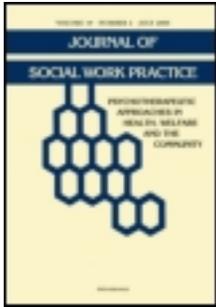


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THE FAMILY DRUG AND ALCOHOL COURT SERVICE IN LONDON: A NEW WAY OF DOING CARE PROCEEDINGS

In this article, three professionals from the Tavistock & Portman NHS Foundation Trust, who have been instrumental in developing the Family Drug and Alcohol Court (FDAC) clinical model, introduce the background to this project. The FDAC model is highly dependent on a collaborative approach from local authorities, Government, the Courts, the NHS and the charitable sector, and we hope to give a flavour of that here. In addition to describing what it is that makes FDAC significantly different from other models of working, we also want to give a description of what it is like to be a social worker within the multi-disciplinary team.

Keywords drug and alcohol; care proceedings; parental substance misuse; family work

Introduction

In this article, three professionals from the Tavistock & Portman NHS Foundation Trust, who have been instrumental in developing the Family Drug and Alcohol Court (FDAC) clinical model, introduce the background to this project. The FDAC model is highly dependent on a collaborative approach from local authorities, Government, the Courts, the NHS and the charitable sector, and we hope to give a flavour of that here. In addition to describing what it is that makes FDAC significantly different from other models of working, we also want to give a description of what it is like to be a social worker within the multi-disciplinary team.

Structure and history of the FDAC

Parental substance misuse affects a significant minority of children. The Advisory Council on the Misuse of Drugs: Hidden Harm (2003) estimated that 2–3 percent

of children in England and Wales 'have a parent with serious drug problems' which translates as 250,000–350,000 children in the UK are affected by parental drug use. It is also a major public health issue in the USA, where the National Survey on Drug Use & Health (2002–2007) found that a similar percentage (3 percent) of young people 'live with a parent who is dependent on or abused illicit drugs', whereas 10.3 percent 'live with a parent who is dependent on or abused alcohol'.

Parental substance misuse is strongly represented amongst those children requiring protection by the state. For example, Forrester and Harwin (2006) found that parental substance misuse was a significant problem in almost two-thirds of families in 'care proceedings'.

Parental substance abuse exposes children to a complex mixture of risks including impaired foetal development, neonatal withdrawal, abuse and neglect, domestic violence, crime, parental mental illness, social isolation and destitution. The result is very damaging to children's health and well-being (Shaw & De Jong, 2012). Traditional 'adversarial' methods of conducting care proceedings can fail to motivate parents to change or get agencies working together (Harwin *et al.*, 2011), which can then result in children spending long periods in foster care; and despite considerable expense very few families overcome their problems.

The FDAC is a fresh approach to children who are put at risk by parental substance misuse. It is a new service for the UK based on similar 'problem solving courts' in the USA. District Judge Nicholas Crichton saw the model working successfully in the USA and believed it would translate well to the UK and help deliver better outcomes for the parents and children involved in proceedings. After a great deal of research and feasibility work by the Brunel University research team, and key professionals within local and national government departments, the first UK FDAC was launched in London in January 2008.

FDAC is a multi-agency, multi-disciplinary joint venture between the Tavistock & Portman NHS Foundation Trust, Children's Charity Coram, the Inner London and City Family Proceedings Court and the five London boroughs that commission it (Camden, Hammersmith & Fulham, Islington, Southwark and Westminster). Four Government departments (Department of Health, Department of Children and Families/Department for Education, Ministry of Justice and Home Office) substantially funded FDAC during the first 4 years (2008–2012). There have been additional contributions from four charitable trusts (David Isaacs, Monument, Pilgrim and Vintners). A research team from Brunel University has been studying the project since its inception with grants from the Nuffield Foundation and Home Office.

The success of FDAC has been recognised and awarded by a variety of organisations. FDAC has been cited as an example of excellence in the Home Office's Drug Strategy (2010) and the Munro Review of Child Protection (2011) and the Family Justice Review (2011). It has also received a number of awards including, 2011 London Safeguarding Children Award, 2011 Guardian Public Services Award for Service Delivery for Children and Young People, 2011 Outstanding Achievement Award at the Legal Aid Lawyer of the Year awards, 2011 Outstanding Contribution to the Field of Family Law from Family Law, 2012 Working in Partnership Award at the British Medical Journal Group Improving

Health Awards and Best Psychiatric Team of the Year 2011 from the Royal College of Psychiatrists.

