It is crucial to recognise that it was not only the judiciary who opposed an RCT at this stage. Senior managers in Croydon, and some LIFT staff, expressed their view that it would be unethical, not least because they claimed that services as usual did not involve similar levels of input. The absence of a robust alternative, such as Glasgow has with FACS, led some participants in the Croydon area to conclude, as the President of the Family Division had done a year earlier, that it would be inappropriate and inequitable to conduct an RCT in the LB Croydon. One senior manager said they could not condone it going ahead without an equivalent service in place, and the resources were not available to establish one:

> If we had an RCT we shall not be able to access or employ any of that knowledge until 2019. We might also know that it would be best for a child but we'd have to deny the service if the dice fell the other way. We'd be prioritising the research project, and that's very uncomfortable. I think it's more than uncomfortable; I think it's wrong.

A key driver to conduct a pure RCT in the case of LIFT is the view that most new NHS health interventions have to be ratified by the National Institute for Health and Care Excellence (NICE) and, in order for this to occur, there has to have been at least one RCT demonstrating its effectiveness. While the LIFT intervention includes health components, it includes others as well. It may be time to engage with NICE on the matters that have arisen around this RCT, as well as to continue the links already made with the Nuffield Foundation, which is working with Lancaster University and the Alliance for Useful Evidence to establish the scope and delivery of a new Family Justice Observatory. The Observatory is intended to address the dearth of empirical research evidence in this area for policy-makers and practitioners, disseminate what does exist, and explore the implications for practice and decision-making.[15]

There are, however, also methodological considerations. The argument for conducting an RCT is that, without one, there is the danger of over- or under-estimating the effectiveness of an intervention or failing to identify harm amidst claims of benefit. But this requires a calculation to be made of the statistical power of the trial to detect effectiveness. A trial with very low statistical power may not be worth pursuing (see Wittes, 2002). The service is very new and it is widely recognised that it is necessary for services to become established before an evaluation is able to measure effectiveness (see Kerr et al., 2010). In terms of conducting an RCT, much depends on the number of eligible families being referred to the service, and the pace at which they increase as the service becomes more established. The sample has to be of a size that would give a reasonable level of certainty in relation to any effect, so it has to be large enough to demonstrate statistical significance. The two-site trial (that includes the existing Scottish

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[15] This follows the recommendation in the Family Justice Review (Norgrove, 2011) for a coordinated and system-wide approach to research and evaluation, supported by a dedicated research budget - see Towards a family justice observatory and Rodgers et al. (2015).

care proceedings were listed to be heard in FDAC. The evaluation team compared these cases with a sample of families referred to the Inner London Family Proceedings Court because of parental substance misuse by three other (non-FDAC) local authorities. Whatever the shape of the evaluation in the future, it will be essential to continue with the existing, detailed data collection system that has been developed already.

Limitations of the Stage 1 evaluation

This evaluation was commissioned to report on lessons learnt on implementation of the innovative services - including early expectations and perceptions of the fit between the intervention and multiple systems (legal, health, social care) and the degree to which the intervention is acceptable to key stakeholders - as well as to inform the decision on whether or not it is possible to conduct an RCT in the future.

The methodology adopted enabled these questions to be addressed. However, while the report has explored the lessons for future rollout, there have been challenges in reaching a clear understanding of the fit between the intervention and other services. Despite a good level of engagement with children's social care in the early stage of the evaluation, this was not sustained. Difficulties over communication, and access to key informants, proved to be a problem. Whatever approach is taken to the future evaluation of LIFT, it is essential to gain a commitment that the local authority will support and participate in all aspects of the study. To this end, it will be necessary to have the appropriate research governance processes in place and to appoint someone as the one link in the local authority who has sufficient seniority to make decisions in key areas. The absence of such a person meant it was not possible to conduct planned elements of the current evaluation. The difficulties in communicating with those who would have been able to facilitate contact means that it was not possible to look in detail at the decision making process on the cases referred to LIFT, or to judge social care's reaction to early cases that have been assessed by the service. Although there was a significant level of input from a member of the CAMHS team in a neighbouring authority, the many attempts to engage with the CAMHS service in Croydon proved unsuccessful (which may indicate high levels of demand for their services). Judges in the family court, and members of local solicitor firms, did, however, engage with the project throughout and, despite concerns about the idea of conducting an RCT, were positive about the contribution which LIFT would be able to make. The timing of the data collection meant it was not possible to cover their reactions to the outcomes of early LIFT cases . Nevertheless, this report has examined the fit between the service and Government's policy aimed at speeding up the adoption process, and improving the life chances of those children waiting in care, as well as how it has the potential to address concerns expressed by judges over the quality of assessments.

In any future evaluation, it would it be essential to have opportunities to interview parents, carers and professionals involved in the project, in order to understand their experiences. There are also key decisions relating to referrals and progression that would need to be

explored and which would require the co-operation of the local authority. Early on in the project, concerns were expressed about the exclusion of target children with siblings who were over 5 years of age. It is important to understand how this concern is being managed and whether, for example, it is having any impact on referrals that might otherwise be considered to be appropriate for LIFT. While there is recent research indicating the problems that can arise in trying to keep sibling groups together (Rushton et al., 2010; Saunders and Selwyn, 2011), it is a contested area, and keeping sibling groups together continues to be a strong priority in many authorities.

The timing of the evaluation meant that the LIFT staff group was in the process of forming, and members of the group were still exploring ways of working, both collectively and individually. Thus it was not possible to collect their reflections on the impact of operationalising the service and the extent to which the support and supervision in place met their needs.

There are other key questions that will need to be considered in the future that could not be addressed by this evaluation, given the early stage of the service's development. These include whether the extended multidisciplinary assessment offers more reliable information for the courts and enables better outcomes for children in terms of earlier intervention. It was also not possible to assess the pilot's replicability and sustainability. It will only be possible to judge these elements when LIFT is operating at full, or near full, capacity and when the local authority and courts have had experience of working with the model. At the moment, it is a free service to the local authority, but as only a handful of cases had accessed LIFT by the end of the evaluation, it was a very expensive service in terms of the actual cost overall. In addition there has not yet been an assessment of the call on public funds that may be needed - for example, in terms of additional meetings and hearings. In April 2016 the project was granted additional Innovation Programme funding; any future evaluation must build economic models on the basis of the willingness of the NSPCC and/or local authorities to fund the service.

Implications and recommendations for policy and practice

> We stand on the cusp of history. 22 April 2014 marks the largest reform of the family justice system any of us have seen or will see in our professional lifetimes. On 22 April 2014 almost all the relevant provisions of the Crime and Courts Act 2013 and the Children and Families Act 2014 come into force. On 22 April 2014 the Family Court comes into existence and the Family Proceedings Court passes into history. On 22 April 2014 we see the implementation of the final version of the revised PLO in public law cases and the implementation in private law cases of the Child Arrangements Programme. Taken as a whole, these reforms amount to a revolution. Central to this revolution has been – has had to be – a fundamental change in the cultures of the family courts. (President of the Family Division, Views from the Presidents' Chambers' newsletter, April 2014)

There are lessons to learn from the early development of the LIFT project between October 2015 and March 2016. Some apply to the establishment of any new service; some are specific to the introduction of a multidisciplinary service designed to engage with a range of agencies, and others to the current changes in the family justice system. If the decision were taken to replicate the LIFT service in another authority in England or elsewhere. it would be important to establish a realistic timetable and make allowance for the fact that new interventions often take longer to become established than their originators expect. The development team in NSPCC's central office played a key role in establishing the service, but with hindsight it would have been helpful for there to have been closer liaison, from the outset, between development managers and those who would be charged with delivering the initiative. Operational staff were largely absent from early discussions, when it would have been helpful to have had someone present with a strong connection to practice and experience of the time needed to set up a service. This may also have avoided the early deployment of some staff, who were largely responsible for determining their own work activities until the clinicians were appointed. This leads to a strong recommendation that, in future, clinicians are appointed before any other team members.

At various points in the present evaluation, references were made to the contact that had been established with staff in the court team within the Children's Service Directorate in Croydon, and how this contact had subsequently declined. Participants recognised that there needed to be more engagement with the team initiating proceedings, and members of the LIFT team were taking steps to address this over the coming months. It was suggested that one way to improve engagement would be to offer relevant training to social workers. While making time for this was seen to be a challenge, both in terms of the social workers and LIFT team, it is perhaps something that could be developed when resources and capacity allow.

One issue emerged in discussions with LIFT staff members which does require a resolution. Some of those interviewed were concerned that judges expected LIFT to provide an expert view equivalent to the experts that had often been appointed. But if LIFT is not providing an expert view in their assessments it is, perhaps, unclear what they are providing, so it is important to resolve any misunderstandings – perceived or actual – as soon as possible.

The absence of very early engagement with the courts seems to have been a missed opportunity. Given the central role of courts in this project, it would have been advisable to engage the judiciary at the highest level at the point when the project was being discussed. Instead, the initial approach was made to the then District Family Judge (DFJ) before discussions took place with the President of the Family Division. The Family Court and Alcohol Court (FDAC) has shown that it is possible to do things in a very different way (Harwin et al., 2014) and this is now (2017) being introduced into Croydon. It will be important to continue the contacts now established to plan the relationship between FDAC and LIFT, so that each evolves with reference to each other.

If, in the future, there are constraints on the extent to which LIFT may be replicated in other authorities, it might be possible to use the expertise that exists in the team to explore alternative ways in which aspects of the model might be applied, and to look at examples of how this has happened in the US and elsewhere. The task would be to identify any elements of the model that could be adapted for use where it is not possible to embed the whole.

The announcement in April 2016 that the LIFT project had been granted additional Innovation Programme funding should be seen alongside another significant parallel development. In March 2016 the government announced plans to change the law to allow more children to be adopted as part of a wide-ranging four-year strategy set out in Adoption: A Vision for Change (Department for Education, 2016b). In light of judicial concerns over the parenting assessments received, and the judgements that have been made on the responsibilities of local authorities to take all steps to ensure a care plan for adoption is progressed only when every other option has been applied, LIFT has the potential to make a significant contribution. The strategy and the plans for proposed legislation also set out goals for more babies to be placed with foster parents who may want to adopt them permanently, which fits with the approach in place in Tulane.

