Department for Education

Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence

Research report

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Contents

Contents 2

Table of Figures 8

Table of Tables 9

Acknowledgments 10

Note on Terminology 10

Executive Summary 11

Introduction 11

Key findings 11

Background 13

Aim 13

Methodology 14

Findings 14

The impact of risk and protective factors on parenting capability and capacity to change 14

The potential impact on children of abuse and neglect 15

Informing structured professional judgments using standardised measures 15

Useful conceptual models to facilitate analysis and case conceptualisation 16

Elements requiring consideration within the change process: resistance, motivation, engagement and relapse 17

Understanding effective interventions – parenting skills, specific and multifaceted interventions 18

The timing of the change process 19

The implications for social work practice 20

Conclusion 21

Chapter One: Introduction and methodology 22

Introduction 22
Children and Families Act 2014 and revised Public Law Outline 22
Assessing parental capacity to change within a wider context 24
Societal factors and their influence on parenting 24
Interplay of factors 24
Social work assessments in the real world 25
Availability and interpretation of information 26
Factors that skew the decision-making process 27
Checks and balances 29
Purpose of this literature review 32
Methodology 32
Conclusion 34
Key points from Chapter One 35
Chapter Two: Risks of Future Harm 36
Introduction 36
Factors which undermine parenting capability 37
Parents' problems 37
Impact of combinations of problems 39
Environmental factors and their impact 39
Parenting children with additional needs 40
Recurrent abuse 40
Protective factors 41
The impact of abuse and neglect on children's subsequent development 44
Attachment styles and their impact 44
The impact of abuse and neglect as children grow 45

Identifying children suffering, or likely to suffer significant harm 49
Tools to assess risk of significant harm 50
Conclusion 52
Key points from Chapter Two 52
Chapter Three: Models of change: their strengths and weaknesses 54
Introduction 54
Case conceptualisation 54
Parents' attachment styles and their implications 55
Models of change 56
The Trans-Theoretical Model of Change (TTM) 56
Adaptations to the Trans-Theoretical Model and alternative models 61
A procedure for assessing parents' capacity to change (Harnett 2007) 62
Conclusion 66
Key points from Chapter Three 66
Chapter Four: Ambivalence, denial and unwillingness to change 68
Introduction 68
How common is denial or unwillingness to change? 68
Disguised compliance, failure to cooperate, and unwillingness to change 69
Factors underlying unwillingness to change 70
Internal factors 71
External factors 73
Support from other agencies 74
Motivational Interviewing: strengths and weaknesses 75
The Family Partnership (FP) Model 77
Family Group Decision-Making 78

Engagement and satisfaction 79
Children's participation and outcomes 80
Engagement of professionals 81
When parents cannot change within a child's timeframe 82
Conclusion 82
Key points from Chapter Four 83
Chapter Five: Motivation and engagement 84
Introduction 84
Motivation: the decisional balance 84
Turning points 86
Engagement 94
Models of engagement 95
Conclusion 98
Key points from Chapter Five 98
Chapter Six: Building Parenting Capability through Evidence-based Interventions 100
Introduction 100
Understanding effective services and interventions 101
General principles concerning evidence of effectiveness 101
Understanding effective social work 104
Barriers to effective social work 105
Intensive Family Preservation Services (IFPS) 106
Outcomes of care 108
Outcomes of kinship care 109
Outcomes of adoption 110
Returning home from care 111

Specific interventions to support parents and children 111

Targeted preventive programmes 112

Specific programmes to address abusive parenting and prevent impairment 113

Specific interventions to address parental problems that increase the risk of maltreatment 116

Intensive, multi-faceted interventions for families with complex needs 121

Conclusion 124

Key points from Chapter Six 124

Chapter Seven: Relapse and the maintenance of change 126

Introduction 126

The impact of different types of problem on sustained change 127

How long is needed to establish whether parents will successfully maintain change?127

The process of recovery and relapse 128

Virtuous circles 129

Factors supporting or undermining the maintenance of change 129

Examples of factors supporting change 130

Examples of factors undermining change 131

The role of parenthood in supporting and undermining change 132

Relapse and harm to the child 133

Conclusion 134

Key points from Chapter Seven 134

Chapter Eight: Conclusion: Making use of the research findings to inform professional practice and assessments required by the courts 136

Introduction 136

Assessment of parents' capacity to meet needs (parenting capability) 137

Assessments of children's needs 138

Assessing the likelihood of significant harm 139

Analysis of why there might be a gap between parental capability and the child's needs139

Case conceptualisation 139

Gaps between parenting capability and children's needs 140

Implications for day to day practice 140

Court requirements and implications for social work practice 140

Understanding the process of change 141

Relationships between social workers and parents 143

Relationships with other professionals 144

Assessing parents' capacity to change within a child's timeframe 145

Implications for continuing professional development 147

Conclusion 148

Key Points from Chapter Eight 148

Appendices 150

Appendix One: search terms 150

Table 1: search terms 151

Appendix Two: scientific advisory group and steering group members 154

References 155

List of Cases 192

Table of Figures

Figure 1.1: The Assessment Framework 25

Figure 5.1: An Integrated Model of Parental Engagement with Child Welfare Services 97

Table of Tables

Table 2.1: Factors associated with future harm 42

Table 2.2: Impact of abuse and neglect during key developmental timeframes for children47

Table 6.1: Hierarchy of levels of evidence 103

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Note on Terminology

‘Parenting capacity‘ is a phrase deriving from the Children Act 1989 (s.1.3), that refers to the question of whether or not parents are capable of meeting their children’s needs (Department of Health, 1989). ‘Parental capacity to (or for) change’ is the established terminology for describing parents’ willingness and ability to overcome risk factors such as alcoholism and domestic abuse that increase the likelihood of abuse and neglect and improve their parenting practices. The two phrases can be confused with one another. There is movement to replace the term ‘parenting capacity’ with ‘parenting capability’ to avoid such confusion (see Department for Education, 2014a), and for this reason we have used this new terminology in this report.

Some of the issues covered by this report are difficult to express without appearing to denigrate already vulnerable population groups. Throughout, we have been mindful of the need to use non-discriminatory language; terms that we have used, such as ‘denial’, ‘resistant to change’ or ‘perpetrators of abuse’ are modelled on language commonly used in practice. They may differ from the terms used in other arenas such as within organisations supporting service users or promoting policy issues.

Executive Summary

Introduction

Assessing Parental Capacity to Change when Children are on the Edge of Care is an overview of current research evidence, bringing together some of the key research messages concerning factors which promote or inhibit parental capacity to change in families where there are significant child protection concerns. It is intended to serve as a reference resource for social workers in their work to support families where children's safety and developmental functioning are at risk. Its purpose is also to assist social workers and children's guardians in delivering more focused and robust assessments of parenting capability and parental capacity to change, and assist judges and other legal professionals in evaluating the quality of assessment work in court proceedings. The report brings together research findings from a wide range of disciplines, which are not otherwise readily available in one location for social workers, family justice professionals and other practitioners with safeguarding responsibilities.

The research evidence covered in this report confirms that change is both important and necessary when children are suffering abuse and neglect. However it also makes it clear that change is difficult for everyone, but even harder for those parents who are struggling with an interlocking web of problems. It also takes time. Change is a complex process, and although it can be supported and promoted through effective interagency interventions, it cannot be imposed. It will not happen unless parents are proactively engaged. These are the key messages from the review.

Key findings

- An extensive body of evidence shows how factors such as domestic abuse, substance misuse, mental health problems and learning disability undermine parenting capability and increase the likelihood of significant harm, particularly when they occur in combination. Moreover, parenting does not take place in isolation. Parents are also influenced by stressors within the wider environment and family, such as poor housing, poverty and unemployment that make parenting more challenging and increase the likelihood that difficulties will arise.
- There is an extensive and growing evidence base showing how the experience of abuse and neglect may have a long-term, negative impact on children's physical, cognitive, social, emotional and behavioural development that can last throughout the life course.
- The reliability of practitioners' judgments concerning the risks of significant harm could be improved. Judgments based on experience and intuitive thinking should be supported, but not replaced, by information collected through evidence-based tools and standardised measures to inform structured professional decision-making. However, it is important that all tools and measures selected are

validated within a UK context for use with families with complex problems and needs.

- In order to carry out an accurate analysis when assessing parenting capability and capacity to change, social workers need to formulate a case conceptualisation, setting out the various internal and external factors that influence parents' ability to meet their children's needs. Conceptual models are necessary to provide social workers with a framework to analyse the circumstances of each case and assess the likelihood of change.
- The assessment of parenting capability and capacity to change needs to reflect the complex reality of child protection cases, including consideration of the individual challenges and wider environmental problems faced by families; how multiple problems interlock; and the potential impact of factors such as coercion or the pressure on parents to present themselves in a positive light.
- Assessment of parental capacity to change should be undertaken as a dynamic process in which strengths and weaknesses are identified, targets set and agreed, effective interventions identified and implemented and progress monitored over a specific time period.
- The process of behaviour change is well-established, incorporating a number of common elements including resistance, ambivalence, motivation, engagement and action. Lapse or relapse is also viewed as an integral part of the change process.
- False compliance, failure to cooperate and denial are common features of parents involved in the child protection process. Apparent resistance may be the result of fear, stigma, shame, ambivalence, or a parent's lack of confidence in their ability to change. Parents may be resistant to the involvement of social workers rather than resistant to change in itself, particularly where they feel social workers are exercising power *over them* instead of *with them* in a supportive manner. However parental resistance is not necessarily indicative of a lack of skilled social work.
- The Family Partnership Model (FP), Motivational Interviewing (MI) and Family Group Decision-Making (FGDM) offer potential methods of engaging parents who are ambivalent about change, mistrustful of social workers, or not fully ready for change. Such methods can empower parents by giving them an element of control. FGDM also enables families to participate in the decision-making process.
- Social workers need to be mindful that parents may turn to other professionals, who are seen as less threatening, or whose involvement attracts less stigma. This is a strong reason for social workers to develop good inter-agency links with other professionals such as health visitors and practitioners in adult services to maximise engagement with parents.
- Some interventions are effective and others can be harmful. It is important to understand how to interpret evidence of effectiveness, not all of which is of the same quality.

- An increasing range of effective intensive interventions aimed at improving parenting skills or addressing other specific problems, for instance, drug or alcohol misuse, can complement social work support to a family.
- Interventions designed to increase parenting skills can be effective and can have a positive knock on impact, reducing other parental problems by increasing self-efficacy and self-esteem. However, in cases where parents are facing complex, multi-layered problems, an integrated package of support may be required, tailored to meet the needs of each member of the family.
- Many standardised measures and intensive programmes are still relatively new. They may well prove to be effective but many have not yet been adequately validated in the UK and are not available in all areas of the country.
- Finally, interventions take time and change may not always be possible within the child's timeframe, particularly where children are very young or vulnerable, entrenched parental behaviour patterns need to be addressed, progress is slow and relapse is frequent.

Background

When there are serious child protection concerns and children are on the edge of care, the most difficult decisions facing social workers concern the capacity of parents to change. Social workers need to be able to make informed decisions about which parents are unable to meet their children's needs and why, what aspects of parents' behaviour need to change and whether parents have the capacity to make such changes within a timeframe that is appropriate for the child. Decisions will be informed by the social worker's understanding of the likely impact of continuing abuse and neglect on children's life chances and by their assessments of parents' motivation and ability to make and sustain changes to behaviour patterns that compromise their children's development. Parenting does not take place in isolation: social workers must also consider the specific needs of the child about whom there are concerns, and take wider environmental factors such as poverty and inadequate housing into account when making their assessments. They also need to consider the availability and effectiveness of interventions designed to support parents through the change process.

Aim

The aim of the overview is to:

- serve as a reference resource to social workers in their work to support families where children's safety and developmental functioning are at risk; and
- assist social workers and children's guardians in delivering focussed and robust assessments of parenting capability and parental capacity to change and assist judges and other legal professionals in evaluating the quality of assessment work in court proceedings.

Methodology

The methodology employed in this review incorporated a search of the peer reviewed literature supported by expert advice. The findings of the literature search were reviewed by a scientific advisory group made up of academics specialising in areas relevant to parental capacity to change, who also advised on specific issues. The content of the draft report was reviewed by the scientific advisers and by members of a steering group consisting of academics and professionals also working in related fields. The overview is not the report of a systematic review, but of an extensive narrative literature review that draws together information from a wide range of sources.

Findings

The impact of risk and protective factors on parenting capability and capacity to change

There is an extensive body of evidence that shows how parental problems such as domestic abuse, substance misuse, mental health problems and learning disability can undermine parenting capability and increase the likelihood of significant harm to children. Parents' unacknowledged experiences of abuse in their own childhoods can also increase the risk that children will be exposed to maltreatment. However, experiencing any one of these problems does not preclude loving and effective parenting. The research suggests that it is where multiple problems interlock and interact that there is a substantially increased risk that children will be exposed to maltreatment and suffer significant harm.

Parents' problems may reduce parental capability in a number of ways: for instance, parents with substance misuse or alcohol problems may use their resources to fund their addiction and have little left over to feed, clothe and house their children; they may also be too preoccupied with their addiction and too much under its influence to be aware that their children's basic needs are not being met (Fraser *et al*., 2009). Domestic abuse may directly expose children to physical danger and also have a negative impact on their sense of safety and security (Buckley *et al*., 2007). Impaired personality functioning and some mental health problems such as anxiety disorders, depression and some psychotic illnesses may reduce parents' ability to be reciprocal, involved and encouraging with their children and offer them sufficient emotional warmth (Kohl *et al*., 2011; Mowbray *et al*., 2002). Substance misuse and domestic abuse, as well as depression, may engender apathy and listlessness and reduce parents' ability to stimulate their children; such problems are also associated with low self-esteem and unpredictable, inconsistent and ineffective parenting behaviours, reducing parents' ability to provide authoritative guidance and set boundaries. Moreover these parental problems are also all associated with frequent changes of partner and living arrangements, reducing a parent's ability to offer children stability and security. It is also clear that parental problems do not occur in isolation: they are influenced by stressors within the wider environment and family, such

as poor housing, poverty and unemployment that magnify the challenges to parenting and increase the likelihood that problems will arise.

Caring for a child with additional needs can increase parents' stress levels and escalate other problems (Baker *et al.,* 2003). Children with disabilities and health care needs, and younger children are all more likely than others to experience abuse and neglect.

Once abuse has occurred there is a strong possibility of recurrence: 14.7% of children experience further maltreatment within six months of the first episode; 22.6% within eighteen months (Fluke *et al.,* 1999). Factors which have been shown to reduce the likelihood of significant harm include the presence in the household of a non-abusive partner; parents' recognition of their problems and willingness to take responsibility; their engagement with services; and their empathy for the child (see Hindley, Ramchandani and Jones, 2006).

The potential impact on children of abuse and neglect

There is a growing body of research evidence from a wide range of disciplines showing that abuse and neglect are likely to have long-term adverse consequences across children's physical, cognitive, social, emotional and behavioural development (see for instance Norman *et al.,* 2012). Maltreatment has a negative impact at all ages, but is thought to be particularly pernicious in the early years because of the impact on the child's neurobiological development and the attachment process (see for instance Howe, 2006; McCrory, De Brito and Viding, 2012). The negative impact of abuse and neglect has also been shown to continue throughout childhood and adolescence, and into adulthood (see for instance Romer, 2010; Springer *et al.,* 2007). A number of protective factors within the child, the family and the environment may mitigate the impact of abuse and neglect; however the longer maltreatment persists and the more intensive it is, the harder it will be to overcome the consequences (Rutter *et al.,* 2007). Change is therefore necessary in families where abuse and neglect are evident.

Informing structured professional judgments using standardised measures

When social workers assess the risk of harm to children, research evidence suggests that the reliability of professional judgment alone could be improved (Munro, 1999). There is increasing recognition of the need for 'structured professional decision-making' which utilises data collected through evidence-based tools in addition, but not instead of, judgments that can be over-reliant on social workers' intuition and experience (Barlow, Fisher and Jones, 2012). A number of standardised measures have consequently been developed to support professional decision-making in this area. Barlow, Fisher and Jones (2012) undertook a systematic review of tools available to social workers to assist them in deciding whether a child is suffering, or likely to suffer, significant harm. Although the review highlights the need for further piloting and validating of tools within a UK setting,

such tools have the potential to provide practitioners with standardised measures that can support the development of structured professional judgment.

Useful conceptual models to facilitate analysis and case conceptualisation

A number of conceptual models can provide social workers with a useful framework for analysing a family's circumstances and the factors influencing parents' capacity to change in order to develop a case conceptualisation. This is a necessary element in the process of identifying what needs to change and formulating appropriate plans. The different domains of the Assessment Triangle (HM Government, 2013) provide a conceptual map that helps practitioners analyse the strengths and weaknesses in a family and their environment and identify the issues that need to be addressed.

In families where parents' poor personality functioning is an issue, social workers will also need a conceptual framework of the elements of mature adult functioning that can offer secure and responsive parenting. They will also need to be mindful that parents' attachment styles may reflect early childhood trauma and may present an obstacle in assessing and working with families.

A number of conceptual models have been developed to facilitate understanding of behavioural change, the most prominent of these being Prochaska and DiClemente's Trans-Theoretical Model of Change (TTM), incorporating the stages of change (SOC) (see for instance DiClemente and Prochaska, 1982; Prochaska and Prochaska, 2002). TTM incorporates six stages of change: *pre-contemplation, contemplation, preparation, action, maintenance and relapse.* Change is conceptualised as a spiral pattern where people can progress through the stages, but are likely to encounter relapses in which they will regress to an earlier position. The model was originally developed to understand smoking cessation, but has been used more widely including in a child welfare context. However, while it is useful for social workers to have an understanding of the key concepts of the model, they also need to be aware of a number of concerns that have been raised about its applicability to child welfare cases, and about the predictive validity of some of the accompanying materials.

Harnett (2007) offers an example of an alternative model for understanding parents' capacity to change. Rather than relying solely upon a cross-sectional assessment, Harnett's model incorporates assessments of parents' and children's current functioning; specification of targets for change derived from an assessment of current strengths and deficits in the family; implementation of an intervention with proven efficacy for the client group with a focus on achieving clearly specified targets; and objective assessment of measurement of changes in parenting.

Elements requiring consideration within the change process: resistance, motivation, engagement and relapse

The research evidence highlights how social workers need to understand the various elements within the change process, in order to be able to identify where and why parents may face particular obstacles or have certain reactions at different points in time. Real change cannot be imposed on parents, so this understanding will help social workers to support parents and find ways of moving forward. Examples of the elements of the change process that social workers need to understand include unwillingness, ambivalence, motivation, engagement and relapse.

Parents with learning disabilities and/or mental health problems including impaired personality functioning may not understand the impact of neglectful or abusive behaviour on children's welfare. However parents may also deny that there is a problem and appear unwilling to change. Such apparent 'resistance to change' can reflect internal factors such as shame, ambivalence about the need to change, and parents' lack of confidence in their capacity to change. The context of child protection work is in itself likely to create resistance, which may be a response to social worker involvement in the family rather than to change itself (Forrester *et al*., 2012). Social workers need to be aware of their own role in exacerbating or reducing resistance, particularly through the way in which they approach parents. Confrontational styles and the heavy handed use of authority can lead to both parent and social worker focusing on a power struggle rather than the issues to be addressed (Dumbrill, 2006).

The Family Partnership Model attempts to address the difficulties that practitioners encounter in developing relationships under adverse circumstances, such as when parents are hostile or frightened that their children might be removed. The model was developed to 'provide practitioners working with families with an explicit and detailed understanding of the dynamic processes of helping' (Harnett and Day, 2008, p.81). Research evidence also points to the use of Motivational Interviewing to reduce unnecessary confrontation and help parents move on from a position where they deny that a problem exists and are unwilling to change or engage with services (see Bowen and Gilchrist, 2004; Forrester *et al*., 2012).

There is considerable evidence to suggest that approaches such as Family Group Decision-Making (FGDM) involving parents and their wider extended family in the decision-making processes can decrease parental resistance to involvement with social workers by reducing their feelings of powerlessness within the context of statutory interventions and court proceedings. Although there is good evidence that FGDM is viewed positively, further research is required with regard to the implementation of plans and outcomes for the children concerned (Barnsdale and Walker, 2007).

Parents become motivated to change for a number of reasons, many of which are unclear. However it does appear that motivation begins when the perceived advantages of changing the *status quo* outweigh the perceived disadvantages, thereby tipping the

‘decisional balance’ (Prochaska *et al.*, 1994). Events or changes in circumstances such as pregnancy or referral to children’s social services can also create turning points in parents’ lives that motivate them to make the changes needed to overcome adverse behaviour patterns and improve their parenting. Turning points should be viewed by social workers as opportunities to engage with parents and offer appropriate ongoing support.

Children’s views of the situation can also act as a powerful cue for action (Hahn *et al*., 1996; Stanley *et al.,* 2012a). On the other hand, coercion can push parents who were previously ambivalent about the *need* for change into action, while those who are doubtful of their *capacity* to change may become further entrenched in adverse behaviours. It is also possible that parents facing multiple problems may become motivated to change in one area, but may not necessarily appreciate the need for change in others (see DiClemente *et al*., 2008).

Despite being motivated, there is no guarantee that parents who are ready to engage with services will succeed in making changes. There are a number of interlocking factors, including internal and external determinants and background issues which influence parental engagement. Using a theoretical model such as Platt’s (2012) Integrated Model of Parental Engagement to explore the different factors that promote or inhibit parental engagement with child welfare services can facilitate a greater understanding of the issues that need to be addressed.

Lapse or relapse forms a natural part of the change and recovery process and should therefore be expected. Recovery from problems such as substance misuse is a gradual process and can extend over a period of years rather than being a time limited event. Parents’ ability to sustain change in the long term will be affected by the type and number of difficulties they are trying to overcome, and whether these can be fully addressed or only controlled and alleviated. Sustained change will be supported by factors such as demography; self-efficacy; having a ‘normal’ role in society; having a positive support network; and appropriate ongoing support from professionals. Equally sustained change can be undermined, for instance, by stress, negative emotions, the co-existence of problems, isolation, inadequate support networks and poverty.

Understanding effective interventions – parenting skills, specific and multifaceted interventions

Being able to identify appropriate and effective interventions that can complement social work support is fundamental to supporting parents in changing their behaviours. In order to do this, social workers need to understand how different interventions operate and how their reported impact should be interpreted and understood. The quality and rigour of the evaluation process are important factors to consider in assessing the effectiveness of interventions. Ineffective interventions may not only fail to ensure that children are safe, they may also fail to offer parents adequate support in overcoming destructive behaviour

patterns and demonstrating capacity to change. Moreover some interventions are worse than ineffective in that they have been shown to be harmful (see Jarrett, 2008; Lilienfeld, 2007; Rhule, 2005). Interventions which may be effective in facilitating capacity to change include those designed to improve parenting skills and/or address specific problems such as substance misuse, domestic abuse or impaired personality functioning. However a multi-faceted approach that integrates a range of services for the whole family may prove to be a more effective means of increasing parental capability when parents are facing a complex web of long-term problems which are already impacting on parent-child relationships and children's development. The availability of specific, intensive interventions will vary across the country and provision will be delivered by professionals from a range of agencies, requiring close inter-agency working.

The timing of the change process

No one can predict how long it will take for abusive or neglectful parents to develop sufficient capacity to meet their children's needs. It is, however, evident that this is unlikely to happen overnight, that the process of change may be lengthy and that setbacks are common. We do not know how long it takes for parents with multiple interlocking problems to accept the need for change and to engage with services. However, once they become engaged, intensive interventions to address specific problems take several weeks to deliver, and are often followed by a further period of follow up. Relapse is also particularly common within the first six months of entering treatment. Detailed and dynamic assessment procedures, supported by standardised measures and clear conceptual models will provide social workers with the best indication of the rate at which parents are likely to make changes.

In some cases, an assessment of parenting capability and parents' capacity to change will lead professionals to conclude that sufficient change to reduce the likelihood of significant harm is not possible within the timeframe of the individual child and that a permanent placement away from home will best meet their needs. Of particular concern should be children living in homes where the following factors are present: extreme domestic abuse where the perpetrator shows a pervasive pattern of disregard for and violation of the rights of others (Gondolf, 2002; Scott, 2004); there is both substance misuse and domestic abuse and violence in the home Forrester and Harwin, 2008); children are not protected from perpetrators of sexual abuse; and/or where parents consciously and systematically cover up deliberate maltreatment (Brandon *et al.*, 2008). Maltreated children tend to do better in kinship or foster care or placed for adoption than those who remain with or return to abusive or neglectful birth parents (Biehal, 2010; Wade *et al.,* 2011; Farmer and Lutman, 2012).

The implications for social work practice

The messages from the literature review have clear implications for practitioners' assessments for the courts and for every day social work practice.

The findings have particular relevance for assessments of children's needs, assessments of parental capacity (or capability) and the analysis of why there might be a gap between parental capability and children's needs, all required by the courts. Such assessments should inform decisions to initiate proceedings, decisions in proceedings, and be an integral part of day to day social work with parents whose children are on the edge of care. The process of assessment should be dynamic rather than static, for the findings should form the basis for understanding the strengths and weaknesses in the family, agreeing what needs to change and setting goals and timescales.

Relationships matter in everyday social work practice. Many parents will not develop sufficient capability to meet their children's needs without support. If social workers can establish a good working relationship with parents characterised by honesty about what needs to change and why, sensitivity and a willingness to listen to parents' points of view, respectful uncertainty in the face of dissimulation and supportive use of power, they may be better able to help parents become motivated and engage with services (Forrester *et al*., 2008a ; Dumbrill, 2006; Laming, 2003). This relationship needs to continue after completion of an intervention to ensure that parents are provided with appropriate ongoing support to avoid unnecessary episodes of relapse into old behaviour patterns.

Good working relationships with professionals from other agencies are also of fundamental importance. Where parents are trying to overcome complex and entrenched problems, social work support needs to be complemented by other, more specific interventions, delivered by professionals from a wide range of agencies. Tensions between adult and children's services often exist, particularly when one professional focusses on the parent's needs and another on those of the child. It is important to resolve such tensions (Tompsett *et al.*, 2009; Ward, Brown and Westlake, 2012).

Once the risk of harm has been identified, social workers need to manage cases proactively to minimise the potential impacts of abuse and neglect (see Farmer and Lutman, 2012). Proactive case management needs to include early agreement about the goals to be met and the provision of effective services that will support parents in meeting them. What we know about likely timescales for overcoming destructive behaviour patterns and improving parenting capability makes it clear that this work needs to begin as early as possible after the risk of harm is identified in order to ensure that parents have the best opportunities to make necessary changes within a child's timeframe.

Conclusion

The overview of the literature highlights the complexity involved in assessing whether parents have the capacity to change within a child's timeframe. Many of the issues it raises will already be familiar to social workers and other practitioners. The review should strengthen practitioners' understanding of parental capacity to change by bringing together empirical evidence from a wide range of sources, highlighting what research tells us about the process of change and by introducing theoretical models available to social workers to underpin the assessment and decision-making process.

Chapter One: Introduction and methodology

Introduction

In families where there are significant child protection issues, well-informed social work assessments concerning the ability of parents to keep their children safe and meet their developmental needs are essential to making appropriate decisions about whether children can be safely supported at home; whether they should be looked after by the local authority while parents increase their ability to respond to their needs; or whether they should be permanently placed away from home.

High levels of uncertainty and anxiety run through decision-making when there are significant child protection concerns. A better understanding of the lived experience of parents whose children are on the edge of care, together with knowledge of those external and internal factors that influence and inhibit parental change, will help social workers provide more focussed support for families to assist them to meet the needs of their children. Where children cannot safely remain at home, accurate and relevant evidence presented to the courts will help to reduce the need for additional assessments of parenting capability and capacity to change and avoid unnecessary delays in reaching decisions concerning permanence.

Judgments about parents' ability to meet their children's needs, which are based on assessments made at one point in time, are often prone to error. In contrast, an assessment of parental capacity to change within a timescale that is appropriate for the child, based on a systematic evaluation of the extent to which parents are overcoming problems and becoming more able to meet children's needs, with the support of evidence-based practice, provides the clearest evidence for decision-making by social work practitioners and by the courts. This paper brings together the research evidence that can inform such assessments.

Children and Families Act 2014 and revised Public Law Outline

New provisions introduced by the Children and Families Act 2014 have led to a renewed focus on social work assessments. The Act provides the legislative structure for introducing recommendations made by the *Family Justice Review* (Ministry of Justice, 2011), and is supported by a revised Public Law Outline (PLO) (Ministry of Justice, 2014) and updated guidance for local authorities on court orders and pre-proceedings (Department for Education 2014a).

The new measures include the introduction of a 26 week time limit for completing care and supervision proceedings. The strict new timeframe is intended to reduce delays in court proceedings, which have increased in length substantially over the last 15 years.

The new PLO has been piloted in order to assess the use of new practices and procedures to secure case resolution within this timeframe and ensure that proceedings are concluded justly and swiftly. One implication is that there will be a greater onus on local authorities to provide the court with evidence not only that the threshold is met but of a thorough assessment of the child's needs and the available options for meeting them so that the court can make decisions without seeking further expert assessment. There are concerns that this may simply lead to additional delays before taking legal action (McKeigue and Beckett, 2010; see also Masson and Dickens, 2013); in order to counteract this, it is therefore essential that at the outset thorough assessments are made, appropriate timescales for the child are identified and within these, goals are set and progress monitored.

A key focus of the PLO is an expectation that local authorities will submit less extensive but more analytical material to the courts on application than has been the case in the past. Such material must analyse all realistic options for the child, stating why a particular course is being recommended and the others discounted. The President of the Family Court has specifically confirmed that the new evidential requirements should not detract from local authorities' ability to meet the 26 week timeframe (see *Re B-S*, 2013). Social workers have a key role in achieving timely outcomes to care proceedings (see CAFCASS/ADCS undated).

Section 13 of the Children and Families Act 2014 also introduced measures to control the use of expert evidence and assessments in family proceedings concerning children by ensuring that these are permitted only when necessary to resolve a case justly. This is in response to research evidence that indicates that the indiscriminate use of expert witnesses and the commissioning of repeated assessments have played a major role in extending the length of court proceedings (Masson *et al.*, 2008; Ofsted, 2012; Ward, Brown and Westlake, 2012). An intended consequence of these measures is to re-position social work as a trusted profession that has a central role in care proceedings. The President of the Family Court believes that social workers have been overshadowed by the use and reliance upon other experts in the past.

> Social workers are experts. In just the same way, I might add, CAFCASS officers are experts. In every case we have at least two experts – a social worker and a guardian – yet we have grown up with a culture of believing that they are not really experts and we therefore need experts with a capital E. The plain fact is that much of the time we do not (*View [2]* Sir James Munby 2013a, pp.7-8).

However, in order to provide evidence of the quality required by the courts, social workers need high quality supervision and support from managers in the local authority responsible for bringing the case (see Department for Education, 2011), and expertise in a number of areas. Among the core skills are: 'a strong grounding in child development and the impact of parental difficulties on that development; an understanding of effective, evidence-based interventions and how they can be used with families, with progress

effectively monitored and recorded; assessment and analytical skills' (CAFCASS/ADCS, undated, p.4). A key element of assessment is to undertake an 'analysis of the parenting capacity gap, with the reasons for professional pessimism if the judgment is that the gap either cannot be bridged at all, or cannot be bridged in the child's timescale' (CAFCASS/ADCS, undated, p.2).

This report is intended to provide a summary of the research evidence that can be drawn upon in making such assessments. It provides information that can underpin the assessment of parents' ability to meet children's needs, facilitate the analysis of the parenting capability gap and support those who are responsible for making judgments concerning the extent to which it has been bridged (or is likely to be bridged) within a child's timescale (see Brown and Ward, 2012).

Assessing parental capacity to change within a wider context

This review focuses on research evidence concerning parental capacity to change when children are on the edge of care. It explores how parents whose children may be placed away from home because of serious child protection concerns can be helped to become ready, willing and able to make sufficient changes to ensure that they are adequately safeguarded from harm. However it is important to note at the outset that parenting does not take place within a vacuum, and that the capacity of parents to overcome those problems that place their children at risk of significant harm is influenced both by internal factors within themselves and external factors within their families, social networks and the wider environment.

Societal factors and their influence on parenting

The functioning of individual parents is influenced by broader societal factors that are associated with neglect and abuse. It is beyond the scope of this report to explore these factors in any detail, but there is substantial evidence that social and economic inequalities, the impoverishment of communities, low pay and casualization of labour and widespread poverty and debt increase the stressors in families and communities and provide a context in which children are less likely to be safeguarded (see Jack and Jordan, 1999; Jack and Gill, 2003; Jack and Gill, 2010; Wilkinson and Pickett, 2010). This is one reason why indications of increasing inequality and widespread poverty should be viewed with concern and action should be taken to reduce them (see Brewer, Browne and Joyce, 2011; MacInnes *et al*., 2013).

Interplay of factors

The interplay of factors which influence parents' ability to protect their children from harm and to develop the capacity to overcome abusive or neglectful behaviour patterns is acknowledged in the statutory guidance on interagency working to safeguard and promote the welfare of children. *Working Together to Safeguard Children* (HM

Government, 2013) has been radically revised following the recommendations of the *Munro Review on Child Protection* (Department for Education, 2011). However the revised version continues to ascertain that good assessments are those which take a systematic approach to enquiries, using an ecological model as set out in the *Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Home Office, 2000). In considering what action to take, practitioners should investigate the interaction of factors within the following three domains:

- the child's developmental needs, including whether they are suffering or likely to suffer significant harm;
- parents' or carers' capacity (or capability) to respond to those needs; and
- the impact and influence of wider family, community and environmental circumstances (HM Government, 2013, p.19)

The different dimensions for consideration within each of these domains are set out in the Assessment Framework diagram (Figure 1.1), and are referred to in subsequent chapters of this report.

Figure 1.1: The Assessment Framework

(Reproduced from HM Government , 2013, p.20)

Social work assessments in the real world

While a theoretical model of decision-making assumes that practitioners will work with parents and other professionals to access information across these domains, analyse it and make rational decisions concerning the most appropriate and cost-effective plan to ensure that children's needs are met, the reality is rather different, for social workers are faced with often chaotic human situations that do not fit neatly into a carefully constructed

paradigm. Information is rarely complete, and can be interpreted differently by each of those involved; there is often little time available for thoughtful analysis; and plans are constrained by the availability of resources. There is also considerable evidence that professional assessments and judgments in social work and other disciplines are influenced not only by the availability of information and resources, but also by a wide range of philosophical, psychological and organisational factors that have a powerful impact on decision making.

Availability and interpretation of information

Studies of social work practice show that, following referral, a substantial amount of time is taken up with collating information from a wide variety of formal and informal sources (Kirkman and Melrose, 2014). Much of the information from professionals is incomplete: practitioners will have focussed on different aspects of a situation and been involved at different time points, and memories and records are not always reliable. Information collected from different sources may not be adequately collated, and there may be errors in communication (Munro, 1999). All of these issues underline the importance of close cooperation between agencies. However, even when inter-agency working is strong, when decisions have to be made within a specific deadline, there may be insufficient time to gather comprehensive information. Kirkman and Melrose (2014) found, for instance, that in a busy referral team, decisions might be based on photocopied reports from other professionals that had been prepared for a different purpose; in these circumstances salient information was not prominently displayed and could be easily overlooked (p.31).

The available information may also be inaccurate. Munro (1999) points out that:

> There are many reasons why people lie or distort the facts when talking to a social worker. Parents who are actually harming their child have powerful motives for concealing this. Children who are being abused can be scared to say so. Neighbours and relatives can be malicious and exaggerate or falsify what has happened in order to get the family into trouble. Even when not being deliberately dishonest, people tend to be biased in judging what seems significant and worth reporting. Neighbours who dislike a family find it easier to think of examples of their faults than of their virtues (p.752).

This description is supported by data from empirical studies which show that parents do indeed consciously or unconsciously distort or conceal information that might cast themselves in a negative light (see Forrester *et al.,* 2012), and that some professionals in adult services, who are focussed on protecting parents, will occasionally do the same (Ward, Brown and Westlake, 2012).

Not only may the information collected during assessment be incomplete and inaccurate, it is also subject to different interpretations. Professional assessments are informed by the values of an organisation and its practitioners and by the social and political context in which they are working. For instance, practitioners, teams and social work agencies can all hold subtly different positions on the ethics of care and adoption, and the extent to

which they are in tune with the dominant political agenda in this area; these positions will colour their interpretations of information and the decisions they make concerning families (Ward, Brown and Westlake, 2012). Cultural expectations and personal factors may also influence interpretations of some situations, including those involving domestic violence or neglect (see Holland, 2000; Ward, Brown and Westlake, 2012).

Factors that skew the decision-making process

Some commentators argue that, since participants in an assessment may hold competing interpretations of a situation, all based on necessarily partial or biased information, it may be futile to look for any one external reality. Practitioners are dealing with complex, and often chaotic, human situations, where nothing is entirely predictable, and decisions can rarely if ever be based on certainty (see Holland, 1999).

Nevertheless, when children are likely to suffer significant harm, decisions have to be made, and those taken formally by professionals need to be based on the best information available, and to be as objective and fair as possible. Research into social work decision-making has identified a number of factors that introduce bias into assessments and skew the process. These include human behavioural factors that are known to reduce objectivity; tendencies to favour some types of evidence over others; excessive and stressful workloads that leave little room for reflection; limited and diminishing resources that restrict the options for action; and organisational contexts that do not facilitate careful, reflective practice. The impact of all these factors is magnified by the absence of checks and balances that might redress skewed perceptions and a culture that favours intuitive over analytical thinking *(*Munro, 1999; Munro, 2005; Kirkman and Melrose, 2014).

Human behavioural factors

An extensive body of research on human reasoning suggests that there are two types of decision-making – a measured, analytic approach requiring careful analysis of the information available, and faster, intuitive thinking that uses experience and heuristics (short cuts) to reach conclusions (Hammond, 1996; Kahneman, 2011). There is a tendency for social work decisions to rely heavily on intuitive reasoning, partly because this aligns more closely with a practice that focuses on relationships and empathy, and partly because pressures on time and resources leave little room for measured, analytical deliberations (Munro, 1999; Holland, 1999). In fact when most people make decisions they tend to rely on experience and short cuts ‘ rather than face the laborious task of sifting through all the evidence and reaching a rational conclusion’ (Kahneman, Slovic and Tversky, 1990).

