Child Abuse and Neglect – A review of risk assessment, care proceedings and 'what works' to address the issue

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Abstract

This thesis provides an investigation into Care Proceedings and potential treatment interventions to address the risk factors associated with child abuse and/or neglect. After an introduction to child abuse and neglect in chapter one, chapter two focuses on the first systematic review of a NICE recommended intervention, Multisystemic Therapy for Child Abuse and Neglect (MST CAN). This review highlights that there is emerging evidence that the intervention can reduce the risk of further child maltreatment by addressing risk factors identified at referral. However, there are limited high quality studies evidencing this and those that exist are predominantly from the USA.

An empirical study follows (chapter 3) looking at the similarities and differences between family profiles of real-life Care Proceedings whereby at the end of the process children either remained within their family on a Supervision Order or removed on a Care Order. The results of this study indicated that there are very few statistically significant differences between the two groups, providing evidence of the challenges faced by social workers to identify which cases may be appropriate to divert from court in the first place. The differences that were found highlighted that removal from parental care during proceedings was significantly associated with removal being the final outcome at the end of Care Proceedings. Perceived parental engagement was also identified as being significantly correlated with Care Proceedings outcome, those parents that were perceived to engage with services and children's Social Care were more

likely to have their children remain at home at the end of proceedings. Highlighting engagement as a key factor for decision making in Care Proceedings.

Chapter 4 provides a case study of a family engaged in Multisystemic Therapy for Child Abuse and Neglect (MST CAN). The chapter demonstrates how MST CAN is an effective intervention in addressing the associated risk factors for child abuse and neglect. Specifically, parental mental health, parental alcohol and substance use, parenting practice and family communication.

The penultimate chapter provides a critique of the University of Rhode Island Change Assessment (URICA) used with adults who misuse alcohol and/or substances. The review of the URICA is due to it being an assessment of motivation to change which is linked to engagement and also substance use and/or alcohol use is a key risk factor identified during Care Proceedings. The review suggests that the URICA is a useful tool in measuring current stage of change and could help to inform treatment. However, it should not be used as a prediction of treatment outcome. Lastly, chapter 6 brings together the findings and implications for real world practice in the area of assessing and treating the risk factors associated with child abuse and neglect.

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Chapter 5

Glossary of Terms

CAO	Care Arrangement Order
CO	Care order
CP	Child Protection
EPO	Emergency Protection Order
LA	Local Authority
LPM	Legal Planning Meeting
MST CAN	Multisystemic Therapy for Child Abuse and Neglect
NICE	National Institute for Health and Clinical Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
ONS	Office of National Statistics
PO	Placement Order
PICO	Population Intervention Comparison Outcome
PTSD	Post-Traumatic Stress Disorder
RBT	Reinforcement Based Therapy
RCT	Randomised Control Trial
RO	Residential Order
SGO	Special Guardianship Order
SO	Supervision Order
Standard MST	Standard Multisystemic Therapy
URICA	University of Rhode Island Change Assessment

Chapter one – Introduction

Being referred to children's services places children in a position of being part of a process, 'in which decisions are made on their behalf that will have a significant impact on their future and wellbeing' (Dettlaff et al, 2015, p24). Despite the complexities involved in the decision-making process around Child Protection, particularly the removal of children from their parent's care, historically there has been little empirical research carried out to increase our understanding of this process (Shlonsky, 2015, Dettlaff et al, 2015). The majority of research has focussed on; the aetiology of child maltreatment, risk factors for abuse, long-term impact of abuse and potential preventative treatment to address risk factors and reduce the long-term effects on children (e.g. Gilbert et al, 2009, Kolko & Swenson, 2002, Browne & Jackson, 2013). Over the last decade there has been an improved effort internationally to increase our understanding of the individual, organisational and family factors which can affect decision-making in Child Protection and how we can use this knowledge to ensure a fair and robust process for the children who come to the attention of children's services (Benbenishty et al., 2015, Spratt et al., 2015 and Font & Maguire Jack, 2015).

This thesis attempts to increase our understanding of the care proceeding process in England, the multiple factors which contribute to the removal of children from their caregivers' care or not, and consideration of which interventions may help to address identified risk factors in a timely manner.

Child Maltreatment

Childhood maltreatment is currently categorised in England as emotional abuse, physical abuse, sexual abuse and neglect, as described in the Department of Education document, W*orking Together to Safeguard Children* (DfE, 2018). Table 1 outlines the current definitions of child abuse and the categories of physical abuse, emotional abuse and neglect used in the UK.

Table 1: Definitions of the categories of abuse (Source: DfE, 2018)

Abuse	• A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or failing to act to prevent harm. • Children may be abused in a family or in an institutional or community setting by those known to them or more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.
Emotional Abuse	• The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on a child's emotional development. It may involve conveying to a child that they are unloved or worthless, inadequate or valued only insofar as they meet the needs of another person. • It may include not giving the child opportunities to express themselves, deliberately silencing them or making fun of what they say or how they communicate. • It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability. Restricting them from socializing or being overpowering • It may involve seeing or hearing the ill-treatment of another. Some level of emotional abuse is involved in all types of maltreatment however; it can also occur alone.
Physical Abuse	• Physical abuse is a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. • Physical harm may also be caused when parents or caregivers make up or induce symptoms of illness in their child, perhaps

	giving them medicine they do not need and making the child unwell. This is known as fabricated or induced illness (FII).
Neglect	• Persistent failure to meet a child's physical and/or psychological needs likely to significantly impact on the child's development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born neglect may involve a parent or carer failing to: • Provide adequate food, clothing and shelter (including exclusion from home or abandonment); • Protect a child from physical and emotional harm or danger; • Ensure adequate supervision (including the use of inadequate caregivers) or • Ensure appropriate access to medical care or treatment.
Sexual Abuse	• Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. • The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. • Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Prevalence of child maltreatment

The number of children on a child protection plan in England in 2018 was 53,790 (see table 2), with Neglect and Emotional abuse being the highest sub-categories of abuse (DfE, 2018). The largest total percentage of children on a plan were aged between 5-9 years old. The lowest number of children were on a child protection plan under the category of sexual abuse. A rising number of children are being placed in Local Authority care

in England, this was reported as 75,420 at the end of March 2018 (DfE, 2018) which is the highest figure to date. Despite these figures of child maltreatment already being high, it is generally accepted that the prevalence of child maltreatment is likely to be higher as many cases go undetected or unreported (Gilbert et al, 2009 and Radford et al, 2013). Gilbert et al (2009), reported that between 4-16% of children experience physical abuse, one in ten experience neglect and/or emotional harm and between 5-10% of girls and 5% of boys' experience penetrative sexual abuse in childhood. They suggest that this figure increases threefold when considering exposure to other forms of sexual abuse.

Table 2: Children and young people who were the subject of a child protection plan by category of abuse at 31 March 2018 (DfE, 2018b)

Category of abuse	**2014**	**2015**	**2016**	**2017**	**2018**
Neglect	20,970	22,230	23,150	24,590	25,820
Physical abuse	4760	4350	4200	3850	4120
Sexual abuse	2210	2340	2370	2260	2180
Emotional abuse	15,860	16,660	17,770	17,280	18,860
Combination	4500	4110	2810	3010	2820

May-Chahal & Cawson (2005) carried out the largest independent study into the prevalence of child maltreatment in the general population within the UK. They summarised that maltreatment continues to be an extensive public concern with the most at-risk forms of abuse in the home being physical, emotional and neglect. They also identified that the majority of people within the study who gave answers indicating that they had experienced maltreatment in childhood, did not identify themselves that

they had been abused. This lack of insight into what is child abuse and neglect could be a risk factor for future intergenerational child maltreatment.