The quotation at the start of this section illustrates the extent to which the family justice system is evolving and the pace at which this is happening. It does not, however, include all the changes that have taken place, and omits the significant development of the Family Drug and Alcohol Courts (FDAC). The final report of the Family Justice Review (FJR) (Norgrove, 2011) drew attention to a number of issues that are directly related to this present evaluation, and the need for more robust evidence of what is effective. LIFT must be seen as part of this evolution and it is vital that early lessons from the service can be used to contribute to this debate, on the understanding that final conclusions

about the service have yet to be drawn. At a time when the government is introducing legislation as a consequence of the difficulties faced in assessing children and their parents and carers and deciding on the right route to permanence for them (House of Lords, 2016) this evaluation is especially timely. The achievements to date should not be underestimated, not least in relation to the courts. The judiciary has accepted that siblings aged over 5 years are excluded from the project and where an intervention follows from an assessment the case will not have to meet the PLO timescales. A reporting process has also been established which allows a judge to review the progress of a case referred to the service. It is with this in mind that the following recommendations are made:

- ensure that the LIFT team is sufficiently resourced to deliver the service in Croydon, and, if the service delivery/evaluation design involves working with an additional local authority, that adequate planning and resources are agreed and applied
- continue to work to establish strong contacts with all relevant professionals and stakeholders and make sure they have sufficient awareness and understanding of LIFT, particularly in relation to the distinct element of LIFT as a mental health intervention for babies and young children
- decide on a robust evaluation methodology as soon as possible, using quantitative and qualitative methods, and incorporating a cost study similar to that conducted in the evaluation of the Family Drug and Alcohol Court (Harwin et al., 2014). The evaluation should include a review of the criteria used to refer cases to LIFT; an examination of decision making on the referrals; an analysis of costs of establishing and running the service, alongside the development of a template for analysing the costs and potential benefits. It is imperative that the evaluation model is in line with the court process. Otherwise, there is a risk that not enough referrals will be made to the LIFT service.
- obtain a commitment from any authority where LIFT operates, or might be introduced, that the necessary support will be provided to allow the initiative to be fully evaluated, and that appropriate research governance and data sharing processes will be maintained or established
- consider offering training, in the form of continued professional development, based on the model to social workers and other professionals, to support their assessment skills as well as their engagement. Develop processes to learn from the findings of studies conducted in the family justice arena in relation to similar groups targeted by LIFT, specifically evaluations of Cafcass Plus projects (for example, Broadhurst et al., 2013 and Holt et al., 2013) as well as those that might emerge from reports or evaluations of the New Orleans Intervention Model in other countries

Findings Part 2: Planning for implementation of the RCT April 2016 to January 2017

Dennis Ougrin and Kerry Middleton

Introduction

This section updates some of the material considered in Part 1 to explain the process by which agreement in principle was reached on conducting an RCT comparing the LIFT service with business as usual in Croydon. The final protocol has yet to be agreed, but this section aims to show the current state of thinking in terms of a response to the concerns outlined in Part 1, pending agreement about the final protocol.

As discussed earlier, a Randomised Controlled Trial (RCT) of NIM has been ongoing since 2011 in Glasgow. In this RCT, outcomes for children worked with by NIM are compared to outcomes for children assessed by the local social work services, the Family Assessment and Contact Service (FACS), run by a highly specialised team of social workers. As part of this RCT, all 0-5 year old children who come into care due to suspected abuse or neglect, and whose parents and foster carers consent to participation, are randomly allocated to NIM or FACS. The child undergoes an assessment just after coming into care, one year later and then at 2.5 years, using a variety of measures evaluating mental health, developmental and attachment functioning.

A substantial amount of qualitative work has been undertaken as part of the RCT in Glasgow. This revealed both perceived benefits and challenges of introducing a mental health model into work with maltreated children in Scotland, and helped delineate aspects of NIM's implementation and delivery, clarifying relationships between NIM and key stakeholders. With the RCT continuing in Glasgow, the research team aims to expand it to part of South London. The addition of one or more sites in South London will allow the research team to expand the evidence base regarding interventions for the youngest LAC in both English and Scottish contexts, thus increasing generalisability of the findings.

Why does a randomised controlled trial seem to be the most appropriate research methodology to assess the effectiveness and cost- effectiveness of NIM?

NIM was evaluated in the US in a context where there is very little childcare social work. It has never been compared with social work and, in Louisiana, it is more likely to be NIM or nothing. Across England, services for children coming into care are responding to the requirements of the Family Justice Review and, if these enhanced children's services turn out to be as good as NIM, they are likely to be even more cost-effective.

Unless an innovative service has been rigorously tested, it is impossible to be certain that it doesn't have unintended harmful effects. Two examples are the Cambridge-Somerville Trial and the Scared Straight interventions (Petrosino et al, 2003). The Cambridge-Somerville Trial was a particularly well-conducted study: starting in 1939 with a group of more than 500 juvenile delinquents, participants were randomly allocated to either a range of services (including counselling, academic tutoring, medical and psychiatric attention, referrals to YMCA, Boy Scouts, summer camps and community programmes) or to simply checking in at regular intervals. Almost all, 94% of the participants, were followed up 30 years later and, surprisingly, more of those who had had the counselling and other services had committed criminal acts. As noted here by the trial chief investigator 'a larger proportion of criminals from the treatment group went on to commit additional crimes than their counterparts in the control group' (McCord, 1978, p.286). Another apparently positive intervention, Scared Straight, which introduced juvenile delinquents to adults who had already been convicted of crimes, was shown to be harmful across nine studies, as the author of a meta-analysis of nine studies concluded '…programs such as Scared Straight increase delinquency relative to doing nothing at all to similar youths' *(*Petrosino, 2003, p.58).

The reason randomisation is a useful research method – especially in complex settings – is that if enough individuals are randomised, all complexities – both known and unknown – will be balanced out. This should result in two groups that are identical except for the new intervention. It is helpful to imagine a large lecture theatre with students streaming in with groups of their friends. If, at the entrance, a coin is tossed so that students are randomly allocated to sit on one or other side of the central isle, those friendship groups will be spread evenly across the two sides of the lecture theatre. If more than 100 students are allocated randomly to each group, then all sorts of factors will be evenly spread and there will be a very similar number, on each side, of students who have blue eyes, have a parent with an alcohol problem etc. In the BeST? trial, the aim is eventually to randomly allocate around 500 children to receive NIM or social work across all the sites, including the 180+ children already recruited from Glasgow and new recruits from Glasgow and South London. This should balance complex factors such as the number of large sibling groups, the number of asylum-seeking families, the proportion of families in which parent used cocaine, etc.

The potential to use alternative, non-RCT, study designs was explored in detail by the BeST? trial research team, and has been subject to international peer review by experts in complex interventions methodology. In particular, according to the study statistician, Dr McConnachie (individual communication), an individually randomised design is by far the most efficient. In Part 1, it was suggested that a stepped wedge or random cluster design could be considered in the future, should an RCT not prove to be possible. In Dr McConnachie's view, a stepped wedge design is not currently feasible for the evaluation of NIM. This approach is suitable for those interventions already approved for implementation. The evaluation is then done by introducing the intervention in a random

order over the sites. The stepped wedge design could only work if all outcomes are collected via routine data, because the outcomes for all sites are needed simultaneously, throughout the trial phase. As routine data collection is not currently consistent with the quality required for a rigorous evaluation, individual consent and follow-up for every family would be required – again, at all sites for the duration of the trial – which would almost certainly not be feasible, in the view of the trial team. A cluster RCT, and a stepped wedge, both require a large number of sites, because it is the site that is the unit of analysis. The sample size would need to be inflated, often quite considerably, due to clustering of outcomes. One of the original ideas for BeST? was to divide Glasgow into two geographical halves, one of which would receive the NIM service, the other to standard care, but, following a discussion, it was decided this would not be a valid approach.

RCT technology has improved a lot over the last ten years, especially since the publication of the MRC Complex Interventions Framework (Craig et al., 2008). Interventions within trials no longer have to be rigidly manualised, but they are expected to be well described and, before a trial even starts, extensive exploratory work is done to ensure that the new intervention fits the local context. Qualitative work is done throughout the trial so that whatever the outcome, we can get a good understanding of why an intervention worked or didn't work.

This has also been the experience of the Big Lottery funded Realising Ambition programme in which five RCTs in social care were funded:

> Big Lottery took the bold step of investing in four real-world RCTs as part of Realising Ambition. Not because we or others think that RCTs are the only or even best method of evaluation in all circumstances: we don't. But because when it comes to testing the impact of an intervention on outcomes they do a good job of helping us to attribute cause by filtering out other possible explanations for any impact observed. (Young Foundation 2017)

Key tasks identified by this programme, in order for RCTs to be successful, include getting buy in (usually involving intense multi-agency consultation); getting the right size of trial (usually larger numbers than stakeholders initially expect) and thinking about both likely benefits and possible adverse effects of new interventions. They also highlighted some crucial areas of focus in RCTs, including recruitment and retention, model fidelity and avoiding contamination.

The qualitative work – both that included above in Part 1, and the earlier qualitative work (Friedman-Levy 2015) – was essential to gain an understanding of the child welfare practices that exist within LB Croydon, and identifying how the work of the LIFT service has begun to function within this context. This has been an important means of supporting the implementation of the proposed RCT. The sections below summarise some of the concerns raised in the qualitative evaluation of early implementation of the

LIFT service up to March 2016, along with the work that was conducted up to January 2017 to begin to address these issues. Suggestions of strategies and action points for ongoing evaluation are provided.

Concern 1: Absence of a blueprint for conducting RCTs in the family justice area

There are no existing examples of implementing a randomised trial within family proceedings in England. The Stage 1 report highlighted differences between the Scottish and English legal systems, which meant that the trial protocol in Scotland could not be directly transferred to proceedings in England. In her annex to this report, Her Honour Judge Atkinson has considered the factors that have informed decisions by the judiciary about whether and how best to proceed with an RCT in the English legal context.

