents have been introduced to the Programme pre-birth (compared with at around the time of the birth or when their child is an infant) (70%) during the period 2020-2021 compared with the initial period (50%).
- Risks to children and to parents (for example from domestic abuse, drug or alcohol abuse, or exploitation in the community and homelessness) at the start of an

intervention remain high across the full evaluation period 2017-2020. In interviews for this stage evaluation, parents often described how they had been struggling and under-confident about parenting and needing 'all the help they could get'. In many ways, these risks can be described as 'inter-generational'.

In relation to the quality of the Positive Choices service

- Positive Choices continues to respond quickly to referrals (to most within 1-2 weeks).
- Positive Choices key workers continue to be able to engage very well with mothers and fathers referred into the Programme and it is rare for families to 'drop out'. Key workers often have to work hard to attain parental engagement, as parents themselves describe how they can be very wary, reluctant, anxious, and sometimes avoidant, 'pushing the worker away' in the first instance. Effective early engagement demonstrated through this evaluation includes worker: active listening; honesty about concerns but also reassurance for the parent(s); being approachable (not intimidating or intrusive) but persistent and offering practical help in the initial period of getting to know each other. This style of engagement often feels qualitatively different (better) to parents compared with other involvements they have had with professionals in the past. Staff and stakeholders alike recognise the importance of 'real' positive parental engagement as well as support for parents to develop motivation in generating better outcomes.
- Interventions continue to be more intensive initially (up to 3 sessions per week) and then tapered gradually, in terms of frequency and intensity, further into and then again towards the end of an intervention.
- Whilst face-to-face work with families continued where appropriate (mostly with higher risk families or circumstances) during the period of Covid restrictions, Positive Choices workers also used creative ways of communicating and working more remotely with families including through greater use of telephone and 'Zoom' calls. Workers have also got into the pattern of sending materials to parents in advance of sessions, giving them time to look at the materials before the session starts. Positive Choices has mostly managed to sustain highly structured programmes of sessional work with families throughout periods of Covid restrictions. Only approximately 25% of case files sampled for this evaluation showed signs that the intervention had been somewhat to very negatively affected by the restrictions in terms of parental engagement or motivation. The content of both pre-birth and post-birth programmes are described in the initial evaluation report, also in section 3.6 of this report, incorporating 'sessions' with parents on topics as diverse as domestic abuse; child attachment/bonding; baby brain development; modelling baby care; emotional support/help with social isolation; and support with practical things like finances or housing.
- The pre- and post-birth structured sessional programmes are considered by parents, staff, and stakeholders alike to be a key aspect of the programme's quality and success. The programmes can be adapted and provided flexibly to suit the family's particular needs, for example sessions moved around in sequence and/or provided with pictorial support. Staff described having become and feeling very confident in delivering aspects of the programme including those that could be described as relatively specialist, for example the Freedom Programme in relation to domestic abuse or some forms of therapeutic work.
- However, a high-quality relationship between key worker and family members, and a known 'buddy' worker to cover leave, is also described by parents and staff as a

critical element, including so that parents do not have to engage with too many workers at once (most will already also have a social worker for their child and a health visitor / midwife).

- Five key aspects of the programme are consistently described by workers, stakeholders and parents alike as being:
 - The Programme's ability to engage well with both mothers and fathers, also broader family members and influencers – a 'whole family' approach.
 - Parenting education sessions embedded in the pre- and post-birth programmes (for example positive or negative influences on a baby's brain, the importance of attachment).
 - Worker modelling of effective parenting (for example in responding to baby 'cues') with the whole family, in addition to providing advice and support.
 - Effective multi-agency working, including to link parents with practical support, such as help with baby items, budgeting, or housing; or to support the into a more specialist service, for example mental health or drugs and alcohol services. Stakeholders considered the ability of Positive Choices to coordinate and draw down support to be a particular strength. Likewise, Positive Choices workers considered multi-agency working to be a key success factor.

"Multi-agency working in Calderdale is a big thing"
- Reflective work in relation to a parent's life journey (timeline), experiences, feelings, behaviours, and aspirations undertaken mostly towards the start of a programme, ideally during pregnancy. This aspect of the programme appears to have become more significant for staff, including in generating successful parental engagement and outcomes. It is often described as a 'powerful tool' to support a better understanding by parents of past cycles and events and their impact on behaviours, also as a motivational tool.

In relation to outcomes for children and families

- A consistent proportion (63%) families referred to Positive Choices over the 4-year period have had a very positive outcome (and have kept their babies). Excluding families who moved out of area or who could not be involved fully in the Programme for any other reason, this percentage rises to 66% (two thirds). Approximately one third of families did not complete the Programme successfully and mostly the babies or infants of these families became looked after.
- This evaluation finds further evidence¹ that families successfully completing a Positive Choices intervention do not require further statutory interventions at between 3- and 18-months post-completion. This suggests that, where interventions are successful, the benefits of participation endure for families and generate sustainable outcomes in at least the medium term. Stakeholders interviewed for this evaluation described how the Programme appears to help young people to mature and become better able to make positive life choices – things that they can carry with them beyond the end of an intervention, including being able to 'stop and think about the right thing to do'. Another theme from all the interviews is that the Programme generates better resilience in participating parents. They are more confident, determined and better equipped to deal with challenges in the future. Even where parents do not carry this confidence with them beyond the end of an

¹ Further to the earlier evaluation (Burch et al, 2020)

intervention, interviews suggest that they know they can re-contact the service (and other support services) if they need to do so, rather than waiting for a crisis.

- Pre-birth still appears from the combined evidence for this evaluation to be the optimum time to commence an intervention, particularly compared with starting work at or around the time of a child's birth. However, other factors may also play an important part in determining positive or negative outcomes, including (very young) age of the mother at conception, maternal learning disability, and levels of ongoing risks to the child particularly from domestic abuse or parental substance misuse. Positive Choices staff and stakeholders universally described how it is important, even essential, to start work as early as possible in a pregnancy to optimise the positive impact of the Programme on families. The reasons are multiple, including that starting early in pregnancy provides:
 - A longer overall opportunity to establish a trusting relationship between the worker and the mother/parents before some of the more challenging work (e.g. on parenting or domestic abuse) begins.
 - More opportunity for the worker / team around the family to understand a parent's strengths and challenges, including perinatal mental health issues, before the birth.
 - An opportunity for the parent(s) to build confidence and readiness for the baby's arrival (to start off on the right foot).
 - A longer overall opportunity (and fairer chance) for parents to learn and prove themselves to be a good parent.
 - A window of opportunity to engage a prospective parent in reflecting on their past and future hopes and worries without the demands of a baby being present.
- Beyond the parent-child dyad remaining intact, many other positive outcomes for families were evidenced in this evaluation, including:
 - Infants observed by key workers as happy, well-socialised and stimulated.
 - More positive intimate and close family relationships.
 - Parent(s) able to live independently.
 - Parent(s) accessing community supports independently.
 - Parent(s) securing employment and arranging / managing childcare arrangements.
 - Infants de-registered or stepped down e.g. from a Child Protection Plan to Child in Need, or to Early Help Services, even universal services.
 - Parent managing safe contact for the child with the other parent.
 - Parent(s) abstaining from drugs or alcohol.
 - Parent(s) being committed to the infant's care and an absence of further referrals into social care services.
- Analyses of standardised measure data relating to attachment (completed by some but not all parents involved in the Programme) suggests that the quality of attachment both antenatally and postnatally, for fathers as well as mothers participating in the Programme, is high. Improvements in parental feelings of closeness and tenderness towards the baby are also detected across an antenatal through early post-natal involvement period. However, whilst antenatal attachment scores are universally high, completing a Positive Choices Programme successfully is associated with much higher post-natal attachment scores. Analyses of standardised measure data is well triangulated with that from case file sampling

which suggests that very high and growing proportions of participants in Positive Choices evidence good attachment throughout the period of an intervention, irrespective of the overall outcome, which is much more closely related to enduring risks to children from parent attributes or behaviours (such as domestic abuse or substance misuse). Parents described not only the educative aspects of the Programme but also the reassurances, encouragement and modelling from their key worker as being important in helping them to achieve a good bond with their child and to be well-attuned to their needs.

- Many parent interviewees described how the service had literally transformed their life including by giving them more self-confidence, helping them to develop parenting skills, supporting a good bond with their child, and 'getting on' as an individual as well as a parent. Key catalysts for positive change as described by parents included: realising the impact domestic abuse has on infants; and having a better perspective on the things that had gone wrong for them in the past – all achieved through conversations and learning with their key worker.

In relation to the costed benefits of the Programme

- The costs of providing an embedded Positive Choices Programme (approximately 3 years after start-up) are approximately £205K per annum, including staffing, expenses, and overheads. Where approximately 24 families have a full intervention per year (in the embedded model), unit costs are approximately £8,536 per family. Costs during the start-up phase of the Programme were slightly higher, approximately £11,382 per family.
- Although it is difficult to accurately compare Positive Choices with 'business as usual' (pre-Programme) outcomes and costs, because elements of the Programme were being applied before it started, all the evidence suggests that the Programme is unlikely to lead to significantly reduced need for infants to become looked after in the first instance (during or by the end of an intervention). Its major costable benefit lies in the potential for reducing subsequent statutory interventions and the need for children to become looked after in the medium to longer term, where parents and families are successful in the first instance. A conservative estimate of these medium-term cost benefits is relatively modest (at approximately £50K per year from a £205K a year investment).
- However, evaluators believe that there are other real benefits of the Programme which are not capable of being costed so readily within the remit of this study, but which are likely also to have financial implications. These include that:
 - Parents who are involved successfully in relation to one child are likely to have further pregnancies and children in relation to whom they can apply the same learning and good parenting approaches (and in relation to which statutory intervention(s) and/or child potentially needing to be removed are less likely to arise).
 - Parents who are not successful (in keeping their baby) at the end of a Positive Choices intervention are still better equipped to carefully consider or prepare for a further pregnancy (including postponing pregnancy until later when they are more mature; asking for help earlier; and/or having more confidence, understanding and resilience to cope with a further pregnancy). Resilience may be increased even further where they participate in the newly developed Positive Choices II Programme (for parents with one child removed from their care).

- Children who do need to be removed from their parent(s)' care during or by the end of a Positive Choices intervention will be placed for permanency at an earlier stage. Earlier permanency is generally associated with better outcomes for children (Selwyn, 2014). Whereas, remaining for longer in an abusive or neglectful home environment is associated with worse outcomes for children (Wilkinson et al, 2017).
- Most babies and infants involved in the Programme will have experienced good quality attachment from primary carer(s) in their first 18 months to 2 years, irrespective of the eventual overall outcome, including where they need to become looked after. Research suggests that good attachment in early years is associated with better outcomes throughout childhood and into adulthood (Howe, 2005).

Conclusions

- This 12-month extension pilot study provides further evidence of the mostly very positive impact of the Positive Choices Programme on either first-time parents or parents who have already had at least one child removed from their care.
- The extension study also continues to suggest that parents and families get the most out of the Programme and have better outcomes overall when the actual support starts pre-birth compared with at around the time of the child's birth².
- The findings need to be treated with some caution. Firstly, the design of the evaluation was such that it could only establish a correlation between variables of interest, not causal relationships. Lack of a control group means that outcomes could have occurred by chance. A further limitation is that the study could not explore the extent to which interventions resulted in sustained specific outcomes beyond the need for further social care interventions, such as good attachment, good enough parenting over time.
- A further, more extensive study should be capable of exploring not only in Calderdale but also across other sites implementing the model (and those without such a model – i.e. control group or comparator areas) even more robustly what relationship the intervention has to child, parent, and family outcomes over time.

² There are very few infants now referred in

1 Introduction

This evaluation report from the Institute of Public Care (IPC) at Oxford Brookes University is the second of two reports examining the nature, quality, and impact of an innovative and intensive support service for very vulnerable (prospective) parents living in the Calderdale Metropolitan Borough Council area of West Yorkshire. The service is called 'Positive Choices' and it has received start-up funding from the Department for Education (DfE) as part of the [Innovation Programme](#).

The first evaluation report (Burch et al, 2020) was published by DfE at the end of a start-up period of approximately 3 years (2017-2020) and it identified very promising signs of success of the service including significant gains for participating families in terms of attachment and parenting skills, and reductions in risk factors for child maltreatment. Where parents engaged with the service, parental resilience (ability to parent well beyond the end of an intervention) was more sustainable compared with parents who had accessed more traditional supports. Starting to receive Positive Choices support pre-birth seemed to be particularly important in securing a more positive outcomes, including in the birth parent-child dyad remaining intact beyond the end of an intervention.