This thesis focusses specifically on the categories of physical abuse, emotional harm and neglect as these are the more prevalent forms of abuse and higher numbers of children are subject to child protection plans under these categories (NSPCC, 2017). The area of neglect is of particular interest given that a number of researchers have highlighted that historically there has been 'a neglect of neglect (Stollenborgh et al. 2013 and Hobbs & Wynne, 2002)

Wider factors impacting upon the assessment and treatment of cases where there is identified risk of child maltreatment

The increasing number of children both on child protection plans and entering local authority care is occurring alongside a period of time whereby the identification and reporting of suspected abuse has been promoted across agencies (NSPCC, 2017). It is positive that more cases of abuse are being recognised and reported. However, for each of the years that these figures have increased, the amount of financial support available to local authorities to provide support and interventions has decreased. This means that currently, for many children and families, support is being offered at a later stage in their journey when the situation has escalated and is at a point whereby the outcome is more likely to result in their removal. Early intervention resources are becoming less available due to competing

demands in local authorities and budget cuts. Reduced access to services will further exacerbate the problems faced by families, social workers and other agencies around the family.

Councilor Richard Watts (2017), Chair of the Local Government Association's Children and Young People Board, summarized these challenges when he said the following, in response to the **no-good options** report (Clements et al, 2017):

"Councils have been warning government for some time that the pressures facing children's services are rapidly becoming unsustainable, with a combination of government funding cuts and huge increases in demand leaving many areas struggling to cope. The number of inquiries into child protection concerns undertaken by councils has increased by 124 per cent over the past decade, and the number of children needing child protection plans has increased from 26,400 to more than 50,000 over the same period. An increase of more than 23,000 children needing social work support to stay safe from significant harm. The LGA's most recent analysis suggests that councils will be facing a £1.9 billion funding gap for children's services by 2020, and in many areas the pressure on children's budgets is now even greater than that faced by adult social care."

After the publication of a number of serious case reviews (SCR) and situations perceived as missed opportunities (Peachey, 2013), with the most infamous in recent years being Victoria Climbie, Baby P and Daniel Pelka, increasingly wider agencies around the child/ren such as police,

schools and health professionals are placing pressure on children's social care to take immediate preventative action. The language used within the Baby P SCR report emphasised that a more authoritative approach should have been implemented by professionals with the mother. The report also suggested that social workers should have been more challenging when gathering information about the non-accidental injuries than that which was evidenced within the records (Haringey Local Safeguarding Children Board, 2009). SCR are generally carried out when severe harm or death has occurred, whilst an important aim of the SCR is ensuring that lessons are learned and errors are avoided, they do provoke anxiety amongst professionals and fear that they could be blamed if a tragedy occurs (Jones, 2014). A survey by the NSPCC (2017) found that the majority of people who responded believed that the best way to keep children safe was to remove them into local authority care. This type of reactionary practice in response to crises could be interpreted as defensive rather than defensible practice. Defensive practice does not necessarily consider the impact emergency or unplanned removal, can have on a family, particularly if after a period away from home the court decision is for reunification home. This is not a new phenomenon Chapmen and Field (2007) suggest that child protection can swing between models of 'child rescue' and 'family preservation'. These models are on a continuum with a need to consider the possibility of overestimation of safety and minimisation of risk when trying to 'preserve the family' and a lack of consideration of possible safety factors present within families when resorting to a local authority

intervention to 'rescue the child'. Spratt et al (2015), suggest that the decision-making around the removal of children from their family and when and if they are returned is something which is a public issue. They highlight that policy makers and politicians in the UK are concerned about the lack of equality and consistency in the delivery of public services, including access to healthcare, provisions for the elderly, and also the protection and care of vulnerable children. Spratt et al (2015) suggest that social workers and other professionals who care for vulnerable children often have to make relatively quick decisions about complex situations and decide whether they view children should remain in the care of their parents or not. Once professionals have a preferred opinion, Spratt et al (2015) summarise that there is a risk of confirmatory bias taking place with the filtering of information to fit the hypotheses selected.

Munro (1999) reported how a consistent criticism noted within SCRs is how professionals are slow to revise initial judgements that they have made. Confirmation bias is the process of seeking out, interpreting and recalling information that confirms and reinforces our original perspective of something. The term was first described in 1960 by Peter Wason. The concept is one that should be borne in mind by social workers, other professionals and the systems around a family when assessing risk of significant harm and/or making decisions about whether or not a child should remain in their parent's care (Munro, 2008). The SCR of Baby Peter Connolly demonstrated how a number of professionals from different agencies appeared to struggle with changing their original perspective

about the imminent risk of harm he was at risk of. This was despite numerous incidents that evidenced non accidental injury over a relatively short period of time (Haringey Local Safeguarding Children Board, 2009). Silman (2016) suggests that simply being aware of confirmation bias and how it can potentially have a dangerous impact upon information processing is not enough to reduce the risk of its occurrence. Silman (2016) recommends that within supervision, practitioners should be encouraged to consider alternative perspectives to their current view and whether there is any evidence supporting this, in order to mitigate the risk of confirmatory bias and increase awareness.

Davidson-Arad and Benbenishty (2008) demonstrated in their research that social worker respondents to case vignettes appeared to interpret the information shared in a way that supported their final recommendations. They identified that there were two distinct groups, those who favoured removal from parental home and those that did not. They found that those who favoured removal made higher risk assessments and recommended removal significantly more than the other group who demonstrated more anti-removal beliefs.

There is greater risk of confirmatory bias, when information is less clear or can be interpreted based on personal standards if there is no specified guidance (Spratt et al, 2015). For example, an occasion of physical abuse,

which has led to a section 47 inquiry and registration on a child protection register under the category of physical abuse may be easier to assess and monitor than emotional abuse and neglect. These categories of abuse can be more difficult to objectively measure due to the array of issues that can be captured within each definition. For example, home conditions and cleanliness of the child are often identified as areas of concern under the category of neglect however, there can be a huge amount of professional judgement and some of this is likely to be subject to personal bias and beliefs around what is acceptable or not, based upon personal experiences. Whereas taking children to attend medical appointments and ensuring attendance at school are less subjective areas and can be concretely measured and evidenced. Lopez et al (2015), suggest that despite the life changing consequences decision-making in child protection services can have, there is often low reliability and frequent errors.

How we currently work with cases of child maltreatment in England

Although adult perpetrators of child abuse and/or neglect can be tried and convicted within criminal courts, abuse and neglect is generally dealt with by family courts (Hall, 2007). The exceptions to this are cases of sexual abuse, serious physical harm or child homicide, which tend to be presented in both court arenas (Hall, 2007). As pointed out by Krugman (2004), historically there has been a greater tolerance for the physical abuse of children without the instigating of criminal proceedings, though this is

shifting (Radford et al, 2011). This makes sense given physical chastisement or corporal punishment was still being implemented in schools until as recently as 1998 when it was outlawed for the few remaining private schools that implemented it (DfE, 2011). The DfE (2011), points out that whilst parents are encouraged to utilise positive behaviour management techniques, they have not been explicitly prohibited from smacking their children. In contrast, Krugman (2004) states that there has generally been zero tolerance towards sexual abuse and people advocate for the use of criminal proceedings to address it.

In England when there are concerns shared about child maltreatment, the case is discussed between social worker and manager, further enquiries may be made and if concerns are perceived to be validated then an assessment is required. The assessment can either be a s17 (CIN = Child in Need) or a s47 inquiry (to investigate if a child is suffering or likely to experience significant risk of harm). This then leads to an initial child protection conference being held and if there is agreement of significant harm under any of the categories of maltreatment a child protection plan is initiated where it is considered safe for the child to remain in their parents' care (see figure 2). At this point, if imminent risk of harm is assessed then the case may progress quickly to pre-proceedings process.