Response

Although there are no examples of implementing a randomised trial within family proceedings, there are existing studies that can inform the development of an RCT within family proceedings, although neither involve looked after children, and one took place over 30 years ago in a very different legal context. Berg and colleagues (1978) randomly allocated juveniles who were failing to attend school into those whose cases were adjourned and those who received supervision. More recently, an RCT design in which two groups of patients discharged from psychiatric hospitals received the same levels of clinical treatment but for differing lengths of time was used by Burns and colleagues (2013) to test the use of Community Treatment Orders This work required coordinating a complex multi-agency network, and required significant planning with Judges in order for the randomisation to work within the court framework in a way that accorded with legal practices. Gathering research evidence in highly complex systems is challenging, but the technology of RCTs has developed to address this. As noted above, the Medical Research Council's Guidelines for the Evaluation of Complex Interventions Framework (Craig et al., 2008) provides a useful frame for formulating, and then conducting, RCTs that we consider to be potentially applicable in highly complex settings such as the Family Justice System.

While there is indeed no blueprint for the intended RCT, the need for one has been articulated by the National Institute for Health and Care Excellence (NICE). NICE is a non-departmental public body that provides national guidance to improve health and social care. It produces evidence-based guidance and advice for health, public health and social care practitioners and develops quality standards and performance metrics for those providing and commissioning health and social care services. Specifically, when developing its Public Health Guideline (PH 28) on looked after children and young people, it recommended that research should:

> …develop robust methods for evaluating services for looked after children and young people by working with multidisciplinary research specialists in health,

> social care, and economic evaluation …Explore barriers to conducting controlled studies (for example, concerns about random allocation of looked after children and young people) and making recommendations to reduce these obstacles. It should produce clear guidance about when it would be considered unethical, unnecessary, inappropriate, impossible or inadequate to randomly allocate participants (NICE 2010).

Subsequently, the NICE Guideline's on children's attachment in Care (NG 26) made recommendations for research on children with attachment difficulties that state:

> Attachment-focused interventions targeting adoptive parents, carers and children and young people are scarce … A randomised controlled trial should also be carried out to compare the clinical and cost effectiveness of an attachment based intervention to promote secure attachment in children and young people who have been, or are at risk of being, maltreated, with usual care (NICE 2015).

Actions:

- Provide information and ongoing opportunities for discussion with key partners and stakeholders regarding the Medical Research Council's Guidelines for the Evaluation of Complex Interventions Framework, the position of NICE and the Department of Health as regards RCTs and learning from previous RCTs that appear to have relevance to the family justice system. Since data collection for Part 1 of the findings in this report was completed, there have been several meetings between the research team and senior members of the Judiciary in order for the research team to fully understand the challenges inherent in randomising within the Family Court. These included meetings with Sir James Munby, President of the Family Division, with Charles Geekie QC (a local barrister independent of the RCT but willing to discuss challenges) and several meetings with Her Honour Judge Atkinson, designated family Judge for the East London Family Court. We have also held what we hope will be the first multi-agency steering group for the RCT, if it is able to go ahead. Chaired by Her Honour Judge Atkinson, this involves the other East London Family Court Judges, and representation from Croydon Social Work Services, the NSPCC, King's College London and the University of Glasgow. Her Honour Judge Atkinson has reflected on the factors that have informed the judiciary's decision-making about the fit of the RCT design within care proceedings in an annex at the end of this report.
- Continue consultation with the Department for Education, Department of Health (e.g. through the Nuffield Family Justice Observatory), NICE and the Health Research Authority regarding the proposed RCT. Since data collection for the qualitative study reported above in Part 1 was completed, there has been consultation with these organisations, including a Roundtable Event hosted by the Department of Health in June 2016, to discuss the role of evidence in family justice which included a discussion about RCTs in that sector. This was attended

by academics, including some of the authors of the present report, and representatives from voluntary organisations working with vulnerable families; representatives from children's social services, and representatives from the Department of Education.

Concern 2: Anxieties regarding randomisation of children in a social care context

When the Stage 1 interviews took place, senior social work managers, and some LIFT staff, had expressed anxiety regarding the randomisation of children in a social care context. The anxieties were informed by a sense that services as usual did not involve similar levels of input to the LIFT intervention.

Response

After an extensive consultation process following completion of the Stage 1 evaluation, most senior representatives of children and family early intervention and children's social care of the London Borough of Croydon are now generally in favour of facilitating the RCT, in our view. The BeST? trial research team have now joined the project's steering group, which includes senior management representatives of LB Croydon. In the context of an RCT, this group would consider, and address, any ethical challenges highlighted by the process evaluation work. This will assist in finalising the trial protocol.

Despite the recent growth of interest in, and significance of, evidence-based practice in social work, relatively few RCTs have been conducted in children's social care. Solomon et al (2009, p.14) point to possible constraints on the development of evidence based practice from this:

> Social work has not reached the point of designating specific social work practices as [evidence based practice]. One of the primary reasons is the shortage of available evidence, particularly empirical evidence from RCTs. The caution here is that if social work researchers do not engage in RCT investigations, (evidence based practices) may not be developed for social work interventions, nor will social workers contribute to the broader arena of (evidence based practice) for psychosocial interventions.

A challenge faced in social work, and many other human services, from using evidence to inform practice decisions arises from the complexity inherent in their work, that decisions have to be taken to address the particular circumstances in each case: 'It is not a simple application of population-level evidence to individuals' (ibid.).

In addition, the people they are working with are likely to be highly vulnerable and experiencing high levels of stress and distress. This informs an ethical dimension to the concern, namely that it is not acceptable to withdraw, or fail to offer, a service that could benefit them. In such a circumstance, it can feel to the practitioner as if there is a tension

between their practice ethics and research ethics. Solomon et al. (2009) suggest that, while this is experienced commonly, the tensions can be reconciled. They refer to the ethical principles for research and RCTs outlined by the Belmont report in The National Commission (1979) as a way of achieving this: respect, beneficence and justice. Randomisation can be justified meaningfully where there is genuine uncertainty about the effectiveness of the intervention that is being tested, and hence it has been important to explore the notion of equipoise with local stakeholders in Croydon, and to continue this process.

There appears to be no evidence that a higher intensity of input to children, even using infant mental health techniques, is better than the input offered by social work services. In the Glasgow feasibility RCT (Turner-Halliday et al., under review), the qualitative process data showed equivalent levels of enthusiasm for, and concern about, both the New Orleans Intervention Model (NIM) and the social work model. In Croydon, the most recent inspections rated children's services as 'satisfactory' for the overall effectiveness of its safeguarding and LAC services (OFSTED and CQC 2012) and as 'good' for the overall effectiveness of adoption services (OFSTED 2013).

It is suggested that concerns about the ethical consequences of an RCT are best met by a system in which the courts are the final arbiter about who receives LIFT and who receives services as usual, once the randomisation process has taken place. The court has the overarching obligation to consider the best interests of the child, and both parents and professionals need to know that, in some cases, the court could decide to pull the child out of the trial on a welfare basis. It will be made clear to families in recruiting them to the trial, that the services they are being offered are equitable, in our judgement. We argue that this is the case, since we have no evidence that NIM is better than social work services as usual. We have ethical approvals for our consenting process.

Concern 3: Concerns about equity

Participants in the Stage 1 evaluation were concerned that there would be concerns about equity, as LIFT appeared to represent an improvement on business as usual services. Anxieties about equity fuelled opposition and concerns from the judiciary and senior managers in the local authority to the RCT.

Response

Sir James Munby has expressed concern about the way the involvement of independent experts in judicial proceedings can slow things down and cause drift and that, in many cases, social work expertise is sufficient (Munby, 2014). In our discussions with him, as more information was provided on the nature and value of RCTs, he has welcomed the potential for the RCT guiding the judiciary as to the kind of expertise that may be helpful in making the challenging decisions about children's permanent placement.

There are some examples of services offering a higher level of input to children and young people being harmful or not having an effect. Examples include:

- The Scared Straight studies in which young offenders were introduced to adults with a criminal history. A recent meta-analysis showed that these interventions were harmful (Petrosino et al., 2003).
- Group therapy for adolescents who self-harmed was shown to be ineffective (Hazell et al., 2009).
- The Cambridge Somerville Trial in which young offenders were offered medical care, school tutoring and counselling. Over a thirty year follow-up of more than 90 per cent of the cohort, more crimes had been committed by those who had the more intensive interventions (Dishion et al., 1999).
- The Fluid Expansion As a Supportive Therapy (FEAST) trial of fluid boluses for young children experiencing shock in African hospitals. The trial was stopped before completion because of a higher death rate due to fluid bolus treatment, even though this is the standard treatment for shock in the West. The Medical Research Council (2013) has made a video about this, which is available online.

Actions:

- Provide information and opportunity for discussion with key partners and stakeholders regarding previous RCTs in vulnerable populations and complex settings and the potential for negative or little effect findings to emerge. This may apply even with apparently obviously helpful interventions of higher intensity
- Continue our consultation with the Department of Education, Department of Health (for example, through the Nuffield Observatory), NICE and the Health Research Authority regarding the evaluation.

Concern 4: No agreed level of what constitutes ‘services as usual’

The Stage 1 evaluation highlighted that, unlike Glasgow where FACS is a well established business as usual service, the level and type of services allocated to families in Croydon appear to be very variable.

Response

By definition, usual services are the services that these families would receive if they did not get the NIM intervention. Usual services will be described in a detailed process evaluation and will be reconsidered at operational meetings by the BeST? services trial team. The fact that ‘usual services’ will inevitably vary across the UK sites will be an advantage, in our view, especially if NIM is found to be cost-effective across these different contexts: however, this does have implications for analysis and reporting in terms of there being no consistent treatment as usual.

Actions:

- Continue liaison with local stakeholders about our genuine uncertainty as regards the relative cost-effectiveness of NIM and services as usual.
- Between-site differences will be taken into account during the statistical analysis of the trial data.

Concern 5: Rates of referral to LIFT have been low

The Stage 1 evaluation noted the low number of referrals that had been made to the LIFT team in the early months after the LIFT service was established.

Response

It is acknowledged that rates of referral from the local authority were low initially. This may have been partly explained by staff changes within the care planning and permanency planning teams which meant that establishing consistent contact and promoting the LIFT service within standard care was difficult. This included the departure, in February 2016, of the care proceedings manager who was previously the primary point of liaison for referrals. As a result, there appeared to be a lack of clarity from local authority staff on the nature of the LIFT service, and what might constitute a suitable referral. In addition, reservations from local authority staff may also be attributable to the additional workload associated with making a LIFT referral.