This report examines a further 14 months of Positive Choices delivery (between March 2020 and April 2021) and explores, for this as well the full (4 year) delivery period:

- What is the nature of demand for the service?
- What is the nature and quality of support provided by Positive Choices?
- What is the known impact of Positive Choices on parents and families?
- Case studies
- What are the known costed benefits of the service?

It should be noted that, throughout this final evaluation period, there have been several episodes of significant Covid-19 Pandemic restrictions in addition to overall disruptions to both family and professional norms. The planned methodology for this study, which evaluators have endeavoured to keep intact in spite of the Pandemic, has mirrored that utilised in the initial evaluation and includes:

- A very slightly revised and adjusted logic model (attached at Appendix A) co-produced by evaluators and members of the core Positive Choices Team in September 2020 to guide the questions for the evaluation.
- Secondary analysis of pseudo-anonymised administrative and, where available, standardised measure data relating to all parents and families participating in the service.
- With parental consent, analysis of the detailed case records of their involvement with the service.
- With their consent, one to one semi-structured interviews with parents involved with the service between March 2020 and May 2021. These interviews were all conducted remotely, mostly by telephone.
- With their consent, interviews with core Positive Choices staff and stakeholders involved with the same cohort of families or working with the service between March 2020 and May 2021.

- An extended cost benefit analysis relating to the service.

A summary of the evaluation activities and their scale is provided in Table 1 below:

Table 1: Evaluation activity by scale in the 2020-21 and overall (2017-2021) evaluations

Evaluation activity	Scale in 2020-2021	Overall Scale 2017-2021
Analysis of administrative data	24 family units	72 family units
Analysis of standardised measure data	40 parents	82 parents
Sampling and analysis of case records of 'completed' cases	12 family unit case files	46 family unit case files
One to one interviews with parents	12 parent interviews	25 parent interviews
One to one interviews with Positive Choices staff members	5 staff interviews	15 staff interviews ³
One to one interviews with stakeholders	2 stakeholder interviews	11 stakeholder interviews

³ Interviewees participating in the 2000-2021 sample are also mostly represented in the overall 2017-2021 sample

2 Findings relating to referrals for and referral patterns into Positive Choices

At the time of the initial evaluation (reporting June 2020), a total of 52 family units (including 62 parents) had been referred into the Positive Choices Programme between 2017 and 2019. Since then, a further 24 family units have been referred into the Programme making a total of 72 over approximately a 4-year period of referrals. Most (79%) of the additional family units in this more recent evaluation period were referred during 2020.

2.1 Status of the Programme and its impact on referrals

All staff members interviewed for the second evaluation reflected that the Positive Choices Programme felt 'much more embedded' and had developed a 'strong reputation locally'. They described how this, in turn, had led to more referrals at an earlier stage i.e. during pregnancy, mostly via the Children's Social Care Assessment Team(s). They attributed this increase in early-stage referrals to services having 'got the message' about the importance of starting an intervention as early as possible.

"Before, some women we got were really late (referred). It's a real change for us. We've had an input into that. That's about having really strong links with partners" (Positive Choices staff member)

Stakeholders interviewed for the second evaluation also considered that the Programme was now receiving the 'right' kind of referrals with reference to type of presentation, level of need and timing of referrals.

2.2 What are the key differences in parents and families referred over time?

As reflected in the overall observations by staff and stakeholders, a key change in referrals evidenced through the administrative data analysed for this second evaluation period is that a greater proportion of parents and family units have been referred pre-birth (71%) compared with in the initial evaluation cohort (50%)⁴. This trend is explored in Tables 2 and 3 below:

Table 2: Initial evaluation cohort of parents referred 2017-2019 by timing of referral and type

Timing of referral	Single Parents	Couples	Total family units
Pre-birth	21	5	26
Pre-birth (for one child) and other infant child of the family	4	1	5

⁴ Although that difference is not as strong in the case file sample wherein only 58% involved parents referred into the Programme pre-birth

Timing of referral	Single Parents	Couples	Total family units
At / around the birth	9	3	12
Post-birth (infant child)	8	1	9
Totals	42	10	52

Table 3: Second evaluation cohort of parents referred mostly in 2020 by timing of referral and type

Timing of referral	Single Parents	Couples	Total family units
Pre-birth	7	10	17
At / around the birth	2	4	6
Post-birth (infant child)	1		1
Totals	10	14	24

Another key difference is that, by the time of the second evaluation period, parents with another child already removed from their care had begun to be referred into the Positive Choices Programme in greater numbers (50% of all mothers referred into the Programme compared with 21% at initial evaluation stage)⁵. This change in referral patterns was also clearly noted by Positive Choices workers and stakeholders, and it was very much welcomed, although considered sometimes to bring additional or different challenges to the work:

“It has changed in the last year as we’ve seen more older parents who have had a child removed before... That’s nice that they join in, really positive. It’s a really positive development” (Positive Choices Worker)

“Previously, these women weren’t in the right place (to engage with a programme). Second time around, they realise that they do need that support” (Positive Choices Worker)

14% (prospective) parents referred into the Programme during 2020-21 were described as looked after / in care, 21% as a care leaver, and 29% vulnerable for another reason including mostly because of their previous involvement with children’s social care as a

⁵ Just over one third (36%) of all parents (including mums and dads) referred into the Programme in the second evaluation period had another child already removed from their care.

child⁶. This compares with 10% described as looked after, 40% as a care leaver, and 50% as vulnerable for another reason in the initial evaluation cohort⁷.

In the case file sample, a slightly greater proportion of parents in the second evaluation period were described as looked after / in care (17%) and a smaller proportion care leavers (25%) when compared with the initial evaluation period (11% and 33% respectively). About one half of both case file cohorts were not care experienced but had a form of involvement with children's social care as a child (56% in the initial and 58% in the second cohort).

This difference is also reflected in the ages of parents referred at different stages of the Programme:

- At the time of the initial evaluation, mothers had been recruited into the Programme between ages 15-26 years, with most of the cohort (71%) aged 17 to 22 years. Peak ages for referrals were 17 and 19 years and the mean age was 19.13 years.
- In this second cohort, the age range of the mothers was greater at 13-41 years. The mean age was slightly older at 22 years. However, most mothers were still aged up to 19 years (54%) at referral and 42% were aged between 13 and 17 years.

The case file samples had similar mean and mode ages of parents by initial and second cohorts. The parents in this second cohort of case files were aged between 17 and 36 years at the start of the Positive Choices intervention, with the mode (most common) age being 20 years and the mean (average) age 21 years. This compares with a slightly lower mode age of 19 years and a mean age of 19.5 years in the initial case file cohort.

2.3 Other comparisons

The initial and subsequent evaluation cohorts of parents were similar in some other ways, for example, analysis of administrative data suggests:

- There were very similar risk levels at referral, with 89% in the initial evaluation cohort and 93% in the second evaluation cohort identified as 'high risk' in relation to their child at the start of the Programme.
- About a quarter to one third of parents had a learning disability (35% in the initial evaluation and 25% in the second evaluation cohorts). Similarly in the case file cohorts, the proportion of parents with a learning disability was slightly lower in the second evaluation cohort (17%) compared with the initial evaluation cohort (28%).
- About 10-25% of mothers were thought to be affected by sexual exploitation at the time of a referral into the Programme (9% in the initial cohort and 25% in the second cohort).

There were slightly higher rates of specific risks to children (from substance misuse, domestic abuse, and parental mental ill-health) reported in relation to the second evaluation cohort compared with the initial cohort, as illustrated in table 4 below:

⁶ And 36% as having a child already removed from their care

⁷ The difference may be explained in part by 'child already been removed from parent's care' was not a category as such in the first evaluation period

Table 4: Reported specific risks at referral by initial evaluation (2017-2020) and second evaluation (2020-2021) cohorts

Type of risk factor	% first cohort	% second cohort
Domestic abuse	66%	86%
Substance misuse	42%	57%
Mental health problems	65%	79%

More in-depth information about the presence and nature of risk(s) at the start of a Positive Choice intervention is available from the case file sampling. These were similar in the second evaluation case file cohort compared with the earlier cohort, including high levels of parents with mental health, domestic abuse and substance misuse issues.

Table 5: Positive Choices case file cohorts (I and II) by risk factors identified as being present

Risk Factor	Positive Choices case file cohort I		Positive Choices case file cohort II	
	No.	%	No.	%
Parental Mental Health Problems	22	65%	9	75%
Domestic Abuse or high levels of family conflict	26	76%	8	67%
Parental Substance Misuse	19	56%	5	42%
Housing Issues	11	32%	3	25%
Social Isolation	7	21%	2	17%
Parent at risk of sexual exploitation	3	9%	0	0%
Problems managing finances	3	9%	1	8%

The most prevalent 3 factors (domestic abuse, substance misuse and mental health) were all present together in 12/34 (35%) of the original case file sample and in 4/12 (33%) of this cohort. Two of these 3 most prevalent factors were present together in 12/34 (35%) of the original and 3/12 (25%) this case file cohort.

As in the initial evaluation case file cohort, there were specific risks of abuse or neglect to children in most (10/12 or 83%) cases in the second cohort, mostly neglect or neglect with physical abuse. The overall level(s) of need were also very high, as illustrated in Table 6 below:

Table 6: Positive Choices case file cohorts (I and II) by level of need at the start of the intervention

Level of need	Positive Choices case file cohort I		Positive Choices case file cohort II	
	No.	%	No.	%
1. Universal needs	0	0%	0	0%
2. Some additional needs requiring targeted (early help) support	0	0%	0	0%
3. Multiple additional needs requiring coordinated (early help) support	2	6%	2	17%
4. Complex additional needs	3	9%	0	0%
5. Requires a statutory (social worker-led) plan i.e. Child in Need or Child Protection Plan	29	85%	10	83%

Similarly, high levels of children (approximately 80% across both case file cohorts) were thought to require a statutory (Child in Need or Child Protection) Plan.

Resilience factors were also identified across both case file cohorts for high proportions of parents at the start of interventions, including the existence of: supportive extended or substitute family; supportive care-leaver team; engagement with professionals; basic (child) care needs being met; parent(s) preparing well for the baby's birth; or commitment to parenting this baby. Other less commonly identified resilience factors included: parents having some insight into their difficulties; or attending education, employment, or training; having secured own tenancy; or detoxing from drugs.

Parents participating in an interview for the second evaluation all described a personal history prior to their involvement with the Programme that is suggestive of very high levels of vulnerability associated for example with: having been in care themselves; having had previous children removed from their care; being involved with domestic abuse; substance misusing; having additional needs, for example autism; being very young; having fragile mental health; and being homeless.

"I was really struggling" (Mother)

"Social Services referred me to Positive Choices. I needed all the help I could get" (Mother)

Some of these parents described feeling very under-confident at the start that they would be successful in the programme:

"I didn't know about myself and what I wanted and needed. I hadn't met (my baby) since he was born. Could I do it? Am I out of my depth?" (Mother)

These (prospective) parent and family characteristics were also recognised by many of the staff and stakeholders interviewed for the second evaluation:

“A large majority of families we work with have experienced social care in their life. At times they’ve experienced that as negative. We have to listen to that. There’s some element.. they know best. They’re very wise and resilient, certainly know things I don’t. Many are linked to very unhealthy habits, drugs or alcohol related. Sometimes just by their experiences and childhood trauma, they have poor mental health. This affected their mental health in a way they don’t understand and see. For them, it’s normal. It’s inter-generational” (Positive Choices Worker)

3 Findings relating to the nature and quality of Positive Choices support

3.1 Overall reflections

Staff and stakeholders interviewed for this second stage evaluation all considered that the Positive Choices Team had developed a very strong reputation locally for quality and impact, after an initial period of piloting methods and becoming more embedded:

“My sense is it’s really good now, embedded now in the FIT (Family Intervention Team).. Four years down the line, the Positive Choices key workers are pretty expert. They know it works” (Service Manager)

Staff involved in delivering the Programme also noticed how becoming more embedded and recognised locally had generated (even) greater confidence for them in what they were doing, both individually and as a team:

“We’re still delivering how we delivered before. However, we’re more confident now in our roles. The programme is more embedded with the set work and what we’re looking out for” (Positive Choices Worker)

With the exception of some improvements in multi-disciplinary working (explored in more detail below), most Positive Choices workers considered that the Programme and its aims had remained largely unchanged since the time of the earlier evaluation, similarly the needs of the target beneficiary parents:

“The aims of the programme are fundamentally the same and we have the same ethos as before, same outcomes, all about successful parents, this always at the forefront” (Positive Choices Worker)

3.2 Response levels

The case file analysis undertaken for the second evaluation period suggests that the project continues to respond mostly very quickly to referrals made into the service, with the majority of families starting a service within 1-2 weeks of being referred (64%); 18% within 3-4 weeks; and 18% within 6-7 weeks.

