Briefing

Evidence and Practice Briefing:

FDAC Eligibility Criteria

Centre for Justice Innovation

Introduction

This resource is intended for FDAC practitioners and local authority colleagues who participate in decision-making about which families are referred to and deemed eligible for FDAC.

In the original FDAC model piloted in London in 2008, eligibility criteria was very broadly defined, with only a few exclusions: if the parent was experiencing florid psychosis; if there were serious concerns about domestic violence posing a major risk to the children or a history of severe violence where help had been offered in the past and not accepted; or if there was a history of severe physical or sexual child abuse.[1]

Currently, the interpretation of FDAC's eligibility criteria can vary across sites, with some describing themselves as 'open doors' in which families would only be excluded if there were sexual abuse allegations or if the parent's mental health needs were so acute that they were currently hospitalised.

Others only accept cases in which substance use is one of the main issues (not just a factor) and where parents are transparent about their substance use at the outset and demonstrate that they are motivated to engage. This has meant excluding parents with entrenched substance use or mental health issues perceived to be too severe to be resolved within the Trial for Change.

Finally, because FDAC is a limited resource, coupled with concerns that FDACs need to generate positive outcomes to continue to receive funding, some services have expressed the need to prioritise parents deemed 'most likely to succeed' in FDAC based on initial assessments.

In order to achieve consistency across FDAC services and to ensure that referral decisions are evidence-based, this document aims to:

- Clarify the FDAC eligibility criteria by summarising the evidence base to date.
- Provide practical guidance for eligibility decisions.
- Provide clinical guidance and support to ensure consistency across FDAC services
- Explore how key factors - such as trauma, implicit biases and structural inequalities - may affect referral, initial assessments and practice decisions.

Contents

Evidence review

Predictors of Success

A number of studies have concluded that there are no clear predictors showing which parents will succeed in abstaining from substances and achieving reunification in FDACs or Family Treatment Courts (the equivalent of FDAC in the US). Evaluation and research continues to suggest that FDAC can be beneficial for most families due to the quality of the specialist multi-disciplinary practice.

A 2011 evaluation of the London FDAC found:

- *"No clear predictors of which parents would be successful in controlling their substance use.*
- *Success was not linked to length of substance use history, type or number of substances used, or number or age of children.*
- *Similarly, there were no clear predictors of reunification, other than that the main factor here was cessation of substance misuse."*[2]

A longer-term study of the London FDAC, which looked at outcomes up to five years after the court case ended, similarly found:

- That it was "*not possible to explain... who was most (and least) likely to benefit from the programme.*
- *No predictive factors emerged to indicate which parents might sustain cessation and which families avoided reunification breakdown at follow-up.*"[3]

A rapid realist review, which consisted of a literature review, observations of four FDAC sites, and consultations with expert stakeholders, indicated that:

- There was no single predictive factor that determines if a parent will be suitable for FDAC and several factors need to be considered.
- However, expert stakeholders identified a number of factors relating to perceived motivation and complexity, which factored into decision-making.
- Practitioners reflected that parents they thought would not do well did at times succeed in FDAC and vice versa, which suggests that the parents who are less likely to be offered FDAC because they are deemed too 'difficult' may also be "*the group of people who would benefit most if efforts are made to engage and retain them in FDAC."*[4]

This suggests that "*people with wide-ranging and entrenched difficulties can do well in treatment and that programme quality is a crucial influence on outcome. A corollary to this is that it may not be possible to screen parents out of the FDAC intervention*."[5]

This also appears to be largely borne out in research on US Family Treatment Courts (FTCs). Marlowe & Carey (2012) summarised in their research on FTCs that:

- There are few parent characteristics that predict better outcomes, and in fact, "*the effects of FTC appear to be equivalent or greater for individuals presenting with more serious histories*."[6]
- This suggests that Family Treatment Courts might benefit from having the least exclusionary criteria.[7]

However, some studies on FDACs and FTCs have found associations between certain case characteristics and successful family court and treatment outcomes.

A 2014 study of the London FDAC found that experiences of domestic abuse, use of crack cocaine, and a history of more than five years of contact with children's services were negatively associated

with substance use cessation and reunification. However, outcomes in both FDAC and non-FDAC cases were not linked to case characteristics that are commonly thought to make a case more 'difficult', such as the length of a parent's substance use history, having an older child, or a mother's mental health issues. While each of these factors alone were not associated with case outcomes, there did seem to be a cumulative effect: "*where there was a greater combination of problems, parents were less likely to control their substance use or be reunited with their children. Where there were fewer problems, noticeably more FDAC than comparison parents were successful in achieving control of substance use and reunification with their children*." The study concluded that "*identification of risk factors is a relevant but insufficient explanation of outcomes*."[8]

Research on FTCs similarly suggests that participants who were not reunified with their children tended to "*start off with higher levels of severity than those who are reunified, particularly with regard to mental health*."[9] The study recommended that parents with more severe needs receive "*earlier identification and rapid entry into intensive treatments*".[10] However, while there is some emerging evidence that factors such as severe and numerous parental issues affect a family's odds of successful reunification, **the evidence base has not identified consistent predictors of outcomes.**

Overall, there appears to be little evidence to screen parents out of FDAC based on characteristics perceived to make a case more 'difficult'. Moreover, a number of factors may influence practitioners' perceptions of parents during initial assessments. These factors are explored in detail later.

Practice guidance

Common issues to consider in FDAC decision making

The following sections sets out guidance on some of the common issues that arise at the point of referral. This has been separated into two sections: i) capacity and informed consent; ii) other factors impacting referral decisions.

Practice recommendations are included that can guide-decision making and assist in determining the viability of FDAC on a case-by-case basis.

Capacity and Informed Consent

There are two issues of capacity that are relevant to parents signing up to FDAC.

1. Capacity to participate in proceedings

With regards to any court proceedings, there is a consideration of a person's capacity to participate. A person is presumed to have capacity unless that presumption is rebutted by evidence to the contrary. The individual's legal representative will raise concerns about capacity. However, during the course of assessing/engaging with a parent FDAC professionals may have concerns regarding capacity.