Figures 1 and 2, are detailed within the DfE Working Together to Safeguard Children Document (2018). They outline relevant parts of the Child

Protection process that typically takes place prior to cases progressing to care proceedings. For more information on the additional flow charts referred to in the diagrams, please see '*Working Together*', 2018. The working together document aimed to standardise practice across Local Authorities, Police services and Clinical commissioning in Health. It is statutory guidance for everyone who works with children and their caregivers, as they all have a role in ensuring that children are safeguarded and that information is shared appropriately.

Figure 1: *Flow chart of referral to Children's social care (DfE, 2018, p32)*

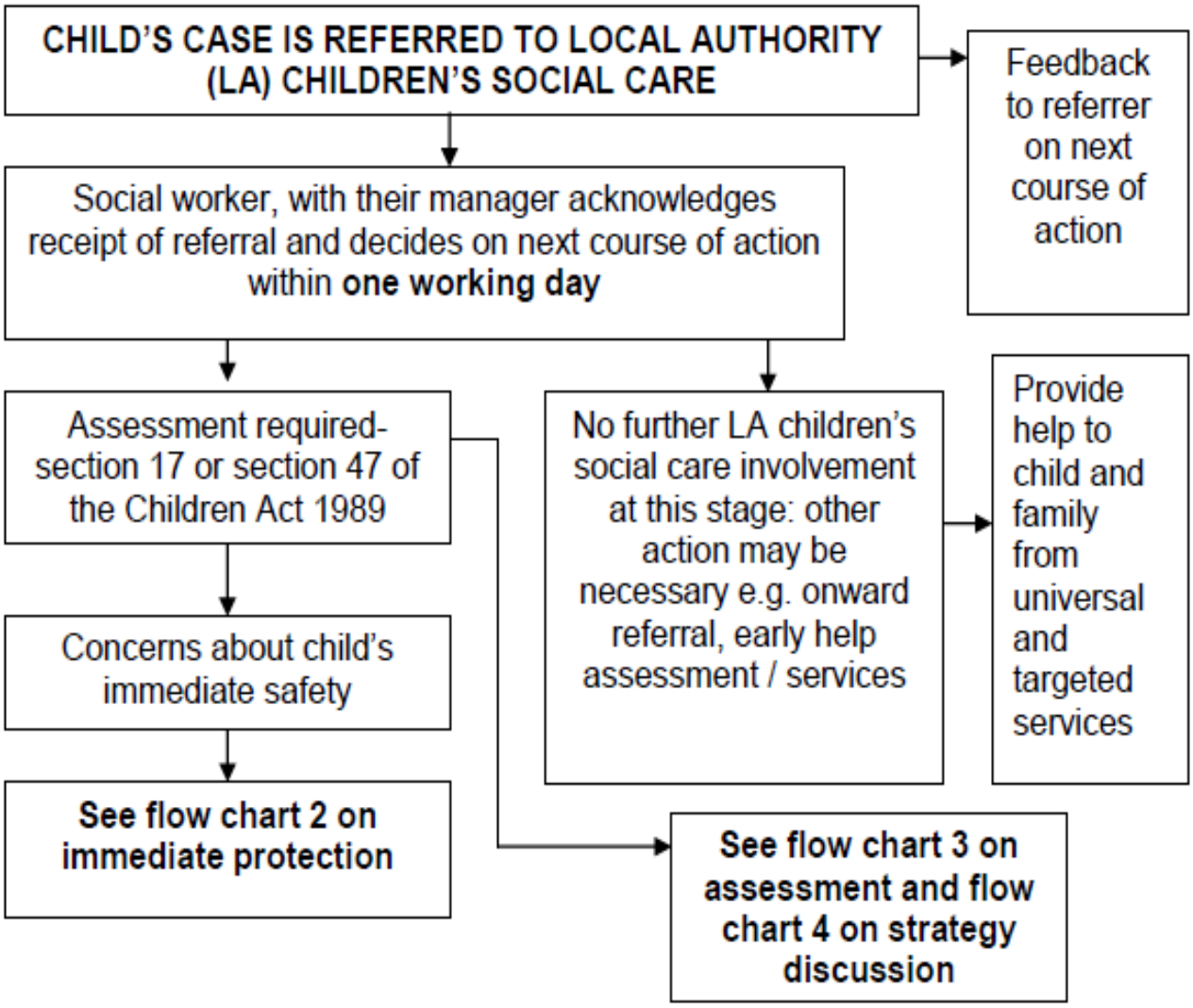
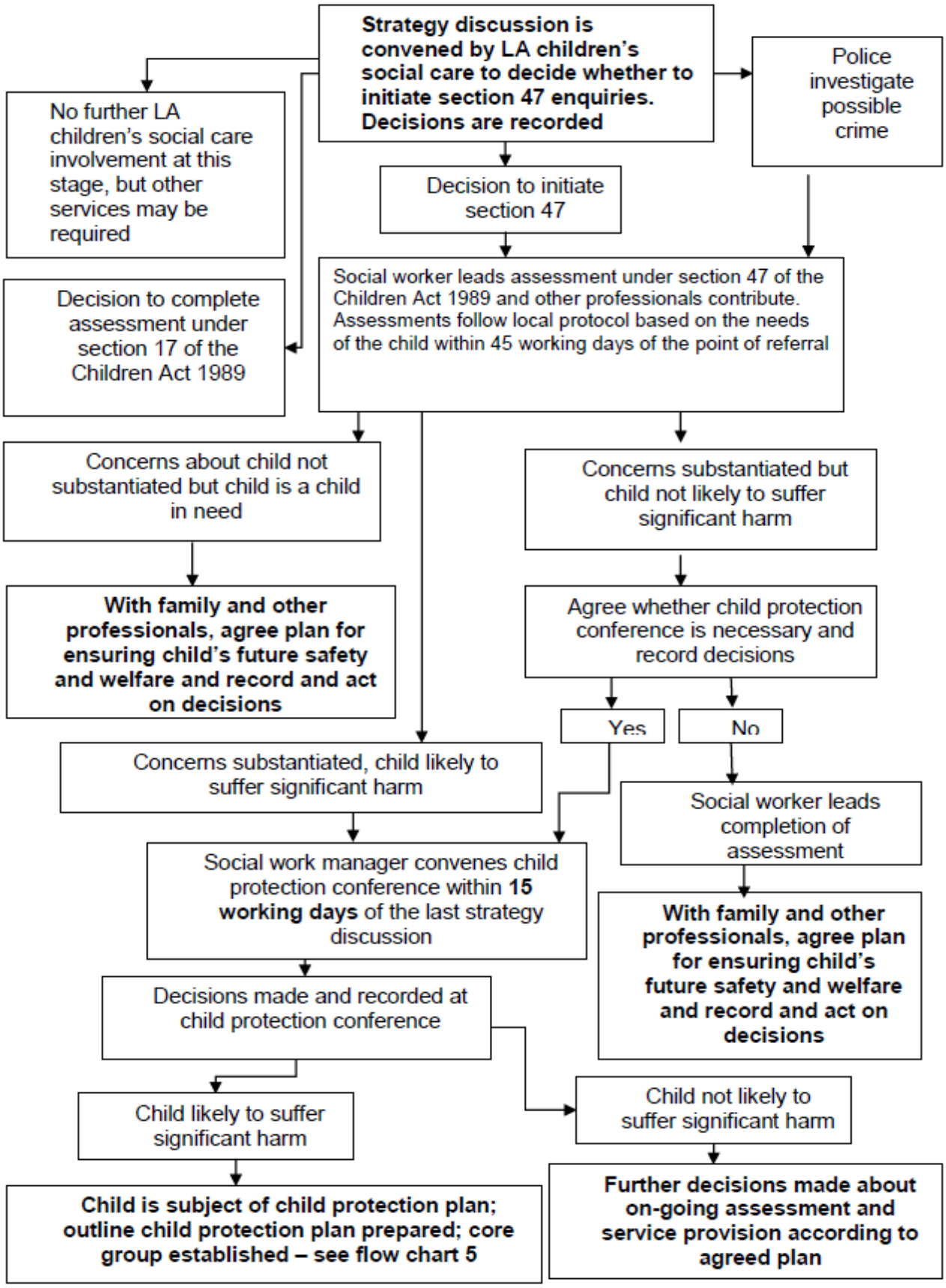


