

Evaluation of Pause

Evaluation report

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Key messages

This evaluation clearly shows the value of support for women at risk of recurrent child removal, and demonstrates that:

- long-term trauma-informed relationship-based intervention provides an effective means of establishing positive changes in women's lives, meeting longstanding unmet health and welfare needs and addressing significant histories of trauma and adversity, including the loss of children into care and adoption;
- there are corresponding benefits through reductions in rates of infant care entry, with indications that the presence of Pause in a local authority has a cumulative effect, as increasing numbers of women go through the service and *continue* to avoid further child removals post-intervention; and
- the costs of intervention are offset by significant financial savings to the public purse.

Assessment of benefits to existing children is beyond the scope of the evaluation, but there are likely to be concomitant benefits for children, given that women and professionals consistently reported improved relationships with children and their carers, in diverse placement and permanency arrangements.

The intervention is effective across population subgroups, including for younger women, care leavers and those who only had one child removed. There was no evidence of reduced effectiveness in new practice areas or in the care leavers pilot, with regard to targeting of eligible women, approaches to practice, and benefits associated with the intervention. It may therefore be concluded that scale-up and diversification has been successful, and maintains consistency with the Pause model.

The benefits reported through the evaluation indicate scope to explore extension of the model as follows:

- the findings provide convincing moral and fiscal arguments for the development nationally of trauma-informed relationship-based support for women who have had a child removed, to prevent risk of recurrence (especially for young women) following the first removal of a child¹;
- given heightened risk of child removal for care-experienced women who become pregnant at a young age, and the sharpened ethical duty of the state as their corporate parent (and 'corporate grandparent' to their children), there is a

¹ See Broadhurst et al. (2017)

particularly strong argument for the extension of this kind of support for young women who are looked after or care leavers;

- finally, while not tested through the evaluation, it can also be hypothesised that similarly resourced and designed work would have preventive value for intervention with women involved with child protection services *before* the removal of a child into public care.

The work is challenging, and depends on a well-supported workforce. Key elements of the approach include:

- an emphasis on working *with and for* women through a trauma-informed relationship-based approach to collaborative engagement that recognises women's strengths and needs, flattening hierarchies and allowing a very different sort of relationship than women have encountered with other professionals;
- recognising the distinctive experiences of complex grief and unresolved loss that are the 'collateral consequences' of child removal;
- practitioners who have the time (in terms of duration of intervention and capacity within workloads), core skills and knowledge for tenacious, relationship-based and trauma informed practice; and
- access to a flexible financial resource, which plays a crucial role in enabling tailored, responsive practice, including capacity to mitigate risk in emergencies.

These features of practice are relevant to work with birth parents across child and family social care.

The process of identifying eligible women for the intervention is necessarily complex, and the research indicates it would be valuable to incorporate family-level indicators into SSDA903 returns. This would make it possible to identify – and facilitate response to – recurrent removals, with added benefits for other policy areas, such as enabling analysis of sibling placement arrangements.

Funding insecurity is a critical consideration for many public services, but continuity may be particularly important for services such as Pause which are predicated on building safe and stable relationships through long-term intensive work.

The extent and complexity of women's needs means that inter-agency involvement is critical to establish a foundation for change that endures beyond the intervention. The need for accessible adult services is relevant across work with child and family social care and child protection; this includes ensuring welfare entitlements and access to safe and secure housing, and specialist support to address significant physical and mental health needs and risk of domestic violence, and to support women's sexual and reproductive health.

The level of cost-benefit evidenced in this evaluation is significant, but the research also indicates the importance of post-intervention Next Steps support, which was developed over the course of the evaluation, and not part of the Innovation Programme investment. The findings indicate an argument for further development and evaluation of an extended service model, offering triaged, reduced but sustained relationship-based support after the intensive intervention is complete, to assess value for money, benefits for human rights, individual well-being, and maintaining reduced risks of future children entering care.

Executive summary

Introduction

This report presents findings from an evaluation of Pause, beginning in March 2018 and supported within Round 2 of the Department for Education's Children's Social Care Innovation Programme. The research was conducted in the context of growing concern² about the risk of 'subsequent removals' of children from mothers who have had children removed into care, and the need to support this vulnerable population of women.

The project

Pause as a national non-governmental organisation (NGO) supports local practices to deliver relationship-based support to women who have experienced removal of at least one child and are judged to be at risk of further removals of children. Established in 2013, Pause was funded to expand in Round 1 of the Innovation Programme, and Round 2 funding enabled further scale-up to 9 new areas in England and development of a pilot for young care-experienced women who have had one or more children removed. The Pause model of intensive trauma-informed relationship-based practice is delivered by practitioners over an 18 month period, and practitioners work flexibly according to women's own perspectives and priorities. The Pause Framework (2017 p8) states that, 'As a condition of beginning this voluntary programme, women agree to use the most effective reversible methods of contraception; [...] Long Acting Reversible Contraception (LARC) so they have the opportunity to reflect and focus on their own needs, often for the first time in their lives.'

The evaluation

This complex realist evaluation examined: **process and implementation**, including evidence of variations in practice associated with roll out and diversification; engagement with eligible populations, including the extent to which the model meets women's reported needs; and **evidence of impact**, in reported change in women's lives, and reduced rates of care entry, including assessment of cost-benefit. The multi-method design included:

- (i) difference in difference analysis of rates of infant care entry in Pause Round 1 and comparator local authorities with no alternative recurrence service, with a cost-benefit analysis examining projected savings;

² See [Research in Practice Change Project on Working with Recurrent Care-Experienced Birth Mothers](#)

- (ii) secondary analysis of: Pause ‘outcomes tracker’ data (N=215 with longitudinal data); and identification and prioritisation data from two practices;
- (iii) longitudinal interviews with: 49 women working with Pause currently and 12 who worked with Pause in Round 1 of the Innovation Programme;
- (iv) interviews with Pause national, regional and local staff (N=47); and
- (v) interviews with senior local authority stakeholders (N=10), representing 8 local authorities: 4 Pause and 4 comparators (including 3 areas with alternative recurrence services).

Key findings

Does Pause have an impact on rates of infant care entry?

There is a statistically significant reduction in rates of infants (<12 months) entering care in local authorities with Pause Round 1 practices, compared to an increase in comparator sites over the same period. Based on published SSDA903 data, in five areas where Pause has operated continuously since Round 1 of the Innovation Programme, the number of infants entering care is reduced by an average of 14.4 per annum per local authority – equivalent to 215 children over three years in the five sites. The estimated benefit to cost ratios associated with these effects are £4.50 per £1 spent on Pause over 4 years and £7.61 per £1 spent over 18 years.

Does Pause intervene with eligible populations of women?

Pause identifies and supports a highly vulnerable population, with a recent history of child removal and significant, chronic and complex intersecting needs that were often unmet at the beginning of the intervention. Women in the Pause population ranged from 18 to 44 years of age; the largest proportion (32%) were aged between 25 and 29 years. The number of children women have had removed ranged from one to 13, but most (68%) had three or fewer children removed. At least 40% of women reported contraceptive use prior to the intervention, but considering this finding in light of the comparative analysis (above), it may be concluded that Pause reduces rates of infant care entry in a local authority *even if* a significant proportion of women may already be using contraception pre-intervention. The implication is that other features of the Pause approach make a key contribution to the effects shown in the difference in difference analysis.

Is there evidence of change in women’s lives?

Longitudinal evidence of positive change for women in Round 2 practices and in the care leavers pilot indicates that scale-up and diversification was successful. Across all areas, the research shows significant improvements, within and beyond the intervention, in key aspects of women’s lives, including:

- improved emotional well-being and reductions in psychological distress;
- housing and financial security, with significant reductions in rent arrears, and the number of women who were homeless or in unstable accommodation almost halved;
- increased engagement in education, employment and specialist services, including a 60% increase in the proportion of women in paid employment; and
- improvements in key relationships in women's lives, including relationships with existing children and their carers, with a 25% increase in the proportion of women reporting face-to-face contact with children.

Comparing women who reported using contraception prior to Pause with those who did not revealed very few differences in trajectories or outcomes. Across the population as a whole, stabilisation in women's lives and positive change in their sense of self appears to scaffold longer-term change, and these impacts were consistently described as being enabled by the intensive relational trauma-informed Pause approach. The duration and staging of intensive intervention allows time to establish trust, stabilise women in relation to key vulnerabilities including housing and financial insecurity, and untangle complex, previously unmet needs in order to scaffold access to and engagement with multiple specialist services. Life continues to be complex for many women post-intervention because of factors outside the scope of the intervention (for example, welfare; housing; complex risk in family or ex-partner relationships). Pregnancies for women using contraception post-intervention highlight the importance of sexual and reproductive health services for this population. Maintaining the benefits of the programme as a foundation for long-term change was enabled by welfare entitlements and the accessibility of specialist services for complex needs, as well as gradual transitions and Pause Next Steps support.

What are the key features of the Pause approach?

Across Round 1 and 2 practices and in the care leavers pilot, women and professionals gave highly positive and consistent accounts of the distinctive value of **holistic relationship-based trauma-informed intensive support**. A fifth of women in the main interview sample raised concerns about contraception, and ethical questions about conditionality were raised by one in six women and also by some practitioners. In local authorities working with alternative models to support recurrent-care experienced women, concerns about conditionality were among the factors said to have informed decisions about commissioning. **Small caseloads** (maximum eight women) and **duration of involvement** appear to be crucial ingredients in establishing change, delivered by a skilled workforce with time and capacity within workloads, and multi-disciplinary knowledge. **Staffing continuity** is important, but could be undermined by funding insecurity. The availability of a **flexible financial resource** for each woman is a

distinctive feature of the Pause model, which played a key role in enabling tailored, responsive practice and in exceptional circumstances could mitigate risk in emergencies. **Next Steps support** was developed over the course of the evaluation period, and was not directly funded through the Innovation Programme. However, both women and professionals highlighted the value of this 'safety net', and the importance of practice capacity to ensure gradual transitions and provide flexible post-intervention support when necessary to maintain change over time in complex lives.

Lessons and implications

- Long-term, intensive, trauma-informed relational work, delivered by skilled practitioners with small caseloads, is clearly effective in reducing rates of infant care entry for local authorities.
- Benefits for younger women, including the care leavers pilot and those who have only experienced removal of one child, indicate clear ethical and economic arguments for extending the model to *all* women who have a child removed into care.
- Benefits to existing children can be hypothesised given consistent reports of improved relationships with children and with carers, across diverse placement and permanency arrangements.
- The evaluation did not compare the impact of Pause with alternative models that do not use contraceptive conditionality, but findings indicate the timeliness of the planned Pause review of practice in relation to sexual and reproductive health, and the need for reproductive health services to work alongside recurrent care provision.¹
- Evidence of positive change in women's lives within and beyond the intervention is relevant to recurrence services *and* other provision for vulnerable populations. The research indicates a clear need for trauma-informed cross-sectoral approaches that link child and adult services, with a critical role for benefits, housing and health services in particular.
- Accessible support helps women deal with potentially destabilising challenges post-intervention, indicating the value of investing in Next Steps support.

1. Overview of the project

Project context

Overall rates of children in care have increased significantly – from 43 to 64 per 10,000 children in the last 23 years (1994-2017). Increased rates of care entry are attributable to a complex mix of factors (Thomas 2018; Bywaters et al. 2018), but recent CAFCASS data² show a growth in care orders since 2009. Broadhurst et al. (2018) found that the rate of newborns in care proceedings more than doubled between 2007/8 and 2016/17, and across policy and services there has been growing awareness and concern about rates of recurrent care proceedings. Broadhurst and colleagues' analyses of CAFCASS data on 65,000 family court proceedings (2015a; 2017; 2018) revealed how commonly recurrent child removal takes place, reporting that one in four women returned to the family court with subsequent children. This research also documented the vulnerability of these women. Most had histories of significant complex trauma; approximately 40% had been looked after children (and late care entry and multiple placement moves were reported by half), and at least two-thirds had experienced abuse and/or neglect in childhood. Women in recurrent proceedings were also likely to have been younger when they had their first child (45% were under 20 years). It is also well-established that young women who have been in care are more likely to experience a clustering of risk factors associated with teenage pregnancy (e.g., Chase et al 2006; Barn and Mantovani 2007; Roberts et al. 2019), and these risk factors in turn make care-experienced women more vulnerable to difficulties that could lead to child removal. Growing evidence of the collateral consequences of child removal also illuminates potential pathways to recurrence, as the trauma of child removal may exacerbate risk in other aspects of women's lives (see Broadhurst and Mason 2020).

A growing number of targeted initiatives have been developed to support women who have experienced recurrent removals of children into care, some of which also report positive findings from independent evaluation (for example, Cox et al. 2017; Roberts et al. 2018). Pause was one of the first such services to be established, in the London Borough of Hackney in 2013. It has since developed into a national organisation, delivering intensive, individually-tailored relationship-based practitioner support over an 18 month period to women who have experienced, or are judged to be at risk of, recurrent removal of children. The development of Pause has been supported through DfE Innovation Programme funding since 2015, when Pause was awarded £4.2m in Round 1 of the Innovation Programme to expand its intervention support package to seven areas nationally.³ In 2017, Pause was allocated £6.8m in Round 2 of the DfE Innovation Programme, to scale up and roll out the model to nine other areas,⁴ and develop and implement a care leaver pilot (in Round 1 practices⁵) that targets care-experienced women (aged 16-25) who have had one or more children removed. Alongside the DfE investment, practices supported through Round 2 of the Innovation

Programme had to secure matched funding. Pause has also expanded into other areas and at the time of the evaluation, had 25 practices across the UK. Pause was evaluated in Round 1 of the Innovation Programme; the research concluded that the programme had a significant, positive impact and that the costs of delivery were likely to be offset by savings to local authorities (McCracken et al. 2017).

Project aims and intended outcomes

Pause works with women who have experienced removal of at least one child (most often, at least two children),⁶ and who currently have no resident children and are not pregnant; are judged to be at risk of further removals of children – whether into care or adoption, or extended family arrangements (formal or informal). Participation in the programme is voluntary, and as a condition of access, within the first 16 weeks of engagement women consent to using long-acting reversible contraception⁷ for the duration of the intervention, on the premise that the combination of relationship-based intensive support and a pause from pregnancy (facilitated by the contraception) creates space for possible change. Pause has continued to refine its theory of change over the course of the evaluation (Appendix 1), but the overarching aims remain consistent. The theory of change sets out **4 direct outcomes**:

- fewer pregnancies;
- better engagement with services;
- improved stability;
- better well-being and sense of self.

These are hypothesised to contribute to **4 long-term outcomes**:

- women have more control of their lives;
- fewer children are taken into care;
- women have better relationships;
- budget savings.⁸

Of course, these broad outcomes are not mutually exclusive and relationships between aims of the intervention are therefore complex. Some will inevitably follow others – most notably, budget savings as a result of fewer children taken into care. Some outcomes might be hypothesised, but are not measurable within the scope of this evaluation. In particular, it seems likely that improved relationships with children previously taken into care would support a range of child outcomes, given an international literature which

documents the benefits of good quality contact for children and young people, and conversely, the negative impacts of poor quality contact, both in care and adoption contexts (for example, Neil et al. 2015; Sen and Broadhurst 2011). Equally, improvements to support through better engagement with services might benefit most other outcomes in the theory of change, but this may not correspond straightforwardly with budget savings, depending on the costs associated with identifying and meeting previously unmet needs.

Project activities

The Pause model is predicated on trauma-informed intensive relationship-based practice, driven by women's own perceived needs and priorities, with practitioners working flexibly and responsively to facilitate change, supported by a dedicated budget allocation for each woman, designed to 'ensure that practitioners are able to, where necessary, pay for things that might otherwise not be available through normal services' (Pause 2017, p32). The theory of change (Appendix 1) places the relationship with the practitioner at the centre of the intervention, generating space for change through 'an intensive and tenacious bespoke support package'. Activities include support to:

- (i) **stabilise lives**, including: domestic abuse support; income review and support to take up benefits and address debt; support to access safe and secure housing; support to reduce alcohol or drug misuse; support to reduce offending; support to engage in learning or work;
- (ii) **develop a sense of self**, through: a safe, supportive relationship with a practitioner; fun activities with an element of risk-taking (including those designed to build strengths and develop new skills, and to explore new experiences); support to address bereavement and loss; mental health support including access to talking therapies; support to establish positive relationships, including appropriate contact with children; support to improve interaction with professionals; and
- (iii) **access effective contraception and have regular sexual health check-ups**, including uptake of a method of long-acting reversible contraception (LARC) unless this is contra-indicated for medical reasons.

Activities take the form of one-to-one key work, group activities, and 'Pause Next Steps' support (including groups) for women who have completed the intervention. Potentially eligible women are identified through a scoping process, initiated by the local authority, to establish the eligible population (and for new practices, the potential projected financial cost-benefit). In new areas, this is done before Pause goes 'live'. If the local authority decides to proceed after initial scoping, practices review the data to decide which women to prioritise for intervention, and the process of engaging women

begins. The total intervention period (including engagement) is 18 months. Each practitioner works with 6-8 women who are 'open' on the programme.⁹ At the time of starting the evaluation, there were on average three practitioners in each practice area, with an extra practitioner funded through the care leavers pilot in each of the Round 1 sites.

2. Overview of the evaluation

Evaluation questions

The evaluation is designed to integrate attention to *process* and *outcome*. This corresponds to recent Medical Research Council (MRC)/NIHR draft guidance on evaluating complex interventions (Craig et al. 2019), and Greenhalgh and Papoutsis's (2018) observation that complexity does not only lie within the intervention *or* the system, but in the interaction between the two. They comment that:

'The gap between the evidence-based ideal and the political and material realities of the here-and-now may be wide. [...] The articulations, workarounds and muddling-through that keep the show on the road are not footnotes in the story, but its central plot. They should be carefully studied and represented in all their richness' (op.cit. p2).

This depiction of rich and contingent complexity is highly relevant to understanding the efficacy of the Pause programme, and demands a pluralistic approach to evaluation. The research was designed to address three core areas: **(i) Process and implementation:** the extension and roll out of the Pause model into new practice areas and the care leavers pilot, as well as the development of post-Pause support; **(ii) Engagement:** the extent to which Pause engages with eligible populations of women and meets the needs of women who participate; and **(iii) Impact, costs and benefits:** in relation to the Pause theory of change, and with regard to maintenance of benefits from Round 1 intervention beyond the end of the programme; benefits to specific evaluation populations; and avoidance of potential secondary externality costs, including prevention of placement of future born children. A detailed account of methodology is in Appendix 2.

Evaluation methods

Rates of infant care entry in Pause and comparison sites

Difference in difference analysis addressed the question: **“Does the presence of a Pause service in a local authority lead to a reduction in the numbers of very young children entering care?”**. This analysis utilised published SSDA903 data in Pause Round 1 and matched comparison local authorities; the outcome measure was the rate of care entry below 12 months, per 10,000 children under 12 months old.¹⁰ The focus on Round 1 authorities enabled assessment of long term change, testing the hypothesis that the effect on rates of looked after children is cumulative, such that women leaving the Pause service will be at lower risk of subsequent child removals. Seven matched comparator authorities were identified as having no known recurrent care service,¹¹ working in similar contexts and with similar prior trends in infant care entry. Matching

variables include poverty rates; Ofsted inspection judgements at the time of intervention; the mean rate of care proceedings prior to the intervention; and the percentage of children leaving care who were aged between one and five. The difference in difference analysis formed the basis of a subsequent cost-benefit analysis, examining projected savings to local authorities associated with impact on infant care entry.

Secondary analysis of Pause data

Pause case identification processes: Following early stage consultation within Pause about identification processes, a review was conducted of all available data on eligible cases in one Round 1 and one Round 2 practice area. **Secondary analysis of Pause project monitoring data:** Pause provided anonymised monitoring data for all practice areas, including outcomes tracker data (baseline, midpoint and endpoint), including characteristics of women who have 'opened' with the programme and progress indicators, including adapted and standardised measures. Analysis examined baseline characteristics and change over time, for the sample as a whole (all practice areas), across practice areas, and in relation to subgroups of interest (for example, age, baseline characteristics). Monitoring data related to 25 Pause practices and analysis of change relates to 517 women with outcomes tracker data at any stage: 185 women had data at baseline, midpoint *and* endpoint and 215 had data at baseline and endpoint. When *no* differences were identified between subgroups, negative findings are not reported.

Qualitative longitudinal research with women who participate in Pause¹²

Interviews were conducted with 61 women who have worked with Pause. **Current population:** Up to 4 interviews were conducted with 49 women (six Round 1 and five Round 2 practices), over a period of up to 20 months. All were 'open' with Pause at Time 1, and recruited to the study as early as possible within the intervention. Not all women participated in all 4 interviews, but at least one post-intervention interview was conducted with 32/49 (65%) women. **Post-Pause population:** Up to two interviews were conducted with 12 women (six practices) who worked with Pause in Round 1 of the Innovation Programme and were identified by practices as providing exemplars of different pathways post-intervention; 11 were interviewed twice over 6-9 months.

Professional stakeholder interviews

Pause professionals: Interviews were conducted with 47 Pause professionals, including the national scoping team; national leadership team; national practice leads; the Pause founder; Round 1 and Round 2 practice leads; and practitioners (three Round 1 practices, three Round 2). **Local authority stakeholders in Pause and comparison sites:** Telephone interviews were conducted with local authority stakeholders: eight LA strategic managers, including four Pause practice areas (two Round 1 and two Round 2); three of the comparator LAs had an alternative service targeting women or families at risk

of recurrence, and one was developing a service; we also interviewed operational leads in two LAs with alternative services targeting risk of recurrence.

Changes to evaluation methods

Amendments to the original design include: (a) revisions to case identification analysis, based on learning about Pause processes; (b) amendments to the timing of qualitative longitudinal research with current service users, and the decision not to conduct interviews and observations in Pause Next Steps groups; (c) a revised approach to sampling women in the 'post-Pause' cohort; (d) no cost-benefit analysis based on Pause monitoring data because there was no appropriate counterfactual; (e) no comparator group of local authorities with alternative services for women at risk of recurrent child placement within analysis of local authority SSDA903 data. See Appendix 2 for details.

Limitations of the evaluation

The complex realist evaluation design utilises multiple sources of triangulation, enabling high levels of confidence in the findings. Key limitations are as follows. It was not feasible to include a counterfactual within the qualitative longitudinal or monitoring data components of the design; sample attrition may also be associated with systematic bias for these components, and there is some missing data as well as variability of timing in the Pause monitoring dataset. The difference in difference approach has not been widely used in evaluating children's services interventions, and is an important innovation in our methodology, but it may under-estimate the impact and cost-benefit of Pause because it focuses on area level effects; it is not possible to identify recurrence within SSDA903 data returns. Hence counterfactual analysis provides an indirect measure of the effect of Pause and there are also limitations in the availability of data (for example, suppression of low values in published data). Difference in difference analysis focuses on Round 1 practices, and it cannot be assumed that the results will be replicable in other practice areas, but analysis of qualitative and monitoring data provides context for gauging the potential generalisability of the comparative analysis. Focusing on Round 1 practices also makes it possible to account for post-intervention effects. There are also distinct benefits in evaluating area-level effects, making it possible to assess the impact of Pause against DfE outcomes framework priorities (reduced days in state care) as well as the Pause theory of change (fewer children are taken into care).

The evaluation assesses change within the Pause population and impact in comparison to local authorities with no alternative service. It has not assessed the effectiveness of Pause versus alternative recurrence services, nor can conclusions be drawn about the role of distinctive features of Pause versus other approaches. The research has not compared Pause with provision that is not conditional on use of LARC, and it is beyond the scope of the evaluation to assess whether the contraceptive requirement is a critical

component of efficacy. There is a risk that inappropriate comparison (for example, in relation to scale and duration of service) would give a misleading representation of the efficacy of Pause relative to alternative approaches. These caveats are discussed further in Appendix 3. However, work is underway, led by Research in Practice and funded by Public Health England, to map provision of services with women at risk of recurrent child removal. Reporting in early 2021, this project aims to establish a national picture of service funding, thresholds and conditions of access (for example, contraception), and will provide a basis for understanding the range of practice activity with this population of women, comparing resources and outcomes with a view to developing equitable provision across England. Bearing those caveats in mind, qualitative and quantitative evidence relating to contraception is discussed where relevant in the report, including in the analysis of monitoring data detailed in Appendix 6.

3. Key findings

Evidence of the impact of Pause

Rates of infant care entry in Pause and comparison authorities

The Pause intervention works with women who have experienced the removal of children into care or adoption, and who have been identified as being at risk of future children being removed from their care. A central question for the evaluation was therefore whether the intervention ameliorates this risk, and specifically, whether the presence of a Pause service in a local authority leads to a reduction in the numbers of very young children entering care. The answer to this question is yes.

A detailed account of the difference in difference analysis is given in Appendix 3, but Figure 1 provides a visual representation of the results. The analysis takes the 'post-intervention' point as 2016-17, allowing that following Round 1 funding in 2015, practices would need time to recruit staff and identify and engage women. There is a statistically significant fall in the rate of care entry in Pause practices, relative to matched comparator authorities, such that Round 1 Pause sites experienced a reduction in the rate of children under 1 entering care, compared to an increase in the comparison group.

Figure 1: Mean rates of infant care entry: Pause Round 1 and comparator authorities, 2012-19

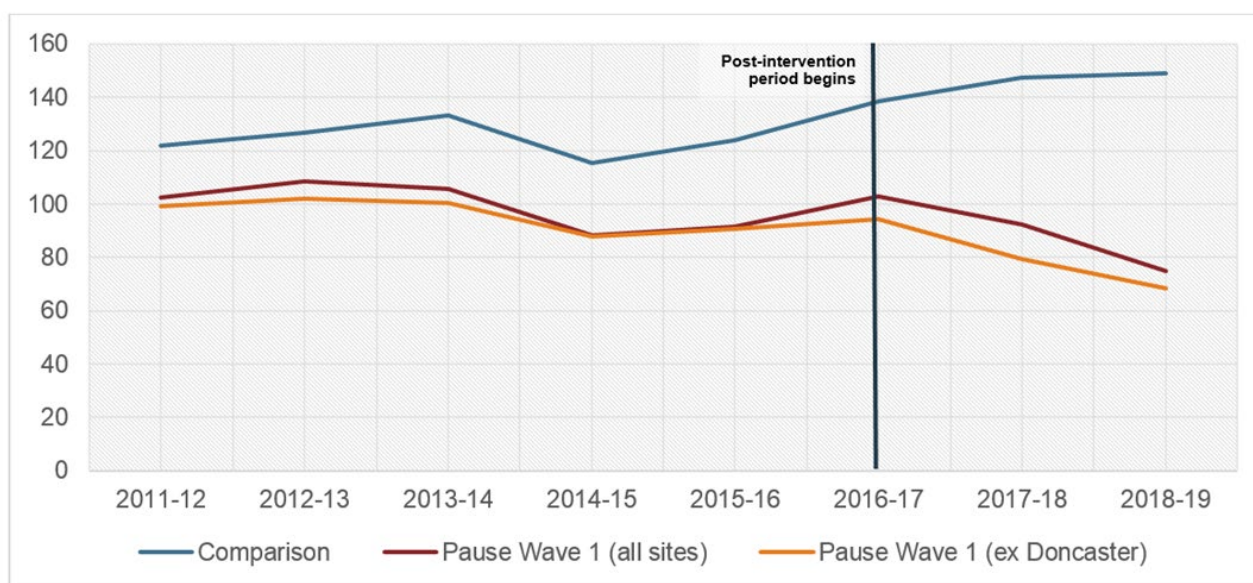


Figure 1 also shows these patterns with and without Doncaster, as Pause provision in the Doncaster practice was interrupted when the practice closed after the end of Round 1 Innovation Programme funding; it restarted work in 2018. The analysis indicates that the effect of Pause on reducing rates of infant care entry is *smaller* when Doncaster is included. As detailed in Appendix 3, Doncaster saw an increase in rates of infant care entry between 2016/17 and 2017/18, when rates in the other Pause authorities start to

fall; Doncaster then saw a sharp fall between March 2018 and March 2019, which corresponds to the period when the practice started again. In summary, two key points emerge. First, while both Pause and comparator authorities have parallel trends prior to the intervention, Round 1 Pause authorities do not begin to diverge significantly from the trends in the comparison group until 2016-17. This shows that the reduction in rates of infant care entry corresponds to the introduction of Pause. Second, considering the analysis with and without Doncaster, the findings indicate that the presence of Pause has a cumulative effect, as increasing numbers of women go through the service and *continue* to avoid further child removals post-intervention. These findings indicate that continuity in provision is likely to be beneficial for the impact of the service.

Value for money

To conduct cost-benefit analysis, the rates identified in the difference in difference analysis were used to estimate the change in the number of children under one entering local authority care (see Appendix 4 for a detailed account, including comparisons with and without Doncaster). As detailed in Table 1, based on the five practices where Pause operated continuously, the number of children below 12 months entering local authority care is estimated to be reduced by an average of 14.4 per annum, per local authority, which aggregates to 215 children over three years and five sites. Calculations focused on cost savings associated with fewer children entering local authority care in the five sites, relative to Pause delivery costs (average £300k per annum per practice; the cost of five sites between 2016 and 2019 is estimated at £6.0m¹³) and assuming that impacts are durable to the age of 18 years. Calculated cost savings are linked to (a) cost of proceedings and (b) length of time and destinations in local authority care. On this basis, cost savings on pre-birth assessments and proceedings are estimated at £8.9m over three years. The calculated cost savings per child not taken into local authority care *not* including costs of pre-birth assessments and proceedings corresponds to a discounted estimate of savings of £17.9m over 4 years, and £36.5m over 18 years.¹⁴ Table 2 summarises the overall value for money of the Pause model based on these calculations. The estimated benefit to cost ratios (savings per £1 of cost) are calculated at £4.50 over 4 years and £7.61 over 18 years. Even at the lower bounds of confidence intervals (see Appendix 4), the savings exceed HM Treasury (2018) thresholds for assessing acceptability in value for money (normally a saving of £2 for every £1 spent). Moreover, it should be noted that these projected savings are very likely to be an *under*-estimate of the cost-benefit of the intervention because (in the absence of a counterfactual) the calculations do not account for benefits accrued to women participating in the programme (for example, related to reductions in high cost service use, engagement in employment, or increases in well-being). Analyses of qualitative and monitoring data, discussed below, demonstrate positive change in these domains, suggesting that the true cost-benefit of the model will be greater than reported here.

Table 1: Rates of reduction in infants entering local authority care

| Practice areas | (a) Average annual no. children under one taken into LA care per 10,000, 2016-19 | (b) Cube root of (a) | (c) Average number of children under one per LA area, 2016-19 | (d) Average number of children under one taken into LA care, per annum, per site |
|---|---|---------------------------------|--|---|
| Round 1 Pause LAs | 81.0 | 4.33 | 4188 | 33.9 |
| Comparator LAs | 115.3 | 4.87 | 4188 | 48.3 |
| Net reductions in removals per annum, per LA | | | | 14.4 |

Table 2: Cost-benefit of the Pause intervention (based on five Round 1 practices)

| Time horizon | Present value of delivery costs (£m) | Short-term cost savings via pre-birth and proceedings (£m) | Longer term cost savings (£m) | Total cost savings (£m) | Benefit to cost ratio (£s cost savings per £1 spending) |
|---------------------|---|---|--|------------------------------------|--|
| 4 years | 6.0 | 8.9 | 17.9 | 26.8 | 4.50 |
| 18 years | 6.0 | 8.9 | 36.5 | 45.4 | 7.61 |

Characteristics of the Pause population

A key question for the evaluation was whether Pause successfully targets eligible populations of women at risk of recurrent removal of children. The impact analysis presented above indicates that this is the case. That conclusion is reinforced through triangulation of analysis of Pause identification processes and administrative data on women’s characteristics, and qualitative interviews with professionals and with women in the post-Pause and current population samples. The analysis shows that Pause identifies and supports a highly vulnerable population of women, with high levels of chronic and complex intersecting needs (including in relation to mental health, finances and housing, alcohol and substance use, and experiences of trauma and violent relationships). Basic needs (including benefit entitlements and housing) were often unmet at the beginning of the intervention, and this could exacerbate risk in other aspects of women’s lives. These

findings are consistent with the Round 1 evaluation (McCracken et al. 2017), which also highlighted the range and complexity of women's needs.

Identification and engagement of eligible women

The process by which Pause identifies eligible women (hereafter referred to as the Pause identification process) involves three core elements:

- (a) desk review of local authority case files to identify women who meet inclusion criteria for the programme;
- (b) a triage prioritisation of women for targeted engagement activity, producing a shortlist; and
- (c) a period of engagement, from which a final population of women described by Pause as 'open and on' the programme is established.