2. Capacity to consent to treatment

Capacity and consent are inter-linked issues; a person needs sufficient capacity to consent to any type of treatment. Parents entering FDAC do not have a choice as to whether they participate in proceedings, but they do have a choice as to whether they sign up to FDAC. Even where a parent has capacity to participate in proceedings, consent to sign up to FDAC cannot be assumed and needs to be obtained by a process of informed consent. A person can only give informed consent when they have been provided with 'all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead'.[11]

Factors Affecting Mental Capacity

The below section outlines a number of factors that can affect mental capacity and provides practice recommendations for FDAC teams to consider when working with families in FDAC.

Cognitive impairment

Parents involved in care proceedings often present with cognitive or learning difficulties. These may be due to organic factors (e.g. in utero exposure to alcohol, head injury, substance use or neurodiversity) or environmental factors (e.g. social and educational disadvantage). Many parents may obtain low scores on formal IQ tests; however, this does not necessarily mean they lack mental capacity – in fact, very few people with cognitive impairment or learning difficulties actually lack mental capacity.

In general, people need to have a very significant cognitive impairment to be found to lack capacity. Most individuals with cognitive difficulties can usually be supported to make informed decisions provided that the language and communication is adapted to their needs.

The overriding principle is one of empowerment where at all possible.

Practice recommendation:

- FDAC practitioners should consider cognitive functioning during the assessment and raise concerns with the parties if the parent appears to be struggling to understand and retain information discussed. This may indicate a capacity assessment with a Clinical Psychologist, which may be internal or external to FDAC. In the case of cognitive impairment, a capacity assessment should include a cognitive assessment (if not already available) and a capacity interview to assess decision-making ability.

- It is important to recognise that people with learning problems may feel anxious when presented with demanding tasks such as reading reports, completing questionnaires or attending hearings and support with this can improve their mental capacity considerably.

Mental state

Major mental illnesses such as psychosis may significantly affect a person's decision-making.

Practice recommendation:

- In these situations, a capacity assessment by a psychiatrist is appropriate to determine whether the person is suffering from such an illness and the degree to which this is affecting their ability to make informed decisions. Such mental illnesses may fluctuate. As such, it is important to consider whether the person may gain capacity at a later point in time, and to consider re-assessment then.

Historically, capacity issues have been largely confined to psychotic disorders, with a reluctance to consider personality disorders as a qualifying mental disorder.[12] However, some have argued that the extreme emotions and distorted belief systems seen in Borderline Personality Disorder (BPD)[1] could impact upon mental capacity, particularly in terms of consent to treatment.[13] Since BPD is a 'disturbance of mind or brain', some suggest that it may be covered by the Mental Capacity Act 2005 (MCA). However, the MCA 2005 clearly states that a person cannot be said to lack capacity just because they are making 'unwise decisions'; in other words, people have a right to make their own decision even if the outcome could be bad for them. In current practice, the debate about BPD and capacity is limited to life threatening situations; however, FDAC practitioners can be mindful of the potential impact of personality disorder and trauma-related psychological conditions that could affect decision-making.

Practice recommendation:

- FDAC practitioners should support parents to weigh all the information available to them when making significant decisions about their treatment, welfare or the proceedings. FDAC practitioners can also support parents with emotional regulation so that they can participate effectively in meetings and hearings.

Intoxication

Parents may often attend appointments or court under the influence of a substance. Whilst this is not ideal, this does not mean they do not have the capacity to participate, and it may not be feasible or safe in the early stages of FDAC for parents to be expected to attend all appointments substance-free.

However, some states of acute intoxication can significantly affect a parents' mental capacity.

Practice recommendation:

- FDAC team members have a clinical duty to make an assessment of the person's capacity and, if necessary, to recommend rearranging the appointment or hearing to another time.

Substance use can mask other issues and it may be that even when a parent has achieved abstinence they continue to have difficulties with taking in and understanding information.

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1 Also referred to as Emotionally Unstable Personality Disorder or EUPD.

Practice recommendation:
• It is important to raise this with the parties so that capacity issues can be reconsidered.

Coercion

Parents may feel considerable pressure to engage in FDAC because of the fear of losing their children. They may be strongly advised by their solicitor, for example, that it is in their best interest to participate in FDAC. Moreover, certain power imbalances may make parents vulnerable to placing the influence of others over their own decision-making.

Practice recommendation:
• This is not an issue of capacity, but it does mean that FDAC practitioners should try to give parents clear information about the FDAC process and the time and space to ask questions and carefully consider their decision to sign up.

However, there may be situations where a parent is in a coercive and controlling relationship in which there are concerns that they are not free to make their own decisions due to fear of the consequences. These situations present a considerable ethical dilemma for professionals. Although coercion may influence decision-making, this does not constitute incapacity in terms of the Mental Capacity Act 2005 if the individual does not have a disorder of mind or brain. As noted above, the Act is clear that an 'unwise' decision alone is not a basis to determine lack of capacity.

Practice recommendation:
• A guidance sheet is available which sets out the case law and considerations for situations where individuals are at risk from coercive abuse.[14] It notes that those within coercive relationships may be acting self-protectively given the risks, for example, of leaving their partner, and recommends against imposing decisions upon them but rather working to build trust.

However, in reality, parents are often under considerable pressure to separate from abusive partners when there is an escalation into proceedings. Voluntary sign-up to a collaborative process such as FDAC may in and of itself signal a threat to a coercive partner, for example of disclosure of abuse, and as such may increase risk to the parent at risk.

Practice recommendation:
• Commencing FDAC with a parent who is in a coercive relationship may require careful consideration of risk and a recognition of the impact of threat and coercion upon decisions made by the parent at risk.

Intermediaries

In certain circumstances where a person has additional cognitive or learning needs, an intermediary may be sought to assist them to participate effectively in court proceedings. Upon an appropriate application being made, an assessment will be undertaken by the intermediary service. The cost of the assessment and the cost of the intermediary attending court and conferences with legal representatives, in the event that an intermediary is required, is met by His Majesty's Court and Tribunal Service.