3.3 Parental engagement in the programme and support

As in the first evaluation, all parents participating in an interview for the second evaluation described the qualities of the early engagement activity they had experienced very positively. Some of these parents described having been quite to vary wary of becoming involved with the programme, based on their earlier experiences with support professionals. They also described how their Positive Choices worker had overcome this initial wariness:

“I pushed the support away at first. I didn’t want any more social workers involved” (Mother)

“I was a bit worried as I struggled to trust professionals and I felt like I was being judged at first. But, we’ve got past that now” (Mother)

“The first time I ever met X, I didn’t want her in my life. I didn’t trust her. But she grew on me” (Mother)

Other parents described having been worried initially, because they were not sure that they could care effectively for their child:

“As a new-born, you grow into his needs, but I had missed out and I was scared. I wasn’t sure I could bond. It was daunting” (Mother)

In these situations, parent interviewees all described how their Positive Choices worker had overcome their initial worries and concerns including by: listening and being reassuring, sometimes by using less intrusive communications (e.g. initially calling and texting before face to face). In some ways, these kinds of gentle introductions seemed to have been accentuated by the Covid-19 lockdown rules, from the perspectives of some parents:

“I was hesitant, I cut her off. She wanted to come to my home, and I avoided it. So, she said let’s speak on the phone instead and text. She phoned and texted and gradually I felt more comfortable. She did it to make me feel more comfortable. She always listened and remembered things” (Mother)

“She rang me.. then I met her in person. She definitely did this well. She definitely understood me...I over-think everything and she gave me feedback... the positives, like I’m determined. She’d say, ‘you’ve done well, be proud’” (Mother)

“The first call was a phone call, then telephone calls and texts. She would also pop round a couple of times and we’d distance and wear masks... less pressure. She got to know me and what’s going on. It was bonding! She’s not like a high-up professional and not intimidating. Listened really well” (Mother)

“It was all over the ‘phone because of Covid. It was not pushed on me. I didn’t have to do it. She listened... really well. She got to know me; I was telling my own story” (Mother)

Other parents described how their Positive Choices worker had been honest and direct about existing concerns (about the baby), but had still managed to listen well and/or convey the optional nature of participation:

“She’s honest. She doesn’t skirt around the issues. I have no problem talking to her. She is brilliant. (Mother)

“In the first session, she explained herself and what she could do to benefit me. She asked me what I already know... she gave me ideas (straight away) for example a calendar and a diary!” (Mother)

“She reassured me and showed me the plan. This made me feel OK... gave me the option to do it. She came and we talked. Asked me about concerns I had about being a parent. She asked what help I needed. She is a gem” (Mother)

Some parents went on to describe how this type of engagement felt qualitatively different to what they had experienced previously from social care and other family support services:

“I’d had Social Care from when I got pregnant at 16 and had my first baby. There wasn’t as much support then. I felt like they were setting me up for a failure (then). This time round, they’ve got better in how they approach people” (Mother)

“Before, it felt like they were pulling people apart and now they’re pulling people together” (Mother)

“No offence to social workers, but she puts in time and effort. Not daunting. She reassures me. She does her job but more friendly and approachable. I’d rather get advice off her. With a social worker, you have to do what they say” (Mother)

Similarly, stakeholders interviewed for the second evaluation described very high-quality engagement by Positive Choices (workers) with parents and families:

“.. The women and families seem to have a really positive experience. They enjoy having someone to guide them through but someone who’s not a social worker. They tend to shut down with social workers. There’s a stigma with having a social worker. It gets in the way” (Stakeholder)

“They (Positive Choices workers) just seem to have a knack of explaining things very, very clearly without being condescending. It makes what they do really relatable” (Stakeholder)

Stakeholders also described how this early engagement including motivational work was important in securing positive outcomes. For example, they described how parental motivation and parent openness to information and advice, to engage ‘willingly and meaningfully’ significantly influenced the overall outcome of an intervention:

“It’s down to each individual and their desire to move forward” (Stakeholder)

3.3.1 Engagement of mothers

100% mothers represented in the case file analysis for the second evaluation had engaged with the Positive Choices Programme in some way (58% fully and 42% more partially). This is a slightly lower proportion of mothers engaging well or fully compared with the earlier evaluation and larger case file cohort where 89% engaged fully. In some instances, the mother had engaged well pre-birth but not so well post-birth or vice versa. In other cases, the mother was inconsistently engaged and/or offered some resistance to supports.

3.3.2 Engagement of fathers

The case file analysis for the second evaluation suggests that the Programme continues to engage fathers well. In 50% cases, fathers were well-engaged; in 17% they were

partially engaged; and in 33% they were not engaged. This is very similar to the rates in the first evaluation, as illustrated in Table 7 below:

Table 7: Positive Choices case file cohorts (I and II) by father engagement level

Father engagement level	Positive Choices case file cohort I		Positive Choices case file cohort II	
	No.	%	No.	%
Very involved	17	50%	6	50%
Partially involved	7	21%	2	17%
Not at all involved	10	29%	4	33%
Total	34	100%	12	100%

As in the initial evaluation, it was clear from the second stage case file analysis that workers made significant attempts to engage fathers, including through joint sessions (with the mother) as well as sessions with the father individually. Often these sessions involved exploring the impact of domestic abuse / intense arguing; healthy relationships; impact of substance misuse and fathers' own emotional health and wellbeing. Where fathers were not involved, in all cases this was where they were not living with the mother and/or had disengaged early in the programme.

Some of the mothers interviewed for the second evaluation said that the baby's father had not been involved or not much involved. Others described how their key worker had interacted with both parents, encouraging both to participate individually and as a couple. This approach was described as having had varying levels of success. Where fathers did not want to engage, mothers described how their key worker had encouraged them to have positive interactions where possible, including to enable positive contact.

"She would sit and watch me plan and smile (encourage) me. She noticed the bond. She helped me to know what to do to be a good Father, to get the bond, to work to get it" (Father)

"She always interacted with both of us. He didn't want to do it. She tried. He did engage with her but at least one of us did the work. He is older.. didn't think he needed to do it, so I did the work" (Mother)

"She asked how he was doing as he had depression. She would chat to him at our house. Men don't usually want to have that support. He was comfortable around her" (Mother)

"We work together in sessions. We live and care for (baby) together" (Father)

"Practical sessions, like bathing and holding, have worked well for him" (Mother)

3.3.3 Engagement of parents with a child previously removed

Positive Choices workers involved in an interview for this evaluation often reflected

they had to work harder with parents who had already had one child removed to build an effective, trusting relationship:

“With a child already removed .. there is a lot more resistance to professionals, a lot more history. They automatically think that you’re there to remove their child. We have to strip it right back. It’s about building that trust” (Positive Choices Worker)

Often, workers considered that the more successful outcomes were achieved with parents (with a previous child removed) where there was a relatively significant change for them, either before or during the intervention, prompting renewed reflection or motivation, for example: a new relationship; stopping using drugs or alcohol; or having sought help with domestic abuse. Less successful outcomes were noticed for parents who were in more or less the same situation as before (when their older child was removed) and/or where they did not recognise the reasons why that child was removed.

Successes with these parents were sometimes described as being harder to achieve and therefore particularly satisfying from a worker perspective:

“They stand out when you get a success story when they’ve had children removed before. To change that, it feels massive for us, as professionals, to be part of that” (Positive Choices Worker)

3.4 Duration of support

The second evaluation case file sample also provides more information about the duration of Positive Choices interventions. It suggests that families have been receiving an intervention of between 5 and 18 months with a mode (most common) length of 9 months and mean (average length) of 11.6 months. This compares with the previous case file sample which revealed a larger range (between 1 and 23 months) but a similar mode (9 months) and mean (10 months) length.

Positive Choices staff described how a newer option for the Programme at intervention end included a referral on to ‘Positive Choices II’ for women who had a child removed at the end of their Positive Choices (I) intervention.

“These parents (for whom it doesn’t work out) can then transition to Positive Choices II. There’s always a difficult period when we’re waiting for the judge’s decision. We always offer this pathway. People do take to it... It’s a good pathway, immediate emotional and practical support” (Positive Choices Worker)

3.5 Number of sessions

As with the case file cohort for the initial evaluation, the second stage case file cohort revealed that the intensity of sessions for families varied between once to 3 times a week, often more frequent during an initial or intensive and risky phase of the work and less frequent or ‘tapering’ towards the end. Face-to-face sessions continued to be provided but were often and perhaps more frequently supplemented by outreach telephone calls or texts, additional meetings, and support to attend appointments.

3.6 More about sessional work

As in the first evaluation, evaluators identified through case file analysis that the service continued to provide highly structured, sessional work on all (100%) case files. Similarly, a very wide range of sessional support was undertaken by Positive Choices key workers and parents, including very typically⁸:

- Exploration of the significance of baby or child attachment and support for bonding.
- Work on domestic abuse including the impact of domestic abuse or arguing in front of babies and children, and broader work on couple and family relationships. In this second cohort, there was evidence of some workers completing a whole or most of a 'Freedom Programme' course online with their clients.
- Support for specific parent 'issues', most commonly substance misuse and/or emotional health and wellbeing but also personal hygiene and smoking cessation.
- Educational support and practical modelling of basic baby routines and meeting baby needs including feeding, weaning, modelling, and supporting play time.
- Support for parents 'through' social services processes including emotional support but also ongoing explanations of statutory processes.
- Support for contact arrangements with other parents or family members.
- Practical support including in relation to finances, budgeting, and money management; to access appropriate housing; with home conditions (including to understand the impact of poor home conditions); and to access nurseries.
- Support for parents to gain self-esteem not only through emotional support but also achievements such as being able to organise effective contraception, or to access college or other educational or employment opportunities.
- Support for parents to reduce social isolation and access broader community (baby) groups.

In relation to the 1:1 work with parents pre-birth, researchers noted a highly structured (often 8 week) pre-birth pathway programme with learning sessions on topics including: health in pregnancy; birth planning; preparing for baby; baby development; safe sleeping; breastfeeding; coping with crying; and learning about baby brain development. These 'baby learning' sessions were complemented by many, or all the other forms of support listed above.

Interviews with Positive Choices staff suggest that many of the key aspects of the Programme are delivered in the same way as before, including a balance of:

- Pre- and post-birth work (with a pre-birth structured programme lasting for approximately 8 weeks).
- Listening and being non-judgemental alongside confident advice and pro-active support for parents, treating them as 'experts in their own lives'.
 "We listen and ask families. We work alongside and don't take over" (Positive Choices Worker)
- A structured programme with expected core 'elements' to be included in all interventions, combined with a strong degree of flexibility, to meet the needs of

⁸ More information about the tools used to support this work can be found at Appendix 3

individual families and their circumstances and an ability to deliver messages in a non-patronising way.

“For example, helping parents to understand why baby massage and eye to eye contact is so good. Explaining it in a way they can understanding without being patronising” (Positive Choices Worker)

- Use of an evidence-based toolkit including regarding the impact on babies of intensive, unresolved arguments and domestic abuse. Many key workers described feeling increasingly comfortable with delivering key aspects of the Freedom Programme themselves one to one with parents. Parents can still access a full group-based programme at a later stage and thereby benefit from being around and receiving peer support from other parents with a similar experience.
- Use of standardised measures to measure distance travelled.
- Help for parents into other key supports including those that can help them in the future, supported by effective multi-agency working.
- Having a consistent, persistent key worker, team and ‘buddy’ system undertaking much of the core work with parents, rather than involving lots of different workers:

“Our families really notice a change of worker, for example a social worker. They know I’m the person for them” (Positive Choices Worker)

“Consistency of worker: the simplest thing for a young family, they have no surprises, don’t have to tell the story again. It’s very key” (Manager)

“Having lots of people involved means parents can feel ‘over-faced’, particular parents with mental health problems. Having too many professionals involved can be challenging also for some young parents” (Positive Choices Worker)

“A lot of these young people are effectively children. They’ve never had a chance to learn skills from their own family. They have one person who can follow through for them, not telling them what to do, trying to relate to them as much as possible” (Positive Choices Worker)

- Flexibility of the programme to work to what parents need, as they need it, including out of office hours work (7am to 7pm) and use of pictorial methods and materials for parents who find it difficult to read.