Multi-disciplinary teamwork

FDAC is a multi-agency collaboration between the family court, a designated assessment and intervention team, the commissioning local authorities, local child and adult treatment and rehabilitation services and finally other agencies such as housing and probation.

Wherever possible FDAC gives families a chance to overcome their difficulties and meet their children's needs provided they can do so in a timescale compatible with their children's needs. Where families are unable to overcome their problems in time, FDAC seeks not only to place children permanently as soon as possible but also to help parents avoid getting stuck in a pattern of repeated pregnancies and removals.

To understand what is different about the FDAC, it is helpful to start with a description of the assessment and intervention team. Reflecting the intergenerational nature of the problem, the assessment and intervention team is multidisciplinary and made up of both child workers (child protection social workers and a child and adolescent psychiatrist) and adult workers (substance misuse workers and an adult psychiatrist). To help engage these hard-to-reach families, the team includes volunteers with personal experience of overcoming substance misuse, some of whom are FDAC graduates.

In the interests of fairness, most families are offered an individualised, highly coordinated and time limited 'therapeutic trial for change'. The type of trial varies but is likely to require parents to evidence an extended period of abstinence from street drugs and alcohol in the community, and a move away from a substance misuse-centred lifestyle to one based on the child. Parents will receive treatment to help them understand and manage the problems underlying their substance misuse, and to be more sensitive, responsive and reflective with their children. Most families require help to address a history of domestic violence, and any additional mental and physical health difficulties are diagnosed and treated.

The 'trials' require multi-agency working. To ensure it is well coordinated, the assessment and intervention team get the family, social services and treatment agencies together to agree common objectives, methods and timescales. The authority of the court is used to hold all the participants to their promises.

To avoid delay, the assessment and intervention team meets the family on the first day of proceedings, completes an initial assessment the same week and can have treatment running by the following week. Timescales are firmly fixed to watersheds in the child's development. For example, the sensitive period for attachment is between 6 and 18 months, so the decision on whether to return the child must be taken by the time the child is 6 months. For clarity, the tasks and time available are broken down into steps and the plan is reviewed fortnightly in court and revised every 2 months (again with all the participants present).

In the FDAC model, the court proceedings form an integral part of the treatment process and take a new form. The family works with the same judge throughout. Two District Judges sit for 1 day alternate weeks (with a third judge providing occasional cover when the principal judges are on leave), and one of the major innovations within

the legal aspects of FDAC is the concept of the ‘therapeutic judge’ or therapeutic jurisprudence.

Weiner *et al.* (2010) usefully explore the concepts of distributive and procedural justice in problem-solving courts, in which the judge engages the client in motivating them towards change. The judges of course remain independent of the clinical team and have undertaken training in therapeutic interventions – anybody who has seen an FDAC in action can see striking differences from normal care proceedings. Weiner also reviewed some of the evidence about

when people experience procedural justice and to a lesser extent distributive justice . . . they engage with the group, adhere to its norms and respect the group’s demands on their conduct . . . they are more likely to view their choice to participate as voluntary rather than coerced, thereby gain the psychological value of intrinsic motivation and to avoid negative effects of coercion.

This less-adversarial approach to care proceedings has other features such as the ability of the client to speak directly to the judge during the regular hearings, the problem-solving multi-agency approach to the issue of rehabilitating the family and non-lawyer reviews in court.

In addition to the hearings mandated by the Public Law Outline, the judge meets with the parents once a fortnight to review progress and timescales. The parents and judge speak to each other directly, without lawyers present; however, the social worker, Children’s Guardian and members of the assessment and intervention team are also present. The judges have additional training in motivational interviewing and will encourage the parents to overcome their problems while remaining mindful of the children’s needs and timescales.

In the FDAC model, local authorities are encouraged to finalise their care plan in collaboration with the family, the assessment and intervention team, and the treatment and other agencies. Only where this is not possible will the matter need to be settled by the court.

The assessment and intervention team maintain close links and provide regular training opportunities with housing, treatment services, social services, lawyers, guardians, etc.

