Pause Project: reducing the number of children taken into care: DfE evaluation

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Summary
The Pause Innovation Project is a voluntary programme for women who have experienced, or are at risk of, repeat removals of children from their care. Its aim is to reduce the number of children being taken into care by working intensively with women in these circumstances to improve their wellbeing, resilience, and stability. It also requires the take-up of contraception for 18 months to provide a ‘pause’ from pregnancies, in order that therapy can work. The DfE commissioned research Evaluation of Pause (July 2017) by Opcit Research and the University of Lancaster evaluates the effectiveness, potential savings through a cost benefit analysis, and implications of the approach. Recommendations are made for those thinking of implementing a programme.

This briefing will be of interest to elected Members, Police and Crime Commissioners, senior officers in Social Care, Domestic Violence, Sexual Health, Mental Health, Drug and Alcohol Abuse and Housing Services, as well as financial directors and social workers.

Background
Pause launched its first pilot in Hackney in 2013 resourced through local public health funding. By 2015 it was receiving funding from the DfE Innovation Programme to expand the pilot within Hackney, and to start working in other local authorities. It now operates in five London boroughs as well as Hull and Newcastle, and has worked with 137 women who have had two or more children removed. The Evaluation of Pause is looking at the Innovation Programme funded work. Numbers used throughout this briefing will refer to the numbers participating in an element of the programme or responding to a question rather than the total number in the project.

Briefing in Full
Pause offers women who have experienced, or are at risk of, repeat removals of children from their care, an 18-month, individually-tailored, intensive package of support, delivered by a dedicated practitioner (not a social worker) intended to address their emotional, psychological, practical, and behavioural needs. The founders felt it to be essential that the women this project aims to support benefited from a period free of pregnancy, where they can focus on themselves. A condition of this voluntary project is therefore agreeing to use an effective form of reversible contraceptive for the 18-months duration of the programme. As the Pause Programme puts it “it seeks to give women the chance to pause and take control over their lives, breaking a destructive cycle that causes both them and their children deep trauma, as well as costing the taxpayer hundreds of millions of pounds”.

The Evaluation Report collected information and used statistical analysis techniques to come to its conclusions. It also analysed qualitative data from the various professionals working with the project and client monitoring forms from the women themselves.
How does Pause work?

Pause does not work by assessing pre-defined ‘problems’ and then providing a programme to address these. It starts with the client’s life as it is, and a shared assessment of the strategies that can help to improve things. For these women the starting point is the factors that may have led to their children being removed from their care and/or the things that may make it possible to re-establish or improve contact with them. It recognises that issues such as domestic violence, drug abuse, mental health and poverty are often interlinked with each other and with a client’s emotional needs and feelings of self-worth. Intensive support work by professional workers carrying a caseload of 6 to 8 cases is provided, for period of 18 months.

Highly skilled practitioners are crucial to the success of the model. To be effective they not only need professional expertise in a relevant area, but should also be able to demonstrate belief in, and empathy for, their clients and have advanced interpersonal, communication, and relationship-building skills. They need to provide consistent and tenacious support, honour commitments to clients and be creative and solution-focused. Because of the intensity of the work they also need high levels of personal resilience to thrive in the job. Clinical supervision to address Practitioners’ own mental health needs was noted by evaluators as particularly crucial to the avoidance of burn-out.

Women starting the programme often defined their aims for the future in terms of parenting, either through having their children returned, or improving contact, or, for a smaller group, having a further child which they could care for properly. They felt Pause could help them to become more emotionally or financially stable, perhaps overcoming addiction, or improving their housing. For some Pause could be important in enabling children’s services and the courts to understand them better, and to a recognition that improved contact arrangements could be allowed. A key aim for many women was to develop good self-care and independent living skills, including budgeting, paying bills, and shopping for food and household products. Most women also reported that, before engaging with Pause, they had not received any support to deal with the psychological impact of losing their children.

Women in the group wanted support with housing, benefits, debt, health, employment, volunteering, education, or access to particular services. The report referred to a “restricted sense of agency” with participants feeling overwhelmed by the complex and intersecting range of factors affecting their lives, making it difficult for them to deal with the issues they face. Perhaps inevitably for a group who have had their children removed, there was also a sense of hostility towards professionals and social workers in particular. The report recommends that Pause Practices should avoid locating offices within local authority buildings.

An objective of Pause is to provide a therapeutic intervention which can help develop a person’s capacity to “build a more positive future for themselves”. As well as providing advocacy and practical support, Practitioners often held difficult conversations with their clients, offering challenging support to enable them to see things from a new perspective. A key issue for many women was who was responsible for the removal of their children. A significant minority reported that talking with their practitioner had enabled them to understand why their children had been removed, and to accept their share of responsibility for that outcome.