Other factors impacting referral decisions

The following section outlines other factors that may affect referral into FDAC. It includes clinical management practice recommendations to aid practitioners.

Active risk

By the very nature of being in proceedings, all FDAC cases carry a degree of risk either to children, parents, family members or even the broader community. Active risks are not necessarily a reason to exclude cases from FDAC.

However, there are certain live risks which may pose a problem for FDAC involvement. Active concerns about sexual abuse of children, or live domestic abuse risks may need further screening to ensure that FDAC is appropriate and that these risks can be managed and properly assessed within a problem-solving model.

Practice recommendation:

- In making these decisions, key considerations might be:
    - Is the risk sufficiently managed so that the family can meaningfully and safely engage with FDAC?
    - Is there at least one caregiver who does not present this high active risk who is willing and able to work with the FDAC team to manage risks in the future?
    - Does the FDAC team have sufficient knowledge and experience to assess the longer-term risks associated with this issue?

Sometimes risks cannot be known in advance and will emerge during the proceedings. This is where FDAC's model of dynamic risk assessment is helpful.

Practice recommendation:

- All team members need to fully understand their duty to raise risks on an ongoing basis, and clinical leads need to be ready to give and change recommendations based on new and evolving information.
- Management of risk is not the sole responsibility of FDAC and clear policies should be in place with the local authority and other agencies that set out how risks should be actively and collaboratively managed across the professional network.

Non-attendance

Ambivalence and non-attendance are very frequent within social care interventions and (as discussed in the following section) engagement difficulties may be underpinned by many factors.

Engagement is a core part of the FDAC process but limited engagement is not in and of itself something that should exclude someone from the service.

Practice recommendation:

- A pattern of missing important meetings such as court hearings or contact may indicate that factors such as the parent's substance use, mental state or sense of safety may be impairing their functioning to such a significant degree that they may not benefit from the FDAC process at this point in time. In such cases, efforts should be made to better understand the barriers these parents are experiencing. Efforts should also be made by the system to support stabilisation in the first instance.

There are instances where parents struggle to attend any appointments to the point that it affects the team's ability to have any meaningful engagement or progress in the Trial for Change. This in itself can be a good indicator for the outcome of proceedings and provide the judge with evidence to support their decision-making – a low engagement response to a high intensity intervention can be more informative than a low response to an intervention that requires a low level of engagement.

Objection by another agency

The success of the problem-solving approach does, to some extent, rely on the active participation of other professionals within the system. FDAC is a collaborative problem-solving model, and the problem-solving 'team' should include all of the parties. It is an explicit move away from adversarial proceedings, which some parties may find a difficult adjustment.

Practice recommendation:

- It is important that parties are in broad agreement for cases to enter FDAC and that they have a clear understanding of what the FDAC process is.
- Any concerns should be heard and responded to by the FDAC team as this can cause later problems and discord within the team or with families, if parties have concerns they do not feel are heard.

Couples where one partner does not want to engage

Although it is ideal to work with all of the primary carers, non- engagement by one parent is a relatively common situation in FDAC and should not prevent a willing parent from signing up. This situation most often occurs in the case of separated partners, but occasionally with current partners.

Practice recommendation:

- In either scenario, all parents should be offered FDAC, and some efforts can be made to talk through any concerns with the parent who does not wish to engage.
- FDAC is voluntary; however, where a parent does not wish to engage with FDAC, their legal representative should explain any independent assessments they would need to engage with that would run parallel with FDAC.
- The non-engaging parent will not be invited to FDAC Intervention Planning Meetings and Non-Lawyer Reviews, but should be included in meetings relevant to the child (e.g. Child's Needs Meeting).
- They will also attend all of the Case Management Hearings.
- In situations of suspected domestic abuse, the role of non-engagement in a pattern of coercive control should be considered.
- The team should also consider the impact of one parent making significant progress, where the other does not engage in treatment. This is particularly important for couples remaining together, where each parent's recovery could affect the other.

Specialised areas of expertise

Certain presenting issues may call into question the viability and validity of an FDAC assessment, such as an incident of serious violence, active risk of child sexual abuse or a medical condition. In these situations, the parties may question whether the FDAC team has sufficient expertise to provide an assessment.

As a general principle, outside expert assessments are discouraged in FDAC. The FDAC team already provides their independent expert advice to the court through their holistic parenting assessment. However, if outside assessments are necessary, these can run concurrently to FDAC. The FDAC team should be provided with any reports produced by the experts and likewise, FDAC reports should be made available to other independent experts.

Practice recommendation:

- The first consideration when determining if an additional expert assessment is required is **relevance**. In some cases, whilst there may be a specialised issue, such as a brain injury, this may not be of central relevance to the question of parental capacity. Other issues may be very specifically related to the question of risk, e.g. non-accidental injury.

- The second consideration is **whether the FDAC team has the expertise to provide opinion on the matter,** which will vary by team.

- These two considerations may determine whether the case is appropriate for FDAC, or whether an outside expert might be needed to answer a specific question alongside FDAC. However, in the latter scenario, the questions should be limited to those that FDAC is not able to answer, rather than forming a parallel parenting assessment.

When an independent expert is requested or FDAC's expertise is challenged, it is helpful to ask the parties what question they are seeking to answer. For example, issues of diagnosis may be important in giving prognosis and treatment recommendations, such as the likely course of a progressive neurological illness. However, if a diagnosis is already established, then further diagnostic assessment may not be needed. Of greater importance is assessing *how* that condition impacts upon the parent's day-to-day functioning, their children and what level of insight the parent has into this, as well as their engagement in any treatment or rehabilitation.

Concurrent residential placement

Residential treatment

FDAC teams often work alongside residential treatment and this should not be a barrier to engaging in FDAC. Residential treatment is usually planned and time limited, allowing for FDAC to coordinate with the unit around pre and post treatment support.