Brief overview of the research into FDAC’s effectiveness

Harwin *et al.* (2011) followed the first 41 FDAC families and 19 comparison families to the end of the court process and found better outcomes for children including higher rates of parent–child reunification (39 percent vs 21 percent) and swifter permanent placement for children not returned (7 weeks). FDAC parents accessed substance misuse services quicker, received a broader range of services and were more successful at staying in treatment. More FDAC mothers stop substance misuse (48 percent vs 39 percent) with an even bigger difference for fathers (36 percent vs 0 percent).

Harwin found

parents were overwhelmingly positive about the FDAC (assessment and intervention) team: for motivating and engaging them, listening to them, not

judging them, being honest with them, being and both strict and kind, providing practical and emotional support, and coordinating their individual plans.

Parents were also positive about the judges: for being fair, sensitive, ‘treating you like a human being’, because they felt motivated by judicial praise and encouragement, and because they were aware of the authority of the judge and valued their role in mediating and solving problems. Two-thirds of parents were positive about review hearings and valued being able to have their say in court. Parents valued judicial continuity because it meant the judge was clear about the details of their case and knew them and their children.

Harwin also found that the professionals working with the family, but external to the FDAC team (the statutory social workers, Children’s Guardians and adult treatment professionals),

valued the FDAC (assessment and intervention) team for: their skill and dedication, being multi-disciplinary, their specialist knowledge, their ability to engage parents, the speed of their initial assessments, their efficient coordination of services, and their partnership working, including reflective practice. FDAC is unanimously regarded by professionals as a better court experience than ordinary care proceedings because it is more focused, less antagonistic and more informal, yet sufficiently rigorous when needed. Judicial continuity was valued by all professionals, in part because it leads to better case management and shorter hearings. Judges were praised for their role in engaging with and motivating parents and for being firm with them when necessary . . . All professionals are in favour of regular court reviews without lawyers because they: keep cases on track and ‘on the boil’ and reduce drift, identify problems early so solutions can be found, keep parents motivated, and enable social workers and guardians, as well as parents, to speak directly to the judge.

Harwin also found immediate cost savings, including less time in foster care for children (at an average savings of £4000/family) and reduced court costs (£1882/family). Whereas Ernst & Young with RyanTunnardBrown (2012) estimated that FDAC saved the public purse £40,000 per year for each family that recovered. This suggests that FDAC saves far more than it costs (currently £12,000 per family).

These findings replicate those in the USA where the model has been studied with much bigger samples (Worcel *et al.*, 2008). Professor Harwin and her team are working on a larger longer term outcome study.

Social work and the clinical model

When the Tavistock & Portman NHS Foundation Trust and Coram constructed the FDAC team and established the clinical model, both institutions used their extensive experience in providing specialist services to very challenging populations. Social workers constitute the largest discipline within the multi-disciplinary team, with the specification for the service tendered by the original three London Boroughs (Camden, Islington and Westminster) in 2007, asking for both an adult and a child social worker

to be part of the team. The Tavistock & Portman NHS Foundation Trust decided to develop instead a staff team with principally a child focus but with the aim of developing the skills of all the team in a family-oriented approach consistent with the Think Family agenda (Think Family, 2008). Although the team would consist of child and adult specialists, the majority would be experienced and versed in working systemically with families within a child-oriented approach. Much of the early dialogues with commissioners and within the Steering Group were about whether the FDAC model was indeed a child- or an adult-oriented service and there were competing views about this. We were all able to agree, however, on the benefits of promoting and developing services within the partnerships we worked with (adult treatment services, children's social care services and adult services) a crossover of child and adult expertise.

At the same time FDAC was being developed, there were other innovative social work research and practice emerging. Tony Nagle and Gill Watson's report on Child Abuse Review (Nagle and Watson, 2008) explored the rationale behind innovative strategies within the London Borough of Islington to meet the needs of families of families affected by drug and alcohol misuse. They proposed 'a crossover post, for example, a childcare worker placed in adult services' in order to bridge the gap between services which can be marked by 'lack of coordination, poor links and mutual mistrust between child and adult services'. In addition, within Islington children's social care, drug and alcohol testing was introduced offering assessment and ongoing engagement and developing better evidence for validating whether a parent was remaining abstinent or not and therefore measuring change and motivation.