However this ‘everyday’ approach is prone to a number of errors. When people rely too much on intuitive thinking they become attached to their initial impression and are slow to revise their judgment even when new and challenging information comes to light (Sutherland, 1992). They tend to base their decisions on the most readily available evidence – for instance events that are most dramatic or recent – rather than exploring

the full range of information available (Tversky and Kahneman, 1973); and they may be guided by their emotions rather than the evidence before them (La France and Hecht, 1995). Group decisions can be dominated by a desire to avoid conflict rather than a determination to establish the basic facts. People who have to make difficult or emotionally charged decisions may cope by postponing them or avoiding making them at all (Anderson, 2003; Redelmeier and Shafir, 1995) (for further information see Munro, 1999; Kirkman and Melrose, 2014).

This body of research undertaken by behavioural psychologists has provided a valuable context for studies of social work decision-making in child protection work. Both Munro (1999) and Kirkman and Melrose (2014) argue that many of the recurrent mistakes in social work decision-making are 'due to the bias introduced by using everyday habits of reasoning in assessing and reviewing cases' (Munro, 1999, p.747). For instance, the tendency to become attached to one's first impression means that some practitioners are reluctant to alter their initial decisions, even after further allegations of maltreatment have been made; this has major implications in serious cases of abuse that are first assessed erroneously as having a low risk of significant harm (see Farmer and Owen, 1995; Munro, 1999). The tendency to base decisions on the most recent or dramatic evidence means that some practitioners do not take sufficient account of the parent's history (see Munro, 1999; Kirkman and Melrose, 2014), although previous maltreatment has been shown to be a powerful indicator of subsequent abuse (see Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press). This has particular implications in cases of neglect where it is the long-term, chronic exposure that places the child at risk of significant harm (Egeland, Stroufe and Erickson, 1983; De Bellis, 2005). Studies of child protection conferences show high levels of consensus, suggesting that 'group think', or the desire to avoid conflict may skew decisions (see Farmer and Owen, 1995). And a number of studies have found that practitioners and their managers frequently postpone or avoid difficult decisions which will have a long-term impact on the lives of vulnerable children and their families (see Kirkman and Melrose, 2014; Ward, Munro and Dearden, 2006; Ward, Brown and Westlake, 2012).

Factors that favour some types of evidence

Studies of social-work decision-making have also identified how some types of evidence are given greater weight than others. The source of the evidence may skew the response it receives. More attention may be paid to concerns made by other professionals than to those made by neighbours and relatives (see Munro, 1999; Kirkman and Melrose, 2014). Children's allegations of abuse do not always raise appropriate concerns. They are sometimes ignored (see Farmer and Lutman, 2012); or their testimony may be accepted if it matches the social worker's assessment, but regarded as unreliable if it is at odds with it (Munro, 1999; see also Holland, 2000).

The type of evidence may also have an undue impact on decisions. Munro (1999) found that less attention is paid to written than to verbal information, a point that was illustrated by Holland (2000), who asked social workers to describe the main factors that influenced

their decisions in assessing parental capability and capacity to change. The core types of evidence cited were:

> parent-related factors, including parenting skills and the relationship between parents; the ability of parents to change their behaviour and lifestyle within an acceptable timescale; and the verbal interactions between the assessing social worker and the parent being assessed' (Holland, 2000, p.152).

However the verbal interaction was frequently given the highest status, and the assessment of practical parenting skills, including emotional engagement with the child, appeared to have had little impact on decision-making.

This is an important point because it indicates how an over-emphasis on intuition and empathy, which lie at the heart of social work practice, can obscure the need for analysis and objectivity in making decisions in highly complex child protection cases. Verbal interactions are inextricably bound up with the relationship between the social worker and the parent. Relationships are thought to be key components of effective social work practice (see Trevithick, 2003; de Boer and Coady, 2007); however if the nature of the relationship is allowed to have an overriding influence on the outcome of the assessment while other information is discounted, decisions then tend to be biased in favour of those parents who are plausible and articulate, and to disfavour those who are uncommunicative or who appear passive (see Holland, 2000).

Excessive workloads and diminishing resources

Research on social work practice in assessment provides graphic data concerning the sheer volume of work with which practitioners and their managers are struggling. Social workers are faced with making innumerable decisions under extreme pressure each day, and many of these are very complex and have far-reaching consequences (Kirkman and Melrose, 2014). Frequent, sequential decision-making is known to lead to depletion of mental resources, and this in itself can lead to poor quality decisions, or to inaction (Danziger *et al.*, 2011). In such circumstances there is often little room for proactive social work or creative thinking (see Farmer and Lutman, 2012).

Moreover, social workers often have very little room for manoeuvre. Decisions can be constrained both by the actions of external bodies such as the police and the stipulations of the local authority concerning, for instance, use of resources and application of thresholds. The latter may be driven by diminishing resources following cuts in local authority spending (see Hastings *et al.*, 2013). Finally, and most importantly, parents and children will have a major influence on professional decision-making. Practitioners' options are constrained if they cannot reach an agreement with parents concerning the severity of a situation or appropriate plans for the future (see Holland, 2000).

Checks and balances

The pressures and constraints detailed above show how difficult it is in the everyday world of social work practice to make objective decisions based on a careful analysis of

all the available information. Nevertheless, a number of checks and balances could be introduced to guard against some of the pitfalls and improve the quality of decisions, particularly in the most complex cases, when children are on the edge of care.

Firstly, children's social work services are often organised in such a way that practitioners receive insufficient feedback concerning the consequences of their decisions. When cases are passed on from one team to another as their complexity becomes more evident, practitioners have little opportunity to find out what happens to the children and families with whom they are concerned. Kirkman and Melrose (2014) advocate the introduction of stronger feedback loops to help practitioners develop the experience that enables them to make more reliable decisions.

Secondly, social work assessments tend to be undertaken as private transactions between practitioners and parents; there need to be opportunities for sharing information and reflective discussion with others in order to identify whether the focus on the relationship is obscuring other indicators that should influence decision-making. Encouraging practitioners to play devil's advocate and present the arguments for an opposing point of view is an effective strategy for helping people to question their first judgments (see Koriat, Lichtenstein and Fischoff, 1980). Offering supportive one-to-one supervision, in which common errors of reasoning are acknowledged and practitioners have opportunities to reflect and identify potential mistakes in a safe environment may also improve decision-making (Munro, 1999, 2012).

Standardised, evidence-based tools

Commentators argue that the insights that come from intuitive reasoning and experience need to be counterbalanced and tested out by an exploration of more objective data (see Munro, 1999; Holland, 1999, 2000). There is therefore a strong case to be made for making greater use of standardised, evidence-based tools to support social work decision-making, and check some of the common errors of human reasoning discussed above. Validated, actuarial scales have been found to be more accurate in predicting behaviour, including the likelihood of future abuse and neglect, than clinical judgment alone (see Shlonsky and Wagner, 2005). Psychometric instruments and scales can also collect empirically valid information concerning, for instance, strengths and difficulties of children's functioning, parenting, and the individual and family environment (see Bentovim and Elliot, 2014).

The reader should be aware that although standardised, evidence-based tools can provide rigorous, valid data to support social work decision-making, there are a number of caveats. The issues are more complex than can be reflected in a numerical score or a simple actuarial table, for the range of external and internal factors interact in complex and fluid ways and the complexity of the interactions and feedback loops creates an often chaotic process of change that confounds accurate predictions of future adult behaviour or harm to a child. Moreover each case will have its own particular circumstances and unique pattern of interaction between risk and protective factors. Estimates of probability concerning *groups* of parents or children can provide a context which practitioners should

take into account, but they cannot predict what will happen to an *individual* child or their parents. Numerical data from inventories and scales can improve understanding but not provide answers to questions concerning whether parents are ready and able to change or whether children are likely to be harmed. Such instruments can inform, but not replace structured professional decision-making.

Understanding evidence based interventions

Finally, Kirkham and Melrose (2014) found that the many psychological and resource factors that can compromise effective decision-making are compounded by social workers' poor grasp of the evidence base relating to effective practice: 'stronger emphasis is placed upon the 'experience' and 'expertise' of an individual , than an understanding of which interventions are likely to have the most positive effect' (p.34). Poor understanding and use of research evidence is identified by many other commentators as an impediment to effective practice (see Munro, 1999). Further information concerning how interventions are evaluated and how to identify 'what works' is given in Chapter Six.

Effective assessments

Intuitive, relationship-based assessments produce valuable hypotheses concerning family situations and the ways in which children might better be protected. However these then need to be rigorously tested out, using a wide range of resources. Children's views should be given due weight as a fundamental element of an assessment. Historical information, written records, observation and scores from validated instruments and scales need to be fully utilised, in order to counterbalance what is learnt from verbal discussions. Assessments of individual children and families should also be informed by a thorough understanding of up to date research on parents' problems and their likely impact on children, on processes and indicators of change, and on effective strategies and interventions to support change. An important skill for social workers is applying what is known about child development, family functioning and 'what works' to test out intuitive hypotheses, to make sense of the available information about an individual family, and to support them through the process of change. This overview of the research evidence is intended to provide a resource for promoting understanding and developing these skills.

It is important to note that while this overview can identify a number of factors that should help practitioners in making assessments of parental capacity to change, these are indicators that change may (or may not) occur, and not determinants of specific actions. A significant element in the process of behavioural change is the part played by parents themselves who will exercise their free will to act idiosyncratically within the constraints of the circumstances in which they find themselves. This is one of many reasons why change in human behaviour is not a mechanistic process that can be accurately predicted.

Finally, some consideration should be given to the purpose of assessing parental capacity to change. While the primary objective is to ensure that children are safe, ethical

practice in a humane society demands that parents are given opportunities to change, and support in doing so. So assessment is not only about making a relationship with a parent and understanding their situation, or collecting and analysing information concerning risk and protective factors and the effectiveness of interventions, but also about balancing the requirement to treat parents fairly and give them sufficient opportunities for change against the demands of a timeframe that is appropriate for the child.

Purpose of this literature review

There is an extensive body of research that focusses on the risk factors that can inhibit parenting capability and the protective factors that mitigate their impact. A wide range of interventions has also been developed to help parents improve their ability to meet their children's needs. There is also a substantial body of literature on the process of change, the factors that enhance or inhibit motivation to change and engagement with services, and the timescales for change and relapse. However, this literature comes from a variety of sources and is not readily available to social workers, family justice professionals and other practitioners with safeguarding responsibilities. This narrative review of the literature is intended to produce a distillation of existing research findings and knowledge in this area and present them in a manner that is accessible to practitioners. It is not a comprehensive, systematic review of the extensive evidence base: multiple systematic reviews would have been required to cover the range of subject matter to be included in the report, and these would have taken substantially more time and resources than were available. It should also be noted that although specific intervention programmes and assessment tools are referred to in this report, they are included in order to demonstrate the link between research theory and practice. It is beyond the scope of this review to produce a comprehensive list of interventions and tools that might be used by practitioners in this field.

The purposes of the review are to:

- serve as a reference resource for social workers in their work to support families where children's safety and developmental functioning are at risk; and
- assist social workers and children's guardians in delivering focussed and robust assessments of parenting capability and parental capacity to change, and assist judges and other legal professionals in evaluating the quality of assessment work in court proceedings.

Methodology

The methodology employed to produce this evidence paper includes a literature search of peer reviewed research papers supported by expert advice from a scientific advisory

group. The literature review involved a search of relevant databases using terms including: parent, intervention, treatment, substance, domestic abuse, alcohol and mental health. A full list of the databases used and search terms is included in Appendix One. The search was limited to papers published in English within the last ten years, although earlier key papers were included in the review where they were extensively referenced by published, peer reviewed articles, or recommended by scientific advisers.

The initial search returned 16,364 results. The relevance of the results was then considered against the aims of the review. This was initially achieved by excluding papers where the title clearly bore no relevance to the review subject. The abstracts of the remaining papers were then scrutinised in order to identify those which appeared to contribute to the review aims. Using this process, 343 papers were identified as relevant to the subject of parental capacity to change and were examined in detail. The researchers focussed on papers based on empirical data, but did not apply rigid inclusion/ exclusion criteria as it was important to gain an overview of the range of literature available.

A specific form of evidence frequently referred to in this report is the systematic review. These differ from more general reviews of the research by involving a particularly structured and robust review process. Conducting a systematic review involves formulating a review question, defining the inclusion criteria for studies, developing search strategies and terms to identify all eligible studies, reviewing those studies, extracting and analysing the relevant data and assessing study quality (Uman, 2011). Systematic reviews often incorporate a meta-analysis, which uses statistical analysis to combine findings. The evidence provided using systematic review and meta-analysis is therefore particularly robust as it involves a rigorous review process. Where both were available we have given priority to systematic reviews and meta-analyses over individual papers.

The selected papers were complemented by scrutiny of a number of recent research reports that focus on these topics but which would not have been included in the databases. Those included met the study criteria and, before publication, were subject to an equivalent rigorous peer review process as academic journal articles.

A scientific advisory group made up of academics specialising in fields including child protection, socio-legal issues, social work, psychiatry and psychology were asked to review the findings of the literature search and advise whether there were any additional peer reviewed papers that had not been identified. The group also provided expert advice on specific issues and reviewed the content of the draft chapters.

A steering group, consisting of professionals from local authorities, the judiciary, organisations promoting children’s and parents’ rights, and academics was consulted throughout the review to ensure the relevance of this paper to social workers undertaking work in this area and/or presenting evidence of parents’ capacity-to- change to the

courts. At the request of the steering group the authors have taken particular account of literature reporting parents' views. The steering group also reviewed the draft report.

Written comments from the scientific advisers and the steering group were collated and drawn upon in producing the final version of the report.

Conclusion

The results of this review of research evidence are presented in the following chapters.

- **Chapter Two** briefly summarises those risk factors that undermine parents' ability to respond to children's needs, the mitigating value of protective factors and the evidence concerning the impact of abuse and neglect on the developing child.
- **Chapter Three** considers methods of assessing the risk of future harm, and models of parental change.
- **Chapter Four** explores why some parents may find it difficult to accept that there is a problem and appear to be 'resistant to change'. It explores those barriers that are known to exacerbate the difficulties that some parents have in accepting that a problem exists and considers ways of overcoming them.
- **Chapter Five** considers how parents become motivated to change and engage with services.
- **Chapter Six** sets out how interventions intended to support parents in overcoming problems that pose a risk to their children can be evaluated, and how information concerning impact can be interpreted. It explores the outcomes of social work support and placements in care and adoption, and presents some examples of specific interventions designed to improve parents' ability to respond to children's needs that are currently being piloted or implemented in the UK.
- **Chapter Seven** considers the evidence concerning timescales for parental change and its sustainability. It explores how change can best be supported.
- **Chapter Eight** considers the implications for practice of the research findings covered in this report. It draws together practice messages concerning early support work with families, essential decision-making around thresholds for action including instituting legal proceedings and the collation and presentation of evidence to the courts.

Key points from Chapter One

- New provisions introduced by the Children and Families Act 2014 have led to a renewed focus on social work assessments. This report is intended to provide a summary of the research evidence that can be drawn upon in making such assessments. It focuses on research evidence concerning parental capacity to change, and explores how parents whose children may be placed away from home because of child protection concerns can be helped to make sufficient changes within a child's timeframe.
- Parenting does not take place within a vacuum, and assessments of parental capacity, and capacity to change, need to take an ecological approach, exploring the interrelationships between factors within the three domains of the Assessment Triangle.
- Social work assessments tend to be informed by intuitive reasoning, partly because this aligns more closely with a practice that focuses on relationships and empathy, and partly because pressures on time and resources leave little room for measured, analytical deliberations.
- Such intuitive, relationship-based assessments produce valuable hypotheses concerning family situations and the ways in which children might better be protected. However they are prone to bias and need to be rigorously tested out and counterbalanced by information from other sources including children's views, historical information, written records, observation, scores from validated instruments and scales, and research evidence concerning 'what works'.
- This wide ranging narrative literature review is intended to provide a distillation of up to date research on parents' problems and their likely impact on children, on processes and indicators of change and on effective strategies and interventions to support change that should inform such assessments.

Chapter Two: Risks of Future Harm

Introduction

The Children Act 1989 is based on the principle, also enshrined in the United Nations Convention on the Rights of the Child, that 'children are generally best looked after within the family, with both parents playing a full part' (Department of Health 1989, p.1). This principle is reflected in the duty laid on local authorities to provide services and interventions to safeguard and promote the welfare of children in their area who are in need. The local authority should promote the upbringing of such children by their families *so far as is consistent with that duty* (our italics) (Children Act 1989, s.17.1). The argument that, where there is no risk of significant harm, some children might nevertheless be better looked after elsewhere, is not a sufficient basis for care proceedings (see L (Children), 2006; *Re L (Care: Threshold Criteria)* , 2007).

There is an extensive body of evidence that shows how parental problems such as domestic abuse, substance misuse and mental health problems undermine parenting capability and increase the likelihood of significant harm, particularly when they occur in combination. There is also an extensive and growing evidence base showing how the experience of abuse and neglect may have a long-term, negative impact on children's physical, cognitive, social, emotional and behavioural development that can last throughout the life course. However parental problems do not occur in isolation. They are influenced by stressors within the wider environment and family such as poor housing, poverty and isolation that make parenting more difficult and increase the likelihood that problems will arise. Parents' own attributes, and their perceptions of self-efficacy and confidence will also affect the ways in which they respond to difficult circumstances.

In families where children are on the edge of care, social work decisions should be supported by an assessment of the risk of significant harm and of parental capacity to change: that is, the assessment of a parent's capacity to improve their ability to respond to their children's needs sufficiently to ensure that they are safeguarded from significant harm within an appropriate timeframe for the child. Knowledge of the extensive research evidence summarised in this and subsequent chapters should inform these assessments. Social work practice is known to focus too often on the mother to the exclusion of the father (Brown *et al*., 2009; Scourfield, 2006); wherever possible assessments should include both parents and the strengths and weaknesses within their support networks.

It should also be noted that, although this review focuses on parental capacity to change, such assessments are not undertaken as an isolated exercise. Parenting capability and capacity to change need to be assessed within the context of a child's needs and wishes, and decisions will also need to take account of the strengths and limitations of the other options available: a parent with a serious alcohol problem might be assessed as being unable to protect an infant from significant harm within an appropriate timeframe, but

might nevertheless be considered to be an acceptable carer for a fifteen year old who desperately wants to stay at home.

Risk factors do not in themselves determine whether a child will be neglected or abused, but they are important indicators of potential problems that practitioners need to be aware of when assessing parenting capability in families where children are on the edge of care. This chapter sets out those parental factors that are known to be associated with a risk of significant harm to a child, factors that can reduce the risk of harm, and the likely nature of that harm. Subsequent chapters then set out the research evidence concerning parental capacity to change.

Factors which undermine parenting capability

Parents' problems

There is an extensive body of research which shows that a range of problems can impair parents' ability to meet the needs of their children. These include, but are not restricted to, poor mental health, problem drug and alcohol use, learning disability and domestic abuse. Serious case reviews continually emphasise the importance of understanding and acting on concerns about children's safety and welfare when living in households where these types of parental problems are present (Brandon *et al.,* 2008; 2009; 2010).

The research literature highlights how problems such as these can impact on parenting capability in each of the dimensions identified in the Assessment Framework. The following are some examples, though not a comprehensive list (for a fuller discussion see Cleaver, Unell and Aldgate, 2011, pp.66-74). They show how problems which diminish parents' ability to respond to their children's needs in each of these dimensions lead to situations in which abuse and neglect are likely to occur.

Basic care: Domestic abuse, mental health problems, learning disabilities and problem drug and alcohol use can diminish parenting skills and mean that parents have difficulty in organising day to day life. Parents with substance misuse or alcohol problems may use all their resources to fund their addiction and have little left over to feed, clothe and house their children; they may also be too preoccupied with their addiction and too much under its influence to be aware that their children's basic needs are not being met (Fraser *et al*., 2009). Some mental health problems may also reduce parents' awareness of their children's basic needs or their ability to meet them. Parents with learning disabilities may want to meet their children's basic care needs but need additional support to understand what is required and learn appropriate skills (Booth and Booth, 1993; MacIntyre and Stewart, 2011).

Ensuring safety: Parents' problems may distort their perceptions of the world, diminish their ability to control their emotions and prevent them from ensuring that children are safe. Domestic abuse may literally expose children to physical danger, but it may also have an impact on 'children's sense of their own safety and security and the fear and

dread that it instil[s] in them' (Buckley *et al*., 2007, p.300). Similarly drug taking, drinking and some mental health problems may distort parental perceptions of reality or diminish their self- control, reducing their ability to ensure that children are safe (Fraser *et al*., 2009). Used needles and drug paraphernalia may pose a risk to young children, while substance misusing parents may also resort to theft, drug dealing and prostitution to feed their habit, and thereby potentially expose their children to a range of criminal activities and inappropriate sexual behaviour (Barnard and McKeganey, 2004; Magura and Laudet, 1996; Powis *et al*., 2000).

Emotional warmth: Domestic abuse, mental health problems and substance misuse can have a negative impact on parent-child relationships. A parent who is the victim of domestic abuse may experience excessive stress, resulting in their becoming emotionally unavailable or distant from their children and unable to provide emotional warmth (Holt *et al*., 2008). Impaired personality functioning and mental health problems such as anxiety disorders, depression and some psychotic illnesses may reduce parents' ability to be reciprocal, involved and encouraging with their children (Kohl *et al*., 2011; Mowbray *et al*., 2002). Parents whose 'principal attachment is to a substance' may have difficulty in forming attachments with their children (Kroll and Taylor, 2003).

Stimulation: Parents' problems can reduce their ability to provide adequate stimulation for their children. Substance misuse and domestic abuse, as well as mental health problems such as depression, may engender apathy, listlessness and poor self-esteem, thereby reducing parents' capacity to play or interact with their children or take an interest in their activities (see Barnard, 2007; Oyserman *et al*., 2000; Stanley *et al.,* 2009). Parents with learning disabilities may require additional support and training to understand how to provide adequate stimulation (see Cleaver and Nicolson, 2007).

Guidance and boundaries: Parents' problems are also often associated with low self-esteem, and unpredictable, inconsistent and ineffective parenting behaviours. Children may not have clear boundaries, consistent guidance or adequate supervision (see Barnard, 2007; Cleaver and Nicolson, 2007; Oyserman *et al*., 2000; and Stanley *et al*., 2009). For example, domestic abuse has been found to have a negative impact on the level of control and authority an abused parent has over their child (Holt *et al*., 2008; Ulman and Strauss, 2003). Parental substance misuse may lead to even very young children being unsupervised (see Ward, Brown and Westlake, 2012).

Stability: Parental problems also have a number of psychosocial consequences that can have a negative impact on their ability to provide children with adequate stability. For example, maternal mental illness can diminish children's sense of stability when everyday care becomes disrupted by emergency hospital admissions, or when panic attacks or depression leave a parent feeling unable to play with their child (Kohl *et al.*, 2011; Stallard *et al*., 2004). Impaired personality functioning is associated with hostility and difficulty in controlling anger (Morse *et al.*, 2005), and with disharmonious personal relationships (Reder, Duncan and Lucey 2003). Parents with these problems may

experience multiple changes of partner. Domestic abuse, substance misuse and mental health problems are all associated with frequent changes of address, homelessness and separation through children's entry to care (Anderson and Christian, 2003; Baker *et al*., 2003).

Impact of combinations of problems

Many parents who suffer from these problems do *not* present a risk to their children's wellbeing. Cleaver and colleagues' (2011) review of the evidence concluded that: 'much research indicates that, with adequate support, parents who are experiencing a single disorder are often able to be effective and loving parents and present little risk of significant harm to children' (p.63). However, as is evident from the above, the review also found that these factors often interlock in complex combinations and are compounded by the age or previous experiences of the parents. Interlocking, multiple problems substantially increase the likelihood that children will be exposed to maltreatment (p.65). Dixon and colleagues' (2005) found that the risk of children being abused within the first thirteen months of life is fourteen times higher when parents have been abused themselves as children, are under 21 years old, have a history of mental illness or depression and are living with a violent adult.

Environmental factors and their impact

Parents' ability to care for their children adequately is also affected by the presence of wider deprivation including poverty, poor or overcrowded housing and unemployment. It is important to note that the vast majority of poor families do *not* neglect or abuse their children (see Connell-Carricks, 2003; Sedlak *et al.,* 2010; Slack *et al*., 2004). However as well as providing a context that makes parenting more difficult, poverty also increases the stressors in families that make abuse more likely, and there is a particular association between poverty and child neglect (see Chaffin *et al*., 1996). When combined with specific issues such as mental health problems or domestic abuse, poverty magnifies the challenge to parenting (Fernandez, 2007). Moreover there is an intricate, symbiotic relationship between parental problems and socio-economic circumstances (Jack and Gill, 2013). For example, mental health problems such as depression may reduce a parent's ability to find or hold down employment, thereby restricting the household income. The stress of living on limited income will potentially exacerbate a parent's mental health problems, thus creating a vicious circle. Brandon and colleagues (2009) describe poverty as one of the life stressors which affect parents' 'states of mind and the way they understand and interpret the needs and behaviour of any children in their care' (p.110).

Parenting children with additional needs

Parents face particular challenges when their children have health problems, disabilities, or emotional or behavioural difficulties. Caring for a child with additional needs can increase parents' stress levels and escalate other problems (Baker *et al*., 2003). Parents of children with disabilities may find it difficult to access appropriate information or consistent services (Redmond and Richardson, 2003). Children with disabilities and special health care needs are 3.4 times more likely than others to experience abuse or neglect (Sullivan and Knutson, 2000). Younger children are also at greater risk of recurrent abuse, and more likely to suffer significant harm (see Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press).

Recurrent abuse

Once abuse has occurred there is a strong possibility of recurrence. Fluke and colleagues (1999) found that 14.7% of children experience further maltreatment within six months of the first episode, and 22.6% within eighteen months. Hindley, Ramchandani and Jones (2006) found that the risk of recurrence is highest within 30 days of the index episode of maltreatment and then begins to diminish. These researchers undertook a systematic review of cohort studies investigating factors associated with substantiated maltreatment recurrence in children (Hindley, Ramchandani and Jones , 2006). White, Hindley and Jones (in press) updated the original review to include studies published up to 2009 and to widen the original scope by including, in addition to fully substantiated cases, studies examining cases with varying degrees of substantiation. Table 2.1 below sets out 'those factors that were found to be associated with an increased likelihood of future harm, contrasted with those where the likelihood is decreased following identification of significant harm to an index child' (see Jones, Hindley and Ramchandani, 2006, p.276). Items in italics were most strongly associated with recurrent maltreatment; the other factors were identified by the studies in the reviews but were less strongly associated with recurrence. These findings have important implications for decisions concerning returning abused and neglected children home from care and the nature of support required in these circumstances (see Chapter Eight).

Risk factors that were most strongly associated with recurrence across both reviews included: maltreatment involving neglect; cases where the child had suffered more than one previous episode of abuse; and cases involving very young and/or disabled children. Parental factors included: personality disorder (impaired personality functioning); learning disabilities when accompanied by mental health problems; paranoid psychosis; substance misuse and inter-parental conflict and violence. A wide range of family and environmental factors were also associated with higher rates of recurrence; these included family stress; a lack of social and family support networks; parent-child relationship difficulties and living in a violent or unsupportive neighbourhood (Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press).

Some factors were not found to be significant in terms of the recurrence of maltreatment. These included parental marital status, caregiver age, employment status and ethnicity (Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press).

Protective factors

The reviews also identified factors that can interact positively with parental problems, mitigating their impact, and reducing the likelihood of maltreatment recurrence. These include the presence of a non-abusive partner; the presence of a supportive extended family; parents' adaptation to their own experience of childhood abuse; parents' recognition that there is a problem and their willingness to take responsibility for it; and parents' willingness to engage with services (Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press). These factors have been found to protect children from initial experiences of abuse and neglect as well as from recurrences (see Cleaver *et al*., 2007; Cleaver and Nicholson, 2007; Kroll and Taylor, 2003; Smith, 2004; Somers, 2007).

Table 2.1: Factors associated with future harm
NB Items in italics most strongly associated with maltreatment

Factors	Future significant harm more likely	Future significant harm less likely
Abuse	Severe physical abuse including burns/scalds *Neglect* Severe growth failure Multiple types of maltreatment More than one affected child in the household *Previous maltreatment* Sexual abuse with penetration or repeated over a long duration Fabricated/induced illness Sadistic abuse	Less severe forms of abuse (defined in terms of harm, duration and frequency)
Child	*Developmental delay with special needs* Child's mental health problems *Very young child – requiring rapid parental change*	Healthy child Child does not blame themselves for sexual abuse and recognises that it caused harm Later age of onset One good corrective relationship
Parent	*Personality disorder (anti-social, sadistic, aggressive)* Lack of compliance Denial of problems Learning disabilities *plus mental illness* Substance abuse *Paranoid psychosis* *Significant parental mental health problems* Abuse in childhood – not recognised as a problem History of violence or sexual assault	Non-abusive partner Willingness to engage with services Recognition of problem Responsibility taken Mental disorder responsive to treatment Adaptation to childhood abuse
Parenting and parent/ child interaction	Disorganised; severe insecure patterns of attachment Lack of empathy for child Own needs before child's *Parent-child relationship difficulties*	Secure attachment; less insecure attachment patterns Empathy for child Competence in some areas

Family	*Inter-parental conflict and violence* *High stress* (associated with family stress; parental stress; large family size, poor home conditions and housing instability) Power problems: poor negotiation and expression of emotions; poor sense of autonomy Children not visible to the outside world and continuing perpetrator access	Absence of domestic abuse Non-abusive partner Capacity for change Supportive extended family
Professional	Lack of resources Poorly skilled professionals	Therapeutic relationship with child Outreach to family Partnership with parents
Social setting	Social isolation *Lack of social and family support networks* and lone parenthood Violent, unsupportive neighbourhood	Social support More local child care facilities Volunteer network Involvement of legal or medical services

(compiled from Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, in press)

The impact of abuse and neglect on children's subsequent development

There is a strong and increasing evidence base showing that the early childhood environment, and the first three years of life in particular, play a major role in shaping children's neurobiological, cognitive, socio-emotional and behavioural development (for summaries see Barlow and Scott, 2010; Brown and Ward, 2012). Abusive and neglectful parenting can have severe negative consequences for all aspects of children's future learning, behaviour and health, and these may persist well into adulthood. Norman and colleagues (2012) have recently completed a systematic review and meta-analysis examining the long-term health consequences of child physical abuse, emotional abuse, and neglect. They found robust evidence showing causal relationships between non-sexual child maltreatment and a range of mental disorders, drug use, suicide attempts, sexually transmitted infections and risky sexual behaviour.

Attachment styles and their impact

Abuse and neglect can have a negative impact at all ages and stages of development, but are thought to be particularly pernicious in the early years because of the impact on the child's neurobiological development and on the attachment process. The developing child will respond as much to negative as to positive stimuli, and many of the *sequelae* of abuse and neglect can be interpreted as ways of adapting to a hostile environment (see McCrory, De Brito and Viding, 2012).

The key feature of an infant's early environment is the relationship with the primary carer, usually the mother, whose initial role is to ensure the infant survives by responding to their basic needs. Howe (2006) argues that 'the goal of the attachment system is protection from danger…. and attachment behaviours are triggered whenever a highly vulnerable human infant experiences anxiety, fear, confusion or feelings of abandonment' (p.128). Children whose parents or other primary carers are responsive to their needs and sensitive and emotionally attuned to their mental states are likely to develop an internal working model of themselves as loveable, valued and socially effective and others as positively available, understanding and interested. These children develop *secure* attachments, and these form the basis for 'healthy psychosocial development, improved social cognition, and raised levels of resilience based on high self-esteem, self-efficacy and coping capacity' (*ibid*. p.128).

A number of aspects of early parent-child interactions have been identified as laying the foundations of secure attachments. These include: *sensitivity/attunement* (the use of eye contact, voice-tone, pitch and rhythm, facial expression and touch to convey synchronicity with the infant); *mind-mindedness/reflective function/ mentalisation* (a parent's capacity to experience their baby as an intentional being with their own personality traits, strengths and sensitivities); *marked mirroring* (when a parent shows a

contingent response to an infant such as looking sad when the baby is crying); *containment* (when a parent uses touch, gesture, and speech to take on an infant's powerful feelings and make them more manageable); *reciprocity* (turn-taking); and *continuity of care* (providing infants with sufficient continuous caretaking from a small number of carers to enable them to become securely attached) (Tronick, 2007).

However, parents and other primary carers differ in their ability to help children develop secure attachments. Children whose carers are less available, sensitive or responsive may develop insecure attachments. Children with *insecure/avoidant* attachments have carers who become anxious or rejecting when others place emotional demands on them. These children adapt by over-regulating their emotions and are anxious that any display of need or vulnerability may drive their carers away. More extreme avoidant strategies are found in children who have experienced rejection, physical abuse or emotional maltreatment (Howe, 2006).

Children with *insecure/ambivalent* attachments have caregivers who are unable to respond consistently or to recognise their needs and those of other people. These children respond by maximising their distress and attachment behaviour in order to gain attention. They develop 'a passive and fatalistic attitude to events; an anxious preoccupation with other people's inconsistent emotional availability; and an angry, demanding, dissatisfied, needy, pleading and provocative approach to relationships' (Howe, 2006, p.129). Pronounced versions of this strategy are found in some children who have experienced chaotic neglect (Howe, 2006).

Children with *disorganised* attachments are unable to develop an attachment strategy because their carers are both the source of their distress and fear and the solution to it. These children have caregivers who may be frightening in that they menace, abandon or physically or sexually abuse them; or carers who may be frightened in that they may behave in a helpless and emotionally dysregulated way when faced with their needs. These children do not know what response to expect from their caregivers: sometimes they may be picked up and cuddled, but at other times they may be shouted at or smacked. In such circumstances children may not be able to develop a strategy to maximise their carer's availability. Children with disorganised attachments have considerable difficulty regulating their emotions and will develop highly negative and inconsistent internal working models in which they perceive others as not to be trusted. Up to 80% of children brought up in neglectful or abusive environments develop disorganised attachments (Van Ijzendoorn *et al*., 1999), and these are strongly associated with later psychopathology (Green and Goldwyn, 2002). (For further details on the development of attachment styles, see Howe, 2006).

The impact of abuse and neglect as children grow

Young children are entirely dependent on their carers for survival, therefore the attachment formed with the primary caregiver(s) shapes the way in which the child

develops, particularly their capacity to regulate their emotions and stress levels. As a child grows, the impact of abuse and neglect will continue to be felt across different aspects of their development. They may exhibit behavioural difficulties such as aggression or cognitive issues including delayed language skills.

Once children reach middle childhood, behavioural and developmental issues become apparent as they start school and interact with an increasing number of other children and adults. Trickett and McBride-Chang's (1995) review of the developmental impact of abuse and neglect found that from early childhood through to adolescence, neglected children consistently show poorer cognitive development and school performance than their peers. Abuse and neglect continue to impact on children's emotional development including the ability to regulate their feelings and responses and the ability to recognise expressions of emotion in others (Pollak *et al*., 2001).

As children become older and more socially aware, the difficulties faced by their parents will impact upon them in new ways. Those in middle childhood will become increasingly aware of the stigma attached to certain conditions such as schizophrenia or drug dependence and may try to keep their families together by hiding problems from the outside world (Barnard and Barlow, 2003; Somers, 2007). Young people can do this so effectively that they miss out on the professional support they need (Velleman *et al.*, 2008). This can be a sources of stress, which despite employing a range of coping strategies, can leave young people feeling 'extremely angry, frustrated and very sad' (Velleman and colleagues, 2008, p.402).

Adolescence is the point where young people are becoming more socially independent and peer relationships become as important, or more important, than those with family. The formation of these relationships, however, can be compromised where young people have developed insecure attachment styles (Levendosky, Huth-Bocks and Semel, 2002). Abuse and neglect have also been linked to antisocial and risky behaviours in adolescents (Romer, 2010; Scaramella *et al*., 2002).

Even when young people reach adulthood, the impact of abuse and neglect can be seen in a number of negative outcomes including mental and physical health problems, unemployment and antisocial or criminal behaviour. Where adults have not resolved their own insecure attachment issues, when they become parents themselves, this can negatively impact on the attachment relationship with their own children.

Table 2.2 sets out examples of the potential impact of abuse and neglect from birth through to adulthood.