The client group

Recruitment to the programme is for those who have experienced, or are likely to experience, repeat removals of children, and is reserved for women who do not have other ties or
dependencies which might restrict them from focusing on their own needs. As a requirement of participation, women agree to take an effective, long-acting, reversible form of contraception for their time on the programme, monitored through sexual health services.

Pause practitioners observed that many women had not had the benefit of security, stability and support during their own development through childhood and adolescence and the report noted an absence of positive role models and supportive relationships, and the presence of unhealthy or abusive relationships. Women reported experiencing abuse, often perpetrated by family members, or growing up witnessing domestic violence and abuse. Women, who had experienced being in care as a child, often reported feeling a lack of reliable and loving parent figures.

In addition to the removals of 368 children from their care, the women in the group have experienced high rates of domestic violence and abuse, ‘higher risk’ drinking, Class A drug use, and involvement with the criminal justice system. Most women also reported high levels of grief associated with the loss of their children, although the majority of women still had some form of contact with their children; through supervised contact arrangements for almost half of them.

A significant majority of Pause women reported a mental health diagnosis, with almost 70% of those that answered questions on mental health revealing a diagnosis. The most common was depression, followed by anxiety, bipolar and personality disorder. Various psychological scales were used to assess self-esteem and attitudes to grief in particular. The group were classified as having low self-esteem and most of them as feeling overwhelmed by the grief they felt at the loss of their child.

Higher risk alcohol use was explained by many as a way of coping with grief, or the “constant challenges” of day to day life. A significant number also reported drug use, often perceiving a conflict between their use of drugs as a coping mechanism and their need to stop the habit to be a better mother. A smaller, but significant proportion of the group also reported some form of connection with the criminal justice system (e.g. they had been arrested, in prison, or on probation).

A very high percentage of the women had experienced domestic violence at some point in their lives. In depth work with counsellors revealed that they often faced a range of obstacles to exiting abusive relationships. These could include financial and housing insecurity, inadequate support networks, and low levels of self-esteem. Some women directly attributed this to their own experience of abuse as a child.

**Effectiveness**

The report indicates that the requirement to take an effective, long-acting, reversible form of contraception was met by the overwhelming majority of Pause women within the first few months of their engagement with the programme. This is the basis from which major short term cost savings can be made, and provides the platform that allows therapeutic work to proceed which can enable further longer term savings. The statistical analysis estimated the number of pregnancies likely to result in children being taken into care that were avoided. Compared to these women’s previous patterns of pregnancy, the estimate was 36.8 pregnancies avoided during the 18 month period. Compared to a control group not in receipt of Pause, the saving was 21.1 pregnancies.

The findings suggest an increase over time in women’s access to, and engagement with, the services they need to meet their basic needs, including GP and housing services. A significant
proportion of women began their engagement with Pause living in insecure housing. More than 25% of these women moved into secure housing during their time with the project.

Pause women, as a cohort, have experienced relatively high levels of domestic violence. Analysis during the programme produced a mixed picture: with some women reporting fewer incidents as they progressed through the programme and others still experiencing incidents of violence by the end of the evaluation.

Drug and alcohol consumption levels of a significant minority either fluctuated, or remained stable at, a relatively high level. However, just under one-third of those who started the programme with high levels of consumption of alcohol or drugs were found to have considerably reduced their intake. In some cases this resulted from an engagement with alcohol and substance misuse services.

When the measure of self-esteem was checked at various points during the programme, a mixed picture emerged, with some experiencing an increase in self-esteem, but for others there was a decrease. Similarly when the measures of loss and grief were collected during the programme some experienced a reduction in the sense of being overwhelmed, while for others there was no change, or an increase. Most women on the programme were recorded as being more resilient as the programme progressed. As this study is the first, with relatively small numbers, it may be that further work with a larger cohort, or follow up tracking of this cohort through time, will strengthen our understanding of the effects of the programme.

**Impact on other services**

At the start of the programme women reported being in contact with social care (31 women), mental health services (23 women), drug and alcohol services (19 women), housing (14 women), employment (8 women), probation (7 women), GPs (6 women), education (2 women), and Independent Domestic Violence Advisor (IDVA) services (2 women). Given the high level of needs identified in these areas, the data suggests relatively low levels of engagement with services.

Pause practitioners reported professional attitudes they found in other services as important to the success of their work. Some professionals in other services were perceived as willing to go for the ‘quick wins’, but not necessarily to engage in a hard slog with a ‘difficult’ client. Levels of understanding, willingness to be pro-active, flexible or innovative, etc. were seen as important factors by Pause Practitioners. The evaluation found the advocacy provided by Pause practitioners as very important, with the tenacity of the practitioner a key feature.