In overcoming the simple alternative of adult or child focus, and developing a system of working which could focus on a parent's need to recover from addiction, but within a timescale consistent with that of their child, the social workers in the FDAC team undertake a number of tasks:

- therapeutic work and treatment of the clients,
- establish key-working relationships with the clients,
- coordinate multi-agency planning and treatment packages,
- coordinating multi-agency meetings,
- assess parenting and the capacity to change,
- planning for the child's optimum developmental trajectory,
- substance misuse testing of the clients and
- giving evidence in court.

There are also a number of therapeutic interventions offered by the FDAC team including:

- Video Interaction Guidance
- Social Behavioural Network Therapy
- Mentalising Group
- Motivational Interviewing
- Systemic Therapy
- Couples Work

- Cognitive Analytic Therapy
- Anxiety-Management Group.

So the idea, commensurate with the Munro Review's emphasis (Munro, 2011) on professional judgement in decision-making (including taking necessary and reasoned risks), early intervention, social work expertise and relationship-based social work, is the development of a social work expertise which can carry out *therapeutic* assessments. These are assessments which are time limited and which incorporate in-depth thinking about risk, and the skilful analysis of evidence, but which include a component of therapeutic intervention in order to *test the capacity* to change and *begin the process* of change for the client. The authors of this article are very used to talking to local authority statutory social workers who have little time, or permission, and often confidence, to contemplate the possibility of including an intervention in their work with families and this, in our view, is a lost opportunity.

It is worth saying that this confidence in social worker's ability to deliver therapeutic and assessment work in specialist areas has grown out of the experience of both the Tavistock and Coram delivering social work-based services and promoting a style of work which engages the emotional learning from distressing professional encounters and the ability to process what Andrew Cooper calls the

central difficulty that child abuse faces us with as professionals and also as a society . . . we know that terrible things are happening but the pain of knowing is too great for us to be able to sustain our attention.

(Cooper, 2005)

Other innovative aspects of FDAC

Parent mentors. Parent mentors (who are volunteers acting as credible role models for change to the client) also engage the client at the first court hearing and assist the client in making the decision to change their lives and sustaining that change. The parent mentors are carefully selected and trained volunteers who have experienced substance misuse in the past and difficulties within their families as a result. FDAC clients have expressed appreciation of having someone alongside them in the highly stressful process of recovery and care proceedings, who has experienced something very similar and can empathise on a qualitatively different level with them compared with the rest of the team. The parent mentors receive support in reflecting upon the impact of the work upon them and we help them in maintaining their own sustained recovery. Many of them progress to employment within the social care field, and supervising them is one of the enriching and profound learning experiences of working in the FDAC team.

Pre-birth assessment. Pre-birth assessments received their own pilot within FDAC during 2010 and each of the involved local authorities began referring pre-birth cases to the service. This recognised the benefits of early intervention with pregnant women who have substance misuse problems in order to lengthen the time available for

change; the timescales of the child are extended simply by virtue of the time we can make use of to effect change before the baby's birth. Pre-birth assessments raise their own unique legal issues and assessment complexities and it can be difficult to engage the women after the baby has been born, if FDAC have had to recommend the baby's removal in order to ensure the child's safety.

Roll-out. The FDAC project in London has received interest from other areas in the UK which are interested in the model, and there are working groups in several areas of the country, both city and rural based, which are working on developing their own FDACs. A recent development in Gloucestershire (GEYST – Gloucestershire Early Years Specialist Team) is a specialist under-5's team working with chronic neglect where substance misuse is a problem and is an example of a service which has adapted FDAC to its own local needs. It uses an adapted family nurse partnership and FDAC approach to deliver a multi-disciplinary programme of assessment, intervention and support.

The experience of working in FDAC

One of the less obvious aspects of the FDAC model is its careful balancing of an optimistic stance towards the possibility of change, with a realistic view of the serious challenges presented by substance misuse and the tight timescales dictated by the child's needs. It can feel very much like a 'dictatorship of the children's timescales' which frame the brutally realistic limitations on the hope invested in change by the client, the team and the treatment services. These timescales have been further reinforced by the Family Justice Review's ambition (Ministry of Justice, 2011) released in the Children's Bill in March 2013, to have all Care Proceedings completed within 6 months unless there are exceptional circumstances.