“I take out ‘ready to relate’ cards – picture cards about the importance of mirroring and so on” (Positive Choices Worker)

“We do have a model, but we do go at their pace” (Positive Choices Worker)

“When it doesn’t work, for me, as long as we think we’ve done everything, been creative. We ask ourselves ‘Is it us?’ quite a bit through supervision. ‘Why isn’t it working? Can we be more creative, should we change the worker?’” (Positive Choices Worker)

- Working with Fathers as well as Mothers where possible, also the extended family.

“We expect Fathers to do what Mothers do. You tell Father about bathing and making bottles. It puts Father at ease too. So, when baby comes, they’re aware they’re being observed, yes, but they’re less anxious. They’re more confident” (Positive Choices Worker)

“We do sessions with the extended family too. They’re learning too. You’re not preaching, just giving information in a friendly manner” (Positive Choices Worker)

- 4 key aspects of the programme that are described as combining:
 - ‘Parenting education (for example: around what happens to a ‘baby brain’; impact of domestic abuse on babies and infants).
 - Worker ‘modelling’ of effective parenting, for example in relation to responding to baby ‘cues’ and regular interactive play, and also basic life skills.
 - Provision of practical support, such as help with housing or budgeting.
 - Reflective work in relation to the parent’s life journey (timeline), experiences, feelings, behaviours, and aspirations. This latter work is described by workers as being undertaken mostly at the start of a programme, ideally during pregnancy.

However, the staff interviews suggest that the reflective work is becoming more significant for them in generating successful engagement and outcomes with parents:

“The use of reflective, particularly ‘timeline’ work with parents is emerging as a particularly powerful tool in the work with parents, to support a better understanding by them (as well as by the worker) of past events, cycles, behaviours and their impact, also to explore motivation to change. It also helps to build trust” (Positive Choices Worker)

“One of the first sessions in the pre-birth work is about feelings about pregnancy. Those may be tinged, mixed feelings of regret as well as excitement. We try to unpick that and think about ‘what’s different now?’” (Positive Choices Worker)

“Every family is different. Some parents get it about their ‘cycles’ (of behaviours) and there can be some big breakthroughs for example why an ex-partner had been in prison. As soon as someone shows them any attention or affection.. without understanding the risks. To understand not to do the same things again” (Positive Choices Worker)

One aspect of the work with parents that is described by Positive Choices workers as remaining as important is the quality of the relationship with the parent(s) and extended family. Stakeholders likewise emphasised the relational aspects of the programme and what they described as the ‘positivity’ of the workers and the work:

“With Positive Choices, the clue is in the name. There’s a total move away from past negatives. It’s all about a fresh start and keeping it upbeat and positive and moving forward...rather than other programmes that are very different, all a bit doom and gloom. They’re told to do things. We don’t hear that with Positive Choices” (Stakeholder)

3.6.1 What is important about the Programme from parent perspectives

Parents participating in an interview for this evaluation all described elements of the intervention they remembered and valued, including all four key elements described above i.e.

- **Structured sessions** on specific topics relating, for example, to: preparing for the birth of a baby, attachment, aspects of parenting and/or domestic abuse. Written materials ('worksheets') were often described by parents as having been shared with them by the Positive Choices key worker in advance of the session when further discussion took place. From parents' perspectives, this seemed like a good pattern, and many were keen to describe the learning that had 'stuck' with them, that they had utilised in practice. During the Covid period, materials were frequently shared by email and then discussions could take place over the telephone or in person. Many parents described how these sessions were also 'flexible' to take on board specific things that they wanted to discuss or deal with, whilst continuing to keep the structure of the programme.

"She sent worksheets by email, about interacting with the baby and bonding. We did work on baby needs and what is good for them, even before the birth. It was about understanding that babies feel and see everything.. how to handle things in the future" (Mother)

"She would send the work.. It was the Freedom Programme. It was really good. It opened my eyes. It was about bullying and control. She sent me things and we talked" (Mother)

"We planned as we went along. I learned about child development, cot safety, sleeping safely, bonding, safe bath time.." (Mother)

"..Sleeping, relationships, baby's arrival, coping with crying, shaking baby, SIDS, breast feeding.." (Mother)

"Breastfeeding, sleeping patterns, types of crying and that this is a sign of needs the baby is telling me, different needs" (Mother)

"Being shown about domestic violence. Not arguing. I had 3 kids taken away because of this" (Mother)

- **Advice on and discussion about specific topics** that they had received from the Positive Choices key worker. Parents described how this advice was valued by them, as it came from a trusted source. It often further developed areas that had been covered in the structured sessions.

"It was not just about the work.. she'd give advice. I could ask questions.. I can always ring her" (Mother)

"There is clarity. She explains everything. If I'm confused, she doesn't jump to conclusions. She is not condescending. She treats me like I'm the parent. This is rare, as I have grown up in care" (Mother)

"Stuff on relationships. What a healthy relationship is... how arguments can affect (baby). She gives us scenarios. She asks lots of questions! I answer and she asks me to say more (Father)

"The worksheets were helpful but.. what was really helpful was that we talked. I mainly needed help with ending my ...relationship with the baby's father and

keeping things positive with contact. She gives me different perspectives. She tells me to breathe. This is the biggest thing for me” (Mother)

- **Help into specialist or community-based support**, for example for help with mental health needs, into drug and alcohol services, or to join in group-based family oriented and childcare services.

“She referred me to a group, and I went.. the kids loved it and I met new Mothers” (Mother)

- **Practical help**, for example with housing or finances or with obtaining baby essentials from charitable organisations like ‘Mothershare’. Some parents also mentioned how their key worker had helped or was helping them to access further education.

“She is helping me with money and.. (also) to get into college and education” (Mother)

“I struggled financially, and she helped me get support from a person a Citizens Advice. She brought pyjamas for the kids” (Mother)

“She helped me with getting stuff for the baby, like a basket and a pram” (Mother)

“.. got CAB. They kept reapplying (to a PiP Tribunal) for me. I won it. If I hadn’t had X (key worker), I would not have won it. I wouldn’t have kept reapplying” (Mother)

Many parents mentioned how important it had been to them that their key worker had helped with reading and / or writing things or had provided prompts or visual aids to help them to remember things:

“She wrote everything down so I could remember” (Mother)

“Using visual aids and taking notes” (Mother)

- **An element of therapeutic support.** Many parents described how their Positive Choices key worker had supported them to explore their past and how it affected them.

“Understanding issues that have gone on for me and my mental health” (Mother)

“There is so much about yourself that you might lock away. Memories I’d not thought about. It’s good it (the talking) triggers things” (Mother)

“I could do things at my own pace. I could open up when I wanted to. I had to feel ready, and she didn’t rush me. She is the only support worker that has fitted me. I’ve had lots” (Mother)

3.6.2 What is important about the Programme from stakeholders’ perspectives

Stakeholders also described as important to the success of the programme, from their perspective its:

- Whole-family focus
 - “It’s different to other places. They look at the whole family and how they’re affected and what support they need” (Stakeholder)
- Combination of a core programme and flexibility
 - “It seems really flexible, really tuned in to what women want to talk about, but also quite comprehensive. I don’t think there are any limitations. They’ll fit around family needs” (Stakeholder)
- Ability to draw in helpful support from elsewhere and encourage parents to access it:
 - “They seem to be really good at knowing what’s available including changing charitable organisations. They have a finger on the pulse about what’s available and what’s up-coming. They support women to access things like parenting groups, giving them a bit of encouragement to look into things themselves as well, trying not to spoon feed. It’s what you want parents to do, encouraging independence” (Stakeholder)

3.7 The impact of Covid on sessional work

During periods of Covid-19 restrictions, case file analysis suggests that most sessions were undertaken ‘on the doorstep’ or, where possible, in the parent(s)’ garden. These sessions were supplemented with increased telephone calls, texts and WhatsApp calls. Workers also emailed information to parents during this time, for example to share tips on play and stimulation. Where parents were socially isolated, workers did conduct some face-to-face sessions, with appropriate PPE. In some (approximately 25%) cases, it seemed that the intervention was quite to very negatively affected by these restrictions, for example in relation to their overall motivation levels and/or interest in engaging in online sessional support.

For some of the parents who were interviewed for the second evaluation, the Positive Choices intervention had started during a Covid-19 lockdown period or had included one or more of these periods. The disruption to ‘normal’ service attributes, including mostly face to face meetings and sessions with a key worker, was described by parents mainly as involving a greater or complete use of arms’ length methods of communication i.e. telephone calls, texts and Zoom calls. However, some mentioned that their key worker had either come to the door or garden for some ‘visits’.

Parents tended to minimise the impact of these disruptions:

“It was fine on the ‘phone” (Mother)

“It was on the telephone once a week. This was fine. I met her at the end with a mask on” (Mother)

During the period(s) of Covid restrictions, Positive Choices key workers described how they had continued to visit families and to undertake forms of one-to-one work in person, where appropriate, for example: where the babies were new-born and/or risks relatively high level.

“Staff were brilliant and, when we needed to go in, we did. We got through. They would send handouts in advance and that worked” (Manager)

“(Visits) felt even more important than ever. Isolation was a massive issue, especially where there were concerns about DV. It was important we saw what was going on, babies who couldn’t articulate” (Positive Choices Worker)

However, the work was described as having become more blended for some families, with a mix of one-to-one visits (often at the doorstep or in open air spaces) and some remote communication including WhatsApp, Zoom and telephone calls.

Workers described how they had tailored support to the family during the period of the Pandemic, and that some parents had needed more one-to-one (for example if they had a learning or hearing difficulty or problems accessing internet) whilst others seemed to prefer mainly telephone, or other remote communications. In some but not all circumstances, more remote means were used to undertake the pre-birth work.

“Very flexible approach, not one model fits all. What works” (Positive Choices Worker)

Core staff reflected that, whilst challenging at the time, the service had learned and developed as a result of Covid-related experiences, including to make a judgement about when and where face to face support was necessary or useful, and where remote methods could be equally if not more effective. Particularly effective seemed to have been sending written or visual materials before each ‘session’ so that the parents could have a head start on absorbing some or all the material and be more ready for the discussion.

“We’ve shown we can do things remotely for some parents, so that there’s that option in the future. For some people, we sent out resources before the session and then they had them already. It gave them a head start. It shows the commitment (if they look at them)” (Positive Choices Worker)

Other aspects of the service that were described as having (needed to) adapt included:

- Referrals to other agencies for forms of support. Where these were non-operational at times during the Covid period, the workers themselves had often incorporated this into their own work, in particular work around domestic abuse.

“We used to refer into the Freedom Programme, so we’ve taken on a lot of that work ourselves, work to understand about perpetrators” (Positive Choices Worker)

Some other services had continued, for example forms of counselling, support with finances and mental health support in the 3rd sector.
- Step-downs to other services after the end of an intervention had to be severely adapted or delayed at times during Covid.

“If de-escalating to Tier 3, there’s been quite long waiting lists. It’s been hard without Children’s Centre support during Covid. We’ve picked up more things like caring Fathers (groups).. as the group isn’t running” (Positive Choices Worker)
- Greater use of universal, open access supports available online, for example a national support group for care leavers.

3.8 Service coordination

All aspects of the second evaluation suggest that service coordination and multi-disciplinary working has become a real strength within the service.

Positive Choices workers described how the service benefitted from Calderdale being an area where service coordination and multi-agency working was well-embedded within and across the Council's broader family support offer (and Family Intervention Teams), also across agencies:

"We're unique in that we've got the Family Group Conferencing in our team, employment advisors, housing workers.." (Positive Choices Worker)

"Multi-agency in Calderdale is a big thing" (Positive Choices Worker)

Similarly, Positive Choices workers considered that there was now 'even better multi-agency working' than earlier in the Programme, including with both statutory (such as health visiting and midwifery/specialist midwifery, drugs and alcohol services) and third sector organisations such as Mothershare and Noah's Ark. Newer services that they could link with for the benefit of parents included in particular a relatively recently established Perinatal Mental Health Team.