LIFT members have been proactive in addressing these issues. Continued attempts have been made to promote the LIFT service by attending weekly drop-ins within standard care services to answer queries. LIFT members are also providing presentations to standard care services in order to continually update new staff. Other efforts made to engage staff members include inviting social workers to visit the LIFT service. Most recently, a new care proceedings manager has been appointed (October 2016). All of these measures have led to a substantial increase in the number of referrals. As reported above, between January 2016 and January 2017, there were 21 referrals of LAC to LIFT, which is in line with expectations. At the point of reporting (January 2017), 17 of the children referred had been discharged by LIFT. These families had received 96 days of LIFT input, on average. Of the 21 children referred, 18 had attended at least one face-to-face session; at the point of reporting (January 2017) the average number of sessions was 28.7, and LIFT had recorded an average of 14.1 phone calls per case. 14 cases were closed early . Early closure occurred primarily due to the LIFT service decision not to intervene (3 cases); court decisions (4 cases); Local Authority decisions (2 cases), and family decisions (5 cases). These early discharges provide valuable data on the way the NIM intervention may perform in a real life environment in parts of South London. In good quality RCTs, statistical analyses are performed on all randomised participants, irrespective of whether or not they completed the interventions studied. This approach, called Intention To Treat analysis, ensures any effects found are not exaggerated, and it improves both the generalisability and the applicability of the findings.

If LIFT becomes part of the RCT, an NIHR funded research team would include a trial recruitment coordinator who would contribute to ensuring a steady flow of referrals. This would be a social worker whose role would be to identify eligible referrals from all the children coming into care in Croydon; ensure randomisation occurs, and approach eligible families for consent. This has been extremely successful in Glasgow, and very few eligible children appear to have been overlooked. This role will be subject to agreement by the local project steering group.

In order to reach our target number of families participating in the UK RCT (500 in total across all sites), we have estimated that we need to recruit 4 families per month in South London (2 randomised to LIFT, 2 randomised to services as usual). Given the current referral rate, this would require expanding the RCT beyond Croydon. The number of eligible families that can be randomised in South London is only bound by the capacity of LIFT to take referrals, and this has been carefully modelled in the Glasgow Infant and Family Team (GIFT).

Actions:

- LIFT to continue to build communication links, and promote the LIFT service within LB Croydon.
- Conduct parallel planning with neighbouring local authorities and key stakeholders in those areas to prepare the ground for the possible expansion of the RCT to achieve the target recruitment rate in South London. This work will require close liaison with the relevant personnel, and learning from the evaluation.

Concern 6: Exclusion of target children with siblings over 5 years of age

Participants in the Stage 1 evaluation suggested that keeping sibling groups together continues to be a strong priority in many authorities such as LB Croydon. This had generated a concern that the RCT would make this problematic, because different children would be seen by different teams, or some of the sibling group would not be seen at all.

Response

The fact that a family with children aged both over and under age 5 is randomised to LIFT does not imply different placement or permanency outcomes for the siblings. Where sibling groups include a child over age 5, the Glasgow Infant and Family Team has dealt with this on a case by case basis. The same approach will be used in South London.

The direct work used in the NIM model is designed for children under age 5: however, the detailed report on family functioning that is produced by NIM is likely to be highly relevant for older children, even though any direct work with the older sibling would not usually be conducted by LIFT. Child and Adolescent Mental Health Services (CAMHS)

are more available for children over the age of 5 than for pre-school children, and there is theoretically no reason why younger children should not have direct work from LIFT while an older child in the same family that requires it receives direct input from CAMHS. However, the pressures on CAMHS are not under-estimated and there is no guarantee that children over 5 will get such a service.

Guidelines for social workers around working with families with older siblings have been developed by GIFT and, in November 2016, were shared with LIFT, who will continue to develop these to ensure they are as useful in the South London context, if it is decided to go wider than LB Croydon.

Actions:

- Maintain close liaison between the LIFT team, Croydon Children's Services, the GIFT team and Glasgow Social Work Services, in order to ensure that systems around these sibling groups are set up appropriately.
- Continue to share practice experience between GIFT and LIFT with families with older siblings and in other circumstances.

Concern 7: Arrangements for analysis of data from a multi-site study

The Stage 1 evaluation noted the differences between Glasgow and Croydon in terms of the legal system, population demographics, and the range and type of services offered between the two sites. A concern was expressed about the implications for the use of data arising from this being a multi-site study.

Response

It is true that some RCTs report significant inter-site differences. However, inter-site differences are not necessarily a problem. They might reflect real-life differences in practice. In this case, having both Scottish and English research sites may improve generalisability of the findings. Appropriate statistical approaches will be used.

Research assessments are designed to be identical in all study sites involved in the multi-centre RCT, and we already have ethical approval for this.

We have drafted research agreements between the various partners. These must be signed off before the site in Croydon, and sites across parts of South London, can open for recruitment.

Actions:

- Continue to work towards opening a South London RCT site with Croydon as the lead authority

Concern 8: Difficulties communicating with key staff from children's social care

Some adaptations had to be made to the Stage 1 evaluation when it proved impossible to arrange interviews with some parts of Chidren's Social Care and the CAMHS service in Croydon. The number of children referred to LIFT appeared to be lower than the number of eligible families, and some participants questioned whether this had arisen because some members of some social work teams dealing with potentially eligible families were unfamiliar with the LIFT service and the research.

Response

Difficulties in communication is a key issue in most trials. It is especially pertinent to the evaluation of NIM, an intervention with multiple stakeholders. Standard social care also typically involves multiagency and multidisciplinary work, which makes communication a challenge.

There have been several meetings and phone-calls in the latter half of 2016 and in 2017 between Mr Lewis, Director of Children and Family Social Work in LB Croydon, Mr Forde from the NSPCC (funder of the LIFT service), and Professor Minnis, Chief Investigator of the multi-centre RCT. These have allowed detailed discussions to take place about how the RCT would work in Croydon and other areas of South London, and have continued during meetings with Mr Lewis, Mr Forde, Professor Minnis and Her Honour Judge Atkinson at the East London Family Court.

In the 2015 South London feasibility work, we interviewed key informants from Children's Services and relevant health services (Friedman-Levy 2015). We have learned, from this work and from our Glasgow feasibility work, that communication with key stakeholders is crucial at every stage of the study.

It has been helpful that, in Glasgow, a Steering Group, chaired by Glasgow's Chief Social Worker and involving senior social work managers, the NHS, the NSPCC and the University, has met regularly. We hope to replicate this in South London.

In addition, the BeST? trial research team members have joined the London project steering group, which is likely to facilitate communication and troubleshooting where there are challenges with access to informants.

Actions:

- Liaise with multi-agency partners in South London – particularly Mr Lewis and Her Honour Judge Atkinson – in order to develop the most efficient and effective multi-agency governance structure to oversee a South London RCT site.
- There has been progress with finalising data sharing agreements between the NSPCC, KCL and LB Croydon.

- Liaise with, and learn from, Glasgow city council about effective research governance arrangements that can be shared with LB Croydon through this project.

Discussion and next steps

Three main areas are discussed below:

- LIFT appears to be a generally feasible model for ooked after children aged 0-5 living in Croydon
- LIFT is associated with high intensity of contact
- despite several reservations, there appears to be good progress to commencing an RCT evaluation of NIM in LB Croydon.

In the pilot study that used all referred cases, both the numbers and the intensity of work were in line with what was expected. Although lacking a control group, the process variables revealed significant intensity of input from professionals, delivered by LIFT. Given the differences in characteristics of child and family service users, and the nature of the LIFT intervention, comparisons of the process variables between LIFT and other programmes, including services as usual, should be made cautiously.

The number of children referred to LIFT (21 between January 2016 and January 2017) was in line with expectations. A greater number of referrals is expected in the subsequent years as the referral pathways become clearer. The number of referrals is in line with the sample size calculations undertaken for the RCT, and suggest that the RCT is likely to be feasible. We found that, out of the 17 children referred and discharged by LIFT, families received 96 days of LIFT contact, on average. Of the 18 children that have had at least one face-to-face session, the average number of sessions was 28.7 and 14.1 phone calls. We did not have access to direct comparisons with services as usual: however, social work practice is likely to be significantly less intensive, and therefore the costs associated with LIFT are likely to be high. In LIFT, duration and intensity of contact varied widely and these factors are not likely to be indicators of quality. A substantial number of cases were closed early. This is an important indicator, consistent with the real life, pragmatic trial design. The intensity of the interventions is an important variable in any trial. Harm can result from both over-servicing and under-servicing patients and families (Furman and Jackson 2002). Further research is needed to explore the efficacy of LIFT. In particular, a very long-term evaluation is required, taking into account wider societal costs. While many LAC do well, LAC are at an increased risk of a number of adverse outcomes, including suicide and self-harm; physical and mental health disorders, and criminal activity. For example, a study on the cost of care for young offenders found that antisocial young people use fewer services in the community, thus appearing to incur less cost (Barrett et al., 2006). However, the concurrent cost of their criminal activity overshadowed this, showing that they had difficulties when not engaged with the healthcare system. Similar consideration will apply to the costs associated with suicide, loss of productivity, and certain physical and psychiatric disorders.

As discussed above, plans are being designed to overcome all potential barriers and objections uncovered during the qualitative phase of the evaluation. It is worth noting

that, from the second half of 2016 onwards, progress is being made in gaining approval for the RCT by all major stakeholders, including the judiciary and the senior social workers. The challenges of conducting an RCT in the socio-legal context are not unique to Croydon and have been discussed in detail by Greiner and Matthews (2016). These authors have examined the possible reasons why the US legal profession, in contrast to the US medical profession, has been reluctant to adopt the use of the RCT as a knowledge-generating tool. The studies they analysed were 'field experiments conducted for the purpose of obtaining knowledge in which randomization replaces a decision that would otherwise have been made by a member of the US legal profession' (Greiner and Matthews, 2016, p.295). Their findings are strikingly similar to the obstacles and objections uncovered by this service evaluation, partly reflecting constraints in social care sectors in relation to RCTs. Greiner and Matthews (2016) found that, despite significant philosophical and practical obstacles, the number of RCTs that have involved the legal profession is growing, with over 50 RCTs published to date.