Practice recommendation:

- Ideally, residential placements should not be so far away as to make it very difficult for parents to have contact and to attend some meetings. However, FDAC will generally reduce the frequency of key work and hearings for parents in residential treatment, whilst maintaining telephone contact until discharge. Consideration also needs to be given towards the length of any recommended residential treatment placement, balancing this with the recovery needs of the parent and the children's timescales.

Parent-baby units

In some cases, a parent-child placement is proposed at the start of the proceedings and it is queried whether this is compatible with FDAC. This has generally been discouraged as it is likely to significantly interfere with the FDAC intervention. However, there are situations where a residential placement is suggested to avoid separation between parent and child. In these situations, it is important to consider whether concurrent engagement with FDAC is viable and likely to be of benefit.

Practice recommendation:

There are **three** key considerations here:

- Geography
  FDAC is an intensive programme and requires parents to engage at least weekly with the clinical team, and fortnightly with the judge. Parent-child units may not be providing treatment and therefore parents should be able to readily access the team and the other treatment services they need. Travelling long distances can be a barrier to engagement, and infrequent face to face appointments can leave gaps in testing. In some situations, the distance from the residential placement will be prohibitive for FDAC.

- Duplication
  Some residential placements include a parenting assessment component. This poses a risk of duplication, which is particularly hard for parents who may feel overwhelmed by engaging in concurrent assessments. In this situation, coordination between FDAC and the residential unit can help to reduce duplication and consider how to best manage the burden on the family.

- Decision making
  Related to the above, if the residential unit is asked to provide a report, it is possible that
  (a) this is produced at a different time to FDAC's report; and
  (b) the opinion and recommendations are different.
  This can be distressing for the family and pose dilemmas for the parties and the court. This situation could be addressed by an expert meeting, as might happen in standard care proceedings.

Pre-birth

Some FDAC teams do accept referrals pre-birth and there is a protocol available for the assessment and sign-up of parents pre-birth. There are advantages to starting treatment pre-birth for both the parent and the unborn child and it allows for a longer timescale.

Practice recommendation:

- In these cases it is vital that all parties agree for the case to come into proceedings and that there is an explicit understanding of how issues such as separation will be managed upon birth.

Older children

There is no age limit on children within FDAC. Theoretically, children up to the age of 18 can be subject to care proceedings but it is less common for older teenagers[15] [2] and often occurs where there are siblings.[16] However, there are certain considerations about older children who are subject to proceedings.

Practice recommendation (for court):

- These children are always parties to the proceedings, whether FDAC or otherwise.

- A Children's Guardian appointed by CAFCASS/CAFCASS Cymru will instruct a solicitor to act on behalf of the children to represent their interests.

- Older children may be of sufficient age and understanding to be regarded as competent to instruct their own legal representatives and are said to be 'separately represented'.

- Even where they are not separately represented, older children may wish to have more involvement with the court process, and may wish to write or speak directly to the judge. Any such contact needs to be set up in collaboration with the children's guardian who should be involved and present at any hearings where the child is present.

2 In 2019/2020 of children subject to S.31 care proceedings in England, 3.7% were 15yrs, 1.9% were 16yrs & 0.1% were 17yrs.

Practice recommendation (for FDAC Child's Needs Meetings):

- Older children may participate more actively in the FDAC Child's Needs Meetings and should be supported to have a voice within the process.
- FDAC practitioners should be aware that decision making around older children may be affected by perceptions that older children are more resilient or may have a poorer prognosis in care. Whilst these are important considerations, it is important for any risks to be clearly highlighted as they would be for younger children.

Legal Constraints

Concurrent criminal proceedings

It is not unusual for parents to be involved with criminal and family proceedings at the same time. Concurrent criminal proceedings are not incompatible with FDAC, but may require consideration and liaison between the two sets of parties.

Practice recommendation:

- Issues of relevance might be the timings of decisions and how decisions made in one set of proceedings may impact decision making in the other. *For example, criminal sentencing may affect a parent's capacity to engage in FDAC proceedings and FDAC decisions about parental capacity and engagement may be raised in mitigation in criminal proceedings.*

Concurrent immigration proceedings

A parent whose immigration status is not determined may still engage with FDAC; however, it may depend upon the stage of their immigration application.

Practice recommendation:

- The team may need to consider the likelihood of the parent remaining in the UK and the viability of engaging in FDAC (e.g. if they are in detention and due to be deported).
- The team will need to consider that decisions regarding parental rights may influence the immigration proceedings, or influence motivation to engage with FDAC.

Parents who are incarcerated

Some parents referred to FDAC may be incarcerated.

Practice recommendation:

- It is important to ascertain the parent's release date to determine how this may affect any assessment of them and decision-making regarding their children.
- Detained parents may still attend hearings via a production order and under escort.
- If a parent is due to be released within the FDAC timescales, it may be appropriate to carry out an assessment of that parent in custody; however, careful consideration is needed regarding the viability of engagement in a Trial for Change, particularly if this is later on in proceedings.
- Engagement with FDAC may be viable if it is possible to undertake keywork at the prison.
- Even where a detained parent is not involved with the FDAC Trial for Change, liaison with probation or the police is important to consider risks to the family upon release.

Interface with non-FDAC family proceedings

FDAC is not a universal service and legal professionals and judges outside of FDAC may not have a clear understanding of how FDAC works. This has, on occasion, led to difficult situations such as cases being ordered into FDAC, and indeed cases being ordered out of FDAC. It is rare that cases will

come out of the FDAC process and this should always be a decision by the FDAC judge having taken advice from the FDAC team.

Practice recommendation:
• The FDAC Code of Practice outlines the conditions for cases being accepted into FDAC or ordered out of FDAC.

Finding of Fact

In certain situations, a Finding of Fact Hearing may become unavoidable but overall this is antithetical to the FDAC problem-solving approach. The process is likely to delay proceedings and also interfere with an open spirit of engagement, which may be at odds with a parents' concerns about the findings.