"..so lucky to have charities who provide equipment" (Positive Choices Worker)

"If we have a case with Mother struggling with mental health, we can ring and talk to people and get advice. The Perinatal Team are really good, and we can refer to them pre-birth. It might be they don't need to pick up on things then, but they can do assessments and know the parent later if they need a referral" (Positive Choices Worker)

They also reported a more accessible 'single point of access' for mental health therapies that had developed since the time of the first evaluation. Workers also reflected that the work they did directly with parents also contributed to positive mental health:

"We can also encourage positive mental health ourselves, for example encouraging parents to get out with baby" (Positive Choices Worker)

Stakeholders interviewed for the evaluation likewise described the ability of Positive Choices workers to effectively coordinate services as well as the overall strength of multi-agency working to have become a key programme strength:

"In more recent years, there's more of a relationship between us and the team. Statutory agencies and the voluntary sector building more of a trust, to see how we can help. It's useful if we get a bit more involved. We can do a lot to help if we understand more. There's other things we can help with" (Stakeholder)

"There's a lot more dialogue and more direct contact between us..That feeds into an ongoing relationship with the families. They can still feel comfortable to come back to us after they've finished with Positive Choices. It builds a relationship and, for us, that's great. We want families to be able to come to us" (Stakeholder)

3.9 Supports for effective Positive Choices practice

At the time of the second evaluation, all Positive Choices staff participating in an interview considered that their line manager and broader organisational support was 'excellent', including with reference to:

- One to one supervision.
- Group or 'pod' supervision.
- Good quality training including in particular in systemic practice (via an in-house, 10-week programme).
- Their ability to share resources with the Positive Choices team but also more broadly with the Family Intervention Team (FIT)

"As a team we have masses of support. From our senior (also from seniors in other pods). Our manager. One to one supervision monthly – seniors really know our cases. Also POD supervision. We used to have this once a month but now we have it every week, since Covid and I think that's really beneficial. We can take a case to POD reflect and bounce ideas off each other" (Positive Choices Worker)

"I have a fantastic team and line manager. If my line manager is not available, I can ring another line manager. Supervision looks at my workload and that I'm 'well'. It's very supportive. Always someone you can go to" (Positive Choices Worker)

Whilst not being able to come into the office to work alongside team members had felt a little isolating at times during the period of the Covid Pandemic, workers considered that the supports for their practice had overall been well adapted to their needs during that period.

Key workers described feeling confident that this style and way of working 'worked' for families, they felt that there were constant new challenges (and that this was part of their interest in the role) that kept them on their toes.

"You have to be confident going into families, they're looking to you to be confident. But always space to learn more" (Positive Choices Worker)

"There are always challenges but you can't become blasé. People are the experts in their own circumstances so, whilst I'm confident that our team and what we do 'works', and that we have resources, and skill set to do that, but you don't want to become overly confident. It's being approachable and personable" (Positive Choices Worker)

All Positive Choices staff interviewed for the evaluation would like to see the service continue in its current form. Being dispersed into the broader FIT pods (by locality) was a potential challenge to the model, but most thought that there might also be potential benefits, for example broader sharing of effective ways of working with vulnerable including young parents. Similarly, stakeholders described wanting to see the service continue in its current form:

"Continue in the same spirit as now. It works, it clearly works" (Stakeholder)

4 Findings relating to family outcomes

4.1 Overall family outcomes

4.1.1 As evidenced in the whole cohort administrative data

The first evaluation reported that, of the 35 family units in the whole Positive Choices cohort where outcomes could reasonably be ascertained (out of a total of 52 who had started an intervention during the relevant period), 21 (60%) had an overall successful outcome including child(ren) remaining in the care of their parent(s) and 14 (40%) had largely unsuccessful outcomes including child(ren) being removed from the parent's care.

More of the families opened to Positive Choices at the time of the earlier evaluation have now completed an intervention so that there are 46 family units overall (11 more than at the first evaluation) from that cohort where an outcome is now known.

Out of all these 46 'original cohort' family units, the administrative data suggests 59% completed the programme successfully (and kept their baby). In almost all these cases, there were also no further referrals at 3 months post-closure. In 33% cases, a child was removed from their care, or the parent(s) gave their child up for adoption at or by the end of the intervention.

Table 8: Family units referred to Positive Choices during 2017-2019 and completed intervention by overall outcome type (number and %)

Type of outcome	Number	Proportion
Successful completion	27	59%
Child(ren) removed	15	33%
Declined involvement	1	2%
Could not be involved (moved or still birth)	3	6%
Total	46	100%

Of a further 24 families recruited into the Positive Choices Programme since the time of the earlier evaluation, most (18) were not yet closed at the time of this evaluation (they were still active cases). In all (6) of the cases that had been completed, the outcome was considered to be very positive with the parent-child dyad remaining intact. One half of these (3) involved a mother with a child previously removed.

Therefore, of the 52 family units with a completed Positive Choices intervention at May 2021: approximately two thirds (63%) had completed the Programme successfully including with the parent-child dyad remaining intact.

Table 9: Overall cohort of family units with a completed Positive Choices intervention by overall outcome type (number and %)

Type of outcome	Number	Proportion
Successful completion	33	63%
Child(ren) removed	15	29%
Declined involvement	1	2%
Could not be involved (moved or still birth)	3	6%
Total	52	100%

If those parents or families who could not or who would not become involved in the start of a Programme are taken out of consideration:

- 66% (33/50) of the whole cohort completed the programme successfully.
- 34% (17/50) had their child removed.

4.1.2 As evidenced in the case file sampling

In the majority (9/12 or 75%) of the cases examined in depth by evaluators for the second evaluation, the overall outcome for the child and family was positive or very positive. This is slightly higher than in the earlier evaluation case file analysis (at 61% or 19/31). In 2/12 cases, the outcome was considered to be neither positive nor negative, although the child remained living with their key parent, because there had been some progress but ongoing concerns regarding substance misuse or domestic abuse. In one case, the overall outcomes were considered to be negative, as the child had needed to be removed from the parents' care.

The child(ren) remained living with parent(s) or were successfully rehabilitated with parent(s) in all but one case (11/12 or 92%).

The positive outcome cases were characterised by:

- Children observed as being happy, well-socialised and stimulated.
- Parent(s) being committed to the infant's care.
- More positive intimate and close family relationships.
- Parent(s) able to live independently.
- Parent(s) accessing community supports independently.
- Parent(s) securing employment and arranging / managing childcare.
- Child de-registered or stepped down from a child protection plan to child in need or early help or to universal services.
- Parent managing safe contact for the child with the other parent.
- Parent(s) abstaining from drugs or alcohol.

Cases had been closed for 0-18 months prior to the case file analysis (in 2 instances, the case was still technically open although the intervention largely ended). Of those where the case had been closed for at least 3 months, there were no re-referrals or assessments required.

This second case file analysis overall cohort and the number of 'negative outcomes' are too small to draw any conclusions regarding patterns of positive outcomes compared with presenting parent 'type' (e.g. care leaver or vulnerable because of previous experience of Children's Social Care; learning disability or not, whether the parent engaged pre-birth, post-birth or at birth). However, in the one case in the case file sample where the child was removed from their parent's care, the mother was only 17 years old and still a looked after child when the intervention started.

4.1.3 Outcomes as described by parents in interview

Parents participating in an interview for the second evaluation described positive impacts of the programme (in particular their key worker) on them in a number of ways including: in gaining self-confidence; improving their parenting skills; achieving a bond with their child; and 'getting on' as an individual as well as a parent.

Some parents described how they thought they had changed significantly as a result of the intervention:

"I turned my life around. They said I had done well and deserved to get my baby back. I have been abstinent for many months (now)" (Mother)

"I've changed a lot. The people that used to influence me I've stepped back from. My lifestyle has changed and now I see clearly. I've matured. The past is the past and I'm a lot happier" (Mother)

"I am a completely different person now to what I was. I grew up in care and I wasn't sure I wanted (my baby).. Now I have my head screwed on. I have (parenting) tools now" (Mother)

"Help to keep baby safe, help with mental health. She pushed me in the right direction. I've benefitted and moved in the right direction. I've matured. I don't just think about myself now. I understand things from the baby's point of view" (Mother)

"I thought everyone was against me. I've learned to trust people" (Father)

Some parents mentioned a particular aspect of the programme and their self-development that they thought had helped or helped most, for example how the work on domestic abuse had helped them to really recognise the impact on children:

"The work we did about domestic abuse... so you can recognise it .. in front of the children and the effect it has on them" (Mother)

Other parents emphasised how having had an opportunity to talk, including about relationships past and present, had been a positive catalyst for them.

4.2 Impact on infant/parent attachment and parent attunement to the child's needs

4.2.1 Findings from analysis of standardised measure data

Standardised measure data relating to the quality of baby/parent attachment was available in relation to some but by no means all parents participating in the Positive

Choices Programme within the timescales of the second evaluation. Researchers have therefore undertaken analyses relating to this second cohort as well as overall (across all parents participating in the Programme) who have completed any of the following:

- The Maternal Antenatal Attachment Scale (Condon, 1993) known as MAAS.
- The Paternal Antenatal Attachment Scale (Condon, 2015) known as PAAS.
- The Maternal Postnatal Attachment Scale (Condon and Corkindale, 1998) known as MPAS.

The analyses are complex, not least because only a small proportion of parents completed both a baseline (for example an antenatal or first post-natal) questionnaire. Others completed only a baseline questionnaire or only a post-natal questionnaire some months into their intervention. More information about this can be found in the technical document at Appendix 2. Furthermore, what could be described as a 'baseline' antenatal questionnaire was mostly completed at least 6 weeks into an intervention – in order for the Positive Choices key worker to get to know the parent and come alongside them before administering such instruments. Therefore, arguably parents had already had some of the benefits of the Programme before completing their first questionnaire. Alternatively, a small number of antenatal questionnaires were requested from prospective parents by the unborn child's social worker when in fact the Positive Choices Programme did not commence until around the child's birth.

The results of analyses are still interesting in that:

- Overall, the quality of attachment between babies and mothers completing a MAAS (n. 43) who began to be involved in the Programme antenatally, and their intensity of preoccupation with the foetus is high (towards the upper end of the range).
- Similarly, the quality of attachment between babies and fathers completing a PAAS (n. 13) who began to be involved in the Programme antenatally, and the intensity of their preoccupation with the foetus was high (toward the upper end of the range).
- Similarly, the quality of attachment between babies and mothers completing a first MPAS questionnaire postnatally (n.33) was high.
- Whilst there is no statistically significant difference in (MAAS and MPAS) scores between first and further collection points from mothers involved with the Programme with reference to total (overall) attachment scores, there is a statistically significant difference (improvement) over time with reference to the Quality of Attachment sub-scale between an antenatal and first post-natal collection point. The quality of attachment sub-scale measures parental feelings of closeness and tenderness versus feelings of distance and irritation. This suggests that the service aims of improving maternal attachment are being achieved, in particular in the early part of service delivery. However, the overall number of mothers who can be compared in this way is relatively small (n.23).
- Whilst there is no statistically significant difference between the maternal antenatal attachment (MAAS) scores of those who successfully completed the programme and those who did not, there is a statistically significant difference between these scores at the post-natal stage (MPAS). In other words, at the antenatal stage, all types of parents involved with the Programme had relatively high levels of baby/parent attachment – whether or not they went on to keep their baby. Whereas, at the post-natal stage, the attachment levels of those who mostly did not keep their baby were much lower than those who were successful in keeping their baby. The effect sizes are medium to large in this respect.

4.2.2 Findings from the case file sampling in relation to attachment

In 11/12 (92%) of the case files sampled with parental consent for the second evaluation, there was relatively robust evidence of good baby/parent attachment during and by the end of interventions, including observation notes from key workers regarding eye contact, smiling, positive natural interactions and parental insight into attachment. In just 1/12 cases there was less extensive evidence of this kind. This appears to be an improvement on the earlier stage evaluation case file analysis which identified strong evidence of good baby/parent attachment in only 21/31 (68%) cases, although the numbers are relatively small.

Similarly in 11/12 cases in the most current sample, there was evidence of parental attunement, particularly that of the mother but sometimes also the couple, to baby's needs, for example: good responses to baby cues; parental warmth; a clear focus on the needs of the child; good routines; baby thriving.