Figure 2: *Flowchart showing possible outcomes of strategy discussion when concerns about child maltreatment have been raised (DfE, 2018, p41).*



Pre Proceedings

Care proceedings is when the local authority applies to the court for an s31 Care Order (CO) or Supervision Order (SO) under the Children Act 1989. A Care Order during s31 proceedings is when children are removed from parental care and placed in Local Authority Care with joint parental responsibility, this is known as an Interim Care Order. Whereas a Supervision Order during s31 proceedings is when children remain within Parental care during proceedings and the Local Authority have a responsibility to befriend and assist the parents, this is known as an Interim Supervision Order. A significant change was made to s31 proceedings in the Children and Families Act 2014 and this was the legislation that care proceedings should conclude within 26 weeks unless there are exceptional reasons for delays. Applications to extend beyond 26 weeks should be applied to the family court and these can be for a maximum of 8 weeks.

For a small number of cases that come to the attention of Children's Social care and enter s31 proceedings, there are grave concerns that the child is at imminent risk of harm and they need to be immediately protected by being removed from parental care. For example, a child who is assessed with significant non-accidental injuries or are living in a house where the conditions are considered inhabitable, a decision may be made to apply for an Emergency Protection Order (EPO). Parents are usually given 24 hours'

notice however, if there have been threats to life or a perceived flight risk; this is not always given and can occur immediately. Local Authorities usually apply for EPOs however, the police and NSPCC (National Society for the Prevention of Cruelty to Children) can also make applications. For the majority of other cases there is a process prior to proceedings called pre proceedings and includes Public Law Outline (PLO). The PLO process was introduced in the Children's Act 2008 after being piloted in 10 LA areas.

Before a case will be considered in court, Local Authorities have to demonstrate that the s31 'threshold' for care proceedings have been met. The s31 threshold has two stages that must be met as defined within the Children's Act 1989. The first 'risk of significant harm' is evidence that events have already occurred which have caused significant harm to a child, or that there is a serious risk that significant harm will happen in the future or evidence that demonstrates the child is beyond parental control (e.g. in cases of Child Sexual Exploitation, exploitation by gangs or serious youth offending behaviour).

The second stage, is the welfare test and this involves considering whether s31 proceedings are in the best interests of the child and emphasises consideration of meeting the needs of the child and hearing their voice whilst also taking into account the attitudes and behaviour of the parents.

The first stage of the pre proceedings process usually involves a meeting which is called a Legal Planning Meeting (LPM), within this meeting the case social worker, team leader and service manager meet with a representative from the LA legal team and present their case. At this point, the legal representative will advise whether or not the threshold has been met.

If s31 threshold has been met, the LA has a choice whether to proceed immediately with EPO, apply to enter care proceedings or initiate the PLO process.

The PLO process involves sending a letter, inviting parents to a meeting with the LA with legal representation, if they want to discuss concerns and next steps. The next stage of the PLO process is to agree terms and conditions within this meeting. This often involves a written agreement between the LA and parents to address concerns e.g. not to allow certain people in to the home, not to drink alcohol in the presence of the children or to seek mental health support. A review date is agreed usually around 6 weeks later and progress is reviewed, with outcomes being to continue within PLO, exit PLO or enter s31 proceedings. Within the Care Crisis Review (2018) many parents reported that the initiation of PLO provided them with a 'wakeup call', it also indicated the severity of the concerns and was an opportunity to reflect on what needed to be changed in order to ensure that their child was not at risk of significant harm. Masson (2020) describes the aims of PLO as an opportunity to divert cases away from care

proceedings, increase fairness for families and for LA to prepare cases for s31 if the process is necessary. In their research on child protection and outcomes for children, Masson et al. (2019) reported that of the cases that had utilised the pre proceedings process only 27% had not entered s31 within the following 12 months. After 6 years this figure was 20%, they summarised that although a fifth of all cases being diverted from care could be viewed as successful, they did observe significant delays which negatively impacted upon some children having a secure and permanent plan of care. They also found that the majority of cases that did not enter proceedings, continued to need support and remained open to services.

When a case enters s31 care proceedings there are a number of final outcomes. These are summarised below:

- Order of no order – children remain at home with parents with no order in place.
- Supervision Order (SO) – children remain at home with parents with a Supervision Order which means that the local authority has a role in assisting and befriending. These orders are usually 12 months but extensions can be applied for up to a maximum of three years.
- Special Guardianship Order (SGO) – children are placed in the care of family or friends who then have parental responsibility for them, although birth parents will retain some responsibilities, the guardians are able to make the majority of decisions without consulting them.

A supervision order may also be attached to an SGO. An SGO is often used when adoption or a Care Arrangements Order (CAO) is not thought to be appropriate (ref).

- CAO (known as a Residence Order prior to the Children and Families Act 2015) – children are placed in the care of family or friend and the caregiver shares parental responsibility with the birth parents.
- Care Order (CO) – children are placed in local authority care, either foster care or residential.
- Placement Order (PO) – children are placed for adoption.

This thesis focusses specifically on the s31 outcomes of CO and SO, it aims to look at the similarities and differences between families with each outcome. It also aims to review evidenced based support that could bolster diversion from care and away from Children's social care in the longer term due to the risk factors no longer being present. Chapter three will further consider the current literature and studies into care proceedings and outcomes.

Interventions to reduce the risk of child maltreatment

For many of the risk factors which may be contributing to the perpetration of child maltreatment such as substance use, mental health, poverty,

domestic abuse and social isolation there are universal services that caregivers are expected to access support from. These include accessing support from alcohol and drug agencies, adult mental health support either at primary or secondary care level, sure start support (to address isolation) and other third sector providers offering housing and/or benefit support. However, these services can be difficult to access due to a range of barriers such as waiting lists, lack of childcare to attend appointments, fear and cuts in provision.

There are some interventions which have been identified in NICE guidance (2017) (see table 3) to prevent and/or address risk factors for child maltreatment. However, barriers to some of these interventions include whether or not they are offered in the area in which the family reside (e.g. Triple P parenting programme and Multisystemic therapy for child abuse and neglect) the caregivers age and number of children (family nurse partnership) and the age range of the children subject to maltreatment.

Table 3: Adapted from *NICE guidance (2017) recommended interventions to prevent or address child maltreatment*

Intervention	Age range	Outline of aims and number of sessions
Family Nurse Partnership	Unborn	Family Nurse Partnership is a preventive programme for vulnerable and young first-time young mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two. Only available for first time mums aged between
Triple P parenting programme	Under 7	Attend group sessions on a weekly basis. • develop skills in positive behaviour management • address negative beliefs about the child and their own parenting • manage difficult emotions, including anger.
Attachment based intervention	Under 5	Deliver the attachment-based intervention in the parent or carer's home, if possible, and provide at least 10 sessions. Aim to: • improve how they nurture their child, including when the child is distressed • improve their understanding of what their child's behaviour means • help them respond positively to cues and expressions of the child's feelings • improve how they manage their feelings when caring for their child.
Child-parent psychotherapy	Under 5	Ensure that child–parent psychotherapy • is based on the Cicchetti and Toth model • consists of weekly sessions (lasting 45–60 minutes) over 1 year • is delivered in the parents' home, if possible, by a therapist trained in the intervention • involves directly observing the child and the parent–child interaction • explores the parents' understanding of the child's behaviour • explores the relationship between the emotional reactions of the parents and their perceptions of the child on the one hand, and the parents' own childhood experiences on the other hand.
Multisystemic therapy for Child Abuse and Neglect	Referred child aged between 6-17	Consider Multisystemic Therapy for child abuse and neglect (MST-CAN) for parents or carers of children and young people if the parent or carer has abused or neglected their child. This should last 6-9 months and: • involve the whole family • address multiple factors contributing to the problem • be delivered in the home or in another convenient location • include a round-the-clock on-call service to support families to manage crises.