Practice recommendation:
• Where a Finding of Fact Hearing is planned, it may be more appropriate to wait until its conclusion before commencing FDAC, or pausing FDAC intervention until it is resolved.

Legal representation

Although parents involved in care proceedings are eligible for non-means and non-merits tested Legal Aid funded representation, parents may choose to represent themselves. In general, this is discouraged in FDAC due to the complexity of the process; however, in some cases it may not be avoided. There is currently no guidance for FDAC practitioners on how to interact with litigants in person and given the frequency and nature of communication between parties within a problem-solving process, this may be something that needs to be developed. In particular, with regards to cases involving domestic abuse.

Initial assessments of motivation for change: uses and limitations

This section of the document provides information about different factors to consider when referring families to FDAC and why it is not straightforward for FDAC services to determine consistent predictive local eligibility criteria for increasing success.

Practice recommendations have been included to help FDAC teams and local decision makers understand best practice and support quality FDAC referral practice.

Assessing motivation to change

Many factors can make it difficult to determine when one first meets a parent whether they are genuinely motivated to change. Parents should be given consideration to participate in FDAC regardless of whether they have a stated desire to change at the outset.

FDACs commonly assess a parent's 'motivation to change' to determine whether or not they are an appropriate fit for FDAC. Motivation can be assessed both directly (e.g. their acceptance that they have a problem, their insight into why, their willingness to engage in treatment) and indirectly (e.g. attendance, and responsiveness to the FDAC team). It is also recognised that 'motivation' can be complex and interpreted in different ways. Building an understanding of a parent's circumstances and drivers behind their behaviour can support practitioners to determine the parent's desire to make changes, even if there are barriers which mean parents are presenting in ways which have been interpreted as 'a lack of motivation'. Some of these barriers will be discussed in more detail below, particularly in relation to trauma responses

However, there are several reasons why a parent's apparent 'motivation to change' at their initial assessment may not accurately reflect their actual capacity to change:

A parent may be at a pre-contemplation stage of change

The Stages of Change Model is a model of behaviour change that posits that people experience different stages before they are ready to take action to modify their behaviour: pre-contemplation, contemplation, preparation, action, and maintenance of change. During the initial 'pre-contemplation' stage, parents either do not yet recognise that they have a problem, or recognise the problem but are not yet ready to change their behaviour.[17]

Practice recommendation:

- FDAC practitioners should try to assess where parents are in the stages of change, parents who are at a pre-contemplation stage of change should not be automatically screened out of FDAC.
- When working with parents at a pre-contemplation stage, practitioners should strive to be non-judgmental about low motivation, and instead focus on how to build a therapeutic alliance. Certain parents may appear to lack motivation to change initially but through a therapeutic alliance they may be able to move to the next stages of contemplation and preparation. Practitioners should strive to establish rapport and trust before raising the topic of change, which may take several sessions.
- There is evidence that strategies based on the Stages of Change Model have promising outcomes both for individuals with substance use and domestic abuse issues. In particular, Motivational Enhancement Therapy (MET) interventions may be effective for pre-contemplative parents experiencing issues with substance use and/or domestic abuse.[18]

Denial and minimisation are common initial responses

Denial and minimisation are common responses in both the substance use and domestic abuse contexts.

During an initial assessment, parents may be in denial about the impact of their behaviour on their children or may be minimising the harm to their children. Roffman et al. (2008) explain that this is particularly common in people who use substances where minimising the severity of consequences, blaming others for causing the behaviour, and making excuses for one's actions are common.[19] Often, parents are screened out of FDAC on the basis that they are displaying these kinds of defence dynamics and are unable to identify 'treatment needs' in their initial assessment.

Practice recommendations:

- Practitioners should expect to encounter 'defence dynamics' among parents– including denial, minimisation, blaming others, and making excuses– and give parents a meaningful opportunity to engage before determining that they lack the motivation to change within the timescales of FDAC.
- An important early task of FDAC engagement is to understand what is underlying these dynamics such as fear or shame, and use the therapeutic engagement to help parents feel safer to acknowledge and discuss these issues.

A seemingly motivated parent may be trying to answer in socially desirable ways

Some parents may appear to be highly motivated and agreeable at an initial assessment because they are trying to present in socially desirable or favourable ways. Levenson explains that "*abuse survivors are particularly vulnerable to instinctive compliance and may need to be reminded that they have the right to ask questions, decline services, or make requests.*"[20]

This instinct to appear well to others is likely exaggerated in the context of court assessments, where people are under great pressure to present themselves positively, particularly when they are aware that a negative outcome could result in the removal of their children. This phenomenon, known as 'socially desirable responding,' is well-documented in the literature on assessments.

Socially desirable responding is generally broken down into two distinct biases: impression management (a deliberate attempt to look favourable to others) and self-deceptive enhancement (an unconscious bias based on an overly positive self-image, without deliberate manipulation).[21] It can be difficult to determine when one first meets a parent whether they are genuinely motivated to change, or whether they are consciously or unconsciously seeking to answer in socially desirable ways.

Child welfare practitioners often use the term 'disguised compliance' to refer to parents who are misleadingly presenting as if they will comply with an intervention plan. Disguised compliance is defined by the NSPCC as "*parents and carers appearing to cooperate with professionals in order to allay concerns and stop professional engagement*."[22]

Practice recommendation:

- Parents should be considered for FDAC regardless of whether they have a stated desire to change at the outset for the below reasons:
    - While 'disguised compliance' implies a conscious effort to deceive, often parents exhibiting 'disguised compliance' are acting from a place of fear. They might be doing their best to engage outwardly by saying 'yes,' but inwardly may feel frightened and impulsively drawn into withdrawal.[23]
    - While some responses during an initial assessment can present as a strong motivation to change, there is a difference between a parent's stated desire to change and someone who shows fundamental insights into the degree of problematic behaviour and its impact on others– which will likely need time to develop.