Table 2.2: Impact of abuse and neglect during key developmental timeframes for children

	Impact of abuse/neglect
Before birth	Exposure to drugs/alcohol *in utero* can increase the risk of preterm birth, low birth weight and foetal alcohol syndrome (Autti-Rämö, 2002; Pinto *et al*., 2010). Pre-natal exposure to domestic abuse can be fatal; it can also damage a child's future ability to cope with stress (Shonkoff *et al*., 2012). The process of attachment begins before birth (Benoit *et al*., 1997; Canella, 2005).
0-3 years	Maltreatment during early childhood can cause functional and structural changes to brain development which can predispose to psychiatric vulnerability in adulthood (McCrory, De Brito and Viding, 2012). Child neglect can have severe, deleterious short- and long-term effects on children's cognitive, socio-emotional, and behavioural development. Consistent with attachment and related theories, neglect occurring early in life is particularly detrimental to subsequent development (Hildyard and Wolfe, 2002). Infants and very young children are dependent on caregivers for survival. Feelings of hunger, cold or discomfort indicate a threat to survival and generate stress. Infants cannot regulate their own stress response systems and are therefore dependent upon caregivers to re-establish their equilibrium by meeting their needs and soothing away their stress (Hofer, 1995). The stress response system begins to self-regulate at around six months, but does not become fully established until a child is around four years old. It will develop atypically in response to aggressive, hostile or neglectful parenting. Children and young people with maladaptive stress responses will find it difficult to control their behaviour, or to regulate their emotions (Tarullo and Gunnar, 2006). The attachment formed with the primary caregiver(s) shapes the way in which the child develops, and may be influenced as much by negative as by positive parenting behaviour: up to 80% of children brought up in neglectful or abusive environments develop disorganised attachments, and these are strongly associated with later psychopathology (Van IJzendoorn, Schuengel and Bakermans-Kranenburg, 1999). Children are more likely to demonstrate early developmental delay if their mothers demonstrate avoidant attachment styles and depressive symptomatology including postpartum depression (Alhusen, Hayat and Gross, 2013). Physically neglected toddlers have been found to cope less well with problem-solving tasks, reacting with frustration or anger (Hildyard and Wolfe, 2002). A systematic review by Naughton and colleagues (2013) identified negativity in play, reduced social interactions and deficits in memory performance as potential developmental outcomes of neglect and abuse.
3-5 years	Between the ages of three and five there is a dramatic spurt in the development of executive function skills such as working memory, inhibitory control and cognitive flexibility. The sequential nature of childhood development requires earlier stages to be completed before more complex skills can be acquired (Blair, 2002; Knudsen, 2004). As maltreated children start pre-school and school they are likely to have fewer positive social interactions than their peers, occurring as a response to previous insensitive care giving (DiLalla and Crittenden, 1990). They show an increased risk of aggression and other conduct problems, find it difficult to recognise that others will help them, and complex language skills may be developmentally delayed (Naughton

	et al., 2013). Studies suggest that early negative emotional experiences can alter the way maltreated children recognise and process emotions such as anger (Pollak *et al*., 2001). Deficits have been identified in the moral development of neglected and abused school aged children, which have been associated with an increase in negative behaviours including cheating and stealing (Koenig *et al*., 2004).
5-10 years: middle childhood	In middle childhood maltreated children may experience delayed cognitive and educational development. For example, their complex language skills may continue to be delayed (Naughton *et al*., 2013). They may exhibit emotional or behavioural problems including fear, anxiety, anger or aggression (Barnard and Barlow, 2003; Covell and Howe, 2009). The may have difficulty understanding emotional expression and not recognise others as a source of help (Naughton *et al.,* 2013). Children at this age are starting to become aware of the stigma attached to their parents' issues (Somers, 2007). They may also begin to take on caring responsibilities both for their parents and their siblings, and consequently miss out on school and social activities (Aldridge and Becker, 2003).
Adolescence	Adolescence is the point where young people are becoming more socially independent and peer relationships become as important, or more important, than those with family. The formation of these relationships, however, may be compromised where young people have not developed secure attachment styles (Levendosky, Huth-Bocks and Semel, 2002). The ability of adolescents to form social networks can also be hampered where they have to assume a caring role for a parent or sibling because of their parent's problems (Aldridge and Becker, 2003). Caring responsibilities or anxiety about their parent's wellbeing during school hours may also detrimentally affect young people's education (Aldridge and Becker, 2003; Barnard and Barlow, 2003). However children who experience domestic abuse may find that school can offer a 'safe haven' for several hours a day (Buckley *et al*., 2007). Adolescents who have not experienced nurturing and involved parenting are more likely to become involved in antisocial behaviour and delinquency (Scaramella *et al*., 2002). Early stressors such as abuse and neglect have been linked to adverse adolescent outcomes and risky behaviours including drug taking, addiction, teenage pregnancy and suicide (Herrenkohl *et al*.,1998; Romer, 2010).
Adulthood	Adults with unresolved attachment issues may find it difficult to open up and trust others or develop supportive social networks (Anders and Tucker, 2000). Unless parenting skills are learnt and attachment issues resolved, there is a risk that parents' unresolved or disorganised attachments will impact on the nature of the relationship with their own children (Hesse and Main, 2000). Childhood abuse and neglect has been linked to negative physical and mental health outcomes (Springer *et al*., 2007); lower educational attainment, employment outcomes and earnings (Currie and Widom, 2010; Perez and Widom, 1994); and an increased likelihood of re-victimisation in adulthood (Widom, Czaja and Dutton, 2008).

The research evidence shows how abuse and neglect in the early years can have an adverse impact on children's development, although it does not imply that this will always be the case. Such changes are not irreversible, and there are many factors both within the child, the family and the environment which can mitigate the developmental consequences of maltreatment. Nevertheless, the more prolonged and persistent the abuse or neglect, the more difficult it is to overcome the impact. For example, a longitudinal study is comparing outcomes of children who were removed from Romanian orphanages and placed for adoption in England with those of children born and adopted in this country. The study has explored the impact of severe institutional deprivation across cognitive, intellectual and behavioural domains, among others, and concluded that there has usually been a large improvement in functioning following adoption, although 'significant problems continued in a substantial minority of the children placed after the age of six months' (Rutter *et al*., 2007).

It is therefore imperative that professionals with responsibilities for safeguarding children make and implement effective and timely decisions both to identify those likely to suffer significant harm and to take action to prevent its occurrence (or recurrence). Understanding how far parents are capable of addressing the difficulties which render their children more likely to suffer maltreatment, within a timeframe which recognises children's developmental needs and that is sustainable in the long term, is fundamental to effective safeguarding.

Identifying children suffering, or likely to suffer significant harm

Many parents will be capable of change and, with appropriate support, will be able to provide a safe and nurturing family context for their children within a timeframe which is in their best interests, and that is sustainable in the long term. Ward and Brown's prospective longitudinal study of infants suffering or likely to suffer significant harm has identified a number of parents who succeeded in overcoming significant adverse behaviour patterns before their children's first birthdays and have now provided nurturing homes for them for at least seven years (see Brown, Hyde-Dryden, Thomas and Ward, forthcoming; Ward, Brown and Maskell-Graham, 2012; Ward, Brown and Westlake, 2012). However, not all children can be safely looked after within the family. Social workers' assessments, analyses and judgments about the impact of abuse and neglect on children's development; parents' understanding of the need to make changes; and their readiness, motivation and ability to change will be crucial components of decisions about whether it is in the best interest of the child to remain with parents, or to be placed away from home on a temporary or permanent basis. The child's welfare should remain central to this decision-making process; the identification of families where children are exposed to ongoing maltreatment with little prospect of change should occur as soon as

is practicably possible, supported by robust assessments prepared for the courts. As Jones (2009) points out:

> We have to acknowledge that some situations cannot be changed for the better, and that some families are simply untreatable. These situations are major challenges for children's social care and other services, but must be faced and responded to by front-line workers and their supervisors. These cases do not represent failure, but in fact successful professional practice, to the extent that a sustained focus on child welfare has been achieved (p.302).

Tools to assess risk of significant harm

Chapter One discussed how difficult it is for social workers to make objective decisions based on careful analyses of all the available information, within the pressures and constraints of everyday practice. It also explored some of the pitfalls of relying too heavily on intuitive, relationship based assessments, and how these might be addressed, particularly through testing out initial hypotheses with more objective data collected by using validated evidence-based tools. Social work assessments when children are on the edge of care involve both an assessment of child and family functioning and parents' capacity to change, and an assessment of the risk of future harm, both of which are key elements in decision-making (Shlonsky and Wagner, 2005). Research from at least 100 comparative studies of practice in several disciplines within the social sciences has found that professional observation and clinical judgments are less accurate in predicting future behaviour than the actuarial methods upon which validated risk assessment tools are based (Dawes, Faust and Meehl, 1989; Shlonsky and Wagner, 2005). It should be noted, however, that the complexities of cases where there are serious child protection concerns mean that no tool will be 100% reliable, and standardised actuarial instruments are only 70%-80% accurate in identifying risks of future harm (Leschied *et al*., 2003). Such tools are a valuable aid to structured professional decision-making, but they cannot replace professional observation and judgment.

All assessment tools designed to identify whether children are suffering or likely to suffer significant harm need to have been formally evaluated in the context within which they will be used, and many of those currently available still require further validation in the UK before they can be relied upon. Only a limited number of standardised tools are routinely used in a small number of local authorities in England. Nevertheless they are increasingly being introduced across the country, and it is important for practitioners to understand their strengths and weaknesses.

Barlow, Fisher and Jones (2012) undertook a systematic review of tools available to social workers to assist them in deciding whether a child is suffering, or likely to suffer, significant harm. Sixteen tools met the criteria for inclusion. These included:

Risk assessment tools that measure a small number of historical and static risk factors that research has shown to be strongly associated with future harm. The evidence

supported the use of one actuarial risk assessment tool 'in some contexts, as part of the assessment process in order to classify the presenting nature and severity of any harm' (p10). This was the California Family Risk Assessment Tool included in the Children's Research Centre Structured Decision-Making System (CRC-SDM). However the review suggests that further evidence is needed about its validity, impact, rigour and acceptability in a UK context.

Strengths and Needs Assessment tools that typically measure dynamic factors that are often defined as needs and which, if remedied, can reduce the risk of harm posed (p.33). The review identified two tools developed in the UK: the Graded Care Profile and the Safeguarding Assessment and Analysis Framework which, when compared with the other tools reviewed, were more consistent with the Assessment Framework, included assessment over a wide range of domains, and provided clear guidance for social workers on use and analysis of the data. Barlow and colleagues consider that these tools 'could potentially improve both the assessment and analysis of data about children in need and children with complex needs in terms of the likelihood of them suffering significant harm'(p.10). However, the review again points to the need for formal piloting of both tools in the UK to test for reliability, validity, impact and acceptability.

The Signs of Safety tool (Turnell and Edwards, 1997), used by a number of local authorities across the UK, focuses on the joint setting of goals and parents' strengths and resources rather than deficits. However, Barlow, Fisher and Jones (2012) found that it 'has a limited number of assessment domains, none of which focus on children's development, limited consistency with the Assessment Framework (HM Government, 2013) and provides limited guidance in terms of analysing and making sense of the data vis-a-vis other tools such as the Safety Assessment and Analysis Framework (SAAF)' (p.73). Its strengths are that it can be used to map evidence in the process of making sense of it and that it provides a visual means of supporting partnership working with children and families to help them understand strengths as well as weaknesses.

*Response Priority Decision Trees***:** tools that are used to 'improve the consistency across workers and to prioritise decisions about initial reports of abuse and neglect, in order to focus the workload on the most relevant cases and aid decision-making about the rapidity of response that is needed' (Barlow, Fisher and Jones, 2012, p.6). The CRC-SDM Response Priority Decision Trees meet this requirement but again the review indicates that they would require testing in a UK setting.

Permanency/Placement and Reunification Checklists have been developed as part of the CRC-SDM structured decision-making system and 'focus explicitly on the likelihood of recurrence of harm in relation to decisions about permanency/ placement and reunification' (Barlow, Fisher and Jones, p.6) but once again would require testing out in a UK setting.

Audit Tools, which are similar to the risk assessment tools, but have been used to date as a means of auditing retrospectively whether cases have been classified accurately.

Ward, Brown and Westlake's (2012) risk classification is based on the work of Hindley, Jones and Ramchandani (2006). It has been developed from an audit tool into a more dynamic methodology for identifying risks and setting goals and timescales in consultation with parents when reunification is being considered. This is currently being piloted and evaluated by the NSPCC.[1]

Conclusion

This chapter has explored the evidence base upon which social workers should be able to draw in making decisions about whether abused and neglected children who are on the edge of care can safely remain with birth parents without being placed at continuing risk of significant harm. It has considered the risk factors that make continuing abuse and neglect more likely, and the protective factors that can mitigate their impact; it has also considered the research evidence concerning the continuing impact of abuse and neglect across the dimensions of children's development. Finally it has explored a number of standardised tools that may be usefully implemented to support structured professional decision-making concerning the risk of significant harm. It has, however, focussed on baseline indicators of abuse and neglect, their potential impact and the likelihood of future harm and presented research evidence that demonstrates why change is necessary when children are living with carers who abuse or neglect them. It has not considered how parents' (and children's) circumstances might change, and how positive change might be facilitated and sustained. The remainder of this review focusses on these issues.

Key points from Chapter Two

- Parental problems such as domestic abuse, mental health problems and substance misuse may increase the likelihood of children being maltreated. Parents experiencing a single such problem can often provide effective and loving care. However, the risk of maltreatment substantially increases where parents are experiencing interlocking combinations of problems.
- Parents' ability to care for their children adequately is also affected by environmental factors, for example, the presence of wider deprivation including poverty, poor or overcrowded housing and unemployment. Parents also face particular challenges when their children have health problems, disabilities, or emotional or behavioural difficulties.

[1] See NSPCC *Taking Care* project: http://www.nspcc.org.uk/what-we-do/the-work-we-do/priorities-and-programmes/looked-after-children/reunification-of-maltreated-children/reunification-of-children_wda87216.html

- A number of factors associated with an increased risk of harm or the reoccurrence of harm have been well established, in addition to protective factors which decrease that risk.
- Abuse and neglect can have negative consequences across the whole spectrum of children's development, and can continue to have an impact into adolescence and adulthood.
- A range of materials have been developed to assist practitioners in assessing the likelihood of current or future significant harm. Most of these need further validation and/or translation and piloting in a UK context. Once properly validated they should provide practitioners with standardised measures that can support the development of structured professional judgment.

Chapter Three: Models of change: their strengths and weaknesses

Introduction

An individual's readiness and motivation to change is influenced by several interrelated factors, and the assessment of change is likely to be a complex process. In addition, in families where there are serious child protection issues, parents may need to undertake a considerable number of changes in order to ensure that their children are adequately safeguarded. With support from professionals, they may need to address the underlying factors in their own lives that make maltreatment more likely; they may need to address the abuse and neglect itself, and understand the manner in which their children are likely to be harmed; and they may need to develop more effective parenting skills, that are designed to promote children's satisfactory development, improve family relationships and reduce tensions within the family that may be the consequence of past abusive behaviour patterns. A key element of assessment is to 'undertake an analysis of the parenting capacity gap, with the reasons for professional pessimism if the judgment is that the gap either cannot be bridged at all, or cannot be bridged in the child's timescale' (Cafcass/ADCS, 2012, p.2). This chapter considers how social workers can map out and analyse the circumstances of individual cases in order to understand the factors promoting or impeding parental change of behaviour. The chapter then discusses the strengths and weaknesses of models for assessing parent's readiness and capacity for change.

Case conceptualisation

Social workers need to be able to assess whether parents have the capacity to make changes in many interlocking areas. In order to do this they need to formulate a case conceptualisation, setting out the various external and internal factors that impact on parents' ability to meet their children's needs, and identifying strengths as well as weaknesses. The social worker's ability to form a relationship with the parent and explore with them their perceptions of their current situation and how it has arisen is an important element in case conceptualisation (see Holland, 2000), but the process also needs to be supported by more formal, methodical collection of and analysis of relevant information (see Kirkman and Melrose, 2014). The different domains of the Assessment Triangle (HM Government, 2013), covering the developmental needs of children, the capacity of parents or caregivers to respond appropriately to those needs and the impact of wider family and environmental factors on parenting capability and children's progress provides a conceptual framework for reaching a structured professional judgment concerning the strengths and weaknesses in a family and their environment and the issues that need to be addressed (for further information see Sperry, 2005). This type of conceptual map,

that helps practitioners make sense of the interrelationships between factors concerning the child, the family and the environment, is sometimes described as an integrated theoretical framework (see Harnett, 2007; Harnett and Dawe, 2008; Harnett and Day, 2008).

In families where parents' poor personality functioning is an issue, social workers will also need a conceptual framework of the elements of mature adult functioning that can offer secure and responsive parenting; without this they are unlikely to identify the salient features that underlie the deficits in parenting capability, or to assess parents' capacity to act as beneficial attachment figures. There is no universally agreed framework for mature adult functioning, but it will include: parents' ability to recognise emotions in others; their ability to control and manage their own emotions; their relationship to authority; their ability to trust; their capacity for intimacy; and their capacity to take responsibility for the impact of their actions (Dimitrova *et al*., 2010; Marganska *et al*., 2013; Shean and Meyer, 2009).

Parents' attachment styles and their implications

Parents' experience of childhood trauma is likely to have a negative impact upon their own internal working models and may continue to affect their attachment style into adulthood. Childhood experiences may therefore impact on a parent's relationships with their own children, with partners and with peers (Styron and Janoff-Bulman, 1997; Turney and Tanner, 2001). Practitioners therefore need to be mindful that parents' attachment styles may present an obstacle when assessing and working with families and take this into account when formulating a case conceptualisation (see Holland, 2000).

Where parents have unresolved or disorganised attachments, their resultant behaviours will impact on the nature of the relationship with their own children. Hesse and Main (2000) suggest that parents with unresolved or disorganised attachments may exhibit inconsistent behaviours or ones which frighten or alarm children who look to them for safety and care. The authors describe children in these circumstances as being confronted with a 'biologically channelled paradox: the simultaneous needs to approach, and take flight, from the parents' (p.1118) and suggest that this leads to disruptions in the child's behaviour.

Insecure parental attachment style also poses potential challenges for professionals seeking to improve parenting capacity. Parents with an avoidant attachment style may appear distant, believe others are unreliable and distrust close relationships (Riggs and Kaminski, 2010). This can result in parents being suspicious of those in authority and unwilling to build relationships with professionals. Relationships with social workers or other practitioners and engagement in parenting programmes are therefore likely to be affected by an insecure attachment style. Anders and Tucker's (2000) study of social support networks found that adults with avoidant attachment styles tended not to open up and disclose to others, and this 'inhibits the possibility for close, supportive relationships

to develop and endure' (p.387). This study also found that individuals with avoidant attachment styles have lower levels of support satisfaction, associated with their tendency not to open up to others and their lack of assertiveness. The authors suggest that this lack of assertiveness may, in part, be due to adults' expectations of others' indifference towards them. An avoidant style may make it difficult for social workers to discuss issues with parents fully and gain a true picture of whether parents are coping. Holland (2000) found that parents' verbal interactions with social workers frequently carried the greatest weight in assessments of parental capability and capacity to change, with the result that those whose attachment styles led them to be inarticulate or passive may have been disadvantaged. When assessing parental capacity to change, social workers therefore need to recognise that exhibiting an avoidant, ambivalent or disorganised attachment style is a foreseeable, although not inevitable, reaction from parents who have themselves experienced childhood trauma.

This chapter now considers a number of conceptual and theoretical frameworks of behavioural change that should help facilitate social work understanding of parental readiness and capacity to overcome those difficulties which place their children at a greater risk of significant harm.

Models of change

When adverse behaviour patterns are entrenched, the process of change can be complex. Psychological models of change can offer helpful insights into behaviour patterns when parental capacity is being assessed. Without a conceptual framework of the process of change, practitioners may fail to appreciate its complexity and rely on compliance as a proxy indicator of success. For instance, parents who attend parenting programmes or drugs counselling are sometimes viewed as making sufficient changes even if their adverse behaviour continues (Brandon *et al*., 2008). However, compliance with voluntary or statutory interventions does not in itself constitute psychological readiness or provide evidence of genuine behaviour change (see Prochaska and Prochaska, 2002), and will do little to protect the child from future harm.

The Trans-Theoretical Model of Change (TTM)

A number of psychological models have been developed that are designed to facilitate understanding of the processes of behavioural change (see Hegarty *et al*., 2008; Higginson and Mansell, 2008; Littell and Girvin, 2005; Prochaska and DiClemente, 1983, and discussion below). Many of these models originated in attempts to understand addictive behaviours that have a long-term impact on health, such as smoking or alcohol abuse (see Prochaska and DiClemente, 1982; Tober and Raistrick, 2007).

The most prominent of these is Prochaska and DiClemente's Trans-Theoretical Model of Change (TTM), incorporating the stages of change (SOC) (DiClemente and Prochaska,

1982; Prochaska and DiClemente, 1983; Prochaska, DiClemente and Norcross, 1992; Prochaska and Prochaska, 2002). The model was originally developed in the United States to understand the process of change for smoking cessation (DiClemente and Prochaska, 1982; Prochaska and DiClemente, 1983). However, it is a generic model, that has since been widely used in the treatment of a range of problems, including addictions (see for instance Snow, Prochaska and Rossi, 1994; Tober and Raistrick, 2007); domestic abuse (see for instance Frasier *et al*., 2001); adult sex offenders (see for instance Ginsberg *et al.,* 2002); and HIV prevention (see for instance Aggleton *et al*., 1994). The TTM has been developed and refined on the basis of empirical evidence from this wide range of populations (Prochaska *et al*., 1992). It dominates much of the literature relating to behavioural change and has become a prominent and widely accepted feature within the health promotion field (Whitelaw *et al*., 2000).

The TTM has also been applied specifically in child welfare cases (Prochaska and Prochaska, 2002; Tuck, 2004). In the UK it features prominently in the social work literature on assessment, where it has been developed as a framework to assist practitioners in conceptualising processes of change in relation to work with families where children are suffering, or likely to suffer, significant harm, and in the preparation of reports for the courts (see Horwath and Morrison, 2001; Morrison, 2010). While it is useful for social workers to have an understanding of the key concepts of the model, they also need to be aware of a number of concerns that have been raised about its applicability to child welfare cases, and the predictive validity of some of the accompanying materials (see below).

Prochaska, DiClemente and Norcross (1992) and Prochaska and Prochaska (2002) identify six psychological stages through which individuals advance during intentional behavioural change: *pre-contemplation, contemplation, preparation, action, maintenance and relapse*.[2]

Pre-contemplation: describes the stage where the individual has no intention of changing their behaviour and is unaware of their problems or will not acknowledge them. Pre-contemplators may feel coerced or threatened to change their behaviour, and this can be particularly pertinent in child welfare cases. These individuals may demonstrate some change, as long as there is pressure to do so. However, once this pressure no longer exists, they are highly likely to revert to their previous behavioural patterns.

Contemplation: during this stage individuals are aware that a problem exists and are seriously thinking about addressing their difficulties, but have not made any commitment to take action. The contemplation stage can last for long periods and involves weighing up the disadvantages of the problem behaviour *versus* the amount of effort, energy, and

[2] The following descriptions of each stage have been adapted from Prochaska and colleagues (1992 and 2002).

loss it will cost to overcome it. Parents in this stage may agree with statements such as: ‘I have a problem and I really think I should work on it’ or ‘I have started to think I have not been caring for my children as well as I should’. Individuals in the contemplation stage give serious consideration to problem resolution.

Preparation: this stage combines intention and behavioural criteria. For instance, individuals in this stage may make or support statements such as the following: ‘I have questions for my social worker about caring for my children’ or ‘If I do not change I will not be the type of parent my children need’. These parents may report making some small behavioural and cognitive changes, such as reducing their intake of alcohol or drugs; however, they have not yet met the criteria for effective action and may continue with their adverse behaviour.

Action: individuals in this stage have made modifications to their behaviour, experiences, or environment in order to overcome their problems. These modifications tend to be most visible and receive the greatest external recognition. However, ‘people, including professionals, often erroneously equate action with change. As a consequence, they overlook the requisite work that prepares changers for action and the important efforts necessary to maintain changes following action’ (Prochaska *et al*.,1992, p.1104). In relation to addiction, this would involve reaching abstinence. Reducing intake of drugs or alcohol would not satisfy the criteria for the action stage. Parents in this stage may agree with the following types of statement: ‘I am really working hard to change’ or ‘I am doing things about my problem that got my social worker involved’. The hallmarks of the action stage include modification of the problem behaviour and substantial overt efforts to address it.

Maintenance: during this stage individuals work towards preventing relapses and consolidating the gains attained during the action stage. However, this stage can go on to last a lifetime. Parents in the maintenance stage may make statements such as: ‘I may need a boost right now to help me maintain the changes I have made’ or ‘I sometimes feel nervous that when my social worker is out of my life I will fall back to my old behaviour’. Parents in this stage will be working hard to prevent relapse and to stabilise their behavioural change.

Relapse: in response to their research on addictive behaviours, Prochaska and colleagues (1992) added *relapse* as an additional stage in the model. The Trans-Theoretical Model of Change was originally conceptualised as a linear model, within which individuals would successfully progress from one distinct stage to another. However, Prochaska and colleagues have subsequently argued that it would be better conceptualised as a spiral pattern that illustrates how people can progress through the stages, but are likely to encounter relapses in which they will regress to an earlier position.

Most people taking action to modify chronic dysfunctional behaviour do not successfully maintain their gains on their first attempt. Relapse is the rule rather than the exception

across virtually all chronic behavioural disorders (Prochaska and Prochaska, 2002 p.380). Individuals may need particular support through the relapse stage, as those who have been able to progress from contemplation to action to maintenance may feel as though they have failed when they return to their previous adverse behaviour patterns. They may then resist consideration of subsequent behavioural change and regress to the pre-contemplation stage.

According to its developers, the TTM offers a 'more reliable, valid, and complex assessment of behaviour change than simple recording of compliance' (Prochaska and Prochaska, 2002, p.379). It has been used as a theoretical construct to understand the structure of intentional behaviour change, as well as a tool to help practitioners understand what will be the most effective intervention to bring about change. For instance, the developers argue that action-oriented therapies will be effective if a person is in the preparation or action stages, but will be ineffective or detrimental for individuals in the pre-contemplation or contemplation stages (Prochaska *et al*.,1992).

Validated assessments and scales

The TTM is supported by a number of questionnaires and scales that have been developed to determine an individual's stage of change readiness or motivation and therefore facilitate an understanding of the type of intervention that would be most beneficial either to improve their readiness, reduce resistance to change or to address the underlying issue. These are mostly in the public domain and free to use without permission. These measures include the University of Rhode Island Change Assessment Scale (URICA), a measure of motivational readiness to change that can be used to determine where an individual is along the stages of change. There are also a number of self-report measures which can be used in a variety of circumstances to assess, for instance, an individual's confidence in their ability to abstain from substance use and how tempted an individual is to engage in problematic health behaviours.

However, caution is needed in using such measures. These types of scales should inform rather than replace professional judgment, and those judgments should also be informed by a thorough knowledge of processes and indicators of change and an understanding of how these relate to the particular individual. They may help to assess a parent's psychological readiness to change, but they cannot predict whether that parent will or will not eventually succeed in making and sustaining change, particularly in the long term. Moreover, assessments based on self-reports are appropriate in a therapeutic relationship, but may not be so valuable in situations such as care proceedings where parents have a strong incentive to present themselves in the best possible light.

In addition, a number of systematic reviews have questioned the strength of the evidence in support of the TTM, particularly in relation to the use of a stage based approach to implementing interventions as a basis for behaviour change (see Bridle *et al*., 2005; Littell and Girvin, 2005; Whitelaw *et al*., 2000). Therefore caution is needed in considering the use of this model, particularly as the systematic reviews cited above show that the

standardised scales show no clear evidence of predictive validity. Moreover, the model is not informed by goal setting theory (discussed later in this chapter), which appears to provide a valuable basis for engaging parents in the process of identifying appropriate targets and monitoring the progress of change (Dawe and Harnett, 2007).

Issues concerning the use of the Trans-Theoretical Model of Change as a conceptual framework in child welfare cases

Morrison (2010) presents the TTM in a UK context as a practice tool designed to offer a 'common language about motivation for use between practitioners and service users, between different agencies or between supervisors and staff to understand and assess progress towards change' (Morrison, 2010, p.312). He argues that it can be applied in three practice contexts: first, on a voluntary basis, where parents request help with problems and engage with services themselves; second, where there are concerns about the welfare of a child and the family are aware that if they do not engage with services, statutory action will commence; and third, where statutory proceedings have already been decided upon.

There are, however, difficulties in translating a model developed in response to evidence concerning how individuals *intentionally* overcome adverse behaviour patterns into a context in which coercion plays a part. Parents in both Morrison's second and third categories may well perceive their engagement with services as an involuntary process, and this may lead them to respond in a conflicting manner, moving between withdrawal, disguised compliance and aggression (see Brandon *et al*., 2008; Morrison, 2010). Girvin (2004) argues that some parents will be aware that being labelled 'unmotivated' can have serious consequences and may result in the removal of their children; therefore they may learn that it is advantageous to assert that they are working on their problems, when in reality this is not the case. In Girvin's view: 'The SOC [stages of change] model does not distinguish between responses that reflect genuine interest in behaviour change and those that are intended to appease caseworkers' (2004, p.900).

Parents who maltreat their children are also likely to have complex and multifaceted problems that may not fit into a single-stage classification such as that proposed in the TTM. Therefore over-reliance on the TTM classification system with its focus on readiness for change might offer a limited view of the challenges to be faced. Littell and Girvin (2005) argue that it is likely that readiness for change varies across problems, and parents who are ready to change one problem behaviour may not be as ready to change another.

The TTM remains a valuable framework for understanding the process of behavioural change as part of a broader assessment; however there is a danger that it could be too simplistic, or used too simplistically in child welfare cases. A model for smoking cessation involves only the individual concerned. In care cases at each stage it is the interrelationship between parent and child and the impact of the parental problems upon the child which are central; change will have much more far-reaching implications, and

relapse will impact not only on the parent, but also on a child who may have begun to trust in a safer environment.

To reflect the complexity of child welfare cases, a number of additional constructs have been proposed, specifically to facilitate understanding of parental engagement with services and readiness to change during the early stages of the process. These are discussed in the following section.

Adaptations to the Trans-Theoretical Model and alternative models

Hegarty and colleagues (2008) utilised and adapted the stages of change theory for work with female victims of domestic abuse and proposed a psychosocial model of readiness to change. The psychosocial model takes into account internal factors, including acknowledging abuse, perceived support from others, and self-efficacy or power (Cluss *et al*., 2006). It also takes into account external factors, including knowledge and skills of professionals supporting women, community and financial resources (Hegarty *et al*., 2008). The model involves the rating of these internal and external factors along a continuum.

Humphreys and colleagues (2011) explored how the psychosocial model of readiness to change could be applied to strengthening the relationship between mother and child following domestic abuse. The authors argued that the concept of readiness to change should include not only an individual's motivation to change, but also external factors such as the layers of intervention that are required by organisations, workers, mothers and children to lay the foundations that support the change process. The authors concluded that it was 'clear that there were a number of different dimensions to the change process for women that included: being beyond the immediate crisis; recognising that there was value in talking about aspects of the past with their children; and being in a position to be able to refocus on their children's needs. Children also have their own views and needs that should be independently heard as part of their change process' (Humphreys *et al*., 2011, p181).

Littell and Girvin (2005) argue that the predictive validity of the stages of change theory is weak, and propose that motivation or readiness for change should be explored using a two dimensional model consisting of problem recognition and intention to change, rather than a single continuum or multidimensional construct. They examined the predictive validity of a number of domains associated with readiness for change among caregivers receiving home services following reports of child abuse or neglect, and found that initial problem recognition and intentions to change predicted 'a few improvements in individual and family functioning, along with significant reductions in the likelihood of additional reports of child maltreatment within one year' (Littell and Girvin, 2005, p.59). However the authors concluded that there were few advantages of an overall readiness score; that it is unlikely that greater problem recognition or intention to change results in better outcomes; and that it should not be 'assumed that initial problem recognition, intentions

to change, or apparent readiness for change determine who is most likely to benefit from treatment' (Littell and Girvin, 2005, p.76). Instead, the concepts should be used as an indication of the issues as part of a broader assessment process. Social workers should therefore conduct comprehensive assessments of parents' views about their problems; goals and values; levels of discomfort with the status quo; hopes about whether the situation can improve; and their opinions about available alternatives (Littell and Girvin, 2006).

A procedure for assessing parents' capacity to change (Harnett 2007)

Harnett (2007) develops some of these theories further and proposes a procedure to assist social workers in assessing parents' capacity to change, which addresses some of the limitations of current assessment. The limitations he identifies include the narrow focus on particular aspects of family functioning; the absence of social workers' views about the reliability and credibility of parents' reports in light of the potential bias towards responses which are perceived as being desirable; and the absence of observations of parent-child interaction. Where the evidence of parental capacity to change is equivocal, Harnett identifies reliance upon cross-sectional assessment as a serious weakness because it only provides a snapshot of family functioning at one point in time. To address these issues, Harnett proposes a procedure for assessing parents' capacity to change over a period of four to six months during which they are engaged in a brief, intensive intervention.

This extended procedure directly assesses parents' motivation and ability to change and requires practitioners to consider any further interventions that might be necessary and identify the level of support required for change to be maintained. This model of 'capacity to change' is less concerned with a parent's report of their intentions to change and more concerned with the direct assessment of actual change. The assessment model considers the attainment of goals as evidence of parents' capacity to change, and it is this that allows for a better prediction of future family functioning.

Harnett's procedure for assessing parents' capacity to change involves four elements which are described below:

- *conduct of a cross-sectional assessment of parents' current functioning;*
- *specification of targets for change derived from an assessment of current strengths and deficits in the family;*
- *implementation of an intervention with proven efficacy for the client group with a focus on achieving clearly specified targets for change; and*
- *objective measurement of changes in parenting*

(descriptions adapted from Harnett, 2007).

The procedure does not therefore exclude the use of cross-sectional assessment of family functioning, but incorporates it as one element within an extended process.

Cross-sectional assessment of parents' current functioning

This stage involves a cross-sectional assessment following best practice guidelines to provide a baseline from which to assess change, and includes an assessment of problems in child and parent functioning and child-parent interaction. The cross-sectional assessment is based on an integrated theoretical framework of child development and family functioning. First the child has an assessment which covers physical problems and developmental delays in daily living skills, together with emotional, cognitive, social and behavioural functioning. Next, drawing on attachment theory, the parent-child relationship is assessed, with a focus on parents' capacity to be emotionally available to the child. An assessment of the parents includes gathering historical information about their own experience of abuse and the impact of this on current parenting practices; knowledge, attitudes and beliefs concerning childrearing; and their intellectual functioning. The ability of the parent to regulate their own emotional state is seen to be a key factor influencing their capacity to be emotionally available, to implement non-punitive discipline, and maintain regular family routines. Finally, the social ecology of the family is assessed, in particular an assessment of stressful life events, external demands and availability of support.

The cross-sectional assessment is used as a basis for developing a case conceptualisation. Social workers employ standardised psychological tests and scales as part of the cross-sectional assessment to provide a baseline on which to formulate an objective measure of parental change.

Specifying targets for change using goal setting theory

The next step is to work with parents to identify achievable goals that are meaningful in the context of the particular family undergoing assessment. Within this context, goal setting theory can help social workers understand how best to support parents to change behaviours. It can also help to focus parents on changing particular aspects of their behaviour and reduces ambiguity as to the extent to which they need to change, by establishing specific targets (Locke and Latham, 2002).

Key to the theory is that goals need to be meaningful to parents and perceived by them as being manageable. In this way, goal setting can bring parents 'on board' and give them a sense of being an active participant in the change process rather than having change thrust upon them. Dawe and Harnett's (2007) study of the Parents under Pressure (PUP) programme for methadone users highlights how setting meaningful goals is more likely to result in parents feeling committed to attempting change, whereas imposing goals on them may lead to frustration and resistance. A goal set tersely by someone else without any explanation will result in lower performance (Latham, Erez and

Locke,1988). Thus the model blends the collection of more objective data by which change can be measured with a strong relationship-based element.

Although the ultimate goal for parents may be to overcome their difficulties so that their child is no longer at risk of harm, goal setting theory suggests that parents will be more successful if smaller, interim goals are set in addition to an end goal (Latham and Locke, 2007). In this way, parents have manageable targets and are not set up for failure. Providing feedback to parents may also motivate them, helping them feel they are progressing towards each goal; the combination of goal and feedback has been found to be more effective than goal setting alone (Locke and Latham, 2002). In addition, the feedback process will give social workers the opportunity to assess progress for themselves as part of the assessment of parents' capacity to change.

A collaborative approach to goal setting is also important because individuals with low levels of self-efficacy (belief in their ability to succeed) have been found to be more likely to set lower goals for themselves than those who strongly believe they can be successful (Latham and Locke, 2007). Parents whose children are on the edge of care are often attempting to overcome multiple, entrenched difficulties and may have low levels of self-efficacy. By agreeing goals collaboratively, social workers can ensure that the goals are realistic yet not set too low. Low goal setting may mean that change is too slow to be sufficient to meet the timescale for the child.

Harnett proposes the use of Goal Attainment Scaling (GAS) (Kiresuk *et al.*, 1994; Ogles *et al*., 2002) as a useful tool for identifying appropriate goals and monitoring parents' achievements, using a five point outcome rating system which permits quantification of the change achieved.

Implementing an intervention with proven efficacy for this client group with a focus on identified targets for change

Harnett states that the outcome of a capacity to change assessment will be significantly influenced by the delivery of an effective intervention, which addresses the multiple needs of the particular family being assessed. Parents whose children are on the edge of care are frequently faced with a complex web of problems; single issue programmes, which focus on one specific area of concern are less effective than multifaceted programmes that address the interlocking domains of family functioning that may need to change (see Dawe and Harnett, 2007). Chapter Six explores further some of the evidence-based interventions that have been shown to be helpful to parents and children in such circumstances.

Assessment of change

Following completion of the intervention, the social worker will evaluate the results of the standardised psychological tests administered pre-and post-intervention, the structured observation of parent-child interaction, using methods such as the Emotional Availability

Scales (Biringen, 2000) and the results of the GAS procedure. Changes on the standardised assessment measures and the extent to which goals have been attained provide the required evidence of capacity to change.

Employing different types of assessment to understand parents' capacity to change

Using the multiple types of assessment proposed by Harnett enables social workers to assess motivation, readiness and ability to change from a number of perspectives and across a period of time. Harnett's procedure for assessing parental capacity to change recognises that social workers are faced with the difficult task of producing sufficient evidence for the courts concerning families with complex needs who may be living chaotic lives, in circumstances where multiple factors will potentially impact upon parenting capability. By using different types of assessment over an extended period, this procedure for assessment provides a framework for considering capacity to change across a number of domains. The procedure applies a layer of formal objective assessment to highly individual circumstances and, as such, provides social workers with a framework for providing hard data that will support evidence based decision-making, and help counteract some of the recognised pitfalls of relying on professional judgment and experience alone (see Chapter One). Importantly, the assessment model is based on a theoretical framework that is derived from evidence-based models of child development and family functioning.

Limitations of the procedure for assessing parents' capacity for change

It is possible that different elements of the assessment procedure will provide conflicting evidence of capacity to change. For example, an interview will provide the parent's views on their ability and motivation to change, whilst an observation of parent-child interaction using validated scales may tell a different story. The evaluation of the evidence therefore needs to be clearly set out in the social worker's assessment. Where the practitioner considers that the evidence from validated scales should be disregarded, reasons should be given.

It is important to appreciate that although the tools used in Harnett's procedure for assessing parents' capacity for change can help to provide a broader evidence base for social worker decisions, no assessment procedure can provide conclusive evidence of a parent's motivation, willingness or ability to change. Moreover parents are free agents in the process of change, and may not follow anticipated pathways. Unforeseen events may also impact on the change process. The procedure should not be used mechanistically in a tick box approach, and should inform rather than replace structured professional judgment concerning whether parents are able to make sufficient changes within a child's timeframe.

Conclusion

Practitioners will find it difficult to understand whether parents are able and ready to overcome adverse behaviours unless they have some means of conceptualising what needs to change, how such change might be achieved, and the factors that promote or facilitate it. The best known models of change have been developed within health promotion services to facilitate understanding of single issues such as overcoming addiction to tobacco or alcohol. While these may provide a foundation for conceptualising how change might be modelled in child welfare, they need to be modified to reflect the complexities of child protection cases, including the potential impact of coercion and the pressure on parents to present themselves in a positive light. Harnett's dynamic model of assessing parents' capacity to change, through collecting baseline data, case conceptualisation, and then setting mutually agreed goals and monitoring progress towards them should provide the necessary evidence to inform structured professional judgments. Such judgments will focus on whether parents have made sufficient progress to demonstrate that there is no longer a likelihood of significant harm within a timeframe that is appropriate for the child.