The report found collaboration and innovation to be important at a strategic, as well as operational, level. They reported that whilst partner services were invariably supportive at board level, this did not always translate into service change. Mental Health services in particular were slow to implement changes in most practices, Housing services were slow in some practices, and Probation services slow in one practice. However, the report also noted a number of significant adaptations to procedures, with important examples in housing.

Third sector organisations were found to be very supportive, understanding and flexible. Pause practitioners were overwhelmingly positive about their engagement with Sexual Health Services and their willingness to be flexible.
Cost Benefit

The analysis indicates that whilst in year 1 the costs of delivering Pause are greater than the savings realised, by year 2 a small net cost saving appears which is likely to increase in year 3 and continue for several further years as the costs of children removed into care avoided will last for some time.

The cost per woman supported was £20,202 over 18 months, equivalent to £13,468 for a 12 month period. The report suggested that costs “are likely to be offset by savings to local authorities within 2 to 3 years”. The analysis also suggested there are further future potential cost savings from reductions in levels of domestic violence, or harmful alcohol or Class A drug use.

The yearly cost savings attached to each child removal avoided are estimated at £57,102. This is the mean yearly cost of a child in care across a range of placement types (special guardianship, foster care, adoption, etc) estimated at £52,676, plus an estimate of other associated costs (a child protection core assessment, and the legal cost of care proceeding). Children & Young People Now suggest that for the authorities involved, this DfE innovation project ‘saves councils up to £2m a year’ (July 2017).

Implications/Recommendations

The report found that the removal of children had a profound and deeply traumatic effect on the women concerned which made addressing the problems that had led to the removal more difficult. Key mechanisms of change identified were:

- an intensive, bespoke programme of support addressing women’s emotional, psychological, practical and behavioural needs;
- direct advocacy to influence professional practice within partner agencies and work at the strategic level to increase Pause women’s access to partner agencies;
- a pregnancy-free period.

Enabling all of these mechanisms at the same time allowed problems to be tackled holistically. The central factors that enabled programme success were:

a) highly skilled, committed and resilient practitioners working intensively with low caseloads
b) flexibility in how interventions are delivered to each woman;
c) independence from Social Care Services, as a non-statutory, voluntary programme.
d) a full complement of Practice staff, including Coordinators and Leads;
e) effective training, management and supervision for Practitioners;
f) active Pause Boards with participation from professionals in partner agencies.

The report recommends practitioners should be equipped with a budget to spend on each individual woman. This facilitates the delivery of key elements of the support package, including therapeutic activities, and essential items, such as furniture or passports.

Efforts should focus, in particular, on implementing adjustments to improve access to health (including GP and mental health) services, housing services, and alcohol and substance misuse services

The report recommended further research to identify the medium- and long-term impact of Pause on (i) women, (ii) the number of children removed into care. It also suggested further research to
consider the relative benefits of intervening at earlier stages in women’s lives, before multiple removals have occurred.

The researchers also felt Pause provides opportunities to learn more about the kinds of support vulnerable care leavers might need to avoid entering a cycle of child removals and to identify how gaps in service provision to women with complex, and often high-level, needs can best be addressed. The report suggests that fathers who have experienced child removals might also benefit from a man-centred equivalent to the woman-centred Pause model.

**Comment**

Pause is clearly worth considering both for the cost savings it provides and the support given to a very vulnerable group at a crucial point in their lives.

It is worth noting that it is also about changing the way health and social services are delivered. In starting with the client’s circumstances and working supportively across their social context, Pause has some similarities to Multi Systemic Theory (see related Briefings) which provides intensive support to young offenders and to young people and their families when returning from residential care. The same focus on connecting across the client’s range of needs is evident. The Guardian *Mother courage: swapping pregnancy in exchange for help* (January 2017) reported the Pause founder as seeing “her future focus is on influencing commissioners so that services are designed to fit women’s needs rather than vulnerable women being told to act in a way that suits providers”.

The Guardian article also raised ethical considerations, asking whether a very vulnerable group were being put into a position where they are forced to use contraception in order to access services that they need. Whilst an important question, the responses of the women themselves quoted in the evaluation report seem to suggest that they understood its importance in giving them a period to focus on their own needs.

**External Links**


Hackney Learning Trust: [Pause – creating space for change](https://www.hackneylt.com/pause-creating-space-for-change)

CYPN: [DfE innovation project 'saves councils up to £2m a year’](https://www.gov.uk/government/publications/dfe-innovation-project-saves-councils-up-to-2m-a-year) (July 2017)


**Related Briefings**


[Social work reform – Commons Education Committee](https://www.gov.uk/government/publications/social-work-reform-commons-education-committee) (August 2016)


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