In a slightly lower proportion (7/12 or 58%) there was robust evidence of parental understanding of what constitutes good enough parenting. This compares with 22/33 (67%) in the earlier evaluation case file analysis. In 5/12 (42%) cases in the second evaluation, there was only partial evidence that the parent had such understanding, often 'let down' by their lack of real insight into the impact of parental conflict and/or safety work. However, 10/12 (83%) parents did evidence good parenting in fact, in that, during the time of the intervention, the child could be described as 'well cared for' overall. In 2/12 cases there was evidence that the child had been partially well cared for.

In addition to the educative sessions and advice forming the core programme, parents participating in an interview for the second evaluation frequently mentioned that the most important thing for them (in helping them to be a good parent) was the reassurance and encouragement they received from their Positive Choices key worker. These key attributes of the support provided seemed particularly important from parents' perspectives as they were coming from a low base in terms of self-esteem and self-confidence.

"I was really worried. But she said it's common sense and it will come to you, everyone gets scared" (Mother)

"I haven't had the best people in my life, and she sees the positives in me" (Mother)

"She was always reassuring... always nice the way she tells me things. Not criticising me. She really helps me" (Father)

"I was worried about bathing. I explained my worries and she put my mind at ease" (Father)

".. never judged my parenting, always positive. She praised my understanding of (baby's) cues and our bonding" (Mother)

Similarly, parents described how their Positive Choices worker had helped their bonding with baby through specific advice, reassurance, and encouragement:

“I wasn’t very comfortable changing Y’s nappy or seeing her without her clothes on. She helped me overcome that fear. I wear shorts in the bath with her, but I can have a bath with her, which is great! She helped me build my confidence, made me feel really good” (Father)

“When (baby) was born, I didn’t have a connection with him. She told me about skin to skin (contact) and to always do that for as long as he needs it” (Mother)

“They are genuinely there to help, not for the money. I get a vibe that they enjoy it, and they care and want families to do well” (Mother)

4.3 Impact on risks and risk levels

By the end of the intervention, risk levels for many children whose families have participated in Positive Choices decrease, as evidenced in both the administrative and case sampling data. However, in some cases (approximately one third), risk levels continue to be relatively high at the end of an intervention, warranting a continuation of a statutory (Child in Need or Child Protection) Plan.

The case file analysis sample (n:12) provides more insights into specific ongoing risks for some children and families participating in the Positive Choices Programme including approximately one sixth still at risk from or at possible risk from neglect and/or physical abuse at the end of the intervention. Linked with these more specific risks to children, a proportion (approximately one third to one half) of parents represented in the case file sample continued to have risky or potentially attributes including substance misuse; mental health issues; and exposure to domestic abuse at the end of their Positive Choices intervention.

This proportion (approximately one third) ties in with the one third (approximately) of families who currently do not complete a Positive Choices Programme successfully.

4.4 Impact on parent life choices

A theme from the stakeholder interviews was that the programme generates not only improved parenting but also better life choices for parents in their own right:

“They (Positive Choices parents) might contact us again..You can see how they’ve developed as parents. They have become better, more aware parents. They know they’re doing it too, making better choices and decisions... stop and think about the right thing to do. They’ll tell you about it freely as well” (Stakeholder)

Case file analysis undertaken for this evaluation supports this hypothesis in that it provides evidence that parents involved with Positive Choices are routinely (i.e. all) supported to reach their potential and to make positive life choices beyond the parenting task. In approximately three quarters of cases, there was evidence that the parent(s) had responded very well to this aspect of the support.

In approximately 20% cases examined through the case file sampling for this evaluation, the mother had gone on to have another pregnancy during the course of the

intervention (others had not). This is the same rate as reported in the (larger) initial evaluation case file analysis.

4.5 The significance of longer-term resilience

A strong theme from the stakeholder interviews is that, where able to engage effectively with parents, the Programme often generates greater (long-term) resilience in families:

“When that’s worked, it’s an amazing thing to see. That’s the key difference... parents more resilient. Some families we see, referred from elsewhere, they give up. The families involved with Positive Choices they are much, much more determined, much better attitude” (Stakeholder)

Many parents participating in an interview for the second evaluation also described how their involvement with Positive Choices had made them more confident in themselves going forward in the short term, also sometimes more optimistic about the future generally, rather than dwelling on the past, and able to plan realistically but confidently:

“Definitely made me not question myself anymore. She made me realise everyone has struggles. Everything is a learning curve. Because things happened (in the past), I am not a bad person” (Mother)

“I am on a course called Tiny Tots for care leavers and parenting. She opened doors for me. I want to go to university next year and be a maths teacher” (Mother)

“I am very confident now. I can put things into practice. We are adapting to having (baby) first and then we will adapt to working as well. We are slowly moving forward” (Father)

“I feel very positive. I have a lot of plans... going on holiday.. I want to get a mortgage and go to college. But I must get (baby) into school first” (Mother)

“I want to go to college and set up my own business” (Mother)

“When (baby) is older, I will get childcare and go back to education” (Mother)

“We were both under-confident. It’s brought us closer, made us stronger” (Mother)

Some parents interviewed for the evaluation were a little less confident about the future, a little more anxious about the ending of their Positive Choices intervention and their ability to sustain progress that had been made. However, they were often simultaneously reassured by the thought that they could contact this worker again in the future if needs arose:

“... she still rings me now. I can just ring her whenever. She’s at the end of the phone (at 4 months post-closure)” (Mother)

“I kept going to groups. I had my debts under control. My kids go to nursery. But in Covid I had a rocky patch. She helped with the shopping. I’d not asked for help before, and she was pleased I did” (Mother)

“I didn’t want it to end, but she said if I needed anything, I could keep in touch” (Mother)

4.6 The impact on parents who do not keep their babies

This evaluation has not explored in depth what is the impact of Positive Choices on parents who do not keep their babies beyond the end of an intervention. However, a strong theme from the stakeholder interviews was that the Programme was valuable, even to these women:

“It’s really, really valuable. The women..are really positive, even those who don’t have a completely positive outcome. They’ve been given the tools for moving forward. Gives them empowerment, knowledge. It all builds up” (Stakeholder)

4.7 The significance of starting work during pregnancy

The initial evaluation found that first time very vulnerable first-time parents starting a Positive Choices intervention pre-birth were more likely to respond positively compared with those receiving the same type of support either at birth or post-birth. Around the time of a child’s birth appeared to be the worst time to commence support (Burch et al, 2020).

Administrative data collected for this evaluation includes more ‘closed cases’ where outcomes can be identified. However, the nature of referrals has also changed over time, particularly in the most recent 12-month evaluation period, to include parents who have already had a child removed from their care.

Analysis of the data relating to all closed cases (from evaluation one and two) suggests that interventions commencing pre-birth are still more likely to be successful, particularly compared with those that start at or around the time of a child’s birth. For example, when discounting ‘other’ outcomes (for example family moved out of area or child was still born or family declined involvement), 70% of families participating pre-birth had successful outcomes. This compares with only 57% of families beginning to participate at birth being considered successful (but also with 83% participating when their child is an infant). However, as outlined in Table 10 below, the data is still relatively small-scale and the number of families participating at birth or in infancy have become even smaller by comparison to those participating pre-birth (as referrals at this early stage become more ‘the norm’) so it is difficult to compare accurately.

Table 10: Successful, unsuccessful and ‘other’ outcomes by whether the intervention started pre-birth, at around the time of the birth or when the child is an infant

	Successful outcome	Unsuccessful outcome	Other
Pre-birth	16	7	4
At around the time of birth	8	6	0
When the child is an infant	5	1	3
Total	29	14	7

Further analysis of the administrative data relating to families engaging in the programme pre-birth but who are unsuccessful suggests that these mothers are often very young (most were 16-17 years at the time of initial involvement) and have a known learning disability. They are also often parenting on their own (without a supportive partner).

Standardised measure analysis suggests that attachment levels for parents starting the programme during a pregnancy are better than those for parents starting at or around the time of the child’s birth (the scores for parents starting during infancy are too small to be viable for the purposes of analysis). However, the difference is not statistically significant. More about these findings can be found in the technical document at Appendix 2.

Positive Choices workers participating in an interview for this second evaluation all considered that it is important or even ‘essential’ to start the work during a pregnancy, in order to maximise the impact of the Programme. When asked why this is, a variety of responses were provided by staff including that:

- It provides a more extended opportunity to establish a trusting relationship before undertaking some of the harder or more challenging work for example on parenting skills or domestic abuse.
 “That build-up of the relationship with parents before the baby comes, talking about their hopes and fears, so when the baby comes, the relationship is formed. So, when you are challenging parenting and things later, they take it better from you” (Positive Choices Worker)
- Doing so helps to gain a better understanding at an earlier stage of the parent’s strengths and challenges, including perinatal mental health issues.
 “..going out and meeting, and really listening then, meeting early enough and talking to them as a human being, not all focused on baby. Being able to flex, have pieces of work to do but listen first. Tailor to them” (Positive Choices Worker)
- Getting support ‘in’ early gives parents an overall better and fairer (longer) chance to learn and prove themselves to be a good parent.
 “I think getting in early is key. Getting as much support before the baby comes” (Positive Choices Worker)

- Starting work early provides a window of opportunity to engage a prospective parent in reflecting on their past and future hopes and worries without the demands of a baby being present:

“When baby’s born, it’s much more rushed and stressed. If we have that trust already, it’s helpful” (Positive Choices Worker)

Some staff reflected that the referring services (mainly children’s social care and midwifery) increasingly understood the significance of such (early) referrals:

“Services increasingly get that it’s important to refer early. Previously, the children’s assessment team did the investigating but not the intervention. We flipped that around and whilst the social workers do their investigation, we’re doing the supports. They’ve seen the difference our service can make. Investigating doesn’t ‘do’ anything. If we can get in there really early, we can get supports in place. It gives parents a fairer chance (to start early)” (Positive Choices Worker)

The importance of work starting early with parents, during pregnancy, was described by staff as having been ‘written into’ guidance and guidelines for all support services locally, as a result of the successes of the Programme.

Starting interventions during pregnancy was similarly considered by a broader range of stakeholders to be vital, including to help build confidence and readiness for the birth, also because it may be easier for many parents to focus on challenges and issues pre-birth:

“I think it’s massively important they get engaged during pregnancy...Usually there’s been some kind of trauma or breakdown. They’re vulnerable. There’s nothing more upsetting than thinking you have nothing ready. It builds a huge amount of anxiety and starts you off on the wrong foot. We know it’s important to know they’re sorted. ‘I’m good to go’. Having nothing is so negative, a dark place to be in” (Stakeholder)

“They’ll do practical things with the women. It gives them the tools antenatally, to have confidence in a scary situation, especially if there’s social worker involvement. To do it after baby’s born, it’s too late with such a vulnerable group, for example if there’s a learning disability. It’s scary and for someone who doesn’t learn quite as well... confidence giving is really important. The majority of people want to be prepared (for a birth). (Stakeholder)

“I think it’s easier for parents to focus on things pre-birth. After the baby’s born, it’s harder for them to focus on learning new things” (Stakeholder)

“It’s about making a first positive connection and changing their mindset in a lot of ways. They look forward to the team coming to see them. A lot don’t have anyone else to have these conversations with” (Stakeholder)

4.8 Impact on the number of infants becoming looked after year on year.

Partly because of the (relatively small) size of Calderdale population, the number of infants (aged under 2 years) becoming looked after by the local authority year on year is

very small. Between 2016 and 2020, the number of infants becoming looked after in any 12-year period of reporting varied from 1 to 8 infants.

Whilst the number rose between 2016-17 and 2017-18 (from 1 child to 4 infants) and then again in 2018-19 (to 8 infants), these rises are also reflected in the overall number of children of all ages becoming looked after in Calderdale during the same time period. By 2020-21, the number of infants becoming looked after had dropped again to 2.

These numbers are so small as to not be useful for the purposes of determining the impact of the Positive Choices Programme on demand for infants' entry into care. Furthermore, the Programme is already known (Burch et al, 2020) not to have a significant impact on initial entry into care: its real value is, for the parent-child dyads remaining intact at the end of an intervention, the longer-term resilience of that family's ability to remain together and thrive.

5 Cost benefit analysis

5.1 Costs of Providing the Positive Choices Programme

At June 2020, 4 key workers were involved in delivering Positive Choices (one full time equivalent and three part time). They were supported by one FTE senior key worker / team manager and a percentage of business support from within the broader FIT.

Per annum, the core costs of this workforce are estimated at £181,046. In addition, the travel costs of key workers are estimated at £2,322 per annum.