Unsurprisingly, identification processes varied between Round 1 and Round 2 sites; Round 1 sites were working with their second or in some cases third cohort of women, and this informed their approach to prioritisation (see Appendix 5). In Round 1 sites, scoping and identification of eligible women drew on established links with children's services and the legal team; partner agency referrals (for example, substance abuse, mental health, domestic violence, housing, health services, probation service, police); and re-contacting women who did not take up the offer of support in the first cohort. In Round 2 practices, the local authority (or in some cases the Pause scoping lead) undertook a scoping exercise to gain an understanding of the eligible population of women (either done by a social worker or, in some cases, the IT team), based on searching case file records of children entering care in the last five years. Relevant data are recorded on a bespoke spreadsheet and sent to a Pause analyst for cleaning. Local contextual knowledge was clearly valuable as data on women at risk of recurrence were not straightforward to obtain. For example:

They gave criteria to some IT people and data people to come up with a list and to be honest, it was awful. [...] And I looked at the list and knew straight away that it wasn't right because in my head I knew of women that should have been on that list. [...] I went back to the raw data, which was basically anyone who'd had a child removed in the last three years. [...] and just, yes, went line by line. (Round 2 practice lead)

Whilst not specifically discussing scoping processes, a local authority data analyst also discussed issues with identification of recurrence in SSDA903 data returns:

I would probably advise that care proceedings would be a useful dimension to integrate into the SSDA903 return which then links through to packages of care and placements. [...] Software developers would need to [...] build in a more structured

approach with a workflow which brings key dates and decisions together rather than the current set up which does not seem to format the proceedings in a useful way.

Without such systems in place, practice identification processes inevitably adapted to data availability and local knowledge. Most worked with women who had two or more children removed, but the care leavers pilot and some other areas included women who had experienced removal of one child and were judged to be at risk of subsequent removals. Other eligibility factors included: children having entered care in the last 3-5 years (or birth within the last 5 years); woman not pregnant and no children at home; not over 40 if no child in the last 3 years. In line with the Pause model, there was flexibility if women did not meet eligibility criteria but there was a clear rationale for inclusion (for example, last removal more than five years ago, but multiple pregnancies since then). Practices do not have capacity to work with *all* eligible women, and so there was often a process of prioritisation once women were identified as eligible, drawing on information from case files and discussions with key professionals. Practices varied in approaches to prioritisation and in how much information they gathered, but all had systems for collation of pre-engagement information. The analyses of case identification processes detailed in Appendix 5, from an exemplar Round 1 and a Round 2 practice, indicate that both practices were engaging with eligible populations of women (see also Figures 2 and 3) with significant, complex needs and a history of recent child removal. This conclusion is triangulated by monitoring and interview data. Nonetheless, the development and standardisation of pre-engagement data collection would be useful to enable comparative analysis across practices of the characteristics of women who do or do not engage, and this would enhance Pause capacity for organisational learning.

Figure 2: Characteristics of women by prioritisation in a Round 2 Practice (averages)

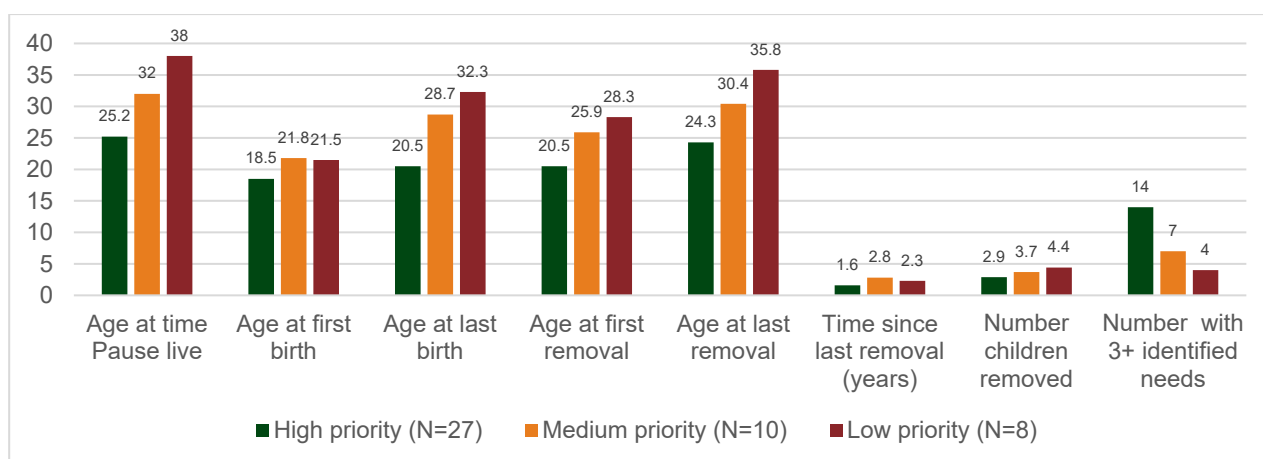
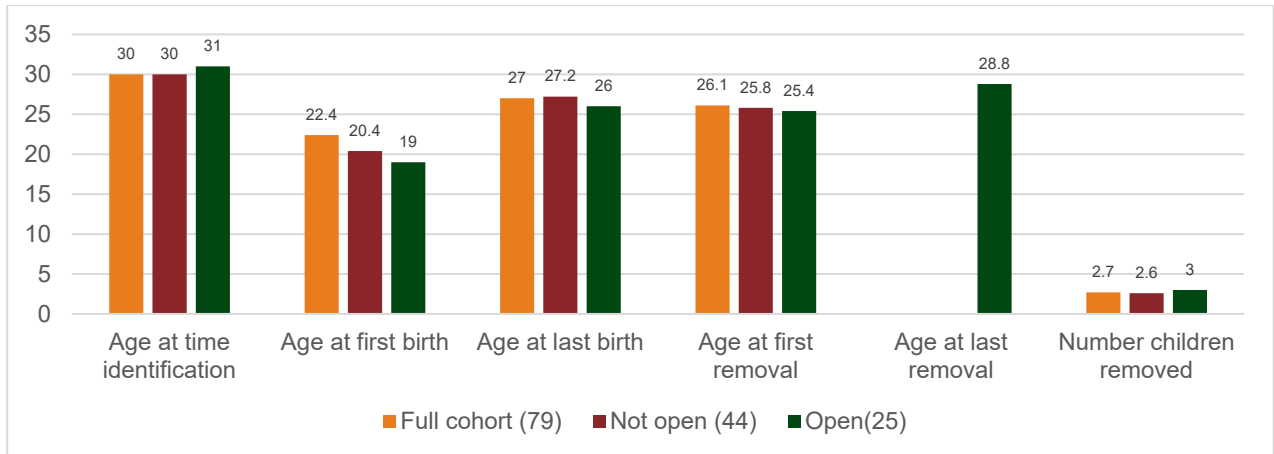


Figure 3: Characteristics of eligible women by whether 'open' in a Round 1 Practice (averages)



Women's reported needs

Monitoring data and interviews with women and professionals show that women who work with Pause have significant and complex needs across multiple domains. There was no evidence of systematic differences between Round 1 and 2 practice areas, although women in the care leavers pilot have some distinctive needs as discussed below. Comparing women who reported using contraception prior to Pause with those who did not indicates there are no systematic differences in recorded pre-intervention characteristics (see Appendix 6 for more detail). Figure 4 shows monitoring data analysis of professionally reported¹⁵ issues at baseline. As with case identification analysis, there are high levels of need related to mental health, domestic violence, drug or alcohol issues, and/or learning difficulties.

Figure 4: Professionally reported issues in baseline monitoring data (N=517)

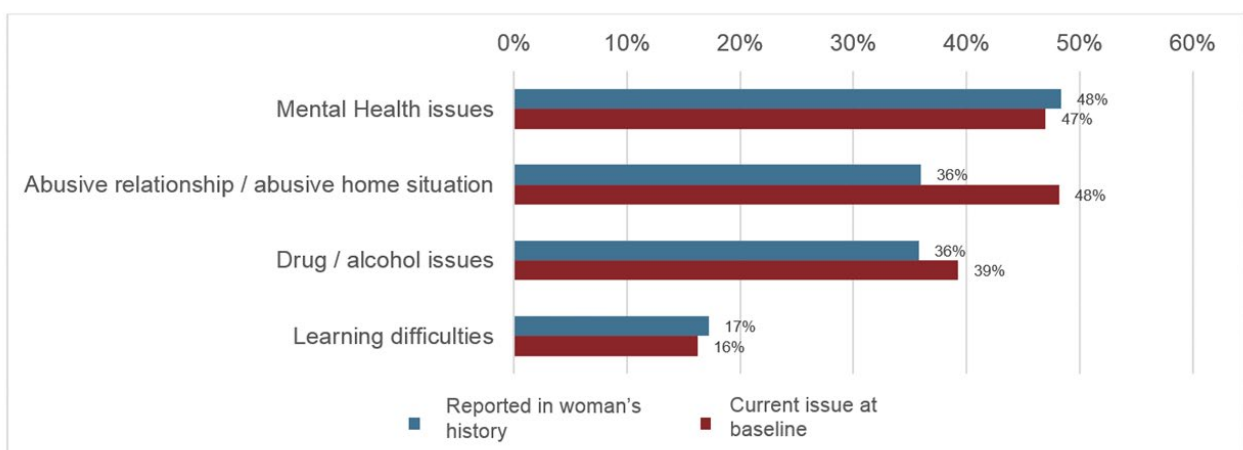


Table 3: Interview sample: current Pause women

| | N | Average age in years (range) | Average no of children (range) |
|---------------------|----------|-------------------------------------|---------------------------------------|
| Care leavers pilot | 14 | 23.0 (19-28) ³ | 1.5 (1-3) |
| Pause Round 1 women | 13 | 28.7 (23-37) | 2.3 (1-5) |
| Pause Round 2 women | 22 | 30.3 (20-39) | 3.1 (1-5) |
| Total | 49 | 27.8 (19-39) | 2.4 (1-5) |

Interview participants in Round 2 practices were on average slightly older and had a larger number of children than women in Round 1 practices, as might be expected given that the former were working with their first cohort (see above); equally it is to be expected that women in the care leavers pilot were younger and had fewer children on average (Table 3). Across all three groups, however, reported needs reinforce evidence in monitoring data of complex vulnerability. At baseline:

- 39/49 women (80%) reported specific mental health needs, most commonly anxiety and depression;
- several reported suicide attempts and/or significant psychiatric diagnoses including schizophrenia or borderline personality disorder;
- 20/49 (41%) reported significant drug or alcohol problems (either currently in recovery or still working to address);
- 39/49 (80%) referred to domestic violence in their interviews; of those who disclosed partner violence, 16 women (33% of the total sample) described ongoing risks, related to current relationships for five women and active threat or violence from ex-partners for 13 women;¹⁶ one other woman had received a police warning about her partner's offending history; and
- 8/49 (16%) reported learning disabilities, including non-specified learning disabilities and autism.

Interview and monitoring data record similar prevalence of domestic violence. It is well-established that women experiencing domestic violence fear the consequences of disclosure and therefore under-report, and this tendency is exacerbated for women with mental health problems who are more likely to self-blame (for example, Rose et al. 2011). The recorded prevalence is thus likely to be an *under*-estimate (not least given the

³ Note: The normal age range for the care leavers pilot is 16-25, but one woman in the sample was 28 at the time of interview.

rates of historic abuse), but must be also seen in context of a national estimated prevalence of 6.4% for partner violence experienced by adult women (16-59 years) in the general population.¹⁷

Many women also reported problems with physical health, in some cases related to other health issues (for example, arising from intravenous drug use), or from injuries associated with domestic violence. Several reported chronic health difficulties, including physical disabilities, degenerative conditions, and chronic pain conditions. The research also indicates a high prevalence of significant childhood trauma, including periods in care (not only in the care leaver pilot); several women had experienced homelessness at a young age. Some reported experiences of sexual violence or exploitation and/or involvement in sex work. The anonymised case example, below, exemplifies the accumulation and intersection of risk for women in the sample.

Anonymised case example 1 (Round 2 practice)

This woman first entered care at 14, moving through a series of foster placements and subsequently residential homes, before having her child at 16. At the time she was living in foster care, with carers that she described as unsupportive, and was in an abusive relationship with the child's father. The baby was removed into foster care when she was a month old, at which point the woman became homeless. She moved back to live with her mother (after a period of complete estrangement) before eventually moving again into temporary supported accommodation where she was living at Time 1.

The prevalence of mental health problems must also be understood in light of women's experience of complex trauma. Several women described multiple or shifting diagnoses over the course of the research. Women and practitioners discussed the challenges of access to mental health services; some women managed symptoms (for example, anxiety or hallucinations) by self-medicating (for example, using cannabis). One (Round 2 practice) highlighted thresholds for specialist mental health provision as a factor in the removal of her children, observing 'it's not severe enough in the NHS's eyes but it's too severe in the social work's eyes.' The collateral damage (Broadhurst and Mason 2017) of child removal was evident in the cumulative intersection of risk factors, as for women who described escalation of problems following the removal of children. For example:

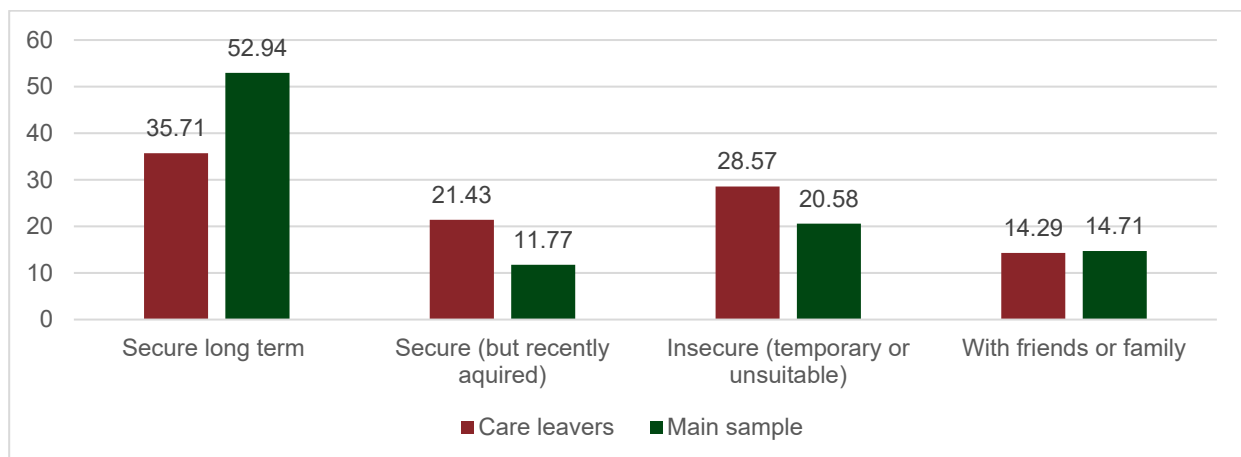
They had already taken [the children], that's part of the reason I started smoking [crack cocaine]. They took the kids and dumped me on my own in a flat and just basically just leave you there on your own. So obviously my way of dealing with the pain was just smoke drugs. (Post-Pause sample)

Economic and housing insecurity also emerged as key sources of vulnerability. Only 2/49 women were not reliant on benefits at Time 1, and difficulties with debt, benefit eligibility and sanctions were very common. At baseline, a third of women (16/49) were in receipt

of basic welfare benefits (for example, Universal Credit) and 29/49 (57%) received benefits relating to health or disability. Nearly 40% (18/49) lived in insecure or unsuitable housing at Time 1, and of 30 women who were in secure housing, seven had achieved this recently with support from Pause (discussed further below).

Women in the care leavers pilot were more likely to live in accommodation that was insecure or unsuitable (see Figure 5), although some had lived in these settings for considerable time. One had spent four years in supported lodging for people with disabilities; she shared facilities with two older men and explained, ‘It’s disgusting but I share a bathroom and a toilet and the people here, I don’t want to judge, they’re very filthy, they’re nothing like me. [...] I had a really bad incident in the past which sort of broke me, like the guy showed his thing down there.’ Another, living in supported lodgings and previously in emergency accommodation, was about to move again, possibly to a unit that she described as being ‘where drunkies and chumps go when they’re homeless’. She observed, ‘Why have me in care since I was bloody 12 to tell me I’m going homeless? It doesn’t make sense.’

Figure 5: Women’s housing situation at baseline interview (% in QLR sample)



Problems with (non)payment of benefits or with housing could exacerbate risk. This was starkly illustrated by two women in the care leavers pilot, both of whom relied on boyfriends for money and/or accommodation because of non-payment of benefits. Asked how she managed financially, one said, ‘That would be my boyfriend. He gets a decent amount of money from his job at [workplace] so with me staying with him until the flat’s sorted [...] he sort of provides for both of us food-wise and otherwise. He basically buys food and keeps us both stable and in good living condition. [...] Thank goodness I have a lovely boyfriend.’ Both women were being actively supported by their Pause practitioners to resolve their financial situation, but it is striking that both were in situations of significant dependence with relatively new romantic partners – in each case the relationships had only lasted 6-8 months at the time of interview.

Contraceptive status pre-intervention

In addressing the question of whether Pause engages eligible populations, pre-intervention contraceptive status offers a proxy indicator of risk that women will have further children who are removed into care. Monitoring data record that 44% (94/215) reported already using some form of contraception before they engaged with Pause,¹⁸ and 53% of the interview sample said they were already using contraception at the time of engagement: 21/49 women (43%) using LARC methods (usually implant or coil) and 5 (10%) using the pill.¹⁹ To draw any conclusions about the meaning of these patterns for the question of whether Pause engages eligible populations, they must be considered in light of the difference in difference analysis. Assuming rates of contraceptive use are likely to be similar for the equivalent population in Pause and comparator local authorities, the divergence in rates of infant care entry after the introduction of Pause practices cannot be explained by pre-intervention patterns of reported contraceptive use. Taking these two sets of findings together (difference in difference analysis and pre-intervention reported contraception) indicates that Pause reduces rates of infant care entry in a local authority *even if* a significant proportion of the women the programme supports may already be using long-acting reversible contraception. The implication is that other aspects of the Pause intervention are key in contributing to the effects on reducing rates of infant care entry, and this will be considered in relation to analysis of women's experiences of change during and beyond the intervention.

Conclusions: Complex intersecting needs

A consistent picture of women's characteristics emerges from interview, monitoring and case identification analyses. A significant proportion of women report using contraception prior to engagement, but the research also clearly shows that they have complex and high level needs, with multiple intersecting risk factors and a history of significant and complex trauma, including (but not restricted to) placement of their children. The findings closely correspond with other studies of women at risk of recurrent child removals (for example, Cox et al. 2017; Roberts et al. 2018; Morriss 2018; Broadhurst & Mason 2020), enabling confidence in the conclusion that, across practice areas, Pause appropriately targets women with significant and complex needs. Practices prioritise in line with staffing capacity. The analysis of needs also highlights an ethical imperative to respond to the collateral consequences for women of child removal, 'otherwise we assign this group of parents to a stigmatized caste, whose life chances will be severely blighted' (Broadhurst & Mason 2017, p55).

Understanding change in women's lives

In the absence of a comparison group, triangulation across data sources lends confidence in the conclusions, while qualitative longitudinal analysis illuminates the mechanisms that women associate with change in their lives through and beyond the intervention period, and so the functioning of the Pause theory of change. Just as risk factors intersect, improvements and changes in women's lives were also interlinked. There was no evidence of systematic differences between Round 1 and 2 practices or between the care leavers pilot and the main sample, indicating that roll out and diversification of Pause is not associated with variation in implementation of the Pause model or in impact on women's lives. Hence, subgroup analyses are only presented where there are differences (for example, for younger women). Comparing monitoring data for women who reported using contraception prior to Pause with those who did not shows that women who were already using contraception were in a slightly better position at baseline on some indicators (for example, well-being measures), but overall there are relatively few differences given the number of indicator variables in the outcomes tracker, and so these results are summarised in Appendix 6 and not in the main report.

Life satisfaction and emotional well-being

Pause monitoring data show improvements in reported ONS life satisfaction (Figure 6) and reported emotional distress (modified CORE-10 Scale;²⁰ Figure 7) from baseline to endpoint. There is no apparent difference between the smaller longitudinal sample (with data at baseline, midpoint *and* endpoint) and the Pause population as a whole. The average baseline score on the ONS life satisfaction questions is in the bottom five percent for the general UK population;²¹ the average endpoint score is approaching the national population norm for women of 7.69, although it remains lower than 82% of the UK population at end-point. Subgroup analysis indicates that improvements in well-being are more limited for those with recorded substance use problems.²² For the adapted CORE-10 measure, a decrease in score indicates a positive outcome: a lower score indicates a reduction in psychological distress, and thus improved emotional well-being. At baseline, average scores are at the borderline of moderate/severe emotional distress according to norms for the scale, while the endpoint mean is indicative of 'mild' emotional distress.²³ On both scales, the largest improvements in emotional well-being were for the youngest age groups (below 30 years old); Figure 8 shows that the extent of improvement in CORE-10 emotional well-being diminished with age.

Figure 6: Women's reported life satisfaction (ONS questions)

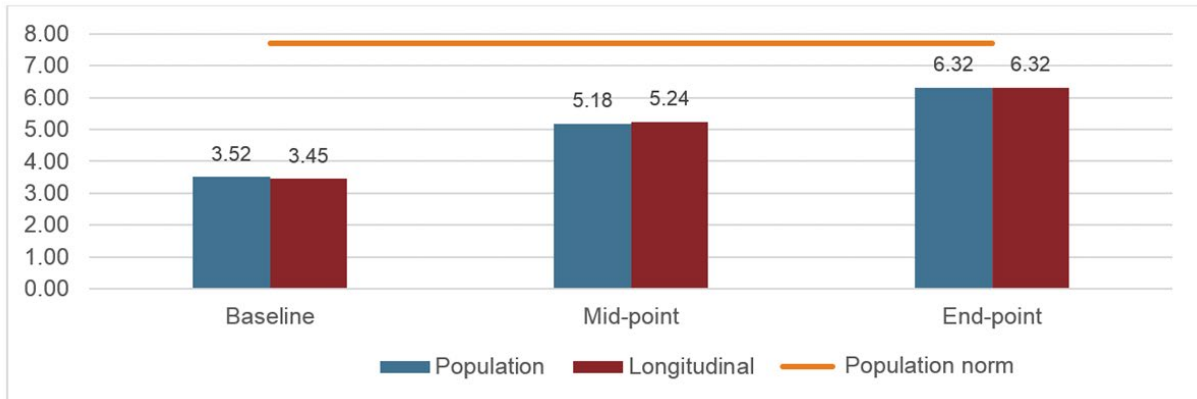


Figure 7: CORE-10 Assessment of emotional well-being

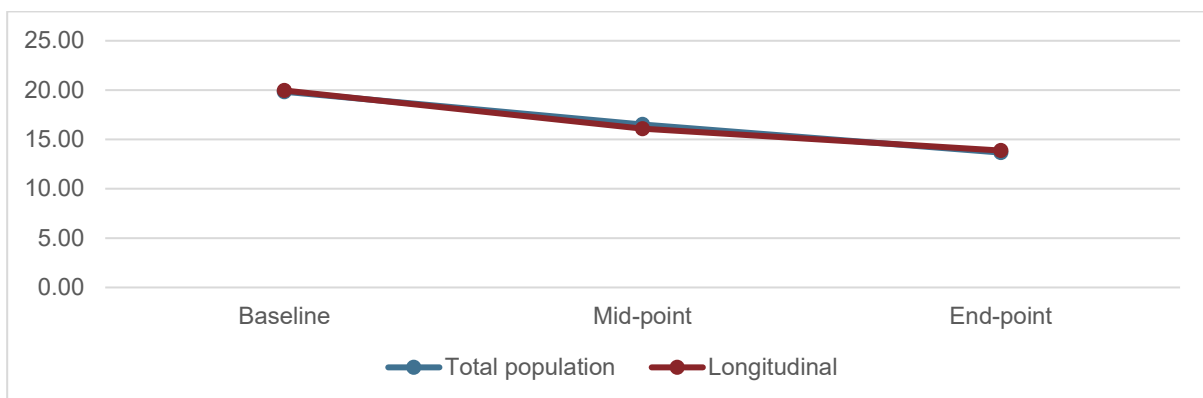
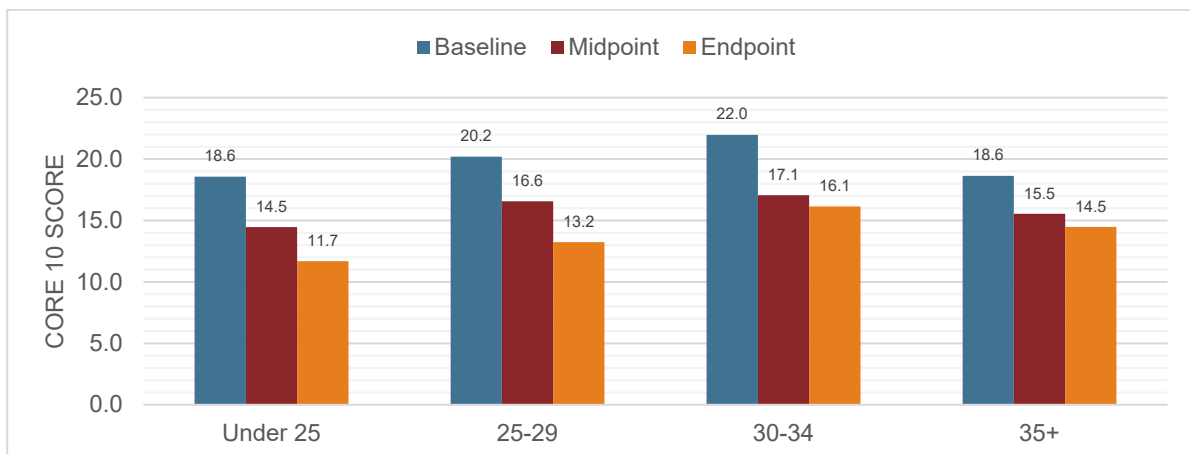


Figure 8: CORE-10 Emotional well-being by age (N=215)



Women who reported using contraception prior to working with Pause had slightly higher well-being at all time points than those who were not. However, in absolute terms, the differences are relatively small and the trajectories very similar for both ONS well-being and adapted CORE-10 measures (see Appendix 6).

A changing sense of self?

The changes in well-being reported above can be seen to correspond to the outcome ‘a changing sense of self’ in the Pause theory of change. The Pause model emphasises the centrality of long-term intensive trauma-informed relational work as the basis for change, and small caseloads and long-term involvement were seen by women *and* professionals as essential for trust-based trauma-informed relational work, especially when women have a long history of negative experiences with professionals. A practice lead explained:

The difference with Pause is that in other services there’s been an acknowledgment that relationship-based practice is necessary [...]. With Pause, for me it feels like the first time I’ve worked in a service where it’s actually built into the model, that people aren’t going to tell lifetimes of trauma to somebody when they first meet them.

The time necessary to establish trust was highlighted by many women in both interview samples, such as one from a Round 2 practice:

You need to talk to someone. [At first] I didn’t really talk to them. I, kind of, like, held back a bit, because I was scared. I’ve never had anything like it, and then it gradually built up and built up. Now, I tell them absolutely everything [...] They basically brought me out of my shell. I talk about everything in the past, how I feel, and just ... I don’t know. It’s just trying to make me get out of the past, because I used to live in the past, but now, I don’t even live in the past. (Time 1 interview)

Through the lens of trauma-informed practice (for example, Leveson 2017), relational work can be understood as crucial for modelling relationships and behaviour, as well as for building trust. Within Pause, this is predicated on time spent with women, in one-to-one and joint activities which were consistently very highly valued. Practitioners often made reference to attachment theory, and in this context it is relevant to note that their availability to women depended on manageable caseloads. However, the activities described can also be understood with reference to the social pedagogic concept of the common third (see Boddy 2011): collaborative engagement flattens hierarchies, allowing a very different sort of relationship than women have encountered with other professionals. For example:

I don’t see her like [...] she’s a staff member, it’s more like she’s my older sister and I’m just going to rant at my elder sister because I’ve had a shit day or something. We’ve done loads of stuff, we’ve been to the cinema, we’ve been and had pedicures done. Like, they’ve helped me build on my confidence so much even as a woman. Like before, I would never have had the guts to go and have someone playing with my feet and doing my toenails. (Care leavers pilot, Time 1)

The distinctiveness that this woman ascribes to her Pause practitioner is rooted in her extensive experience of both trauma and professional involvement: as a child before and

during her time in care, as a birth mother, and in relation to services linked to her mental health and experience of partner violence. The examples of cinema and pedicures evoke friendship rather than professional intervention, but they also illuminate how practitioners scaffold social inclusion, building confidence in distinct ways. Her reflection on the pedicure shows her ability to engage in previously unimagined activities, and a changing sense of her right to occupy public spaces. Moreover, she can trust that someone cares to listen when she has had a 'shit day'. These activities can be seen to contribute to the reconfiguration of self proposed in the Pause theory of change, and understood with reference to Honneth's (2012) concept of *recognition*, and his argument that understanding of oneself depends on being understood, and recognised, by others. This accords with the observations of a member of the Pause national team, who said, 'There's something that makes it unique or stands out about Pause is the way we're not defining somebody by their issues [...] our focus is to think about them as a woman first.' The value of a sense of recognition was consistent in women's accounts of change over time. At her final interview, the woman quoted above had just been on her first ever holiday (with a family member) and was learning to drive and waiting to hear the results of a college application. Her child, who lived with a relative, stayed regularly; children's social care had approved this and were no longer involved. She talked about taking him on holiday in future, once she has finished college and is working, and reflected:

I'm one of these people though that if I set my mind to something, I can definitely do it. If I set my mind in the right place, it doesn't matter what it is, whether it be driving, whether it be emptying my whole flat and reorganising it [...] I will end up getting it actually where I need to be. (Time 4 interview, care leavers pilot)

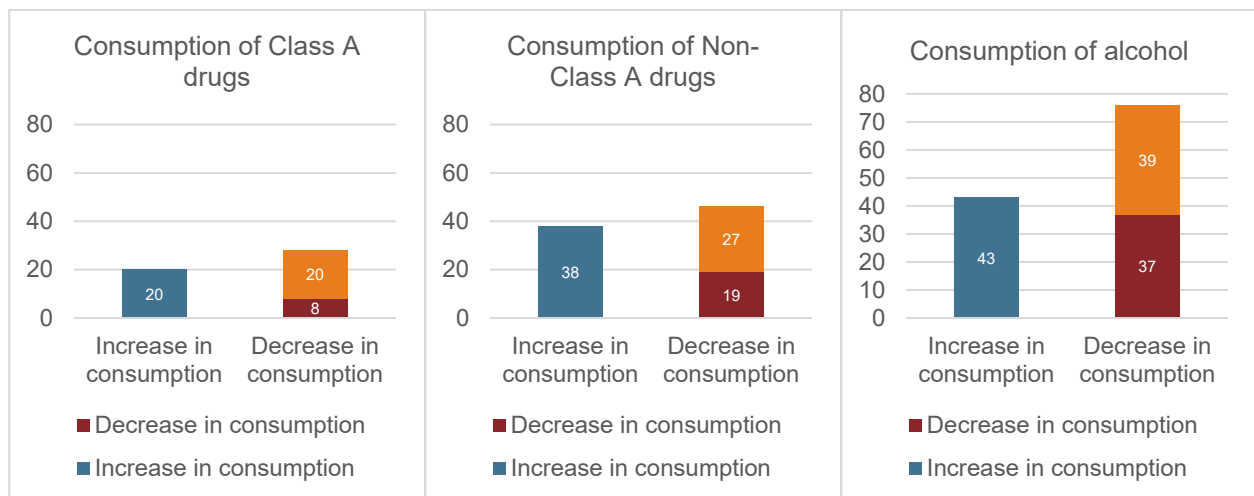
In Honneth's theory, recognition encompasses three components: love and care; acknowledging human rights; and identifying strengths and social contributions (see also Turney 2012; Houston 2016). Fraser's (2001, p24) feminist critique of Honneth's work additionally highlights political and economic injustice, arguing that recognition entails 'establishing the misrecognized party as a full member of society, capable of participating on a par with other members'. Everyday life still posed challenges for many, including the woman above, who still experienced anxiety and was sorting out an issue with benefits at Time 4. But a more empowered sense of self appears to help women to secure their rights and maintain positive trajectories of change in the face of ongoing challenges within complex and structurally disadvantaged lives.