Rigorous evaluation of LIFT will require administering a number of quantitative measures to the children and their carers. Alongside this quantitative measurement, detailed qualitative and quantitative process evaluation will be needed throughout the trial. Qualitative aspects of this work will need to include focus groups and/or individual interviews with social workers, foster carers, birth parents and legal professionals associated with the trial, as well as focus groups and interviews with the LIFT team and professionals involved in delivering social work services as usual. Quantitative process evaluation work will need to include ongoing careful monitoring of the way families move through the services, as well as recording of the number of hours and type of input (and by whom) that families receive in each arm of trial. This will enable health economic analysis to examine cost-effectiveness of LIFT as compared to services as usual. Together, this process evaluation work could provide a detailed description of the context surrounding the trial, and explore the functioning of the services being compared, so that, whatever the quantitative outcome of the study, we may have a better understanding of the interventions and how they functioned in the contexts in which they were delivered.

The process described above has highlighted an evolving journey towards the decision on the most rigorous and scientifically sound design for NIM evaluation. This journey has also highlighted how unusual RCTs are at the intersection of the legal, health, social professions. The journey is an exciting one. It provides learning for other researchers who might design RCTs in this field in the future.

Conclusions

LIFT appears to be a feasible service for LAC in Croydon, but probably not in LB Croydon alone. A robust impact evaluation would need a larger sample size than from this one London borough. Rigorous evaluation of LIFT is required before any recommendations are made about wider implementation of the model. Several barriers to both implementing LIFT, and evaluating LIFT in an RCT, uncovered by the qualitative part of this evaluation have been successfully tackled, but this is a changing service environment and further challenges are to be anticipated. While the number of referrals, and the intensity of input, are in line with those expected, the number of early dropouts is an important variable with implications for the delivery of NIM services. The initial objections and barriers uncovered by the qualitative research are being addressed. The LIFT evaluation team remains hopeful of securing the support of the key stakeholders to undertake an RCT of the NIM model in Croydon and wider areas of South London.

Annex: Issues arising for the judiciary in the introduction of an RCT within family proceedings

It is the responsibility of the Designated Family Judge (DFJ) for East London to lead the delivery of fair and efficient family justice across the East London Family Designated area. East London Family Court has the highest volume of public law and private law children cases across London. Within that area, there are 10 separate issuing local authorities, one of which is the London Borough of Croydon. Croydon is one of the biggest issuing authorities in the East.

In keeping with the President's commitment to support any appropriate alternative means to deliver proper outcomes for children, the President and DFJ supported the introduction of the NIM model in Croydon (LIFT). The President gave his permission to remove LIFT cases from the 26-week timetable, as he had done with Family Drug and Alcohol Court cases.

From the outset the NSPCC was very keen to introduce the study through a randomised controlled trial (RCT). The judiciary, supported by the President, initially opposed the introduction of an RCT for the following reasons:

- lack of informed consent. The original plan was that randomisation would take place on issue; the family would be unaware that they had been randomly assigned to services as usual or LIFT
- concern that pre-proceedings services in Croydon was so poor that there was an immediately attractive argument that anyone not being given access to the multi-disciplinary team would have a legitimate complaint that they were not being treated fairly
- most significantly, a concern that random selection of the means by which a family is assessed might curtail the Judge in the exercise of his/her duty to make a fully considered welfare decision about the child

Accordingly, the feasibility study was approved as a qualitative piece of research without the RCT. The President has been clear throughout that, without the agreement of the judiciary and, in particular, the DFJ, there could be no RCT. However, following further requests that continued consideration should be given to the possibility of an RCT, the DFJ was tasked with exploring how, if at all, an RCT could be accommodated within the legal process.

Proposals for a modified RCT

To understand the original hurdles to the RCT, there needs to be an understanding of the legal process in England and Wales and the role of the Judge in that process. This is very different to Scotland where an RCT on the NIM model is already in place.

The moment the local authority issues proceedings in relation to a child, the Judge is fixed with a statutory responsibility to make decisions only in the best interests of that child. This is best demonstrated by the fact that, even if the local authority wishes to withdraw its proceedings, it needs the permission of the court before it can do so. That permission is only given if a welfare analysis supports withdrawal as being in the best interests of the child.

The principle that the child's welfare is paramount guides all decisions during the process, including the gathering of evidence for the essential welfare determination. Further, since April 2014 there has been a time imperative imposed upon that decision making, reminding us that delay is contrary to the welfare of children, and requiring that we manage a case so that the welfare decision is made within 26 weeks.

Dealing with each of the original obstacles in turn:

Informed consent

The proposal has been modified to enable parents to make an informed choice as to whether they are part of the trial or not.

A rethink about what amounts to BAU

On reflection, the Judges thought that the concern about the lack of pre-proceedings work within Croydon was not an issue, because BAU within the context of care proceedings was not simply the ordinary services provided in Croydon, but rather the services that the court orders must be provided in order for it to make its welfare decision. In the family justice system, BAU is a rigorously managed application within which evidence is gathered so as to enable the court to make welfare decisions about a child's future within 26 weeks. If Croydon falls short in its pre-proceedings work, then judicial case management will make up that shortfall by ensuring that proper assessments are carried out to inform decision making. So, in fact, the judicial role could be seen as ensuring the BAU is up to the standard necessary to produce the necessary evidence for a welfare determination. It is assumed that the multi-disciplinary assessment produced by LIFT will provide that evidence, and, by that means, there could not be any legitimate argument that there was in-built discrimination against those proceeding along the standard care proceedings route.

Compromising the judicial role

The key issue that remains is not compromising the judicial role.

There is no precedent for the implementation of a randomised trial within family proceedings. Nevertheless, if it can be achieved, the Judiciary is very keen to support the RCT and we have offered our commitment to finding a way to implement an RCT in this research trial. As DFJ, I am in the process of working on a model which guarantees the Judge is able to override the study in order to take welfare decisions for a child and

ensures that there is no curtailing of the judicial role. That is a work in progress but indications are favourable.

Her Honour Judge Carol Atkinson

Designated Family Judge for East London

28 June 2017

References

Baginsky, M. (2012 unpublished). *Survey of adopters' and prospective adopters' views on the processes involved in adoption and post-adoption.* Report for Department for Education and The Treasury. Available from the author.

Barrett B., Byford S., Chitsabesan P., Kenning C. (2006) Mental health provision for young offenders: service use and cost. *British Journal of Psychiatry*. 188, 541-546.

Berg, I., Consterdine, M., Hullin, R., Mcguire, R. & Tyrer, S. (1978) 'The effect of two randomly allocated court procedures on truancy'. *British Journal of Criminology,* 18, 232-244.

Biehal, N., Dixon, J., Parry, E., Sinclair, I., Green, J., Roberts, C., Kay, C., Rothwell, J., Kapadia, D. & Roby, A. (2012) *The Care Placements Evaluation (CaPE) Evaluation of Multidimensional Treatment Foster Care for Adolescents (MTFC-A). Department for Education Research Report, RR 194.* London: Department for Education.

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., Mason, C. & Kershaw, S. (2015) Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. *British Journal of Social Work,* 45, 2241-2260.

Broadhurst, K., Doherty, P., Yeend, E., Holt, K. & Kelly, N. (2013) *Coventry and Warwickshire Pre-Proceedings Pilot.* London: Cafcass.

Broadhurst, K., Harwin, J., Shaw, M. & Alrouh, B. (2014) Capturing the scale and pattern of recurrent care proceedings: initial observations from a feasibility study. *Family Law,* August.

Burman, M. (2013) Therapeutic provision for parents in care proceedings – who should be footing the bill?. *Family Law Week,* 30 October 2013.

Burns, T., Rugkåsa, J., Molodynski, A., Dawson, J., Yeeles, K., Vazquez-Montes, M., Voysey, M., Sinclair, J., & Priebe, S. (2013). Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *The Lancet*, 381(9878), 1627-1633.

Carpenter, J., Jessiman, T., Patsios, D., Hackett, S. & Phillips, J. (2016) *Letting the Future in: a therapeutic intervention for children affected by sexual abuse and their carers. An evaluation of impact and implementation.* London: NSPCC.

Carrey, N. J., Curran, J. A., Greene, R., Nolan, A. & McLuckie, A. (2014) Embedding mental health interventions in early childhood education systems for at-risk preschoolers: an evidence to policy realist review. *Systematic Reviews* [Online], 3. Available: http://dx.doi.org/10.1186/2046-4053-3-84 [Accessed 21 November 2016].

Clayton, S., Bambra, C., Gosling, R., Povall, S., Misso, K. & Whitehead, M. (2011) Assembling the evidence jigsaw: insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people. *BMC Public Health* [Online], 11. Available: http://dx.doi.org/10.1186/1471-2458-11-170 [Accessed 21 November 2016].

Craig, P., Cooper, C., Gunnell, D., Haw, S., Lawson, K., Macintyre, S., Ogilvie, D., Petticrew, M., Reeves, B., Sutton, M. & Thompson, S. (2012) Using natural experiments to evaluate population health interventions: new Medical Research Council guidance. *Journal of Epidemiology and Community Health,* 66, 1182-1186.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., Petticrew, M., et al. (2008). Developing and evaluating complex interventions: The new medical research council guidance. *BMJ (Clinical Research Ed.), 337*, a1655.

Department for Education (2016a) *Adoption: a vision for change.* London: Department for Education.

Department for Education (2016b) *Children looked after in England including adoption: 2014 to 2015* [Online]. Available: https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015 [Accessed 21 November 2016].

Department for Education (2016) Children looked after in England including adoption: 2015 to 2016. Published online: https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2015-to-2016 (Accessed 04/05/2017)

Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, 54(9), 755.

Dixon, J., Biehal, N., Green, J., Sinclair, I., Kay, C. & Parry, E. (2014) Trials and tribulations: challenges and prospects for randomised controlled trials of social work with children. *British Journal of Social Work,* 44, 1563-1581.

Donald, T. & Jureidini, J. (2004) Parenting capacity. *Child Abuse Review,* 13, 5-17.