Key points from Chapter Three

- In order to assess parental capacity to change, practitioners first need to formulate a case conceptualisation, mapping out the various external and internal factors that impact on parents' ability to meet their children's needs, and identifying their strengths as well as their weaknesses.
- Practitioners need to be mindful that parents' prior experiences may have led to severely insecure attachment styles and that these can affect their relationships with professionals. They may, for instance, be unwilling to open up or be suspicious and distrustful of authority.
- Models of change can offer helpful insights into how parents overcome adverse behaviour patterns, particularly where these are entrenched and the change process is complex. Models of change can provide useful conceptual frameworks for appreciating this complexity and prevent practitioners from relying on compliance as a proxy indicator of success.
- Although models of change can provide an enhanced understanding of the processes and mechanisms involved in behavioural change, they cannot predict whether an individual parent will or will not change or whether they will sustain progress in the long term.
- The best known models of change, such as the Trans-Theoretical Model (TTM) have been developed in response to evidence concerning how individuals *intentionally* overcome adverse behaviour patterns. There are difficulties in translating these into a context in which coercion plays a part.
- Parents who maltreat their children are likely to have complex and multifaceted problems that may not fit into a single-stage classification. Over-reliance on

classification systems that focus on readiness for change alone might offer a limited view of the challenges to be faced.

- The procedure for assessing parents' capacity to change proposed by Harnett offers a useful model by which change can be assessed over time. This involves the use of standardised screening tools before and after an intervention, together with identification of goals to be agreed between the social worker and the parent and met within a specific timeframe.

Chapter Four: Ambivalence, denial and unwillingness to change

Introduction

Many parents in families where there are significant child protection issues and children are on the edge of care may deny that problems exist. They may be overwhelmed by the struggle to cope with issues such as poverty and poor housing, which provide a context that increases the likelihood of abuse and neglect (Brandon *et al*., 2012; Merritt, 2009). They may not perceive that personal changes are necessary and can vehemently defend adverse behaviour patterns (Prochaska and Prochaska, 2002; Ward, Brown and Westlake, 2012). Assessing parental capacity to change in these situations requires empathy and relationship skills (Forrester *et al.*, 2012; Holland, 2000); it also requires professional objectivity and understanding of the common pitfalls of intuitive reasoning (Munro, 1999), and a working environment in which decisions can be openly discussed and tested out with colleagues and staff receive supportive supervision in which mistakes can be acknowledged without fear of censure (Munro,1999,2005; Kirkman and Melrose,2014; for further discussion see Chapter One).

This chapter explores the factors underlying denial or unwillingness to change, and discusses how parents might be helped to accept that there is a problem and move forward. The following chapter looks at the more positive side of the picture and explores how parents can become motivated to change and engage with the services designed to support them through this process.

How common is denial or unwillingness to change?

Parents who appear to deny that that there is a problem or to be unwilling to make changes that might protect their children from future harm are sometimes described as 'resistant, or highly resistant to change' (Fauth *et al*., 2010, *passim*). A recent knowledge review concluded that there were no clear or consistent statistics on the numbers who fit this description (*ibid*., p.27); moreover prevalence rates will be highly variable as behaviour patterns will change as parents move in and out of this stage. However, Farmer and Lutman's (2012) study of neglected children returning home from care found that 39% of parents actively resisted or attempted to sabotage interventions from professionals, and Dawe and Harnett found that 36% of families remained at high risk of child abuse and neglect after receiving support from the Parents Under Pressure (PUP) programme (2007, p.1185). Moreover, Brandon and colleagues (2008, 2009) found that between 66% and 75% of parents involved in serious case reviews had shown disguised compliance, unwillingness to change and/or ambivalent or selective cooperation with services. Cases before the courts are more likely to involve parents who are unable or unwilling to change; where previous involvement with children's services under a child protection plan or the formal pre-proceedings process has helped parents make and

sustain changes that ensure their children are now adequately safeguarded from harm, applications to court are unnecessary.

Disguised compliance, failure to cooperate, and unwillingness to change

Brandon and colleagues' studies of serious case reviews, where children have been seriously injured or died, found extensive false compliance. In these instances, on the surface parents appear to engage with services to avoid raising suspicions, but in reality are not making progress towards improving their capacity to provide a nurturing home for their children:

> Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents engineered the focus away from allegations of harm, children went unseen and unheard (Brandon *et al*., 2008, p.4).

Forrester and colleagues (2012) argue that cases in which parents consciously and systematically cover up deliberate abuse are relatively rare. However, this is more likely to occur in situations of such severity that they are followed by a serious case review, and indeed false compliance and deliberate concealment were factors in the recent high profile deaths from abuse and neglect of Victoria Climbie (Laming, 2003), Peter Connelly (Haringey LSCB, 2010) and Daniel Pelka (Coventry LSCB, 2013).

While systematic and conscious concealment of deliberate abuse may be rare, denial of adverse behaviour patterns and/or their impact on children is a recognised response of parents and other adults who have not yet understood or acknowledged the need to change, or who are overwhelmed with their difficulties and fearful about their ability to do so. It may manifest itself in anger or hostility and/or refusal to admit that there may be a problem. For instance, perpetrators of domestic abuse may avoid taking responsibility for their behaviour by denying or minimising its severity, or by blaming their partner or external circumstances beyond their control. As such, 'the batterer is preoccupied with his own needs and wants, and views his wife as another "object" to control and manipulate for his own advantage' (Gondolf, 1987, p.341). For these individuals there is no problem, and therefore no reason to change or to engage with services. Parents with mental health problems or learning disabilities may also refuse to accept that there is a problem because of the stigma attached to their condition (see Booth and Booth, 1993; Hinshaw, 2005). Within certain black minority ethnic and refugee (BMER) communities there can be acute shame in admitting difficulties such as domestic abuse or mental health problems and stigma attached to seeking the assistance of social services (Bhardwaj, 2001; Qureshi *et al*., 2000). This may lead families to hide their problems from the outside world, making it difficult for social workers to assess how parents are coping.

Denial may also show itself in more passive resistance, for instance in a failure to undertake the actions specified in child protection plans, to attend appointments with professionals, or to complete a programme of treatment. Ward and colleagues found that written agreements made between parents or carers and agencies, and intended to formalise safeguarding arrangements, could be an ineffective means of protecting children from harm because their terms were frequently broken, often without consequences (Ward, Brown and Westlake, 2012, pp.168-169; see also Farmer and Lutman, 2012). Daly and Pelowski (2000) found that at least one in five perpetrators of domestic abuse fail to complete treatment, and that the drop-out rate is as much as 99% for some programmes; Damashek and colleagues (2011) calculate that between one in five and one in three participants fail to complete home based programmes designed to prevent child abuse and neglect (p.9).

Adults who deny that there is a problem or that their behaviour has an impact on their children, may exhibit false compliance, and go through the motions by keeping appointments, but fail to collaborate by genuinely participating in treatment (see Dawson and Berry, 2002). Ward and colleagues found that abusive and neglectful parents who denied the impact of their behaviours had often had long-standing involvement with children's social care and were familiar with child protection processes; as a result, they were better able to persuade practitioners that they could safeguard their children, regardless of their readiness or ability to change their lifestyles (Ward, Brown and Westlake, 2012, p.135). Ekendahl (2007) found that adult substance misusers who generally spent their time on the streets might occasionally go through the motions of entering treatment if they needed to do so to fulfil the criteria for obtaining help with housing (p.250).

Denial and passive resistance are not the only reasons why individuals do not seek or use available help, fail to attend appointments or drop out of programmes (see below), although they can be a major contributing factor. It is also always important to bear in mind that denial may also mask a genuine lack of insight and understanding of concerns that require greater clarification.

Factors underlying unwillingness to change

We have already seen that a small number of parents feign compliance with services in order to deflect suspicions and conceal systematic and deliberate abuse. However, in the majority of cases, false compliance and feigned engagement are thought to be more subtle – and more complex. A number of authors have argued that combinations of interlocking factors contribute to parents' denial that a problem exists or unwillingness to make changes, and that these broadly fall into two groups:

- internal factors present within the individual and their family; and

- external factors present within parents' social contexts, covering not only their immediate environment, but their relationships with the external world, including their encounters with social workers and other professionals (see Forrester *et al*., 2012; Gladstone *et al*., 2012; Randolph *et al*., 2009).

The range of interlocking factors that underlie an individual's motivation to change and engage with services can be seen as presenting the obverse but more positive side of this picture, and are discussed in the next chapter.

Internal factors

Failure to understand that a problem exists

Parents living with learning disabilities or with mental health problems, including impaired personality function, may not deny the need for change. They may simply not recognise or understand the types of behaviours they are exhibiting, or why they can have a damaging impact on children (Booth and Booth, 2004; Brophy *et al*., 2003). Booth and Booth (2004) state that parents with learning disabilities are 'anywhere between 30 and 60 times more likely to be the subject of a care order application than their numbers in the general population would warrant' (p.10). Likewise, Brophy and colleagues (2003) found that up to 43% of social work cases that lead to care proceedings involve parents with mental health problems.

Increased isolation

Taylor and colleagues (2008) explored some of the challenges of engaging and accessing parents and children in families experiencing interlocking problems, in which the key components are alcohol or substance misuse. Their focus was parents who drop out of alcohol misuse programmes, but many of these issues are also common to parents struggling with mental health problems, substance misuse and domestic abuse, partly because these often co-exist, but also because the barriers to acceptance and engagement are often the same.

The fear of stigma experienced by parents facing these problems, together with the potential child protection implications, may lead them to close off contact with those outside the immediate family, including professionals. A vicious circle may then develop, in which alcohol or substance misuse may become a way of coping with the pressures of maintaining secrecy, but also exacerbate the problems. Poor mental health may be a compounding factor (see Hinshaw, 2005), with existing feelings of depression or paranoia magnified by the fear of stigma and the perceived need for secrecy. In such families secrecy may become the dominant concern: the family may be split between those who know what is happening and those who do not, and children may feel unable to talk to others about their experiences (Taylor *et al*., 2008).

Barnard and Barlow (2003) interviewed 36 children whose parents misused substances and found that they experienced a 'weight of forced silence' (p.54), in which they

struggled with the contradictory experiences of knowing that there was a problem, yet being unable to raise questions at home because the subject was never discussed, or outside the home because of the unspoken need to maintain family loyalty. Very similar dynamics have also been found in families in which domestic abuse (Humphreys *et al*., 2011) or sexual abuse (Bradley and Wood, 1996) is an issue, for the same forced silence often exists between family members (perpetrators, victims and non-victimised children), and the same perceived need to protect the family by keeping its secrets hidden from the outside world. Taylor and colleagues (2008) argue that the need for secrecy alters the family dynamics, because it undermines trust and leads to fluctuating emotional relationships between parents and children.

Shame, ambivalence and a lack of confidence

Forrester, Westlake and Glynn (2012) identify three further internal factors that contribute to denial and unwillingness to change within individuals: shame, ambivalence and a lack of confidence. Shame is related to the stigma surrounding many of the behaviours, past experiences and current situations of parents who have dealings with child protection services. Ambivalence refers to the conflicting emotions that parents may feel when they perceive both positive and negative consequences of overcoming behaviour patterns such as alcohol misuse, which professionals may view in terms of the negative impact on their children, but which they may see as also offering some comfort and protection from the reality of their situation. Parents who experience acute ambivalence may not yet have accepted a need to change. Some authors have suggested that the threat of legal proceedings may reduce ambivalence and act as a positive driver of change (see for instance Gregoire and Burke, 2004; Hiller *et al.,* 1998; Joe *et al.,* 1999). This, in part accounts for the effectiveness of the formal pre-proceedings process in diverting cases from care proceedings (Masson and Dickens 2013). On the other hand, parents who lack self-confidence may be ambivalent about their *ability* to change and this may be at the root of their denial (see also Forrester *et al*., 2012; Saint-Jacques *et al*., 2006; Taylor *et al*., 2008).

Morrison (2010) argues that practitioners need greater understanding of the internal factors that may lie behind the apparently perverse responses of some parents when involved in child protection interventions:

> Much is at stake for these families: fear of exposure, stigma, removal of their children or even prosecution. Fearful and anxious at the intrusion of external agencies, they may be defensive, angry and unwilling to acknowledge the reality of any difficulties. Negative previous experiences of statutory agencies may exacerbate this. Blame and responsibility may be externalised in terms of ‘we were fine until you lot came along’ (pp.314-5).

Alternatively pre-contemplation may be expressed in a more passive or helpless response, where parents cannot comprehend what has happened to their child, and seemingly do not react to professionals’ high levels of concern. Such responses may

result from shock, depression, mental illness or learning disabilities, all of which limit the parent's capacity to understand the concerns (Morrison, 2010).

External factors

Resistance to the involvement of social workers

Resistance to the involvement of social workers is not the same as resistance to change, though the two are often confused. Forrester and colleagues (2012) explored the factors that underlie parental resistance to the involvement of child and family social workers in families. They conceptualise resistance to involvement as an active behaviour that encompasses: 'any form of non-co-operation from parents, including apparent co-operation that masks issues of concern, not engaging, violent or threatening behaviour and other manifestations of non-engagement' (p.118) and argue that 'parental lying - whether conscious and systematic or simply minimizing the extent or impact of an issue - is almost omnipresent in child protection work' (p.123). In their view 'the context of child protection involvement is …in itself likely to create resistance' (p.120). This is because there is a particular imbalance of power in child protection work in that the parent is aware that the social worker's role is, at least in part, to assess and make judgments upon their parenting capacity and that ultimately social workers have the authority to remove the children.

Parents' responses also need to be understood in the light of their own history of engagement with professionals, their early life experiences of shame and anger, their current social context and the ways in which they habitually relate to authority figures. Experiences of discrimination and disadvantage in the past and in the present will be powerful factors behind parents' responses to social work interventions. Past experiences of involvement with children's social care may reawaken feelings of powerlessness, and lead to greater resistance to change.

Dumbrill (2006) explored the part that power relationships between parents and social workers played in the development and maintenance of parents' resistance to social work involvement. He used a grounded theory approach to analyse in-depth interviews with eighteen parents who had been involved in child protection interventions and to build a model representing how parents perceived and reacted to such interventions. The power imbalance was central to this model, but Dumbrill found that parents might perceive such power as being exercised *over* them, in a coercive or penalising manner, or *with* them as a form of support.

Many parents may be mindful of the power imbalance and approach a relationship with social workers with caution; however, those who perceive social workers as exercising power *with* them are more likely to respond by 'working with services in what appear to be genuine and collaborative relationships' (Dumbrill, 2006, p.33). If power is perceived as supportive, then parents can respond positively to small words of encouragement (*ibid.,* p.31). They also appreciate it when workers exercise 'power with them through

advocacy' by, for instance, supporting their case against landlords who are unresponsive to their needs (*ibid*., p.31).

On the other hand, those parents who perceive the relationship as characterised by power *over* are more likely to be fearful of social workers whom they perceive as quickly categorising their cases to fit pre-established plans. In such circumstances there is little room for dialogue, and parents feel that they have little opportunity to challenge workers' opinions and plans even if these seem illogical and against the best interests of their children. Parents tend to respond to perceptions of power being used over them by 'fighting' through openly challenging or opposing workers in court or by 'playing the game' by feigning cooperation. In these circumstances the power struggle becomes the focus of the relationship with the social worker, and gets in the way of achieving the objectives of the intervention (Dumbrill, 2006).

It is apparent from this and other studies (see Forrester *et al.,* 2012; Forrester and Harwin, 2011; Humphreys *et al.,* 2011; Miller and Rollnick, 2013; Platt, 2008; Scott, 2004) that practitioners need to be aware of their own role in exacerbating or reducing resistance to engage with children's social services. Several writers have argued that the way in which the social worker approaches the family can increase or decrease the parent's resistance. Forrester's studies of social workers' communication styles found that the majority adopted 'a highly confrontational' approach in child protection work, and that confrontation tended to create high levels of resistance (see Forrester and Harwin, 2011; Forrester *et al*., 2008a). Dumbrill (2006) found that descriptions of power being used *over* parents were 'far more evident' than descriptions of power being used *with* them (p.32). Forrester and colleagues (2012) argue that social workers need to learn how to interact with parents in such a way that they do not exacerbate or cause resistance, their first duty being to cause no harm (p.124); they point out that an approach which underlines parental deficits is more likely to lead to resistance than one which focuses on and reinforces positive behaviours and acknowledges the challenges parents are facing.

Support from other agencies

In times of need, other professionals may be seen as less threatening than social workers, and parents and children may choose to circumvent children's social services by engaging with them (see Stanley *et al*., 2003). The evidence concerning parents' resistance to social work involvement, and the tendency of some to seek support from elsewhere, also emphasises the importance of social workers developing strong inter-agency links with professionals such as health visitors and practitioners in adult services (see Ward, Brown and Westlake, 2012).

Advocacy is a promising approach being implemented to promote the active engagement of parents whose children are on the edge of care (see Department for Education, 2014a). Holt and colleagues (2013) suggest that effective advocacy provides a means of moderating the 'imbalances of knowledge and entitlement' faced by parents involved in

formal child care proceedings (p.166). There is also some evidence to suggest that increased participation by parents in decision-making processes leads to improved engagement (Featherstone *et al*., 2011; Featherstone and Fraser, 2012; Healy and Darlington, 2009). Advocacy may therefore provide a means of reducing resistance and may re-focus parent-social worker interaction on the substantive problems which need addressing rather than the problematic relationship between the parties.

Motivational Interviewing: strengths and weaknesses

A number of authors argue that motivational interviewing can reduce unnecessary confrontation and help parents move on from a position where they deny that a problem exists and are unwilling to change or engage with services (see Bowen and Gilchrist, 2004; Forrester *et al*., 2012; Zalmanowitz *et al*., 2013). As Morrison (2010) states: 'change does not start when parents enter the action stage; it starts when we enable an anxious, fearful, or angry parent to make the first steps along the pathway of [contemplating the need for change]' (p.321). Harnett (2007) argues that clear specification of goals that are meaningful to parents and a promise that progress will be acknowledged will facilitate this process.

Motivational interviewing (MI) is a counselling method, originally developed in response to the treatment of problem alcohol users. It focuses on exploring and resolving a person's ambivalence about change, and accepting that ambivalence is a normal part of the change process. The core value of MI is that it does not impose change; rather it supports change in a manner which is congruent with the person's own values and concerns (Miller and Rollnick, 2013). MI was developed as a clinical tool for individuals who are not yet ready for change, to help them move forward (Miller and Rollnick, 2013). MI is characterised by a particular approach, based on three key elements: collaboration between the therapist and client; evoking or drawing out the client's ideas about change; and emphasising the autonomy of the client (Miller and Rollnick, 2013).

There is an extensive and increasing evidence base relating to the effectiveness of MI. A meta-analysis of 72 clinical trials across a range of target problems found some evidence that MI could be an effective method of approaching addictive and health-related behaviours (Hettema, Steele and Miller, 2005). The strongest support for the efficacy of MI was in reducing substance misuse, with slightly larger average effect sizes[3] (0.51) for illicit drug use than for alcohol abuse (0.41) (*ibid.*, p.102). However there was a wide variability in effect sizes across studies, even within the same problem areas, indicating that the way in which MI is delivered can have a substantial impact on outcomes.

[3] An effect size of 0.2 is considered to be small; an effect size of 0.5 is medium and one of 0.8 or greater is large (Cohen, 1969) see Chapter Six.

Across all the studies covered by the meta-analysis, the average effect size of MI was relatively high (0.77) within the first month after treatment, but it diminished fairly rapidly, to 0.30 within six months and 0.11 after a year (*ibid.*, p.100). The exception was in those studies where MI was used in promoting intervention engagement, retention and adherence at the beginning of an active treatment programme. In these circumstances the effect was maintained or increased over time, and averaged 0.6 (Hettema, Steele and Miller, 2005, p. 101).

There is also some slight evidence showing that MI could be useful for men undertaking court mandated treatment for domestic abuse. For instance, Zalmanowitz and colleagues (2013) undertook a large quasi-experimental study[4] comparing 211 men who attended a domestic violence prevention programme in a large Canadian city. About half of them (105) received MI before attending the programme, and about half (106) did not. All of the men in this study showed positive change following therapy, and those who received MI did better than those who did not. However the differences were not sufficient to rule out the possibility that they had occurred by chance, and none of the participants in this study had initially shown extreme levels of violence and distress.

Individuals who respond to MI may have more discrete and less entrenched difficulties than the multi-layered problems that can overwhelm parents whose children are on the edge of care. Di Clemente and colleagues (2008) argue that motivational interviewing may not be so effective in a child welfare context because: 'brief motivational interventions prior to treatment have not always improved treatment engagement and outcomes in populations of drug-abusing individuals who are poor, minority and less educated with multiple problems' (p.27). Nevertheless, parallels have been drawn between the values of MI and child and family social work (Forrester *et al.,* 2008a). Forrester and colleagues (2012) argue that in child welfare cases, MI can be used to increase parental engagement and to address the factors underlying parental resistance to involvement with child and family social workers. The authors discuss five principle causes of parental resistance: social factors; individual and family factors; shame; ambivalence; and lack of confidence. They propose MI as a useful skill for reducing social worker contribution to resistance as well as other causes, and identify three strategic aims in working in child protection using MI:

- a focus on the child's welfare and possible harm to the child;
- a focus on engaging the parent;
- a focus on eliciting 'change talk' to resolve ambivalence about behaviour change.

A randomised controlled trial of MI in child protection work in the UK is currently underway. The study explores whether training and supervision in MI helps social

[4] A two-group non-randomised comparative trials with a relatively high level of evidence (Level B, see Chapter Six).

workers to engage parents, and whether this is related to improved outcomes for children. The project is due for completion in 2014 (see Forrester, forthcoming).

The Family Partnership (FP) Model

A number of studies have identified how the professional relationship between the social worker and the service user is central to effective practice (see for instance Barlow and Schrader McMillan, 2010; Sudbery, 2002). The Family Partnership Model attempts to address the difficulties that practitioners encounter in developing such relationships under adverse circumstances, such as when parents are hostile or frightened that their children might be removed and are reluctant to engage with social workers. The model was developed to 'provide practitioners working with families with an explicit and detailed understanding of the dynamic processes of helping' (Harnett and Day, 2008, p.81). Partnership is at the heart of these processes, and this will only be successfully established if practitioners are able to communicate 'genuine respect for, interest in and commitment to parents, regardless of the conditions that have brought about statutory involvement' (Harnett and Day, 2008, p.81). Effective partnership working is characterised by: working closely together with active participation and involvement; sharing decision-making power; recognition of complementary expertise and roles; sharing and agreeing aims and how to achieve them; negotiation of disagreement; mutual trust and respect, openness and honesty and clear communication (Harnett and Day, 2008).

Barlow and colleagues (2007) evaluated the effectiveness of home visiting delivered by health visitors using the Family Partnership Model[5]. The study involved a sample of 131 women recruited through GP practices, who had been identified as vulnerable and specifically at risk of abuse and neglect (e.g. with mental health or housing problems), 67 of whom received the home visiting programme and 64 standard services. Visits took place from 6 months antenatally to 12 months postnatally and were designed to promote parent-child interaction. At 12 months small differences favouring the home visited group were observed on an independent assessment of maternal sensitivity ($p < 0.04$) and infant cooperativeness ($p<0.02$), but this was no longer apparent at 3 years (Barlow *et al*., 2008). No differences were identified on measures of maternal psychological health attitudes and behaviour, infant functioning and development at either 12months or 3 years. Slightly more of the intervention group infants became the subject of child protection proceedings, or were removed from home; this was thought to relate to improvements in health visitors' sensitivity to abuse and neglect (Barlow *et al*., 2007). Kirkpatrick and colleagues (2007) conducted 20 interviews with women who had completed this programme and found that, although they had initially had negative

[5] This was a multicentre randomised controlled trial with a high level of evidence (Level A, see Chapter Six).

expectations of health visitors and social workers, they greatly valued the relationships that had developed and thought that they had benefited by 'increased confidence, improved mental health, better parenting, improved relationships and changes in their attitudes toward professionals' (p.32).

The Family Partnership Model was also evaluated as part of the European Early Promotion Project (EEPP)[6] (Davis *et al.*, 2005; Puura *et al.*, 2005). Similar improvements were found in mother-child interactions, particularly in Greece (Davis *et al.*, 2005). In the UK, mothers who participated in the programme were found to be 'more responsive towards their children, provided more appropriate play material, had a better relationship with the children, were more involved and used less control than comparison mothers', although the average effect size was small (0.27) and they did not show significant changes on all the measures used (Puura *et al.*, 2005, p.90).

The Family Partnership Model focuses on the development of a collaborative partnership with parents which is perceived as inextricably bound up with the specific tasks of the helping process. These include 'exploration, understanding, goal setting, strategy planning, implementation, review and ending' (Harnett and Day, 2008, p.81). These tasks are integral to Harnett's (2007) procedure for assessing parental capacity to change (see Chapter Three). The Family Partnership Model offers practitioners an evidence-based approach for developing the effective relationships with parents that are a key element in such assessments (see Harnett and Day, 2008). However, although the trials identified by our literature search show some encouraging results in terms of improved relationships with professionals, they do not show a strong or enduring impact on parent-child interactions.

Family Group Decision-Making

There is considerable evidence to suggest that involving parents and their wider extended family in the decision-making processes can decrease parental resistance to involvement with social workers by reducing their feelings of powerlessness within the context of statutory interventions and court proceedings. Family Group Decision-Making (FGDM), sometimes referred to as 'family group conferencing', was introduced in the UK in the 1990s, with the support of the Family Rights Group. It represents a departure from traditional decision-making models in child welfare, where there can often be an emphasis on expert knowledge and skills within an adversarial context (Barnsdale and Walker, 2007). FGDM was first developed in New Zealand, where it is now mandatory,

[6] This was a large multi-centre non-randomised comparative trial in five European countries with a relatively high level of evidence (Level B, see Chapter Six).

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and has since been applied in a child welfare context in more than 150 communities worldwide (Crampton, 2007). FGDM is defined as 'a clear process bringing together professionals and the family, including extended family, in a meeting to resolve issues of child care and protection' (Morris and Connolly, 2012, p.42). Its core components are:

- the family has the services of a co-ordinator, independent of their case management, to assist in the facilitation of the meeting;
- the family has private family time during the meeting when they can make decisions and plan for the care and safety of their child without professional influence; and
- there is a commitment to respecting the family plan unless a child is placed at risk of harm (*ibid*., p.42).

Our search identified two extensive literature reviews, but no rigorous systematic reviews of studies reporting on the impact of FGDM. Barnsdale and Walker (2007) undertook a comprehensive literature search and interview study to examine the use and impact of FGDM within a UK context. Morris and Connolly (2012) reported on an extensive review of international literature on FGDM that forms the basis of an annotated bibliography, collated for the American Humane Association (Burford *et al*., 2009). Both reviews appear to have been wide-ranging, but neither gives details of exclusion (or inclusion) criteria.

Engagement and satisfaction

Both reviews found considerable evidence to show that FGDM is effective in engaging the wider family in decision-making; that families value the opportunities to become involved and feel positive about their experiences; that they become more committed and engaged with plans for the child; and that FGDM opens up new possibilities for the care and protection of children within family networks. They also found evidence that FGDM can increase the role of fathers and male and paternal relatives (Barnsdale and Walker, 2007; Morris and Connolly, 2012; see also for instance Holland *et al*., 2005; Titcomb and LeCroy, 2005). A further study evaluating a project in North West England, and not covered by either of these reviews also shows that FGDM can be effective for BME[R] families as it is: 'respectful of family culture and prioritises the voice of the family over the voice of the professional, thereby dealing with many of the issues raised by BME[R] families' (O'Shaughnessy *et al*., 2010). The emphasis of FGDM on communication is also viewed as being important to those BMER families requiring interpreters, who are not always available when other mainstream services are used (*ibid*.).

Although there is good evidence that FGDM is viewed positively, is effective in engaging with family members and in facilitating the preparation of plans, there is less research evidence concerning successful implementation of plans and outcomes for the children concerned (Barnsdale and Walker, 2007, p.102).

Children's participation and outcomes

Concerns continue to be raised about whether children's voices and those of vulnerable family members such as victims of domestic abuse are adequately heard in an FGDM context which can be easily dominated by professionals or adults from the extended family. The studies reviewed by Barnsdale and Walker (2007) suggest that 'children and young people frequently attend FGDM conferences; however, a 'significant minority' can find themselves excluded from the process itself' (p.40). Morris and Connolly's (2012) analysis is more positive, and points to the value of an advocate being present at decision-making meetings, to support the child (p.47).

Although the research evidence is limited, a number of the studies reviewed by Morris and Connolly (2012) report a range of positive outcomes for children and young people following FGDM. These include increased support by family members and better family relationships (Staples, 2007) and increased rates of relative care: for instance, Titcomb and LeCroy's (2005) study of 291 families who completed the programme in Arizona found that the numbers of children placed with relatives increased from 47% at referral to 77% after the FGDM meeting (see also Morris and Connelly 2012, p.46).

However two studies which have compared the outcomes of family group conferencing with traditional child protection investigations and child welfare services have produced less positive findings. A randomised controlled trial[7] undertaken in America (Berzin, 2006) which compared 197 families receiving FGDM with 126 families assigned to traditional services, found no significant differences in outcome, although the results showed 'trends that suggested higher rates of maltreatment, more placement moves and higher rates of service refusal' for children in families receiving FGDM (Berzin, 2006, pp.1455). Similarly, a three year follow-up of 97 children involved in family group conferencing in Sweden[8] who were compared with a random sample of 149 children from families that received traditional services, found that young people involved in FGDM were more likely to have further substantiated re-referrals for maltreatment (60% *vs*. 40%); were more frequently placed in out-of –home care (42% *vs*. 21%); and spent more time in care (205 days *vs*. 103 days) (Sundell and Vinnerljung, 2004).

Outcomes such as these may appear disappointing, but they may be indicative of greater involvement and concern by members of the extended family following FGDM (see Berzin, 2006, p. 1456), in much the same way that the evaluation of the Family Partnership Model found increased sensitivity of professionals to abuse and neglect (Barlow *et al.*, 2007). The Swedish study found that children in the FGDM group more often placed with relatives (22% *vs*. 3%) and that 'the extended family members seem to

[7] A study with a high level of evidence (Evidence Level A , see Chapter Six)

[8] A two group comparative study with a relatively high level of evidence (Evidence Level B, see Chapter Six)

have submitted knowledge of the parents and children that the CPS did not have before…, leading to proposals in the plans for services on parental substance abuse and children's problems in school' (Sundell and Vinnerljung, 2004, p.281). There is also evidence in this and other studies that, on average, families referred to FGDM have more serious problems than those referred to traditional services: 71% of the FGDM group and 51% of the comparison group had previously been referred to children's services because of child protection concerns (Sundell and Vinnerljung, 2004, p.274. See also Cashmore and Kiely, 2000; Lupton and Nixon, 1999). Greater levels of need may be one reason for negative outcomes.

Engagement of professionals

A number of research studies confirm that the vast majority of plans made in FGDM meetings are approved by professionals. However, only about two thirds appear to be fully implemented (Barnsdale and Walker, 2007, pp.42-3). One Australian study (Cashmore and Kiely, 2000) which found that most of the plans made during New South Wales FGDM conferences were only partially carried out, identified the main reasons for partial (or non-)completion as: failures among family members to change unhelpful behaviours (particularly in relation to drug and alcohol use); changes in circumstances; and statutory agencies' slowness or inability to perform their duties. Both social workers and families viewed a joint lack of commitment to plans and the resulting failures in delivery as the main problem with the FGDM approach. A number of 'key stakeholders' interviewed by Barnsdale and Walker (2007) confirmed this point, indicating that there could be difficulties in implementing plans because either the family or social work services did not keep to the agreement.

This issue is indicative of one of the major difficulties identified concerning FGDM: resistance from professionals to the participative practice it encompasses, and difficulties in introducing innovative service developments into a risk averse, professionalised system (Morris and Connelly, 2012, p.47; see also Brown, 2007). Marginalisation and poor implementation of the FGDM model may be behind other problems noted such as: inadequate preparation, limiting family attendance, professionalisation of the conference, inadequate resourcing and information provision, and reluctance to refer families (Barnsdale and Walker, 2007). An important issue to resolve is the inherent 'tension between the central tenets of the FGDM model and the role of social care professionals and traditional decision-making processes' (Barnsdale and Walker, 2007, p.23), and difficulties in bringing it into mainstream practice. Barnsdale and Walker (2007) point out that 'when FGC becomes procedurally or legally required, the paradoxical prospect is raised of families being required to take part in an 'empowering' process which aims to increase self-determination' (p.3).

When parents cannot change within a child's timeframe

Where parents appear to be denying the need for change and/or are ambivalent about its benefits and there are concerns that children are suffering or likely to suffer significant harm, assessments of parenting capability should be used to explore their current functioning, identify what approaches have been employed to engage, motivate and help them to change, and show what approaches have been made to the extended family.

A range of interlocking factors lie behind some parents' refusal to accept that a problem exists and their apparent resistance to change when faced by child protection concerns. Internal factors within the parent may be exacerbated by external factors, including the approach taken by professionals. Changes in the way that these issues are approached, perhaps through improving practitioner understanding of the dynamic processes of helping, and/or through further development of motivational interviewing and greater involvement of the extended family in participative decision-making may prove to be fruitful ways forward.

Nevertheless, in child protection work, the first responsibility is to ensure that children are safe. Not all resistance to social work involvement is engendered by poor relationships between the parent and the social worker, or by the failure of professionals to accept participative decision-making, and not all parents are able to move on from denying that a problem exists, or being unwilling to change it, to taking action to resolve it within a child's timeframe. Some authors argue that a small number of parents are so far from accepting the need to change entrenched and damaging behaviour patterns that separation is likely to be the only option for the present. Gondolf (2002) and Scott (2004) put forward this argument in cases of extreme domestic abuse where the perpetrator shows a pervasive pattern of disregard for and violation of the rights of others (an antisocial personality disorder). Forrester and Harwin (2008) draw similar conclusions in cases of substance misuse where there is also violence in the home.

Conclusion

There is insufficient research concerning how many parents whose children are on the edge of care persistently deny that a problem exists or how long it may take them to acknowledge the need for change. Their situations, and those of their children, are amongst the most complex, and are likely to take up a disproportionate amount of practitioners' time and energy (Kirkman and Melrose, 2014). Practitioners who are assessing parental capacity to change in these circumstances require opportunities for reflective discussion with others and extensive support from supervisors, designed to help them explore and test out their case conceptualistion (see Chapter One).

The process by which parents overcome unwillingness to change and resistance to the involvement of social workers may prove to be lengthy, and should not become a reason

for delaying decisions concerning alternative permanence plans if these may ultimately be necessary to the child's long-term wellbeing (see Brown and Ward, 2012). Nevertheless, there is evidence to show that some parents with extensive and complex problems who have previously denied that change is necessary, do eventually succeed in overcoming their difficulties and go on to provide nurturing homes for their children (see Ward, Brown and Maskell-Graham, 2012; Ward, Brown and Westlake, 2012). The next chapter explores how such parents become motivated to change and engage with supportive services.

Key points from Chapter Four

- False compliance, failure to cooperate and resistance to social work involvement are common features of parents involved in child protection interventions.
- Mental health problems including impaired personality functioning and/or learning disabilities can reduce the ability of parents to understand the impact of their behaviour on children's wellbeing or to acknowledge the need for change.
- Apparent unwillingness to change can reflect internal factors such as shame, ambivalence about the need to change, and lack of confidence about capacity to change.
- External factors such as the imbalance of power, if not handled carefully, can compound and exacerbate resistance to social work involvement.
- The professional relationship between the social worker and the service user is central to effective practice. The Family Partnership Model was developed to provide practitioners working with families with an explicit and detailed understanding of the dynamic processes of helping, and may facilitate the development of supportive and more effective partnership working with parents.
- A sensitive social work approach, based on principles employed in Motivational Interviewing, can reduce resistance and help parents contemplate change.
- Family Group Decision-Making involves relatives and others in sharing responsibilities for addressing children's needs and gives families a real opportunity to make their own decisions about how to solve family problems; however the research evidence does not indicate that it prevents further maltreatment.
- Where there is no acknowledgement of a problem, in families where there are: perpetrators of sexual abuse; extreme domestic abuse where the perpetrator shows a pervasive pattern of disregard for and violation of the rights of others; there is both substance misuse and violence in the home; and/or where parents consciously and systematically cover up *deliberate* abuse, parents are unlikely to make sufficient changes to protect children from harm within an appropriate timeframe.

Chapter Five: Motivation and engagement

Introduction

The previous chapter focused on ambivalence, denial and resistance to change; it considered the research literature concerning those parents who, for various reasons, are unable to acknowledge the existence of harmful behaviour patterns or their damaging impact on children's wellbeing, and some of the approaches that may reduce barriers to change. This chapter looks at the more positive side of the picture, and explores how parents whose children have previously been likely to suffer significant harm can become motivated to change and engage with services designed to support them through the process. Practitioners who are responsible for making structured professional decisions concerning how far parents are motivated to change, and how they can be supported in translating motivation into action will require the same skills in relationships supported by knowledge of the issues, information from a wide range of other sources including data from standardised instruments, and the same supportive working environment as those who are assessing capacity to change in situations where parents deny that there is a problem.

Much of the extensive literature on capacity to change is drawn from studies that explore how adults overcome problems such as alcohol and substance misuse and domestic abuse, and how long-standing mental health problems can be controlled and alleviated. However, this evidence largely comes from studies of adults who are attempting to overcome a relatively discrete, single issue, while those whose children are on the edge of care are more likely to be facing complex combinations of such problems, together with a whole range of other exacerbating factors which further reduce their ability to parent. The combination of factors which place their children at risk of future harm may well prove overwhelming. As Chapter Three has indicated, theories of change that have been developed from different, less complex, populations may not be sufficiently nuanced to reflect the multi-layered changes that may be needed to overcome the multiple problems faced by such parents.

Motivation: the decisional balance

Research on human behaviour suggests that becoming motivated to change self-destructive behaviours is not a straightforward, rational process. There are factors that increase motivation, and counteracting factors encouraging individuals not to leave the familiar *status quo*. It appears that change occurs when the decisional balance reaches a tipping point, and the potential gains begin to outweigh the anticipated losses (see Prochaska *et al.*,1994). In a seminal paper, Janis and Mann argued that the anticipated gains and losses could be categorised into four different types of consequences: (a) utilitarian gains or losses for self, (b) utilitarian gains or losses for significant others, (c) approval or disapproval from significant others, and (d) self-approval or self-disapproval

(Janis and Mann, 1977, quoted in Prochaska *et al.*, 1994, p.40). Although commentators have since argued that these categories could be simplified into pros and cons (see Prochaska *et al.*, 1994), they form a useful construct for helping practitioners and parents to understand why behavioural change is so difficult, and identifying where the tipping points might be. There is some evidence to suggest that motivation to change involves an increased understanding of the benefits, while action is triggered by a decreased perception of the costs (Prochaska *et al.*,1994).