Of all of the interventions described above, Multisystemic therapy for child abuse and neglect is the only one which targets multiple risk factors including parental mental health, substance use and parenting strategies. This type of approach could be beneficial to families who find it difficult to engage with services and meeting different workers from various organisations. Chapman and Field (2007) suggest that being strength focussed when working with vulnerable families and supporting them to be able to ensure their children's safety are critical components in developing conditions that engender lasting change across the ecological systems involved in child protection. Focusing on the family strengths is a core principle of MST CAN. This thesis examines MST CAN firstly in chapter two with a systemic review and again in chapter four with a single design case study.

Another intervention to minimise the risk of child maltreatment is also the removal of children from their caregivers who are perpetrating harm and placement with either extended family members, foster carers or residential placement.

The What Works Centre for Children's Social Care has reviewed and recommended the following interventions as being effective in supporting families to stay together and reducing risk of harm.

Intensive Family Preservation Services – this is described as an intensive intervention that should be offered to families in crisis and on the edge of care. Ideally, it should be offered within 24 hours of contact with the family. An assumption and underpinning of the intervention, is that people are often motivated to change when in crisis and willing to learn new behaviours. The support is intensive and short term. Age of child at risk of care differs in the studies with some being between 3-13 and others 6-16 years old.

Family Drug and Alcohol Court (FDAC) – A structured intervention that aims to reduce risk of future harm by addressing problematic drug and alcohol use. Delivered by a multidisciplinary team comprising of a District Judge, child protection social workers, substance misuse workers and a psychiatric nurse. Some teams also have psychologists or domestic abuse workers. The family are supported to problem solve their difficulties and access support to overcome drug and/or alcohol use. FDAC has strong evidence to support its ability to effectively reunify families, compared with treatment as usual.

Family Group Conferencing (FGC) – A family group conference is whereby the extended family within a child's network come together to plan around meeting the needs of the children. It is an opportunity to foster engagement and ensure wider family members are aware of concerns and an opportunity to identify support to achieve goals. Feedback from families has been positive and they have felt involved and heard, they have engaged in the process. However, The What Works Centre for children's social care

(2020) conclude that there is mixed evidence supporting the effectiveness of FGC, there is lack of reporting on fidelity and it is implemented differently in studies and also there is minimal studies (2) on its implementation in the UK.

The long lasting consequences of Child Abuse and Neglect and the impact in adulthood

One of the largest studies investigating the impact of childhood abuse and neglect and childhood challenges on adult physical and mental health and wellbeing is the CDC-Kaiser Adverse Childhood Experiences (ACES) study carried out in the late 90s (Felitti et al, 1998) with 17000 participants. They asked people a series of questions about their childhood, e.g. whether they had experienced abuse, witnessed domestic violence, deaths, divorce, lived with a parent with alcohol and/or substance abuse etc. They found that people who had experienced four or more ACEs during childhood experienced a range of significant higher number of physical and mental health challenges in adults than those who had experienced fewer or no ACEs. Such health difficulties included, chronic diseases such as cancer, stroke, coronary heart disease, Type 2 diabetes and COPD.

Similar studies have been carried out in the UK and replicated these findings (Bellis et al, 2015). In the UK compared to someone who has experienced no ACEs, people who have experienced four or more, are more likely to experience the following:

- 4 times more likely to be a high-risk drinker.
- 6 times more likely to have had or caused a teenage pregnancy.
- 6 times more likely to have underage sex.
- 11 times more likely to have smoked cannabis.
- 14 times more likely to have been a victim of violence in the past 12 months.
- 15 times more likely to have been violent against another person in the last 12 months.
- 16 times more likely to have used crack cocaine or heroin.
- 20 times more likely to have been in prison at any point in their lives.

We cannot prevent all ACEs from occurring, but we can work to minimise their negative impact and strengthen protective factors to reduce the long term negative consequences for the individual and lessen the financial impact upon society.

The longer-term outcomes of children entering Local Authority care

The prevalence of mental health difficulties for looked after children is significantly higher than that of the general population in the UK (Ford et al, 2007). These findings were indicated, in the results of the Office for National Statistics (ONS) mental health surveys of looked after children (Ford et al, 2007). Ford et al (2007), reported that 45% of looked after children experienced mental health difficulties, of concern is that this figure

rose to 72% for those in residential based placements. In contrast, the figure they recorded for the general population of children experiencing mental health difficulties was 10%. This figure for the general population has recently been indicated, in a Public Health document on the mental health of children and young people (2016). The Public Health document (2016) indicates that nine years later this figure remains relatively stable. Similarly, the document also reported that up to 60% of children and young people looked after experience some form of emotional or mental health illness. The literature base clearly indicates that for the cohort of children looked after worldwide, there is a need for support around emotional, behavioural and mental health difficulties (Munro & Hardy, 2006).

The National Audit Office (2014), report that in addition to the emotional, behavioural and mental health difficulties which looked after children are more vulnerable to, they are also more likely to do less well than peers in school and are less likely as care leavers to be in employment or higher education. When removing children from their family the aims are to protect them from harm, improve future outcomes and address a child's basic need for access to good enough parenting. For further information on the impact of child maltreatment and the far-reaching consequences for children as they enter adulthood, see Gilbert et al, (2009). The National Audit Office (2014) recommends that we ensure that we review whether it is possible to offer early interventions to reduce the need for children to

enter care and that we ensure for those children who do come into care the placement is matched to their needs from the outset.

Aims of this thesis

- Review the current evidence base and evaluate the efficacy of MST CAN (chapter 2) in a systematic review.
- To evaluate real life cases of court proceedings and identify similarities and differences between cases whereby the children are removed from parental care and those that are not (Chapter 3).
- To evaluate the implementation of MST CAN with a family where there are multiple risk factors identified as driving child maltreatment (Chapter 4).
- To critically evaluate the University of Rhode Island Change Assessment Scale with individuals recommended for treatment for substance use (chapter 5).

Chapter Two – The effectiveness of Multisystemic Therapy for Child Abuse and Neglect: A systematic review

Abstract

Background: Child maltreatment can have a significantly negative impact on the child in both the short and long-term. The cost of child maltreatment to the public is high, in England Local Authorities are overspending on an annual basis in the area of Children's Services with increasing numbers of children being placed in to care due to maltreatment. An effective intervention is required to manage and address active child maltreatment in the categories of physical abuse and neglect. Multisystemic Therapy for Child Abuse and Neglect (MST CAN) is an intensive home-based treatment and is recommended by the National Institute for Health and Care Excellence (NICE) to address child abuse and neglect. There has not yet been a systematic review of the evidence base for MST CAN.

Method: Four online databases were searched in addition to contacting expert researchers and identifying papers from references. Risk of bias for each study was assessed.

Results: Seven papers met the inclusion criteria and were included in this review. MST CAN was shown to significantly improve both child and parental mental health, reduce the risk of re-abuse and significantly improve social supports for the family.

Conclusion: A review of the evidence base indicates that MST CAN consistently demonstrates that it can reduce the risk of further child maltreatment however, there are limited high quality studies evidencing this and those included are predominantly from the USA. Further studies need to be carried out testing the efficacy in England.