Evans, C. J., Stone, K. A., Manthorpe, J. & Higginson, I. J. (2013) *MRC Guidance on Developing and Evaluating Complex Interventions: application to research on palliative and end of life care.* London: NIHR School for Social Care Research.

Friedman-Levy, C., (2015) Unpublished Masters dissertation, MSc Health, Community and Development; London School of Economics

Furman, R., & Jackson, R. (2002). Wrap-around services: An analysis of community-based mental health services for children. *Journal of Child and Adolescent Psychiatric Nursing*, 25, 124–131.

Goldberg, E. M., with, Mortimer, A. & Williams, B. T. (1970) *Helping the Aged: a field experiment in social work.* London: George Allen and Unwin.

Greiner D., and Matthews A. (2016). Randomized Control Trials in the United States Legal Profession. *Annual Review of Law and Social Science,* 12, 295–312.

Handley, M. A., Schillinger, D. & Shiboski, S. (2011) Quasi-experimental designs in practice-based research settings: design and implementation considerations. *Journal of the American Board of Family Medicine,* 24, 589-596.

Harwin, J., Alrouh, B., Ryan, M. & Tunnard, J. (2014) *Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings.* London: Brunel University, Centre for Child and Youth Research.

Hazell, P. L., Martin, G., McGill, K., Kay, T., Wood, A., Trainor, G., Harrington, R.. (2009). Group therapy for repeated deliberate self-harm in adolescents: Failure of replication of a randomized trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(6), 662-670.

Hind, D., Mountain, G., Gossage-Worrall, R., Walters, S. J., Duncan, R., Newbould, L., Rex, S., Jones, C., Bowling, A., Cattan, M., Cairns, A., Cooper, C., Goyder, E. & Tudor Edwards, R. (2014) Putting Life in Years (PLINY): a randomised controlled trial and mixed-methods process evaluation of a telephone friendship intervention to improve mental well-being in independently living older people. *Public Health Research,* 2, 1-222.

Holt, K., Kelly, N., Broadhurst, K., Doherty, P. & Yeend, E. (2013) *Liverpool Pre-Proceedings Pilot.* London: Cafcass.

House of Lords Hansard (2016) *Queens Speech, 18 May 2016, volume 773* [Online]. Available: https://hansard.parliament.uk/lords/2016-05-18/debates/16051852000171/QueenSSpeech [Accessed 21 November 2016].

Hutchings, J., Bywater, T., Daley, D., Gardner, F., Whitaker, C., Jones, K., Eames, C. & Edwards, R. T. (2007) 'Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial'. *British Medical Journal,* 334, 678.

James Bell Associates (2013) *Conducting Randomized Controlled Trials in Child Welfare Practice Settings: challenges and solutions.* Arlington, VA: The Children's Bureau.

Kerr, J., Turley, C., Webster, S., Purdon, S., Barrett, B., Farrington, D. P., Iphofen, R. & Knapp, M. (2010) *Assessing the Feasibility of Conducting a Randomised Control Trial or Other Evaluation of the FOR…A Change Programme.* London: Ministry of Justice.

Luke, N., Sinclair, I., Woolgar, M. & Sebba, J. (2014) *What Works In Preventing and Treating Poor Mental Health in Looked After Children?* London: NSPCC.

Macdonald, G. & Turner, W. (2005) 'An experiment in helping foster-carers manage challenging behaviour'. *British Journal of Social Work,* 35, 1265-1282.

McCord, J. (1978) A thirty-year follow-up of treatment effects. *American Psychologist,* Vol 33 (3), Mar 1978, 284-289. http://dx.doi.org/10.1037/0003-066X.33.3.284

Medical Research Council (2013) *Feast: An anatomy of a clinical research trial.* Film available online*:* https://www.youtube.com/watch?v=GdMMuURsZQg

Minnis, H., Bryce, G., Phin, L. & Wilson, P. (2010) 'The "Spirit of New Orleans": Translating a model of intervention with maltreated children and their families for the Glasgow context'. *Clinical Child Psychology and Psychiatry,* 15, 497-509.

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D. & Baird, J. (2015) 'Process evaluation of complex interventions: Medical Research Council guidance'. *British Medical Journal,* 350.

Moriarty, J., Baginsky, W., Gorin, S., Baginsky, M. & Manthorpe, J. (2016) *Mapping Mental Health Services for Looked After Children in London Aged 0-5 Years.* London: King's College London, Social Care Workforce Research Unit.

Munby, J. (2014). *Latest view from the President's Chambers. View (3): The process of reform of expert evidence*. Retrieved from: https://www.judiciary.gov.uk/publications/view-from-presidents-chambers/ (Accessed 04/05/2017)

NICE (2010). *Looked-after children and young people. Public health guideline [PH28].* Retrieved from: https://www.nice.org.uk/guidance/ph28/chapter/5-Recommendations-for-research (Accessed 04/05/2017)

NICE (2015). *Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. NICE guideline [NG26].* Retrieved from: https://www.nice.org.uk/guidance/ng26/chapter/Recommendations-for-research (Accessed 04/05/2017)

Norgrove, D. (2011) *Family Justice Review: final report.* London: Ministry of Justice.

Office for Standards in Education, Children's Services and Skills (2013) *Inspection report: London Borough of Croydon adoption service:* London. OFSTED

Office for Standards in Education, Children's Services and Skills and Care Quality Commission (2012) *Inspection of safeguarding and looked after children services:* London Borough of Croydon*:* OFSTED

Petrosino, A., Turpin-Petrosino, C., & Buehler, J. (2003). Scared straight and other juvenile awareness programs for preventing juvenile delinquency: A systematic review of the randomized experimental evidence. *The Annals of the American Academy of Political and Social Science, 589*(1), 41-62.

Powers, E. & Witmer, H. (1951) *An Experiment in the Prevention of Delinquency: the Cambridge Somerville youth study.* New York, NY: Columbia University Press.

Priebe, S. & Slade, M. (2001) *Evidence in Mental Health Care.* London: Routledge.

Pritchett, R., Fitzpatrick, B., Watson, N., Cotmore, R., Wilson, P., Bryce, G., Donaldson, J., Boyd, K., Zeanah, C., Norrie, J., Taylor, J., Larrieu, J., Messow, M., Forde, M., Turner, F., Irving, S. & Minnis, H. (2013) 'A feasibility randomised controlled trial of the New Orleans Intervention for infant mental health: a study protocol'. *The Scientific World Journal* [Online], 2013. Available: http://dx.doi.org/10.1155/2013/838042 [Accessed 21 November 2016].

Ritchie, J. & Lewis, J. (eds.) 2003. *Qualitative Research Practice: a guide for social science students and researchers,* London: SAGE Publications.

Robinson, L. R., Boris, N. W., Heller, S. S., Rice, J., Zeanah, C. H., Clark, C. & Hawkins, S. (2012) 'The good enough home? Home environment and outcomes of young maltreated children'. *Child & Youth Care Forum,* 41, 73-88.

Robling, M., Bekkers, M.-J., Bell, K., Butler, C. C., Cannings-John, R., Channon, S., Martin, B. C., Gregory, J. W., Hood, K., Kemp, A., Kenkre, J., Montgomery, A. A., Moody, G., Owen-Jones, E., Pickett, K., Richardson, G., Roberts, Z. E. S., Ronaldson, S., Sanders, J., Stamuli, E. & Torgerson, D. (2016) 'Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial'. *Lancet,* 387, 146-155.

Rodgers, B., Trinder, L. & Williams, T. (2015) *Towards a Family Justice Observatory to Improve the Generation and Application of Research.* London: Nuffield Foundation.

Rushton, A., Monck, E., Leese, M., McCrone, P. & Sharac, J. (2010) 'Enhancing adoptive parenting: a randomized controlled trial'. *Clinical Child Psychology and Psychiatry,* 15, 529-542.

Saunders, H. & Selwyn, J. (2011) *Adopting Large Sibling Groups: The Experiences of Adopters and Adoption Agencies.* London: British Association for Adoption and Fostering.

Selwyn, J., Wijedasa, D. & Meakings, S. (2014) *Beyond the Adoption Order: challenges, interventions and adoption disruption. Research report.* London: Department for Education.

Sempik, J., Ward, H. & Darker, I. (2008) 'Emotional and behavioural difficulties of children and young people at entry into care'. *Clinical Child Psychology and Psychiatry,* 13, 221-233.

Sinclair, I. A. C., Shaw, M. J. & Troop, J. (1974) 'The relationship between introversion and response to casework in a prison setting'. *British Journal of Social and Clinical Psychology,* 13, 51-60.

Solomon, P., Cavanaugh, M. & Draine, J. (2009) *Randomized controlled trials.* Oxford: OUP

The National Commission for the protection of human subjects of biomedical and behavioral research: *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Bethesda: The National Commission

Turner-Halliday, F., Kainth, G., Young-Southward, G., McMahon, L., Watson, N., Cotmore, R., & Minnis, H. (under review) Clout or doubt? Perspectives on an infant mental health service for young children placed in foster care due to abuse and neglect

Turner-Halliday, F., Watson, N. & Minnis, H. (2016) *Process and economic evaluation of the New Orleans Intervention Model for Infant Mental Health in Glasgow. Impact and evidence series.* London: NSPCC.

Welch, V., Turner-Halliday, F., Watson, N., Wilson, P., Fitzpatrick, B., Cotmore, R. & Minnis, H. (2016) 'Randomisation before consent: avoiding delay to time-critical intervention and ensuring informed consent'. *International Journal of Social Research Methodology* [Online]. Available: http://dx.doi.org/10.1080/13645579.2016.1176751 [Accessed 21 November 2016].

Wilding, J. & Dembour, M.-B. (2015) *Whose Best Interests? Exploring unaccompanied minors' rights through the lens of migration and asylum processes (MinAs).* Brighton: University of Brighton, Centre for Research on Management and Employment (CROME).

Wittes, J. (2002) 'Sample size calculations for randomized controlled trials'. *Epidemiologic Reviews,* 24, 39-53.

Woods, B. & Russell, I. (2014) *Randomisation and chance-based designs in social care research. Methods Review 17.* London: NIHR School for Social Care Research.