Tipping the decisional balance: becoming motivated to change

Ekendahl (2007) found that current circumstances, such as an individual's time perspectives and social context, had an impact on their willingness to make the changes necessary to overcome substance misuse. Experiencing the negative consequences of destructive behaviour patterns, such as loss of employment, health problems or separation from a partner and/or children, can all be factors that motivate people to seek change. There is evidence that people who have the most severe problems are most likely to seek help (see Ekendahl, 2007; Gossop *et al*., 2006).

However, Freyer and colleagues (2005) have shown that there is a difference between readiness to seek help or treatment and readiness to change (see also Littell and Girvin, 2005). Engagement with services can be superficial and sometimes instrumental. These authors cite a number of studies that focus on motivation to overcome substance misuse to support their argument that treatment for addictive behaviours may be perceived as offering a brief respite from the immediate adverse consequences rather than a means of achieving long-term abstinence (see O'Toole *et al.,* 2006, 2008).

Parents facing multiple problems may also become motivated to change in one area, but may not necessarily appreciate the need for change in others. For instance, nearly 50% of adults with mental health problems have met the criteria for a substance use disorder at some stage in their lifetime (see DiClemente *et al.,* 2008, p.25). The coexistence of these two problems is associated with: 'non-adherence with medication, symptom exacerbation, rehospitalisation, poor social adjustment and worse prognosis'. These patients may accept hospitalisation in order to alleviate a particular symptom, and while there, take medication and accept treatment to overcome substance misuse; however, once discharged they may avoid all treatment (see DiClemente *et al.,* 2008,, p.25).

A recent study of motivation for change through perpetrator programmes for fathers who are violent towards their partners (Stanley *et al.,* 2012a) distinguished between intrinsic (internal) and extrinsic (external) motivation. The study found that whilst both forms of motivation were valuable, intrinsic motivation was generally more closely associated with greater long-term behaviour change. Men with greater intrinsic motivation wanted to control their behaviour and change their lives; they were motivated by a desire to secure access to their children, avoid losing their children to the care system, and to free their family from the scrutiny of children's services. Strong intrinsic motivation appears to be associated with a shift in self-image such that, for instance, men who come to regard themselves primarily as fathers who want the best for their children may be better able to

appreciate the impact of domestic abuse and improve their parenting capability than those whose self-image remains focused on developing a macho persona that controls and demands respect from their partners and other family members (Stanley *et al.,* 2012a).

The motivation to change behaviour may also be related to an individual's *locus of control*, i.e. whether they feel that events in their lives are within their own control (*internal locus of control*) or whether they are in the hands of others (*external locus of control*). Fisher and colleagues (1998) found that an internal locus of control among sex offenders prior to treatment was an important predictor of treatment success. However, Bowen and Gilchrist (2004) found that when self-referred perpetrators of domestic abuse are compared with those referred by the courts, the role of locus of control is not straightforward. This study found that although self-referred men had higher internal locus of control than those mandated by the courts to attend treatment, self-referred men also saw others as having power over their actions. The authors suggest that this could be interpreted as 'illustrating the importance of their partner's involvement in their treatment' (p.289).

Turning points

Some parents will experience events or circumstances which create a turning point in their lives and motivate them to make the changes needed to overcome adverse behaviour patterns and improve their parenting. Social workers need to be able to recognise these potential turning points so that they can help parents make the most of this window of opportunity. Although the circumstances of every parent will be unique, the literature highlights certain commonalities in how parents experience turning points and the factors which trigger them.

Sudden realisation and gradual change

Parents can experience turning points following a sudden realisation or as the result of a gradual process of change. Where sudden realisation occurs, individuals have described experiencing 'key instances and pivotal moments' (Higginson and Mansell, 2008, p.319) or an 'Aha!' moment (Jung-Beeman *et al*., 2004, p.500). Participants in a study by Carey and colleagues (2007) described this moment as 'the lights going on, putting a shilling in the meter, a load being lifted' (p.182). On the other hand, reaching a turning point through a process of gradual change has been described as 'realisation creeping up' (Higginson and Mansell, 2008). An example might be a parent referred to children's services who does not appreciate the risk of losing their child until well into the referral process (Ward, Brown and Westlake, 2012). It is possible for parents to experience turning points as both a sudden and gradual realisation (Carey *et al*., 2007). This has been described as:

> A period in which there was a slow, cumulative build-up of information and the beginnings of new tentative perspectives which was followed by a significant

instance which stuck in the participant's memories as being of high importance (Higginson and Mansell, 2008, p.319).

Hitting rock bottom as a turning point

A common hypothesis is that some people need to hit rock bottom before they reach a turning point and make positive changes (Field *et al*., 2007). The findings of Carey and colleagues (2007) support this hypothesis, with participants describing a moment of realisation occurring as they reached a particularly low point in their lives. However, other research has cast some doubt on this theory. Field and colleagues' (2007) study of motivation to change among substance users produced conflicting findings. Although increasingly negative life events made seeking treatment more likely among their sample, experiencing increased emotional distress did not.

The role of specific circumstances as a turning point

Certain specific life events or circumstances have been identified as turning points that could lead to improved parenting. The threatened loss of a partner can provide a turning point for domestic abuse perpetrators, for instance, leading them to enrol in treatment programmes (Hester *et al*., 2006; Stanley *et al*., 2012a). Stanley and colleagues (2012a) also found that the involvement of the courts or children's services led some violent fathers to enrol in voluntary treatment.

King and colleagues' (2009) longitudinal study of young people who were homeless or at risk of homelessness found that young women saw pregnancy as a turning point in their lives. These young women differentiated between their past and present selves, with pregnancy providing an opportunity to distance themselves from their street identity and assume the role of parent. Resultant changes included finding more secure housing, going out less, and staying away from drugs and street-involved friends. In some cases, pregnancy became the trigger to reconnect with family for support and it created a renewed interest in returning to education. Pregnancy has also been found to provide a turning point for drug or alcohol dependent women (Bessant, 2003; Etherington, 2007; Kreager *et al*., 2010). The birth of a child can also act as a turning point for fathers, and has been found to lead to a reduction in their levels of criminal behaviour and use of alcohol and tobacco (Kerr *et al*., 2011). However, the changes triggered by pregnancy and the birth of a child are potentially short term in nature. Women participating in King and colleagues' (2009) study described anxiety about the future and their ability to maintain change. They emphasised the importance of access to interventions supporting them in the longer term. Moreover, Bessant (2003) found that the ability of substance misusing mothers to maintain change in the long term was dependent upon their being able to access drug treatment, which in turn hinged on the availability of suitable housing. Turning points should therefore be viewed by social workers as opportunities to engage with parents and introduce appropriate ongoing support.

Collins and colleagues (2012) found that individuals with alcohol dependence sought treatment because it offered a brief respite from the negative consequences of their

addiction. Likewise, studies have found that concern over physical health and acute hospitalisations among homeless and non-homeless substance users provides a 'treatable moment' to engage with them (O'Toole *et al*., 2006, p.144; O'Toole *et al*., 2008, p.1329). However, as with research involving pregnant women discussed above, these studies found that the window of opportunity for engagement was limited. Motivation to change behaviour reduced as an individual's physical condition improved following medical treatment.

Cues for action: listening to children

Hahn and colleagues' (1996) study of parental engagement in health prevention activities explored the impact on parents of different cues to action and found hearing their children's views of their behaviour to be 'the most pervasive and effective cue' (p.168). Humphreys and colleagues (2011) and Stanley and colleagues' (2012a) research on domestic abuse reached a similar conclusion. Studies of domestic abuse have also found that a potent cue for action for male perpetrators is the realisation that, in the eyes of their children, they may become like their own abusive fathers (Sheehan *et al.,* 2012; Stanley *et al*., 2012a).

However, Randolph and colleagues' (2009) review of parental engagement identified a dearth of literature on cues for action, generally suggesting that this is linked to the difficulties in measuring the influence of the varying cues. The relationship between cues for action and parental engagement could usefully be explored by further research.

Coercion

Prochaska and Prochaska (2002) assert that if parents become conscious of how they defend themselves when they feel threatened, for instance, by care or adoption proceedings, they will be more likely to progress to the next stage in the change process. However, given the internal dynamics, coercive action can have a kill or cure effect, pushing some parents who have previously been ambivalent about the *need* for change into taking action to overcome their problems, while those who have been ambivalent about their *capacity* to change become further entrenched in adverse behaviours that shield them from reality. The point is vividly illustrated by the extent to which parents who are permanently separated from their children tend to become deeply enmeshed in the behaviours that led to the initial intervention immediately after an adoption order has been made (see Forrester and Harwin, 2008; Neil, 2010; Ward, Brown and Westlake, 2012).

There is therefore some debate as to whether coercion strengthens motivation to change, or whether it is counterproductive. Bowen and Gilchrist (2004) examined how engagement varied between perpetrators of domestic abuse attending programmes in the UK on a voluntary or a mandatory basis. Using the Trans-Theoretical Model of Change (Prochaska and DiClemente, 1983), the authors found that self-referring domestic abuse offenders were more likely to be in the 'contemplation' stage and court-referred offenders in the 'pre-contemplation' or denial stage. The results of this study

suggest that self-referred offenders have already acknowledged their problem and believe that they are taking steps to change their behaviour, whereas court-referred offenders have yet to accept that a problem exists. The two groups of offenders may fundamentally differ in their levels of motivation to change; by ignoring these differences when referring them to offender programmes, we may be reducing the chances of successfully helping them to change their behaviour (Bowen and Gilchrist, 2004).

Voluntary participation in domestic abuse treatment programmes can therefore be a strong predictor of the likelihood that an individual will remain in treatment (Bowen and Gilchrist, 2004; Cadsky *et al*.,1996). However, other factors may also be important. For instance, men who have invested the most effort in the programme, such as those who have had the greatest distance to travel to participate, have been found to be more likely to continue in treatment (DeHart *et al*., 1999). In addition, individuals with greater insight into their own problematic behaviour will be more motivated to change because they are less likely to blame external factors for their domestic abuse (Fisher, Beech and Browne, 1998). Zalmanowitz and colleagues (2013) make a distinction between internal and external motivational factors. A court requirement to participate in an intervention can be an external motivator; however, internal motivation will also need enhancing as part of the intervention to reduce the likelihood of recidivism. In the UK the courts do not have the power to impose such participation on parents in care proceedings, but participation in these programmes is sometimes a term of a written agreement made at the pre-proceedings stage.

Some studies have, however, produced conflicting evidence about whether court-referred or self-referred domestic abuse offenders have higher levels of attrition from treatment programmes. For instance, in an evaluation of a domestic abuse intervention programme in London, Burton and colleagues (1998) found that some self-referred offenders attend treatment in the short term as an attempt to prevent their partners leaving them. The authors suggest that if this initial display of intent to change behaviour is effective, or their partner decides to leave them anyway, there is insufficient reason to continue attending the programme, indicating that their motivation was largely superficial and instrumental, rather than rooted in a genuine desire to change. Bowen and Gilchrist (2004) also suggest that court-referred men have the added incentive of further legal action to maintain their attendance in the programme.

Gregoire and Burke (2004) explored the relationship between coercion and motivation to change alcohol consumption. The study found that involvement in the criminal justice system may be linked to an increase in motivation to change, even when controlling for problem severity. The study suggests that legal coercion may help to tip the decisional balance and move individuals from denying that a problem exists towards taking action to overcome it. The authors conclude:

> Legal coercive pressure over the course of the treatment experience may have the most potential for influencing client behaviour toward outcomes since it is perhaps

> the most consistent type of coercion, less subject to a change than coercion by a family member or employer, and less subject to influence by client manipulation (Gregoire and Burke, 2004 p.35).

There may therefore be some merit in legal involvement in encouraging individuals to engage with interventions.

As we have already seen, in families where adult behaviour patterns impose a risk of harm to the child, the issues become more complex. A key principle set out by the Children Act 1989 is that local authorities should work in partnership with parents, whenever such an approach is consistent with the child's welfare (Department of Health, 1989). Programmes such as the Family Partnership Model (Harnett and Day, 2008; see also Chapter Four) are designed to facilitate this. However, the imbalance of power between parents and social work practitioners means that both parties are well aware that such partnerships are unequal and that, ultimately, the social worker has the authority to take coercive action by obtaining a court order for the child's removal. Where children are on the edge of care, the potential use of coercion becomes a particularly pertinent issue. Arguably there will always be a level of involuntary engagement in social work practice where children are suffering, or likely to suffer, significant harm. It is therefore important to understand which factors can inhibit or facilitate the likely success of interventions where participation is mandatory.

In evidence submitted for the Munro Review, the Family Rights Group asserted that parents feel scared to trust and work openly with social workers, and to reach agreement about how their children can be kept safe when they fear they may be removed by the local authority: 'the system does not support families to take responsibility; instead parents often feel decisions and actions are done *to* rather than *with* them, thus encouraging a sense of dependency and resentment' (Family Right Group, cited Department for Education, 2011, p.36). In some cases therefore, once court proceedings have begun, the opportunity to engage parents can be lost (Harwin and Ryan, 2008). On the other hand, the threat of removal can act as a turning point for some parents, tipping the decisional balance and providing a wake-up call that jolts them into action. The following quotation comes from one of a number of interviews with mothers who succeeded in overcoming substance misuse following a social work intervention:

> And I think the scare what social services gave me was a kick up the arse and the scare that I needed… They were going to put [baby] into foster care… And I thought to myself, I just cannot, you know, you know what, I felt like a movie, I felt like, oh my god, my baby, not my baby. And he was so tiny, I felt like, oh no my baby, I felt like, and I thought you're having a laugh, I couldn't believe, you know… A big shock, a big shock, it was a big wake-up call and it was just a terrible feeling, I couldn't believe it (see Ward, Brown and Westlake, 2012, p.137).

Therapeutic jurisprudence

In both the USA and now England, child welfare interventions have been developed that use the element of coercion provided by a court to address problematic parental behaviour patterns. These interventions are based on the theory of therapeutic jurisprudence, described by one of its founders as 'the law as therapeutic agent' (Wexler, 1993, p.17). This approach uses the power of the courts as a means of solving problems rather than offering punishment, and may provide an effective means of engaging parents in changing their behaviours. It also requires judges and lawyers to be aware of the therapeutic and anti-therapeutic consequences their actions and decisions can have for offenders (Casey and Rottman, 2000). Harwin and Ryan (2008) describe its focus as being 'the health, welfare and rehabilitation of the offender, as well as their punishment' (p.283). The approach does not place therapeutic considerations above all others, but incorporates them within the judgment process (Wexler, 1993). The use of therapeutic jurisprudence with parents to reduce risk to their children would therefore involve judges and magistrates assuming a more proactive and involved role (Harwin and Ryan, 2008). Wexler suggests that therapeutic jurisprudence provides an opportunity for the courts to help offenders deal with their 'cognitive distortions', recognise the problems with their current behaviours and start a change process (Wexler, 1993).

Family Drug and Alcohol Courts

In the USA principles of therapeutic jurisprudence underpin the development of specialist problem-solving courts which acknowledge that problematic parental behaviours require a range of interventions from other disciplines supported by the element of authority provided by the courts. Problem-solving courts have been developed widely across jurisdictions, but they have a number of key elements. These include a focus on case outcomes, non-traditional roles in the court room, multi-disciplinary collaboration and specially trained judges or magistrates who regularly monitor the progress of the case (Harwin and Ryan, 2008).

A national evaluation of this approach in family drug treatment courts in the USA produced positive findings (Worcel *et al*., 2008). It has now been introduced in England through the Family Drug and Alcohol Court (FDAC), an approach to care proceedings in cases where parental substance misuse is a key element in the local authority decision to take legal action (Harwin *et al*., 2011). FDAC was developed in response to concerns in relation to care cases involving parental substance misuse, including poor child and parent outcomes; insufficient co-ordination between adult and children's services; late intervention to protect children; delay in reaching decisions; and the increasing costs of proceedings, linked to the cost of expert evidence (Harwin *et al*., 2011; see also Masson *et al*., 2008, Ward, Brown and Westlake, 2012).

The distinguishing features of FDAC are that: the judge adjudicates the care proceedings and also holds responsibility for running a specialist treatment court; he (or she) plays a non-traditional role in order to motivate parents as well as to remind them of their responsibilities; a specialist multi-disciplinary team is attached to the court and

coordinates an intervention plan for parents which includes ongoing support and monitoring as well as assessment; parental progress is monitored and supported through regular fortnightly problem-solving therapeutic reviews during which the judge talks to parents and social workers directly; and parents are advised and supported by parent mentors who have themselves come through similar experiences (including, ideally FDAC) (Harwin *et al*., 2011, 2013, 2014).

FDAC has been piloted by three local authorities in London. An evaluation of the pilot initially compared a sample of 55 families (with 77 children) who entered FDAC with 31 families (49 children) who were the subjects of usual care proceedings during the same period in three other London authorities (Harwin *et al*., 2011, 2013, 2014).[9] Parental substance misuse was a key issue in all cases. From this original sample, it was possible to follow 41 FDAC and 19 comparison cases until the final court order. The results show that more FDAC (48%:19/41) than comparison parents (36%:7/19) had controlled their substance misuse by the end of proceedings and had been reunited with their children. FDAC parents were also engaged in more substance misuse programmes over a longer duration than the comparison parents. FDAC makes use of motivational interviewing techniques, and interviews with parents suggest that this may be one reason for positive findings (see Harwin *et al*., 2013). Data on the costs were analysed for a sub-sample of 22 FDAC cases and 19 comparison families. Although the samples were small, the findings were encouraging; for instance, the data suggest that local authorities saved £682 per FDAC family on court hearings and £1,215 per family on the provision of expert evidence to the court. Financial savings in FDAC cases were made because assessments performed 'in house' by the FDAC team were less expensive than those undertaken by independent experts in ordinary proceedings; children spent less time in out-of-home-placements; and there were fewer contested hearings (Harwin *et al*., 2011).

A second stage of the evaluation (Harwin *et al*., 2014) extended the sample to 106 FDAC families (149 children) whose cases were listed to be heard by FDAC between January 2008 and December 2010, and 101 comparison families (151 children), with the aim of increasing the robustness of the findings and testing outcomes after completion of court proceedings. Once again, more FDAC parents were offered substance misuse services (95% (52/55) FDAC mothers and 58% (28/48) FDAC fathers) than comparison parents (55% (45/82) mothers and 27% (17/64) fathers, and more.stopped misusing substances. Of those cases which could be followed until final court order, 40% (35/88) of FDAC mothers and 25% (13/52) of FDAC fathers ceased misusing compared with 25% (24/95) and 5% (2/38) in the comparison group. These differences were all statistically significant. These data also indicate that FDAC may be more successful in engaging and supporting fathers than ordinary proceedings, a point also made by some of the

[9] This was a non-randomised comparative trial in six local authorities with a relatively high level of evidence (Level B, see Chapter Six).

children's guardians and social workers who participated in the study (Harwin *et al.,* 2011, p116).

A one year follow-up of 42 families where the courts decided that children should live with their parents found that there were fewer further episodes of abuse or neglect in FDAC than in comparison families (25%: 6/24 *versus* 56%:10/18). Further evaluation with a larger sample would provide more robust data, particularly as there appear to have been quite high attrition rates in some of the earlier samples studied. Nevertheless the English pilot of FDAC shows that, when combined with a package of timely, co-ordinated interventions from a range of professionals, the authority provided by the courts can play a constructive role in motivating parents to change.

Stress – Strain – Coping –Support Model (SSCS)

While therapeutic jurisprudence utilises the formal power of the courts to motivate parents to change, other models use the informal power of family and social networks. Historically, service providers have paid only limited attention to the impact of addictive behaviours on the family, ignoring the family's potential influence on the course of addiction problems and the severe stress and strain addiction can cause to family members (Copello *et al*., 2009; Orford *et al*., 2005). The Stress-Strain-Coping-Support model (SSCS) conceptualises addiction in a family 'as creating chronic stress for family members, giving the latter the task of finding ways of coping with that stress, and of seeking support, both professional and informal, in meeting that task' (Orford *et al*., 2005, p.1613). The SSCS model rejects the idea that families or their members are dysfunctional or pathological and instead views them as ordinary people trying to cope with issues not of their own making (Copello *et al*., 2009; Orford *et al*., 2010).

Social Behaviour and Network Therapy

Social Behaviour and Network Therapy (SBNT) was originally developed to help treat alcohol addiction and is based upon the SSCS concept that involving family and friends of the person undergoing treatment to create a network of social support is essential in helping them overcome addictive behaviours (Copello *et al*., 2006). The approach has three stages: identifying and approaching those family and friends who could form part of a support network; building, engaging and mobilising the social network over a number of training sessions by covering a range of topics including communication, coping and dealing with lapse and relapse; and preparing for the future, including planning how to deal with changing circumstances to provide the best chance of long-term success (Copello *et al*., 2002).

A large randomised controlled trial compared the impact of SBNT in treating alcohol addiction with that of Motivational Enhancement Therapy (an approach based on Motivational Interviewing, see Chapter Four) with 742 participants across seven sites in the UK. It found that both groups reported substantial reductions in alcohol dependence and problems, and better mental health-related quality of life over the subsequent twelve months (UKATT, 2005a). Both therapies also saved about five times more in expenditure

on health, social, and criminal justice services than they cost (UKATT, 2005a, 2005b). However SBNT did not differ significantly in effectiveness and cost effectiveness from Motivational Enhancement Therapy (UKATT, 2005a, 2005b)[10].

SBNT has also been adapted for use by therapists in the treatment of drug addiction. A small before and after study[11] involving 12 specially trained therapists delivered SBNT over an eight month period to 24 drug users in the West Midlands. Standardised measures used at baseline and at a three month follow-up showed a significant reduction in drug use and improvements to the participant's family environment (Copello *et al*., 2006). Although the findings are promising, the small sample and lack of a comparison group means we do not know whether the intervention is better than service as usual. However, a randomised controlled trial is currently underway in the UK, looking at the use of a reduced programme (Brief-SBNT) with heroin users in opiate substitution treatment (Day *et al*., 2013). This approach mirrors some (but not all) of the elements of Family Group Decision-Making (see Chapter Four).

Engagement

Whether or not coercion or pressure from courts and family members play a part, there is no guarantee that engagement with services will lead to change. A number of studies have found little correlation between engagement and outcome (see Gossop *et al.,* 2006; Littell and Girvin, 2005, 2006), and Platt (2012) points out the danger 'of assuming that good engagement is predictive of change' (p.139). Some adults are able to make significant changes to self-destructive lifestyles without support from services (see Sobell, Cunningham and Sobell, 1996; Ward, Brown and Westlake, 2012). Others may be strongly motivated to change, but lack the self-esteem, confidence and skills required to translate motivation into capacity. External factors will also act as barriers to change, and almost all parents will, in varying degrees, experience some ambivalence about both the necessity and the desirability of change.

The absence of a single definition has resulted in a lack of clarity about how parental engagement can be assessed (Altman, 2008). Broadly, engagement can be considered as compliance, involvement, attendance rates and participation (Gladstone *et al*., 2012); a process rather than a one-off event (McCurdy and Daro, 2001), and continuing over prolonged periods (Randolph *et al*., 2009). There is also a distinction between engagement as an outcome (i.e. service usage behaviours) and engagement as a causal influence (a state of mind, affect, or attitude) (Yatchmenoff, 2005). Social workers and parents both play a role in the engagement process, with both parties contributing to the success of an intervention (Altman, 2008; McCurdy and Daro, 2001). Taylor and

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[10] This was a large randomised controlled trial in seven sites with a high level of evidence (Level A, see Chapter Six).
[11] Evidence Level C , see Chapter Six

colleagues' (2008) study of parents who dropped out of an alcohol treatment programme found that the positive and negative factors relating to engagement meant that it frequently became a staged process, with parents going through a testing out period, and then dropping out, or missing appointments before re-engaging.

Platt (2012) proposes the following definition:

> The mutual, purposeful, behavioural and interactional participation of parent(s) and/or carers in services and interventions provided by social work and other relevant agencies with the aim of achieving positive outcomes (Platt, 2012, p.142).

Models of engagement

A number of theoretical models of parental engagement have been developed for use in differing contexts. However models based on factors associated with parents' voluntary engagement in programmes (for example, McCurdy and Daro, 2001 and Randolph *et al*., 2009) may not be entirely relevant for use in a child welfare context where a level of coercion often has a role.

An Integrated Model of Parental Engagement

Platt (2012) proposes an integrated model of parental engagement, specifically developed for use in a child welfare context in the UK. This comprehensive model incorporates conceptual advances from a number of fields including clinical psychology (Drieschner *et al*., 2004); models of parental engagement in voluntary family support services (Littell and Tajima, 2000; McCurdy and Daro, 2001); and the Multifactor Offender Readiness Model (MORM) (Ward *et al*., 2004).

Platt (2012) maps out the specific factors that are known to be associated with engagement. These include the family's particular circumstances; the parents' perceptions of their situation and the intervention; and factors related to provider and programme. His model demonstrates how these factors interact to produce varying degrees of engagement. The model has not yet been formally evaluated, and the relationship between the different factors and the outcomes of engagement are not yet fully understood. Nevertheless, it is designed to offer practitioners 'a framework for thinking and analysis, within which to understand and assess parental engagement, to attempt to anticipate problems of engagement, and to identify key issues to address where engagement is problematic' (Platt, 2012, p.146). Motivation to change and engagement with services are complex issues. A model such as this cannot predict change; for instance, parents will exercise their own free will and may perceive different factors related to engagement in unexpected ways. Nevertheless such a model should provide social workers with a conceptual map that facilitates a greater understanding of the issues to be addressed, as well as a guide for adopting an analytical approach to the evidence they are required to present in court proceedings (see Ministry of Justice, 2013). This is discussed further in Chapter Eight.

Figure 5.1 provides an illustration of Platt's model of engagement. Background factors include social issues such as poverty, unemployment and housing; individual psychology or psychopathology; the nature of the problem; and the overall efficacy of the chosen treatment. These may play a role in parental engagement, although research evidence in relation to their significance has been varied (Platt, 2012).

The two key types of driver in Platt's model are *internal*, parent-related determinants, and *external*, service provision determinants. *Internal* determinants are personal, psychological or behavioural factors. These include whether a parent has negative feelings towards services; how their past experiences may influence their attitude; how they perceive their own ability to address their problems; and their fears and expectations. These factors may also be compounded by depression, anxiety, mistrust, confusion and self-blame, as well as an inability to seek help, and poor communication skills, inadequate literacy skills and a lack of confidence (Platt, 2012).

Internal determinants of engagement clearly overlap with internal factors that contribute to parents' understanding and acceptance of the need for change, discussed in Chapter Four. They also encompass the parent's perception of those factors that contribute to the decisional balance between potential gains and anticipated losses that underlies motivation to change. They operate in combination with external factors to produce different levels of engagement.

In Platt's model *external* determinants of engagement include circumstantial factors, such as the nature of the behaviour towards the child and society's response to it; whether the intervention is voluntary or mandatory; the availability of resources; the availability of social and professional support; community cohesion and cultural factors; the efficacy of the programme, such as matching parent and programme goals, perceived appropriateness, and tailoring of services to meet parents' needs; and the knowledge, skills and values of the practitioner including their reliability, honesty, listening, role clarification, empathy, even-handedness and collaborative problem-solving abilities (Platt, 2012).

One of the strengths of Platt's model is the emphasis it places on the organisational and professional factors that promote or inhibit engagement. Inadequate resources (Farmer and Lutman, 2012), frequent staff turnover (Ward, Brown and Westlake, 2012), and levels of staff experience (Gladstone *et al*., 2012) have all been shown to contribute to parents' willingness (or unwillingness) to engage with services.

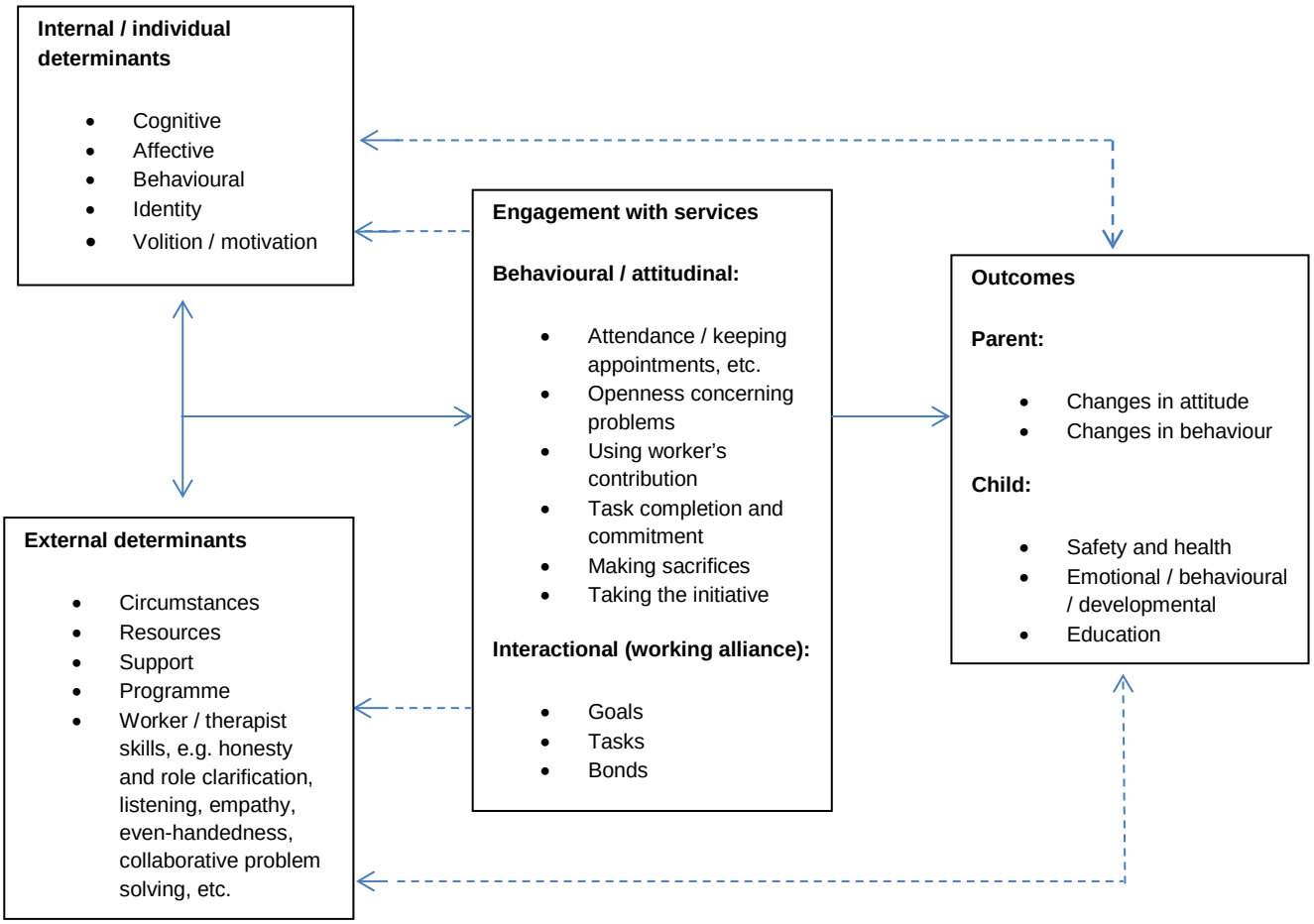
Figure 5.1: An Integrated Model of Parental Engagement with Child Welfare Services

(Developed from Ward *et al.,* 2004 and reproduced from Platt, 2012, p.141, with permission)

Background conditions

Social (poverty, unemployment, housing, etc.) Individual psychology and psychopathology

The nature of the problem



(Solid arrows indicate primary direction of effects. Broken arrows indicate feedback loops).

Platt (2012) identifies two observable features of engagement with services affected by the determinants discussed above. These are *behavioural indicators* (i.e. keeping appointments, parent's openness concerning their problems and whether they complete tasks) and *interactional indicators* or 'the working alliance' (mutual agreement on goals and tasks and the bond between social worker and parent). An assessment of overall engagement needs to explore systematically the various determinants identified as being relevant to a particular case and consider how they impact on the observable behavioural and interactional indicators. It should help practitioners reach a judgment concerning the extent to which parents are ready and willing to take the actions necessary to ensure that children who are on the edge of care could be better safeguarded in the future.

Conclusion

Previous chapters have explored the interlocking factors that undermine parenting capability and increase the likelihood of abuse and neglect. These include factors which may relate to the parent themselves, their environment, or their children. They have also considered how these factors promote or inhibit change. This and the preceding chapter have considered how constellations of these factors facilitate or discourage the engagement with services that may be necessary for change to occur. Compliance is not the same as engagement; assessing parents' motivation to change and the strength of their engagement with services are by no means simple tasks, as the complexity of the models described in this and the preceding chapter show. Potent factors include the nature and delivery of services themselves and the parent's own perceptions and actions. The next chapter carries the argument further by presenting some of the research on what is known about which types of services are effective.

Key points from Chapter Five

- Change is a complex process, particularly for parents facing multi-layered combinations of problems and whose children are on the edge of care.
- There is a difference between readiness to seek help or treatment and readiness to change, although one may lead to the other.
- Some parents will engage superficially with services in order to meet short-term objectives without the intention of making lasting changes.
- Becoming motivated to change self-destructive behaviours is not a straightforward matter. Change occurs when the decisional balance reaches a tipping point and the potential gains are perceived as outweighing the anticipated losses. Clarifying the perceived advantages and disadvantages of change may help practitioners and parents understand why change is so difficult and how it might be facilitated.
- Parents facing multiple problems may become motivated to change in one area, but may not necessarily appreciate the need for change in others.
- Some parents will experience events or circumstances which create a turning point in their lives and motivate them to make the changes needed to overcome adverse behaviour patterns and improve their parenting. Turning points provide opportunities to promote and support change.
- There will always be a level of coercion in statutory interventions where children are suffering, or likely to suffer, significant harm. Coercion can be the cue to action that is required to help parents realise that change needs to happen, but it can also be counterproductive and push parents who are uncertain about their capacity to change towards becoming further entrenched in adverse behaviours that shield them from reality.
- When combined with a package of timely, co-ordinated interventions from a range of professionals, the authority provided by the courts and informal pressure from

friends and family members can play a constructive role in motivating parents to change.

- There is no guarantee that engagement with services will lead to change.
- Parental engagement is influenced by a number of interlocking factors, including internal and external determinants and background factors.
- A theoretical model of the different factors that promote or inhibit parental engagement with child welfare services can facilitate a greater understanding of issues that need to be addressed and serve as a framework for assessing how far parents are ready and willing to change.

Chapter Six: Building Parenting Capability through Evidence-based Interventions

Introduction

The previous chapter considered how parents whose children may be suffering or likely to suffer significant harm can become motivated to address those difficulties which are undermining their parenting capability and engage with services. This chapter explores how different types of interventions can support parents in overcoming these difficulties and how their impact can be interpreted and understood. Although some parents are able to change without formal support, most will need help in overcoming abusive or neglectful behaviour patterns, improving their parenting capability and in addressing the underlying risk factors that reduced their capacity to provide a nurturing home. Children may also need support in overcoming the impact of maltreatment. Both parents and children may need support in repairing the dysfunctional family relationships which both engender, and are exacerbated by, abuse and neglect.

Local areas are required to have a range of effective, evidence-based services available to support children and families in need, including those where there are significant child protection issues (HM Government, 2013). These may range from universal (primary) and targeted (secondary) services to prevent maltreatment before it has taken place, through to specialist (tertiary) services designed to prevent further impairment, or a recurrence of maltreatment in families where abuse and neglect have already been identified and children are on the edge of care. There is a very wide spectrum of services available, delivered by a range of practitioners who have safeguarding responsibilities across numerous agencies, although the same services are not available from every local authority or NHS Trust. This chapter identifies some of the issues that need to be taken into account in considering whether a service is likely to be or has been effective, and sets out some examples of interventions that are known to have a positive impact and are increasingly available in this country. However, it is outside the scope of this report to offer a comprehensive overview of the multiplicity of interventions in this area. Fuller information about a wider range of specific interventions can be found in the numerous systematic reviews that have been undertaken (see for example Barlow and Schrader McMillan, 2010; Barlow, Simpkiss and Stewart-Brown, 2006; MacMillan *et al*., 2009; Montgomery *et al*., 2009).

Current guidance states that services that focus on parents 'should always be evaluated to demonstrate the impact they are having on the outcomes for the child' (HM Government, 2013, p.13). Not only do social workers need to be aware of the types of support available, they also need to know whether they are appropriate to the needs of the family and what each might be expected to achieve. This is another reason why case conceptualization and goal setting are important (see Chapter Three). Without a theoretical understanding of the interplay of factors within the family that lie behind

maltreatment, it is not possible to set realistic targets or to identify the types of support that might help parents achieve and sustain change. The most effective services may not be available, or may not be acceptable to the family, and this chapter also considers some of the organisational barriers to successful service delivery. As Chapter Seven points out, change can be a lengthy process; many parents of children on the edge of care will need long-term support of varying intensity. This support will need to be offered well before the question of legal proceedings arises.

Understanding effective services and interventions

There are both ethical and economic reasons why it is important to understand the likely impact of services that are designed to ensure that children are adequately safeguarded. Ineffective services may not only fail to ensure that children are safe, they may also fail to offer parents adequate support in overcoming destructive behaviour patterns and demonstrating capacity to change. Moreover some interventions are worse than ineffective in that they have been shown to be harmful (see Jarrett, 2008; Lilienfeld, 2007; Rhule, 2005). A number of services have been developed in other countries, but translating them into a UK context can be a complex exercise and so only interventions that have been shown to have a positive impact in this country should be regarded as likely to be effective. An evaluation should show whether one of the services studied has significantly greater impact than another (or than no service at all) and how long the impact is likely to be sustained. It is unlikely that any service will benefit all participants, so it is important to know for what proportion of people a desired outcome has been achieved in the past, and whether people with some types of need are more likely to benefit than others.

General principles concerning evidence of effectiveness

Practitioners need to be able to assess whether evaluations of effectiveness have been sufficiently rigorous to produce reliable findings about impact and how these can be interpreted. Early evaluations of a new service are often undertaken by the developers, and so there may be a conflict of interests and a possibility of bias: rigorous reviews of evidence such as those undertaken by NICE take this into account. Services which have been evaluated with a very small sample, or which have had a high drop-out rate, so that a large proportion of participants failed to complete the programme, have not shown sufficient evidence of impact. Moreover, not all of the evidence is of equal quality: the weight given to the findings of an evaluation will be determined both by the rigour with which the research exercise was conducted and by the methodology employed. There is an established hierarchy of methodologies, and each level is considered to produce a different standard of evidence, as shown in Table 6.1.