The care proceedings may be a strong extrinsic, rather than intrinsic, motivational force

People are often moved from the Pre-contemplation to Contemplation stages of change by extrinsic sources of motivation.[24] It is well-established that many parents involved in court proceedings start from a position of external motivation. Part of the task of the FDAC intervention is to help parents develop that into intrinsic motivation that will sustain change beyond the end of proceedings.

Practice recommendation:

- A parent who is only participating in the FDAC assessment because they feel compelled to by the court proceedings should not necessarily be excluded from FDAC on that basis.

Trauma responses and bias during initial assessments

Complex trauma

The term 'complex trauma' has come to describe the various types of mechanisms by which chronic, repeated exposure to trauma can have an enduring and wide-ranging impact on the mind and body.[25]

Experiences of trauma and adverse childhood experiences (ACEs) are closely linked to negative outcomes and psychological consequences such as substance use and addiction, depression, post-traumatic stress disorder, and personality disorders.[26] Experiencing trauma is not the same as being traumatised, but greater psychological impacts are associated with sustained or repeated exposure to trauma, particularly when perpetrated by a person of trust. Childhood complex trauma in particular is associated with a range of cognitive and emotional impairments, including issues with emotional regulation, attention, executive function and behavioural control.[27]

Experiencing a child welfare investigation and the initiation of care proceedings as a parent is in itself a highly traumatic experience which can compound any existing trauma, particularly for those parents with childhood experiences in care proceedings: "*involvement with the child welfare system also causes trauma to … parents… Mere interaction with the child welfare system may cause additional*

trauma to parents who had involvement with the child welfare system as children, as the fear, anticipation, and lack of control of the future may be beyond their capacity to cope."[28]

Practice recommendation:
• FDAC audit data indicate that a significant proportion of parents have previously been in care themselves, indicating not only a history of significant early trauma, but also a lengthy history of previous contact with local authority professionals. Their experience of services and systems will have already shaped their perceptions of authorities and expectations of helping professionals. Moreover, re-entry into a statutory system may reactivate traumatic memories and behavioural responses related to their earlier experiences in care. FDAC practitioners should be aware of the potential impact of this upon engagement and what FDAC may represent to these parents.

Trauma responses

Most FDAC parents have experienced trauma. An informal audit of 61 consecutively referred parents within the London FDAC found that over 70% of FDAC parents had experienced a known childhood trauma.[29] As such, FDAC practitioners approach their work with a nuanced understanding of trauma and its impacts. However, trauma can affect a parent's initial presentation in varied and complex ways that may confound an FDAC team's ability to accurately determine whether they are capable of making the changes necessary during the Trial for Change.

While there are some common responses to trauma that practitioners can expect to encounter, the impact of complex trauma will not be the same for everyone. Some people have issues that cannot be overcome within the limited timescales of court proceedings, but these parents will be difficult to identify based on their initial presentation alone.

The Center for Substance Abuse Treatment cautions that "*there is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counsellor's efforts to address substance abuse–related behaviours in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled.*"[30]

There are a wide range of 'trauma responses' that trauma-experienced individuals may exhibit while being evaluated in an initial assessment. It is easy to misinterpret these common indicators of traumatic stress as "*a lack of interest in the outcome, lack of appreciation for the significance of the proceedings, or lack of willingness to cooperate.*"[31]

The following are examples of known trauma responses that may appear in an initial assessment:

Emotional dysregulation and hostility

Many trauma-experienced individuals have difficulty regulating emotions like anger, shame, anxiety, or sadness.[32] This can manifest in explosive or volatile reactions to professionals, which in turn impacts how professionals respond to them and lead to perceptions of elevated risk.[33] Because these dysregulated responses can be challenging to manage, FDAC practitioners might screen out these parents because they perceive their case as too 'difficult' to handle. However, "*those with the most off-putting behaviour may be most in need of trauma-informed responses.*"[34]

Practice recommendation:
• Trauma-experienced parents may be inaccurately perceived to be 'lacking capacity to change' or to have issues that are too severe to be addressed. However, these parents are often the same parents most in need of FDAC's trauma-informed, therapeutic approach.

Dissociating and numbing

Dissociation is a mental process by which people feel distant from their experiences, actions, and sense of self, and can include signs such as long periods of silence, a monotonous voice, a flattened affect, or glazed eyes.[35] Dissociative disorder diagnoses are associated with histories of severe childhood trauma. Similarly, numbing is a reaction to traumatic stress in which emotions appear detached from one's behaviours and thoughts. Parents may appear to be numb during assessments by talking about their history or their behaviours in a matter-of-fact, detached, emotionless way. Parents may tell you they have "*dealt with their past*" and not connect their current problems to their past trauma.

Practice recommendation:

- Parents who exhibit a disassociated response may be perceived as lacking in motivation to change or unable to thoughtfully reflect on their behaviours. Numbing may lead practitioners to perceive the impact of a parent's trauma as less severe than it actually is.[36] It is important that practitioners are aware of these responses and don't exclude parents from taking part in the FDAC process on this basis.

Distrust of professionals and non-engagement

Because of the interpersonal nature of traumatic injuries, many people with complex trauma experience difficulties in building relationships with people.[37] Feeling distrustful of others can be seen as a protective strategy among those who have experienced repeated trauma. Developing out of a need for self- protection, these strategies can "*make a survivor's entrance into a service setting seem fraught with danger*."[38] In the child protection context, parents' interactions with the professionals who exert power over them are particularly "*demanding and anxiety-provoking interpersonal interactions*."[39] Non- engagement is often underpinned by fear, hypervigilance to threat, and a wariness of professional helpers.

Practice recommendation:

- Rather than interpreting this response as resistance to services or a lack of motivation, practitioners should view this as a normal protective reaction and "*recognise that the burden is on us to facilitate trust*."[40] Non-engagement can be thought of as a clinical issue, and practitioners should remember that the same tools that they have to help parents with other clinical issues can be used to support parents in engaging and feeling safe.