Young Foundation (2017) *The trials and tribulations of Realising Ambition. Doing randomised controlled trials in the real world.* Retrieved from http://youngfoundation.org/wp-content/uploads/2017/01/Programme-Insight-6.pdf (Accessed 04/05/2017)

Zeanah, C. H., Boris, N. W., Heller, S. S., Hinshaw-Fuselier, S., Larrieu, J. A., Lewis, M., Palomino, R., Rovaris, M. & Valliere, J. (1997) 'Relationship assessment in infant mental health'. *Infant Mental Health Journal,* 18, 182-197.

Zeanah, C. H., Larrieu, J. A., Heller, S. S., Valliere, J., Hinshaw-Fuselier, S., Aoki, Y. & Drilling, M. (2001) 'Evaluation of a preventive intervention for maltreated infants and toddlers in foster care'. *Journal of the American Academy of Child & Adolescent Psychiatry,* 40, 214-221.

Appendix A: GIFT, FACS and the RCT

In the feasibility study, the names of all families in Glasgow with a child aged six months to five years entering foster care were referred to the trial by social workers. Parents were contacted by very experienced social workers who provided information and an explanation of the study; answered any questions, and asked them if they would agree to participate in the study. The randomisation protocol took place at this point. If the parent consented to take part in the research they would then be randomised to FACS or GIFT. A sub-study (Welch et al., 2016) within the feasibility study explored what parents understood about the study. The findings indicated that many families found it difficult to understand that participation in the trial process was separate from the processes surrounding the entry of their children into care. The researchers, therefore, recommended randomisation before consent. The original timing was also found to lead to delays of up to eight weeks. As a result, randomisation has been repositioned to take place at the start of the process.

This means that when a child is accommodated by Families for Children (Glasgow City Council) the research team is notified and the case is randomised to FACS or to GIFT. If parents do not consent to take part in the trial, they can still engage with FACS or GIFT, whereas previously they would only have been able to work with FACS. The change has implications for the work GIFT is expected to undertake and, for the first time, in early 2016 a longer waiting list has emerged[16]:

> The reality is we've had an increase roughly from two referrals a month to five referrals a month under the new randomisation, so we're swamped and we've been developing strategies to try to manage that in a fair and equitable fashion. (Member of the GIFT team)

At the time of the present evaluation's visit to the Glasgow research team (February 2016) it was not yet known how many families would consent to the service but not to taking part the research, and how many would consent to both. There were families who had waited several months to engage with GIFT. This was leading to concerns amongst professionals working alongside GIFT both about the model's sustainability and how the problem of possible delay would be resolved. In circumstances where a child had been waiting for three months, GIFT team members have started to arrange consultations with social work colleagues to see if it is possible to apply what is described as 'a GIFT perspective', prior to the assessment commencing.

Several informants thought that the expectations of the GIFT project had been raised too quickly and were now too high. Some considered the service's credibility would soon be questioned if the GIFT team could not find a way to meet demand. In an attempt to avoid

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[16] Over time, a waiting list developed for GIFT anyway, compared with FACS, because of the longer time with which the GIFT team is involved with families.

this happening, what was described as a Catch 22 situation had developed. The offer of a consultation on some cases has raised the possibility that the team might not be involved in every case that is randomised to GIFT. One GIFT team member described the solution which had been adopted:

> So it's an interesting time. So we don't know how it's working yet and we may try it out and decide it's not the best idea we've had, but I think we definitely need to be actively trying something because the waiting time. We've projected that if we're resourced to see two cases a month and we're getting five in, even if one or two of those don't come off a month, our projection is that our waiting list will grow and grow, so we really do have to do something.

If families are being dropped at this stage, not because they have made a choice, but because of the limited capacity of the team, it was expected to lead to questions over the research process and fidelity to the randomisation protocol:

> Sometimes we have been in the position of not being able to offer treatment when, if there wasn't the capacity issue, I think we might have, and that's one of the things that I find most uncomfortable about it in terms of the rigour of the model and applying the model.

All the GIFT team members who were interviewed in this present evaluation were very enthusiastic and committed to the model. They recognised the importance of the trial in contributing to evidence of whether the model survived the Atlantic crossing. Nevertheless, some informants inside and outside GIFT saw the trial itself as a potential constraint that placed limitations on how the model was used. For example, a number of references were made to assessments conducted by the FACS where the families concerned might benefit from the type of intervention offered by GIFT, but the trial meant this was not possible.

Appendix B: Interview schedules

Interview schedule: LIFT staff

1. What do you consider to be the key components of NIM and how these are being translated into practice locally?
2. Reflecting on the ways NIM has been introduced, are there things that:
    - have been particularly helpful/gone well?
    - have made the introduction more difficult?
    - could have been better if done differently?
3. In your experience, how do the NSPCC delivery team and local authority LAC team fit together?

    (Prompt, if not covered, for meetings/informal contacts/coordination; location; priorities and any strategic objectives.)
4. Overall, do the arrangements work? If not how could they be improved?
5. Which would you say are the main agencies involved with NIM? And what about any other agencies – can you tell me which they are and how they are involved?

    (Explore what is meant by 'involvement'; any systems in place to facilitate intra and inter agency work re NIM; ways in which involvement could be improved or broadened; any agencies/services that should be involved but are not at present and vice versa.)
6. You said that you thought the key aims and aspects were (…) Do you consider this reflects how things are at the moment? If not, how does it differ?
7. How, if at all, do you think NIM fits in with the government's plans for adoption reform, e.g. the move to regional adoption agencies?
8. It has been suggested that an RCT will be conducted in relation to NIM? Do you think this is:
    - acceptable?
    - feasible?

    (Feasibility and acceptability are separated here – may merge in interview but still vital to discuss them both.)

    (Explore the reasons for response; conditions that could make it hard to do such research; views on the acceptability of any objections to RCT; any implications for

the continuation of NIM if an RCT is not conducted; views on alternative if an RCT not feasible/possible or practicable.)

9. If an RCT is conducted, some families not receiving NIM will be offered services as usual. What would this involve?

   (Check for services for birth parents; foster carers; 0–5s in care; cross agency services.)

   (Looking for an explanation of what families have been offered pre-NIM and how, if at all, this would be different from a services as usual offer in the future – need to be clear about the components of services as usual.)

10. What if anything have you learnt from what is happening in:
    - the USA
    - Glasgow
    - elsewhere?

11. Between now and the end of March 2016, what do you consider to be the key steps that need to be taken in relation to:
    - the development of NIM in Croydon and by whom
    - embedding the service in Croydon
    - the development of a robust evaluation?

12. How do parents get approached to take part in the service?

13. Are there any services available for them to consider when they are approached on i) consent ii) anything else?

14. Have you read, seen or heard anything about NIM that you found particularly helpful in explaining the model (e.g. journal article, website, report?)

    (Please check: Has the interviewee worked with the 0–5 age group before? Does s/he know of any 0–5 therapeutic services for under 5 year olds? Check for any information on areas with good provision.)

Interview schedule: Key stakeholders

1. Would you explain to me how you became aware of the NIM model and the work that NSPCC are doing to test it?

   (Make sure these areas are addressed: key individuals involved at that stage; how processes were explained; your initial reactions to the proposal; others' initial reactions to the proposal; any contact with/information from (whom/which sources and how?))

2. What do you consider to be the key components of NIM and how these are being translated into practice locally?

3. When NIM was first explained to you, what did you understand to be:

   a. the key aims (for organisation, children, birth parents, foster parents, etc);
   b. key aspects of the NIM project?

4. What do you recall about the ways NIM was introduced into Croydon?

   (Clarify timings and processes for each step.)

5. On a practical level, in your experience how do the NSPCC delivery team and local authority LAC team fit together?

   (Prompt: meetings/informal contacts/coordination; location; priorities and any strategic objectives; overall – do the arrangements work? If not, how could they be improved?)

6. Have you read, seen or heard anything about NIM that you found particularly helpful in explaining the model (for example, journal article, website, report?)

7. Thinking back over how NIM has been introduced, are there things that:

   - have been particularly helpful/gone well?
   - have made the introduction more difficult?
   - could have been better if done differently?

8. Which would you say are the *main* agencies involved with NIM? And what about any other agencies – can you tell me which they are and how they are involved?

   (Explore: what is meant by 'involvement'; any systems in place to facilitate intra and inter agency work re NIM; ways in which involvement could be improved/broadened; any agencies/services that should be involved but are not at present and vice versa.)

9. You said that you thought the key aims and aspects were (…) Do you consider this reflects how things are at the moment? If not, how does it differ?

10. Up to this point, how has Croydon approached the question of permanency decisions – from the perspective of i) the local authority ii) the judiciary?

    a) In what way(s), if any, do you think the introduction of NIM would represent an improvement?

    b) Do you have any concerns about the introduction of NIM?

11. How, if at all, do you think NIM fits in with the government's plans for adoption reform – for example the move to regional adoption agencies?

12. How important is the evaluation to your decision making? Are you able to provide any examples of implementing evidence-based practice in Croydon's social care services (adult or children)?

Where appropriate ask:

Has it been suggested that an RCT will be conducted (explain using showcard) in relation to NIM?

(If YES or NO, ask why thinks will/will not be feasible?)

(Explore: the reasons for response; conditions that could make it hard to do such research; any implications for the continuation of NIM if an RCT is not conducted; views on alternative if an RCT not feasible/possible or practicable.)

(If YES or NO, ask why thinks will/will not be acceptable)

(Explore: the reasons for response; conditions that could challenge acceptability.)

If an RCT is conducted, some families not receiving NIM will be offered services as usual. What would this involve?

15. Looking for an explanation of what families have been offered pre-NIM and how, if at all, this would be different from a services as usual offer in the future – need to be clear about the components of services as usual.

16. Between now and the end of March 2016, what do you consider to be the key steps that need to be taken in relation to: the development of NIM? (and by whom); the development of a robust evaluation?

Interview schedule: Judges in Croydon Family Court

1. Can we start by asking you about the key problems and challenges with which you are faced in situations where permanency decisions are being made about looked after children?

2. How did you become aware of the LIFT initiative prior to its introduction? Were you involved in any negotiations prior to its being set up?