The peculiarly intense and highly emotive aspect of FDAC's work is within a combination of exceptionally difficult life events – the parent's recovery from addiction at the same time as the state's intervention to protect the child. The parent's decision to become abstinent and enter treatment is voluntary. The protection of the child is state authorised. The permanent removal of the child from the parent's care is dependent on the parent's ability to engage in a timely manner in treatment and to a sufficient degree to reduce the damage to the child, and ensure the child's developmental trajectory is on an appropriately healthy course. So although there is an optimistic and hopeful rapid engagement of the parent in treatment, the team also has to be hardened to the possibility that the parent's pathway to recovery may simply not be in the child's timescale and this requires a certain psychological resilience to be able to withstand the painful disappointment that the family can face when the recovery has not been sufficient or quick enough for the child.

Bearing this in mind, careful attention was given from the very beginning on the project, to the emotional needs of the clinical team undertaking the work. It was felt that a facilitated, regular reflective team meeting was an important aspect of the model, giving the team a space in which to discuss the painful nature of the work and process the specifically corrosive nature of work with clients who use mind-altering substances. Familiar patterns and processes in this work include manic excitement and hope, relapse, denial (sometimes with a delusional quality), the trauma and pain which the

client has been unable to process, the weight of expectation and guilt, and the sense of having failed one's children. The clinical team often has to make very finely calibrated decisions about a parent's capacity to change in the long term and be able to meet their children's emotional needs despite the fact that the client may have already made very significant changes for the better – just not enough to ensure safe and sufficiently attuned parenting.

There has to be an acknowledgement, a verbal processing and a working through of these feelings as a team in order to reduce the poisonous nature of the intensive work we do. This is often best accomplished in FDAC by the development of a 'team mind' in the reflective team meetings which use the group to reflect upon and think about the content and difficulty of the work we do. However, the team often gets to the point where we have to simply face the reality of our clients' histories and the repeated patterns of abuse and maltreatment we read and listen to and digest for our clients.

One of the most important (and elusive) thoughts we have come across regarding substance misuse is by the psychiatrist Wilfred Bion who said

drugs are substitutes employed by those who cannot wait. The substitute is that which cannot satisfy without destroying the capacity for discrimination of the real from the false.

(Bion, 1991)

It takes some time to grasp the condensed wisdom of this statement, but the work of FDAC with parents who misuse substances has given a particular resonance to Bion's words. We understand this statement in an attachment and a linguistic sense; the gratification in living comes hard-earned through building social relationships of meaning and has to emerge through many failed and retried attempts at making oneself understood and understanding others, attempting proximity and distance, failing and repairing. When this process is seriously compromised by a traumatic or abused childhood, which can disrupt our ability to develop a reasonably coherent personality and an attachment which is able to engage in the rich, frustrating and hard work of shared human companionship and communication, then there can be a resort to a quicker solution to find a synthetic mimic of the human emotion of secure attachment and gratification, which is the drug. Often it can be difficult in talking with clients who misuse substances, to find a genuinely mutual and open ability to engage in a shared enterprise of change, growth and learning, and indeed this finds some support in the work of the French psychoanalyst Jacques Lacan, who pointed to drug use being the *opposite* of the linguistic act

(the removal of the addict) from the social link, separates the subject from the other . . . and leaves the subject to their own private jouissance.

(Baldwin *et al.*, 2011)

This quote raises the idea of a core difficulty in what it means to be a social worker in social work with people who have problematic drug and alcohol use; the social worker being a person who works (thinks struggles and communicates) to build the social link or its basic components, between the addict and society, working against the destructive act of the addiction which aims to destroy the link. In FDAC the clinical

team regularly discuss and think about how we can help the clients make links. Social work is an act of restoring the struggle in the difficult reality of repairing human relations. And we sometimes have to make recommendations to sever family relations in order to achieve this for the child.

This has been very well captured by Angela Foster in an article on female drug addicts (Foster, 2011) when she writes:

One of the big challenges facing workers in this field is to resist being over hopeful about a client's therapeutic progress by holding the aggressor in mind and addressing that part of the personality. We have to dare to spoil the good feeling in the present in the belief that this will lead to longer term gain; something our clients generally resist.

Case examples

On coming to the end of this article, it may be useful to have two case examples to illustrate something of the issues faced in the FDAC on a regular basis.