The extreme complexity of most child welfare cases can make it difficult to be certain that like is being compared with like, and this needs to be considered in assessing the

evidence from comparative evaluations. Nevertheless, rigorously conducted randomized controlled trials (Evidence Level A), where service users with similar needs are randomly allocated to the intervention being evaluated or to a control group that receives no service or service as usual, are considered to produce the strongest evidence of effectiveness. However, they may be inappropriate in many areas of children's social care, where to place children in a control group that receives no service is not an option. There are also, quite rightly, ethical constraints on randomly allocating children to highly intrusive interventions such as adoption which will have long-term consequences for both them and their families. Unless we genuinely do not know whether an intervention is likely to be beneficial, not only for one child but for all children participating in a trial, random allocation cannot be justified. Comparing the impact of two types of existing service (Evidence Level B) is often more ethically appropriate, but the results will only tell us whether one service is likely to be more effective than the other, and not whether either is more effective than doing nothing. Before and after studies (Evidence Level C) may measure changes over time, but they cannot tell us how far (if at all) such changes are attributable to the service received, or to other factors within the service user's life that have contributed to change. Retrospective quantitative studies (Evidence Level D) and small case studies (Evidence Level E) may identify correlations between services and outcomes if appropriate data have been collected, but they are not evaluations in themselves; their findings indicate the questions that need to be asked in prospective studies of impact (for a fuller discussion see Davies and Ward, 2012, pp.96-99).

Findings from quantitative studies are generally considered to be statistically significant if they could have occurred by chance less than five times in a hundred ($p=<0.05$). Results are also often (but not always) given in terms of effect sizes: these represent the known impact of an intervention, using a simple statistical formula. In the statistical tests used in the studies in this report, an effect size of 0.2 is considered to be small, one of 0.5 is medium and one of 0.8 or greater is large (see Cohen, 1969, 1992). No service is 100% effective – the question to ask is whether it is more effective than an alternative.

Many intensive interventions, such as programmes designed to address parents' problems or multi-faceted programmes that address the needs of both parents and children, are standardised, and those who deliver them are expected to follow a particular procedure, often specified in a manual. The different elements of these interventions have been tested out with different groups of people and the manual reflects what has been shown to be effective. Altering the procedure may mean that the intervention is no longer so effective and the revised version will need to be re-evaluated. Implementation of a new intervention is a complex business and takes on average two to four years to complete (Fixsen *et al*., 2005; see also Wiggins, Austerberry and Ward, 2012).

Table 6.1: Hierarchy of levels of evidence

Hierarchy of levels of evidence		
Design	Advantages	Disadvantages
Level A Randomised Controlled Trials	No systematic differences between conditions therefore any changes are due to treatment effects	Can be impractical or unethical to implement
Level B Two-Group Non-Randomised Comparative Trials	Groups can be matched to minimise known differences Practical for pre-existing groups	Groups may differ on factors for which the groups were not matched, potentially confounding the results
Level C Single-Group Pre-Post Studies	Measures change over time Often the only practical option	Impossible to know whether changes are due to the intervention or other factors
Level D Retrospective Quantitative Studies	Data may already be available and may provide some useful indications for more rigorous evaluation at a later date	Data may not have been collected specifically to evaluate this intervention and may therefore be incomplete or inadequate
Level E Case Studies	Data may provide useful indications for more rigorous evaluation at a later stage. Qualitative data may indicate potential areas for further explorations and analysis – suggesting why rather than what is happening	Data from a small number of examples may not be generalisable

*Compiled from Montgomery, P., Gardner, F., Bjornstad, G. and Ramchandani, P. (2009) *Systematic Reviews of Interventions following Physical Abuse: Helping Practitioners and Expert Witnesses Improve the Outcomes of Child Abuse.* Report to Department for Children, Schools and Families: University of Oxford (Department for Education Research Brief DCSF-RBX-09-08A) pp.12-15, and reprinted from Davies, C. and Ward, H. (2012) p.96.

Understanding effective social work

The general case management and family support provided by social workers in England has not been formally evaluated (see MacMillan *et al*., 2009). Where evidence of effectiveness exists it is often relatively weak (Levels C, D or E), and much of it has to be pieced together from studies where this issue was peripheral to the main focus of the research.

Nevertheless, while experimental trials of social work practice in England are in their infancy, research in this area increasingly incorporates a comparative element, making it possible to explore change over time or whether one group of children has had more successful outcomes than another (see Davies and Ward, 2012, p.27). Studies which make use of survey and case file data and interviews with professionals indicate that social work interventions for maltreated children are effective if they are characterised by thorough assessments leading to the identification of clearly specified goals and targets concerning what needs to be changed; provision of social work and specialist services to support such changes; careful planning that includes children and families; and strong proactive case management (Farmer and Lutman, 2012; Wade *et al*., 2011).

Studies of users' views about social work case management rarely measure impact by exploring changes over time. Single, unrepeated interviews provide a weak source of evidence (Level E); they are sometimes undertaken with a convenience sample rather than with one that has been carefully selected and the findings may not be generalizable (David and Sutton, 2011). They are also often skewed by the untoward effect of rigorous gatekeeping and consent procedures that can result in a poor and uneven response rate (see Heptinstall, 2000; Ward, Brown and Westlake, 2012). Repetition of data collection over time, response rates and sampling techniques should all be taken into account when exploring what users say about the effectiveness of a service. Nevertheless users' views provide an important source of information that cannot be accessed in any other way, and the requirement to take them into account is enshrined in both legislation and policy (Department of Health *et al*., 2000; HM Government, 2013). Qualitative data from interviews with parents indicate that they value child and family social workers who are 'not afraid to break bad news' and are straightforward and honest about what needs to change and the likely consequences of failure to do so (Spratt and Callan, 2004; Ward, Brown and Westlake, 2012); who show sensitivity and are prepared to listen to their point of view and understand their circumstances (Forrester *et al*., 2008b; Morgan, 2008; Ward, Brown and Westlake, 2012); who use their power to support rather than to penalise them (Dumbrill, 2006); and who offer practical support and advocacy (Dumbrill, 2006). Thus both sources of information corroborate one another and point to the important part the relationship between the parent and the social worker can play not only in assessing capacity to change, but also in supporting the change process.

Evidence about the characteristics of *ineffective* relationships between social workers and parents, taken from studies of serious case reviews, can shed further light on how

social workers can support parental change. These show that the relationship can become dysfunctional if the social worker's decisions are influenced by factors such as unrealistic expectations of capacity to change, parents' overt hostility, or by theories of cultural relativism which are sometimes used to condone abuse or neglect (see Brandon *et al*., 2009, 2010, 2011; Ward, Brown and Westlake, 2012). All of these turn the focus away from the central purpose of safeguarding the child. Laming (2003) argued that social workers should adopt a position of 'respectful uncertainty', keeping an open mind about information presented to them by parents for whom much is at stake. Such a position needs to be supported by supervision that encourages the development of reflective practice (Dalzell and Sawyer, 2007), and should help social workers maintain sufficient distance to remain clear sighted about their role in supporting parents to change and the extent of progress that has been made.

While there is evidence concerning the components of effective social work practice, a number of studies have identified areas where practice is weak or ineffective. For instance, Farmer and Lutman (2012) found that care planning had been inadequate for over a third (36%) of a sample of 138 neglected children; Ward, Brown and Westlake (2012) found that about one in three infants identified before their first birthdays as likely to suffer significant harm, were still experiencing abuse and neglect by the time they were three. Both Farmer and Lutman (2012) and Wade and colleagues (2011) found that plans for maltreated children who return home from care are often unrealistic, with children frequently returning to parents who have been unable to overcome the behaviour patterns that precipitated the original removal. Farmer and Lutman (2012) found that in half (51%) of the families in their study 'a clear focus on the key issues in the case had not been consistently maintained by children's services' (p.68).

Barriers to effective social work

There are a number of reasons why social work practice in supporting parents to change is not always as effective as it might be. First, some studies have identified deficiencies in training, which may give too little weight to the acquisition of up-to-date knowledge in areas such as the impact of abuse and neglect on childhood development and risk and protective factors in families where children are likely to suffer significant harm (see Brandon *et al.,* 2009, 2010, 2011; Daniel *et al.,* 2011; Ward, Brown and Westlake, 2012). Child development is still not covered thoroughly in all social work qualifying courses, many of which fit it within a broader curriculum of human growth and behaviour or lifespan development (see Brandon *et al.,* 2011, p.20; Department for Educaton, 2011, p.75). Training may also fail to explore sufficiently the inherent conflicts in the social worker's role, such as how statutory responsibilities to define and act on child protection concerns can be reconciled with values that emphasise the importance of empowering parents (see Healy and Darlington, 2009).

Secondly, there are wide variations between authorities (see Farmer and Lutman, 2012; Sinclair *et al*., 2007; Wade *et al*., 2011). These are likely to relate to the prevalence of a number of organisational factors that have been identified as barriers to effective social work practice. Differences in organisational cultures can be reflected in the nature of supervision, which in some authorities still focuses more on performance management than on the development of reflective practice (Carpenter *et al*., 2012). Changes of social worker have also often been noted as detrimental to successful case management because they obstruct the development of constructive, supportive relationships with parents and children, and the implementation of plans (see Skuse and Ward, 2003; Ward, Holmes and Soper, 2008). Such changes reflect the widespread use of agency staff, the high turnover of more permanent staff, and the organisation of services which often require cases to be transferred from one team to another as families move through the system. Furthermore, pressure to close cases, frequently due to restricted resources, means that social work interventions are often relatively short term. The national statistics indicate that 29% of children remain the subject of protection plans for three months or less, only 19% for more than a year, and as few as 3% for two years or more (Department for Education, 2014b). Moreover, both social work and more specialist interventions tend to end abruptly with often inadequate arrangements for long-term, less intensive support or monitoring of children's circumstances (Ward, Brown and Westlake, 2012). Given the entrenched and complex difficulties facing parents whose children are likely to suffer significant harm and what is known of timescales for recovery (see Chapter Seven), there appears to be a mismatch between needs and services.

Intensive Family Preservation Services (IFPS)

While our search did not find any formal evaluations of general social work case management and family support, it did identify studies that explored the impact of Intensive Family Preservation Services (alternatively known as family preservation services or intensive family support services), often delivered by social workers. IFPS are intensive programmes, introduced to reduce the need for placing children in care by addressing crises, improving family functioning and promoting the use of social support systems (Al *et al*., 2012). Many programmes are based on the American 'Homebuilders' model (see: http://www.institutefamily.org/programs_IFPS.asp). IFPS incorporate a number of common characteristics; for instance, families are usually considered to be 'in crisis' with the crisis generally linked to the possibility of a child entering care; services take place in the family's home; services are flexible and available to families 24 hours a day, seven days a week; they are concentrated in a period targeted at four weeks; and workers have very small caseloads (see Forrester *et al*., 2008b, p.412). Two extensive meta-analyses of IFPS programmes (Dagenais and colleagues' (2004) study of 27 programmes involving 10,296 children or families and Al and colleagues' (2012) meta-analysis of 20 programmes involving 31,369 participants) have found that IFPS have little impact on preventing children from being placed away from home, although there is

some evidence of improvement in family functioning (Al and colleagues (2012) found a medium positive effect of 0.486 on this variable).

IFPS have also been implemented and evaluated in the UK. For example, Option 2 is a Welsh intensive family preservation service aimed at reducing the need for children to enter care from families experiencing parental substance misuse (Forrester *et al*., 2008b). The Option 2 Service is based on the American Homebuilders model and uses a combination of motivational interviewing, solution focused counselling styles and other therapeutic and practical interventions. The service is delivered over four to six weeks and staff members are available to families 24 hours a day. The evaluation of Option 2 (Forrester *et al.*, 2008b) compared the outcomes for 278 children receiving the service with those for 89 children who were referred, but could not be offered it immediately because there was no capacity[12]. The average follow-up period was 3.5 years. As with the US studies, the evaluation found that participation in the Option 2 service did not reduce the likelihood of entering care (40% of the children in Option 2 entered care *versus* 41% in the comparison group). However, children in the Option 2 group entered care on average 117 days later than those in the comparison group; they spent less time in care (766 days *vs.* 958 days) and were more likely to return home (68% of Option 2 children were at home at follow up compared with 56% of the comparison group). The reduction of time spent in care meant that there were considerable cost savings (over £1000 per child in one of the participating local authorities). All families interviewed valued the service, the key components they regarded as helpful being: 'a non-judgmental and understanding approach, good open communication between the worker and family, availability, reliability and high frequency of contact, suggesting helpful strategies and offering practical support if needed, support with substance misuse when required and help with family relationships when required' (Forrester *et al.*, 2008b, pp 417-8). However, although Option 2 appeared to have a lasting impact with those families whose problems were less severe and entrenched, change was not maintained in the longer term with the families which were facing more complex and severe problems. Moreover, the finding that the impact of Option 2 was to delay entry rather than reduce the likelihood of admission to care raised questions concerning whether children benefited from the service if it prolonged their experience of abuse or neglect (see Forrester *et al.*, 2008b, p.423). In both the American (Al *et al.*, 2012) and the Welsh (Forrester *et al.*, 2008b) evaluations there is some indication that the brief intensive crisis intervention that is characteristic of IFPS may not be of a long enough duration to help families in which there are concerns about child abuse and neglect to address complex and entrenched problems sufficiently to prevent their children from coming into care.

[12] This was a non-randomised comparative trial with a relatively high level of evidence (Level B).

Outcomes of care

Even with long-standing support from social workers and other agencies, some parents are unable to protect their children from harm. In cases where there is clear evidence of significant harm or its likelihood, multiple risk factors that are known to be associated with future harm, no mitigating protective factors and no active engagement or evidence of parental change, there is a strong possibility that children's life chances will be seriously compromised unless they are placed away from home (see Brown, Hyde-Dryden, Thomas and Ward, forthcoming; Ward, Brown and Maskell-Graham, 2012; Ward, Brown and Westlake, 2012; Wade *et al*., 2011).

There are long-standing and well-documented concerns about the poor outcomes of separating children from their birth families and placing them in the care of local authorities (see for instance House of Commons Children, Schools and Families Committee, 2009; Sergeant, 2006) and there are some difficult issues that need to be confronted. These include instability of placements, low aspirations and insufficient support for young people making the transition to independence. Such evidence will be of concern to social workers who are faced with parents who are unable or unwilling to change. It is easy to argue that care can be damaging for children, and this has been the assumption behind much public debate over the last few years. It is difficult to ascertain the validity of such assertions because this is an area where randomised controlled trials are ethically problematic and few comparative studies have been undertaken. However, a number of increasingly sophisticated research studies indicate that the majority of children who become looked after benefit from care. International studies need to be approached with caution in this area because differences in definitions, perceived objectives, thresholds for entry, and the quality of provision may all contribute to misleading comparisons (see Ward, 2009). Nevertheless, research from France (Dumaret and Coppel-Batsch, 1998), Australia (Barber and Delfrabbro, 2005), Norway (Moe and Slinning, 2001) and some, though not all, studies from the USA show that placing children in care can have a positive impact on their welfare (Horwitz *et al*., 2001; Taussig *et al*., 2001; but see Lawrence, Carlson and Egeland, 2006 and Lloyd and Barth, 2011). Forrester and colleagues (2009) undertook a review of British research undertaken since 1991 that included data on changes in welfare over time for children in care. Twelve studies met their rigorous criteria. They concluded that:

> …there was little evidence of the care system having a negative impact on children's welfare. Indeed, in almost all of the studies children's welfare improved, while there was none in which it deteriorated (p.450).

Maltreated children tend to do better in care than those who remain with abusive or neglectful families or return to them (see Wade *et al.,* 2011).

Outcomes of kinship care

Where children cannot remain with their birth families, both legislation and policy indicate that local authorities should make arrangements for them to live with 'a relative, friend or other person connected with [them] who is also a local authority foster parent, unless that would not be reasonably practicable or consistent with [their] welfare' (Children Act 1989, s.22.6 (a)). However, although there are obvious ethical as well as legal reasons why children should be placed within their extended families, research on kinship care has produced mixed findings.

Many of these findings are positive. Children in kinship care have been found to be less likely to be maltreated and to have greater placement stability than those placed with strangers (Newton, Litrownik and Landsverk, 2000). Kin carers are also more likely to go the extra mile in trying to meet the child's emotional needs, and to promote stronger ties with the extended family (Hunt, Waterhouse and Lutman, 2008). A systematic review by Winokur and colleagues (2009) concludes that children in kinship care 'experience better outcomes in regard to behaviour problems, adaptive behaviours, psychiatric disorders, wellbeing, placement stability, and guardianship than do children in foster care' (p.15). However MacMillan and colleagues' (2009) review of the international literature also found that some studies showed negative outcomes in terms of more delinquent behaviour and slower cognitive development among children in kinship care.

There is some evidence of lower standards of approval for kinship carers, so that children are sometimes placed with carers who are unable to meet their needs, and/or who do not know them and have extremely tenuous links with their birth family (see Sinclair *et al*., 2007; Ward, Brown and Westlake, 2012; Ward, Munro and Dearden, 2006). Hunt and colleagues (2008) found that kinship placements tended to be more positive for younger children than for those who were older; they also identified concerns about the extent to which kinship carers met the basic needs of one in four children placed with them. Similar concerns have been raised by other studies (see Peters, 2005; Sinclair *et al*., 2007). More rigorous assessment and higher thresholds for approval should address this issue.

There is also evidence that kinship carers may be particularly vulnerable. MacMillan and colleagues (2009) found that, on average, kinship carers were 'older, less well educated, less likely to be married, report more problematic parenting attitudes, and receive fewer non-child welfare services than unrelated carers' (p.260). If birth parents or other relatives do not accept the placement decision, kinship carers may also be dealing with difficult family situations (see Farmer, 2010). The research evidence indicates the need for extensive post-placement support; yet this is not always forthcoming. Kinship carers receive less caseworker support than unrelated carers (MacMillan *et al*., 2009). Despite the legal requirement for parity of financial support with unrelated carers (*R v. Manchester City Council,* 2001), inadequate remuneration remains an issue. There has, for instance, been an increase in numbers of informal kinship arrangements, where financial support is discretionary and social work support is not always readily available (Selwyn *et al*., 2013).

Outcomes of adoption

Studies of the long-term outcomes of infant adoptions are necessarily based on children who were placed several decades ago at a time when there were still powerful economic and social pressures on unmarried women to relinquish their children. Adoptions of these children, who are now in late middle age, show favourable psychosocial outcomes and low disruption rates (see Selwyn *et al*., 2006 for further details). It is unlikely that many of these children will have experienced abuse before placement.

However, the majority of children placed for adoption currently in the UK have experienced maltreatment prior to entry to care or accommodation, and many will have experienced lengthy delays, insecurity and instability before permanence decisions are made and adoptive placements found. On average, children are looked after for two years and seven months before the adoption is finalised (Department for Education, 2013b), though they reach their permanent placement within a shorter period (Ward *et al*., 2006).

Given their experiences it is not surprising that both looked after children and those who are adopted, experience emotional and behavioural difficulties, depression and confusion over identity (Neil, 2000; Smith and Brodzinsky, 2002). Biehal and colleagues (2010) found no significant difference in average scores on a standardised measure to identify clinically significant emotional and behavioural difficulties (the Strengths and Difficulties Questionnaire) between adopted children and those in long-term foster care, but both groups had higher scores than the general population. A study conducted in the USA (Keyes *et al*., 2008) also found that the prevalence of behaviour problems was (marginally) higher amongst adopted children than in the general population. These comparisons do not include children who have been subject to child protection proceedings but returned home.

About 3% of adoptions from care disrupt within twelve years; substantially fewer than placements with foster carers, special guardians or carers with residence orders (Biehal *et al*., 2010; Selwyn, Wijedasa and Meakings, 2014). However, research using the self-reported feelings of adopted children suggests that statistics on placement breakdown hide an underlying unhappiness for some children in placements that do persist (Thoburn, 2002), and about one in four adoptive parents describe major challenges and inadequate support in caring for a child with multiple and overlapping difficulties (Selwyn, Wijedasa and Meakings, 2014). Disruptions are closely associated with emotional and behavioural difficulties, and especially ‘aggressive, acting out behaviours including cruelty to others, getting into fights, threatening others, over-activity, restlessness, hanging out with bad friends and overt sexualised behaviour‘ (Selwyn *et al.,* 2006). There are greater risks in adoption for sibling groups and children with additional needs (Rushton, 2003). Nevertheless, the majority of adoptions last until adulthood. Moreover, Howe’s (1998) review of outcome studies found that, on

a measure that combined disruption rates, developmental rates and adopter satisfaction rates, 50-60% of adoptions of older children were successful.

There are strong indications that, the younger the child is when placed in local authority care or accommodation, or with an adoptive family, the better the chances of both a stable placement and successful psychosocial outcomes (see van den Dries *et al.,* 2009; Ward, Holmes and Soper, 2008). The older children are at placement, the more likely they are to display behavioural problems, including problems with peer relationships, attachment, conduct disorder and poor concentration (Biehal *et al*., 2010; Haugaard, Wojslawowicz and Palmer, 1999), and therefore the greater the risk of disruption. Both adoption and local authority care can provide a nurturing environment from which most children will benefit, but they cannot always overcome the consequences of extensive experience of abuse and neglect.

Returning home from care

Only a very small proportion of children who become looked after are placed for adoption. Just over one in three children (35%) who leave care or accommodation each year are reunited with birth parents or other relatives (Department for Education, 2013a). Reunification is by far the most common reason for leaving care, and the proportion of maltreated children who return home is almost exactly the same as that for those who become looked after for other reasons (Wade *et al*., 2011). However these children frequently return home to parents who have not been able to overcome the problems that led to the separation. About a third of maltreated children who return home re-enter care or accommodation within six months and two thirds within four years, including 81% of those who return home to substance misusing parents (Wade *et al*., 2011). Children who experience repeated attempts at reunification to parents who have shown insufficient capacity to change experience the least satisfactory outcomes (Farmer and Lutman, 2012; Wade *et al*., 2011).

Specific interventions to support parents and children

It is evident that social work support needs to be complemented by other, more specific interventions, delivered by a range of professionals if parents are to be given the best opportunities to overcome adversities and meet their children's needs within an appropriate timeframe. An increasingly wide range of effective specific interventions are now available; there is, however, some evidence that the majority of parents whose children are on the edge of care 'do not currently receive any formal intervention to improve their parenting skills' (Barlow *et al*., 2008, p.3), and that many have inadequate access to the type of services designed to address specific problems such as alcohol and drugs misuse, domestic abuse, and mental health problems (see Farmer and Lutman, 2012). Social workers need to be aware of the range of specific interventions available within their area, and what is known about their effectiveness. Some of these are

designed to prevent problems from occurring or recurring in families where children are at high risk of being abused and neglected and others to support parents in overcoming problems that are already compromising their children's life chances.

Targeted preventive programmes

Parenting programmes

Safeguarding children is increasingly seen as a public health issue, and the growing prevalence of parenting programmes is part of an international initiative, supported by the World Health Organisation to increase at population levels the prevalence of parenting that is sensitive to children's needs (Eshel *et al*., 2006). Parent education programmes are almost all designed to help parents to develop appropriate expectations of their children, to respond sensitively to their needs and to learn how to discipline children by using positive techniques rather than corporal punishment (Barth, 2009). Some programmes, such as Triple P-Positive Parenting and the Incredible Years Parent Programme have been implemented on a population-wide basis in a number of countries and have been shown to be successful (Health Scotland, 2007; Prinz *et al*., 2009; Sanders *et al*., 2008; Webster Stratton *et al*., 2011). However, a number of studies have found that community based parenting programmes, designed as universally available services for low-risk populations, or targeted preventive services for families with moderate levels of need, are less effective with parents in families where the likelihood of maltreatment is high (see Casanueva *et al*., 2008; Chaffin, Bonner and Hill, 2001).

Parent training as targeted prevention for parents with learning disabilities

Parents with learning disabilities are defined as having significant limitations in both intellectual functioning and adaptive behaviour. Both these limitations are likely to have an impact on parenting capability, and these parents benefit from support being provided at the earliest opportunity (MacIntyre and Stewart, 2011). There is evidence that parents with learning disabilities are able to acquire adequate parenting skills to provide sufficient and safe care for a child through parent training programmes (Glazemakers and Deboutte, 2013), home based safety interventions (Llewellyn *et al.*, 2003) and developing supportive peer relationships (McGaw *et al.*, 2002; see also McConnell and colleagues, 2011). However, such parents are likely to need ongoing support to adapt to new challenges as children develop, and to help them address issues such as poverty, social isolation and poor psychological wellbeing (Darbyshire and Kroese, 2012), to which they are vulnerable. They and their children may also need more intensive support if their inherent vulnerability is compounded by other factors such as substance misuse, mental health problems and/or domestic abuse.

Targeted prevention for vulnerable teenage parents: Family Nurse Partnerships

The Family Nurse Partnership programme is specifically designed for vulnerable young pregnant mothers expecting their first child, and their partners, and is now available in 90 English local authorities. It offers intensive, structured home visiting, delivered by a specially trained nurse on a weekly or fortnightly basis until the child's second birthday.

Nurses support the mother's personal health, including use of drugs and alcohol; their environmental health, including attempting to ensure adequate housing and helping her to access optimal support from the community; and life course development. They also work with the mother 'to help her develop the knowledge and skills to confidently support the health and development of her child' and to manage her relationships with others including the baby's father. The nurse also supports the mother throughout the pregnancy, helping her to attend ante-natal appointments and make adequate preparations for the birth (see: https://www.education.gov.uk/commissioning-toolkit). The programme has a strong theoretical basis, drawing on human ecology theory to explore how parents can be helped to consider the impact of their social context on their growing child and develop strong relationships with those who can play a supportive role; on attachment theory to guide parents on sensitive and responsive care-giving and on self-efficacy theory to 'enable parents to understand why particular actions are important, to develop the confidence necessary to achieve these' and to support positive change (http://fnp.nhs.uk/about/history/theories).

The Family Nurse Partnership programme has been extensively evaluated in the USA in randomised controlled trials (Evidence Level A) where it has been shown to be effective in reducing child abuse and neglect and parental welfare dependency. Positive impacts on outcomes for children and young people, such as reduced anti-social behaviour, engagement with the criminal justice system and substance misuse have been shown to persist for at least fifteen years, except in homes where there are moderate to high levels of domestic abuse (Eckenrode *et al*., 2000; Olds *et al*., 1986, 1998). When the Family Nurse Partnership programme is delivered by paraprofessionals (home visitors without professional training) rather than specially trained nurses, outcomes have been found to be only half as successful; lack of training may also account for the ineffectiveness of some other home visiting programmes (Olds, 2006). The Family Nurse Partnership programme is currently undergoing an extensive trial (Evidence Level A) in the UK that is exploring the extent to which it improves outcomes for young mothers and their children in comparison with standard services. The potential for pregnancy to act as a catalyst for change was also discussed in Chapter Five.

Specific programmes to address abusive parenting and prevent impairment

Barlow and colleagues (2008) undertook a systematic review of studies evaluating the effectiveness of brief individual or group based parenting programmes designed to treat physical abuse or neglect in high risk families. Only seven studies, however, were sufficiently rigorous to be included in this review. The findings suggest that 'parenting programmes that incorporate additional components aimed specifically at addressing problems associated with abusive parenting (e.g. excessive parental anger, misattributions, poor parent-child interaction) may be more effective than parenting programmes that do not' (p.9).

Some parenting programmes include modules that are specifically tailored to meet the needs of abusive or neglectful parents. These include the Triple P-Positive Parenting Programme (Triple P); The Incredible Years, and Parent-Child Interaction Therapy (PCIT).

The Triple P-Positive Parenting Programme (Triple P)

The Triple P-Positive Parenting Programme (Triple P), is made up of four standard modules, plus a fifth module (enhanced Triple P) tailored specifically to 'parents of children with concurrent child behaviour problems and family adjustment difficulties such as parental depression or stress and partner conflict' (see: http://www.triplep.net/files/4413/6057/1876/The_Triple_P_System.pdf). This module addresses parental attitudes, beliefs and practices that are known to be related to child maltreatment such as blame and misattribution, unrealistic expectations, harsh parenting styles, poor parental satisfaction and low efficacy. Triple P has been extensively evaluated in several countries (see http://www.pfsc.uq.edu.au/research/evidence/ for full details). A systematic review and meta-analysis of 101studies (Sanders *et al.*, 2014) shows that Triple P has an enduring positive impact across a wide range of parenting problems and children's behavioural difficulties. A randomised controlled trial (Evidence Level A) with 98 participants found that the enhanced version of Triple P has a particular impact on negative parental attributions, potential for child abuse and unrealistic parental expectations in families where parents' anger management is an issue (Sanders *et al.,* 2004). Tellegen and Sanders (2013) undertook a systematic review and meta-analysis of twelve studies involving 659 families participating in Stepping Stones, a version of Triple P designed specifically for families of children with disabilities. They found significant medium effect sizes in respect of reducing child problems (0.537), satisfaction and efficacy (0.523), and improvements to observed child behaviour (0.523), and a medium to large effect size on improving parenting style (0.725).

There have, however, been some suggestions that the impact of Triple P has been overstated (Wilson *et al.,* 2012), with an attempt to implement it in Birmingham showing little impact (Little *et al*., 2012[13]). Triple P may prove to be less effective with disadvantaged parents whose children are on the edge of care: a meta-analysis of eleven evaluations (Thomas and Zimmer-Gembeck, 2007) concluded that a high proportion of evaluations of Triple P have focussed on its use with parents in middle or higher socio-economic groups and that 'it is not certain that findings can be generalised to low income or high risk groups' (p.491).

[13] A randomised controlled trial with a high level of evidence (Level A)

Webster Stratton Incredible Years Parenting Programme

The Incredible Years Parenting Programme is aimed at parents, teachers and children and has been implemented in a number of countries. The programme consists of a basic universal element designed for any parents whose children have behavioural problems and an additional advanced programme designed for use with families with more complex needs, such as those involved with children's social care. The programme is delivered over a number of weekly sessions (see: http://incredibleyears.com for further information). High quality (Level A) evidence from evaluations in the UK of the basic programme shows an improvement in parenting skills (Hutchings *et al*., 2007; Jones *et al*., 2007; Scott *et al*., 2001). The study by Hutchings and colleagues (2007)[14] involved 153 parents living in socially disadvantaged areas with children aged 3-5 years at risk of conduct disorders. It found that the Incredible Years had a significant positive impact on parenting behaviours, with a medium effect size (0.57). A combination of the basic and advanced Incredible Years Parenting Programme has been evaluated in the UK in a single group pre-post study (Evidence Level C) that involved 280 parents of children aged 8-13 at risk of adolescent antisocial behaviour in six local authorities (Hutchings *et al*., 2011). Data from parents showed high levels of socio-economic disadvantage, substance misuse, depression and a member of the family with a history of crime. The evaluation found statistically significant evidence of improvements to parenting skills and a reduction in parental depression, both with large effect sizes (1 and 0.8 respectively), although the authors concluded that 'the parents of children living in homes where there is a history of criminality may require an additional targeted intervention' (p.141).

Parent Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT) is an individualised intervention developed for parents and children aged 4-7 years old with behavioural problems. Its aim is to alter parents' behaviour through direct coaching strategies. The change in parental behaviour is expected to reduce the child's problem behaviours and improve parent-child interaction. The use of direct coaching and practice of skills in didactic parent-child sessions in which parents are treated alongside children differentiates PCIT from most other parent-training interventions (Thomas and Zimmer-Gembeck, 2007; for further details see Davies and Ward, 2012). A meta-analysis of thirteen evaluations of PCIT (Thomas and Zimmer-Gembeck, 2007) found better evidence for the effectiveness of PCIT when compared with Triple P, for instance, where studies involved a control group of participants on a waiting list for an intervention, were based upon parents' reports of child negative behaviours, or observations of

[14] A randomised controlled trial with a high level of evidence (Level A)

parents' negative behaviours. However, it was thought that these findings could have been the result of weaknesses in the evidence base rather than a genuine disparity in effectiveness.

High quality evidence (Level A) from a randomised controlled trial showed that after about two years, considerably fewer parents receiving PCIT had continued to physically abuse their children (19%) than had those attending a standard community based parenting group (49%). A further trial (Evidence Level A) (Thomas and Zimmer-Gembeck, 2011) tested the most commonly used PCIT standard protocol with 150 mothers at risk of, or with a history of, maltreatment who were randomly assigned at a ratio of 2:1 between PCIT and a waiting list. After 12 weeks, the PCIT group showed significant improvements in parent-child interactions such as giving praise compared with the waiting list group. They also showed a significant reduction in child abuse potential (with a small to medium effect size of -0.4). An association was also found between PCIT and a reduced chance of being referred to children's social care because of suspected child abuse.

Specific interventions to address parental problems that increase the risk of maltreatment

Barth (2009) argues that those elements of parent training programmes that emphasise the development of self-efficacy through learning the skills of sensitive, responsive parenting can also have a positive impact on the types of parental problem that increase the risks of maltreatment: 'first helping parents to be more effective with their children can help address mental health needs and improve the chances of substance abuse recovery' (p.109). Certainly there is evidence that learning how to improve parenting reduces mental health problems (DeGarmo, Patterson and Forgatch, 2004), and that improving mothers' positive interactions with their children can reduce dependency on drugs (Pajulo *et al*., 2006). Barth (2009) suggests that a staged parenting programme such as Triple P might act as a filter, providing support for those parents whose problems respond to increased self-efficacy, and identifying those who require additional, specialist support alongside parenting interventions.

A relatively high proportion of parents whose children are on the edge of care are likely to require such support. Parents who are trying to overcome issues such as alcohol or substance misuse, mental health problems and/or domestic abuse may need support from a range of specialist adult services, many of which are provided by health professionals. The National Institute for Health and Care Excellence (NICE) produces evidence-based guidance and advice to improve outcomes for people using the NHS and other public health services. The guidance is based on wide-ranging and rigorous reviews

of evidence concerning effective (and cost-effective) interventions[15]. The reviews provide detailed evidence of the impact (effect) of interventions, and the duration of effects, as well as indicating the quality of the supporting research (e.g. sample numbers, attrition, and comprehensiveness of data). NICE has produced guidelines on issues such as the management of drug misuse (CG51 NICE, 2007a; CG52 NICE, 2007b); alcohol-use disorders (CG115 NICE, 2011a); common mental health disorders (CG123 NICE, 2011b) and the identification and prevention of domestic abuse (NICE, 2014). There is also guidance on co-existing problems, such as psychosis with co-existing substance misuse (CG120 NICE, 2011c). NICE guidelines indicate which interventions are most likely to be effective for people with different configurations of problems (and which are ineffective and therefore not recommended) and the expected length of treatment programmes. For instance, alongside a number of other effective interventions, detoxification programmes are recommended for substance misusers who 'have expressed an informed choice to become abstinent' (CG52 NICE, 2007b, p.7); these are generally thought to be effective when offered for up to twelve weeks in a community setting, although up to four weeks detoxification in a residential setting is more effective for people who have significant co-morbid physical or mental health problems or who require concurrent or sequential detoxification from more than one substance. Following detoxification, six months continued treatment, support and monitoring should be offered, to avoid relapse (CG52 NICE, 2007b).

People experiencing domestic abuse

While there is a wide range of effective interventions for adults who have problems with alcohol and drug abuse and/or mental health problems, there is much less evidence concerning effective interventions for people experiencing domestic abuse, and fewer specialist services available. Following the identification of 'impairment suffered from seeing or hearing the ill-treatment of another' as a form of significant harm in the Adoption and Children Act 2002 (s.120), police now notify children's social care when they are called to a domestic abuse incident in a family where children are involved. Stanley and colleagues (2011) studied the social work response to 184 families following police notification in two local authorities, using a retrospective quantitative design (Evidence Level D), but including the collection of some qualitative data. Sixty per cent of referrals resulted in no further action (although over half of these were re-referred in the 21 months follow-up period), and only 15% received further assessment or family support/safeguarding services. In 23% of cases the response was to send a letter to parents, advising them that the authority was aware of the incident and would take action if it was repeated. These letters were perceived as threatening by parents (and by the

[15] In April 2013 NICE acquired new responsibilities under the Health and Social Care Act 2012 to develop guidance and quality standards for social care in England, to be undertaken through similarly rigorous reviews of evidence. This is expected to provide an opportunity to apply an evidence-based system to decision-making in the social care sector, similar to that provided for the NHS. NICE Guidance on identifying and responding to child abuse and neglect is due to be published in 2016 (see www.nice.org.uk/socialcare).

researchers), and were ineffective in preventing further referrals. The families received some social work support, but it was sporadic and:

> the 'stop-start' approach appeared inadequate to effectively address the complex web of long term problems that often involved mental health problems and/or substance misuse and for some families, behavioural or mental health problems in children as well as long-established patterns of domestic abuse (p.309).

The authors concluded that the pattern of repeated referrals, assessments and case closures that this study showed 'will not contribute to building the consistent and trusting relationship between social workers and families that promote disclosures of need and engagement with relevant services' (p.311).

Although men and women in heterosexual relationships may both be perpetrators of domestic abuse, men are the perpetrators in a greater number of incidents and the violence they use is much more severe and more likely to involve controlling their partners through fear (Hester, 2013). A frequent response to domestic abuse is to exclude the male perpetrator from the household. However, as Stanley and colleagues (2011) point out, separation is not an assurance of safety because many men do not 'conveniently disappear' (p.311). Moreover, separation in itself often results in an escalation of violence. Richards's (2004) analysis of multi-agency domestic abuse murder reviews in London found that women were particularly at risk of femicide in the first two months following separation. Domestic abuse provides the most common context for femicide in the UK, with most deaths occurring in the period after a woman leaves her partner (Povey, 2004**)**.

Perpetrators of domestic abuse

The recent NICE (2014) review concluded that there was 'a lack of consistent evidence on the effectiveness of programmes for people who perpetrate domestic violence and abuse' (p.30). However, it did find moderate evidence[16] that individual interventions for abusers may 'improve aggressive feelings towards the partner, attitudinal change, understandings of violence and accountability, and short-term help-seeking' (p.57). Gondolf (2004) undertook a large scale evaluation of male perpetrator programmes in four sites in the USA using 'a naturalistic comparative design' (Evidence Level B). Although the interventions varied, they all used a gender-based cognitive behavioural approach. Those who completed two months or more of the programme were less likely

[16] NICE guidance summarises the overall strength of research evidence (meaning its quality, quantity and consistency) using the following categories: no evidence; weak evidence; moderate evidence; strong evidence; and inconsistent evidence. It does not refer to size of effect. For further information, see: http://publications.nice.org.uk/methods-for-the-development-of-nice-public-health-guidance-third-edition-pmg4/reviewing-the-scientific-evidence#assessing-the-quality-of-the-evidence

to re-assault their partners than those who did not (36% *vs*. 55%) (p.618). Moreover, although just under half (49%) of the perpetrators did at some stage re-assault within four years of entering the programme, the rate of re-assault was highest within the first six months (when the men were still in the programme) and subsequently diminished. Furthermore, over two-thirds of the women said their quality of life had improved and 85% felt very safe at follow up. The authors conclude 'There is a clear de-escalation of re-assault and other abuse, the vast majority of men do reach sustained nonviolence' (p.605). However they also found that 'about 20% continuously re-assault'.