Drug and alcohol consumption

Interview data reveal a complex picture of change in relation to drug and alcohol consumption, which does not appear to be fully captured by reported use in the Pause outcomes tracker. Within the Pause monitoring data, women who reported having drug and alcohol issues at baseline were more likely to reduce their consumption,²⁴ consistent with other evidence that that higher levels of baseline reporting may also be associated

with greater readiness to change (see DiClemente, Schlundt and Gemmell 2004). However, monitoring data analysis (see Figure 9) indicates that while the largest proportion of women report reduced drug and alcohol consumption compared to baseline, some women report increased use between baseline and endpoint. This is self-reported and so is very likely be influenced by changing patterns of disclosure over time, as trust is established between women and practitioners. Many participants spoke about the time needed for women to start to recognise and speak about chronic problems in their lives (discussed further below; see Key Features of the Pause Approach). In this context, higher levels of reporting for some women could reflect a shift towards readiness to change; this hypothesis is illuminated by interview data.

Figure 9: Changes in consumption of drugs and alcohol (%) (n=215)



In the interview sample, women with chronic alcohol and drug problems discussed the time it took to be ready to address longstanding addictions, and the ways in which change was disrupted by other life events. This is illustrated by one woman in the post-intervention sample who, at the time of our first interview, had been accepted into a residential rehabilitation facility and was awaiting a place:

When I was working with Pause, we put forward the application, but I wasn't ready, I had so much other shit going on. It wasn't the right time for me. I've been linked in with a drug service for years. [...] It's just one of those things, when you're ready, I suppose, and my support worker basically put in an application for me. I went for the interviews and I passed with flying colours. They said I'm more than a candidate. Like I said, on Monday, I'm going to view the place [...]. It's a very, very, very long process.

By the second interview, this plan was on hold because of a court case, but she was managing her addiction using a heroin substitute, regularly attending a drugs service, and planned to enter the residential rehabilitation unit once the case was resolved. Her account shows her steps towards recovery, as well as the role of the Pause intervention and of post-intervention support from other services in securing possibilities for change.

Monitoring data analysis also showed that women with recorded mental health issues were more likely to decrease their drug and alcohol consumption than those without mental health issues, particularly in alcohol consumption. This may be explained by improved access to mental health services (discussed below); interview data indicated women's use of drugs and alcohol to self-medicate in response to mental health problems, as with one woman (Round 1 practice, Time 1) with complex mental health problems, who had made repeated suicide attempts. On a waiting list for counselling, she was having difficulties with the referral because she continued to use cannabis:

I don't get any sleep, so when I haven't got it I don't sleep, but when I do have it I can get some sleep. So we've contacted the mental health team. They're saying, "Oh no, you've got to be abstinent from it for six months." I'm like, "No, that's not going to help me," [...] [Pause practitioner]'s saying, "No, that's not realistic. She's using this as a coping mechanism till she's got support there." [...] I don't want to have to smoke, but it is the only thing that is helping me right now. They won't give me sleeping tablets because I'll overdose on them. I can't take antidepressants because I'll overdose.

Her use of 'we' to refer to herself and the practitioner illustrates something else that was highlighted by both women and practitioners: the importance of recognising women's needs and acting *with* them to ensure those needs are met. In light of accounts such as this, it seems plausible that reductions in substance use for women with mental health problems may depend on support to access to mental health services.

Stabilisation

Women who work with Pause have complex needs, and many (in current and post-intervention interview samples) said their lives were highly chaotic when Pause first got in touch. Across areas, practitioners reported that the work they do changed as women move through the 18 months of the programme, with the early stages characterised by intensive practical support to meet basic unmet needs. In the early stages, this was often centred on financial and housing issues; improving stability in these areas was said to create a foundation for change in other aspects of women's lives.

Housing and financial security

The rationale for a staged approach was apparent in accounts of financial and housing needs. Negotiating complex formal systems such as benefit entitlements can take many months, and there was evident value in consistent support through lengthy processes. In several cases, appeals for Personal Independence Payments (PIP)²⁵ that had been initiated at the time of our baseline interviews were only recently concluded at the time of our final follow-up. At Time 1, two-thirds of women (32/49) talked directly about Pause support to access benefit entitlements and a similar proportion (33/49) described help in addressing critical housing needs, including safe housing in the context of domestic

violence, addressing homelessness and supporting access to appropriate and secure accommodation. Some women had been unable to be rehoused from larger properties (often where they had lived since before children were removed) and struggled with bills or payment of the 'bedroom tax'. In these cases too, Pause practitioners helped them to navigate housing systems and associated debts. Women repeatedly highlighted the 'tenacious' support outlined in the Pause theory of change, and the flexible capacity to use the women's resource budget as an emergency financial resource. While not the primary function of the budget, it ensured women's stability and wellbeing in exceptional circumstances, such as for women fleeing domestic violence, or as in one case when a woman was sanctioned when she prioritised supervised contact over a job centre appointment, and was left with £130 to live on for a month. She commented, 'I'd rather starve for a couple of days than not see my children.'

Monitoring data analysis examined changes in financial security, showing a modest decrease in the proportion of women reporting rent arrears from baseline to endpoint (from 38% to 32%), although the value of rent arrears fell more dramatically: the total value at baseline was a self-reported £61,500 across 81 women (average £760), whereas at the endpoint this had fallen to £33,400 (average £485). A slightly higher proportion of women were in debt at both baseline and endpoint than in rent arrears (53 percent at baseline and 47 percent at the endpoint), and the size of debt had increased, from an average of £1,600 at baseline to £2,100 at the endpoint. These apparent increases may reflect awareness and consolidation of debt, rather than increases per se – for example, through financial support processes (for example, consolidating multiple debts through Debt Relief Orders) as well as women's growing insight into their financial situation. Chronic and complex debt was a long-term challenge for some, such as one woman in the post-Pause sample who was being helped with debt management through through Next Steps support. There was also geographic variation in change in rent arrears and debt; monitoring data showed that women in the London Pause practices, reported larger reductions in both rent arrears and debt than women in other areas (see Appendix 6). There were no significant differences in the characteristics of women in London and other practice areas, which implies that these differences may be related to wider systemic factors relating to the functioning and accessibility of financial support and referrals.

Interview data illuminated the role of practitioners in helping women navigate engagement with multiple services, as illustrated by a woman in the care leaver pilot (but typical of many in the sample as a whole), who had a history of drug addiction and substance use, alongside domestic violence and significant mental health problems:

[My benefit payment] was 170 to 190 on average a month [...] I couldn't believe it was right but it's 'cause they didn't realise I was sick at that point, like, had mental health problems [...] [Pause practitioner] did give me a lot of help with that to be honest. [...]

Especially if you're already depressed and whatever you can't be bothered, you think, I'll just leave it unless you've got someone actually to help you to fill them forms up.

This account, at Time 1, highlights how mental health needs make it more difficult to navigate a complex benefits system, and so to secure her entitlements and address the debt she had accumulated, including as a result of benefit underpayment. Her practitioner was not simply signposting, but, crucially, was disentangling and addressing intersectional needs, and recognising and enabling the woman's welfare and healthcare rights. Alongside a practical focus on finances, the practitioner supported the woman in accessing specialist therapy. This combination of support had helped her to manage her mental health, address domestic violence and maintain recovery from addiction. At Time 1 she had also applied for PIP with the support of her Pause practitioner, but was unsuccessful. By her final post-intervention interview, she had applied again, and subsequently appealed. She told us, 'I fought against PIP and I won', and explained:

They turned me down, because I had tried to do it before and I ended up feeling worse and getting told no and feeling really down [...] and then I got to a point where I felt like no, I am appealing it, I am unwell, I'm not scamming the system, I'm not well, my doctors agree with me so I'm entitled to it. And I fought and they said, "Alright, you can have it." (Time 4)

Her example indicates the foundational role of her sense of self – including her recognition of economic injustice – in giving her the strength to fight for her entitlements, in spite of her mental health problems. Following her successful appeal, her payments were backdated to 2018. Supported by her mother, who 'helped me spend it on the right things, things that are going to last', she was making improvements to her council flat, including replacing a cooker that had long had only one functioning ring. Again, progress is not always straightforward; as reflected in her award of PIP, this woman lives with chronic mental health problems that had recently been exacerbated after a traumatic event. She sought the support of Pause (with whom she remained in touch through Next Steps) and was securing a new referral for therapy. Her experience indicates the value of systemic thinking and multidisciplinary involvement, but also of intensive long-term key work, because of the time involved in gaining trust, working through longstanding problems and navigating bureaucracies. The time taken to resolve such problems was a recurrent theme, with implications for understanding impact and for practices' capacity to provide flexible and accessible Next Steps support.

Housing security

Monitoring data analyses (see Figure 10) show an increased proportion of women in stable accommodation by the end of the intervention; the number who were homeless or in unstable accommodation almost halved, from 48 (22%) to 29 (13%). Women were also

asked how safe they felt in their current housing; Figure 11 shows a significant increase reporting they felt safe all or most of the time and a reduction in those feeling unsafe.

Figure 10: Housing situation of participants (self-report, N=215)

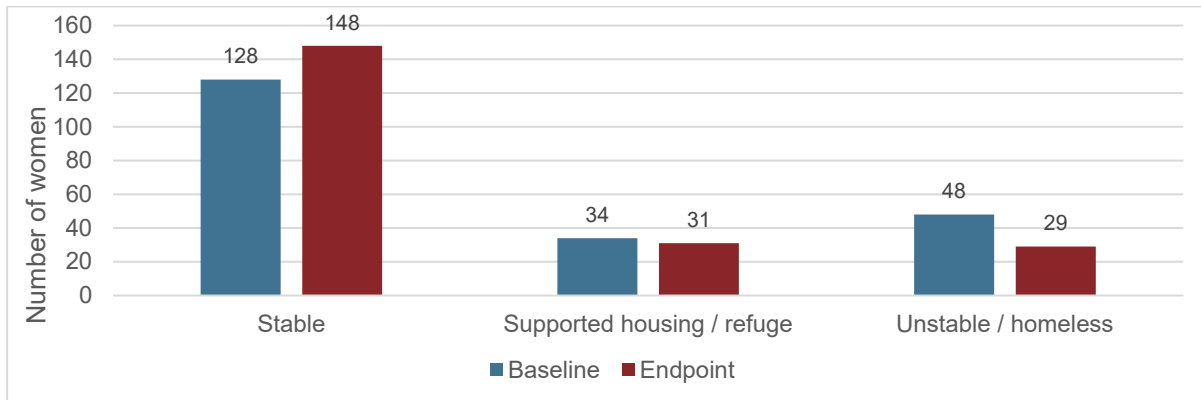
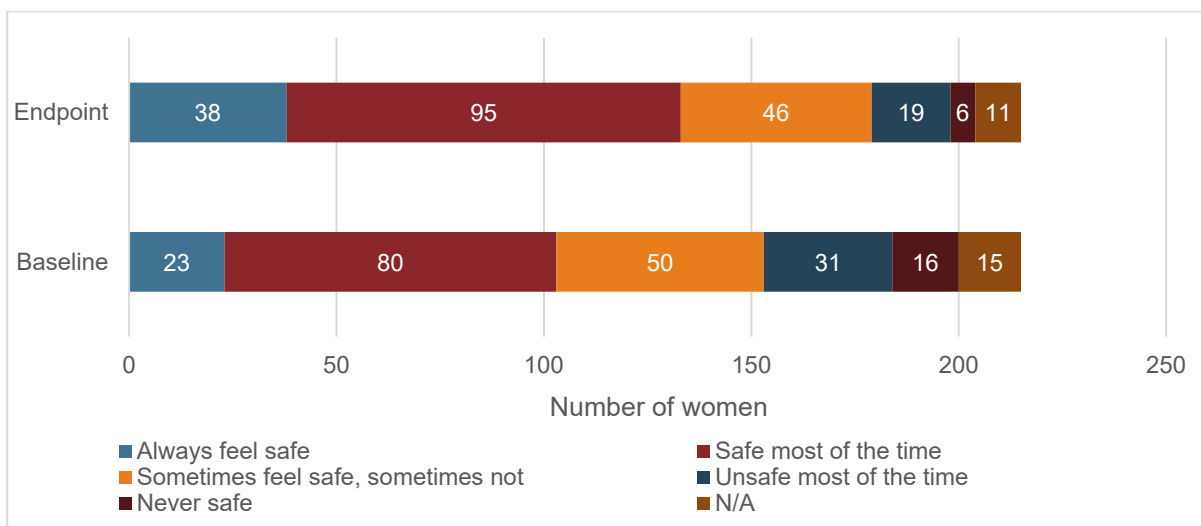


Figure 11: Frequency of feeling safe at home (self-report, N=215)



In both interview samples, women talked about Pause working with housing services, in relation to problems such as rent arrears or risk of eviction, supporting access to safe and secure housing, and providing practical support to establish women in their homes. This is illustrated by a woman (Round 2 practice) whose housing problems were related to her and her former partner’s history of addiction:

My housing officers, I think they’ve spoken with [practitioner] and because I had Pause behind me they were happy to give me the place. [...] Because I have the support from Pause so they were quite confident to let me [...] And with [local charity], [practitioner] got me the washing machine, I got £250 from the charity which I bought my washing machine and I’ve got a Hoover [and] the cooker and the fridge [...] Basically this place is like, I wouldn’t have got it, all my appliances, if it wasn’t for Pause.

Education, training and employment

Pause monitoring data indicate a significant increase in women who report receiving any education or training in the past nine months (from 19 percent at baseline to 31% by the endpoint). Figure 12 shows increased engagement in training across all age groups, but for older women (aged 35 and above) the proportion of women engaged in learning is lower than for younger age groups. There was an increase in engagement in formal learning, and a particularly marked increase in informal learning (for example, cooking classes, classes at community centres or charities). Monitoring data on employment followed a similar pattern (Figure 13). The proportion of women in work at all ages increased between baseline and endpoint (at slightly higher levels than for education and training), with women in the oldest age category having the lowest levels of employment. The proportion of women *not* in employment, education or training also fell. Analysis of the type of work being undertaken showed that at the endpoint there were more women in paid employment than at the baseline (72 women compared to 45, out of 215 cases).

Figure 12: Women in education or training by age group

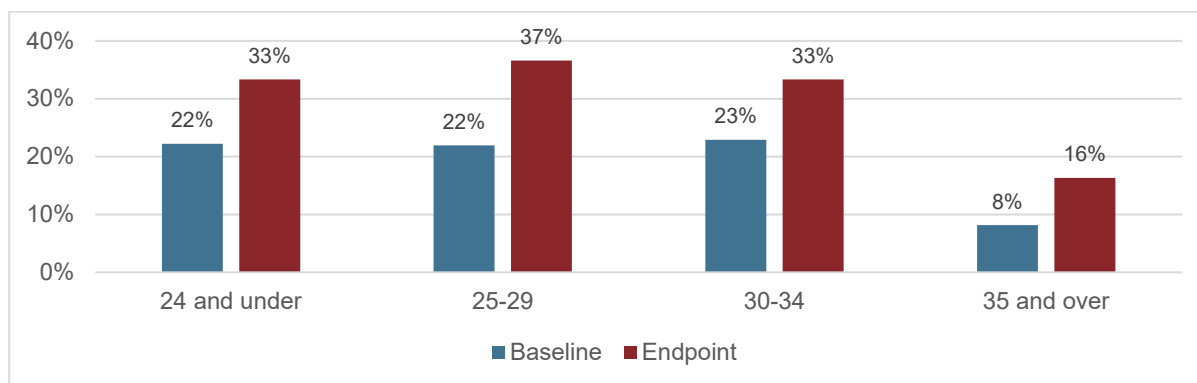
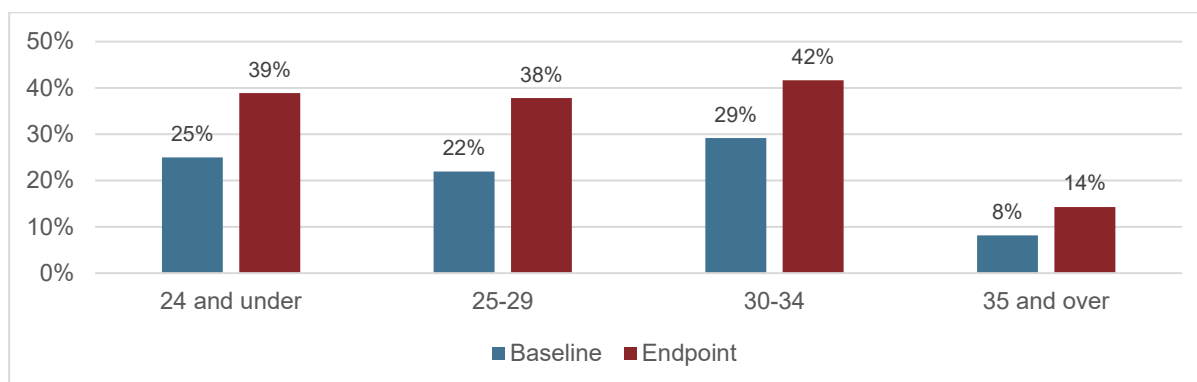


Figure 13: Women in work by age group (N=215)



Evidence of increased participation in education and employment is perhaps particularly significant given that many women described highly disrupted formal education including school exclusions. Given such experiences, engagement in education and employment relates to reconfiguring women's sense of self, in terms of the third domain of Honneth's concept of recognition: identifying strengths and social contributions. Longitudinal

analysis of interview data indicates the value of a gradual and staged approach for achieving this, as illustrated by the case example below.

Anonymised case example 2 (Round 1 practice).

In her early 20s, this woman had learning difficulties and a history of complex trauma, with corresponding mental health problems that disrupted formal education. At Time 1, she spoke about wanting a job, and about Pause support with life skills, commenting, ‘at first I wasn’t good with my skills and then I started to get better, I mean I can cook now, I could iron, I’m quite good with money which I was struggling with’. At Time 2, she had done a Level 2 Maths qualification and was, through Pause, getting support from a work coach. By Time 3, she had found temporary local work, and at Time 4 had just been offered a permanent part-time job. She explained, ‘How did I get it? First of all, I done a two week or three week trial, and then they got back to me and then they told me because I was that good, I had got the job.’

In interpreting the proportions of women in education and employment, it must be remembered that many live with chronic illness or disability, and are navigating manageable long-term change. One woman (Round 2) had secured several jobs but not kept any long-term, which she attributed to ongoing mental health issues. At Time 3, she was accessing Pause Next Steps support and working with her job centre towards supported employment for people with mental health issues. As her experience suggests, pathways to change continue beyond the end of the 18 month Pause intervention. They may be *enabled* by Pause, but they also depend on wider systems and services – and without that, women may struggle to access employment or training. Similar issues were raised in the post-Pause sample, as with one woman with learning disabilities who described her experience of employment support at the time of her follow-up interview:

It’s like a job place but they’re not very helpful when you really want a job. [...] Once you’re finished, what’s supposed to happen is you get an award for whatever you did, so I got an award, then after it you’re supposed to have a mentor. [...] They cancelled the first one and I thought I was going to get another one. It’s like she’s just gone off the course and that’s it. [...] I just kept leaving messages and no one’s got back to me.

These two case examples relate to employment support, but they also reveal these women’s persistence in engaging with services that they want and need, which corresponds to another key outcome from Pause.

Engagement with services

Given their levels of complex need, women might be expected to have high levels of service involvement, but analyses also showed that Pause practitioners play a key role in addressing *unmet* needs. If the intervention is effective, one might predict reduced use of

high cost emergency services, because acute risks are better managed and women access appropriate alternatives. For other forms of provision, change is likely to encompass: increased service use by women who were not previously accessing specialist support aligned to their needs; maintenance of service use for women who already accessed specialist services but have long-term needs; and reduced service use only if underlying needs have been resolved.

Impact on high cost services can be examined in relation to A&E attendance and criminal justice.²⁶ Analysis of monitoring data (Figure 14) shows reductions in frequency and number of visits to A&E, from an average of 3.8 visits per woman to 3.1 visits in the previous nine months. At baseline, 32 women (15%) reported being arrested in the past nine months; by the endpoint this fell to 19 women (9%). The crimes women were arrested for at the baseline were more serious, as well as being more numerous. At the baseline, offences included sexual offences, child neglect, serious drug offences and serious violence or damage. At the endpoint, there were just three arrests for serious crimes (violence and serious drug charges), with the remaining crimes being minor.

Analysis of practitioners' activities, recorded in monitoring data, indicate the extent of their support for the complexities of women's engagement with multiple services, and so for addressing intersecting unmet needs. Activities recorded include support with appointments (99% of 215 women); emails (97%); meetings (93%); advocacy (85%); and referrals (81%). These patterns correspond with change in access to public services. Monitoring data show that the number of women reporting that they had tried unsuccessfully to access a service decreased from the baseline to the endpoint (see Appendix 4), and access increased across all services. As shown in Figure 15, the largest increases were for mental health services and debt services.

Figure 14: Use of A&E services (N=215)

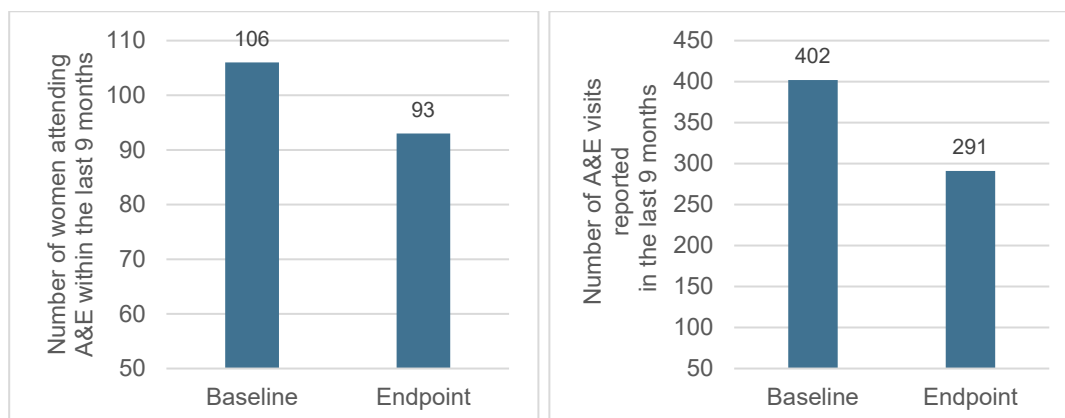
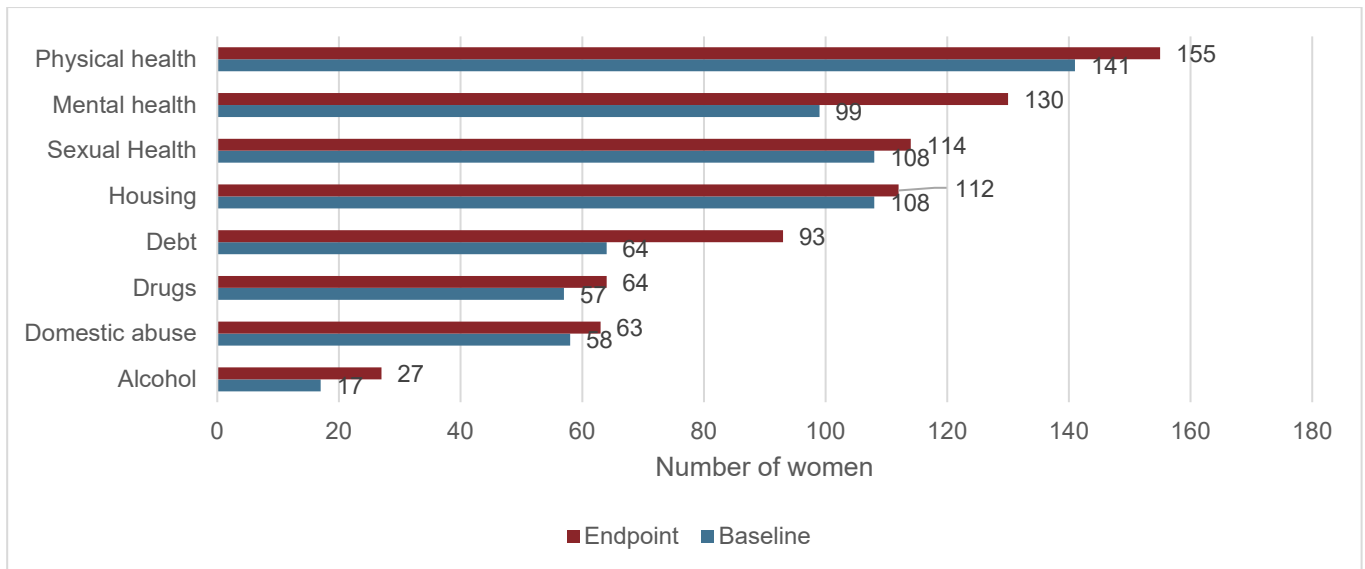


Figure 15: Number of women accessing different public services in the last 9 months



Women and professionals discussed the role of Pause in enabling access to services that addressed previously unmet needs. One care-experienced woman in the post-Pause sample commented that, ‘Pause did things that social workers were meant to do when they had been engaged with me from a young age.’ Women’s accounts often linked such change to their Pause practitioner’s *recognition* of them as people with needs, especially when they had learned to hide their vulnerabilities, as one explained:

People think, because I’m so quiet [...] that I don’t care about anything and nothing fazes me; it does, I just know how to block it out now, I’ve learnt how to act, like I’m ice. (Post-Pause sample)

She said Pause differed from other services in that, ‘To everybody else we’re just a number on a piece of paper; with them we’re humans and they treat us like we are.’ This woman had a complex mental health diagnosis, and as well as learning stress reduction techniques with her Pause practitioner, she had accessed specialist mental health support. By the time of our final follow-up interview she was stable in her medication and only attended her mental health service for six monthly reviews. Experiences such as hers can be understood with reference to Fraser and Honneth’s (2003) arguments about recognition of human rights and social injustice, as well as the emphasis in the Pause theory of change on sense of self: we see women’s recognition of their entitlement to be treated as humans, to have the support that professionals are ‘meant to do’. Crucially, a local authority manager commented that the presence of Pause in their area had changed other service providers’ perceptions of vulnerable women:

People are really seeing women in a different way... [within housing services] there wouldn’t have been as much effort to see this woman as more of a priority to support and make sure that they don’t become homeless and that’s just one example.

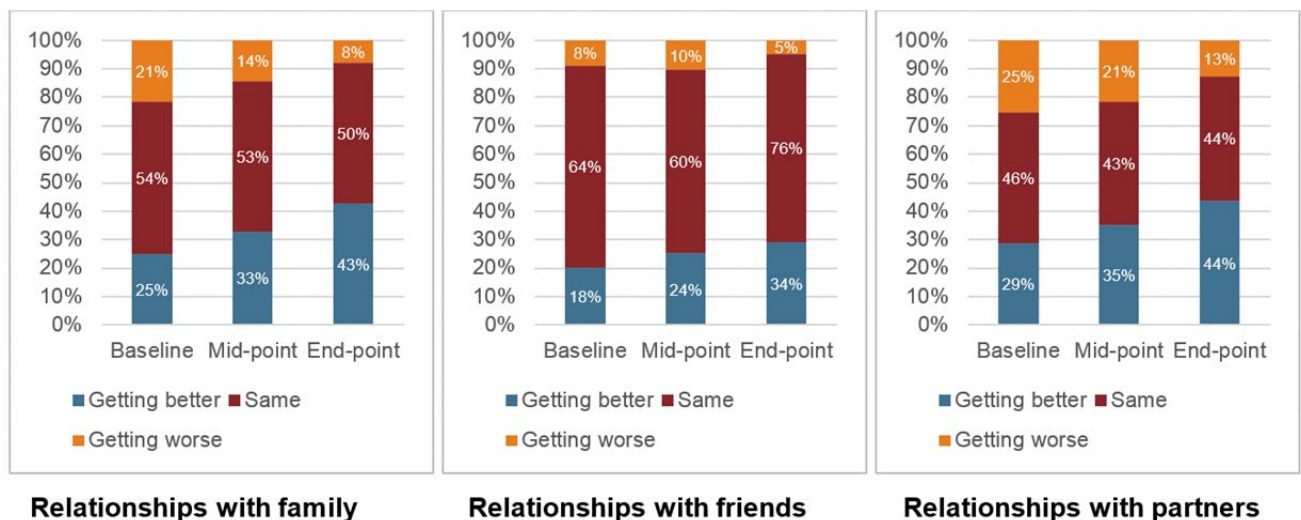
Pause support for access to services was far more complex than merely signposting, especially when access to services was constrained. The woman last quoted above commented that her practitioner did not take no for an answer – both with services that were difficult to engage and in encouraging the women with whom she worked: ‘she’ll push you, because she can see your full potential, she can see it, and she will push and push’. This twofold tenacity is likely to have particular value for women with many adverse previous experiences of professional involvement. However, accessible post-intervention support was also critically important. Many women lived with chronic difficulties (including complex relationships and long-term physical or mental health problems) and/or faced new disruptions in their lives after the intensive intervention had ended. The absence of appropriate support could be highly destabilising, and flexible access to Next Steps support could play a pivotal role in mitigating risk. For example, one woman, who had an unplanned (and unwanted) pregnancy post-intervention explained:

I reached out to [Pause practitioner] and just basically told her that I was in a bit of a situation and I needed her help because I didn’t really feel like I had anyone I could talk to and then I come and met with [practitioner] and [they] took me to my appointment [...] and we got everything sorted there and then.

Relationships

Monitoring data show overall improvements in the key relationships in women’s lives (see Figure 16), but interview analysis indicates a complex picture of change.

Figure 16: Monitoring data on change in relationships (N=215)

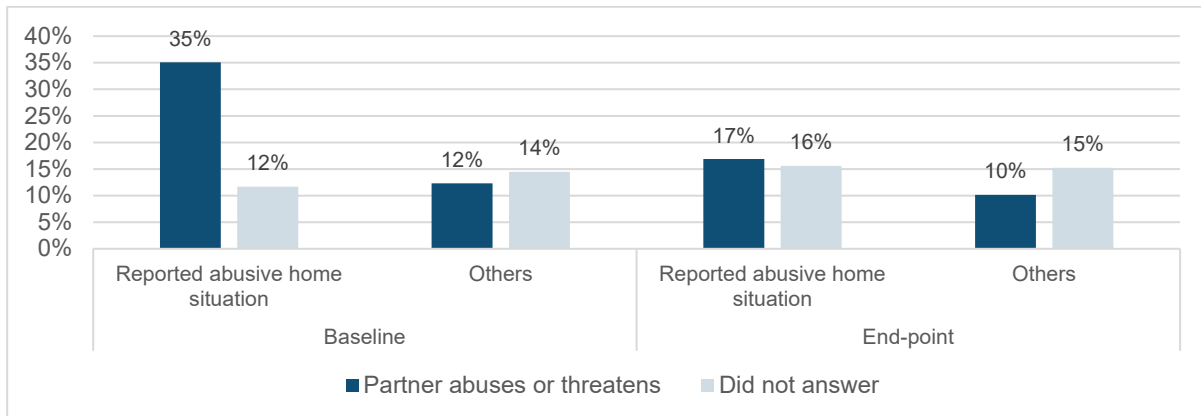


Relationships with partners

The Pause outcomes tracker asks women if key relationships in their lives are getting better, the same, or getting worse. Given the high rates of domestic violence in the sample, we focus first on women who, at baseline, reported that they were in an abusive

relationship or home situation. Women’s self-report of living with a partner who hurts or threatens them showed a slight decrease (see Appendix 6). But when the analysis is expanded to explore change by whether the woman was *professionally* reported as being in an abusive relationship, there is a significant decrease (from 35% to 17%) in women reporting that their current partner hurts or threatens them (Figure 17).

Figure 17: Women with professionally reported abusive relationship or abusive home situation reporting that their partner hurts or threatens them (N=215)



Given a substantial literature on barriers to disclosure of domestic violence, it is hardly surprising that there should be variation in extent of change depending on whether the threat is self-reported or recorded by professionals. Moreover, interview data suggested that women’s gradually building trust in their practitioner was crucial in enabling the confidence to disclose violence, and understandings of threat and their tolerance of unacceptable behaviour also shifted over time. All these factors shaped the extent and timing of disclosures to practitioners, as for one woman (Round 1 practice) who only revealed the extent of her partner’s violence to her practitioner at the end of the intervention. At her Time 3 (post-intervention) interview, she was living in her new home and had just got her first job. Reflecting on the changes in her life, she explained:

When I first actually got involved with Pause it was almost like I was frightened to open that can of worms but now that can of worms has been opened and I’m going in so many directions now.