Overheads (including use of buildings, business support, human resources, and middle to senior management oversight) are estimated at £21,500.

Therefore, the overall estimated cost of the service per annum at 2020-2021 is £204,868.

At the time of the second evaluation approximately 24 families had been referred into the Positive Choices Programme in the latest 12-month period. Overall, across the 4-year period focus of the study, 72 families had been referred, approximately 18 per 12-month period. This suggests that more families were being supported in the most recent period of service delivery, when the service was more embedded.

Positive Choices key workers report average caseloads (number of families with whom they work at any one time) to be approximately 7.

An average length of involvement in the Programme is just under 12 months. Therefore, an **approximate cost per family unit of participating in the Positive Choices Programme in the most recent 12-month period is £8,536** (£204,868 per year divided by 24 families having a full intervention). Over the longer period, including start-up of the Programme, the unit cost per family is likely to be slightly higher at approximately £11,382 (£204,868 per year divided by 18 families having a full intervention).

5.2 Costed Programme savings

Generating accurate costs for the savings associated with the largely very positive outcomes associated with this service is complicated.

The initial evaluation sought to compare outcomes for early Positive Choices cohorts with 'business as usual' (i.e. before the service started). In this earlier evaluation period and throughout the Programme now evaluated in its entirety, approximately the same rate (approximately 66%) of parents referred into it have been very successful including by 'keeping their babies'. This is very similar to the 'business as usual' cohort (Burch et al, 2020).

However, as identified in the initial evaluation, during the lead up to Positive Choices officially commencing, some key aspects of it were already being trialled in Calderdale, which means that some of the families in the 'business as usual' cohort were effectively receiving a prototype Positive Choices Programme. Analysis of whole cohort numbers of infants becoming looked after in Calderdale over the last 5 years do not provide much further illumination regarding the question of whether Positive Choices increases or reduces need for care for infants in the first instance. This is because the numbers are very small (e.g. between 1 and 8 per year) year on year.

As suggested in the initial evaluation, the real comparative savings that may be attributable to the Programme are more likely generated by the difference in family resilience over time for parent/child pairs remaining together at the end of an intervention. The initial evaluation compared the medium-term outcomes across Positive Choices/pre-Positive Choices cohorts and found that, whilst two thirds of the Positive Choices cohort remained successfully at home with birth parents without the need for further statutory support, only 37% of those in the retrospective cohort did so. These findings are repeated here in detail in Table X below:

Table 11: Percentage medium-term⁹ outcomes for Positive Choices and retrospective case file analysis cohorts

Medium term outcome	Positive Choices cohort	Retrospective cohort
Child became looked after in the short to medium term	32%	33%
Child / family required an additional, significant intervention in the medium term	0%	30%
Family did not require any further intervention	68%	37%

We note that not all the children from the retrospective cohort who required further statutory support became looked after in the medium term: many were the ongoing subject of a further Child in Need, Child Protection or Targeted Prevention Plan. However, based on all the evidence available on the case files, evaluators estimate that approximately one third of this group still remaining at home but with further statutory

⁹ Short to medium term references by the end of an intervention and a follow up period of up to 3 years (average of 19 months) post-intervention

interventions in the medium term were likely to go on to become looked after, including as a result of the (accumulation of) statutory plans and little change in home conditions.

Over the 3-year initial period of the service, a conservative estimate of projected savings accrued in this way to the local authority children's social care services alone¹⁰ was calculated by evaluators to be in the region of £781,744. This is calculated as follows:

- Without Positive Choices, in a cohort size of 54, 30% need at least one further intervention, giving you 16 children. Based on the evidence from case files, evaluators estimate that each of these children will require an average 1.5 further interventions, with each intervention lasting approximately 1 year. A conservative estimate of the cost of a Child in Need or Child Protection intervention of a 1-year duration (based mostly on social work case management costs) is £3,402^{11 12}. Therefore, the total social work costs saved in relation to these further interventions alone are calculated as follows: $16 \times 1.5 \times £3,402 = £81,648$.
- Without Positive Choices, evaluators also project that some at least of the 30% (16) families who remained together in the short to medium term but who required additional interventions including child protection plans relatively soon after the first (at least a third of the 16, or 10% of the total) will need to come into care as a result of the further child protection concerns. 10% of an overall 3-year Positive Choices referral cohort of approximately 54 children would mean that an additional 5.4 children would be likely to come into care without the service). On the basis of an average period of being looked after of 2.21 years¹³ and an average cost per year of being looked after of £58,664¹⁴, the savings can be calculated as follows: $2.21 \times 5.4 \times £58,664 = £700,096$.
- **Therefore, a conservative estimate of the total projected savings is £781,744 across a 3-year period of delivery (or £260,581 per annum), these savings accruable directly to local authority social care services rather than to other organisations.**

Therefore, there are only very modest short to medium term savings from the Programme to individual children that we can be fairly certain are accruable directly to the local authority social services department (in the region of £55K per annum).

Although beyond the scope of this study, evaluators believe that there are other realistic benefits that are not capable of being costed so readily but which are likely to have financial implications. These include that:

¹⁰ There may be other benefits accruable for example to the Police and health services through reductions in domestic abuse incidents

¹¹ Source: New Economy Manchester Unit Cost Database (2019) <https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/>

¹² There are no costs within this estimate relating to actual support interventions e.g. family support services

¹³ Based on the average duration of a period of care for children who ceased to be looked after in the year 2018-2019 (808 days) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/850306/Children_looked_after_in_England_2019_Text.pdf

¹⁴ Source: New Economy Manchester Unit Cost Database (2019) <https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/>

- Parents who are involved successfully in relation to one child going on to have further successful pregnancies (that do not require a statutory intervention and/or child potentially needing to be removed).
- Parents who are not successful (in keeping their baby) at the end of a Positive Choices intervention still taking more time to think about or prepare for a further pregnancy (including postponing pregnancy until later when they are more mature; asking for help earlier; or having more confidence, understanding or resilience to cope with a further pregnancy). This likelihood may be increased even further where they participate in the Positive Choices II Programme (for parents with one child removed from their care). Whereas, research suggests that without such support or resilience, mothers with babies removed from their care are likely to seek a further pregnancy to replace their loss (Broadhurst & Mason, 2013).
- Children who are removed from their parent(s)' care being placed for permanency (through adoption or other forms of placement) earlier. Earlier permanency is generally associated with better outcomes for children (Selwyn, 2014). Whereas, remaining for longer in an abusive or neglectful home environment is associated with worse outcomes for children (Wilkinson et al, 2017).
- Most babies and infants involved in the Programme having experienced good quality attachment from primary carer(s) in their first 18 months to 2 years, irrespective of the eventual overall outcome including the need to become looked after. Research suggests that attachment in early years is a powerful predictor of social and emotional outcomes (Lyons 1996, Lyons 2008, Howe, 2005).
- Parents who are successful in the medium to longer term in parenting their child effectively will avoid not only the damaging effects of separation on the child, but also on themselves, e.g. mental health deterioration or social exclusion (Lewis et al, 1995, Klee 1998, Chapman, 2003) which themselves carry costs to society.

6 Conclusion

- This 12-month extension pilot study provides further evidence of the mostly very positive impact of the Positive Choices Programme on either first-time parents or parents who have already had at least one child removed from their care.
- The extension study also continues to suggest that parents and families get the most out of the Programme and have better outcomes overall when the actual support starts pre-birth compared with at around the time of the child's birth¹⁵.
- The findings need to be treated with some caution. Firstly, the design of the evaluation was such that it could only establish a correlation between variables of interest, not causal relationships. Lack of a control group means that outcomes could have occurred by chance. A further limitation is that the study could not explore the extent to which interventions resulted in sustained specific outcomes beyond the need for further social care interventions, such as good attachment, good enough parenting over time.
- A further, more extensive study should be capable of exploring not only in Calderdale but also across other sites implementing the model (and those without such a model – i.e. control group or comparator areas) even more robustly what relationship the intervention has to child, parent, and family outcomes over time.

¹⁵ There are very few infants now referred in

7 References

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8 Appendix 1: Logic Model

Inputs	Outputs	Short term outcomes	Longer term outcomes
<p>Trained family support workers intervening with a '<i>behaviour change model</i>' for very vulnerable parents including those who are care experienced or who were 'in need' as a child or who have had a previous child removed.</p> <p>Team members supported by reflective supervision and a systemic practice framework.</p> <p>Service embedded in a broader Family Intervention Team providing a range of targeted supports to families</p> <p>DfE funding for 2020-21.</p>	<ul style="list-style-type: none"> Work with parents as early as possible in a confirmed pregnancy and perinatally 1:1 strengths-based, therapeutic key worker support including an evidence-based pre-birth pathway, parenting programmes, and other 'change model' supports Interventions targeting mothers and fathers, also extended family members as appropriate Multi-agency support for the whole family, tailored to their needs (a team around the family approach) Ongoing work with the parent even if the child is removed from their care 	<ul style="list-style-type: none"> Reduced risk factors for compromised parenting (e.g. domestic abuse, substance misuse, mental health problems) and reduced negative environmental factors (e.g. poor housing, insufficient income, social isolation, poor community supports) Increased resilience factors, both parent-specific and environmental Parents have a good or improved understanding of what constitutes and what had an impact on effective parenting of infants Good child-parent attachment, parent attuned to the child, demonstrating empathy and responsiveness during the perinatal period 	<ul style="list-style-type: none"> Good outcomes for child(ren) of the family e.g. good health, attachment, cognitive skills, social skills, safety Children remain safely at home with parent(s) Parents are resilient including knowing where to go to access support after they leave the programme before crises are reached Parents reach their potential and make positive life choices, irrespective of whether the child remains at home with them Improved parental sexual health and access to contraception Reduced incidence of further unplanned pregnancies Parents who have had previous children removed go on to parent successfully and keep their child.

9 Appendix 2: Technical Document relating to Standardised Measures' Analysis

9.1 Introduction

For this evaluation, standardised measure data collected from Positive Choices service users (parents) across the whole 4-year period of the Programme (2017-2021) was analysed. This data was concerned with child/parent attachment and the measures were as follows:

- The Maternal Antenatal Attachment Scale (Condon, 1993) known as MAAS.
- The Paternal Antenatal Attachment Scale (Condon, 2015) known as PAAS.
- The Maternal Postnatal Attachment Scale (Condon and Corkindale, 1998) known as MPAS.

The following analysis is based on a dataset of 82 individuals who had participated in the Programme overall, 40 of whom had provided data for the first evaluation report. A total of 43 mothers completed the MAAS and 33 parents (mostly mothers but some fathers) completed the MPAS when their child was an infant. Completion of an antenatal and a post-natal measure varied by family unit. For example:

- 29 mothers and 13 fathers completed an antenatal (MAAS or PAAS respectively) questionnaire only.
- 14 mothers completed both an antenatal (MAAS) and a postnatal (MPAS 1) questionnaire.
- 19 mothers completed a postnatal questionnaire (MPAS 1) only.
- 23 mothers completed a second postnatal questionnaire (MPAS 2) only.
- 20 parents participating in the programme did not complete either an antenatal or a post-natal questionnaire.

62 parents (76%) recorded as having had an involvement with Positive Choices completed at least one of the questionnaires.

9.2 Maternal Antenatal Attachment Scale (MAAS) / Paternal Antenatal Attachment (PAAS) Scale Whole Cohort Results

The MAAS (Condon, 1993) consists of 19 items divided over two sub-scales: 'quality of attachment' (11 items) and 'time spent in attachment mode' (8 items). The first subscale represents the quality of the mother's affective experiences towards the foetus (feelings of closeness and tenderness versus feelings of distance and irritation). The second subscale represents the intensity of preoccupation with the foetus in terms of time spent thinking about, talking to and palpating the foetus. All items are scored on a five-point scale. The minimum (lowest) score for the Total MAAS is 19 and the maximum (highest) is 95. The scores for subscales range from 11 to 50 and 8 to 40. High scores reflect a positive quality of attachment and a high intensity of preoccupation with the foetus. The MAAS subscale statistics for the whole cohort (of mothers completing MAAS) are summarised in Table 12 below:

Table 12: MAAS subscale statistics for Whole Cohort Positive Choices mothers completing a questionnaire

MAAS subscale	No. questionnaires	Median (SIQR) score	Range of scores
MAAS Total Attachment Score	43	85.00 (7.00)	59 - 95
MAAS Quality of Attachment Score	43	46.00 (2.50)	32 - 50
MAAS Time spent in Attachment Score	43	34.00 (4.76)	18 - 40

The median (average) MAAS subscale scores are all towards the upper end of the possible score ranges for each scale. Overall, all three MAAS subscale results indicate that the sample possessed a very positive quality of attachment and a very high intensity of preoccupation with the foetus antenatally.