3. What were your views on the need for such a service at the time negotiations started? (Prompt for views on quality of assessments, delays in reports, local council procedures/policies)

4. In your opinion, what are the most important aspects of the model for you? How important is the quality and/or timeliness of the reports? How does access to advice and treatment for birth parents or foster carers compare with what is usually provided?

5. Have your views changed since the team has become operational? What are the reasons for this?

6. Can I just check about your expectations about the role played by children's social care in helping you reach decisions about permanency? What is the fit between mental health and social care? Is it important to you that the LIFT team is multidisciplinary?

7. How would you describe relationships between the judiciary and the local authority in relation to permanency decisions for children?

8. Do you have any experience of working with an authority where there is a similar service? Any similarities and differences between that (these) experiences and this model?

9. We know about the timescales introduced by PLO. How does LIFT fit with these? Is the time allowed to complete the assessment too long, too short or about right? Do you have any views on the balance between the assessment and intervention phases?

10. What, if anything, is going well with LIFT at the moment? Is anything in need of improvement? How does it compare with the 'usual service' children, birth parents and foster carers might receive?

11. In the long term, do you see this as a service that could be available to all parents, or should it be offered to a select group? If so, how should these parents be selected?

12. What do you think would be the best method to evaluate a service such as this? (Views on RCT or comparison within Croydon or in Croydon plus another local authority?)

Appendix C: Informants contributing to the qualitative evaluation

Interviewee	Role
Jenni Ashmead	GIFT Consultant Psychiatrist
Her Honour Judge Atkinson	Designated family judge for the East London Family Court
Nick Axford	Senior Researcher and Head of What Works at the Dartington Social Research Unit
Robin Balbernie	Clinical Director, Parent Infant Partnership UK
Chantelle Barker	Duncan Lewis Solicitors, Croydon
Jane Barlow	Professor of Public Health, University of Warwick
Nina Biehal	Professor of Social Work, Department of Social Policy and Social Work, University of York
Johnny Boorman	LIFT Principal Clinical Psychologist
Kevin Brown	FACS Service Manager
Richard Church	Consultant Psychiatrist and CAMHS lead for Lambeth
Melanie Claxton	LIFT Clinical Psychologist
Jessica Colaiaco	LIFT Team Manager
Lee Cormack	Senior Solicitor, Glasgow Council
Nicola Cosgrave	LIFT Consultant Clinical Psychologist
Richard Cotmore	Head of Evaluation, NSPCC
Nicholas Crichton	Resident District Judge at the Inner London Family Proceedings Court from April 1997 until 2014.
Jessica Cundy	Development Manager Programme Manager
Julia Donaldson	GIFT Consultant Clinical Psychologist
Aileen Downey	Circuit Judge, South Eastern Circuit, based at Croydon County Court
Helen Entwistle	LIFT Social Worker
Jude Eyre	Senior Strategy Analyst at NSPCC.
Matt Forde	Head of National Services, NSPCC Scotland
Rachel Green	Case Progression Care Proceedings Manager, Croydon
Brian Jacobs	LIFT Consultant Psychiatrist

Interviewee	Role
Karen Lacey	Croydon Drop In
Ian Lewis	Director of Children's Services, Croydon
Ian Luke-Macauley	Senior Service Manager, Cafcass
Debbie MacCormack	Strategic Manager, Early Intervention and Family Support Service, Croydon
Lynn McMahon	Senior Project Manager, Mental Health and Wellbeing, University of Glasgow
Kathryn Major	District Judge, South Eastern Circuit, based at Croydon County Court
Sherry Malik	Director of Children's Services, NSPCC
Judith Masson	Professor of Socio-Legal Studies, University of Bristol
Julia Mayes	Programme Manager, NSPCC
Susanne Miller	Chief Social Work Officer, Glasgow
Helen Minnis	Professor of Child and Adolescent Psychiatry, University of Glasgow
Louise Nankivell	LIFT Clinical Psychologist
Barry O'Sullivan	LIFT Social Worker
Maria Orme	Solicitor, Atkins Hope Solicitors
Laura Porter	Clan Child Law Ltd
Siobhan Pritchard	Duncan Lewis Solicitors, Croydon
Anna Rickards	Head of Practice and Learning, Pause
Petrina Roberts	Duncan Lewis Solicitors, Croydon
Kelly Rodd	Solicitor, Atkins Hope Solicitors
Liana Sanzone	LIFT Social Worker
Sue Schofield	NSPCC Service Manager Croydon
Helen Thomson	Children's Guardian, Cafcass
Hugh Thornbery	Chief Executive, Adoption UK
Alison Timpson	FACS Social Worker
Wendy Tomlinson	LAC Service Delivery Manager, Croydon

Interviewee	Role
David Torgerson	Director of the York Trials Unit, University of York
Emily Waddington	LIFT Family Liaison Worker
Karen Walker	Duncan Lewis Solicitors, Croydon
Harriet Ward	Professor of Child and Family Research - Research Professor, University of Loughborough
Karen Ward	Children’s Development Manager, Croydon
Charles Zeanah	Sellars-Polchow Professor of Psychiatry and Professor of Clinical Pediatrics, and Vice-Chair for Child and Adolescent Psychiatry, Tulane University

Appendix D: The process in Scotland

Once a child protection order (CPO) is granted, the grounds for referral are drawn up and put to the parents at a children's hearing on the eighth working day CPO. The CPO comes to an end at this children's hearing. The children's hearing can grant an interim compulsory supervision order at this time, which can secure a child in a place of safety.

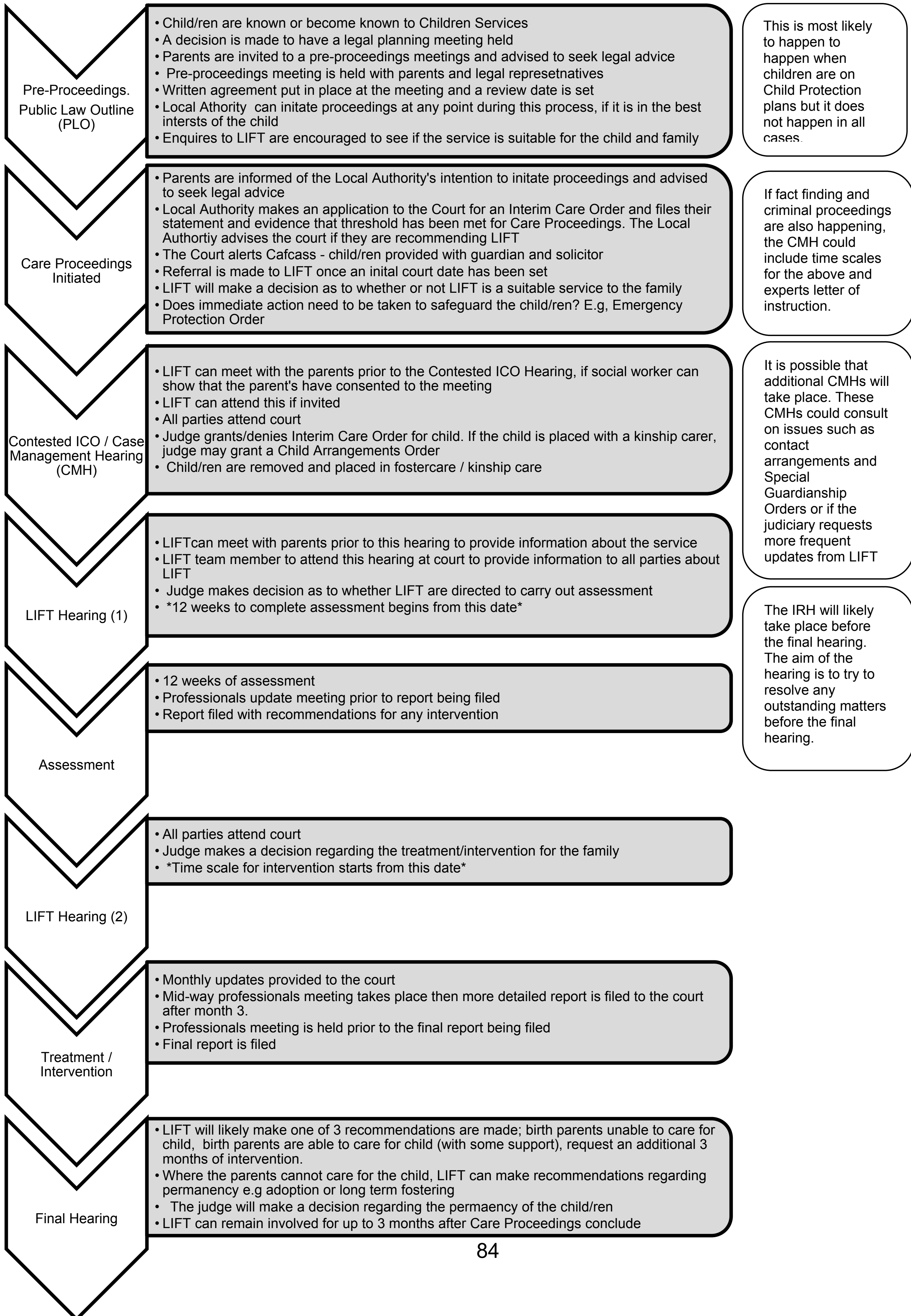
If there is no CPO, but only a referral to the children's hearing, the grounds for referral are drawn up and put to the parents. With a CPO in place everything is done much faster, but the steps are the same. The children's hearing can grant an interim compulsory supervision order at this time, which can secure a child in a place of safety.

If the grounds are denied, or not understood, then they are sent to the sheriff for proof. The sheriff will hear evidence and will decide if the grounds for referral are established. If no grounds are established, the matter ends there and then. If there are grounds established, then the matter is sent back to the children's hearing to decide whether there should be a compulsory supervision order put in place.

The only role of the sheriff at this stage is to decide whether there is enough evidence to decide whether grounds are established. The sheriff can later be called upon, if individual decisions of the children's hearing are appealed. When dealing with the appeal, the sheriff can send it back to the children's hearing for disposal, or can substitute his or her own decision in.

The children's hearing does not have the power to compel a parent through a compulsory supervision order. Measures attached to these orders can only compel the child to do something or can require the implementing authority to do something. This is different from the judicial power that a sheriff or judge can wield.

Appendix E: Legal flow chart



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