In commenting that her work with Pause had enabled her to ‘open that can of worms’, her experience again indicates how a developing sense of self might enable change in other aspects of women’s lives. This was further illustrated by a woman (care leavers pilot) who was in a relationship at Time 1 with a partner who was previously violent. She said things had improved as a result of both of them separately engaging in therapy, commenting that this had helped her get ‘skills to deal with my thoughts whereas before I was very forceful, if I felt something that was a fact and I would be abusive, not physically but verbally, I would be abusive which would then lead into a bad situation.’ By Time 2,

she had just finished working with Pause and had ended the relationship, but her account also made clear that the threat of violence was not wholly resolved:

Once I started to actually like take the therapy in and then value myself more, I thought, “Although you haven’t been violent recently, I can’t be with you for what you’ve done to me in the past.” [...] I waited until he had gone home to first tell him because I didn’t want him to get violent.

Nonetheless, at Time 3 (post-intervention) she said she had carried on living ‘like I was still in a relationship even though I wasn’t’, and had become pregnant with this former partner (and subsequently had a termination) at around the time her contraceptive implant was running out. Her account shows that even when women show considerable insight into their experience of domestic violence, the pull of important relationships may endure. As for several in our sample, the relationship appeared to have been (re)established just after the end of the Pause intervention. It may be that women who miss the close emotional bonds with their practitioner might seek (consciously or not) to replace those in other ways. In several cases, by the final follow-up interview, new relationships had ended, and some were clearly destabilising or risky. For the woman quoted above, the experience led to a deterioration in her mental health. Another woman was pursuing serious sexual assault charges against a partner (now ex-) that she had started seeing after she stopped working intensively with Pause. Experiences such as this suggest that Pause support for sex and relationships education could usefully prepare women to navigate romantic relationships post-intervention.

Not all relationships with partners were problematic, and several women described stable and supportive relationships over the duration of the longitudinal interviews. Recent research highlights the frequency with which fathers and couples appear in recurrent care proceedings; Bedston and colleagues’ (2019) analysis of CAF/CASS data showed that more than a third of fathers who appeared in recurrent proceedings were part of ‘an enduring partnership between the parents, which led to the birth of a new child’ (p9). Some women in our study spoke about partners’ complex or unmet needs, relating to trauma, mental health or substance use. Pause practitioners do not work separately with men, but they were involved in scaffolding women’s support for their partners or signposting into relevant services, and several women highlighted the value of this. In one case, a partner was a heavy cannabis user and suffered from anxiety, but was unwilling to take part in formal interventions. At Time 2, with advice from her practitioner, she was supporting him:

I’m helping him out. Because I do like this little diary from Mondays to Sundays, and I write out how many times he has a spliff. I made that up. So, he’s like that, “Yes, yes, let’s do it.” [...] Yes, he’s doing better than he was before, and he is having seven spliffs a day now. [Before, he was smoking] about 20 to 30 a day, which is really bad.

At our final (T4) post-intervention interview, his cannabis use had reduced further, and they had recently moved into a new home, linked to her work. Several women suggested that it would be valuable for Pause to work with fathers as well as mothers who have had their children removed²⁷. One commented of her violent ex-partner, 'he's allowed to have loads of kids, get people pregnant and [social services] don't do anything but then it's the mum who then has social on their back and he just gets off scot free'. Fathers were also sometimes involved in custody arrangements (including when children were removed in a context of domestic violence). Given the extent of partner violence in the population, any future development of Pause work with men would need a differentiated and gender-sensitive approach – balancing the significant risk to women posed by some men with work within committed but nonetheless complex relationships.

Relationships with friends

Monitoring data on relationships with friends (Figure 16) do not provide information about the nature of relationships at each time point, and could relate to better relationships with pre-Pause friends, or to new friendships. The number of women reporting *no* friendships fell from 20 to just 4 between baseline and endpoint. Interviews showed how group activities create opportunities for supportive peer relationships that often continued post-intervention. Women's views of group activities were positive overall, although some found it difficult to engage because of health needs. For example, one woman (Round 2 practice) said she wanted to take part, but, 'because I suffer from anxiety, so something will happen and then I'm like, I can't be dealing with going today'. Others commented that they preferred to focus more directly on their needs, and some raised concerns about conflict or competitiveness, as with one woman who said she spoke about this with Pause staff, opting out of some activities because 'I don't want to be put in a playground situation no more', although she still attended activities that involved learning new skills (such as cookery and yoga).

In contrast, several women discussed how groups provided structure in their week and space to make friends. Women spoke of having lost former friends – for example, as they moved away from people involved in activities such as substance use that they were trying to avoid, or due to the stigma associated with losing a child. Many highlighted the value of establishing friendships within a non-stigmatising shared space. The comments of one woman (Round 1 practice), shows how shared activities enable friendship – and recognition in Honneth's terms, supporting a reconfigured understanding of the self:

We have all made friends with each other, so we don't judge each other because we are all working with Pause for the same reason, that is how you feel. You can walk in there knowing nobody is going to say she hasn't got her kids do you know? Because we are all there for the same reason. But we are allowed to say it and have a laugh. And they take us on courses, they don't just take us fun places [...] We do go out for dinner sometimes and we do nice things but we also do things we need to do.

Over the course of the evaluation, Pause has developed Next Steps support groups (this development was not resourced through the Innovation Programme). These were highly valued by women who took part, including for maintaining friendships established through Pause, although those who were busy – in employment for example – were unlikely to be able to attend. Concern about group dynamics could also impact on women’s views of Next Steps activities, and as this provision develops, there is a need to consider how support is made accessible for women who feel unable or unwilling to participate in groups. Overall, however, space to build non-stigmatising alternative networks – and subsequently to maintain those through the Next Steps groups – is clearly valuable, illuminating why what appears to be ‘fun stuff’ is a crucial ingredient in the Pause model. Group activities provide collective spaces of positive recognition for women who have shared experience of stigma and oppression in relationships with professionals and in their personal lives.

Relationships with family

Monitoring data (Figure 16) and qualitative interviews show clear improvements in relationships with family, although women also highlighted the challenges of life with complex families, including care for relatives with significant needs. Pause support with family relationships was consistently emphasised, and evidently facilitated by stabilisation in other aspects of women’s lives. One woman (Round 2) described a turbulent relationship with family at Time 1. At Time 2, accessing a domestic violence service with Pause support, she said she had gained a new perspective:

I put it in my head so I’m able to just think about it. [...] It [coercive control] can happen in any relationship I reckon, it can happen outside, with friends, family. [...] It just gives me that bit of courage and I can say no and it’s alright to say no. Before I would be accepting it all and be like, “Alright.” Now I’m like, “No” – feisty, I tell you.

At her final interview, her family remained ‘up and down’, but her improved relationship with her mother was clearly a valued source of ongoing support. In other cases, however – as for case example 3 – chronic difficulties with family could disrupt positive change.

Anonymised case example 3 (Round 2 practice)

At Time 1, this woman said she particularly appreciated the way Pause had accepted her complex history, including abusive relatives who were still in touch. Post-intervention, she described improved confidence, but caring responsibilities for a disabled relative had escalated and her financial situation had deteriorated because she lost her PIP benefits. She attributed this to being a carer, saying ‘they don’t really see [that] if you look after someone, you can’t look after yourself.’ As a result, she accrued debt. She was in touch with Pause through Next Steps, but felt ‘so embarrassed that I was in debt again.’ and described uncertainty about what she could ‘ask’ in terms of further support.

Relationships with children

I've always said I will never give up on my children. And whatever ... if they push me down, or whatever, I still pick myself up and still go ahead with it, because I'm a mother, you know? (Round 2 practice, Time 4)

One of the core outcomes specified in the Pause theory of change (Appendix 1) is improving women's relationships with children previously taken into care. Professionals and women reported that the Pause programme made a significant positive contribution to relationships with existing children, both in managing the emotional and practical challenges of diverse contact arrangements and in coming to terms with complex forms of loss and in recognition of their maternal identities (as in the quote above). Monitoring data analyses illuminate the complex and dynamic context of work to support women's relationships with their children. Around three quarters of women have contact and this proportion remained fairly constant between baseline (161/215) and endpoint (168/215), but the analysis shows change in the type of contact: the proportion with face to face and letterbox access increased, whereas the proportion with supervised access decreased (Figure 18). A shift from supervised to letterbox contact would be expected if children were going through adoption proceedings at baseline; as that would imply, the proportion of women in weekly contact with children decreased, while an increased proportion only have contact once or twice a year (Figure 19). The decrease in supervised contact and increase in face to face contact suggests something different – a positive change in women's relationships with children and their carers – and is illuminated by women's interviews over time as well as by practitioners' accounts.

Children of women in both interview samples lived in a wide range of situations, from adoption through to informal kinship arrangements, and there was a correspondingly variable picture of contact. In line with monitoring data, some had no current contact, some only letterbox contact and some only supervised arrangements. Others (particularly those with children living with relatives in kinship arrangements including Special Guardianship) described high levels of contact, and even overnight stays. For women with children in kinship arrangements, improved contact was often linked to improved family relationships. One woman (Round 1 practice), who had no contact at Time 1 but regular face to face contact at Time 2, explained that this happened because 'My mum saw a really big change in me. She basically said I'd started to change my lifestyle, I'm starting to stand on my own two feet. [...] I don't lash out at my mum anymore.'

One child had returned to the custody of his/her parents and social services had no involvement by Time 4. In this case, Pause did not work towards reunification, but the woman described changes linked to support through and after the intervention (with contact and in dealing with the child's social worker, access to therapy, and signposting her partner to appropriate services for his needs). This case is not typical, but it indicates

the potential of Pause to enable changes that – when appropriate and in the child’s best interests – support reunification.

Figure 18: Type of contact with children (N=215)

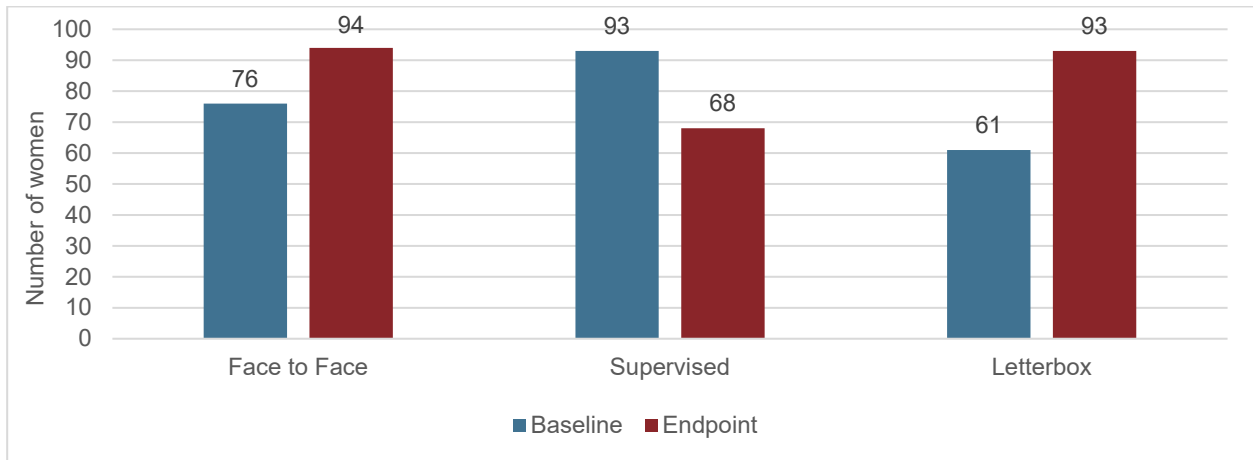
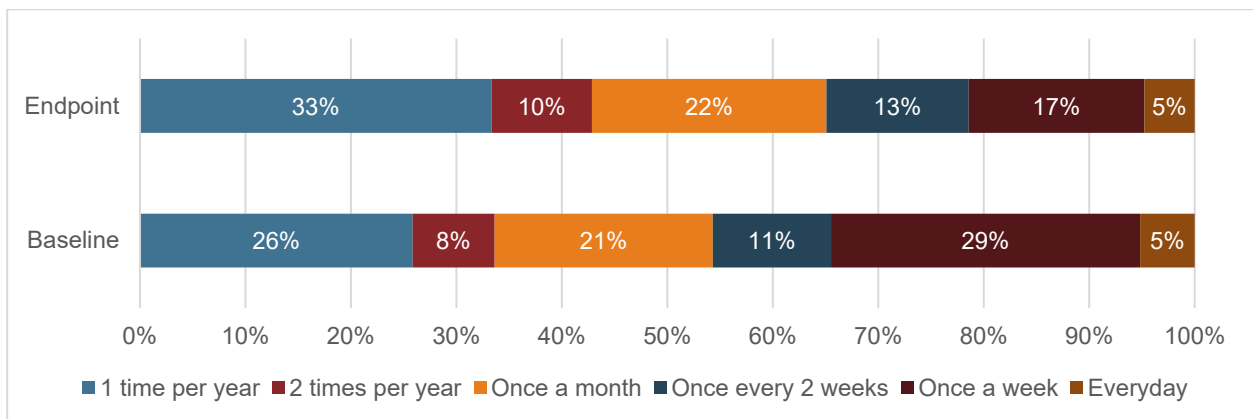


Figure 19: Frequency of contact with children (N=215)



Arrangements often varied for different children and the psychological task of managing multiple different arrangements – and hence multiple forms of loss – was inevitably complex. This was also a challenge for Pause group work, because women were alongside others with very different experiences and arrangements. Contact experiences could also change significantly over time, for example, when placements or social workers changed. One woman described a very positive relationship with her child’s social worker and carers at Time 1; post-intervention, the child was in a new placement and had a new social worker, and she described a variety of concerns. For example:

I think [child] is getting bullied, [child] keeps talking about how they don’t like [their] colour. I’m not being funny, they have taken a black kid basically and stuck [them] in the whitest place ever with a fully white family that doesn’t know how to maintain [their] skin, doesn’t know how to maintain [their] hair. (Time 4, care leavers pilot)

Contact changed most starkly as a result of court (including adoption) proceedings, and Pause practitioners could play a crucial role in supporting women through that change.

For example, one woman started working with Pause during a traumatic period when she still had twice weekly contact 'because they hadn't found adopters for the children':

[Practitioner] would meet me at the contact afterwards, once I was finished there she would be outside waiting, I could guarantee it, ready to take me for a coffee and she was a shoulder to cry on, because the children would go and I would just break because my daughter would be sobbing and hanging on and, "Take me home, take me home." And my son was like, "Mummy, I want you, I want you." And [practitioner] was like literally holding me like through all of it. (Round 2 practice, Time 1)

Many women described active support from Pause practitioners in letterbox contact. One woman (Round 1 practice, care leavers pilot) had ceased letterbox contact with her younger child when her drug and mental health problems were at their worst. At Time 1, she was hoping to re-establish this, and to involve her older child, who she saw regularly:

I stopped writing for a while because I didn't have anything positive to say [...] so I left it especially when I was taking drugs and stuff so recently me and [Pause practitioner's] been talking about it and me and [older child] are going to write a letter to [adopted child] and start it back up again, yeah, and get [older child] writing to [adopted child] [...] So I'm going to definitely start writing that soon. We were only talking about it yesterday, [Pause practitioner] was here actually, yeah.

By Time 2, letterbox contact had been re-established, including the older child, and it was ongoing at Time 4. As this example indicates, improvements in mental health and stability enabled new possibilities. Other interviews also demonstrated that improved contact could be maintained post-intervention, as for a woman in the post-Pause sample:

Christmas was the first time he came and stayed for four days, and he comes as and when he wants and also my younger children, who I was having very infrequent contact with, I now have unsupervised contact and they did their first visit of coming to my home which is a real big deal because I would never have envisioned that would ever, ever happen, so they had their first visit at my house last weekend.

Practitioners also highlighted their work to improve the quality of contact; for example:

One woman in particular who was very chaotic after the care proceedings came to an end and then just knowing that she really wanted to maintain contact but she didn't really have any idea about how to continue that, how to work with professionals to make that happen because her labels were she's not engaging, that she's unreliable, she's unpredictable, and actually for the over a year, she has managed to maintain the contacts with her children that she's been given, and that was achieved by working one to one with her and also advocating for her and role-modelling how to sit in a meeting, how to speak to professionals, and also giving her tools to know what to do when she's not happy with something.

In another area, a woman who had supervised contact described the support of her practitioner when her child, now 13, asked challenging questions:

A few months ago, [child] wanted to ask me a lot of questions, and [Pause practitioner] came along with me to that meeting. And it was a big help, do you know? [Child] wanted to know why [they were in care], and stuff like that. And [they] asked the questions, and then the Social Services gave the questions to [practitioner], and [she] brought me the questions [...] So, I could plan what to do, what to say, and write. [...] It went really well in the end. Because [child] didn't know whether to still see me, and stuff like that, but in the end, [they] decided to see me. (Round 1, Time 2)

Her account illustrates how Pause supported her to engage with life story work with her child – supporting their identity and wellbeing – as well as making it possible for both to enjoy positive regular contact, which was maintained at her final (Time 4) interview.

Pause practitioners also had an important role in ensuring the fulfilment of court mandated arrangements. Women often found it very difficult to challenge in these circumstances, and the support of practitioners was highly valued. For example, one woman (Round 2) explained, 'Meetings that I had when I went on my own, they belittled me, and as soon as she came on board to the meetings with me they changed their attitude, they were listening to me instead of not listening to me.' She said this experience built her confidence, and by the time of the post-intervention interviews she was regularly attending reviews and had been permitted unsupervised contact with her children in foster care. Pause professionals also identified the importance of creating wider cultural change around working with women with complex needs and who have children permanently removed from their care. One practice lead had worked with the local authority to change the way in which the last pre-adoption contact is run:

What I've done is talked to the manager of our supervised contacts and agreed that a specialised second contact officer will be present at the goodbye contacts to be support for the birth parents and that they will offer to meet the parent before the goodbye to talk about how they want that contact to be and to support them afterwards, which is a major shift because up until now they've been expected to just rock up on their own and the supervisor's there to supervise.

In another area, two women with adopted children commented that Pause had helped them stop the adoption team referring to them as 'tummy mummies'. As one said (Time 4), 'I'd understand if I was a surrogate mother called a Tummy Mummy, because that's all I am. But [...] he's my child, so why are they calling me a Tummy Mummy? That doesn't seem right to me.' Her comments evoke Fraser's (2001) arguments about misrecognition, and Broadhurst and Mason's (2013) observations about birth mothers' disenfranchised grief. Women consistently highlighted ways in which work with Pause could help with the ongoing reconfiguration of their loss, and their identities and practices

as mothers-at-a-distance. They also gave examples of practical support with costs of travel or help to buy small birthday presents – especially important for those on very low incomes. One spoke with pride about choosing cards for letterbox contact:

[Practitioner] got these, I chose them, I told her what kind of cards they love, [daughter] likes, she likes sparkle and stuff. You know at first you don't really know your kids and then you get better with them.

Maintaining identities as mothers also appeared important in managing hopes for potential future children. Several women discussed their existing identity as mothers in relation to the decision to use long-acting reversible contraception, including continued use post-intervention. One reflected, 'Me and [partner] decided not to have kids no more because we don't want our third kid to go through the pain that [children] went through, taken away from their parents.' Another said, 'Through all this that's happened to me [...] even though I've got this confidence, losing another child would just break me, because my [children] have a piece of my heart each.' Such comments indicate that recognising women as mothers, and supporting identities as mother-at-a-distance to existing children, may contribute to reducing the risk of having further children who are removed into care.

The research indicates that work with Pause has a positive impact on quality of diverse forms of contact and relationships with existing children. This corresponds to stabilisation and change in other aspects of women's lives (for example, mental health and substance use) as well as support in reconfiguring loss and maternal identity, and with the emotional and practical complexities of contact itself, in all its fluidity and diversity. Assessment of the impact on children is beyond the scope of the evaluation. Nonetheless, an established literature highlights the importance of enabling children in care or adoption to make sense of complex relationships with birth families (for example, Neil et al. 2015; Ellingsen et al. 2012), and it seems probable that supporting birth mothers in navigating contact would have concomitant benefits for children's lives and identities.

Key features of the Pause approach

This final section of analysis examines the distinctive features of the Pause model, focusing in particular on facets of practice set out within the Pause theory of change, and the implications of the model for experiences of the end of the intervention and for Next Steps support. Pause professionals were highly consistent in their account of the model, highlighting the importance of trust and holistic relationship-based trauma-informed intensive support, enabled through small caseloads and duration of involvement, as well as practitioners' qualities and approach to the work. These features are also prioritised in other services for women at risk of recurrent child removal (for example, Cox et al. 2017; Roberts et al. 2018), and also noted by stakeholders involved in such provision in other local authorities. For example, one said, 'We've got to be able to work in a different way which is not our traditional way of working in order then to be able to get aligned with that

parent, to see it from their perspective, sit in their shoes to see how that might have felt for them. An understanding of why they go back to the repeated trauma of having children removed'. Pause professionals made similar observations, as with one who said, 'You're working with women who've had multiple children removed [but] you're working with them because of the 100 different issues that led to it.'

Recognition of the challenging nature and intensity of relational trauma-informed work was key to recruitment in Pause practices. Key skills, values and personal qualities were consistently identified (across Round 1 and Round 2 practices and in the national organisation) and included: tenacity in engaging and working with women; the ability to build trusting relationships; and being compassionate but not afraid to challenge women. Formal supervision (including clinical supervision) and informal support from peers, practice leads and the national organisation was highly valued in managing the intensity and emotional nature of the work. Practitioners came from a wide range of backgrounds (for example children's social care, domestic abuse services, housing services (including homelessness), and criminal justice). Within the Pause approach, a disciplinary mix is a requirement for practice, because of the complexity of women's needs. The consistency of professionals' descriptions of the Pause approach was mirrored in women's accounts of the work.

Apart from contextual and geographical factors (for example, variations in local service provision, and the distance practitioners needed to travel to meet women), there was little indication of any systematic differences between Round 1 and Round 2 practices, or between care leavers and other Pause women. Professionals from the Round 1 practices discussed the positive changes to Pause since the first round of Innovation Programme funding, particularly in relation to the development and clarity of the Pause framework and the national infrastructure and processes that had been formalised since the pilot. Having a clear framework and infrastructure that practices understood, whilst allowing for creativity and innovation to fit into the local context, were identified by Pause professionals as important for wider roll out, allowing practitioners the flexibility to vary their approach according to both women's needs and circumstances, and to the local context, within a consistent overarching framework.

Pause professionals commented on the scale of organisational change with the expansion through Round 2 of the Innovation Programme, and some pointed to distinctive challenges in the care leavers pilot. For example, one practitioner commented that because care leavers are younger:

[There is] definitely more challenge around contraception, but [they] also know themselves better, quite often they were already in activities or looking for work. They just had more interests that they could verbalise. They're much more – even though there's a huge lack of confidence, more confidence. They know their rights a lot more.

Her comments are illuminating in relation to the patterns of change noted earlier, with greater improvements in emotional well-being and engagement in education and employment for younger women (rather than care leavers specifically) in monitoring data. Across the sample, including the care leavers pilot, women consistently described their experience of work with Pause practitioners as different, and more positive, than previous professional involvements, and their accounts echoed practitioners' emphasis on building trust through relational work. An emphasis on strengths-based approaches and building self-confidence was also evident in interviews with women. At Time 1, one woman (Round 1) commented, 'she keeps saying [...] "you know, you're a strong lady, to be honest when I first met you I've noticed that you're a strong lady, like you're very brave".'

Duration and endings

The evidence discussed above, of positive impacts in women's lives and of the value of a staged approach to addressing complex intersectional needs, indicates that the duration of intensive involvement may be a crucial ingredient in establishing change. It took considerable time to support women in negotiating complex and often bureaucratic systems across multiple services (for example, benefits, housing, health, employment, social services). More substantively, duration of involvement was seen by both women and professionals as important in enabling trust-based trauma-informed relational work, and identifying and disentangling complex needs in order to work on stabilisation. One practice lead argued for a two to three year model, especially when women may only disclose the extent of their difficulties many months into the programme:

I've never thought a year and a half is an appropriate length of time to be working with these women, because it takes six months for them to stabilise. I want to spend six months transitioning them out and embedding their learning. That gives us six months to get the work done.

Unsurprisingly, given how much women valued their relationships with practitioners, at midpoint interviews many women expressed anxieties about endings. Post-intervention, several spoke of realising that they had been ready to manage on their own, such as one (Round 1 practice) who joked that 'now I don't have them, it's kind of like [...] Nanny McPhee? Where you think you don't need them, but you do, and then when you don't need them, you want them back.' As noted earlier, over the course of the evaluation Pause have been developing Next Steps support (not through Innovation Programme funding) and several women spoke of the importance of this as a 'safety net'.

Women and practitioners described ending celebrations for women, for example with photo-books as mementos. These were clearly highly valued, and many women (in both the current and post-Pause interview samples) spoke of feeling like they were part of the Pause 'family'. Many also described the benefits of Next Steps support, both groups and occasional telephone support, which could play a crucial role in maintaining peer

relationships and (re)establishing stability when women faced challenging times. Several remained actively involved with their practice – for example, demonstrating crafts in group activities, or participating in recruitment of practitioners – and were enthusiastic about possibilities to develop their role as experts by experience. One (post-Pause sample) commented that groups allowed women to support each other across cohorts:

So I can support someone that's just coming to the end because I've been through that, and then they can help the ones who've just started because they're just coming to their end. So we're all supporting each other and there's different bases.

Endings could feel destabilising for some women, particularly if they experienced Next Steps support as inaccessible, or struggled when the loss of one-to-one support coincided with major events (for example, finalisation of an adoption order). In exceptional circumstances, transitions were extended or support activated in the context of crises (for example, for women who were victims of serious crimes, or had critical issues with housing). Pause²⁸ estimates that about 70% of women access Next Steps post-intervention. For some, new commitments (for example, work) meant they were unable to attend groups or call practices at set times; others were not comfortable with groups (as discussed earlier) or were hesitant about help-seeking, or felt ashamed to be struggling again. Some women (from both Round 1 and 2 areas, and from the post-Pause sample) described endings that felt abrupt. Others, with long-term needs, expressed doubts about working with other services. Considering these findings alongside evidence of the positive impacts of Pause indicates the value of development and diversification of Next Steps provision, including tailored or triaged approaches as well as post-intervention volunteering opportunities.

Women's response to endings related partly to the capacity of other services to meet their needs; as with the case example below, this depends on local provision.

Anonymised case example 4 (Round 1 practice)

This woman has learning disabilities and complex health needs that mean she has multiple professional appointments, and she valued her practitioner's support to engage with services. In a supported transition process, she was linked with a volunteer from a local charity, but at Time 3 she explained that the volunteer was a student whose course commitments meant 'she wouldn't have been able to come with me on the days that I have appointments so I was like, "Well what's the point?"'. By Time 4, she said she was more confident with appointments, but found it challenging: 'sometimes I don't really like going on my own to places like that, because sometimes I forget what they say'.

Accounts were more positive when women described services working with approaches that are sensitive to complex lives and biographies. At Time 3, one woman (Round 1 practice) had got her first job, supported by an organisation she was introduced to by

Pause. Describing Pause, she said, 'the key for me [was] that I knew that they was there for me', and she echoed these words when describing the employment support service:

You get a one-to-one worker who kind of supports you, and like if you've never done a CV before or if you need help on how to do an interview, going to an interview, or if you need help with interview clothing. They're there for you to basically... job opportunities or training opportunities or volunteering opportunities.

In some cases, women's concern about endings related to Pause staffing changes. One practice lead commented that, 'it's a challenge to recruit somebody as resilient as you need to be to be a Pause worker', and there were occasional accounts of the effects of staff turnover. One practitioner suggested that changes could be positive when well managed, giving women 'an understanding that relationships can come to an end in a positive way and somebody else can come in and still support you.' This was echoed by some women who experienced changes of practitioner. One, who worked with three practitioners during the intervention, said of the last one, 'She really is brilliant. But I think they are all as equally brilliant, you don't get one that is better than the other. Like they all do the job the same.' For others, the impact of change was clearly challenging, and could disrupt progress. One woman explained this experience in the context of her past relationships:

She promised she was going to be with me for a long time, blah, blah, blah, but then she left. [...] It was really hard because I'd told her loads. I was building a relationship with her. She was going to help me reconnect with friends [...] be a bit of a better person than what I already am and try and maintain relationships, because I'm rubbish at maintaining relationships with friends, absolutely rubbish.

Funding insecurity inevitably affected practitioners' sense of security in their role, and hence their relationships with women. One practitioner commented, 'You feel guilty every time you're going out with a woman or you're starting a piece of work [...] and you're thinking, oh, am I going to still support her next year, am I not? Am I going to be there at the worst time?'. Across Round 1 and 2 practices, funding and delivery models varied, including mainstreamed core funding, annually reviewed models, resourcing from local authority children's services and multi-agency funding. End or review dates for funding also varied considerably. Funding insecurity is a critical consideration for public services, and the challenges this wrought were highlighted by local authority stakeholder interviews, such as one who observed, 'getting a proportionate financial commitment to this, over and above local authorities and housing for us in [LA] has been really disappointing – we recognise the benefits but we just don't have the money'. As noted earlier, the research indicates clear cost-benefit from Pause, but beyond that, continuity and security of funding is likely to be particularly important for services which are predicated on building safe, stable relationships through long-term intensive work.

Use of contraception

Following the first 16 weeks of engagement and as a condition of becoming 'open' on Pause, 'women agree to use the most effective reversible methods of contraception [...]; Long Acting Reversible Contraception (LARC)' for the remainder of the intervention (Pause 2017 p8). Women's contraceptive use raises complex considerations, and the analysis discussed here has wider relevance given that the contraceptive requirement is not unique to Pause; equally, other models may not use conditionality but nonetheless strongly encourage use of long-acting reversible contraception (see Broadhurst et al. 2015b). New services working with this population are developing in various regions and localities,²⁹ and the issue of conditionality raises important ethical and practical questions that are the focus of intense debate in this emergent area of practice. Indeed, senior managers in local authorities that were delivering an alternative recurrent care service said they considered conditionality when developing their service. For example:

The bit around the Pause things that we were a little bit hesitant about was that, before you engaged in the programme, you have to be committed to a particular type of contraception... we had a little bit of anxiety about people receiving services on the back of having to do something.

Contraceptive requirements were not a concern for most women in the interview sample – either because they had already been using LARC methods before starting work with Pause, or because they appreciated the benefits. Within the main interview sample, as noted earlier, 53% of women said they were using contraception (usually a LARC method) prior to working with Pause. All 32 women for whom there were post-intervention interviews, and almost all (10/12) in the post-Pause sample, reported continued use of contraception after finishing with Pause, although several had changed method.³⁰ Some women positively argued for the value of long-acting reversible contraception, because they did not want further children who might be removed, or did not want more children in the near future. In her final post-intervention interview, one woman reflected: 'because of having to have the rod [implant], I wouldn't have had that rod and I'd have probably been pregnant or fighting for a kid again'. Women and Pause professionals also commented that the security of LARC took pressure off women when they were very vulnerable. At Time 1, a woman who had not previously used contraception explained, 'The thing is once your kids get taken away from you, you don't really have much. You've got room for all the bullshit – getting into drinking, getting into drugs, you could end up making another child'. Several women emphasised their Pause practitioner's care to ensure they did not feel pressured into uptake of LARC, such as one who described her practitioner as 'very soft and gentle about it'. Some also commented positively on side effects of LARC; one, very pleased that the contraceptive injection had stopped her periods, said 'I love it. Best thing ever.'

It was common for women to report side effects from contraception, as might be expected given clinical guidance (for example, Faculty of Sexual and Reproductive Healthcare (FSRH) 2014). Across all time points, 8/49 women (16%) in the main sample described minor or non-physical effects from contraception, such as minor mood changes or initial issues (for example, problems with fitting the coil) that were quickly addressed. Another 11 women (22%) raised more significant concerns about their experience of contraception. In some of these cases, initial difficulties (such as an implant pressing a nerve) were resolved by the time of follow-up, but difficulties persisted for some women. The FSRH clinical guidance on the implant (the method most women used) notes common non-physical effects such as weight gain, headaches and mood swings, but cites NICE guidance that there is no robust evidence of a causal relationship. This same guidance also records that unscheduled bleeding is common, and that 'Fewer than one-quarter of women using the progestogen-only implant will have regular bleeds. Infrequent bleeding is the most common pattern [...] and approximately one-quarter have prolonged or frequent bleeding. Altered bleeding patterns are likely to remain irregular' (op.cit. p6). Given this, it is not surprising that bleeding difficulties were commonly reported, although some practitioners spoke of working to overcome what they perceived to be misunderstandings about side effects such as heavy bleeding. Women who work with Pause may well have histories of non-engagement with health services and poor sexual/reproductive health, and FSRH guidance notes that 'although bleeding changes are associated with the implant, it is also important to consider other factors such as sexually transmitted infections [...] and gynaecological pathology' (op.cit. p6). Women and practitioners also noted health issues that complicated contraceptive choice (for example, history of ectopic pregnancy).