Complexity of needs

Relatedly, parents with complex trauma may present with multiple severe needs which may seem daunting and beyond the remit of the FDAC team. Research on ACEs has shown a dose-response relationship between the number of adverse childhood experiences and many health, behavioural, substance use issues, and social problems, which tend to co- occur.[41]

Practice recommendation:

- Practitioners may worry that people with several co-morbid issues have needs that are too complex to be met within the timescales of FDAC, but co-morbidity may be merely a proxy for the extent and severity of one's experiences of trauma. Since trauma might be underpinning a parent's issues, applying a trauma-informed treatment approach has the potential to simultaneously address concerns in several different domains.

Bias - Cultural competency, implicit biases, and intergenerational trauma

Parents going through the court process often have very different life experiences and backgrounds than the practitioners assessing them. This can result in issues with cultural competency, practitioners' implicit biases, and parents experiencing traumatic stress due to historical, intergenerational, or racial trauma.

Practice recommendation:

- There have been initial concerns that parents accessing FDAC may be disproportionately white and British, although more research is needed to establish this definitively. The referral process is a critical stage to understand if and why disproportionality occurs, and how families able to access FDAC can be made more inclusive and equitable.

Cultural competency

Cultural competency refers to the ability to understand how one's own cultural background influences client interactions and to have the tools to work effectively with individuals from various cultural backgrounds.[42] FDAC practitioners are often tasked with assessing parents from different sociodemographic, cultural or ethnic backgrounds from their own, or parents who have immigrated from overseas.

Parenting practices and behaviours will invariably be impacted by one's cultural values and history, the competencies considered necessary for children to thrive, and dynamics of discrimination that influence that particular group's ability to survive in the larger society.[43] Forehand & Kotchick (1996) argue that "*Attempting to explain, predict, or change parental behavior ... is meaningless without references to cultural beliefs... Ethnic minorities often have been viewed as deficient or defective in terms of their parenting as compared to white, middle-class standards. Before attempting to modify parental behavior simply to match the ideals deemed successful by one particular culture, behavior therapists must allow the family's cultural background to guide the understanding of which... behaviors are valued.*"[44]

Whilst being culturally competent does not mean practitioners must possess knowledge of every culture, it does require that FDAC practitioners recognise the importance of cultural context by asking questions, seeking to understand someone's experiences and behaviours through the lens of their cultural context, and being open-minded.

Practice recommendation:

- During an FDAC assessment, practitioners might perceive a parent to be 'not forthcoming' or feel the parent is unable to recognise why their behaviour is problematic. It is important that practitioners interpret these behaviours through a culturally sensitive lens, and be cognisant that it may take longer for practitioners to understand and build a therapeutic alliance with an individual from a different cultural background.
- FDAC practitioners should strive to not exclude parents from FDAC where their reluctance to participate or 'open up' during an initial assessment may be due to that parent being from a different cultural, ethnic or immigrant background.
- FDAC Teams should explore training and development opportunities and tools to work effectively with individuals from various cultural backgrounds. Scoping the demographics of the local authority area could help identify development opportunities to prioritise.

Implicit biases

Implicit biases are predominantly unconscious thoughts and beliefs that are activated involuntarily and influence our behaviours, assessment of risk, and decisions.[45] We all hold schemas that allow us to quickly analyse people and situations so that we can interpret and predict the world around us.[46] However, schemas also lead to biases and preferences for particular groups.

At many FDAC services, determining whether a parent is eligible for FDAC involves a subjective assessment of whether the parent is motivated and capable of changing their behaviours within the court's timescales. However, a robust evidence base has demonstrated that ambiguity and subjectivity in evaluation criteria leaves room for implicit biases as practitioners "*unconsciously rely on their pre-existing stereotypes about racial groups in their decision-making*."[47]

Biases are more likely to impact decision-making during stressful conditions, when there is time pressure, a lack of reliable information on which to base a decision, fatigue, and cognitive overload.[48] A UK review on decision-making in children's social work identified key factors that complicate social workers' abilities to make complex, challenging decisions, including: time and workload pressures, which increase reliance on 'intuition'; decision fatigue if many decisions have to be made in a single day; and various biases.[49] Implicit biases are unconscious, it is difficult to prove their existence through direct evidence: "*often, the only measure of implicit bias is through disproportionate results – the misrepresentation of an adversely affected subgroup compared to the larger population.*"[50]

Initial FDAC quarterly data suggests that, overall, the families that participate in FDAC may be disproportionately white and British. This suggests that implicit biases could affect the assessment of whether families are capable of making the changes to succeed in FDAC. A study in the US found that families of colour were less likely than white families to be referred from standard child protection proceedings to the Alternative Response (a child welfare pathway that promotes strengths-based, family-centred, supportive approaches).[51] There are various points in the process at which decision-makers may be influenced by implicit biases, and more research is needed to determine if this disproportionality exists in FDAC and at which points in the pipeline this occurs (e.g. if white British families are being disproportionately referred to FDAC by the local authority, being deemed eligible by the FDAC team, and/or choosing to participate as compared to families of colour).

In addition to implicit racial biases, there are a number of other biases that impact practitioners' decisions, particularly when decisions must be made rapidly and under pressure. Practitioners may hold unconscious negative biases toward parents who are from stigmatised or less understood groups, such as parents who:

- are not fluent in English,
- come from different immigrant backgrounds,
- represent sexual or gender minorities,
- are experiencing homelessness,
- use particularly stigmatised substances,
- are engaged in sex work,
- have certain mental health disorders, etc.[52]

Generally, practitioners may experience 'affinity biases,' which is when we view people who are similar to us more positively than people who are different from us.[53] FDAC practitioners working together to make decisions may also be vulnerable to 'groupthink,' a phenomenon in which a group's desire to reach a unanimous decision and avoid conflict leads to biases and extreme decisions being made.[54]

Practice recommendation:

To mitigate the risk of biases impacting eligibility decisions, practitioners and decision makers should:

- Regularly review their local data to assess if FDAC is being offered equitably within their area.
- Try to recognise their own biases and reflect on how these biases might impact their decisions.
- Minimise subjective eligibility criteria which are vulnerable to bias.
- Deliberately slow down decision-making and take time to reflect on reasoning before making decisions
- Challenge one another's possible biases.[55]

Practitioners can also reference this Family Assessment Tool on overcoming bias.