Gondolf (2011) argues that there is strong generic evidence for gender-based cognitive behavioural group-work programmes for perpetrators of domestic abuse, and that poor outcomes from some programmes may be more accurately attributed to inadequate implementation and insufficient attention to those who drop out, rather than the approach itself. In the UK, such programmes have been implemented through the probation and the prison services, and include 'a package of inter-agency risk assessment, proactive offender management and structured victim contact from the women's safety service' (Bullock *et al.,* 2010, p iii). However, although the engagement of partners is widely accepted as central to the management of risk, securing their participation has proved to be problematic (*ibid.,* p.13).

People who have been victimised by domestic abuse

There is also evidence from a number of sources that the low self-esteem and isolation of women who have experienced domestic abuse frequently renders them vulnerable to establishing subsequent relationships with violent men – or to returning to previous abusive relationships. Interventions aimed at supporting mothers to improve their self-esteem or repair relationships with their children may prove to be helpful, and some may benefit from arrangements for delivery that suit their characteristics, such as being placed in single gender groups (Hannett, 2007).

The NICE (2014) review found moderate[17] evidence that advocacy services and skill-building interventions may improve self-esteem, coping and decision-making among people who have been victimised by domestic abuse (pp.51-53). Advocacy services may also improve women's access to community resources and therefore reduce the isolation which so many experience (p.51). Sullivan and Bybee (1999) conducted a randomised controlled trial (Evidence Level A) in which 284 women who had spent at least one night in a shelter were assigned after leaving it either to a control group or to receive advocacy

[17] NICE guidance summarises the overall strength of research evidence (meaning its quality, quantity and consistency) using the following categories: no evidence; weak evidence; moderate evidence; strong evidence; and inconsistent evidence. It does not refer to size of effect. For further information, see: http://publications.nice.org.uk/methods-for-the-development-of-nice-public-health-guidance-third-edition-pmg4/reviewing-the-scientific-evidence#assessing-the-quality-of-the-evidence

counselling for ten weeks. Re-abuse rates were high, but at the end of the intervention fewer of those in the treatment group than in the control group reported re-abuse at the two year follow-up (76% *vs*. 89%). There is also moderate evidence that counselling and psychological therapy interventions are effective in improving some of the psychosocial consequences of victimisation (NICE, 2014, pp.83-4). However, O'Reilly and colleagues' (2010) systematic review of screening and interventions for domestic abuse during pregnancy found little evidence of effectiveness.

Perpetrators of sexual abuse

As with domestic abuse, with which it can overlap, the routine response to sexual abuse is also to exclude the perpetrator from the household. However, many perpetrators of sexual abuse also go on to establish a new, abusive relationship with another vulnerable family (see Cleaver and Freeman, 1995). Most perpetrators are male, and interventions that focus on reducing the vulnerability of the mother or the children may be effective (see MacMillan *et al*., 2009), but they do not address the abuser. Lösel and Schmuker's (2005) comprehensive meta-analysis of the effectiveness of interventions for sexual offenders included data from 69 rigorous (Evidence Level A) studies published before June 2003. They found that the mean rate of sexual recidivism was 17.5% for those in control groups and 11.1% for those who received treatment. The definition of recidivism 'included outcomes ranging from incarceration to lapse behaviour' (p.120), although the length of follow up is not clearly stated. Overall, programmes designed specifically for sex offenders were found to reduce recidivism, whereas non-specific programmes were found to have no effect. When effect size was calculated, physical treatments showed larger effects than psychosocial treatments. Dropping out from treatment was found to double the likelihood of recidivism, a finding which was considered to emphasise the importance of motivating offenders and engaging them in appropriate programmes.

Impaired personality functioning

There is good evidence that some elements of impaired personality functioning can be treated with long-term intensive therapy. These include emotional dysregulation and an impaired capacity for self-reflection or recognising mental states in oneself and others. Programmes such as mentalisation-based treatment (Bateman and Fonagy, 2010, dialectical behavioural therapy (Linehan, 2000; Linehan *et al*., 2002), and schema-focussed therapy (Giesen-Bloo *et al*., 2006) are increasingly available in this country and have been shown to be effective in improving functioning. For instance, Giesen-Bloo and colleagues (2006) compared the impact of schema focused therapy (SFT) and psychodynamically based transference-focused psychotherapy (TFP) in a randomised controlled trial (Evidence Level A) in which 86 patients with borderline personality disorder participated. They found statistically and clinically significant improvements in patients across both groups after one, two and three years of treatment, although significantly more patients in the SFT group recovered or showed clinical improvements in respect of their borderline personality disorder. These interventions are, however, relatively long-term: for instance mentalisation based treatment takes 18 months to

complete, although participants show some improvements after six months (Bateman and Fonagy, 2010), while patients receive schema-focussed therapy for three years (Giesen-Bloo *et al*., 2006). Where parents have these problems and children are on the edge of care, it is important to ascertain the extent to which parental change in response to these programmes fits in with the timeframe for the child.

A recent NICE review (NICE, 2009) on the treatment, management and prevention of anti-social personality disorder found that group-based cognitive and behavioural interventions are effective in addressing problems such as impulsivity, interpersonal difficulties, anti-social behaviour and offending behaviour (p.20). For instance, the review included five studies (Armstrong, 2003; Liau, 2004; Porporino, 1995; Ross, 1988; and Van Voorhis, 2004) involving group-based cognitive and behavioural interventions for the treatment of offending behaviour in adults. It found the intervention had a modest effect on re-offending with a relative risk of 0.78[18] (National Collaborating Centre for Mental Health, 2010). The NICE review found no high quality evidence for the treatment of people who meet the criteria for psychopathy and dangerous and severe personality disorder; however these people represent only a small proportion of those with antisocial personality traits (NICE, 2009, p.22).

Intensive, multi-faceted interventions for families with complex needs

Many of the studies cited in this report draw attention to 'the complex web of long-term problems' that face parents in families where there are significant child protection issues and children are on the edge of care. Parents' problems may be intricately interwoven; they may also be reflected in, and exacerbated by, children's emotional and behavioural difficulties. Interventions that aim to help adults overcome issues such as alcohol and drug misuse or mental health problems do not necessarily focus on improving parenting capability in families struggling with complex problems.

A multi-faceted approach that integrates a range of services for the whole family may prove to be a more effective means of increasing parental capability than a series of discrete interventions, each aimed at a specific parental problem. Such an approach not only addresses parents' needs, but also those of children whose development may be compromised by abuse and neglect. Some interventions that use this approach also integrate parent-training techniques with a programme tailored to address specific problems in the parent, the child and their relationship, and also explore how protective factors in the wider family and environment can be strengthened in order to maintain progress.

[18] Relative risk (RR) is described as, 'the ratio of the treatment event rate to the control event rate. An RR of 1 indicates no difference between treatment and control'. For example, an overall RR of 0.73 is described as indicating that the event rate associated with the intervention is about three quarters of that with the control intervention meaning that the relative risk reduction is 27%. (NICE, 2009, p48).

Parents under Pressure (PUP)

Parents under Pressure (PUP) is an intensive home-based programme developed in Australia specifically to address the needs of multi-problem families (Harnett and Dawe, 2008). The programme 'combines methods for improving parental mood and parenting skills within a multi-systemic framework that takes into account the contextual influences on family functioning such as social support, housing and child care' (Dawe and Harnett 2007, p.383). Cognitive mindfulness techniques designed to help participants learn emotional regulation have been found to be effective in the treatment of addictions and the prevention of relapse following major depression, and these are incorporated into the programme (*ibid.*). PUP begins with a comprehensive assessment and case conceptualisation conducted collaboratively with the family; as part of the process, specific targets for change are identified, and these form the focus of the intervention, which is delivered over a ten to twelve week period. A small randomised controlled trial (Evidence Level A) involving 64 parents receiving methadone maintenance at two clinics in Brisbane, Australia (Dawe and Harnett, 2007) assigned participants to a home-based PUP programme (n=22), a brief, two session parenting skills intervention (n=23), and standard care from the methadone clinic (n=19). The study showed PUP to be effective in reducing parental stress and methadone dose, and there were significant improvements in children's behavioural problems. At the six month follow up, risk of abuse measured using the Child Abuse Potential Inventory had decreased from high to low for 36% (8/22) of the sample receiving PUP and 17% (4/23) of those receiving the brief intervention. There was no decrease in risk for families receiving standard care and in fact the level increased for 42% (8/19) of these parents. The risk of abuse did not increase for any of the parents receiving PUP; however it should be noted that 36% (8 /22) of them remained at high risk throughout the study. The PUP programme is currently being evaluated in a UK context across eleven NSPCC service centres, including a randomised controlled trial at six centres (see: http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/pup/ for further information).

Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN)

Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN) (Swenson *et al*., 2010a), is an example of a more complex multi-faceted intervention, designed specifically for families where physical abuse is a cause for concern. It adopts well-recognised techniques to engage families by interviewing each member to ascertain their views of desired outcomes, and these are then agreed as over-arching goals for treatment. A comprehensive assessment of the family's strengths and needs is then undertaken, and the drivers (or fit factors) of target behaviours are identified; for instance harsh discipline may be associated with parental alcohol misuse, depression and poor parenting skills, and children's non-compliance. The most powerful drivers are prioritised and evidence-based interventions are implemented with the support of the wider family and community. Progress is routinely assessed and the programme adjusted and tailored to meet needs until desired outcomes have been achieved. The programme is usually delivered through

three sessions a week, over six to nine months. Where there are serious safeguarding concerns, all family members agree a child safety plan and the practice team work closely with social workers in statutory services to ensure that social work decisions can be informed by clinical need or progress (for further details, see Davies and Ward, 2012, pp.160-161). MST-CAN has been rigorously evaluated (Evidence Level A) in a trial in which 86 physically abused young people and their parents were randomly assigned to receive MST-CAN or Enhanced Outpatient Treatment (EOS) (the standard service plus enhanced engagement and parent training interventions). Sixteen months after entering the programme, the percentage of parents in the MST-CAN group exceeding clinical thresholds for psychiatric distress had decreased (from 20.5% to 5.3%), and the percentage of young people scoring in the clinical range on self–reported post-traumatic stress disorder (PTSD) symptoms had dropped by half (from 17.8% to 8.9 %). In contrast, in the EOT group, parents showed virtually no change on the first measure (16.7% to 15.8%), and the young people showed slightly greater evidence of PTSD (19% to 21.4%). During the study period the MST-CAN young people reported about half as many incidents of severe assaults by their parent as did those in the EOS group (4.7 *vs*. 9.8 incidents) indicating that the programme does appear to reduce the incidence of physical abuse, although it does not eradicate it (Swenson *et al*., 2010b). At the time of writing, MST-CAN is being piloted or implemented in Leeds, Cambridge and Greenwich in the UK, and also in the Netherlands and Switzerland as well as the USA, where it originated (http://www.mstcan.com/programs/).

Systematic reviews undertaken as part of the Safeguarding Children Research Initiative identified a range of multi-faceted intensive interventions, developed using this approach, which appear to be effective in addressing physical abuse, and emotional abuse and neglect (see Barlow and Schrader McMillan, 2010; Montgomery *et al*., 2009; for further details see Davies and Ward, 2012, Chapter Five). Two of these interventions (Functional Family Therapy and Multi-Systemic Therapy) are being implemented across the UK with support from the Department for Education, with the specific purpose of preventing children from coming into care or custody (Department for Education, 2013a). UK trials are still ongoing for these programmes; not all authorities have access to them. Not all children in families with a complex web of long-term problems will benefit from them, but trials have shown that more will benefit and to a greater degree than those who receive routine services.

Multi-faceted, integrated programmes such as those described above offer a template for addressing the complex web of entrenched problems that beset families struggling to overcome abuse and neglect, and their consequences. As services develop it is possible that a ‘common elements’ approach that identifies those interventions most commonly required in flexible configurations to meet these complex needs can be developed to support training and service delivery (see Bentovim and Elliott, 2014).

Multi-faceted programmes for families with complex needs do not replace social work services, but are part of a planned, multi-agency intervention. They offer intensive

support for a limited period. They need to be dovetailed with other services and to be part of a child protection plan that reflects the need to step-up and to step-down the intensity of support as required.

Conclusion

This chapter has highlighted the various elements to be considered in identifying effective interventions designed to support parents in overcoming problems that compromise children's welfare, and help them meet their needs. Many of the interventions now available will change as research informs new developments in effective practice; this chapter provides an overview of the types of service that have currently been shown to be most effective in promoting change.

Key points from Chapter Six

- Some interventions are ineffective and others are harmful. It is important to understand how to interpret evidence of effectiveness, not all of which is of equivalent quality. No intervention is 100% effective: it is important to note what percentage of participants are likely to change and how much greater this is than the impact of standard services.
- There is very little systematic evidence concerning the elements of effective social work. Social workers who are open, straightforward and clear-sighted, and who adopt a position of respectful uncertainty appear to be most effective in supporting parents through the process of change.
- Organisational barriers such as an unstable workforce, changes that are built into the system and restricted resources can limit the effectiveness of social work interventions.
- Intensive Family Preservation Services (IFPS) have been shown to improve family functioning. However changes have not been maintained in the long term with families with entrenched and complex problems. IFPS delay children's entry to care and reduce the time they spend away from home, but they do not reduce the likelihood of them becoming looked after.
- Abused or neglected children tend to do better in care than those who remain with or return to parents who are unable to change. About one in three maltreated children who are reunified with birth parents become looked after again within six months.
- Parent training programmes have been shown to be effective in the general population, but only those which include specific modules tailored to address attitudes, beliefs and practices related to maltreatment are likely to be effective with parents whose children are on the edge of care.

- Parent training can help learning disabled parents to acquire adequate parenting skills to provide sufficient and safe care, but such parents are likely to need long-term support to adapt to new challenges.
- The Family Nurse Partnership programme is effective in reducing child abuse and neglect in vulnerable young pregnant mothers expecting their first child.
- Professionals offering substance misuse, alcohol abuse and mental health services under the NHS are required to take NICE guidelines fully into account in selecting services that have been shown to be effective.
- Gender-based cognitive behavioural group work can be an effective intervention for perpetrators of domestic abuse. Such interventions are often court-mandated and require close liaison with the probation service. Advocacy services and skill-building interventions may improve self-esteem, coping and decision-making among people who have been victimised by domestic abuse.
- Specific interventions for sex offenders can be effective but, even with treatment, just over one in ten will re-offend.
- Intensive multi-faceted integrated interventions for families with complex needs are more effective than routine services, but should be dovetailed with other services to form a child protection plan that can offer different levels of support as required.

Chapter Seven: Relapse and the maintenance of change

Introduction

The three previous chapters have first examined how parents whose children are on the edge of care may initially find it difficult to acknowledge that adverse behaviour patterns risk causing harm to their children, and then considered how they can become motivated and engage with a wide range of services and interventions designed to support them through the process of change. However, successful engagement in an evidence-based intervention is not the only concern for social workers assessing parental capacity to change. Within the assessment they also need to consider those factors which are known to affect the extent to which change is likely to be maintained in the long term.

Many of the models for assessing or understanding the change process discussed in previous chapters involve considering the likelihood of change being sustained in the long term. For example, relapse is a discrete stage of Prochaska and DiClemente's Trans-Theoretical Model of Change (TTM) (Prochaska and DiClemente, 1982), and Harnett's (2007) extended procedure for assessing parents' capacity to change involves considering what further support and intervention parents will require to maintain progress once it has been made. Models such as these can assist social workers in conceptualising the change process, and provide evidence concerning whether, and for how long, change is likely to be sustained.

Despite the development of various models and validated assessment tools, the evidence base is not sufficiently robust to predict parents' future behaviour accurately; nor is it ever likely to be so because unforeseen events and circumstances will always have the potential to disrupt the change process. The courts rely upon social workers using their professional judgment to decide whether parents are likely to sustain change in the light of all they know about the circumstances of a case and informed by evidence from a range of souces, including that obtained using validated assessment tools and the evaluations of effective interventions, which show their likely impact. Assessments also need to consider what would be the likely impact of a relapse on the child's safety and wellbeing, and this will depend on their age, vulnerability and experience of abuse and neglect. This chapter looks at what the research evidence tells us about maintenance of change following completion of an intervention; the role of relapse within the change process; and the factors that potentially support or undermine parents attempting to sustain change in the long term.

The impact of different types of problem on sustained change

As previous chapters have discussed, parenting capability can be compromised for a variety of reasons including substance misuse; domestic abuse; mental health problems; or because parents never had a satisfactory parenting role model themselves. The ability of parents to sustain change in the long term will depend to an extent upon the type and number of difficulties they are trying to overcome. Some problems can be completely resolved, whereas others can only be controlled or alleviated in such a way that the risk of serious harm to the child is reduced. This is an important distinction to recognise as it may have implications for a parents' ability to maintain long-term change. Where a parent has never experienced appropriate parenting themselves and lacks a role model, gaps in knowledge may be addressed through engagement in a parent training programme. However, where the underlying problem can only be controlled or alleviated, parents face an ongoing challenge as they attempt to meet their children's needs whilst continuing to deal with continuing adversity.

Chronic mental health problems and learning disabilities are two conditions which may always be present and require continuing support or treatment to enable successful parenting. Research has produced mixed messages about the ability of parents with learning disabilities to retain and use parenting skills in the long term (Feldman *et al*., 1989; Peterson *et al*., 1983). There is also mixed evidence on how far they are able to transfer skills learnt into new contexts and situations (Booth and Booth, 1993). McGaw and Sturmey (1994) suggest that to be most effective, skills training should be adapted to the needs of the individual and may need to continue over a period of years. Parents' ability to cope will depend upon the extent of their learning disability and contextual issues such as the support of a partner or family member without learning disabilities as well as long-term support from services (McIntyre and Stewart, 2011, p.6).

How long is needed to establish whether parents will successfully maintain change?

A challenge for social workers in assessing parental capability is that it cannot be assumed that after sufficient progress has been made, a parent will successfully continue to maintain change. In those situations where parents are struggling with a complex web of problems, capacity to maintain change will only become evident over time, and the process of sustaining change may require continuing support. For example, effective interventions are available to help parents overcome substance misuse, but long-term abstinence is required before it is possible to say with confidence that sustained change has been achieved. Laudet and White (2008) describe recovery from substance misuse as 'a process that unfolds over time rather than a time-limited 'event' (p.28) and compare it with having a chronic condition such as diabetes or hypertension.

A study by Hser and colleagues (2001), reporting on a 33 year follow up of 581 male heroin users, found that one in four still relapsed after fifteen years abstinence (p.507). They also found that for those individuals who stopped using heroin within ten years of initial use, achieving stable recovery still took a period of eight to ten years (Hser, Longshore and Anglin, 2007). Similarly, Moos and Moos (2006) found that 42% of people who received treatment for alcohol misuse had relapsed within sixteen years (p.216). Hibbert and Best (2011) also found recovery from alcohol addiction to be a gradual process of change. Their cross-sectional study of 53 people recovering from alcohol misuse identified those who had been sober for between one and five years as being in early recovery and those who had achieved sobriety for longer than five years as in stable recovery. However, they found that five years did not represent a plateau, because considerable further improvement occurred beyond this point. These studies of drug and alcohol addiction show that recovery from some problems may realistically extend throughout a child's formative years. The findings from these studies all support the argument for providing long-term, light touch support to help parents maintain progress once an intensive period of intervention has been completed. However there is considerable evidence to suggest that pressure to close cases means that social work services are often withdrawn prematurely, with inadequate arrangements for stepping down support (Farmer *et al.,* 2011; Farmer and Lutman, 2012; Ward, Brown and Westlake, 2012).

Chapter Six discussed what research tells us about the effectiveness of interventions intended to support parents through the process of change. The remainder of this chapter will explore what is known about the process of recovery and relapse, and identify some of the factors known to support or undermine sustained change.

The process of recovery and relapse

In view of the continuing challenge of maintaining change, it is unsurprising that parents experience instances of relapse within the recovery process. Although relapse is a term commonly associated with recovery from drug and alcohol addiction, its definition, 'to deteriorate after a period of improvement' can equally be applied to a parent who stops adhering to medical treatment or who loses confidence in their new parenting skills. In the field of substance abuse recovery, relapse is viewed as an integral part of the change or recovery process. Hser and colleagues (2001) referred to heroin users experiencing 'repeated cycles of remission and resumption' (p.503). Scott and colleagues (2005) monitored the recovery of drug users over a three year period and identified significant movement in both directions between abstinence and relapse. They described a 'chronic and cyclical nature of addiction and treatment'.

Although the literature describes relapse as part of a process of gradual recovery, risk of relapse is highest in the early stages (Laudet and White, 2008). As we have already seen (Chapter Six), although up to half of male perpetrators of domestic violence assault their

partners again, there is a marked de-escalation of assault after the first six months of treatment (Gondolf, 2004). A follow up study of the Parent-Child Assistance Program (PCAP) aimed at women who used drugs and alcohol heavily during pregnancy found that as the recovery cycle progressed, mothers accrued longer periods of abstinence between instances of relapse (Grant *et al*., 2003). Relapse is more likely to occur where there is temptation (i.e. reminders of positive aspects of the behaviour); where there is perceived need (i.e. stress relief); or in the event of boredom, although there may be no obvious trigger (West, 2011). Social workers and parents should not therefore view relapse as a failure, or an indicator that change will never be maintained, but should regard it as a natural stage in the recovery and change process.

Virtuous circles

It is important to note that a key feature of the recovery and change process is the way in which achieving one small step has been found to enhance parents' sense of self-efficacy or feelings of motivation, thereby propelling them on to achieve further change. In essence, a virtuous circle is formed where success in one area leads to success in others. Hibbert and Best (2011) found that as people recover from alcohol abuse, over time, their feelings of depression reduce and their perceptions of self-efficacy increase. It also seems likely that improved perceptions of self-efficacy may help vulnerable young women break a cycle of engaging in abusive intimate relationships (Wathen and MacMillan, 2003). Jones and Prinz (2005) describe how higher levels of parental self-efficacy are likely to lead to more successful parenting practices, and how these in turn reinforce those feelings of self-efficacy. Higginson and Mansell's (2008) small qualitative study of the process of psychological change found that individuals viewed themselves as changed people after they successfully overcame a problem in their lives, and that this gave them a new found sense of confidence in their capabilities. It is therefore important to support parents through the change process so that virtuous circles can be reinforced, and more positive self-images established and maintained. Recording progress and celebrating achievements will allow both parents and practitioners to measure the distance travelled and support the process of change (Dawe and Harnett, 2007).

Factors supporting or undermining the maintenance of change

As well as identifying the risk of relapse, the research evidence also points to a number of factors that have the potential to support or undermine a parent in maintaining long-term change. In many respects these factors mirror the *internal* (client related) and *external* (service provision) factors identified in Platt's (2012) Integrated Model of Parental Engagement (discussed in Chapter Five) and we therefore use the same categories in the following discussion. The following paragraphs do not offer an

exhaustive list of factors supporting or undermining sustained change, but indicate the broad range of those involved at this stage of the change process.

Examples of factors supporting change

Internal factors supporting change are those which relate to the individual, including personal, psychological or behavioural factors. Relapse has been found to be *less* likely among individuals belonging to certain demographic groups, including those who are female or older, married and better educated (Moos and Moos, 2006). People with higher levels of self-efficacy have been found to have an increased likelihood of maintaining change (Cummings *et al*., 2010; Moos and Moos, 2006). Having a place in society, for example, finding a role or identity, making a positive contribution and 'giving something back' have all been identified as supporting continued change. For example, Duffy and Baldwin (2013) found that former substance misusers wanted to become involved in educating young people about the dangers of drugs. Studies of overcoming substance misuse have also found that the opportunity to assume a 'normal' role in society such as a student, employee, volunteer or parent were viewed as accomplishments and contributed positively to recovery (Skinner *et al*., 2010; VanDeMark, 2007). Being a parent in itself is a powerful factor that supports the achievement and maintenance of change, but the stresses of resuming the role if children have been cared for elsewhere can undermine progress. These issues are further discussed below.

External factors supporting change are those related to personal circumstances and to the provision of services or interventions. The existence of positive support networks has been identified as a factor supporting change (Hibbert and Best, 2011; James, 2004). Duffy and Baldwin (2013) found that 'family contact was the key motivator stated by participants for maintaining their recovery' (p.6). This study also found that peer support played an important role in recovery. In relation to parents with learning disabilities, having the support of someone without a learning disability has been described as 'one of the single most important factors influencing the ability of parents to manage' (McIntyre and Stewart, 2011, p.6).

Support from professionals is also important in maintaining change. Proactive social work support throughout the process is associated with successful reunifications from care (see Farmer and Lutman, 2012). Incorporating parenting training into interventions addressing other issues may also increase the likelihood of successfully maintaining behaviour change (Porowskia, Burgdorf and Herrell, 2004), and this approach may be as relevant to fathers as to mothers (Collins *et al*., 2003).

Tailoring services in response to parents' individual needs and circumstances has an impact on their ability to sustain change. This includes making support available before they reach crisis point and continuing support for as long as is necessary. This is a particularly important issue when parents have learning disabilities. Like all parents they will face different challenges as their children grow older; however, because they need extra support to adapt and to learn, their attempts to continue parenting successfully may

be undermined by the pace of their child's development if they do not continue to receive adequate training and support to help meet these changing needs (Accardo and Whitman, 1990; McGaw, 2000).

It is also worth noting that people's priorities have been found to alter as they progress through the process of change or recovery, with the result that certain factors may have a different impact depending on whether a parent is in the early or later stages of the process (Laudet and White, 2008, 2010). Although substance misusers may initially consider abstinence to be their greatest priority, over time issues such as finding employment or looking after their health may become increasingly important (*ibid.*). Laudet and White (2010) also produced further findings of particular relevance to professionals engaged in supporting changing behaviour: this study showed that achieving abstinence did not automatically lead to improvements in other areas of individuals' lives. This suggests that a wraparound approach is required, which looks at supporting people not only to overcome the particular difficulties that compromise their parenting, but that also enables them to reduce continuing stressors, such as poor housing or living conditions, and unemployment.

Examples of factors undermining change

Negative emotions are among the *internal factors* that undermine change. Feelings of stress can trigger a return to active addiction (Laudet and White, 2008). Likewise, low self-efficacy in relation to parenting and negative feelings about the impact of past drug use on children have been found to undermine parents' attempts to sustain change (Baker *et al*., 2003; Greenfield *et al*., 2000). VanDeMark (2007) found that having the parenting role removed can undermine long term change. However, this must be considered in the light of any risk to the child of continued co-residence or contact.

The impact of co-morbidity on the process of change has been discussed throughout this report and also needs to be considered in relation to parents' ability to sustain change. Charney and colleagues' (2010) follow-up study of individuals receiving treatment for alcohol addiction found that those who had a secondary substance misuse problem were more likely to slip up or relapse in their drinking within the first four weeks of abstinence; such a relapse was then found to be a predictor of alcohol consumption at twelve weeks (p.46). Parents who are struggling with combinations of problems such as poor mental health, substance misuse or domestic abuse are less likely to be able to maintain change in the long term (Duffy and Baldwin 2013; Skinner *et al*., 2010).

External factors which can undermine change include having an inadequate support network. James (2004) highlights the importance of family members in supporting parents with learning disabilities; Edmonson and Schneider (2001) found that the risk of family breakdown in this situation could be minimised by involving as many people as possible in supporting the family to create a circle of support. However McConnell and colleagues (2008) found that parents with learning disabilities often received limited

social support from family, friends or their community, leaving them reliant upon formal support services.

Falkin and Strauss (2003) found that women who misused drugs were likely to become cut off from their social networks. Consequently, attempts at recovery could be compromised by their finding themselves reliant for support upon the very people who were facilitating their continuing drug use. However they were also reluctant to break ties with those who prevented their recovery, as these 'may have also been the main people who were there for them in many constructive ways' (p.142). Other studies have also found that drug or alcohol users who become cut off from their family and friends can find themselves having to live or associate with other substance users, and may then form intimate relationships with them (Carlson *et al*., 2006; Porowskia *et al*., 2004; Skinner *et al*., 2010).

Women who leave their homes to escape abusive relationships may find themselves isolated. This may be a particular problem for BMER women and disabled mothers, who may previously have been reliant on their communities for social support (see Stanley *et al.,* 2012b). Loneliness and a loss of social support can increase their vulnerability and become a major factor in their re-establishing an abusive relationship or entering into a new one (see Ward, Brown and Maskell-Graham, 2012).

There is also evidence that continuing exposure to factors such as poverty, financial instability, debt, and poor housing add to parents' stress and increase the likelihood of relapse (VanDeMark, 2007). MacIntyre and Stewart (2011) identify a tendency for some professionals to assume too readily that parents with learning disabilities are prevented from parenting effectively by their disability, when in reality they too are struggling with the same lack of resources that compound the difficulties faced by many other parents whose children are on the edge of care.

The role of parenthood in supporting and undermining change

Parenthood is a key motivator in sustaining change; however there is also evidence that, if inadequately supported, the stress of resuming greater parental responsibilities can undermine progress. Firstly, there is a wealth of research evidence to show that being a parent motivates people to maintain progress and avoid relapse. Duffy and Baldwin (2013) found that being a parent prevented people from relapsing back into drug use because they wanted to avoid the feeling of 'not being there' for their children (p.7). Kim and colleagues (2006) found that fathers' relationships with their children had a positive impact on their substance use during residential treatment and on recovery. The authors described the parent-child relationship as potentially playing 'a key function in supporting adult individuals throughout the recovery process and encouraging maintained abstinence' (p.92).

The opportunity to retain or regain custody of children is also a strong motivator for achieving and sustaining change (Carlson *et al.,* 2006; Sword *et al*., 2009). However

resuming the parental role may bring with it additional stresses, for reunification can be a lengthy and sometimes problematic process (Bullock *et al*., 1993). It is important to ensure that progress is sufficiently advanced for parents to cope with the emotions and stress that reunification may bring (Carlson *et al.,* 2006). Stressful family relationships can undermine the changes parents have made (Duffy and Baldwin, 2013). For example, family dynamics may become strained when parents are able to resume their role and take over the care of children from grandparents who have previously stepped in to help (Knis-Matthews, 2007).

Stressful family relationships are not the only issues which can undermine parents' ability to maintain long-term change during this period. Carlson and colleagues' (2006) study of mothers who were reunited with their children after overcoming substance misuse identified difficult relationships with social services as a stressful factor which could threaten their progress. Poorly managed reunification can also have an undermining effect on sustained change; family reunification involving multiple children or reunification following a significant period of separation can be particularly overwhelming for parents (Carlson *et al*., 2006; Cordero 2004; Hess and Folaron 1991). Reunification is also particularly difficult for children who return home separately or are reunited with siblings who have been able to remain with both parents (Wade *et al*., 2011), and this can exacerbate the family tensions that add to parental stress.

The availability of resources is also a major factor in parents' ability to sustain change. Inadequate support networks mean that parents may lack the necessary help with child care from family or friends. Harnett (2007) identified this as a major factor that prevented parents from attending ongoing treatment. Finally, being unable to access the resources needed specifically for resumption of the parental role, including a safe living environment, food or recreation facilities can undermine a parent's efforts to maintain change (Carlson *et al*., 2006).

Relapse and harm to the child

When parental recovery suffers a setback, the relapse can impact on both the child's current and long-term safety and wellbeing. The immediate impact may be similar to that of initial exposure to parental problems in that parenting capability may diminish and, unless there are supportive adults available who can compensate and protect them from harm, children may experience the lack of basic care, stimulation, emotional warmth, and so on that contribute to abuse and neglect (see Chapter Two for further details). There may be immediate safety issues if, for instance, children are exposed to physical abuse from a parent whose self-control is diminished by alcohol, or if they are left with access to drug paraphernalia. Relapse will have a different impact depending on the age and vulnerability of the child. Nevertheless, evidence from a number of sources also indicates that the longer children are exposed to abuse and neglect, the greater will be the impact, and the more difficult it will be to overcome (see for instance Hildyard and Wolfe, 2002; Rossman and Ho, 2008). We know, for instance, that behavioural problems

and symptoms of post-traumatic stress disorder (PTSD) increase the longer that children are exposed to domestic violence (Rossman and Ho, 2008), and that the chronicity, rather than the type or severity of maltreatment is the strongest predictor of negative outcomes (Bolger and Patterson, 2001). The impact of relapse needs to be assessed within this context.

Finally, relapse has its own impact in that it can undermine children's sense of stability and security. Relapse may mean that children experience repeated attempts at reunification followed by readmissions to care; those children who move constantly between home and care in an unplanned manner tend to have the least satisfactory outcomes (Wade *et al.,* 2011).

Conclusion

Social work support is often provided for a relatively short period of time. Where parents are able to progress successfully through the stages of change there is a strong case for light-touch monitoring to ensure that their progress is maintained in the long term (see Davies and Ward, 2012). Parents who have maltreated their children are likely to be struggling with deep-seated and entrenched problems that are extremely difficult to overcome. Intensive long-term support for those who are struggling to maintain change is therefore necessary (see Laudet and White, 2010). Even where change appears to be established, swift withdrawal of services and premature case closures are likely to be unreliable and ineffective in safeguarding children in the longer-term (Ward, Brown and Westlake, 2012).

This chapter has highlighted how successfully engaging in and completing an intervention is only one step in the change process. For many parents, the real challenge will be in maintaining that change in the long term. The challenge for social workers will be in assessing whether, in light of what they know about the parent, the nature and number of issues faced, factors which may support or undermine long-term change and the support available for the future, they consider that a parent is likely to achieve and sustain change within the child's timeframe.

Key points from Chapter Seven

- The ability of parents to sustain change in the long term will be affected by the type and number of difficulties they are trying to overcome, and whether these can be fully addressed or only controlled and alleviated.
- Recovery from problems such as substance misuse is a gradual process extending over a period of years rather than a time limited event.
- Relapse forms a natural part of the recovery cycle.
- A key factor in the recovery and change process is the establishment of virtuous circles in which success in one area leads to success in others.

- Internal factors supporting the maintenance of change include certain demographic factors; self-efficacy; having a ‘normal’ role in society. External factors include positive support networks and appropriate support from professionals.
- Internal factors that undermine the maintenance of change include stress, negative emotions, and co-existence of problems. External factors include isolation, inadequate support networks and poverty.
- Parenthood is a key motivator in sustaining change; however, if parents are inadequately supported, the stress of resuming greater parental responsibilities can undermine progress.
- Parents’ priorities are likely to change as they progress through recovery, so different factors will be relevant at different stages of that process.
- Change or recovery in one area of parents’ lives does not automatically result in improvements to other areas.
- Relapse may have a negative impact on children’s wellbeing because they may be at risk of immediate harm; continuing exposure to abuse and neglect may compromise their development; and they may experience greater instability.
- Assessments will need to consider whether, in view of what is known about the child’s needs, the issues parents face, the factors which increase or decrease the likelihood of relapse, and the support available for the future, sufficient change can be achieved and sustained within the child’s timeframe.

Chapter Eight: Conclusion: Making use of the research findings to inform professional practice and assessments required by the courts

Introduction

The preceding chapters of this report present the findings from a body of research that adds to our knowledge of how, and in what circumstances, parents are able to overcome abusive or neglectful behaviour patterns that place their children at risk of significant harm. The research is drawn from a wide range of disciplines and focusses on parents in families where there are significant child protection concerns and children are on the edge of care. The report is intended as a reference resource for social workers in their work to support families where children's safety and developmental functioning are at risk. However the research findings should also help social workers and children's guardians to produce more focussed and robust assessments of parenting capability and parental capacity to change, and assist judges and other legal professionals in evaluating the quality of assessment work presented to the courts by the local authority and Cafcass. This last chapter examines how these research messages might support social work practice with families and more specifically, how they might be used to inform assessments required by the courts in cases where the threshold for significant harm is thought to have been reached and there has been a decision to instigate proceedings.

The President of the Family Division has set out the courts' expectations of the social worker's statement and the children's guardians' case analyses within the revised Public Law Outline (Munby, 2013a, 2013b; Re B-S 2013). There is an emphasis on assessment and analysis, and on the production of succinct, evidence-based reports, supported by other materials if required. Materials placed before the court by the local authority and the children's guardian will include, among other requirements: a threshold statement showing significant harm or likelihood of significant harm (usually drafted by a local authority lawyer); assessments of the child's needs and the parent's capacity (or capability) to meet those needs; an analysis of why there is a gap between parental capacity (or capability) and the child's needs; assessment of other significant adults who are potential carers; and a plan for the child that is consonant with the evidence accepted by the court and produced by these assessments. The expectation is that social workers and children's guardians are already experts in these matters, and that they will play a leading role in undertaking assessments, although they will consult with colleagues from a wide range of other agencies; and that additional assessments from specialists will only be sought in those cases where parents or children have needs that are outside the area of social work expertise. In the following paragraphs we have indicated where the findings from this overview of the literature might inform the assessments for the courts to be made by social workers and children's guardians in care or related proceedings. Findings have particular relevance for assessments of children's needs, parental capacity

(or capability) to meet needs, and an analysis of why there might be a gap between parental capability and the child's needs.

Assessment of parents' capacity to meet needs (parenting capability)

Chapter Two presents up to date findings from empirical research that seeks to clarify the circumstances that lead to parental problems such as domestic abuse, mental health problems and substance misuse, and the ways in which these interact with one another and with learning disability, as well as with parents' previous histories and experiences, to compromise their ability to meet their children's needs. This type of evidence, and its implications for children's development, is fundamental to an assessment of parents' capacity to meet children's needs (parenting capability). Parenting does not take place in a vacuum, and such an assessment also needs to take account of the research data which show how environmental factors such as poverty, debt, poor or overcrowded housing, unemployment and the debilitating experience of living in a dangerous or violent neighbourhood can interact with other risk factors and reduce parenting capability (see for instance Fernandez, 2007; Jack and Gill, 2013). Assessments of parenting capability should identify strengths as well as difficulties and, where appropriate, the information should be checked and discussed with the child and their parents or carers (HM Government, 2013, p.19)

Chapter Two also provides examples of the ways in which parents' problems can impact on their ability to meet children's needs across the six dimensions of parenting capability set out in the Assessment Framework: basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries and stability. Diminished parenting capability in these dimensions increases the likelihood that abuse and neglect will occur. For instance, substance misuse, problem drinking and some mental health problems can all lead parents to misinterpret experiences and observations and/or reduce their ability to control feelings of anger and frustration, so that they cannot ensure their children's safety. These are the types of indicators that can inform social workers' assessments. Concrete examples of how parenting capability has been reduced, taken from social workers' own observations, from talking and listening to children, from parents' own reports and those of other interested parties, including family members and professionals from other agencies, should be included in statements for the courts. Such information should be supported by the results from validated instruments and scales and, where there are specific, additional concerns that are outside the area of social work expertise, specialist assessments from professionals such as psychologists, psychiatrists, probation officers and drug counsellors.