A few women felt unwilling or unable to discuss LARC problems with their practitioner because of their reliance on Pause, and this could be a source of disruption in highly valued relationships. One woman decided to keep the implant against explicit medical advice following very heavy bleeding, commenting, 'I have point blank refused to have it taken out because of me working with Pause'. Another, who struggled with side effects throughout the intervention, commented that, 'for me I had to weigh up the pros and cons of having an implant and being able to get the support that I knew I needed, and I had known that I had needed for so long'. Pause guidance on use of contraception allows exceptions on medical grounds, and it is not possible to draw clinical conclusions about specific cases; the sample also included two women who had switched to the pill on medical grounds. However, even if unusual, such experiences indicate an unintended consequence of conditionality: some women appear willing to tolerate significant negative impacts on health, even against medical advice, in order to maintain support from Pause.

Women and practitioners also discussed ethical tensions in contraceptive conditionality, and practitioners were evidently at pains to address this with sensitivity. One described conditionality as 'really uncomfortable' and in another practice, one commented that 'it

feels difficult, tricky. “You can have all this but you’ve just got to have that,” and it’s gone past the wire with a couple of my women... it feels more like bribery’. In a different practice, another practitioner observed, ‘I think a worker always has unequal power to somebody who’s part of a programme, even though it’s a voluntary programme. [...] I sometimes question whether or not that’s one area of great power [LARC], because actually to be part of the programme you must have that.’ Some practitioners also gave examples of women who went to considerable lengths to get support from Pause without having LARC. Several women also questioned the ethics of conditionality, such as one who observed, ‘We get a choice but not a choice as such if you know what I mean’. Within the main interview sample, 8 (16%) women raised concerns about lack of choice or control; similar points were made by some in the post-Pause sample.

In view of such findings, it is particularly striking that almost all the women interviewed chose to continue using contraception post-intervention. This evidence chimes with reports from stakeholders in the local authorities that had alternative recurrence services, who argued that giving women control meant they made their own decision to use contraception, albeit with strong encouragement. For example, one reported that ‘we know the take-up of contraception has been very successful, so for recruits into the programme, after six months I think 90% are using contraception, when they came in at 10%’. If women are able to make positive choices to use contraception, there is a question about the necessity of conditionality in the Pause model, especially given the concerns and potential unintended consequences noted above.

A further consideration relates to supporting women to manage their reproductive health post-intervention. Nine (of 49) women in the main interview sample reported pregnancies whilst using contraception: two became pregnant very early in the intervention, around the time they started using LARC; two midway through; and five after they finished working with Pause. Three of these five were on the pill, and two reported pregnancies around the time of their implant being renewed. Seven of the nine pregnancies resulted in miscarriage or termination; of the two live births, one child remained in their mother’s custody and the other was going through adoption proceedings at the final follow-up. At Time 4, this woman (who exited the intervention early) observed that ‘I would have liked them to continue working with me to be honest, just because I was taking the pill’, but she also reflected that she would have benefited from ‘more education on sex’. Her comments highlight the importance of women’s engagement in sexual and reproductive health services, especially given that all these women became pregnant when they understood themselves to be protected by contraception. Women who work with Pause access reproductive healthcare because of the contraceptive requirement, but monitoring data showed only a small increase in women who report accessing sexual health services in the last 9 months, from 50% to 53% between baseline and endpoint. Taken as a whole, data on women’s service use, experiences of conditionality and post-intervention management of contraception indicate that it would be valuable to review

Pause practice in relation to sexual and reproductive health. Equally, it must be recognised that Pause is not a specialist sexual health service, and the findings indicate a need for reproductive health services to develop approaches to work alongside recurrent care provision.

Pause in the context of other services

As noted in the introduction to this report, increasing awareness and concern about the prevalence of recurrent proceedings has led to a growth in provision for women at risk of repeat child removal, including the expansion of Pause and the development of other service models (see for example, Cox et al. 2017; Roberts et al. 2018). The small number of interviews conducted with local authority stakeholders provides some insight into how Pause is understood in the context of other services, whilst also highlighting the importance of recognising how the work of recurrence services, including Pause, is situated as part of a wider effort to prevent child placement.

Across the eight local authorities where we conducted interviews, four had Pause, three had an alternative service for women at risk of recurrence, and one was in the process of setting up a service for women who had had children removed from their care. The overarching priority for interviewees in all eight local authorities was reducing the need for children to come into care and/or the need for statutory services. Funding was seen as a challenge everywhere. Within constrained local authority budgets, these objectives were reflected in a focus on preventative services and interventions, as well as specific interventions for women who had had children removed from their care. Examples included using restorative, strengths-based, relationship-based practice, and interventions designed to target all families receiving support from children's services. Partnership working was highlighted everywhere as central to averting the need for children to be removed. This involved working both within children's services, but also across other sectors, including voluntary sector provision, and links with housing and benefits via the Troubled Families programme. Examples were also given of approaches to parent support and training such as Family Nurse Partnership.

The main reason given for setting up a service that focused on risk of recurrence was that social workers were seeing a number of families having successive children removed from their care. For example:

[We were] seeing the same families coming through, and we just couldn't keep doing this saying, "It's not fair to the children. It's not fair to the parents. We've got to do something different" (Pause local authority)

Several respondents also highlighted the importance of intervening early in pregnancy when there were concerns, as with one stakeholder, who explained:

Once women are pregnant and we've got concerns, we get engaged in things around pre-birth assessment [...] One of the things over the years that we've really

tried to do is to ensure that we are undertaking those assessments in an engaging way, but also earlier in the pregnancy, so that actually, by the end of it, you're not getting into circumstances where you're rushing the decision-making because of the imminent arrival of the child. But also, there being enough time to provide some support to mums-to-be where there is a possibility that they're going to hold onto the child. (Local authority with alternative recurrence service)

Among the four local authorities that were using or developing a model other than Pause to support women at risk of recurrence, three main reasons were given for their approach. In two areas, local authority interviewees reported that they had small populations of eligible women, and so it had not been seen as cost effective to invest in a Pause practice. Another participant commented that they had concluded they could develop something 'as good as' Pause within their existing service. Finally, as noted earlier, some respondents noted concerns about contraceptive conditionality within the Pause model; none of the alternative services had a contraceptive requirement.

Overall, there were many similarities in the key features of the three alternative recurrence services in comparison with Pause, as described by local authority stakeholders. These included: tenacity and persistence of practitioners; assertive outreach; trauma-informed and relationship-based work; an initial focus on practical issues (e.g. housing and benefits) and creating stability; working with multi-agency partners; and listening to and valuing the women for who they are. Across all areas, interviewees also highlighted the importance of working across professional groups and agencies, both in setting up the service and in supporting the women. One operational lead in an alternative service commented specifically that the practitioners providing one-to-one support to women were, inevitably, not experts in all areas where women required support, and so it was important to be able to access other services with the expertise and resources to meet women's needs:

It is vital to our service to work with other agencies. [...] Because we know we are not experts in all things and we want to give that woman an enriched service. We know that that woman is likely coming to us with three main struggles which are mental health, substance misuse and maybe domestic violence prior or continuing to happen. Added all the extra things, housing, you know, so we know that we have to build those relationships with other services and we do really. (Local authority with alternative recurrence service)

There are clear commonalities with the work of Pause in these local authority stakeholders' descriptions, both with regard to core features of practice and the emphasis on access to the services necessary to address complex and unmet needs. While it is beyond the scope of the evaluation to compare the efficacy of different models of intervention for women at risk of repeat child removals, this evidence of consistency across models lends confidence in the evaluation conclusions about key elements within the Pause intervention, as discussed above.

Conclusions: Foundations for change?

The evaluation demonstrates positive trajectories of change for the majority of women who work with Pause; the triangulation of findings across monitoring data and multiple interviews with women and professionals ensures confidence in the conclusions. Women consistently emphasised the role of Pause in scaffolding positive changes over time, across domains that map onto the outcomes specified in the Pause theory of change, including stabilisation; engagement with services; better relationships and a changing sense of self. Interviews documented practitioners' sensitivity in negotiating contraceptive use, and most women did not raise concerns about contraception. However, data also indicate the timeliness of Pause plans to review practice in relation to sexual and reproductive health, including women's engagement with specialist services.³¹

Overall, women were overwhelmingly positive about their experience of Pause in recognising and responding to their needs. There was consistent evidence that the intervention is associated with positive changes that continued or even emerged in the post-intervention period, suggesting that support from Pause lays foundations for future change. Nonetheless, life continues to be complex and challenging for many women, often for reasons beyond the scope of the Pause intervention. Gradual transitions, flexible endings and accessible support beyond Pause helped maintain positive trajectories, avoiding disruption and destabilisation as women deal with challenges post-intervention. This last point has implications for approaches to endings, and for developing Next Steps – which was not part of the Innovation Programme investment in Pause – to maintain the benefits of the programme as a foundation for long-term change.

Broadhurst et al.'s (2017) study of women in recurrent care proceedings reported that one in four women will return to the family court (a figure that rises to one in three for women who are below 20 years of age at the time of the index proceedings). Their analysis also showed that women are most vulnerable to returning to court with a subsequent child within two years. These findings highlight the scale of the issue, but also suggest a critical window in which there is a heightened need (and opportunity) to mitigate risk of recurrence. Our evaluation shows that long-term relational support provides a foundation for ongoing positive change in women's lives, improving reported relationships with existing children, and reducing rates of infant care entry in Pause local authorities to the extent that costs of intervention are offset by financial savings to the public purse over time. The study also found that the Pause intervention appeared to be at least as effective for women who had only one child removed, including younger women and care leavers, in comparison to women who had experienced recurrent removals. Considering this evidence of risk and benefit together, it may be concluded that there are ethical and economic grounds for providing intensive relationship-based and trauma-informed support to *all* women when a child has been removed, given the high risk of recurrence especially for younger women.

4. Summary of key findings on 7 practice features and 7 outcomes

Evidence from the first round of the Innovation Programme (Sebba et al. 2017) led the DfE to identify 7 practice features and 7 outcomes to explore further in subsequent rounds. The relevance of the Pause evaluation findings to the framework is as follows.

Practice features

The Pause model's emphasis on women's sense of self corresponds to a **strengths-based practice framework**. Interviews (women and professionals) consistently documented strengths-focused practice; one-to-one and group activities were seen as key to building confidence and self-esteem. The connection between a **holistic, systemic approach and a multi-disciplinary skill set** appears integral to improving wellbeing, mitigating risks and ensuring women's rights (for example, welfare entitlements and contact). The need for a systemic approach was highlighted by evidence that inaccessibility of other services could exacerbate risk and disrupt positive trajectories. **High intensity and consistency of practitioner**, through long-term intervention, was seen as key to relational practice, creating a foundation for change for women with complex histories of multiple professional involvement, often in the context of traumatic experiences. Staff turnover could have a disruptive effect, especially in contexts of funding insecurity. **Skilled direct work** was central to the Pause theory of change, including the ability to build trusting relationships, working *with and for* women to ensure rights and needs are met. The complex, dynamic and at times unpredictable nature of those needs is linked to the importance of flexibility and creativity in direct work.

Outcomes

The evaluation demonstrates significant reductions in rates of infant care entry in Pause Round 1 vs. matched comparator local authorities, corresponding to framework outcomes of **reducing days spent in state care** and **generating better value for money**. Cost-benefit analysis (CBA) indicates that this equates to reductions in placement of 14.4 children per site per annum, and £4.50 saved for every £1 spent over 4 years. Monitoring data also show a reduction in high cost service use (A&E and criminal justice) and improved access to services to meet existing needs (for example, mental health, housing). Participation in Pause is associated with **improved relationships with existing children**, through support for women's ongoing reconfiguration of identities and practices as mothers, and with emotional and practical challenges of diverse and dynamic contact arrangements. There is also evidence of **positive change in women's wellbeing** and in women's **reported relationships with partners, friends, and family**.

5. Lessons and implications

Long-term, intensive, trauma-informed relational work, delivered by skilled practitioners with small caseloads, is clearly effective in reducing rates of infant care entry for local authorities. There are reduced rates of infant care entry in local authorities with Pause Round 1 practices relative to matched comparators, and evidence of cumulative effects over time, consistent with findings from post-intervention interviews. Effects in Round 2 areas could not be assessed within the evaluation timeframe, but can be predicted given evidence that scale-up and diversification into new practice areas and the care leavers pilot retains consistency with the Pause model and benefits for women.

Benefits for younger women, including the care leavers pilot and those who only experienced removal of one child, indicate clear ethical and economic arguments for extending the model to *all* women who have a child removed into care. The research highlights the extent of (unmet) needs and the benefits of supporting them through Pause. The state has a sharpened ethical duty as corporate parent to care-experienced women, and 'corporate grandparent' to their children.

Benefits to existing children can be hypothesised given consistent reports of improved relationships across diverse placement and permanency arrangements. Future research should examine the impact on children and carers of support for birth mothers post-removal. The likely benefits for children add to the ethical arguments for extending this approach to all women who have children removed.

The evaluation did not compare the impact of Pause with alternative models that do not use contraceptive conditionality, but findings indicate the timeliness of the Pause review of practice in relation to sexual and reproductive health. Data on women's service use, experiences of conditionality and pre- and post-intervention management of contraception raise questions about the necessity of conditionality within the model and indicate the need for sexual and reproductive health services to work alongside recurrent care provision.³²

Evidence of positive change in women's lives within and beyond the intervention is relevant to recurrence services *and* other provision for vulnerable populations. Women have significant unmet health and welfare needs and complex histories and there is a clear need for trauma-informed cross-sectoral approaches that link child and adult services, including benefits, housing and health services.

Accessible support helps women deal with potentially destabilising challenges post-intervention, indicating the importance of investing in Next Steps support. Pause developed Next Steps provision over the course of the research; this was not part of the Innovation Programme investment, but post-intervention interviews indicate its value in maintaining the benefits of Pause as a foundation for long-term change.

Endnotes

¹ Personal communication from Pause National Leadership Team: 'As part of continued organisational learning, and to better understand how Pause's position on contraception impacts on women on the programme and Pause Practitioners, the Pause Board of Trustees has commissioned an internal reflection to look at Pause's position on contraception. Pause has commissioned Dr Rebecca French, Associate Professor of Sexual and Reproductive Health at the London School of Hygiene and Tropical Medicine to carry out this piece of work. It will be completed in 2020.'

It is also relevant to note that Public Health England have funded a project, led by Research in Practice, to map service models operating with women at risk of recurrent removal, which will report in early 2021. This evidence should enable more nuanced understanding of the range of service activities working with this population.

² [CAFCASS Care Applications in England](#)

³ Doncaster, Greenwich, Hull, Islington, Newham, and Southwark; Doncaster did not continue after Round 1, but 18 months later re-started, not funded by DfE.

⁴ Barking and Dagenham, Bristol, Cumbria, Derby, North East Lincolnshire, St. Helens, Slough, West Sussex, and Wiltshire.

⁵ Greenwich, Hackney, Hull, Islington, Newham and Southwark.

⁶ Most commonly, Pause works with women who have experienced removal of two or more children, but in the care leavers pilot funded under Round 2 of the Innovation Programme, and in some practice areas, they also work with women who have had only one child removed.

⁷ Contraceptive implant, injection, hormonal coil or non-hormonal coil.

⁸ The nature of budget savings is not specified in the model, but could relate to improvements in women's financial capabilities or, more substantially, to cost savings for the wider public sector (for example, from reductions in placement of future-born children or from changes in use of other publicly funded services).

⁹ Throughout, we use the Pause terminology: 'engagement' refers to the period of up to 16 weeks when they are working towards agreement to the conditions of programme, and 'open' is the term used to describe work with women once agreement is confirmed.

¹⁰ We focus on placements of children below 12 months because two-thirds of all recurrent placements involve children younger than a year and 47% of newborns in care proceedings have mothers who have previously appeared in care proceedings (Broadhurst et al. 2017, 2018). Any evidence in Pause Practice areas of reductions in child placements will be most readily detectable by focusing on this age group.

¹¹ It was originally intended that analysis would include a second comparison group of local authorities with alternative recurrence services, but scoping indicated too much variability in scale and duration of service for comparison to be fair or meaningful at this stage.

¹² Throughout this report, to ensure anonymity, identifiers for individual cases are not used, and when identifiability is a risk, practice areas or phases of interview are not specified.

¹³ Estimated from Round 2 sites due to data availability.

¹⁴ Exit from local authority care probabilities by age group are based on DfE published SSDA903 statistics, but to account for the distinctive pathways of children whose mothers have already had children removed from their care, reasons for leaving LA care (adoption, residence order, special guardianship, return home) are drawn from Broadhurst et al (2017).

¹⁵ This data is collected through a risk assessment completed at the start of contact with Pause, with information is collected by Pause staff from external professionals (outside of Pause).

¹⁶ Two women reported active threat or risk of harm from both past and current partners.

¹⁷ Source: [Crime Survey for England and Wales](#)

¹⁸ Type of pre-intervention contraception is not recorded in monitoring data.

¹⁹ Of the remainder, 21 specified that they were not using contraception pre-Pause, and information was not provided for two others.

²⁰ The CORE-10 tool was designed for the evaluation of changes in emotional distress in the evaluation of counselling and the psychological therapies in the UK; see Connell & Barkham (2007).

²¹ Source: [ONS Estimates of Life Satisfaction by personal characteristics, UK: year ending December 2016](#).

²² This pattern is apparent, but less clear cut, for women with alcohol use problems. See Appendix 6.

²³ Monitoring data also include an adapted version of the widely used Rosenberg Self-Esteem Scale and a modified loss scale, both of which show positive change between baseline and endpoint. However, as discussed in more detail in Appendix 6, results on the assessment of self-esteem are less clear.

²⁴ Specifically: 23 percent compared to 8 percent for Class A drug use, 30 percent compared to 18 percent for non-class A drug use, 51 percent compared to 29 percent for alcohol use. However, and unsurprisingly, women with reported drug and alcohol problems had higher consumption levels at baseline than those without (particularly for drugs, with a less clear difference for alcohol).

²⁵ Personal Independence Payments are designed to help with costs of everyday life for people who have been assessed as eligible because of an illness, disability or mental health condition, and are payable in addition to Employment and Support Allowance or other benefits.

²⁶ The absence of a counterfactual means that this reduction in A&E visits cannot be assumed to be a causal effect of Pause, but it should be noted that over time, even this apparently small reduction will accrue savings to the NHS. For this sample only, baseline value of visits to A&E would be estimated to be £66,700 and the endpoint £48,300, a reduction of £18,400. The baseline costs of arrests and costs to society would be £193,200; the endpoint costs would be estimated to be £94,500, a reduction of £98,700. Source of estimated cost for the A&E appointments is [National Schedule of NHS costs 2018-19](#). Estimated cost for criminal justice is Heeks et al. (2018) [The Economic and Social Costs of Crime](#) (Home Office).

²⁷ The [Research in Practice Change Project on Working with Recurrent-Care Experienced Birth Mothers](#) reports examples of alternative models of provision that work directly with women's partners.

²⁸ Pause National Team, personal communication.

²⁹ For instance the current, DfE funded scaling and spreading across Greater Manchester of Salford's Strengthening Families project, and the Leeds Futures service, developed

over the course of 2017-18. New initiatives not only offer services targeted at mothers who have had children removed from their care, but, in addition, add persuasion into a mix of targeted advice giving and empowerment because women are given a clear 'nudge' in favour of long-acting reversible contraception (LARC). For example, Salford City Council's 'Strengthening Families' programme encourages mothers to engage in a flexible period of rehabilitation having previously had a child removed from their care, before becoming pregnant again.

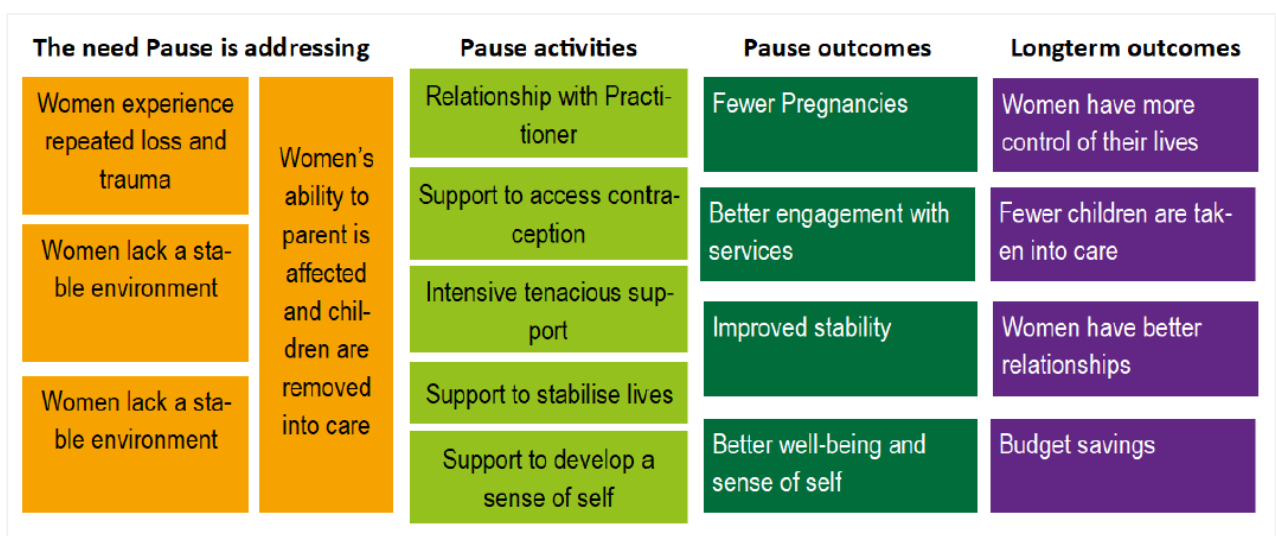
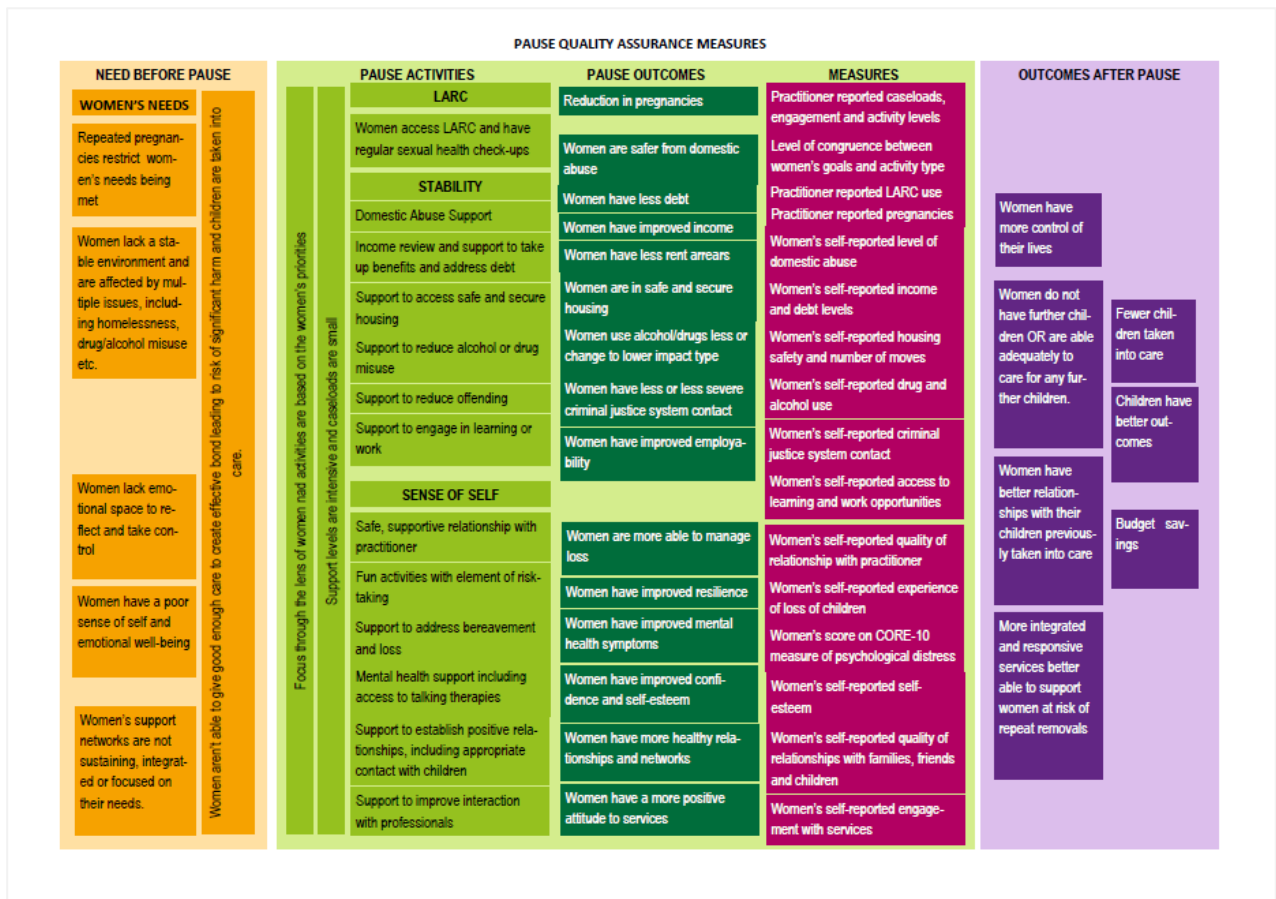
³⁰ Within the main sample, post-intervention 27/32 (84%) reported using LARC methods and 5 (16%) were using the pill. All 10 women in the post-intervention sample were using LARC.

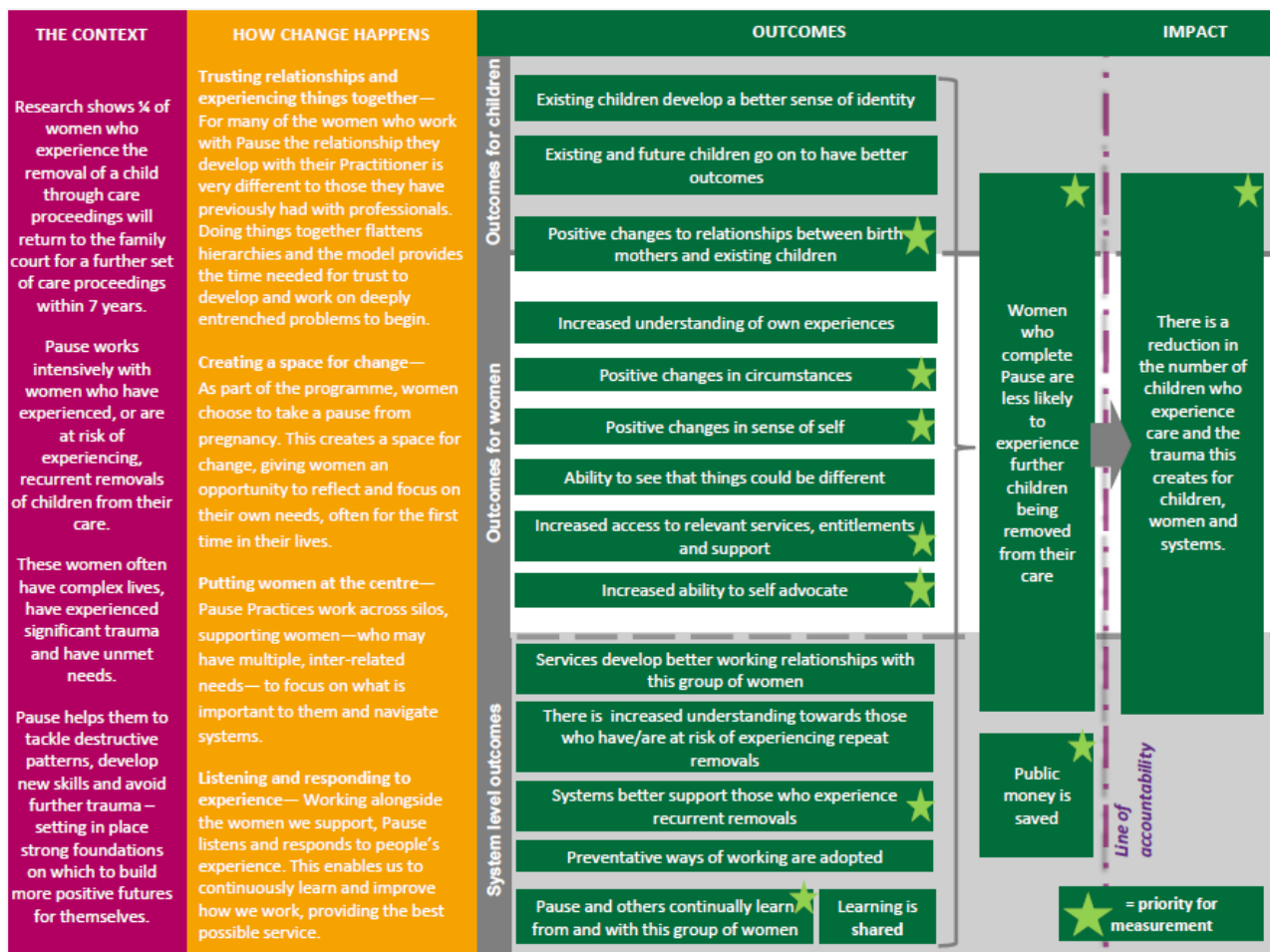
³¹ See Endnote 1.

³² See Endnote 1.

Appendix 1: Pause theory of change

The figures below represent three iterations of the Pause theory of change: first, a detailed model, and second, a summarised version of key elements, both dating from 2017. Pause continue to develop their theory of change; the third figure, overleaf, was being developed through the course of the evaluation, and was finalised in autumn 2019.





Appendix 2: Methodology

The approach to evaluation

The purpose of evaluation is not just to identify *whether* a change in outcomes has occurred, but also to understand *why* changes may have occurred (for example, Greenhalgh and Papoutsi 2018, Craig et al. 2019, Deaton and Cartwright 2016), and this principle is particularly important in light of wider DfE objectives for scale-up and roll out of effective evaluations in the Innovation Programme, as well as in relation to the expansion and diversification of Pause in Round 2 of the Innovation Programme.

A realistic approach to evaluation (Pawson and Tilley 1997) makes it possible to determine ‘why, when and for whom something works, and whether there are any unintended side-effects that need to be taken into account’ (Nutley et al. 2013 p6). In this context, evaluation of distance travelled (through analysis of change over time, including change or maintenance of effects beyond the end of the intervention) is critical for understanding the intersection of process and outcome, and so for informing questions of scale-up and roll out (for example, in relation to the duration of the intervention, or provision of post-intervention support).

Identifying appropriate counterfactuals

Assessment of the counterfactual (what would have happened in the absence of the intervention) can involve a range of approaches (comparison with service users who did not receive the intervention, who have varying degrees of similarity to the intervention group; measurement of the same outcomes in the wider population; within subjects measurement of change over time, including the period before the intervention began; or causal assessment using qualitative methods to gain a detailed understanding of the journey of service users from pre- to post-intervention). All of these approaches include some weaknesses (for example, extent of comparability, generalisability) and all incur some assumptions.

The process of recruiting women to the Pause programme (see Appendix 5) means that randomisation designs are not appropriate. The Pause process involves (a) scoping work with local authorities to identify women who meet broad inclusion criteria for the programme; (b) prioritisation of women for targeted engagement activity; (c) a period of engagement, from which a final population of women who begin the programme (become ‘open’ in Pause terminology) is established. In this context, randomisation is not methodologically feasible or ethically acceptable. Moreover, women consent to data sharing only at the point they ‘open’ on the programme, and this means it was not possible to compare baseline characteristics at the point of identification or engagement of those who do or do not engage or open on the programme. Given these

considerations, quasi-experimental methods were incorporated within the evaluation plan only where this would generate meaningful data.