Introduction

Child abuse and neglect is an area of international concern with increasing numbers of families open to Child Services worldwide (Euser et al. 2015). The cost of child abuse and neglect is high for the child, family and society (Swenson & Scaheffer, 2018). For the maltreated child, the consequences of childhood abuse and neglect have been linked with; an increased risk in adulthood of mental health difficulties, suicidal ideation, criminality, substance abuse and alcohol abuse (Butt, Chou & Brown, 2011 and Norman et al. 2012). The problem of child abuse and neglect in England is becoming increasingly concerning, with large numbers of children on Child Protection Plans, in Local Authority care. These rises are placing workers in Children's Social care under immense pressure with rising caseloads (Watts, 2017). As these numbers rise there is an increasing urgency to identify evidenced based interventions that address the multiple risk factors associated with child abuse and neglect, for those families where there is active maltreatment of children. These risk factors are usually assessed and identified by Children's Social Services. Recommendations are then made for families to engage with agencies that can offer treatment to address the identified needs.

It is well documented that for families where there is physical abuse and/or neglect there are likely to be numerous parental risk factors such as parental alcohol and/or substance use, mental health difficulties and current or historical domestic abuse (e.g. De Bortoli, Coles & Dolan, 2013,

Swenson & Schaeffer, 2018). Additionally, there are often other risk factors such as economic difficulties, social isolation and child factors (Swenson & Schaeffer, 2018), ecological risk factors are summarised in more depth in chapter three. Some families may find themselves in a position of having to meet a number of recommendations within Child Protection Plans to address concerns. These may include; accessing support for their mental health; accessing support to address alcohol and/or substance use and attendance at a parenting programme. Alongside supporting children to attend appointments if they present with any emotional, behavioural and/or mental health difficulties. It is unsurprising that for many this can seem overwhelming. For single-parent families with multiple children this can be challenging as they may not have any childcare support. The co-ordination and funding of attendance at appointments may be a barrier for caregivers. There is also the consideration of waiting lists for universal services such as Improving Access to Psychological Therapies (IAPT) for mental health difficulties (Baker, 2018). Which may be for several months and not within review periods of the Child Protection Plan. Budget cuts has meant that there can be difficulties in accessing support for substance use (Rhodes, 2018).

Even when families do engage in multiple services there can be challenges around the co-ordination of these and ensuring appropriate information is shared between the multiple agencies (Swenson & Schaeffer, 2018). When parents do not access services, this is often interpreted negatively and

increases the risk of 'out of home placement' being the only perceived option to keep the child/ren safe from significant harm (Wilkins, 2017).

Removal from parental care is another response to child maltreatment however, whilst the outcomes for children in care have improved, these outcomes are still not 'good enough' when compared with children who are not in care (Department for Education and Skills, 2006). For example, in 2005 only 11% of children who had been in care attained five GCSEs grade A-C compared with 56% of the general population. The Care Matters report (2006) states that "The long-term outcomes of children in care are also devastating. They are over-represented in a range of vulnerable groups including those not in education, employment or training post-16, teenage parents, young offenders, drug users and prisoners" (Department for education and skills, 2006, p5). When there is substantiated child abuse and/or neglect, Social Workers have a challenging task in identifying both the strengths and needs of families and making an informed decision about whether it is safe for children to remain in parental care. With an increase in Serious Case Reviews and a move for some professionals towards defensive rather than defensible practice (Jones, 2014), the risk of children being removed due to concerns around abuse and/or neglect is high for those parents who are not seen to engage in recommended treatment or demonstrate sustained change (Wilkins, 2017).

In 2014, the Department of Health and Department of Education requested that the National Institute for Health and Care Excellence (NICE) produce guidelines of evidenced based recommendations on 'what works' around recognition, early assessment, response to and interventions for child abuse and neglect. The only evidenced based intervention that is currently recommended by the NICE that attempts to address the multiple risk factors of child abuse and/or neglect is Multisystemic Therapy for Child Abuse and Neglect (MST CAN). According to Shaeffer & Swenson (2018) the four overarching aims of the MST CAN model are:

1. Keep families together safely.
2. Prevent re-abuse and neglect.
3. Reduce mental health difficulties experienced by adults and children.
4. Increase natural social supports.

Multisystemic therapy (MST) is an evidenced based intervention that was designed in the 1980's by Dr Scott Henggeler based on Brofenbrenner's (1979) theory of social ecology to address risks of antisocial behaviour and out of home placement. MST CAN is one of several adaptations of 'Standard MST' that has been developed, trial tested and demonstrated evidence of effectiveness. An assumption in MST CAN, consistent with Brofenbrenner's theory of ecology, is that the risk factors of child abuse and neglect are multiple and within and across different systems. A full description of MST CAN is provided in chapter three. Other interventions are recommended within NICE guidance for the prevention and treatment of child abuse

and/or neglect (see introduction chapter). However, these tend to address only one risk factor at a time such as poor parenting (e.g. Triple P) or are only available to a small population of the at-risk families (e.g. Family Nurse Partnership, Browne & Jackson, 2013).

MST evidence base

In a recent meta-analysis, Van de Stouwe et al. (2014) reported that Standard MST was effective in meeting its ultimate outcomes. These are:

1. Prevent children from entering care and/or custody
2. Reduce antisocial behaviour
3. Improve family functioning

Van de Stouwe et al. (2014) indicated that in line with earlier studies they found that the multimodal approach seems to be an effective way of working, with small but significant treatment effects. They also reported that there was no significant treatment effect evidenced for skills and cognitions of youths. However, this is not surprising given these are not typical factors targeted in Standard MST as they cognitive and social skill deficits are individual risk factors as opposed to being ecological. Similar results were also reported in a later systematic review of MST efficacy with youths who have severe antisocial behaviour and emotional disorders (Tan & Fajardo, 2017). The conclusion of their review was that MST was an effective intervention to address severe antisocial behaviours however,

further research is needed to demonstrate its effectiveness with emotional difficulties.

A criticism of the MST evidence base raised by Littell (2005) was that many of the studies up to that point had been carried out by the researchers and developers of MST and reported higher effect sizes than those carried out independently. The largest independent study of Standard MST in England to date is the START trial (Fonagy et al. 2018) that concluded that Standard MST was not more efficacious than treatment as usual in the treatment of moderate to severe antisocial behaviour. The study highlighted that youths engaged in MST self-reported improved wellbeing at 6 and 12-month follow up, as did parents. However, this was not sustained at 18 months where they found no difference between MST and treatment as usual. Findings in relation to parental wellbeing favoured MST and this was sustained at 18 months. A limitation of this trial is that there was considerable difference in the treatment as usual across the sites included in the study. Some areas offered comparative systemic interventions such as Functional Family Therapy whereas others offered individual based interventions.

Scope

Over the past three years, provision of MST CAN in Local Authorities in England has increased, as evidenced by the development of an MST CAN consultant based in the UK and six MST CAN teams. An initial search of the

databases indicated that whilst there have been multiple systematic reviews and meta-analyses conducted on Standard MST, there has not yet been a systematic review of the literature for MST CAN.

Whilst MST CAN is a different intervention to Standard MST in terms of target population, length of involvement and additional protocols to address targeted risk factors. The way in which it is delivered is the same; within the home, by one team who provide 24/7 support and following the same analytical process and principles. Therefore, some of the findings from previous reviews of Standard MST can be generalised. However, there is a need to review MST CAN in its own right as a potential efficacious intervention to address physical abuse and neglect to children aged between 6-17 years. There may be younger children within the household however, the referred child must be between 6-17 as this is the client group the intervention has been researched with. Children who are emotionally abused only are eligible if there is a critical incident in the previous 180 days however, this category alone rarely meets the threshold for MST CAN intervention. Cases whereby the current category of harm is sexual abuse are excluded from MST CAN, until a more specific MST Child Sexual Abuse intervention is developed to address their differing needs from the targeted population.

The aim of this systematic review is to consolidate and critique the current evidence base for MST CAN and identify limitations and areas for future research or implications for clinical practice.