Assessments of children's needs

Chapter Two also presents up to date findings from empirical research concerning abuse and neglect and its long-term impact on children's development. The research evidence provides a basis for understanding the harmful impact of maltreatment across the whole spectrum of children's development and sets out how, unless adequate action is taken, there can be long-term adverse consequences throughout adolescence and into adulthood. The research evidence should help professionals with safeguarding responsibilities understand how abuse and neglect impact on parent-child interactions, attachment styles, and children's physical, cognitive and psychosocial development. Emotional abuse and neglect are particularly difficult to recognise because they rarely produce a crisis, but the chronic, long-term exposure to these forms of maltreatment has a corrosive impact on children's development (see for instance Norman *et al.,* 2012); the research evidence can identify how this happens and help practitioners understand why these issues are important.

The research evidence also shows how some children, such as those who are very young, those with health problems or disabilities, or those with emotional or behavioural difficulties, can be particularly challenging for parents, and are disproportionately likely to experience abuse and neglect (Hindley, Ramchandani and Jones, 2006; Sullivan and Knutson, 2000). These findings should alert practitioners to the potential significance of concerns about abuse and neglect when children show these characteristics.

Understanding this type of research evidence is fundamental to assessments of children's needs, which should explore how well children are functioning across all dimensions of development and examine whether, and to what extent, this is being compromised by abuse or neglect. Chapter Two presents research evidence showing ways in which abuse and neglect have been found to impact on development from before birth to adulthood. The Assessment Framework sets out seven dimensions of development which assessments should cover: health (including physical development), education (including cognitive development), identity, family and social relationships, emotional and behavioural development, self-presentation and self-care skills. Assessments of children's needs should identify strengths as well as difficulties and, wherever possible, be discussed with the child and their parents (HM Government, 2013, p.19). Neglectful or abusive parenting may have a different impact depending on the age and vulnerability of the child. Concrete examples of the ways in which children's development appears to be compromised by abuse and/or neglect, taken from social workers' own observations, or from those of other professionals such as health visitors and teachers, should be included in statements to the courts. Such statements should be supported by the results from validated instruments and scales, reports from other family members, reports from professionals and, where there are specific, additional concerns that are outside the area of social work expertise, specialist assessments from professionals such as paediatricians, child psychologists and psychiatrists.

Assessing the likelihood of significant harm

Assessments of children's needs that show impairment of health or development should help to determine whether the threshold for significant harm is likely to be reached. A key question that also needs to be resolved is whether children will be exposed to a continuing risk of significant harm if they remain with their birth parents. In a small number of cases the risks are so serious that it is obvious that children cannot safely remain. However in the majority of cases it is important to weigh up the various factors that indicate the extent to which children are likely to be protected in the future. Practitioners who have established a relationship with parents and are aware of their history are in a unique position to make such assessments, but professional judgments alone have been found to be insufficiently reliable as a means of assessing the likelihood of future harm (see for instance Arad-Davidson and Benbenishty, 2008; DePanfilis and Girvin, 2005; Dawes, Faust and Meehl, 1989). There is a strong case for practitioners to use standardised, evidence-based tools as a means of supporting, though not replacing structured professional decision-making. However Barlow, Fisher and Jones' (2012) systematic review of tools available to assist practitioners in assessing the likelihood of current or future significant harm found that most need further validation or piloting in a UK context – an initiative that is currently under way.

Analysis of why there might be a gap between parental capability and the child's needs

Case conceptualisation

There is considerable evidence to suggest that practitioners are usually competent at collecting information, but that they find it more difficult to analyse it and draw out the implications when developing care plans or writing court reports (see for instance Turney *et al.,* 2011). Analysis requires some form of conceptual map or model that serves as a guide for the practitioner, helping them to make sense of information, weigh up its significance and draw out conclusions. The Assessment Framework is recommended by Working Together (HM Government, 2013) as a simple ecological model, which can form the basis for core assessments. Models such as this can facilitate the development of a case conceptualisation – a hypothesis concerning the various internal and external factors that affect a parents' ability to meet children's needs, the strengths and weaknesses within the child, the family and the environment, and the issues that need to be addressed. This type of conceptual map allows practitioners to move from observation to analysis; it helps them to make sense of the interrelationship between factors in each domain and dimension, and set goals for the process of change.

As previous chapters have shown, there is no shortage of more complex conceptual models, designed to guide practitioners through the processes of assessing risks of future harm, parents' capacity to change, and engagement with services. Models such as

the research-based approach for assessing the risk of further maltreatment (Baynes, Jones and Bowyer, 2013), based on Jones and colleagues' systematic reviews of risk and protective factors where children are likely to suffer future harm (see Chapter Two), and Platt's (2012) model for assessing parents' engagement with services (Chapter Five) have been designed to facilitate such analysis, although they have not yet been fully piloted and evaluated in this country.

Gaps between parenting capability and children's needs

An analysis using a case conceptualisation based on the Assessment Framework will help practitioners to identify why there are gaps between parenting capability and children's needs. For instance, this model might guide practitioners into asking whether insufficient stimulation is having a negative impact on children's cognitive development, and whether this is related to factors within the family history or functioning (for example parents' learning disability or substance misuse). However, a more dynamic model would not only explore whether there are gaps in parents' capability, why they have occurred and whether the child's needs are being met, but would also ask whether parents have the capacity to change, and might take such assessments further forward. Harnett's (2007) model (see Chapter Three) can be understood as a further development of some of the theories that support the Assessment Framework; it builds on an initial cross-sectional assessment by guiding practitioners through the process of working with parents to identify and set achievable goals, selecting and implementing interventions appropriate to achieving those goals and measuring progress. A dynamic conceptual model such as this should guide practitioners towards collecting information that will enable them to show what goals have been achieved so far and within what time scale, what services have been offered, how far parents have been motivated and engaged in taking up the services on offer and whether they have made a difference, and what is the likely timescale for parents' capability improving and progress being reliably sustained to the extent that children are adequately safeguarded.

Implications for day to day practice

Court requirements and implications for social work practice

It should be evident from the above that assessments required by the courts should not only be undertaken to inform proceedings, but should also be an integral part of day to day social work with parents whose children are on the edge of care. Such assessments are necessary to monitor parental progress towards agreed goals as well as to inform decisions about the safety of children living in families where there are serious child protection concerns, and also to inform child protection and looked after children plans, effective interventions for parents and children, plans for reunification from care, continuing social work support, and so on.

The literature review identified a number of messages concerning the knowledge and skills that social workers need to acquire in order to undertake such assessments and take appropriate action. Above all, they need to be able to observe and communicate with children and listen to their views. However, they also need to be able to recognise the indicators of substance misuse, alcohol abuse and domestic abuse. They need to be able to recognise parental learning disabilities and identify the symptoms of mental health problems and poor personality functioning. Where social workers recognise indicators, they need to assess matters further using evidence-based assessment tools or, where appropriate, refer the parent for specialist assessment and support. Social workers need to know when and how to refer to mental health professionals, and what interventions are available and might make a difference. They also need to know that harm to children arises from parents' functioning and behaviour, not their diagnosis; that psychiatrists often cannot provide a definitive prognosis; and that mental health assessments are not a substitute for parenting assessments. When parents have mental health problems or poor personality functioning, the social worker's role is to assess the extent to which observable symptoms are impacting on parents' ability to meet their children's needs.

The research evidence also indicates that social workers need to be aware that, in families where there are serious child protection issues and children are on the edge of care, parents are likely to experience overlapping problems that interact with one another. For instance, parents with mental health problems are more likely than others to be problem drinkers and/or misuse substances (Beckwith *et al.,* 1999; Woodcock and Sheppard, 2002); they may also be in a violent relationship (Finney, 2004) and have financial difficulties and housing problems (Jack and Gill, 2013).

Resources such as the NSPCC training pack on substance misuse for child care professionals (see http://www.nspcc.org.uk/Inform/trainingandconsultancy/learningresources/seeingandhearing_wda56195.html), guidance for professionals working with parents who misuse alcohol (Alcohol Concern, 2006), training materials on identifying neglect (Department for Education, 2012) and the Social Work, Alcohol and Drugs (SWALC) website (see http://www.swalcdrugs.com/) provide guidance to practitioners on recognising indicators of different problems and their possible impact on children's wellbeing.

Understanding the process of change

The literature review also provides useful material concerning the process of change. Research on overcoming alcohol or substance misuse has identified a complex process whereby individuals often deny the need to change their behaviour patterns before gradually becoming motivated to change and engage with services. Progress is also unlikely to follow a linear pathway, but is commonly marked by relapse before further engagement (Prochaska *et al*.,1992). This concept of progression through different stages of change in which decisions to engage and take action are finely balanced between perceptions of the advantages and disadvantages of altering the status quo,

may be helpful to social work practitioners in understanding the behaviour patterns of parents whose children are on the edge of care, and who may be struggling with more complex, inter-related problems than adults who are trying to overcome addiction *per se*.

Many parents, when advised of serious child protection concerns will, at least initially, deny that there is a problem or that their behaviour patterns have an impact on their children; others will outwardly comply with social workers' requirements, while inwardly remaining disengaged. Some parents with learning disabilities or specific mental health problems may not understand that certain behaviour patterns and adverse parenting practices can place their children at risk of significant harm. However resistance to change can also reflect internal factors such as fear of stigma, shame, ambivalence about the benefits of change and parents' lack of confidence about their capacity to overcome factors that place their children at risk. Much of the social worker's task involves supporting parents through the process of change – encouraging them to become motivated and engage with services and to persist in the face of discouragement and relapse. Supporting children through this process is, of course, a key element of this task.

Parents become motivated to change for a number of different reasons. Many of these are unclear, although it does appear that motivation to change begins when the perceived benefits start to outweigh the perceived costs. There is also evidence that some parents will experience events or circumstances that create a turning point in their lives and motivate them to overcome adverse behaviour patterns and improve their parenting. Turning points can include: a sudden shock, such as experiencing the death of a close relative or friend from alcohol misuse; hitting rock bottom; life events such as pregnancy and general maturation. Such turning points create windows of opportunity in which practitioners can engage with parents and introduce appropriate support.

Practitioners need to be aware that engagement is determined both by internal factors such as parents' self-confidence and expectations and external factors such as the effectiveness of the service and the availability of resources. Cancelled appointments or changes of staff can reduce parents' motivation to engage with a service. It may prove helpful to map out the different internal and external factors that promote or inhibit engagement in order to understand what can be improved to ensure that parents are more effectively engaged with services.

The process of change is, however, a lengthy business, and there is much evidence to indicate that services are often withdrawn too abruptly, with insufficient step down support following intensive interventions. Continuing support should be provided at least during the six months following an intensive intervention, when the likelihood of relapse is greatest. Thought should also be given to the type and duration of support services required by parents when children are returning home from care.

Relationships between social workers and parents

The research findings emphasise the significance of relationships between professionals and parents in facilitating and sustaining change. Many parents will not develop sufficient capacity to meet their children's needs without support. However a substantial body of research (e.g. Dumbrill, 2006; Forrester *et al.,* 2012; Forrester and Harwin, 2011) suggests that the role of the social worker is, in itself, a major factor in the change process and that many parents may not be so much resistant to change as resistant to the involvement of social workers in their families. Parents' approach to the relationship with social workers will be coloured by their past experience and their current attachment styles, as well as by their awareness that the social worker's role is to assess and make judgments concerning their parenting capability. Social workers may find it difficult to resolve their twin roles of supporting and empowering parents and making judgments and taking authoritative action when children are likely to suffer significant harm. The relationship can therefore be fraught with unresolved tensions that practitioners need to appreciate and understand. The way in which social workers use, and are perceived as using, their power is a major factor in the success or failure of the relationship. The use of coercion, through the instigation of proceedings or threats to remove children can act as a powerful motivator for some parents, but it can also backfire and cause parents to become overwhelmed by their difficulties.

If social workers adopt a confrontational approach in communicating with parents and are perceived as using their power to penalise rather than to support them, they are likely to exacerbate parents' resistance to their involvement and the relationship may become focussed on the struggle for power rather than on the problems that need addressing (Dumbrill, 2006). On the other hand, if social workers can establish a strong working relationship with parents, that is characterised by honesty about what needs to change and why, sensitivity and a willingness to listen to parents' points of view, respectful uncertainty in the face of dissimulation and supportive use of power, they may be better able to help parents become motivated and engage with services.

A number of approaches may be useful in helping social workers develop such relationships. Firstly, social workers may be perceived as more sensitive and appreciative of parents' points of view if they develop motivational interviewing skills. This approach has been found to be an effective way of helping problem alcohol users overcome ambivalence about change and become engaged in treatment (Bowen and Gilchrist, 2004). Its emphasis on collaboration rather than confrontation and on eliciting and building on the service user's views about how change can be facilitated may reduce some of the elements in relationships with social workers that are known to contribute to resistance, and refocus interactions on the welfare of the child. However a formal evaluation of its effectiveness in child protection work has not yet been completed (see Forrester *et al.,* 2012).

Research on parents' experiences of social work involvement suggests that some are unaware of the extent of social work concerns about their children's welfare until care

proceedings are initiated (see Ward, Brown and Westlake, 2012); however this should happen less frequently as it becomes more common to send a letter before proceedings (see Department for Education, 2014a, pp.16-17). Openness and transparency, which are also fundamental to motivational interviewing techniques, are valued by parents, who appreciate social workers who are honest about their concerns and 'not afraid of breaking bad news' (Ward, Brown and Westlake, 2012, p.193). This is one reason why agreeing concrete goals and monitoring progress are considered to be an effective means of supporting parents through the process of change.

Introducing family group decision-making (FGDM) can also redress the imbalance of power in social worker/parent relationships by engaging the wider family in child protection processes. FGDM tends to be viewed positively by parents, can be effective for BMER families as it is respectful of their culture and language, and has been shown to increase the commitment and engagement of family members, including fathers and paternal relatives, in making plans for children's welfare (Barnsdale and Walker, 2007; Morris and Connolly, 2012). Concerns have, however, been raised that FGDM conferences can be controlled by dominant family members (or indeed professionals) who do not give a voice to the views of children and vulnerable adults such as victims of domestic abuse, and that both professionals and family members can show a lack of commitment to implementing the plans that have been agreed (Barnsdale and Walker, 2007; Cashmore and Kiely, 2000). There is also contradictory evidence concerning the effectiveness of FGDM in improving outcomes for children compared with other child protection services (Berzin, 2006; Edwards *et al.,* 2007; Gunderson *et al*., 2003; Sundell and Vinnerljung, 2004; Titcomb and LeCroy, 2005). Some of the mixed research findings may relate to the complex needs of families referred to FGDM (see Sundell and Vinnerljung, 2004) or derive from differences in the ways in which FGDM is implemented. Concerns about variations in standards of FGDM in England are being addressed by the development of an accreditation framework (Haresnape and Brown, 2013).

The literature review has also found considerable evidence of the extent to which external factors such as poverty, unemployment, poor and overcrowded housing and lack of community cohesion can exacerbate parental problems and magnify the challenges faced by parents whose children are on the edge of care. The research also shows that parents appreciate it when social workers use their position of power to act as advocates on their behalf and help them to negotiate with other authority figures such as landlords. Dawe and Harnett (2007) found that too little attention is given to the practical assistance that social workers can provide. Focussing on practical as well as emotional support might be a further means of improving the relationship, as well as supporting very vulnerable families.

Relationships with other professionals

It is obvious that good working relationships with other professionals are also of key importance. Many parents who are concerned about the perceived stigma of social

services involvement will initially turn to other agencies for support. Only just over half of children who are subjects of serious case reviews are known to children's social care (Brandon *et al.,* 2009). Social workers need to have close working relationships with professionals from a range of agencies in order to establish an effective team around the child.

Where parents are trying to overcome complex and entrenched problems, social work support needs to be complemented by other, more specific interventions, delivered by professionals from a wide range of agencies – another reason for the development of good inter-agency relationships. Tensions between adult and children's services are common, particularly if one professional focusses exclusively on the needs of the parent and another on the needs of the child (Tompsett *et al.,* 2009; Ward, Brown and Westlake, 2012). Such tensions will not be resolved without open discussion.

In order to support parents in achieving the goals that have been agreed, social workers need to be aware of the services available in their area. Not all services are effective and some can be harmful. It is therefore important for social workers to know what has been shown to work (and what has not) and to be able to interpret the findings from evaluations. They also need to understand what services are appropriate for parents and children with different configurations of need. For instance, while parents whose children are at serious risk of abuse and neglect will need to learn better parenting skills, they are more likely to profit from programmes that have been specifically tailored to meet their needs than from those that have been developed for a population whose problems are less severe. Tailored parenting skills programmes may help parents develop greater self-efficacy and improved self-esteem, and this may have a knock on effect on their ability to address other problems such as alcohol misuse. However parents with more entrenched needs may also require additional, specialist services to help them address specific problems. An intensive, multifaceted approach that integrates a range of services tailored to meet the needs of the whole family may be most effective when parents are facing a complex web of entrenched problems, parent-child relationships are poor, and children's development is compromised by abuse and neglect.

Assessing parents' capacity to change within a child's timeframe

When there are significant child protection issues and children are on the edge of care, the fundamental question for both social workers and the courts is whether parents can make sufficient changes to ensure that children are adequately protected from harm within an appropriate timeframe. There is substantial evidence to indicate that abuse and neglect can have an adverse and enduring impact across the whole spectrum of children's development. There are factors within the child, the family and the environment which can mitigate and help children overcome the consequences of maltreatment; nevertheless, the longer children are exposed to abuse and neglect and the more severe the maltreatment, the harder it is to overcome the consequences. Therefore

professionals need to base their decisions on what is known about the timeframes for parental change compared with their knowledge of timeframes for childhood development.

No one can predict how long it will take for abusive or neglectful parents to develop sufficient capability to protect their children from harm; it is, however, evident that this is unlikely to happen overnight, that the process of change may be lengthy and that setbacks are common. The review of the literature found no evidence concerning how long it takes for parents whose children are on the edge of care to accept the need for change and begin to engage with services. Some do not appear to do so, or at least not within a child's timeframe. The research suggests that unequivocal cases are rare, but that where there are serious child protection concerns and parents do not acknowledge that a problem exists, they are unlikely to make sufficient changes to protect children from harm within an appropriate timeframe in families where the following factors are present: extreme domestic abuse where the perpetrator shows a pervasive pattern of disregard for and violation of the rights of others (Gondolf, 2002; Scott, 2004); there is both substance misuse and domestic abuse and violence in the home (Forrester and Harwin, 2008); children are not protected from perpetrators of sexual abuse; and/or where parents consciously and systematically cover up *deliberate* maltreatment (Brandon *et al*., 2008).

However where parents do accept that there is a problem and begin to engage with services, there may still be several months before significant and enduring progress is achieved. Intensive interventions themselves take several weeks to deliver. For instance, alcohol withdrawal programmes are typically of two to three weeks duration, and rehabilitation programmes usually last from three to six months (NICE, 2011a, p.33). Some evaluations have shown that adults with complex problems require longer interventions before changes are evident. Intensive, multifaceted interventions for parents and families with complex needs may take up to nine months to complete – MST-CAN is offered over a period of three sessions a week for six to nine months (Swenson *et al.,* 2010a).

Once a programme has been completed successfully, there may also be a vulnerable period before change is fully established – for instance, the highest rate of relapse for alcohol dependency occurs during the first three months post treatment (Raistrick *et al*., 2006); perpetrators of domestic abuse are most likely to assault their partners again within the first six months of entering a programme (Gondolf, 2004). Chapter Seven has also shown that relapse is an integral part of the process of change, and it may take many years for the risk to diminish – five years to achieve stable recovery from alcohol misuse (Hibbert and Best, 2011); eight to ten years if the problem is misuse of heroin (Hser, Longshore and Anglin, 2007). Continued monitoring and reinforcement of progress may therefore also be necessary to support maintenance of change.

These timescales all point to the need for effective, proactive case management once abuse has been identified. This is particularly important where children's development is being compromised by parents' inability to meet their needs. Proactive case management needs to include early agreement about goals to be met and provision of effective services that will support parents in meeting them. What we know about likely timescales for overcoming destructive behaviour patterns and improving parenting capability makes it clear that much of this work will need to be undertaken ***before*** decisions are made to instigate proceedings. The requirement to complete court proceedings within 26 weeks does not allow time for delaying decisions about what may or may not be effective in helping parents to change, but that is not the fundamental issue. Given what is known about the impact of abuse and neglect on early childhood development, and the time it takes for parental change to become established, delayed assessment and service provision will not only compromise children's life chances, but also deny parents the support they need to overcome adverse behaviour patterns within an appropriate timeframe.

Of course parents will show progress before a programme is completed, but practitioners (and, where they are involved, the courts) will need to know how much progress has been made, and how far this is likely to be sustained before making decisions about when and whether children are safe from harm. A parent's slow progress or frequent setbacks will have a different impact depending on the age and vulnerability of the child, and these factors will also need to be taken into account, as well as the child's wishes. Where there is a question of reuniting children with birth parents from whom they have previously been separated, practitioners need to be aware that poorly managed reunification can undermine parents' progress (see for instance Carlson *et al*., 2006); change needs to be firmly established before children return home, and parents will need continuing support following reunification.

Implications for continuing professional development

Research in this area is constantly producing new evidence concerning both the factors within the child, the family and the environment that place children at greater risk of significant harm, and those which protect them; the long-term adverse consequences of continuing exposure to abuse and neglect, and also the ways in which maltreatment can be prevented or its consequences mitigated. The empirical evidence is important because it not only shows what happens to children growing up in adverse circumstances, but it also helps us to understand why. Putting together the evidence from a wide range of disciplines, as we have done in this report, provides a stronger basis for understanding. Learning about the most up to date evidence on these issues should not only be a core element of pre-qualifying training, it should also be an integral element of continuing professional development for all practitioners in this area. The plethora of ongoing research is a major reason why even the most experienced practitioners should be encouraged to participate in post-qualifying training (Carpenter *et al.,* 2010).

Conclusion

The findings from this review of literature have numerous implications for general everyday practice as well as for assessments of children's needs, parenting capability and the analyses of the parenting gap required by the courts. Many of the issues it raises will already be familiar to social workers and other practitioners. The overview of this wide body of research should strengthen practitioners' understanding of parental capacity to change. It has brought together from a range of sources research messages concerning theoretical models that can underpin the process of assessment and analysis and empirical findings concerning the aetiology of abuse and neglect and the process by which adults overcome adverse behaviour patterns, with the aim of improving professional decision-making in situations where there are serious child protection concerns and children are on the edge of care.

Key Points from Chapter Eight

- The findings from this review should help social workers and children's guardians produce more robust and focussed assessments of parenting capability and parental capacity to change, and assist judges and other family justice professionals in evaluating the quality of assessment work presented to the courts.
- The types of assessment required by the courts are necessary to monitor parents' progress towards agreed goals as well as to inform decisions about the safety of children living in homes where there are serious child protection concerns. They should also be an integral part of social work practice when children are on the edge of care.
- Further resources and training materials are available to help practitioners improve their understanding of issues such as parental substance misuse or neglect and its impact on children.
- Concepts of progression through different stages of change and relapse, and the decisional balance that underlies motivation, engagement and action, may all be useful to practitioners in understanding the behaviour of parents whose children are on the edge of care.
- The research findings underline the significance of relationships between practitioners and parents in facilitating and sustaining change, and the key importance of relationships with other professionals in supporting parents and providing a team around the child.
- The process of change may be lengthy. Even after parents have become motivated to change and engage with services, intensive support programmes to address specific problems may last several weeks or months, and relapses are common within the first three to six months of completion. Much of this work needs to be undertaken before the decision is made to instigate proceedings.

- Delayed assessments and service provision will not only compromise children's development, but also deny parents the support they need to overcome adverse behaviour patterns within an appropriate timeframe.
- Research in the areas covered by this report is continually producing new findings of key importance for decision-making, and should therefore be an integral part of continuing professional development for all those who have professional responsibilities for safeguarding children on the edge of care.

Appendices

Appendix One: search terms

Academic Press

British Psychological Society

Directory of Open Access Journals (DOAJ)

Gale collections

JSTOR

Modern Humanities Research Association

PsycBOOKS

Sage

Web of Science

AIP Journals and Conference Proceedings

British Standards Online

Elsevier ScienceDirect

InfoSci journals

LexisNexis Academic Law Reviews

Oxford University Press

PsycCRITIQUES

SpringerLink

Wiley Online Library

BMJ Journals

CrossRef

Emerald journals & ebooks

IngentaConnect

MEDLINE/PubMed

PsycARTICLES

PubMed Central

Taylor & Francis journals

Table 1: search terms

Search Items	Search Items	Search Items
Parent* AND change	Mother AND skill	Violence AND mother AND child protection
Mother AND change	Father AND skill	Violence AND father AND child welfare
Father AND change	Parent* AND ability	Violence AND father AND child maltreatment
Parent* AND assess*	Mother AND ability	Violence AND father AND child protection
Mother AND assess*	Father AND ability	Batter* AND parent* AND child welfare
Father AND assess*	Parent* AND train*	Batter* AND parent* AND child maltreatment
Parent* AND screen*	Mother AND train*	Batter* AND parent* AND child protection
Mother AND screen*	Father AND train*	Batter* AND mother AND child welfare
Father AND screen*	Parent* AND maltreat*	Batter* AND mother AND child maltreatment
Parent* AND tool	Mother AND maltreat*	Batter* AND mother AND child protection
Mother AND tool	Father AND maltreat*	Batter* AND father AND child welfare
Father AND tool	Change AND motivation	Batter* AND father AND child maltreatment
Parent* AND instrument	Change AND willingness	Batter* AND father AND child protection
Mother AND instrument	Change AND opportunity	Alcohol AND parent* AND child welfare
Father AND instrument	Change AND readiness	Alcohol AND parent* AND child maltreatment
Parent* AND program*	Change AND mechanism	Alcohol AND parent* AND child protection
Mother AND program*	Change AND time	Alcohol AND mother AND child welfare
Father AND program*	Change AND relapse	Alcohol AND mother AND child maltreatment
Parent* AND model	Change AND attrition	Alcohol AND mother AND child protection
Mother AND model	Change AND factors	Alcohol AND father AND child welfare
Father AND model	Behaviour AND change AND parent*	Alcohol AND father AND child maltreatment
Parent* AND therapy	Behaviour AND change AND mother	Alcohol AND father AND child protection
Mother AND therapy	Behaviour AND change AND father	Drugs AND parent* AND child welfare
Father AND therapy	Parent* AND resistance	Drugs AND parent* AND child maltreatment
Parent* AND intervention	Mother AND resistance	Drugs AND parent* AND child protection
Mother AND intervention	Father AND resistance	Drugs AND mother AND child welfare
Father AND intervention	Parent* AND engag*	Drugs AND mother AND child maltreatment
Parent* AND capacity	Mother AND engag*	Drugs AND mother AND child protection
Mother AND capacity	Father AND engag*	Drugs AND father AND child welfare
Father AND capacity	Substance AND parent* AND child welfare	Drugs AND father AND child maltreatment
Parent-child AND interaction	Substance AND parent* AND child maltreatment	Drugs AND father AND child protection
Mother-child AND interaction	Substance AND parent* AND child protection	Personality disorder AND parent* AND child welfare
Father-child AND interaction	Substance AND mother AND child welfare	Personality disorder AND parent* AND child maltreatment
Parent-child AND attachment	Substance AND mother AND child maltreatment	Personality disorder AND parent* AND child protection
Mother-child AND attachment	Substance AND mother AND child protection	Personality disorder AND mother AND child welfare
Father-child AND attachment	Substance AND father AND child welfare	Personality disorder AND mother AND child maltreatment
Parent-child AND relationship	Substance AND father AND child maltreatment	Personality disorder AND mother AND child protection
Mother-child AND relationship	Substance AND father AND child protection	Personality disorder AND father AND child welfare
Father-child AND relationship	Violence AND parent* AND child welfare	Personality disorder AND father AND child maltreatment
Parent* AND competence	Violence AND parent* AND child maltreatment	Personality disorder AND father AND child protection
Mother AND competence	Violence AND parent* AND child protection	Psychotic AND parent* AND child welfare
Father AND competence	Violence AND mother AND child welfare	Psychotic AND parent* AND child maltreatment
Parent* AND skill	Violence AND mother AND child maltreatment	Psychotic AND parent* AND child protection
Psychotic AND mother AND child welfare	Bipolar AND mother AND child maltreatment	Dissociative AND mother AND child protection
Psychotic AND mother AND child maltreatment	Bipolar AND mother AND child protection	Dissociative AND father AND child welfare

Search Items	Search Items	Search Items
Psychotic AND mother AND child protection	Bipolar AND father AND child welfare	Dissociative AND father AND child maltreatment
Psychotic AND father AND child welfare	Bipolar AND father AND child maltreatment	Dissociative AND father AND child protection
Psychotic AND father AND child maltreatment	Bipolar AND father AND child protection	Neurocognitive AND parent* AND child welfare
Psychotic AND father AND child protection	Emotional AND parent* AND child welfare	Neurocognitive AND parent* AND child maltreatment
Delusion AND parent* AND child welfare	Emotional AND parent* AND child maltreatment	Neurocognitive AND parent* AND child protection
Delusion AND parent* AND child maltreatment	Emotional AND parent* AND child protection	Neurocognitive AND mother AND child welfare
Delusion AND parent* AND child protection	Emotional AND mother AND child welfare	Neurocognitive AND mother AND child maltreatment
Delusion AND mother AND child welfare	Emotional AND mother AND child maltreatment	Neurocognitive AND mother AND child protection
Delusion AND mother AND child maltreatment	Emotional AND mother AND child protection	Neurocognitive AND father AND child welfare
Delusion AND mother AND child protection	Emotional AND father AND child welfare	Neurocognitive AND father AND child maltreatment
Delusion AND father AND child welfare	Emotional AND father AND child maltreatment	Neurocognitive AND father AND child protection
Delusion AND father AND child maltreatment	Emotional AND father AND child protection	Mental retardation AND parent* AND child welfare
Delusion AND father AND child protection	Mani* AND parent* AND child welfare	Mental retardation AND parent* AND child maltreatment
Neurodevelopmental AND parent* AND child welfare	Mani* AND parent* AND child maltreatment	Mental retardation AND parent* AND child protection
Neurodevelopmental AND parent* AND child maltreatment	Mani* AND parent* AND child protection	Mental retardation AND mother AND child welfare
Neurodevelopmental AND parent* AND child protection	Mani* AND mother AND child welfare	Mental retardation AND mother AND child maltreatment
Neurodevelopmental AND mother AND child welfare	Mani* AND mother AND child maltreatment	Mental retardation AND mother AND child protection
Neurodevelopmental AND mother AND child maltreatment	Mani* AND mother AND child protection	Mental retardation AND father AND child welfare
Neurodevelopmental AND mother AND child protection	Mani* AND father AND child welfare	Mental retardation AND father AND child maltreatment
Neurodevelopmental AND father AND child welfare	Mani* AND father AND child maltreatment	Mental retardation AND father AND child protection
Neurodevelopmental AND father AND child maltreatment	Mani* AND father AND child protection	Development* AND parent* AND child welfare
Neurodevelopmental AND father AND child protection	Mood AND parent* AND child welfare	Development*AND parent* AND child maltreatment
Mental health AND parent* AND child welfare	Mood AND parent* AND child maltreatment	Development*AND parent* AND child protection
Mental health AND parent* AND child maltreatment	Mood AND parent* AND child protection	Development*AND mother AND child welfare
Mental health AND parent* AND child protection	Mood AND mother AND child welfare	Development*AND mother AND child maltreatment
Mental health AND mother AND child welfare	Mood AND mother AND child maltreatment	Development*AND mother AND child protection
Mental health AND mother AND child maltreatment	Mood AND mother AND child protection	Development*AND father AND child welfare
Mental health AND mother AND child protection	Mood AND father AND child welfare	Development*AND father AND child maltreatment
Mental health AND father AND child welfare	Mood AND father AND child maltreatment	Development*AND father AND child protection
Mental health AND father AND child maltreatment	Mood AND father AND child protection	Schizo* AND parent* AND child welfare
Mental health AND father AND child protection	Anxiety AND parent* AND child welfare	Schizo* AND parent* AND child maltreatment
Depress* AND parent* AND child welfare	Anxiety AND parent* AND child maltreatment	Schizo* AND parent* AND child protection
Depress* AND parent* AND child maltreatment	Anxiety AND parent* AND child protection	Schizo* AND mother AND child welfare
Depress* AND parent* AND child protection	Anxiety AND mother AND child welfare	Schizo* AND mother AND child maltreatment
Depress* AND mother AND child welfare	Anxiety AND mother AND child maltreatment	Schizo* AND mother AND child protection
Depress* AND mother AND child maltreatment	Anxiety AND mother AND child protection	Schizo* AND father AND child welfare
Depress* AND mother AND child protection	Anxiety AND father AND child welfare	Schizo* AND father AND child maltreatment
Depress* AND father AND child welfare	Anxiety AND father AND child maltreatment	Schizo* AND father AND child protection
Depress* AND father AND child maltreatment	Anxiety AND father AND child protection	Somat* AND parent* AND child welfare
Depress* AND father AND child protection	Dissociative AND parent* AND child welfare	Somat* AND parent* AND child maltreatment
Bipolar AND parent* AND child welfare	Dissociative AND parent* AND child maltreatment	Somat* AND parent* AND child protection
Bipolar AND parent* AND child maltreatment	Dissociative AND parent* AND child protection	Somat* AND mother AND child welfare
Bipolar AND parent* AND child protection	Dissociative AND mother AND child welfare	Somat* AND mother AND child maltreatment
Bipolar AND mother AND child welfare	Dissociative AND mother AND child maltreatment	Somat* AND mother AND child protection
Somat* AND father AND child welfare	Mother AND sustain*	
Somat* AND father AND child maltreatment	Father AND sustain*	
Somat* AND father AND child protection	Parent* AND maintain	

Search Items	Search Items	Search Items
Addictive AND parent* AND child welfare	Mother AND maintain	
Addictive AND parent* AND child maltreatment	Father AND maintain	
Addictive AND parent* AND child protection	Parent* AND effect* AND treatment	
Addictive AND mother AND child welfare	Mother AND effect* AND treatment	
Addictive AND mother AND child maltreatment	Father AND effect* AND treatment	
Addictive AND mother AND child protection	Support AND child welfare	
Addictive AND father AND child welfare	Support AND child protection	
Addictive AND father AND child maltreatment	Change AND child welfare	
Addictive AND father AND child protection	Change AND child protection	
Behaviour AND parent* AND child welfare	Parent* AND impact	
Behaviour AND parent* AND child maltreatment	Parenting AND capacity	
Behaviour AND parent* AND child protection	Parent* AND treatment AND maintenance	
Behaviour AND mother AND child welfare	Parent* AND drug AND maintenance	
Behaviour AND mother AND child maltreatment	Parent* AND drug AND recovery	
Behaviour AND mother AND child protection	Parent* AND drug AND relapse	
Behaviour AND father AND child welfare	Parent* AND alcohol AND maintenance	
Behaviour AND father AND child maltreatment	Parent* AND alcohol AND recovery	
Behaviour AND father AND child protection	Parent* AND alcohol AND relapse	
Sexual abuse AND parent* AND child welfare	Parent* AND violence AND maintenance	
Sexual abuse AND parent* AND child maltreatment	Parent* AND violence AND recovery	
Sexual abuse AND parent* AND child protection	Parent* AND violence AND relapse	
Sexual abuse AND mother AND child welfare	Parent* AND domestic abuse AND treatment	
Sexual abuse AND mother AND child maltreatment	Parent* AND domestic abuse AND reoffend	
Sexual abuse AND mother AND child protection	Parent* AND substance AND recovery	
Sexual abuse AND father AND child welfare	Parent* AND substance AND relapse	
Sexual abuse AND father AND child maltreatment	Parent* AND substance AND maintenance	
Sexual abuse AND father AND child protection	Parent* AND long-term impact AND intervention	
Parent* AND recovery	Systematic review AND parent*	
Mother AND recovery	Meta analysis AND parent*	
Father AND recovery		
Parent* AND maintenance		
Mother AND maintenance		
Father AND maintenance		
Parent* AND relapse		
Mother AND relapse		
Father AND relapse		
Parent* AND abstinence		
Mother AND abstinence		
Father AND abstinence		
Parent* AND sustain*		

Appendix Two: scientific advisory group and steering group members

Scientific advisory group

Jane Barlow:	Professor of Public Health in the Early Years, University of Warwick
Paul Harnett:	Senior Lecturer in Clinical Psychology, University of Queensland
Judith Harwin:	Director of Social Work Division, Director of Child Focused Research Centre, Brunel University
Judith Masson:	Professor of Socio-Legal Studies, University of Bristol
Duncan McLean:	Consultant Adult Psychiatrist, Anna Freud Centre
Dendy Platt:	Senior Lecturer in Social Work (Child Care), University of Bristol
Nicky Stanley:	Professor of Social Work, University of Central Lancashire

Steering group members

Chris Cuthbert:	Head of Strategy and Development for Under-Ones, NSPCC
Jonathan Dickens:	Senior Lecturer, University of East Anglia
Judith Freedman:	Consultant Psychiatrist, Head of the Consortium of Expert Witnesses to the Family Courts
Liz Gillett:	Consultant Clinical Psychologist, Director of the Phoenix Psychology Group
Bridget Lindley:	Deputy Chief Executive and Legal Adviser, Family Rights Group
Brendah Malahleka:	Service Manager, Business Strategy, Fostering Placement and Procurement, Lewisham Borough Council
Her Honour Judge Lesley Newton:	Circuit Judge Manchester
Helen Pustam:	Head of Senior Legal and Policy Adviser Team, Magistrates' Training Division, Judicial College
Steve Walker:	Deputy Director of Children's Services, Safeguarding, Specialist and Targeted, Leeds City Council

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