In determining the primary outcome measure for counterfactual assessment of the impact of Pause, we have compared rates of infant care entry in Pause Round 1 sites and comparison areas with no known alternative recurrence service, and conducted cost-benefit analysis on this basis. The focus on rates of infant care entry as the primary outcome indicator reflects the long term theoretical outcomes of the intervention as specified in the theory of change (Appendix 1): that women have more control of their lives, better relationships, that there are budget savings, and that fewer children are taken into care (see Appendices 3 & 4). Pause exists alongside an emerging range of targeted initiatives which utilise a variety of approaches to support women who have experienced recurrent removals of children into care (not all of which require contraceptive uptake as a condition of the programme). However, it is beyond the scope of this evaluation to compare the relative costs, benefits and efficacy of Pause with other forms of recurrence provision, not least because differences in project scale and length of time established mean that it was not possible to establish appropriate comparisons. Nonetheless, it is important that the evaluation design takes account of this context, and learning from the research is relevant to the wider development of recurrence provision.

Outcomes related to women having more control of their lives and better relationships are not analysed in relation to a counterfactual, but detailed analysis over time lends confidence that the conclusions of this analysis are robust: in-depth qualitative longitudinal interviews with women who have worked with Pause (including post-intervention follow-up) are triangulated with Pause 'outcomes tracker' monitoring data and professional stakeholder perspectives from Pause and local authorities.

Rates of infant care entry in Pause and comparison local authorities

The evaluation used published SSDA903 data to conduct a 'difference in difference' analysis of local authority statistics on rates of infant care entry (<12 months) in Pause Round 1 local authorities and a matched comparison group of local authorities with no identified recurrence service. The methodology and analysis are discussed in detail in Appendix 3, so here we summarise the rationale for this approach.

The difference in difference approach has not been widely used in evaluating children's services interventions, and is an important innovation in our methodology. Arguably, it may *under*-estimate the impact and cost-benefit of Pause because it is based on matched comparison of local authorities and is not a direct measure of the impact of Pause on individual women, but instead focuses on area level effects. It is not possible to

identify recurrence within SSDA903 data returns, and so published data on infant care entry includes:

- children whose mothers have not experienced prior removals; and
- children whose mothers have experienced prior removals but who have not worked with Pause, for example because:
 - they have had one child removed, and were not identified or engaged because the Pause practice focuses on women who have experienced recurrent removals;
 - limits to practice capacity means that they were not prioritised for engagement in the evaluation timeframe; or
 - they were unreachable or chose not to engage, even if identified by Pause.

It cannot be anticipated that the presence of Pause in a local authority should impact rates of infant care entry for these groups. Other variables (such as improvements in social work practice and 'edge of care' services) may also account for differences in infant placements, but it can be assumed that rates for these groups will not diverge from matched comparators (with prior parallel trends) over time, and therefore that any differences post-intervention can be attributed to the impact of Pause. Moreover, any removals of children born post-intervention to women who have worked with Pause are likely to take place early in children's lives (cf Broadhurst et al, 2017, 2018) and so a focus on infant care entry should maximise the possibility of detecting effects. While Broadhurst and colleagues' (op.cit.) research on recurrence has utilised CAF/CASS data, early communication with Pause indicated that they work with women who have children placed through voluntary arrangements as well as through formal proceedings, and hence it was judged that a focus on SSDA903 data would be more appropriate than CAF/CASS data analysis, because the former could capture Section 20 voluntary arrangements.

With these considerations in mind, SSDA903 analysis incorporates two counterfactuals: pre- and post-implementation of Pause in Round 1 local authorities, and comparison of Pause sites and matched comparison areas. The focus on Round 1 practices means it cannot be assumed that the results will be replicable in other practice areas, but analysis of qualitative and monitoring data provides context for gauging the potential generalisability of the comparative analysis. Focusing on Round 1 practices also made it possible to account for post-intervention effects, which was not feasible for Round 2 practices within the evaluation timeframe. Finally, there are distinct benefits in evaluating area-level effects in that it is possible to assess the impact of Pause against DfE outcome priorities (reduced days in state care) as well as the Pause theory of change (fewer

children are taken into care), and to provide a robust estimate of cost savings to the public purse – including to local authorities who must make difficult judgements about the potential value for money of specialist provision within the wider budgetary context of children’s services.

Cost-benefit analysis

A detailed account of cost-benefit analysis, including key assumptions, estimates and modelling, is provided in Appendix 4 and hence is not repeated here. The proposed approach to cost-benefit analysis has been developed to align with the principles of the HM Treasury Green Book, with benefits and opportunity costs valued at market prices as far as reasonably possible within the constraints set by data availability. The approach combined:

- evidence on the resource costs associated with the delivery of Pause;
- estimates of the causal effects of the programme derived from the impact evaluation; and
- secondary information on the unit costs of key outcomes associated with infant placement (including costs of proceeding, permanence and placement options).

When the evaluation was planned, the intent was to use Pause monitoring data to conduct a fiscal analysis of impacts on women’s lives, for example with regard to changes in service use (for example, reduction of high cost services such as A&E) and improvements in subjective well-being (see Fujiwara and Campbell 2011). However, it was not possible to establish robust comparators within Pause monitoring data (for example, between women who did or did not engage, or between completers and non-completers; see Appendix 6) and this means that cost-benefit associated with impact on women cannot be reliably assessed within the scope of available data.

Secondary analysis of Pause ‘outcomes tracker’ monitoring data

Pause provided access to anonymised monitoring and evaluation data for all 25 Pause Practice areas (including Round 1 and Round 2 practices and all active areas with non-DfE funding to maximise statistical power). Outcomes tracker data is designed to be completed at baseline, 9 months and as close as possible to the end of the intervention and includes questions in relation to physical and mental health; sex and relationships (including partner, children and friends and family); drug and alcohol use; housing; financial circumstances; access to services; police or crime; learning and work; a standardised measure of emotional wellbeing (CORE-10); a measure of self-esteem

(adapted version Rosenberg Self-Esteem Inventory); two ONS life satisfaction questions; and a bespoke measure of feelings about the loss of a child, as well as questions in relation to goals for the work and perceived progress (worker and client report). This component of the work analysed reported evidence of change over time for women engaged in Pause, including:

- analysis of change for the sample as a whole (all practice areas), including modelling of variables that predict variance in impact over 18 months;
- comparison of change across practice areas, including comparison of new and established areas;
- comparison of care leavers with Pause-as-usual clients (in established practice areas that host the care leaver pilots); and
- comparison of completers (those who remain engaged with the programme over 18 months) and non-completers (those who withdraw from the programme).

Additional comparative analysis was conducted to compare the characteristics of women interviewed⁴ with the monitoring data sample; no significant differences were identified with respect to baseline characteristics of ethnicity, age, contraception, alcohol or drug issues, mental health, learning difficulties, housing, criminal justice, or domestic violence. The proportion of women in the interview sample who were in the care leavers pilot was, as would be expected given the sample construction (see below), significantly higher than in the total population (over 30% compared with 7% of the main population). Unsurprisingly, given that the care leavers pilot recruited women who only had one child removed, the average number of children for women in the interview sample was significantly less in the qualitative sample than in the Pause population as a whole (2.4 compared to 3.1 in the main sample). None of the 39 women in the interview sample for whom monitoring data were available had recorded report of physical health problems; interview data discussed in the main report suggest that this may be under-reporting.

A detailed summary of monitoring data analysis is presented in Appendix 6. Given space constraints for reporting, not all analyses are presented and in particular, where there were *no* intergroup differences (for example, between women in Round 1 and Round 2 practices) these are not reported in detail. Pause monitoring data relies on women's self-report and practitioner recording, and the limitations of this are recognised, in terms of potential issues with data quality and consistency of recording, and the possibility that practitioner-recording will over-estimate benefits from the intervention. Issues of data quality were addressed through discussions with the Pause national team, including

⁴ Data were available for 39 women in the interview sample.

those responsible for internal monitoring and evaluation. Members of the evaluation team also took part in one-day workshop with practice leads at the beginning of the project, where we had the opportunity to discuss the plans for evaluation, including analysis of monitoring data, and secure engagement with the evaluation process.

Case identification analysis

This component of the evaluation aimed to assess the extent to which Pause reach the target population of women at risk of child removal, including consideration of variation between Round 1 and Round 2 practices. The original proposal was to conduct a qualitative secondary analysis of a subsample of 30 'pen portraits' (summaries generated by Pause, based on case file analysis, to identify potentially eligible women) drawn from one Round 1 and one Round 2 practice. However, early stage interviews with Pause practices indicated that this approach would not capture the complexity of case identification processes, and hence a revised approach was adopted, as follows: working across one Round 1 and one Round 2 practice (as per the original proposal); undertaking a qualitative analysis of the triage process (including how clients are identified, who makes referrals, the systems used by practices to create a list of women who are a priority for targeting) and the characteristics of women at each stage of the process; and interviewing the practice lead to illuminate the decision making process. All data provided by Pause were transferred securely through a dedicated GDPR compliant Sussex Box folder and with password protected individual files.

Interviews with Pause professional stakeholders

In total, 47 Pause staff took part in interviews for the evaluation (Table 4). All interviews were open-ended, following a common topic guide, while allowing for variation in emphasis depending on role and issues arising in group discussions. As appropriate for respondents' organisational role, interviews addressed: the Pause practice model, including key features of the model and understandings of women's needs; training and roll out systems; the Pause theory of change; processes for client identification; barriers and facilitators of change for women; and barriers and facilitators for effective working.

Table 4: Interviews with Pause professional stakeholders

| Pause team | Individual or Group interview | Number participants |
|---------------------------|--------------------------------------|----------------------------|
| National scoping team | Group interview | 3 |
| National team | Group and telephone interview | Group=3; Telephone=1 |
| National practice leads | Group interview | 6 |
| Founding member | Telephone interview | 1 |
| Round 1 practice leads | Telephone interview | 6 |
| Round 2 practice leads | Telephone interview | 9 |
| Round 1 practitioners | Group interview (x3) | 9 |
| Round 2 practitioners | Group interview (x3) | 9 |
| Total participants | | 47 |

Interviews with local authority stakeholders

Interviews with local authority stakeholders aimed to: explore the perceived needs and available support for the local population of women who have experienced recurrent placements; provide qualitative comparative evidence of perceived benefits or burdens to related services as a result of (or in the absence of) Pause or other recurrent care provision. Telephone interviews were conducted between October and November 2019 with 8 LA strategic leads or managers in the following: two Pause Round 1 practices; two Pause Round 2 practices; two LAs which offered another form of provision for women at risk of recurrent child removal; and two LAs which were not known to have recurrent care provision at the time of recruitment to the study. An additional two interviews were conducted with the operation leads in the two LAs that had alternative recurrent care provision to gain a deeper understanding of the service.

Telephone interviews with local authority stakeholders addressed the perceived needs and available support for the local population of women who have experienced recurrent placements, providing qualitative comparative evidence of perceived benefits or burdens to related services as a result of (or in the absence of) Pause or other recurrent care provision. In all areas, the stakeholders were asked to provide anonymised data on recurrent placements for the purposes of comparative analysis. All interviews were open-ended following a topic guide, and were digitally audio-recorded and transcribed. It was originally intended that these interviews would also be used to seek anonymised data on recurrent placements for the purposes of comparative analysis, but it was apparent that these data were not accessible and so interviews instead explored the feasibility of recording data on recurrence.

Interviews with women currently supported by Pause

Qualitative longitudinal interviews were conducted with a sample of women who were 'open' with Pause when the evaluation began. Interviews were conducted with 49 women as follows (see also Table 3, main report): 21 women sampled from five Round 2 areas; 14 women sampled from three Round 1 areas; and 14 women sampled from six care leaver pilot (Round 1) areas. Practice areas were selected to represent different local authority and delivery characteristics. In all three components (Round 1 and 2 practices and care leaver pilot), the women sampled were, insofar as possible, the most recent entrants to the programme, so they are recruited to the evaluation as close as possible to the point of joining the programme. Each woman was interviewed on up to four occasions, usually twice face to face and twice by telephone⁵. Not all women were reachable at all time points and we exercised caution in pursuing women for interview, given their vulnerability and an ethical concern not to disrupt Pause work or put pressure on people who were in a dependent position as recipients of the service being evaluated. Hence, longitudinal data are subject to sample attrition (Table 5), although at least one post-intervention interview was conducted with 32 women (65% of the sample of 49).

It was originally intended that women would be interviewed at four key timepoints: Baseline (2-6 months from beginning the intervention), Mid-point (10 months), End-point (18 months) and Post-Pause (21 months). However, baseline data collection took significantly longer than originally planned, in part because of the later start date of the project (compared to the submitted proposal) but also because of difficulties in securing the sample. For example, the care leavers sample was intended to be drawn from just three Round 1 practices, but eventually was recruited via all the care leaver pilot sites. This delay meant that a significant proportion of women in the sample were further into the Pause intervention at the Time 1 interview than was originally anticipated in the project design. This was discussed with the Pause evaluation advisory group, who agreed that – while this limits baseline data collection via interview – it had benefits in enabling follow up after the intervention. Accordingly, for women who were 12 months or more into the intervention at the Time 1 interview, the Time 2 interview was an endpoint interview, with two post-intervention interviews (T3 and T4). For women who are less than 12 months into the intervention, the design remains as in the proposal (T1 and T2 are conducted during the intervention, T3 is endpoint and T4 is post-intervention). Interviews were conducted over a period of up to 20 months, enabling stronger evidence

⁵ In some cases, all interviews were face-to-face (for example, if women requested this); some were conducted predominantly over the phone (for example, if a woman was not available for a face-to-face arranged appointment on long-distance fieldwork, the rescheduled interview sometimes took place by phone).

than had originally been anticipated of post-intervention experiences. All women received a £20 gift voucher in thanks for participation in each interview.

Table 5: Current Pause women: sample attrition

| | Time 1 | Time 2 | Time 3 | Time 4 |
|----------------------------------|--------|----------|----------|----------|
| Total sample | 49 | 40 (82%) | 28 (57%) | 18 (37%) |
| Care leavers pilot | 14 | 13 (93%) | 6 (43%) | 7 (50%) |
| R1 practice current women | 14 | 11 (79%) | 10 (71%) | 7 (50%) |
| R2 practice current women | 21 | 16 (76%) | 12 (57%) | 4 (19%) |

Permission was also sought from women to access their monitoring data, to enable a cross-check of their representativeness within the Pause population as a whole (see above). All interviews were open-ended, following a topic guide. The primary focus of the interviews was on women’s experiences of the Pause intervention, including (as appropriate at each timepoint) processes of engagement with (or referral into) the programme, experience of key features of the programme including contraception, and the extent to which the programme meets their perceived needs; the areas covered in the interview included information about current circumstances (including housing, relationships, employment, and contact with children) along with any other issues that women wished to discuss. As is evident from this summary, interviews were potentially highly sensitive, and were conducted with an emphasis on ensuring that women could talk freely about considerations that were important to them, and with care to avoid pressure to discuss issues that they may have found upsetting or been reluctant to discuss. With permission, all interviews were digitally audio-recorded and transcribed. Interviews were analysed thematically using a case-based longitudinal approach, such that an analytic summary was prepared for each timepoint, and these were then combined into a whole case analysis. Subsequently, cross-case analysis was conducted to examine patterns over time and across the sample as a whole, and taking account of intersections between themes as well as any evidence of differences between subgroups (Round 1, Round 2 and care leavers pilot).

Interviews with women previously supported by Pause

Interviews were conducted with 12 women who were supported by Pause during Round 1 of the Innovation Programme, completing the programme approximately two years prior to their first interview. Two women were sampled from each of six Round 1 practices: Greenwich, Hackney, Hull, Islington, Newham and Southwark. Women were interviewed

at two different time points approximately six to nine months apart; 11 out of 12 took part in both interviews. All women received a £20 gift voucher in thanks for their participation in each interview.

It was originally intended that this component of the evaluation would also include group observations and interviews in post-intervention groups, but early stages of work on the evaluation raised a number of questions about the ethics and feasibility of this approach. In particular, Pause were establishing new models for Next Steps support (separately from Innovation Programme funding) over the course of the evaluation, and hence approaches to support were in development and varied across practice areas; this also meant that groups were relatively recently established in some areas, and there were potential ethics risks in group data collection in newly formed groups and in contexts where some women were known to researchers and some were not, especially in light of potential tensions within group dynamics as discussed in the main report. Accordingly, it was decided that group data collection was not appropriate – and not necessary, given that interviews in the main sample produced more post-intervention data than had originally been anticipated, including discussion of Next Steps support.

A further consideration for one-to-one interviews related to the feasibility of establishing contact with women two years post-intervention, and so in consultation with Pause and the evaluation advisory group, it was decided that the sample of 12 women should be targeted to include women who were known by practices to be (a) getting on well; and (b) to be struggling. Given that the sample would inevitably be skewed to these extremes (because of who is still likely to be in contact with practices) there is a clear rationale for systematically seeking a balance of cases that provide emblematic exemplars of different pathways post-intervention. This component of the design is otherwise unchanged.

Interviews were open-ended, following a topic guide, and were conducted face to face, digitally audio recorded and transcribed. The primary focus of these interviews was on women's experiences of the Pause intervention, and on their current circumstances (including housing, relationships, employment, and contact with children) and support needs, and their views of the Pause programme, along with any other issues that women wish to discuss. Again, these interviews were potentially highly sensitive, depending on women's current circumstances and the extent to which their support needs were being met and so they were conducted with an emphasis on ensuring that women could talk freely about considerations that were important to them, and with care to avoid pressure to discuss issues that they may have found upsetting or been reluctant to discuss.

Ethics and data protection

The research was conducted subject to approval from the University of Sussex Cluster Research Ethics Committee for Social Sciences, Arts and Humanities (Approval

ER/JMB55/8), in accordance with the requirements of GDPR and in line with the ESRC Framework for Research Ethics, which spans the different disciplinary perspectives involved in the work. Specific issues addressed included:

- freely given consent, particularly in research with:
 - women in a dependent position in relation to support from the project being evaluated and with regard to risk of undue inducement (including provision of thank you vouchers for participation); and
 - Pause staff who were being interviewed in their professional role;
- appropriately informed consent, particularly in research with women who may have learning disabilities and/or low levels of formal education (a short video explainer was created, in conjunction with information sheets that were shared via practitioners and talked through again by researchers);
- rights of withdrawal and refusal to answer questions, especially in the context of sensitive interviews and longitudinal engagement in the study;
- limits of confidentiality, in terms of:
 - potential for disclosures of safeguarding or welfare concerns, and the researchers' duty of care;
 - risks of recognisability within relatively small qualitative samples, where women are known to Pause staff and to each other;
- data security, including data sharing, data transfer, anonymization, secure storage and destruction of data, particularly in the context of a research collaboration between three organisations (University of Sussex, Ipsos Mori and Research in Practice), and through confidentiality agreements with an approved transcription service (TypeOut);
- safeguarding of participants (including enhanced DBS clearance for researchers interviewing women); and
- researcher safety, including emotional impact of highly sensitive interviews, and safety in lone fieldworking contexts.

Appendix 3: Difference in Difference Analysis

Introduction

As discussed elsewhere in this report, the aim of the difference in difference analysis was to investigate the long-term impact of Pause practices on local authority rates of infant care entry, using quasi-experimental methods. The evaluation aimed to provide that longer-term view of impact and so focused on local authorities where there was a Pause practice funded within Round 1 of the Innovation Programme, which had a Pause practice in place for between 3 and 4 years at the endpoint of the analysis in March 2019. As discussed further in Appendix 2, rather than ask about the long-term impact on Pause women and their children, the analysis focuses on the impact for the local authorities where Pause operates. The research question is “Does the presence of a Pause practice have a significant effect on the number of infants (<12 months) entering care in those local authorities, when compared to authorities without a recurrent care service?”

The research question is explored through secondary analysis of published SSDA903 data on infants starting to be looked after in local authorities, and other data available at a local authority level. Difference in difference, a quasi-experimental approach, is used to compare the change over time in authorities with a Round 1 Pause practice with local authorities without a recurrent care service. This approach has a number of benefits:

- Difference in difference takes into account the different starting points of individual authorities and the effect of changes affecting all local authorities over the period.
- Outcome measures and covariates are drawn from published data, reducing the burdens on the individual women or local authorities involved and allowing for choice of a comparison group unhindered by the need to secure the co-operation of that group to supply data. In this way the method presents the potential for a lower cost, less intensive approach to quantitative evaluations of future innovations. This is discussed further below.
- The availability of a counter-factual allows for cost-benefit analysis to be undertaken to identify costs avoided through a reduced rate of looked after children. Arguably, there is particular value in being able to demonstrate this impact at local authority level, since resources for funding or match-funding Pause projects are commonly drawn from local authority budgets as discussed elsewhere in this report.
- The analysis captures change at a system level as well as change for individual women and children. This reflects the theory of change developed by the original evaluation team which includes changes to service design through strategic

engagement (McCracken et al, 2017). If this element of the service is successful, it might affect the number of children becoming looked after in other ways (for example by changing the way services respond to women after the first child becomes looked after but before they qualify for Pause).

Dependent and Independent variables

Local authorities

The unit of analysis for the analysis is the top-tier local authority with responsibility for children's services. All variables are calculated at this level.

The independent variable is the presence of a Pause practice that began in 2015, funded through Round 1 of the Innovation Programme. One of the Round 1 authorities (Hackney) had a Pause practice from 2013 and has therefore been excluded from the analysis. The analysis uses time as a variable, and excluding the early starter ensures that all the authorities in our treatment group have the same start date, simplifying the data requirements and analysis. One local authority (Doncaster) only had a Pause practice for the duration of Round 1 funding, while the remainder continued to fund Pause after external funding ended. Results with and without this authority are presented below.

The comparison group is drawn from local authorities without a service for women or families at risk of repeat child removals. Round 1 Pause authorities are not the only authorities with a Pause practice in the time period under examination. A number of other local authorities have introduced a Pause practice, including (but not limited to) those being funded under Round 2 of the Innovation Programme. In addition, a number of authorities have introduced alternative services for families experiencing repeat removals of children. These services serve the same target group and have the same aims as Pause, to prevent subsequent removals, though they may have different core features and approaches to practice.

Local authorities with alternative services were identified through a web search of the websites of all authorities except for Round 1 sites, looking for references to "recurrent care proceedings", "repeat child removals" and "Pause". The search included reviewing Joint Strategic Needs Assessments (JSNA), Children and Young People's Plans and reports to various council committees and scrutiny boards for indications that a service for families experiencing repeat removals was planned or in place. This approach was validated in as far as those authorities known to have Pause or an alternative service – through informal contact, information provided by Pause, and through the Research in Practice Change Project on Working with Recurrent-Care Experienced Birth Mothers – were all identifiable using this approach. The assumption is made that where no relevant

results were found, that the authority had no known recurrent service and was therefore a viable comparator. If this assumption is faulty, authorities with a recurrent care service may have been included in the control group. Assuming that service was effective, it would lead to a reduction in the mean rate of care entry in the control group, and reduce the likelihood of identifying a significant difference in the analysis.

As noted elsewhere, it was not feasible to compare the relative costs, benefits and efficacy of Pause with other forms of recurrence provision, because appropriate comparators (with similar scale of service and length of operation) could not be established. To compare different models would require much more detailed work in identifying the different approaches used in each authority, and is beyond the scope of this project. Matching would have to incorporate local authority characteristics (discussed further below) *and* comparability in the scale and duration of the alternative intervention models. Without this, inappropriate comparison would produce spurious findings, and give a misleading representation of the efficacy of Pause relative to alternative approaches. Accordingly, to avoid confounding effects insofar as possible, local authorities with a non-Round 1 Pause practice (N=18) or which were known to have an alternative recurrence service (N=46) were removed from the analysis. Following these exclusions, 83 local authorities with no known recurrent care service were identified.

Young children entering care

Pause works with women who have experienced at least one child entering care and are judged to be at risk of recurrent child removals. Ideally, therefore, the dependent variable for the analysis would be the number of children removed from families where previous children have been removed, or a measure of repeat care proceedings within individual families. These data are not readily available locally due to the recording practices and systems used in local authorities: SSDA903 records focus on individual children, and do not record the family history of involvement with social care. Data on recurrent child removals therefore do not form part of the routine submission and reporting of national statistics by the relevant government departments and agencies. While recurrence can be identified in CAFCASS records (see Broadhurst et al. for example, 2017) early communication with Pause indicated that they work with women who have children placed through voluntary arrangements as well as through formal proceedings. The proportion of very young children entering care through voluntary arrangements is not known, but there is some indication that its use has increased to support fostering for adoption placements which usually involve younger children (Lynch, 2017). Hence it was judged that a focus on SSDA903 data would be more appropriate than CAFCASS data analysis, because the former will capture Section 20 voluntary arrangements. To extract information on recurrence in SSDA903 returns would require significant resource dedicated to the analysis of individual case files and tracking families over time in both the treatment and comparison group, and is beyond the capacity this evaluation.

SSDA903 statistics published by the Department for Education include all children entering care, whether through care proceedings or through voluntary agreements, ensuring that the full impact of Pause on care entry is captured. The statistics on children entering care are broken down by age, allowing the analysis to focus on change in numbers for very young children, those under the age of 1 year. The benefit of using this very restricted measure of children under 1, rather than a broader age group, is to reduce the legacy effect from one year to the next. Very few children in one year's data will appear again in subsequent years and thus the number can be seen as reflecting local authority practice in that year, rather than a combined effect of past and present practice.

The number of children looked after (of any age) in a local authority is partially determined by the size of the underlying population (Newton Europe, 2017). The number of children under one starting care is converted to a rate per 10,000 children under one using mid-year population estimates for children under one provided by the Office of National Statistics (ONS). The data were then transformed to a cube root of the outcome in order to ensure a normal distribution, a requirement for the analysis. It was clear that there is significant variation in the rate of very young children entering care, and that there is variation within the Round 1 Pause authorities too.

SSDA903 data published for individual local authorities by the Department for Education are incomplete due to the suppression of values below five, a threshold intended to ensure the anonymity of individuals included in the count. Twelve local authorities had a suppressed value for one or more years in the time period, none of which are in the intervention group of Pause Round 1 authorities. To avoid confounding effects of missing data, local authorities with suppressed values were removed from the comparison group as this could lead to the sample being unrepresentative (if local authorities in the control group experience a fall in the outcome over time that results in falling below the suppression threshold). Accordingly, the available pool of comparators with no suppression of values was 69 local authorities.

Methods

Difference in difference is a quasi-experimental analytic approach used in econometrics and public health to understand the effect of policy change over time. The approach compares the change in means before and after the introduction of a new policy intervention in the treatment group and the control group, and tests for statistical significance. The benefits of the difference in difference technique are:

- The different starting points of individual authorities are taken into account by comparing the change in rate, not the absolute rate.
- External changes affecting all local authorities over the time period are controlled for, assuming those changes affect the treatment group and control group equally. This is particularly important in the domain of children's social care over this

period, given the fast-paced changes in care and adoption policy at a national level.

- Differences between individual local authorities on co-variates can be controlled for as part of the analysis.

Difference in difference analysis rests on a number of assumptions that must be met before the results can be considered robust. One of the requirements is that selection for the intervention is not determined by the outcome measure at the time of selection. That means that Pause authorities should not have significant differences in the rate of children under one coming into care, compared to non-Pause authorities prior to 2015. It is also necessary to test for selection bias and ensure through matching that the treatment group are similar to the control group on key variables thought to influence selection for inclusion in the treatment group. In addition, difference in difference compares trends over time. The analysis rests on the assumption that any differences between the treatment and control groups affecting the outcome, other than the intervention, are either differences between groups that are stable over time, or differences over time that affect all groups. To test this assumption, prior trends in the outcome measure in both groups are examined to see whether they are parallel - a visual rather than statistical test. A parallel prior trend suggests that the two groups are similarly affected by external factors and differences in the absolute number at any given time are a result of inherent characteristics of local authorities within the groups.

Identifying co-variates

To ensure that the analysis is robust to confounding factors, it is necessary to consider two possible sources of confounding, firstly to identify and correct any bias in selection of authorities for Round 1 Pause practices, and secondly, to identify and control for variables affecting the outcome.

Prioritisation of reduction in looked after children

Local authorities that volunteer for a new intervention with the potential to reduce numbers of children entering care are likely to do so because reducing that number is a strategic priority. This suggests that the overall numbers of children coming into care may be different in authorities choosing Pause and other authorities. The rate of care proceedings prior to the intervention is used as a proxy measure for the priority local authorities are likely to place on reducing care numbers overall, and therefore the likelihood of choosing to introduce an intervention with that aim. The control group is thus required to be similar to Pause authorities in terms of the mean rate of care proceedings in the three years prior to the selection (2012-15).

Readiness to innovate

Some local authorities are less likely to volunteer to try a new intervention because of the capacity and capability within the local authority to successfully oversee change. The priority for inadequate authorities is putting basic processes and quality assurance in place, while outstanding authorities are likely to have the internal capability to design services tailored to the local population, rather than innovation through transferring services that have worked elsewhere (ISOS, 2016). Inspection judgements of overall effectiveness made before March 2015 are used as a proxy matching variable for this readiness to innovate.

Deprivation

There is a known relationship between the rate of children looked after (and rate of involvement in statutory child protection) and the level of deprivation in local authorities, with higher levels of deprivation being associated with a significant increase in the looked after rate (Bywaters et al. 2018). Matching for deprivation was based on the IDACI score, a measure of the proportion of children under 16 who live in households in receipt of particular benefits in a given neighbourhood; the summary statistic provided at a local authority level is the average of that measure for the Lower Super Output Areas within the authority (DCLG, 2017). Round 1 Pause authorities had significantly higher IDACI scores than many non-Pause authorities.

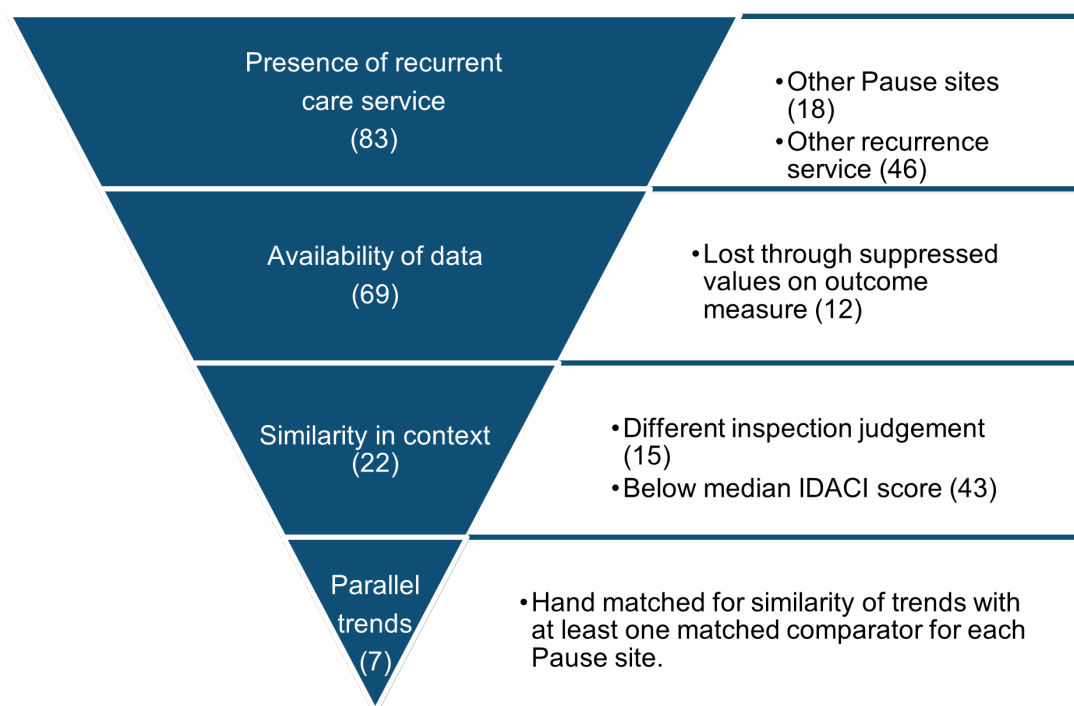
Attitudes to permanence

Matching also sought to account for the question of whether local authorities with Pause practices are distinctive in their approach to permanence than other authorities, such that they may be more likely to choose Pause because they incur different cost patterns associated with very young children entering care and their subsequent journeys to permanence. Taking into account a range of indicators of attitudes to permanence it was not feasible to use the number of adoptions and special guardianship orders; any percentages that could be calculated from them had to be excluded due to the very high rates of suppression of low values, including in some of the treatment group. The number of children leaving care under the age of one suffered from similar issues of suppression. The number of children leaving care between the age of 1 and 4 is more complete, and all the authorities in the potential comparison group and the treatment group have available data. Thus, this indicator was used as a proxy for permanence for young children. The measure used for matching is a transformation (square-root) of the mean percentage of children leaving care who are aged 1-4 between 2012 and 2015.