Methods

Included study designs

The initial scoping exercise highlighted there was only one Randomised Control Trial (RCT) of MST CAN. Therefore, the search criteria were broadened in order to widen the scope to include other study designs such as quasi experimental and case studies to have a more robust review of the intervention. A narrative review approach was not considered because of the risk of bias in study selection and a systematic approach was preferred.

Randomised control trials (RCT) are the 'gold standard' of research study designs (Sullivan, 2011). They are considered to be the most scientific and rigorously designed studies as they are designed to reduce the risk of bias when testing a treatment efficacy. Participants are allocated to either the group receiving the treatment or a control group (treatment as usual or no intervention). In some areas of research, such as child maltreatment, RCTs are not considered to be ethically appropriate as denying potential treatment would be unfair (Sullivan, 2011) and harmful. One way to ameliorate this concern is to use waiting list controls.

The quasi-experimental study design enables a treatment group to be compared to a similar control group who access treatment as usual without denying treatment. Comparison groups are usually matched by identified variables however, the process is not randomised. A limitation of this study design is that statistical analysis may not be as meaningful due to threat to internal validity and lack of randomisation. However, Shrier et al. (2007) found that non-randomised studies tend to produce similar results to randomised studies. They suggested that effect sizes are sometimes reported to be larger than those found in comparative RCT. However, they concluded that advantages of including the studies in meta-analyses outweighed the disadvantages.

The different control group options when carrying out either an RCT or quasi-experimental study include:

- Waiting list control – this is whereby a comparison is made between those who are receiving treatment and those who are not and are waiting for treatment. An advantage of this approach is that the waiting list control will receive treatment however, the delay may have negative consequences and there may be more drop outs due to lack of intervention.
- Usual care – this option is often used in research studies however, a limitation of this is that usual care can differ widely across services and may not be an equally representative comparison.

- Other active treatment – this is whereby two treatments are actively compared against one another for example, Cognitive Behavioural Therapy versus Behavioural Activation to treat depressive symptoms. An advantage of this approach is that all participants have access to an intervention and there may be fewer drop outs because all are accessing treatment. A disadvantage is cost and availability of a directly comparative treatment (Moller, 2011).

Case study designs can provide qualitative data and often represent 'real world' research, giving examples of practicing interventions in clinical settings. However, due to small sample sizes they often lack the rigor and data analysis of other larger scale study designs such as RCTs and it is more difficult to generalise the results.

Search methods for identifying articles

A protocol was developed before the review was undertaken and included the Population Intervention Comparison Outcome (PICO) criteria outlined in table 4. The search was carried out in January 2019 and repeated in March 2019.

Table 4: Eligibility Criteria

	Inclusion	Exclusion
Population	Parents who physically abuse and/or neglect children aged between 6-17	Sexual abuse Emotional abuse only
Intervention	Licensed MST CAN intervention or MST-BSF (Building Stronger Families, another name for incorporating Reinforcement Based Therapy intervention which is now an intervention offered within MST CAN).	Other MST adaptations such as PSB, CM and MST Standard
Comparison	Treatment as usual Parent training Removal of child	
Outcomes	Primary outcome – no further reports of child abuse and/or neglect. Secondary outcomes – improved mental health for parent/s and child/ren, no substance abuse/problematic alcohol use and	
Study Design	RCT, cohort analytical, cohort studies, quasi-experiential and case studies.	Non-empirical studies/papers, e.g. narratives, reviews, editorials, letters, biographies.
Paper Types	Studies from all countries and in all languages; published or grey literature.	

The following electronic bibliographic databases were searched between August and November 2018 and repeated in February 2019: Embase, PsychArticles, PsychInfo and PubMed. Google Scholar and reference lists of identified reviews and empirical studies were searched for previously unidentified papers. Two experts in the field were contacted to locate a referenced paper and any unpublished data.

Key words searched included: (MST CAN) OR (Multisystemic Child Abuse and Neglect) OR (MST Building stronger families) these terms were also combined with (therap*) OR (treat*) or (interven*) or (compar*) or (program*) the term NOT (MST) was used to reduce inclusion of standard MST studies.

Data collection and analysis

Selection of studies

The search generated 123 hits and ten additional articles were sourced via experts dating between 1987 and 2018. After the exclusion of duplicate articles, 104 articles remained. After screening the abstracts, 92 articles were excluded because they did not meet the inclusion criteria. A total of 12 articles remained but once narrative and descriptive papers were removed, a total of 7 papers were included in the final review (see figure 3).

Assessment of Risk of Bias in included studies

A critical appraisal of the included articles was carried out using a quality assessment tool adapted from National Institutes of Health (2014) and also the Cochrane Risk of Bias Tool (Higgins et al, 2011). Data extraction was completed by the primary author and 20% of the studies were independently reviewed by a second assessor. Interrater reliability was assessed using Cohen's *k*, agreement was almost perfect with a score of 0.88. Due to the limited number of studies and the different designs, it was not possible to undertake a meta-analysis of the data.

Figure 3: Overview of articles included and excluded in the systematic review.

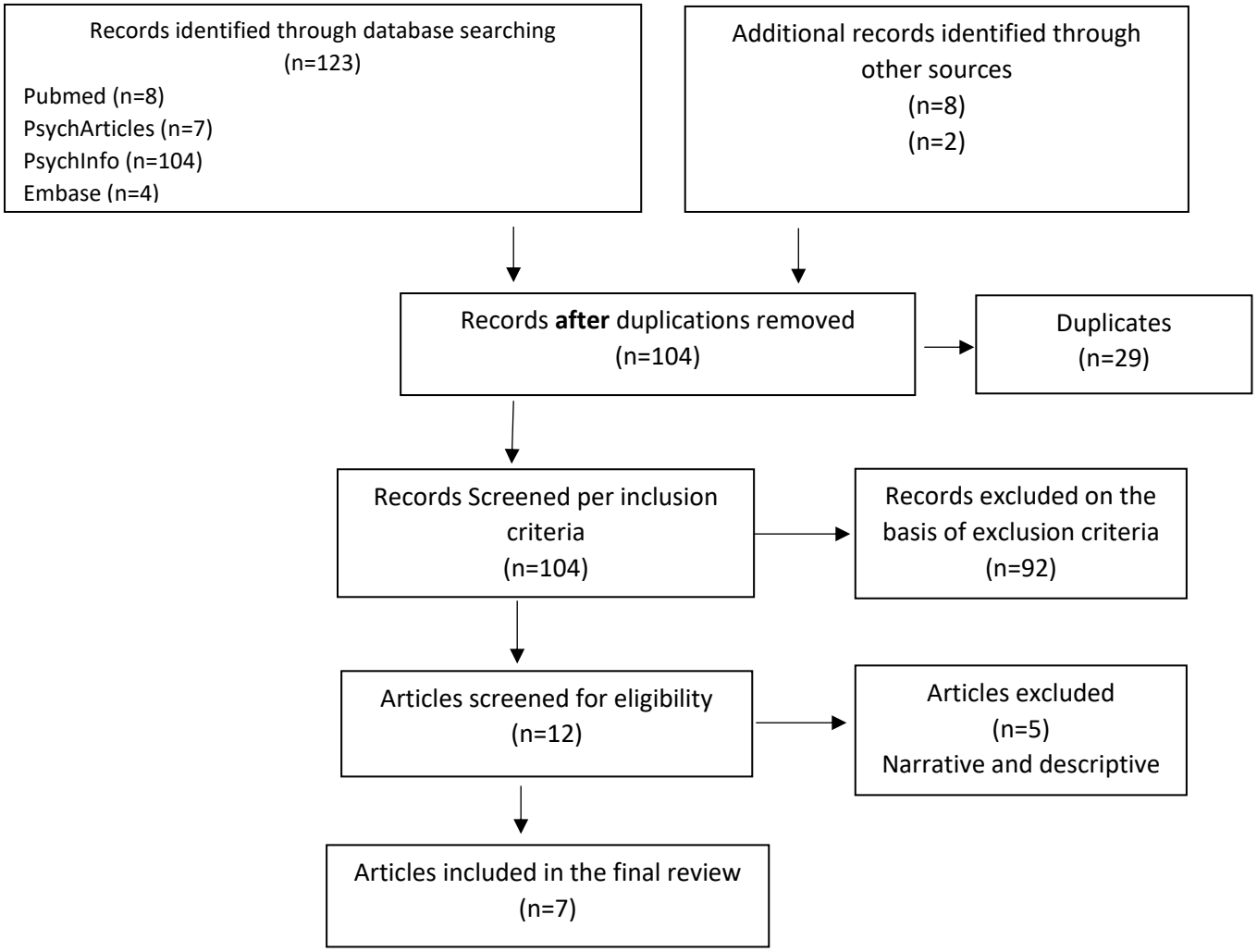


Figure 4: Risk of Bias across the 7 studies.