Implicit biases and assessment of substance use

Implicit biases also impact how professionals perceive the severity and treatability of substance use issues.

Some substances are highly stigmatised, e.g. crack cocaine vs powder cocaine, as are some means of administration, e.g. injecting vs smoking. This stigma can influence perceptions of the person being assessed, and act as a barrier to disclosure. Our implicit racial and cultural biases affect how we assess substance use[56] and the seriousness of the issue, as well as how we assess drivers and treatability: this has a knock-on effect on whether we deem someone eligible for the FDAC service. One follow-up study of families affected by drug and alcohol use indicated that professionals tended to under-estimate the risk associated with alcohol use leading to delays in taking protective action, despite evidence that the longer-term impacts were as significant as with drug use.[57]

Intergenerational, historical and racial trauma

Finally, another dynamic that practitioners should be aware of during initial assessments are the ways in which parents might be impacted by intergenerational, historical, and/or racial trauma– particularly as they interact with professionals who do not share these traumas.

Unlike the personal experiences of trauma detailed above, these kinds of structural traumas are transmitted within families, cultural, and ethnic groups.

- **Intergenerational trauma** refers to "*the transmission of the consequences of trauma from one generation to the next within a particular family.*"[58]
- **Historical trauma** refers more broadly to the "*the cumulative exposure to traumatic events [such as the legacy of slavery, impact of massacres, and removal from homelands] that not only affect the individual exposed[,] but continue to affect subsequent generations.*"[59]
- "***Racial trauma, or race-based stress**, refers to the events of danger related to real or perceived experience of racial discrimination. These include threats of harm and injury, humiliating and shaming events, and witnessing harm to other people of colour due to real or perceived racism.*"[60] Effects of racial trauma include hypervigilance to threat, suspiciousness, and avoidance, and "*involves ongoing injuries due to the exposure (direct and or vicarious) and re-exposure to race-based stress.*"[61]

To address racial trauma and its role during initial assessments, practitioners must first feel comfortable bringing up the topic of race and racism, bringing with them a willingness to acknowledge institutional and societal biases.[62] While this may seem obvious, research suggests "*many therapists feel uneasy discussing race, especially white therapists.*"[63]

Parents may be unlikely to open up and 'disclose' their personal histories at the outset of a case if they feel that the professionals working with them either lack the personal experiences to understand their trauma or exhibit microaggressions, subtle interactions or behaviours that communicate bias.[64] For example, one study found that 53% of clients of colour perceived microaggressions from their therapists, which negatively impacted their working alliance.[65]

Considerations for practice:

- Practitioners must be willing to do the work to continuously educate themselves in the ways oppression and discrimination impact their clients of colour, and FDAC teams should strive for professional diversity reflective of the diverse backgrounds of FDAC parents.
- The experience of a parent of colour being evaluated by an all-white or mostly white FDAC team could potentially trigger race-based stress and a perception of racial discrimination, despite the best intentions of practitioners.

Over-arching FDAC principles

Resource Allocation

The question of eligibility is a distinct issue to that of resource allocation. FDAC is a limited resource in most localities and, as such, decisions need to be made locally about whether this resource should be made available to a particular family.

The question of who carries out the gatekeeping of the resource is determined locally. In most areas, it is the commissioning local authority who weighs up the benefits of offering FDAC to families, against other potential resources they may have at their disposal at any given time. It is still recommended that local authorities discuss all potential FDAC referrals with the FDAC Team Manager.

Screening may appear helpful to ascertain initial motivation to engage with FDAC. However, as noted above, there are also several reasons to be cautious about interpreting a parent's initial presentation during screening and assessment.

Recommended Practice Principles

On the basis of existing research, clinical perspectives, and FDAC experiences set out in this briefing, we recommend these practice principles to guide each service's approach to eligibility:

1. FDAC should be as much of an open door as possible.
2. Decisions on the use of FDAC should recognise that there are multiple benefits to families beyond reunification.
3. Decisions should be informed by an awareness that practitioners' initial perceptions of parents' capacity to change may be affected by a range of factors.
4. The viability of FDAC should be centred on whether potentially solvable problems can be identified rather than on specific case characteristics.
5. Any eligibility approach should consider parental capacity to give informed consent to participate in FDAC and any ethical or risk issues that may preclude a problem-solving approach.

In relation to principle number 5, whilst there is on over-arching starting point of inclusivity, the complex and variable nature of families involved with care proceedings may raise specific legal, ethical and practical issues.

Conclusion

This resource has outlined key considerations, evidence, and practice principles for FDAC practitioners and local authority colleagues involved in referral and eligibility decision-making with regard to FDAC.

The research reviewed indicates that there are no clear predictors of success for parents in FDAC, and many parents with complex needs have demonstrated positive outcomes when provided with high-quality, multidisciplinary support. The findings suggest that strict exclusion criteria are not warranted, and FDAC services should aim for an inclusive approach while ensuring robust assessments of risk, capacity, and informed consent.

A number of factors may influence referral decisions, including trauma histories, implicit biases, and structural inequalities, all of which require conscious attention from practitioners. Additionally, certain legal and ethical considerations, such as having concurrent criminal proceedings, coercion, and resource allocation, must be carefully managed to uphold FDAC's integrity and effectiveness.

To ensure a consistent and fair approach, FDAC services are encouraged to adhere to the overarching practice principles set out in this document.

Ultimately, FDAC's problem-solving approach provides an opportunity to support families in a way that is responsive, evidence-based, and tailored to their specific needs. Ensuring consistency across FDAC sites through informed referral practices and equitable access will help sustain FDAC's success and strengthen outcomes for families in care proceedings. By continually refining eligibility considerations and integrating emerging research, FDAC services can uphold their commitment to best practice and deliver impactful, child-centred interventions.

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