Matching

The matching strategy is set out in Figure 20 below. Exploration of the co-variables specified above indicated significant differences in the means on several co-variables and so a need for careful matching of a control group to the treatment group. In particular, all of the Pause authorities have high IDACI scores compared to the group of authorities with no recurrent care services. The potential comparison group was restricted to local authorities with similar inspection status (either “Requires Improvement” or “Not Inspected”) and an IDACI score above the median for both the treatment and comparison groups combined. After manual matching on these two attributes, the remaining 22 authorities in the control group had similar means on the matching variables. On examination of the prior trend in the mean for Pause and potential comparators, it was apparent that the trends were not parallel. This suggests that there are variables affecting changes in the outcome measure that had not yet been identified.

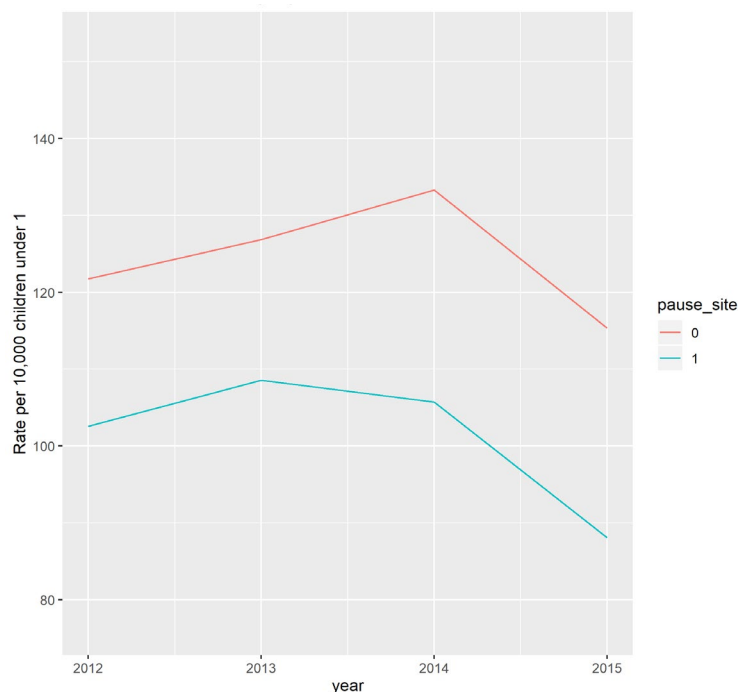
Figure 20: Matching strategy



The strength of the difference in difference approach is that it allows for the assumption that if the prior trends are parallel then those unobserved confounding factors are taken into account, and so by further selection on parallel trends, the robustness of the control group is improved. Further examination made it clear that the trend in individual Pause authorities is varied, and similarly diverse patterns could be found in the comparison group. The comparison group was further narrowed by grouping Pause authorities with local areas with similar trajectories and selecting by hand comparators with similar trends

for each Pause authority. Once the selected comparators for each authority were combined back into a single control group, the trend in group means is close to parallel (see Figure 21). There is no statistical test of whether the trends are parallel enough, visual inspection must be relied upon. Each Pause authority was matched with at least one authority with a similar overall percentage change over the period and where the trend for the selected control for that authority is as close as possible to the Pause authority in that group. Further tests were also conducted to ensure the other assumptions of difference in difference were met, increasing the likelihood that any statistically significant different result in the difference in difference is as a result of the presence of Pause in the time period. Finally, the interaction between co-variates was added into the difference in difference model in order to judge the additional effect of the intervention when these factors are equal.

Figure 21: Prior trends of rate of children under 1 starting to be looked after: Pause Round 1 sites vs selected comparator authorities



Analysis

Difference in difference compares the change in the mean for the intervention group before and after the intervention with the change prior to the intervention. It is necessary to identify a year in which the intervention began in order to divide “before” from “after”. Pause began to be implemented in Round 1 authorities in March 2015, but it is likely that the new service would take time to embed in local systems – for example, recruiting and training staff and identifying and engaging women - and hence the intervention year for the analysis was taken to be 2016-17, such that measures taken in or before March 2016 are considered “before” the intervention and anything after that date as “after”. The

interaction between the three co-variates is included in the model. The difference in difference analysis was conducted twice, once including all Round 1 Pause sites that began in 2015-16 and once excluding Doncaster, as the Round 1 Pause authority where the Pause practice ended in 2017 after the initial funding ended, but subsequently re-started after a break (without Innovation Programme funding). The robustness of the analysis is increased by ensuring that the selection and outcome model are robust and that the assumptions required by the method are met. It is possible that confounding factors affecting selection have not been identified and that some of the effect attributed to the presence of Pause may be attributable to these confounding factors. Further sensitivity analysis would contribute to a higher confidence that this is not the case.

Findings

Effectiveness of Round 1 Pause

The results of the difference in difference analysis of the effect of the presence of Pause show that there is a statistically significant reduction in the rate of children entering care under the age of one in Round 1 Pause authorities compared to the control group, when controlling for co-variates. In Tables 6 and 7, the “time” variable shows the difference in means before and after the time of the intervention for the whole sample. The “pause” variable shows the additional difference in means between treatment and control groups over the whole period as a result of being in the intervention group; the difference is small and statistically insignificant, suggesting our selection model is robust. The “did” variable is the critical result, it shows a statistically significant difference in the difference in means before and after the intervention for the intervention and control groups. The remaining entries in the results table confirm the effect of our covariates affecting the outcome. Comparing the tables, as discussed in the main report, it is apparent that the effect on reduction of rates of infant care entry is stronger in authorities where Pause has been operating continuously since Round 1 of the Innovation Programme.

Table 6: Difference in difference results (Pause Round 1 including Doncaster)

| term | estimate | std.error | statistic | p.value |
|--|----------|-----------|-----------|---------|
| (Intercept) | 94.54 | 33.07 | 2.86 | 0.01 |
| time1 | 0.23 | 0.08 | 2.75 | 0.01 |
| pause_site1 | 0.10 | 0.09 | 1.16 | 0.25 |
| did1 | -0.44 | 0.12 | -3.52 | 0.00 |
| log_idaci | 63.91 | 28.29 | 2.26 | 0.03 |
| sqrt_mean_care_procs | -24.93 | 9.27 | -2.69 | 0.01 |
| sqrt_mean_perc_ceasing_1to4 | -185.22 | 67.84 | -2.73 | 0.01 |
| log_idaci:sqrt_mean_care_procs | -17.26 | 8.19 | -2.11 | 0.04 |
| log_idaci:sqrt_mean_perc_ceasing_1to4 | -125.97 | 58.11 | -2.17 | 0.03 |
| sqrt_mean_care_procs:sqrt_mean_perc_ceasing_1to4 | 50.86 | 18.92 | 2.69 | 0.01 |
| log_idaci:sqrt_mean_care_procs:sqrt_mean_perc_ceasing_1to4 | 33.69 | 16.72 | 2.02 | 0.05 |

Table 7: Difference in difference results (Pause Round 1 excluding Doncaster)

Difference in Difference results, Wave 1 Pause sites excl Doncaster- fixed_year

| term | estimate | std.error | statistic | p.value |
|--|-----------------|------------------|------------------|----------------|
| (Intercept) | 100.58 | 32.21 | 3.12 | 0.00 |
| time1 | 0.23 | 0.08 | 2.86 | 0.01 |
| pause_site1 | 0.07 | 0.10 | 0.72 | 0.47 |
| did1 | -0.54 | 0.13 | -4.25 | 0.00 |
| log_idaci | 72.10 | 28.04 | 2.57 | 0.01 |
| sqrt_mean_care_procs | -27.32 | 9.14 | -2.99 | 0.00 |
| sqrt_mean_perc_ceasing_1to4 | -195.42 | 65.84 | -2.97 | 0.00 |
| log_idaci:sqrt_mean_care_procs | -20.17 | 8.23 | -2.45 | 0.02 |
| log_idaci:sqrt_mean_perc_ceasing_1to4 | -141.25 | 57.31 | -2.46 | 0.02 |
| sqrt_mean_care_procs:sqrt_mean_perc_ceasing_1to4 | 55.26 | 18.57 | 2.98 | 0.00 |
| log_idaci:sqrt_mean_care_procs:sqrt_mean_perc_ceasing_1to4 | 39.30 | 16.73 | 2.35 | 0.02 |

Appendix 4. Cost-benefit analysis

This appendix provides a detailed summary of the cost-benefit analysis of the Pause programme. It explores the degree to which the costs of the programme are justified by their benefits, with a focus on the expected savings in public sector resource consumption resulting from reductions in the numbers of children under the age of one being taken into local authority care.

Assumptions

There several issues that require consideration in providing a cost-benefit analysis of the programme:

- **Costs:** It is assumed that the costs incurred in the delivery of the Pause programme provide a reasonable guide to the total resource costs expended. This assumes that its delivery does not involve costs to local agencies (for example through referral mechanisms) that are sufficiently significant to alter the estimated benefit to cost ratios in a meaningful way. This may also understate the costs (and overstate the rate of return) involved if women take up other services provided by the public sector as a result of their engagement with Pause.⁶
- **Productivity gains:** The primary benefits included in this analysis are the expected reductions in public sector resource use arising from reduced numbers of children under the age of one being taken into local authority care. These cost savings cannot be observed at this stage because they will occur primarily in the future. As such, assumptions are needed to model the relationship between the reductions in the number of children taken into care and the future costs that may be avoided. These assumptions include:
 - **Nature of cost savings:** The potential cost savings include reductions in one-off costs (for example the costs of proceedings) as well as recurrent costs associated with future care. Where possible, the focus has been on marginal rather than average costs to avoid overstating the potential cost savings. For example, reductions in the number of children taken into local authority care are unlikely, at the margin, to lead to savings in the costs associated with buildings).
 - **Future patterns of pathways through the care system:** Cost savings have been modelled on the assumption that current patterns in children's pathways through

⁶ Analysis of interview and monitoring data (see main report) indicate that women's engagement with other services does increase through the course of the intervention. However, interview analysis also indicates that engagement is key to addressing chronic unmet needs and is associated with other gains, in terms of stabilisation and reduction of risks in women's lives, that are beyond the scope of this cost benefit analysis.

the care system to the age of 18 will continue to persist into the future. This may not hold if future policy decisions were to produce changes in these patterns – for example, by increasing or decreasing the number of children in LA care being placed in adoption.

- **Durability of impacts:** The results of the impact evaluation suggest that the effects of Pause were durable over the four years considered in the analysis. There was no evidence that the scheme's effects were temporary. The core results set out in this paper assume that this continues to be the case moving forwards. However, there is uncertainty as to whether this may continue to hold in the future.
- **Productivity growth:** It is assumed that opportunities for future improvements in productivity (for example using technology to provide care of an equivalent standard at a lower cost) will be limited in the care sector. The assumptions are also neutral with respect to the impact of possible future policy or spending decisions. It therefore assumed that the real cost of care will not change over the course of children's lifetime in the system. For context, Department for Education research suggests that spending per looked after child fell by two percent between 2010/11 and 2015/16.⁷
- **Private costs:** There will be further economic costs where the care of children is assumed by private households (for example via adoption pathways). However, it is assumed (by revealed preference) that the individuals concerned derive a benefit at least equal to these costs and are discounted for the purposes of this analysis.
- **Cost savings beyond the age of 18:** Possible cost savings beyond 18 years (for example reductions in leaving care costs) are not considered in the analysis.
- **Benefits not monetised:** The Pause programme is expected to result in several other benefits that have not been monetised in this analysis owing to the absence of a counterfactual group of non-participants that would allow them to be rigorously quantified:
 - **Well-being of participants:** Principal among these are the improvements in well-being reported by participating women. Monitoring data captured by Pause consistently suggests that women that participated in the programme see on-going improvements in their subjective well-being, self-esteem, and emotional resilience over the course of 18 months.
 - **Economic benefits:** Improvements in the employability of participating women can be treated as an increase in the productive capacity of the economy and

⁷ Department for Education (2017) Children's services: Spending, 2010/11 to 2015/16

included as an economic benefit in cost-benefit analysis⁸. It should be noted, however, that if the programme reduces the number of children being taken into care at least partly through reducing the number of children being born, there will also be offsetting effects in reducing labour supply in the future.

- **Other reductions in resource consumption:** Finally, the analysis of monitoring information indicates that the programme may lead to changes in the way that participating women make use of other public sector services. These effects could decrease (or increase) demands on public services potentially producing further costs savings or increasing the costs incurred by the wider public sector.

Costs

Estimates of the present value of Pause delivery costs (treating 2015/16 as the baseline year) are provided below. The assessment of impact focuses on five Round 1 practices that were introduced in 2015 (Hackney was excluded because it was introduced in 2013). As Doncaster was excluded because the service was withdrawn and subsequently re-introduced,⁹ costs are presented with and without Doncaster.

Detailed information on actual costs by practice was not available, but data on the average annual cost per practice was provided on a regional basis for practices post Round 2¹⁰. These were assumed to provide sufficiently accurate estimates of the real costs incurred in delivery of Round 1 (in 2018/19 prices). This implicitly assumes that Pause has not found substantial gains in productivity over the period (if this is not the case then the estimates below will overstate the costs involved). Table 8 sets out estimated costs by year which have been discounted at the rate of social time preference recommended in the HM Treasury Green Book (i.e., 3.5 percent per annum). The present value of the costs incurred in the delivery of the Round 1 practices between 2015/16 and 2018/19 is estimated at £6.0m (£6.5m including Doncaster).

⁸ While there may be substitution effects whereby participating women fill vacancies at the expense of other jobseekers in the short term, the principles set out in the HM Treasury Green Book imply an assumption that those jobseekers will find other jobs in the medium term.

⁹ Analysis was repeated including Doncaster and produced broadly equivalent findings (not reported here).

¹⁰ It is assumed that these reflect prices in 2019/20.

Table 8: Present value of the delivery costs associated with Round 1 Pause practices

| Practice | Estimated annual delivery costs (£m), assumed 2018/19 prices | | | | | |
|---|---|-------------|-------------|-------------|-------------|------------|
| | Annual Cost (£m) | 2015/16 | 2016/17 | 2017/18 | 2018/19 | Total |
| <i>London</i> | | | | | | |
| Greenwich | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | |
| Islington | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | |
| Newham | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | |
| Southwark | 0.33 | 0.33 | 0.33 | 0.33 | 0.33 | |
| <i>Yorkshire and North East</i> | | | | | | |
| Hull | 0.26 | 0.26 | 0.26 | 0.26 | 0.26 | |
| Doncaster | 0.26 | 0.26 | 0 | 0 | 0.26 | |
| Total delivery costs (£m) – excluding Doncaster | | 1.6 | 1.6 | 1.6 | 1.6 | 6.3 |
| Total delivery costs (£m) – including Doncaster | | 1.8 | 1.6 | 1.6 | 1.8 | 6.8 |
| <i>Discount factor</i> | | <i>1.00</i> | <i>0.97</i> | <i>0.93</i> | <i>0.90</i> | |
| Present value of delivery costs (£m) – excluding Doncaster | | 1.6 | 1.5 | 1.5 | 1.4 | 6.0 |
| Present value of delivery costs (£m) – including Doncaster | | 1.8 | 1.5 | 1.5 | 1.7 | 6.5 |

Source: Pause, Ipsos MORI analysis

Benefits

This section provides estimates of the cost savings associated with reductions in the number of children taken into care.

Reductions in the number of children under the age of one taken into local authority care

The results of the impact evaluation indicated that Round 1 Pause practices led to a reduction in the rate of children under the age of one being taken into local authority care between 2016/17 and 2018/19.¹¹ This section provides estimates of the total reduction in the number of children under the age of one being taken into local authority care, which was derived as follows:

- **Annual rate of removals in Pause practice sites:** In Round 1 practice sites between 2016 and 2019, the average number of children under the age of one removed into local authority care was 33.9 per annum (35.3 including Doncaster) against an average population of 4,188 per site (4,081 including Doncaster).¹² This gives an annual rate of removals per 10,000 children aged under one of 81.0 (86.4 including Doncaster). The cube root of this is 4.33 (4.42 including Doncaster).
- **Reduction in the annual rate of removals:** The impact evaluation results suggested Pause led to a reduction in the cube root of the annual removal rate of children under the age of one of 0.54 (0.44 including Doncaster). This implies that in the absence of Pause, the cube root of the annual rate of removals would have otherwise risen to 4.87 or an annual removal rate of 115.3 per 10,000 children aged under one. When Doncaster is included, the cube root of the annual rate of removals rises to 4.86 and the annual removal rate rises to 114.9.
- **Annual reduction in removals:** Applying this to the average number of children aged under one in Round 1 practice sites (4,188¹³) gives an estimate that in the absence of Pause, the average number of children under age under the age one removed into local authority care per annum would have risen to 48.3 (46.9 including Doncaster). This implies Pause reduced the annual number of children aged under one taken into local authority care by an estimated 14.4 per annum (11.6 including Doncaster), per Round 1 practice site.

¹¹ 2015 was not considered an intervention year to allow time for the programme to bed in.

¹² Source: ONS Mid-year Population Estimates.

¹³ Note that if the programme reduced the number of children born, the population of children aged under one would also have increase in the absence of the programme. However, given the volumes involved, this only has a trivial impact on the calculations.

- **Total reduction in the number of children aged under one removed into local authority care:** Multiplying this result by the number of Round 1 practice sites (5¹⁴) and the number of years over which the programme was delivered (3) gives an estimate of the total reduction in the number of removals of 215.3 (209.0 including Doncaster).

Table 9: Net reductions in children under the age of one taken in local authority care

| Practice areas | (a) Average annual no. of children under one taken into LA care per 10,000 children under one, 2016/17 to 2018/19 | (b) Cube root of (a) | (c) Average number of children aged under one 2016/17 to 2018/19 | (d) No. of children under one taken into LA care, per annum, per site |
|--|--|-------------------------|---|--|
| Excluding Doncaster | | | | |
| Round 1 practice sites | 81.0 | 4.33 | 4,188 | 33.9 |
| Comparator local authorities | 115.3 | 4.87 | 4,188 | 48.3 |
| Net reduction in removals per annum, per site | | | | 14.4 |
| Including Doncaster | | | | |
| Round 1 practice sites | 86.4 | 4.42 | 4081 | 35.3 |
| Comparator local authorities | 114.9 | 4.86 | 4081 | 46.9 |
| Net reduction in removals per annum, per site | | | | 11.6 |

Source: Research in Practice / Ipsos MORI analysis. * this is calculated by subtracting the estimated effect of the programme (0.54) from the observed cube root of the removal rate.

Pre-birth and proceedings cost savings

The first component of cost savings considered are those attached to pre-birth assessments and the costs of removal proceedings. Unit costs for these aspects have been estimated by Pause as part of the development of an-house cost-benefit analysis tool. This draws on estimates of the wage costs associated with social work from PSSRU alongside in-house estimates of the time associated with the completion of key

¹⁴ Six where Doncaster is included.

processes. A breakdown of these costs and associated assumptions are set out in the Table 10 below.

Table 10: Pre-birth and proceedings savings – assumptions

| Cost | Unit cost | Assumptions |
|---|------------------|---|
| Pre-birth costs | | |
| Child protection conference | £1,248.84 | Manchester Cost Calculator |
| Single assessment | £424 | Pause estimate of time incurred using PSSRU staff costs |
| Family group conference | £267 | Pause estimate of time incurred using PSSRU staff costs |
| Legal planning meeting | £2,687 | Pause estimate of time incurred using PSSRU staff costs |
| Social worker visits | £496 | Pause estimate (2 hours each, 3 visits) |
| Pre-birth subtotal | £5,120 | |
| Proceedings (assumed 26-week duration) | | |
| Supervised contact | £1,033 | 26 weeks of contact arrangements (Pause estimate) |
| Parenting assessment | £2,477 | 30 hours per parenting assessment (Pause estimate) |
| LAC reviews | £2,152 | 2 LAC reviews over 26 weeks |
| Reg 24 assessment | £1,652 | 20 hours per assessment |
| Social worker visits | £640 | 4 visits over 26 weeks |
| Support for birth families | £315 | Half annual cost estimated in PSSRU (£609) |
| Social work time | £10,735 | 5 hours per week for 26 weeks |
| Medical assessments | £349 | PSSRU estimate of the cost of outpatient attendance |
| Legal costs | £19,787 | Based on Pause practice legal services costs. |
| Proceedings subtotal | £39,141 | |

Source: Pause Cost Calculator. Prices converted to 2018/19 prices using nominal wage growth between 2017 and 2018 (3.2 percent) as taken from the Annual Survey of Hours and Earnings (ONS).

The overall unit costs of pre-birth assessments and removal proceedings are estimated at £44,300 in 2018/19 prices and are assumed to represent one-off cost savings to the local authority and other agencies. The cost of proceedings (at £39,100) is a significant component of this, though this estimate is in line with other studies. For example, Plowden (2009) quotes figures from a 2006 Ministry of Justice review that placed the legal costs of court proceedings at £35,000 per case (which would be £44,000 in 2018/19 prices). A more recent evaluation of the Tri-Borough Care Proceedings Pilot (Beckett et al., 2014) suggested the average legal costs (internal and external to the local authority)

per case fell from £32,800 to £17,600 between 2009/10 and 2012/13. Both estimates did not include the costs of associated social work. Reductions in the number of children aged under one removed into local authority care were assumed to be uniformly distributed over the 2016 to 2019 period. The present value associated with the costs of pre-birth assessments and removal proceedings were estimated at £8.9m (£8.6m including Doncaster) as illustrated in the table below.

Table 11: Estimated cost-savings associated with pre-birth assessments and proceedings

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | Total |
|--|------------|------------|------------|------------|------------|
| Excluding Doncaster | | | | | |
| Reduction in number of children under the age of one taken into local authority care | 0.0 | 71.8 | 71.8 | 71.8 | |
| Unit cost of pre-birth assessments and proceedings (£m) | 0.044 | 0.044 | 0.044 | 0.044 | |
| Value of cost savings (£m) | 0.0 | 3.2 | 3.2 | 3.2 | 9.5 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings (£m) | 0.0 | 3.1 | 3.0 | 2.9 | 8.9 |
| Including Doncaster | | | | | |
| Reduction in number of children under the age of one taken into local authority care | 0.0 | 69.7 | 69.7 | 69.7 | |
| Unit cost of pre-birth assessments and proceedings (£m) | 0.044 | 0.044 | 0.044 | 0.044 | |
| Value of cost savings (£m) | 0.0 | 3.1 | 3.1 | 3.1 | 9.3 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings (£m) | 0.0 | 3.0 | 2.9 | 2.8 | 8.6 |

Source: Pause, Ipsos MORI analysis

Longer term care cost savings

The longer-term cost savings associated with reductions in the number of children aged under one removed into local authority care will depend on the length of time they would have remained in the care of the local authority. These outcomes cannot be observed (by

definition) and have been modelled based on current patterns described in the DfE’s statistical publication ‘Children looked after in England, 2019’.¹⁵

Exit and entry rates by age

The table below provides estimates of the share of children leaving local authority care by age group. These estimates have been derived by dividing the estimated number of children leaving local authority care by the total number of children in local authority care in 2019. These figures have been adjusted to allow for children whose care was transferred to another local authority (1.9 percent of those leaving the care of the local authority and those returning to local authority care from adoption or special guardianship orders (1.5 percent).

Table 12: Net exit rates from local authority care by age group

| Age group | Number of children in local authority care | Number of children ceasing to be looked after | <i>Of which, children whose care was transferred to another LA</i> | Number of children entering care from adoption or SGOs | Net number of leavers | Exit rate from local authority care (%) |
|-------------|--|---|--|--|-----------------------|---|
| Under 1 | 6,260 | 2,230 | 42 | 33 | 2,154 | 34 |
| 1 to 4 | 16,820 | 6,480 | 123 | 97 | 6,260 | 37 |
| 5 to 9 | 18,140 | 3,850 | 73 | 57 | 3,719 | 21 |
| 10 to 15 | 34,630 | 4,350 | 83 | 65 | 4,202 | 12 |
| 16 and over | 30,710 | 12,560 | 239 | 188 | 12,134 | 40 |

Source: DfE, Ipsos MORI analysis. Transfers to other LAs and the numbers entering care from adoption or SGOs is not broken down by age, and the relevant rates are assumed to apply uniformly across age groups.

Reasons children leave local authority care

The cost savings associated with the programme will also depend on the reasons that children leave local authority care, as there may be further costs associated with these outcomes (for example, adoption agency costs). DfE statistics for the reasons children left local authority care in 2019 are not provided by age group (and do not isolate the children of women with multiple children taken into care). Destinations were instead modelled on the basis of the results set out in Broadhurst et al. (2017)¹⁶ which describe

¹⁵ Source: [DfE Children looked after in England including adoption: 2018 to 2019](#)

¹⁶ Broadhurst et al (2017) Vulnerable Mothers and Recurrent Care Proceedings, Table 4.3

the ultimate placement outcomes for repeat proceedings amongst recurrent mothers. These are summarised in the table below. There are some additional points to note:

- The period of analysis only covers cost savings to the age of 18. It is assumed that over these time horizons, no children that would have been taken into local authority care in the absence of Pause would have left because they moved into independent living or transferred to residential care funded by adult social services.
- Other outcomes are largely undescribed in the published data and have been excluded for the purposes of this analysis. This will likely lead to an understatement of the costs involved as this does not factor in the possibility that some children may eventually be placed in more costly residential care.

Table 13: Reasons for leaving local authority care

| Reasons | % of repeat proceedings, current mothers | % of children leaving LA foster care (excluding unknowns) |
|---|---|--|
| Adoption (PO/AO with Foster Carers, Prospective Adopters, or others) | 43.3 | 57.3 |
| Returned home/left care to live with parents or relatives (No order, RO/SO/SGO with parents or kin) | 16.4 | 21.7 |
| Residence order or Special Guardianship Order (RO/SO/SGO with others) | 15.9 | 21.0 |
| Other outcomes (for example LA foster care, unknown outcomes*) | 24.4 | - |
| Total | 100 | 100 |

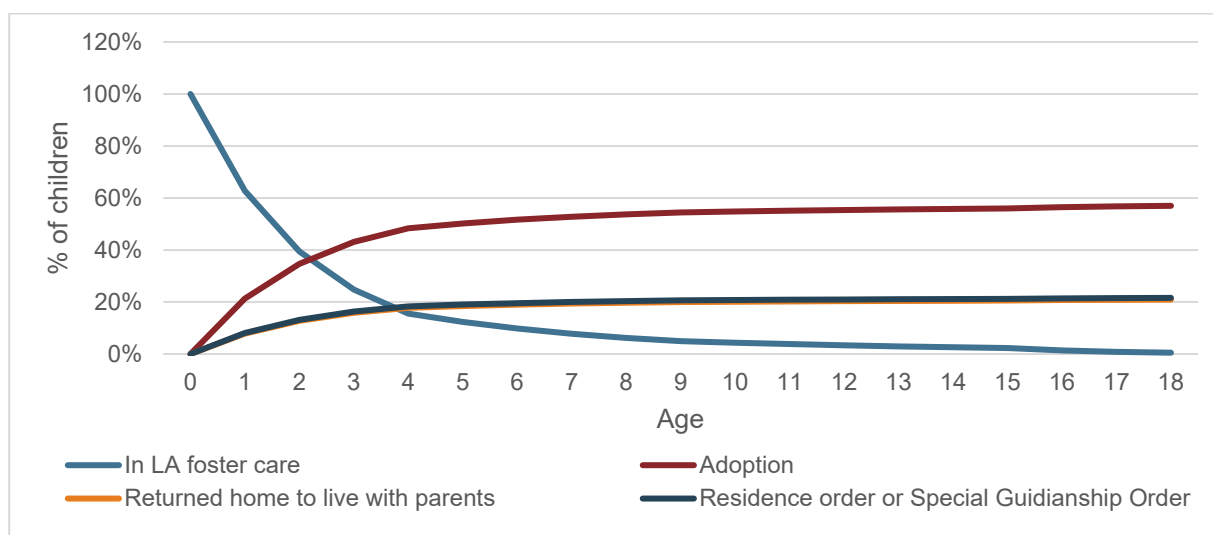
Source: Adapted from Broadhurst et al (2017), Ipsos MORI analysis. * 18% of children left local authority care for other reasons in 2019, of whom 72% had reached their 18th birthday.

Outcomes by age

The assumptions set out in Tables 12 and 13 were combined to estimate the likelihood that each child that would have been taken into local authority care in the absence of Pause would have been (a) in local authority foster care, (b) adopted, (c) subject to a Residence Order or Special Guardianship Order, or (d) returned home/left care to live with parents or relatives, as follows:

- **Leavers:** The exit rates presented in Table 12 were used to estimate the share of children that would have otherwise left local authority in each year between the ages of 0 and 18 (and the share remaining in local authority care).
- **Destinations of leavers:** The assumptions in Table 13 were used to distribute leavers across adoption, Residence Order or Special Guardianship Orders, and those returning home or leaving care to live with parents or relatives. These results are displayed in the following figure.

Figure 22: Modelled care outcomes by age between 0 and 18



Costs associated with care outcomes

Table 14 below provides details of the assumed recurrent and one-off costs associated with the care outcomes described in the Figure 22. These are drawn from PSSRU’s Unit Costs of Health and Social Care 2019 (unless otherwise stated). The analysis did not allow for other possible cost savings that were not described within this document (for example, provision of letterbox service).

Estimated cost savings per child

The assumptions set out in Table 14 were combined with the modelled care outcomes in Figure 22 to estimate the cost savings associated with each child that was not taken into local authority care. These were calculated for both the four-year period following the removal avoided, and over 18 years, as set out in Table 15 overleaf. These estimates were derived as follows:

$$C_i = \sum_{t=1}^{18} a_{ti} S_i$$

Where C represents the total costs associated with care outcome i, a is the modelled likelihood that the child would be associated with care outcome i in year t (as per Figure 22), and S is the annual costs associated with outcome i (as per Table 14).

Table 14: Recurrent and one-off costs associated with care outcomes

| Care outcome | Cost | Type | Unit Value | Description |
|---------------------------|--|-----------|------------|---|
| LA foster care | Annual cost of LA foster care | Recurrent | £31,564 | Estimated weekly cost of LA foster care (£607) multiplied by 52 |
| Adoption | Adoption processes | One-off | £13,982 | Costs of adoption planning, preparation assessment of adopters, adoption panel, linking and matching, placement, and assessment for adoption support. |
| | Consumption of adoption and other services by adoptive parents | One-off | £3,272 | Costs of adoption support and social care, health care, education support, specialist services. |
| | Annual financial support | Recurrent | £8,944 | Assumed at £8,944 on basis of research showing average financial support of £4,472 for a six-month period. |
| Resident Order/SGO | SGO assessment | One-off | £2,398 | Assumed 30 hours per assessment (from Pause cost calculator) |
| | Annual financial support | Recurrent | £8,944 | Assumed in line with adoption. |
| Returned home / left care | Services provided for children returning home from care | One-off | £7,186 | Based on 'Child B' example presented in Section 8.1 of PSSRU (2019) – the costs of a high level of 'Child In Need' support with parents receiving drug and alcohol treatment services |

Source: PSSRU (2019) [Unit Costs of Health and Social Care, 2019](#)

Table 15: Estimated cost savings per child under one not taken into local authority care

| Care outcome | Over 4 years | | Over 18 years | |
|-------------------------------|---------------|---------------|----------------|----------------|
| | Undiscounted | Discounted | Undiscounted | Discounted |
| LA foster care | 71,632 | 69,369 | 96,452 | 88,509 |
| Adoption | 16,302 | 15,233 | 91,510 | 67,244 |
| Resident Order/SGO | 3,748 | 3,480 | 31,451 | 22,558 |
| Returned home / left care | 1,137 | 1,073 | 3,574 | 3,233 |
| Cost savings per child | 92,819 | 89,155 | 222,987 | 181,544 |

Source: DfE (2019), PSSRU (2019), Ipsos MORI analysis

Total cost savings

These results, pertaining to the estimated cost savings per child not taken into local authority care were then used to estimate the total cost savings associated with delivery of Round 1 Pause practices between 2015/16 and 2018/19, as outlined in Table 16.

Value for money

Table 17 provides an overview of the implied value for money associated with the Pause programme. The benefit to cost ratio (costs savings per £1 of expenditure) is estimated at £4.50 over a 4-year time horizon and £7.61 over an 18-year time horizon¹⁷ (£4.03 and £6.81 including Doncaster).

¹⁷ It is estimated that the Pause would have needed to reduce the number removals of children into local authority care by 96 for it to be viable (i.e. to deliver a rate of return of £2 per £1 spent) over a four year period based on models excluding Doncaster.