9.3 Paternal Antenatal Attachment Scale (PAAS) Whole Cohort Results

The PAAS (Condon, 1993) consists of 16 items divided over two sub-scales: 'quality of attachment' (8 items) and 'time spent in attachment mode' (6 items). The first subscale represents the quality of the mother's affective experiences towards the foetus (feelings of closeness and tenderness versus feelings of distance and irritation). The second subscale represents the intensity of preoccupation with the foetus in terms of time spent thinking about, talking to and palpating the foetus. All items are scored on a five-point scale. The minimum (lowest) score for the Total PAAS is 16 and the maximum (highest) is 90. The scores for subscales range from 8 to 40 for quality of attachment and 6 to 30 for time spent in attachment mode. High scores reflect a positive quality of attachment and a high intensity of preoccupation with the foetus.

The whole cohort (of fathers completing PAAS) scores are explored in Table 13 below:

Table 13: PAAS subscale statistics for Whole Cohort Positive Choices fathers completing a questionnaire

Scale Examined	No. questionnaires	Mean (SD) score	Range of scores
PAAS Total Score	13	70.92 (7.97)	56-80
PAAS Quality of Attachment Score	13	36.85 (3.29)	30-40
PAAS Time spent in Attachment Score	13	24.77 (4.25)	17-30

The mean (average) PAAS subscale scores are all towards the upper end of the possible score ranges for each scale. On average, all three PAAS subscale results indicate that the sample overall possessed a very positive quality of attachment and a very high intensity of preoccupation with the foetus antenatally.

9.4 Maternal Postnatal Attachment Scale (MPAS) Whole Cohort Results

MPAS was developed as a self-report measure to assess mother-to-infant bonding in an infant's first year of life. The theoretical framework on which the questionnaire is based is like that used for the antenatal bonding scale (MAAS). In a similar fashion to the MAAS, many of the statements ask for a response based on the mother's experience in the last fortnight. Each item has a range of 2 to 5 options reflecting the frequency with which such an experience occurs. An adjustment to allow for the different number of response categories per item is required before summing the items to obtain the MPAS total score. A higher score on the MPAS indicates higher quality of maternal attachment. The possible range of MPAS total scores is 19-95. The MPAS is also divided over 3 subscales, indicating "quality of attachment", "absence of hostility" and "pleasure in interaction". 'Quality of attachment' consists of 9 items; 'pleasure in interaction' consists of 5 items; 'absence of hostility' five items. The scores for each of the subscales are determined using the average of each of the items from that subscale, providing a range of scores for each subscale between 1 and 5. Higher scores indicate higher quality of maternal attachment.

The average (median) MPAS Total Attachment score at the first data collection point was 87.1 (out of a possible 19-95 range), with an average (median) Quality of Attachment score of 42.20 (out of a possible 9-45), average (median) Absence of Hostility score of 22.60 (out of a possible 5-25) and average Pleasure in Interaction score of 24.00 (out of a possible 5-25). This suggests that the degree and quality of attachment post intervention in this sample of service users was high.

Table 14: Median values and SIQRs for the two MPAS subscales for all Positive Choices parents completing a questionnaire

MPAS subscales	No. parents	MPAS1		No. parents	MPAS 2	
		Median (SIQR)	Range		Median (SIQR)	Range
Total Attachment Score	33	86.60 (7.45)	61.3-95.00	23	87.60(5.60)	76.00-95.00
Quality of Attachment	33	42.20(4.00)	28.7-45.00	23	41.00 (2.00)	33.20-45.00
Absence of hostility	33	22.60 (2.15)	10.60-5.00	23	18.60 (2.20)	11.00-25.00
Pleasure in interaction	33	24.00 (1.60)	13.00-5.00	23	24.00 (1.50)	20.00-25.00

9.5 MAAS and MPAS sores for whole cohort over time

MAAS and MPAS Total attachment scores did not statistically significantly change over the three data collection points, $\chi^2(2) = 1.56$, $p > .05$.

However, there was a statistically significant change over the three data collection points on the Quality of Attachment scale, $\chi^2(2) = 7.60$, $p < .05$. Wilcoxon tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a .0167 level of significance. It appeared that the Quality of Attachment statistically significantly changed from the MAAS data collection point to the MPAS 1 data collection point, $T=12$, $r = .48$. The Quality of Attachment did not statistically significantly change from the MAAS data collection point to the MPAS 2 data collection point, $T=11$, $r = .37$, or the MPAS1 and MPAS2 data collection points, $T = 37$, $r = .25$.

The evaluation is not designed to establish cause and effect relationships between variables and the sample size for the analysis of changes over time is small. Nonetheless, the statistically significant change in Quality of Attachment scores between completion of the MAAS early on in service delivery and completion of the MPAS 1 is interesting. It may suggest that the service aims of improving maternal attachment are being achieved and particularly early on in service delivery. Continuing to collect this data over time to increase sample size is warranted.

Table15: MAAS and MPAS scores over time

Scale	MAAS		MPAS1		MPAS 2	
	n	Median (SIQR)	n	Median (SIQR)	n	Median (SIQR)
Total Score	43	85.00 (7.00)	31	86.60 (7.45)	23	87.60(5.60)
Quality of Attachment	43	42.20(4.00)	33	46.00 (2.50)	23	41.00 (2.00)

9.6 MAAS and MPAS 1 scores by programme outcome

Programme outcomes were dichotomised to “Completed Programme Successfully” and “Other Outcome” (mostly “Child no longer in family custody”). The MAAS and MPAS 1 scores were compared for each dichotomised group.

There were no statistically different MAAS scale scores between the dichotomised groups. However, there were statistically significant differences MPAS 1 scale scores between the dichotomised groups, as explored in Tables 16 and 17 below:

Table 16: Comparison of MAAS scales scores for those recorded as having completed the Programme successfully and those with other outcomes

	Completed Programme Successfully		Other outcome	
MAAS scales	n	Mean (SD)	n	Median (SIQR)
Total Score	13	81.85 (8.17)	8	80.25 (12.09)
Quality of Attachment	13	45.54 (3.21)	8	45.13 (4.88)
Time spent in Attachment Score	13	31.46 (5.53)	8	30.38 (7.39)

Table 17: Comparison of MPAS1 scales scores for those who completed programme successfully and those with other outcomes

	Completed Programme Successfully (kept babies)		Other outcome (mostly did not keep babies)	
MPAS scales	n	Median (SIQR)	n	Median (SIQR)
Total Attachment Score	11	92.20 (1.90)	12	79.75 (9.85)
Quality of Attachment	11	44.00 (1.40)	12	40.10 (4.45)
Absence of hostility	11	25.00 (1.20)	12	20.90 (6.35)
Pleasure in interaction	11	25.00 (.5)	12	21.50 (2.50)

MPAS1 Total Attachment Scores for those who completed programme successfully (Median = 92.20) differed significantly from those with other outcomes (Median = 79.75), $U = 26.00$, $z = -2.47$, $p < .05$, $r = -.52$; Quality of Attachment scores for those who completed programme successfully (Median = 44.00) also differed significantly from those with other outcomes (Median = 40.10), $U = 32.50$, $z = -2.085$, $p < .05$, $r = -.44$.

Furthermore, Absence of Hostility scores for those who completed programme successfully (Median = 25.00) differed significantly from those with other outcomes (Median = 20.90), $U = 32.50$, $z = -2.286$, $p < .05$, $r = -.48$. Pleasure in interaction scores for those who completed programme successfully (Median = 25.00) did not differ significantly from those with other outcomes (Median = 21.50), $U = 38.00$, $z = -1.868$, $p > .05$, $r = -.33$.

The effect size for MPAS1 Total Attachment Scores is large (above the .5 criterion for large effect size). Effect sizes for Quality of Attachment and Absence of Hostility and were medium to large (above the .3 criterion for medium effect size). The effect size for Pleasure in Interaction was medium indicating that a fairly large effect size can still be non-statistically significant in a small sample.

9.7 Analyses of MAAS/PAAS and MPAS scores by timing of commencement of Positive Choices involvement

The stage of child at referral was classified as “Pre-birth”, “Born” (at around the birth) or “Infant” (Table 18).

Table 18: Number of parents in whole cohort completing MAAS, PAAS, MPAS 1 and MPAS2 by timing of intervention commencement

Group	MAAS	PAAS	MPAS 1	MPAS2
Pre-birth	21	9	19	11
Born (at birth)	10	2	10	9
Infant	6	1	4	3
Total	37	12	33	23

MAAS/PAAS and MPAS scores for each group were compared.

9.7.1 MAAS Scores by timing of intervention for whole cohort

37 of the mothers completed a MAAS, but some did not apparently start an intervention until after the child was born (at birth or when the child was an infant). This is possible because we know that some mothers completed a MAAS with their unborn child’s social worker before the Positive Choices intervention started. Average (median) MAAS subscale scores are summarised in Table 19. Whilst the scores for families commencing the intervention pre-birth are better (higher) than those for families starting at around the time of the birth (around the same as for those starting in infancy), the difference is not statistically significant. These measures of antenatal maternal attachment can be interpreted as mothers receiving an intervention possessed a very positive quality of attachment and a very high intensity of preoccupation with the foetus regardless of timing of intervention.

Table 19: MAAS Scores by timing of intervention for whole cohort

	MAAS Total Attachment Median (SIQR)	MAAS Quality of Attachment Median (SIQR)	MAAS Time spent in Interaction Median (SIQR)
Pre-birth (n=21)	85.00 (8.50)	47.00 (4.50)	34.00 (6.50)
Born (at birth) (n=10)	79.00 (8.00)	44.50 (6.50)	30.00 (10.00)
Infant (n=6)	85.00 (4.00)	46.00 (2.00)	34.00 (4.50)

9.7.2 PAAS Scores by timing of intervention for whole cohort

13 of the fathers receiving an intervention completed a PAAS approximately 6 weeks following initial contact with the service. Most of the fathers (n=9) completing a PAAS did so pre-birth. The numbers of fathers completing a PAAS when the child was born (n=2) and an infant (n=1) were too small to conduct a statistical analysis of these subgroups.

9.7.3 MPAS scores by timing of intervention for whole cohort

MPAS 1

32 of the mothers receiving an intervention completed a MPAS 1. Average (median) MPAS 1 subscale scores are summarised in Table 20. The sample size for the Infant subgroup was too small to report meaningful descriptive statistics. Although the attachment scores are better (higher) for families commencing the intervention pre-birth compared with at or around the time of birth, the difference is not statistically significant. These measures of antenatal maternal attachment can be interpreted as mothers receiving an intervention possessed a very positive quality of attachment and a very high.

Table 20: MPAS 1 Scores by timing of intervention for whole cohort

	MAAS Total Attachment Median (SIQR)	MAAS Quality of Attachment Median (SIQR)	Absence of Hostility Median (SIQR)	Pleasure in Interaction Median (SIQR)
Pre-birth (n=19)	87.20 (6.45\0	43.60 (6.25)	23.00 (3.10)	24.00 (1.00)
Born (n=10)	82.30 (11.35)	37.75 (5.20)	22.30 (4.00)	22.36 (1.90)
Infant (n=4)				

MPAS 2

23 of the mothers receiving an intervention pre-birth completed a MPAS 2. Average (median) MPAS 2 subscale scores are summarised in Table X. The sample size for the Infant subgroup was too small to report meaningful descriptive statistics. Whilst with reference to total scores and most subscales the pre-birth group have scored higher (better) in relation to attachment, the difference is not statistically significant. These measures of antenatal maternal attachment can be interpreted as mothers receiving an intervention possessed a very positive quality of attachment and a very high

Table 21: MPAS 2 Scores by timing of intervention for whole cohort

	MAAS Total Attachment Median (SIQR)	MAAS Quality of Attachment Median (SIQR)	Absence of Hostility Median (SIQR)	Pleasure in Interaction Median (SIQR)
Pre-birth (n=11)	90.20 (5.60)	43.00 (3.10)	18.60 (2.50)	25.00 (.50)
Born (n=9)	87.40 (5.40)	40.90 (6.50)	18.60 (3.40)	23.00 (2.00)
Infant (n=3)				