Fiona

Fiona aged 40, of White UK heritage, and her unborn child (Fiona's fourth child, her other three children having been placed in care permanently due to concerns about neglect, her substance misuse being left with unsafe others and developmental delay). The parents have been in a violent relationship for about 4 years and met in a drug treatment service. The pregnancy was planned, while the mother was still using large amounts of street drugs. The father had ruled himself out as a carer and gave no contact details to social services.

Both parents had a long history of heroin, crack cocaine and alcohol misuse. Both were placed in care during childhood. At the time of the referral to social services by hospital, in respect of unborn Ben, the mother was drinking over 80 units of alcohol per week (which is probably a conservative estimate on her part), and on a methadone script. She had a lengthy history of homelessness, sex working and several offences of theft and assault.

She had recently successfully completed a detoxification programme and her recent breath tests were negative. In the FDAC team's planning with the other professionals involved, we felt that although she has made some recent progress, she had stopped the illicit drug use and alcohol use, but this was in the very early stages. The FDAC team acknowledged that Fiona was stabilised on her methadone but was struggling to start any psychosocial treatment. The clinical FDAC team felt that it was important to focus on the issues driving her drug use and encouraged Mrs C to find other ways to manage her problems. The team recommended to the court that the baby be placed in foster care at birth and a decision for his permanence be made by the time he was 12 months old, so that the professional network needed to be confident by the time he was 6 months old, that the plans were progressing for placement with the mother or into alternative care.

FDAC weighed up the options of a placement with the baby in a residential rehabilitation unit or a mother and baby foster placement but concluded that treatment needed to be Fiona's priority at this stage and recommended plotting a course to give

her the best chance. With intensive treatment being 4–5 days per week, up to 7h a day, Fiona would not be able to give the kind of attuned and attentive care which the baby needed, and the likelihood that the baby would require above-average care due to the likelihood of the baby being born withdrawing and some early concerns about health abnormalities, likely to be caused by Fiona's substance misuse during pregnancy.

Our assessment of her parenting potential had raised serious concerns about her ability to separate from the violent relationship she was in, and about her ability to consider the reasons why her lifestyle had become dominated by drugs, alcohol and a marked lack of stability or safety. She did not recognise that she needed help for the damage she had sustained in her early life and blamed others for her drug use and chaotic lifestyle. Her individual sessions with FDAC staff were marked by her manic defences which she used to put a distance between herself and the painful memories, and she struggled to demonstrate any meaningful thinking about her or Ben's situation or her baby's needs.

Ben was born withdrawing and was kept in hospital for a time after birth. The mother had regular contact but struggled to maintain her intensive treatment, had maintained her relationship with a violent man and relapsed. It became clear to the professionals very quickly and also to the mother that she would not be able to meet her baby's needs within the baby's timescales for permanency and she relinquished care of her baby to adoption. She continues to attend treatment with the aim of achieving recovery in the longer term.

One of the benefits of the FDAC approach in this tragic situation was the evidence we formulated which argued for the baby's removal to foster care after release from hospital and early planning and decision-making about the child while giving enough time to test the mother's ability to change and hopefully engaging her in work so that she does not repeat the same pattern again.

Tracey

(This is an account of Tracey's experience as told in her own words)

My name is Tracey and I have 3 year old daughter. I worked with FDAC for over a year while I was recovering from my substance misuse problems and am now training to be a FDAC Parent Mentor.

I had lost my parents within a year of each other and started to drink heavy. I ended up having a breakdown where I attempted suicide and started self-harming. I asked for help but just got given higher doses of medication, stitched up and sent on my way. When I got pregnant with my daughter I was scared about how I would cope so asked social services for help and support.

My daughter was on child protection and I had started drinking again as I was very isolated and had no support. I was on my own due to a fallout with family so my lifestyle was all over the place. I was struggling and finding it very hard to cope with the loss of my parents and drank more so I got taken to the FDAC court. I had to go in a foster placement for 6 months so I could stay with my daughter.

When I first went to FDAC I was so scared I was going to lose my daughter which I didn't want as she was all I had in my life. I had never been in court before or even

in trouble with the law. I felt sick would walk around with my head down no one could hear me talk it was like I didn't have a voice and would talk to the floor.

At my first assessment I couldn't get through it without a panic attack and being sick. I found it very hard to trust anyone, was suspicious, I didn't want to tell people about what was really going on as I was scared of what they would think of me and I had doors closed in my face so many times not only by professionals but family as well so it was hard to think anyone would be there for me.