Table 16: Estimated longer term care cost savings

| | 2015/16 | 2016/17 | 2017/18 | 2018/19 | Total |
|--|------------|-------------|-------------|-------------|--------------------------|
| Excluding Doncaster | | | | | |
| Reduction in number of children under the age of one taken into local authority care | 0.0 | 71.8 | 71.8 | 71.8 | |
| <i>4-year cost-savings</i> | | | | | |
| 4-year cost savings per child not taken into LA care (£m) | 0.089 | 0.089 | 0.089 | 0.089 | |
| Value of cost savings (£m) | 0.0 | 6.4 | 6.4 | 6.4 | 19.2 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings | 0.0 | 6.2 | 6.0 | 5.8 | 17.9¹⁸ |
| <i>18-year cost savings</i> | | | | | |
| 18-year cost savings per child not taken into care (£m) | 0.182 | 0.182 | 0.182 | 0.182 | |
| Value of cost savings (£m) | 0.0 | 13.0 | 13.0 | 13.0 | 39.1 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings | 0.0 | 12.6 | 12.2 | 11.8 | 36.5¹⁹ |
| Including Doncaster | | | | | |
| Reduction in number of children under the age of one taken into local authority care | 0.0 | 69.7 | 69.7 | 69.7 | |
| <i>4-year cost-savings</i> | | | | | |
| 4-year cost savings per child not taken into LA care (£m) | 0.089 | 0.089 | 0.089 | 0.089 | |
| Value of cost savings (£m) | 0.0 | 6.2 | 6.2 | 6.2 | 18.6 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings | 0.0 | 6.0 | 5.8 | 5.6 | 17.4 |
| <i>18-year cost savings</i> | | | | | |
| 18-year cost savings per child not taken into care (£m) | 0.182 | 0.182 | 0.182 | 0.182 | |
| Value of cost savings (£m) | 0.0 | 12.6 | 12.6 | 12.6 | 37.9 |
| Discount factor | 1.00 | 0.97 | 0.93 | 0.90 | |
| Present value of cost savings | 0.0 | 12.2 | 11.8 | 11.4 | 35.4 |

Source: Pause, Ipsos MORI analysis

¹⁸ 95 percent confidence interval - £8.9m to £28.0m.

¹⁹ 95 percent confidence interval - £18.0m to £57.0m

Table 17: Estimated benefit to cost ratios

| Time horizon | Present value of delivery costs (£m) | Short term cost savings via pre-birth and proceedings (£m) | Longer term care cost savings (£m) | Total cost savings (£m) | Benefit to cost ratio (£s cost savings per £1 spending) |
|----------------------------|--------------------------------------|--|------------------------------------|-------------------------|---|
| Excluding Doncaster | | | | | |
| 4 years | 6.0 | 8.9 | 17.9 | 26.8 | 4.50 |
| 18 years | 6.0 | 8.9 | 36.5 | 45.4 | 7.61 |
| Including Doncaster | | | | | |
| 4 years | 6.5 | 8.6 | 17.4 | 26.0 | 4.03 |
| 18 years | 6.5 | 8.6 | 35.4 | 44.1 | 6.81 |

Source: DfE (2019), PSSRU (2019), Ipsos MORI analysis

Margin of error

There is a margin of error associated with the estimates of impact set out in Appendix 3. This section provides lower and upper bounds for the key results of this section (excluding Doncaster) based on the 95 percent confidence interval associated with the central result. This illustrates that at the lower bound of confidence, the rate of return exceeds £2.0 to £1.0, meeting typical thresholds for acceptable value for money.

Table 18: Margin of error associated with key results

| Result | Central result | Lower bound | Upper bound |
|--|----------------|-------------|-------------|
| Cube root of the annual removal rate | 0.54 | 0.28 | 0.80 |
| Reduction in the number of removals per practice per annum | 14.4 | 7.1 | 22.4 |
| Reduction in total number of children taken into care over three years | 215 | 106 | 336 |
| Present value of cost savings – pre-birth assessments and proceedings (£m) | 8.9 | 4.4 | 13.8 |
| Present value of longer term cost savings – 4 years (£m) | 17.9 | 8.9 | 28.0 |
| Present value of longer term cost savings – 18 years (£m) | 36.5 | 18.0 | 57.0 |
| Benefit to cost ratio – 4 years (£) | 4.50 | 2.21 | 7.00 |
| Benefit to cost ratio – 18 years (£) | 7.61 | 3.75 | 11.87 |

Appendix 5. Case identification analysis

Case example 1. Identification and Engagement in a Round 2 Pause Practice

In this practice, 52 women were identified initially as eligible for Pause, of whom 8 were found to be ineligible, and 27 identified as 'high priority'. Case identification data (see Figure 2) indicate that women who were prioritised were younger, had a shorter period of time since their last child was removed, and were more likely to have multiple identified needs. Their identified needs included domestic abuse (22/27), mental ill-health (27/27), alcohol or substance use (9/27), criminal justice involvement (5/27), formerly in care (6/27), and/or learning disability (8/27). Not all 27 women subsequently became 'open' on Pause: 4/27 were unreachable and 2 others refused contact, and 11 engaged but did not 'open', either because they did not agree to contraception, or became pregnant during the engagement period, or in one case because the woman had already achieved significant positive change and felt the service was more needed by others. Ten additional women were subsequently identified through alternate routes (for example, direct referral of women with a recent child removal by social services; further data trawl); less information was recorded about these women, but the time since last removal of a child averaged 0.6 years (range 0.2-1.1) and the average number of children removed was 3.2 (range 2-7), indicating that these cases also fit Pause eligibility criteria.

Case example 2. Identification and Engagement in a Round 1 Pause Practice

In this practice, the triage process to establish their second cohort of Pause women prioritised younger women who had given birth in the last five years. 90 women were identified as potentially eligible via the local authority's legal tracker, of whom 79 met eligibility criteria. Ten of these women were not contacted (7 unreachable and 3 judged by professionals not to be ready for engagement). Because this authority used the local authority legal tracker, there was less systematic data on women's characteristics and needs. However, a comparison of available data on women who became 'open' on Pause relative to those who did not (see Figure 3) reveals little difference between the groups. As with the Round 2 practice, a variety of reasons were recorded for women not engaging with Pause support; reasons were not always known but included: going through care proceedings; found to be ineligible (pregnant or child in their care); in full-time work; not wanting to use LARC; not responding or refusing attempts to contact. However, it is of note that four women who did not become open in cohort two have since signed up to cohort three of Pause, highlighting the importance of readiness to engage.

Appendix 6. Monitoring data analysis

This document presents the findings from the analysis of the Pause Management Information system, Apricot. The Apricot database provides details of the women that began engaging with Pause from 2017 onwards. The data includes:

- characteristics of the women that have engaged with the programme (for example, age, number of children, existing health and housing needs);
- Pause engagement activity (for example, location, how far they have progressed in the programme, type of support they have received);
- intermediate outcomes achieved (including engagement with public services, changes in housing, health, financial and relationship status); and
- longer term impacts (changes in resilience, well-being and employment; education status).

This is a detailed data set which allows inferences to be made about how the programme is affecting the participating women. However, there are some limitations to the data:

- There is variation in the coverage of the data – there are a number of women who have completed their engagement with Pause, but there is no endpoint data available. It is unclear if the lack of endpoint data is random, or whether there are common factors among those that have completed their engagement but not provided data.
- There is no information available about what would have happened in the absence of the programme (no assessment of additionality). The database only collects outcomes data for women that participate in the programme – there is no outcome information available for women who have not engaged (a comparator group). Therefore, we cannot assess what would have happened to the participating women in the absence of the programme.
- The information is self-reported. Therefore, there may be issues around the quality of the data provided, as there may be biases in the reporting.

Descriptive statistics

Potential population

The Pause Management Information system includes information from 25 Pause practices. The records show that these practices had data on 1,600 women who were identified as eligible for engagement, indicating that there is a large population of potential participants for the programme in these areas.

Outcomes data

The Pause database includes measurements of outcomes data collected at three time periods: baseline (the start of the project); midpoint (approximately nine months following first engagement with the programme); and endpoint (when the women finishes the pause programme, approximately 18 months after first engagement). A total of 517 women had provided outcomes data for at least one time period. The table below shows the number of responses at each time period, and the number of women that provided multiple responses. The factors which influenced whether a woman had completed midpoint and endpoint data were investigated. The key factors which influenced this are:

- Women who started their intervention in 2019 were less likely to have provided endpoint data (likewise women whose case has not been 'closed', who have not yet completed).
- The practice they were located with. For confidentiality, these are not specified here, however, the analysis indicates considerable variation between Pause practices. The percentage of women that have completed their intervention that also provided endpoint data ranged from five percent to 91 percent. Overall, those practices which took part in Round 1 of the programme were slightly less likely to provide endpoint data for closed participants than all other practices. This suggests that there are practices where the collection of outcomes data could be improved.

Table 19: Number of women with Pause outcomes tracker data

| Category | Number of responses |
|--|---------------------|
| Total women responding at any stage | 517 |
| Women with baseline data | 494 |
| Women with midpoint | 324 |
| Women with endpoint | 235 |
| Women with baseline, midpoint and endpoint | 185 |
| Women with baseline and endpoint | 215 |

Pause Management information system, N=517

Baseline characteristics of women with outcomes data

The baseline characteristics of the women that provided outcomes data was also explored. This was subsequently used to identify if there were any differences in the outcomes achieved, however an overview of key characteristics is provided here:

- The ethnicity of the majority of participants (76%) was White (British, Irish, Traveller or any other white background). The next highest proportion of participants was Black or Black British (seven percent of participants), although 11 percent of participants did not provide any information about their ethnicity. Due to the small number of participants on most of the ethnic groups, no analysis has been undertaken using participant ethnicity.
- The age of participants ranged from 18 to 44 years of age. When broken down into four age bands, the highest proportion of women were aged between 25 and 29 years of age (32 percent), and each group contains more than 20 percent of participants.
- At least one child had been removed from all participating women, with 68 percent of participants having had three or fewer children removed. However, participants reported having up to 13 children removed. Two participants reported still having children in their care; interview data identified one woman with an adult child living with her temporarily, and another woman who was staying temporarily with a relative who was her child's kinship carer, in the absence of alternative accommodation.
- A small number of participants (39, or 8% of participants) reported being on the Care Leavers pilot.
- Information about the problems and issues facing participants at baseline were collected as self-reported and professionally reported data and are presented in the main body of the report.

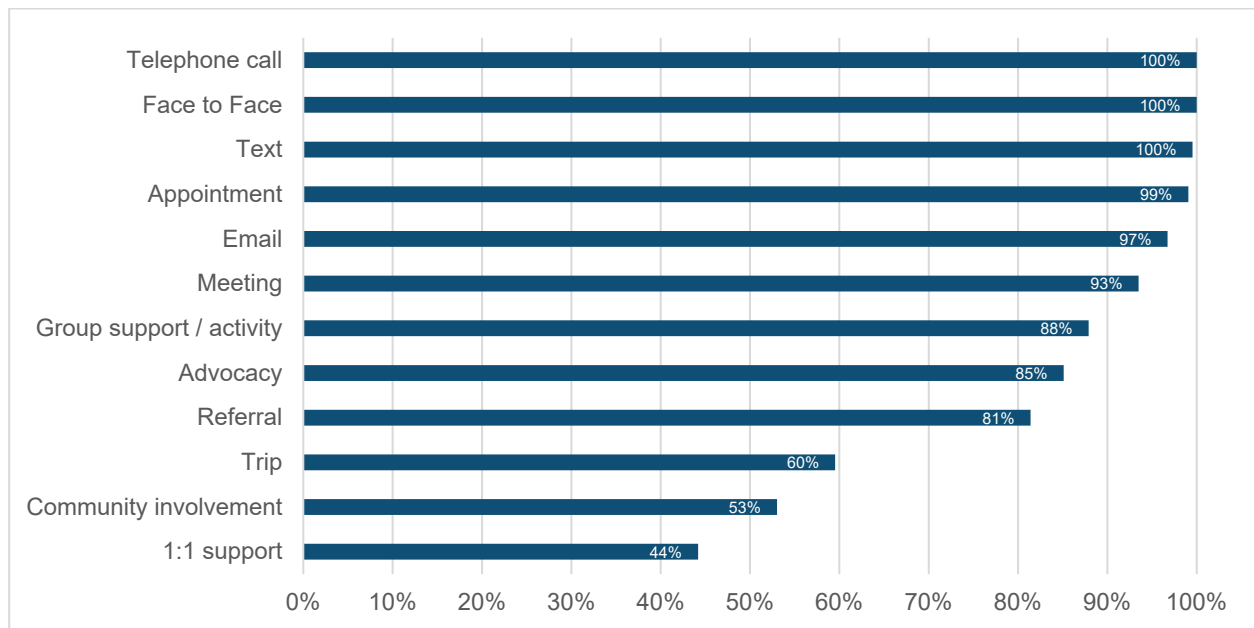
Activities delivered

A total of more than 77,000 activities have been delivered to the 517 women who have provided outcomes data. This is an average of 148 activities per women. The duration of support has also been monitored. For women who had completed baseline and endpoint outcome data, a total 41,300 activities had been provided to the 215 women, an average of 192 activities per woman. The duration of support to these women is an average of 192 hours per woman. There were some noticeable differences in the activities provided to different sub-groups of women:

- Women who were part of the care leavers programme (a small sample) received fewer activities than average (162 activities compared to the average of 192 per woman).
- Women with learning difficulties received a slightly higher number of activities than other women (202 activities)
- Women who had a professionally reported abusive relationship or abusive home situation received slightly fewer than average activities (180 activities)

Most of the women in the longitudinal sample had received most of the categories of support offered by Pause during their involvement with the programme (see Figure 23). The only types of support that less than 80 percent of women had received were community involvement, being taken on a trip and one to one support, which suggests that there may be some ambiguity in reporting (for example, the distinction between face-to-face activities and one-to-one support). As most women have received nearly all forms of support, it has not been possible to identify specific types or combinations of support which contribute to the successful achievement of outcomes.

Figure 23: Type of activity delivered to programme participants



Pause Management information system, N=215

Intermediate outcomes

Data analysis related to intermediate outcomes is presented in the main report and focuses on the longitudinal sample of participants (those with a baseline and endpoint level). Similar analysis has been undertaken for the population as a whole (n=517), and the general findings remain true for the whole population, suggesting those with endpoint data are a good representation of the population as a whole.

Drug and alcohol consumption

The number of participants who altered their level of drug and alcohol consumption between the baseline and endpoint of the programme was assessed. No significant differences were found between the changes in drug and alcohol consumption of women and the type or quantity of support they had received through the programme. However, when the baseline characteristics of participating women was used to assess the

changes in the drug and alcohol consumption there were some significant differences. These were:

- Women that reported having drug and alcohol issues were more likely to reduce their drug and alcohol consumption (23 percent compared to 8 percent for Class A drug use, 30 percent compared to 18 percent for non-class A drug use, 51 percent compared to 29 percent for alcohol use). However, it should be noted that on average those women with reported drug and alcohol problems had higher consumption levels at baseline than those without (particularly for drugs, with a less clear difference for alcohol).
- A higher proportion of women from the care leavers pilot than the general participant population reported decreases in consumption of drugs and alcohol, although this is a very small subgroup (23 women) therefore this should be treated with caution.
- Those with mental health issues were more likely to decrease their drug and alcohol consumption than those without mental health issues, particularly in alcohol consumption.

Relationships

The quality of relationship with family, friends, partners and children was collected, although the information collected was “direction of travel” information (for example getting better, getting worse and so on), and issues with data quality make analysis challenging. Therefore, the analysis of relationships has been limited to fields which can be easily categorised. These are the fields for quality of relationships with partners and the type and frequency of contact with children. Key findings from this analysis are presented in the main report.

Housing and financial security

Information about the housing and financial situation of women is presented in the main body of the report. Overall, changes in housing situation were similar for those that had professionally reported housing issues to those that did not. An examination of the geographic locations of women found that there were no significant differences in the stability or level of perceived safety in housing for women living in London boroughs and those living elsewhere in the UK. The proportion of women reporting rent arrears was explored geographically, which found that comparable levels of women were in rent arrears in London and elsewhere in the UK. In terms of the value of rent arrears, there were large differences between London and the rest of the UK. At the baseline, the average value of rent arrears was higher in London (£925) than the rest of the UK, but at

the endpoint it was much lower (£167).²⁰ There was also a larger decrease in the proportion of women reporting being in debt in London than in the rest of the UK. When examining the debt of those women in London, the average value of debt went from £840 at baseline to £740 at the endpoint, both much lower values than for the whole population (although based on a smaller sample). This may suggest that the financial support and referrals in London work better than elsewhere in the UK, or that there may be fundamental differences between the women based in London and elsewhere in the UK. Figures 24 and 25 show proportions of women in rent arrears and debt, and the average value of rent arrears and debt, for women in London compared to the Pause population as a whole.

Figure 24: Proportion of women in rent arrears and debt (%) (n=215)

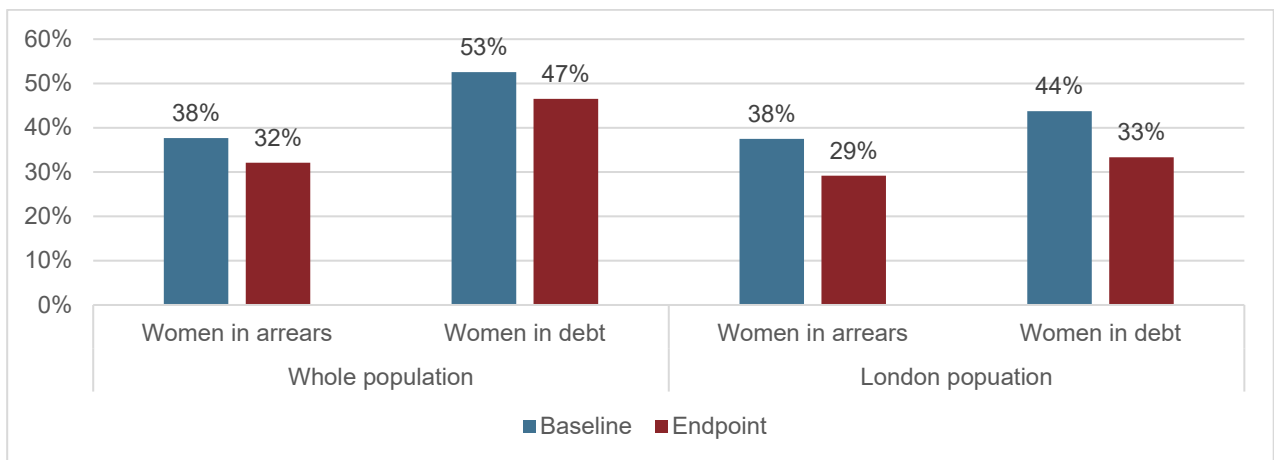


Figure 25: Average value of rent arrears and debt (£) (n=215)



²⁰ It should be noted that the sample of women in London with rent arrears is much smaller than the rest of the UK. At baseline, the range of rent arrears was similar in London to the rest of the UK. However, at the endpoint in London boroughs most women reporting they were in arrears stated the value was zero, which provides questions about the credibility of the data reported.

Use of public services

Women participating in Pause were asked about their use of public services. This is self-reported data, and the frequency of use has been estimated from qualitative entries (where appropriate). Findings are summarised in the main report. The number of women accessing services has increased for all services. The largest increases were for mental health services and debt services. However, it is important to note that access to services is relevant, not the total number of services accessed. Women need to be able to access the types of services they require at the appropriate frequency for their needs.

Education and training

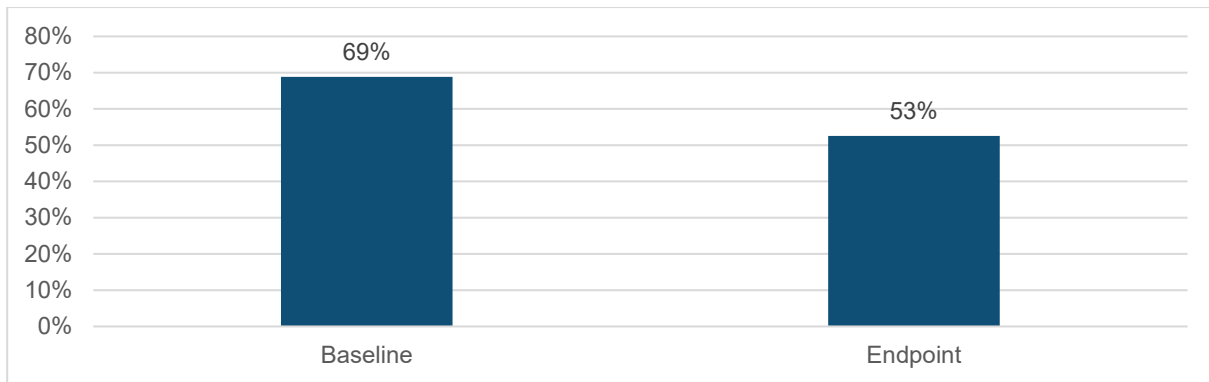
The data analysis presented focuses on the longitudinal sample of participants (those with a baseline and endpoint level). Similar analysis has been undertaken for the population as a whole (n=517), and the general findings remain true for the whole population, suggesting those with endpoint data are a good representation of the population as a whole. In terms of participation in education and training, there were no observable patterns by the type of problems and issues faced by the women at baseline, however when examining by age there was one noticeable pattern – the proportion of women engaged with education or training increased from the baseline measure to the endpoint in all age groups, but for older women (aged 35 and above) the proportion of women engaged in learning is much lower than for all other age groups.

The types of education and training women have been undertaking has also been explored. The education and training has been split into three main categories: formal education and training (working towards vocational qualifications, maths, English and English as a Secondary Language (ESOL) courses); job related training (on the job training, or training courses delivered through work); and informal education (such as cooking and parenting classes, classes at community centres or charities). Analyses of these categories is detailed in the main report

Employment

The work status of women participating in the programme was also assessed, and this followed a similar pattern to participation in education and training, with women in the oldest age category having the lowest levels of being in work. Analysis of the type of work being undertaken (paid employment or unpaid or voluntary work) showed that the proportion of women in paid employment was similar at the baseline and the endpoint (77 percent at the baseline and 74 percent at the endpoint), but at the endpoint there were more women in paid employment than at the baseline (72 women compared to 45). Figure 26 shows that at the baseline, 69 percent (148 women) were in neither employment or education and training. At the endpoint, this had fallen to 52 percent of women (113 women).

Figure 24: Women Not in Employment, Education or Training



Pause Management information system, N=215

Well-being

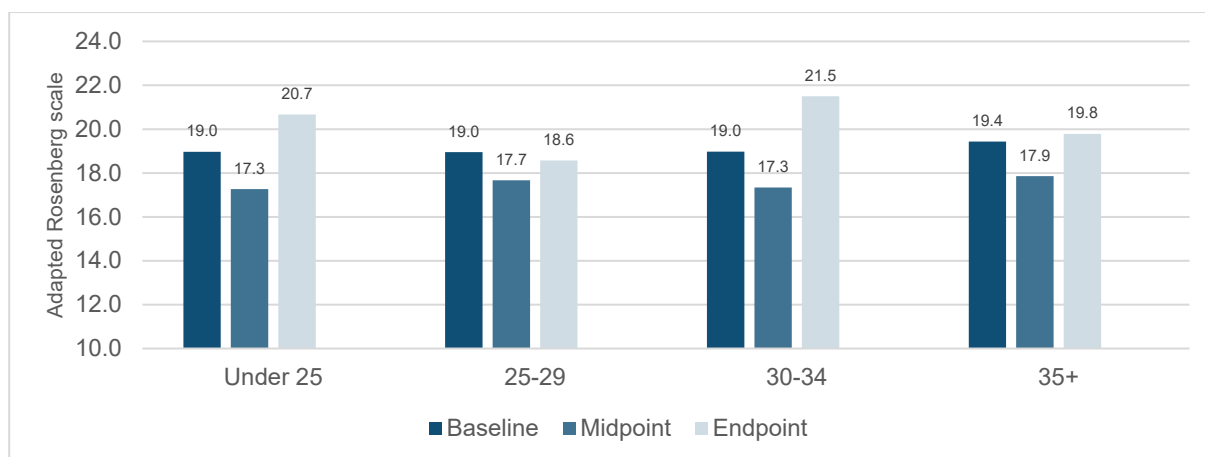
Three measures of well-being were used to assess how the programme has impacted upon women. These have been estimated using adapted scales, and should therefore be viewed with caution when comparing to the outcomes of other programmes. Data analysis is presented in the main report and focuses on the longitudinal sample of participants (those with a baseline and endpoint level). Similar analysis has been undertaken for the population as a whole (n=517), and the general findings remain true for the whole population, suggesting those with endpoint data are a good representation of the population as a whole.

Self-esteem

The self-esteem score was collected using a modified Rosenberg scale. Figure 27 below shows that the self-esteem score among pause participants apparently decreased (from baseline to midpoint), but then increased from midpoint to endpoint. It is, however, impossible to say whether this apparent dip is a genuine effect (for example, as women come to terms with issues that need to be addressed) or an artefact of measurement, given the scale's adaptation. Moreover, discrepant self-esteem (high implicit self-esteem at the same time as low explicit self-esteem) has been associated with social anxiety (see Schreiber et al. 2012), which was commonly reported in the interview sample, and seems possible that this could produce confounding effects, especially if adapting a global measure such as the Rosenberg Scale.

When examining changes in self-esteem by age, the largest decreases between the baseline and midpoint was seen for those aged 25 and under, and the largest rise between midpoint and endpoint is for women aged 30-34. The largest increase in self-esteem scores between the baseline and endpoint measures was for women aged 30-34 (who had the highest endpoint self-esteem score). However, women aged 25-29 reported lower self-esteem scores at the end of the programme than at the start.

Figure 25: Self-esteem scores by age



Pause Management information system, N=215

Overall well-being

The overall measure of well-being of women participating in Pause was collected, and as documented in the main report, shows that the level of well-being increases as women progress through the Pause programme. The changes in well-being have been explored at a sub-population level, and the following differences between groups has been observed:

- Those women who reported that they had decreased their intake of class A drugs had a lower baseline measure of well-being than the total Pause population (2.3 out of ten) and a lower endpoint measure of well-being (5.6 out of ten), but the increase in well-being in this group was higher than for the Pause population as a whole. This pattern was also present but less marked for those reporting reducing their consumption of alcohol (2.8 out of ten to 5.9 out of ten), but the pattern for those reporting reducing non-class A drug use was the same as for the population as a whole (but at lower levels of well-being).
- Linked to this, those who were professionally reported to have drug and alcohol misuse problems have lower scores than the total Pause population at baseline, midpoint and endpoint – but their increase in Well-being scores is less than for those reporting reductions in class A drug use and alcohol consumption (3.4 to 5.6). This suggests that either women without professionally reported drug and alcohol use problems improved their well-being more through reducing consumption, or that those with professionally reported drug and alcohol use problems did not reduce their intake, and this negatively affected their well-being.
- Women who were part of the care leavers pilot have the same average well-being values as the total pause population at the baseline, midpoint and endpoint. Those individuals with mental health issues, learning difficulties and abusive home

situations all have similar starting, midpoint and endpoint well-being values to the total Pause population as well.

- Younger women had a higher endpoint measure of well-being (6.7 out of ten) than for all other age groups, although the second highest well-being score was for the oldest group of women. The increase in well-being for younger women was also slightly higher than for all other age groups, although their baseline measure of well-being was also higher than all other age groups.

Pre-Pause contraceptive status and outcomes tracker data

As noted earlier, a significant proportion of the Pause population reported using some form of contraception prior to starting work with Pause. Accordingly, monitoring data analysis examined whether there was any evidence of systematic differences between women who did or did not report using contraception pre-intervention. There are relatively few areas of difference – reported below. Overall, women who were already using contraception appeared to be in a slightly better position on indicators relating to housing and well-being. These findings must be interpreted with caution (especially given the number of indicators compared within the outcomes tracker dataset) and show associations, not causality.

Housing and financial situation

At baseline, women who reported using contraception prior to Pause were slightly more likely to report they felt safe at home, and the increase over time in the proportion saying they felt safe was higher for those who reported pre-intervention contraception (from 51% to 70%) compared to those who did not (from 47% to 55%).

There were no differences at baseline in the proportion of women in rent arrears or debt, although there was some indication of slightly greater improvements for women who reported pre-intervention contraception.

Well-being

Figure 28 shows change in the ONS measure of well-being, indicating marginally higher scores at all time points for those who reported pre-intervention contraception compared to those who did not. Figure 29 shows a similar pattern for the adapted CORE-10 measure. As these figures demonstrate, the trajectory of change is very similar for both groups.

Figure 26: ONS well-being score by pre-Pause reported contraception

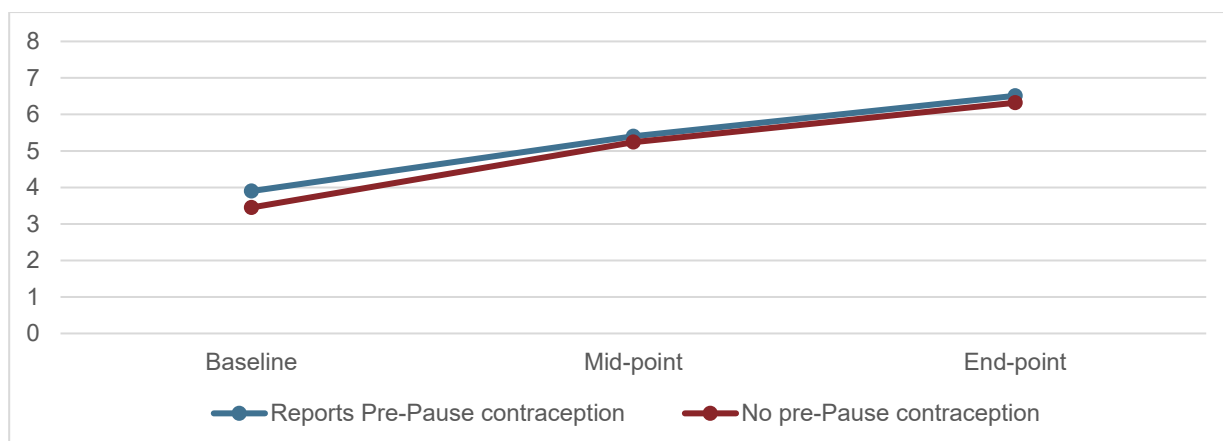
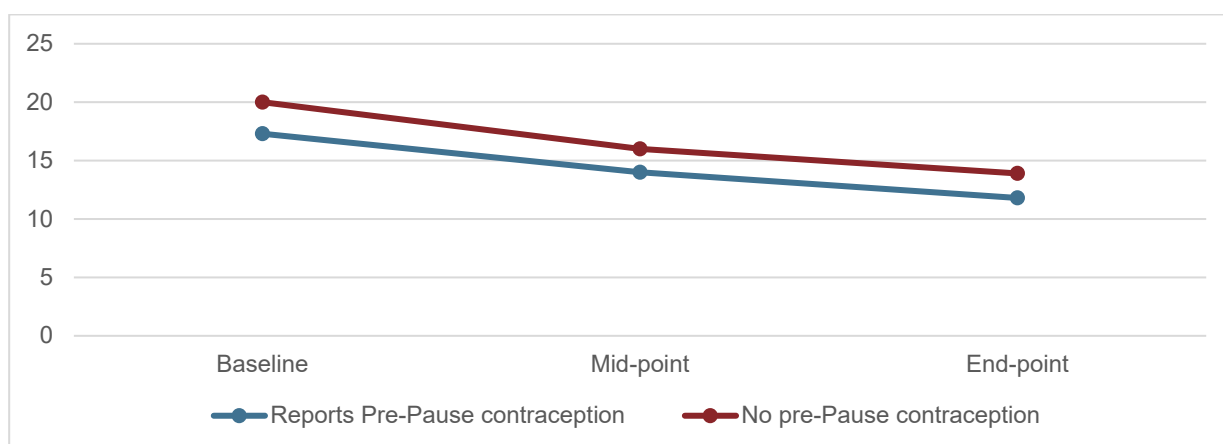


Figure 27: Adapted CORE-10 score by pre-Pause reported contraception



Drug and alcohol use

There was little evidence of differences in patterns of drug and alcohol use for women who reported pre-Pause contraceptive use compared to those who did not. Both groups had similar starting positions, although a slightly smaller proportion of women reporting pre-Pause contraception reported a decrease in non-class A drug consumption (19% among those on contraception v 26% for those not on contraception). There were no differences in reported change in alcohol consumption between the groups.

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