Initially I was able to tell the FDAC team limited information, but was unable to let them in totally. This was a result of thinking I would lose my daughter. Once I got started I had lots of ups and downs, but this time I started to think it would be ok as I had someone on the end of the phone who I felt understood me, that made me feel heard and would treat me as a person. I started feeling emotions which I had blocked out as I couldn't handle them.

I went to family alcohol service which does parenting work and alcohol work and they invited my family to come and talk as well. At times it got really hard and I could have easily given up but my key worker at FDAC, would always sit me down and talk to me and help me get through it.

My key worker was a big part of mine and my daughter's life he helped me talk about my mum and dad and remember the good things about them he made me realise it was ok to cry and be sad, he helped me channel my anger in the right way. He would always highlight the positive things that I was doing or had done, as I would always hold on to the negative things and he would always tell me what a good mum I was as I wasn't very confident at being a parent. I was always be phoning to check if it was ok to do things or go to places as I was so scared of making a decision in case it was wrong.

I didn't have a very good working relationship with social services at first as I didn't trust them but the FDAC team helped me work with them positively and understand their role and we ended up working together well for the sake of my daughter's welfare. I had times were I nearly gave up but thankfully I had my daughter all the way through I think if she wasn't there smiling at me it would of been so much harder than it was.

We use to have a coffee morning with the mentors and we could meet other parents which was very beneficial as I made a really good friend who I am still in touch with. My mentor was very helpful as she had been through it all. I've never felt judged as she had felt what I was feeling which was nice. She was someone I could go to and rant about things and she would talk sense to me. She would also see my daughter and when she would say good things about me and her it went in as she is taking time out of her own life to help me which she doesn't have to do.

I found it hard finishing with FDAC had lots of emotions like the beginning was scared but so happy I had my little girl. When I graduated that was the end. I would have still liked a little contact with FDAC as it was the first time I was totally on my own. The Picnics helped as I could continue some contact with FDAC again which was nice. I would have liked to have a winding down period after graduating.

I now have a great relationship with my family and my older sister has my daughter for the odd weekend to help me we also go there every Sunday for dinner. I've

been clean for nearly 3 years, I am more relaxed and confident as a mum. I find being a mum a lot more enjoyable and my daughter and I have a very close relationship which is very important to me.

My daughter is happy and sociable, I can now see a positive future thanks to FDAC. I don't dwell on things that don't work out anymore. I still have good days and bad days but have learnt how to cope with it rather than turning to a drink and I'm not scared of my emotions anymore.

I wanted to be a parent mentor, to provide parents with a positive experience of the FDAC process. Help parents make a better life for their children and themselves. I know how hard it can be at times but FDAC really works. I would also like to give something back for all the help that was given to me. I just hope my daughter will look up to me and be proud of me and that my mum and dad can now look down on me proudly.

Conclusion

In a very exciting development in March 2013, The Department for Education released a tender for the development of FDAC nationally along four main guiding themes:

- Meeting the 26-week time limit as described in the Children's Bill before Parliament.
- Support to FDAC projects outside London.
- Identification of the wider use of the FDAC model (e.g. in domestic violence and parental mental health).
- Exploration of the use of multi-disciplinary team assessments.

As this article was being written, the Tavistock & Portman NHS Foundation Trust and Coram, together with a panel of expert associate advisers, have been awarded this contract over the next 2 years and will be developing the FDAC model outside of London.

In conclusion, we can see that the FDAC model is a very different way to approach social work with these highly complex and chaotic families. We continue to adapt and change the model with our partners and commissioners in order to apply the learning during the first 5 years. It would be right to say that the work of the FDAC is both extremely difficult and highly rewarding and it is a remarkably rich and powerful learning environment in which to be a social worker, wrestling to repair the social link. At times, the work can provoke pessimistic feelings in the team about the concept of change and what is possible, and we have had to work with the pain and consequences of several of our clients dying. We are modestly realistic in what we think we are capable of achieving in difficult circumstances, optimistic in our encouraging support to help our clients change chronic patterns of self-defeating behaviour, and committed to the principle of minimising damage to the children in these families. We have still much to learn, the independent research into FDAC's effectiveness is ongoing, but we are confident that FDAC is a more progressive, transparent, efficient and humane process than standard care proceedings, and we are hopeful that its development can be protected in austere times.

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