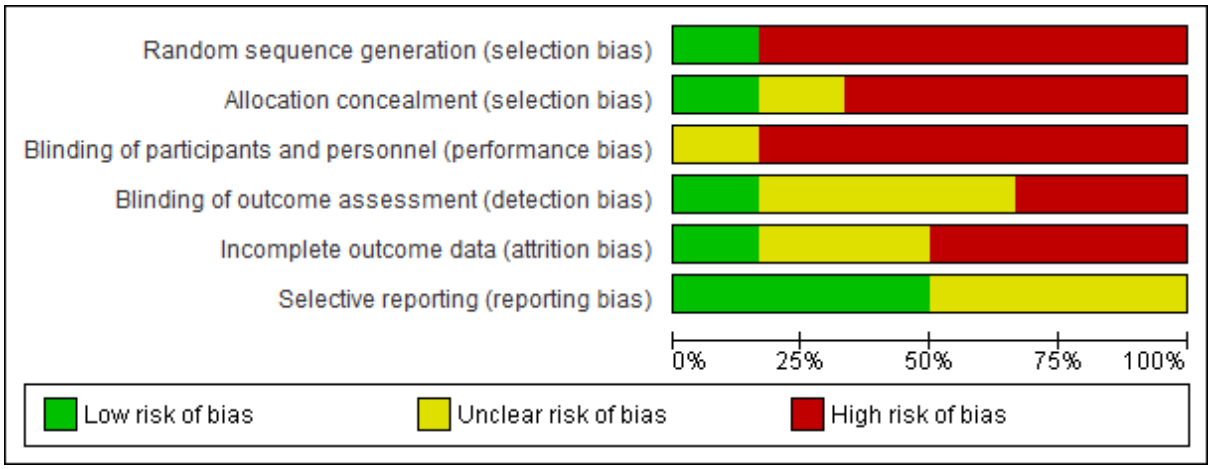


Table 5: Quality assessment of each study.

	Reduction of selection bias	Study design	Blinding	Data collection: appropriate measures	Management of withdrawals and dropouts	Intervention Integrity	Statistical analyses
Brunk, Henggeler & Whelan (1987)	+	+	-	+	-	++	++
Swenson, Shaeffer, Henggeler, Faldowski & Mayhew (2010) *	+	++	+	++	-	++	++
Dopp, Schaeffer, Swenson & Powell (2018) *	+	++	+	++	-	++	++
Stallman, Walmsley, Bor, Collerson, Swenson & McDermott (2010)	+	+	-	+	n/a	+	++
Shaeffer, Swenson, Tuerk & Henggeler (2013)	+	++	+	+	-	++	++
Kamphuis, Wilde & Van der Rijken (2015)	-	+	-	-	-	++	-
Hefti, Perez, Furstenau, Rhiner, Swenson & Schmid (2018)	-	+	-	+	-	++	++

*Denotes same data sample

Note: Strong quality (++), Moderate quality (+) Weak quality (-)

Table 6: Characteristics of Identified Studies and Extracted Data.

Authors (year) Country or origin	Population and total sample size	Age of child	Intervention	Intervention Duration	Main Measures	Main findings
Brunk et al. 1987 USA	Abusive parents N = 18 Neglectful parents N = 15	Age 6+ years	MST N = 16 **Versus** Parent training N = 17	For both interventions it was 90 minutes x1 a week for 8 weeks	The Symptom Checklist - 90, Behaviour Problem Checklist, Family Environment Scale, The Family Inventory or Life Events and Changes, Treatment Outcome Questionnaire and observations using a coding system.	• Parental effectiveness - action improved significantly after MST but not PT. • Improvement in child behaviour was evidenced significantly after MST but not PT. • Neglectful families improved in responsiveness towards the child after MST whereas no change was observed for the PT group. • Parents in PT reported a significant decrease in social system problems whereas those in MST did not. • For both MST and PT therapists reported a greater reduction in family problems with abusive families than in neglectful families.
Swenson et al. 2010 USA *	Physically abusive parents N = 86	10+	MST CAN N = 44 **Versus** Enhanced Outpatient Treatment (EOT) N = 42	Mean length of treatment = 88 hours and treatment length = 7.6 months Mean length of treatment = 76 hours and treatment length = 4 months	Child Behaviour Checklist, Child Behaviour Checklist – PTSD, Brief Symptom Inventory, Conflict Tactics Scale, Interpersonal Support Evaluation List, Re-abuse and placement data.	• MST CAN more effective than EOT in reducing youth mental health symptoms. • MST CAN more effective than EOT at reducing parental psychiatric distress. • MST CAN more effective than EOT at reducing parent behaviours associated with child maltreatment. • MST CAN more effective than EOT at reducing neglect. • MST CAN was more effective than EOT at reducing risk of out of home placement. • MST CAN youths who were placed were more likely to have less placement moves than those in EOT. • Both groups showed a reduction in the use of nonviolent parenting strategies over time however, this decline was significantly less in the MST CAN group.

Stallman et al. 2010 Australia	Neglectful parent with comorbid mental health difficulties and substance use N = 1	7+	MST CAN	15 months of treatment	Children's Depression Inventory, Child Behaviour Checklist, Brief Symptom Inventory and Parenting Scale	• Reduction in alcohol use. • Reliable and significant improvement in parental mental health • Reliable improvement in child mental health. • Improvement in use of parenting strategies although still within clinical range.
Shaeffer, et al. 2013 USA	Physically abusive and/or neglectful parents who use substances	6+	MST- Building Stronger Families N = 25 **Versus** Comprehensive Community Treatment N = 18		The Addiction Severity Index – Fifth edition, The Beck Depression Inventory, Trauma Symptom Checklist, Conflict Tactics Scale. Re-abuse and placement data.	• End of treatment MST-BSF significantly less reports of maltreatment. • MST-BSF significantly less drug and alcohol use. • MST-BSF significantly improved parental mental health • MST-BSF youths spent significantly less time in out of home placement (46% fewer days). • MST-BSF youths reported significant improvements in mental health functioning. • MST-BSF parents reported significant reduction in aggressive tactic with child. • At 24 months follow up MST BSF cases were 3.06 times less likely to have another report of maltreatment.
Kamphuis et al. 2015 Holland	Physically abusive and/or neglectful parents N = 18	6+	MST CAN		Psychiatric Diagnosis	• 12/18 families remained intact at 18-month follow up. • Improved mental health in both children and adults that engaged in treatment for psychiatric disorders.
Hefti et al. 2018 Switzerland	Physically abusive and/or neglectful parents	6+	MST CAN **Versus**	6-9 months	Brief Symptom Inventory and Parenting Stress Scale	• Parental psychological distress decreased significantly and were sustained at a lower level 6 months' post intervention.

	N = 140	• Parental stress did not reduce, though baseline measure was close to non-clinical population at start of intervention. • Outcomes of parental psychological distress post intervention were not dependent upon level of psychological stress at the start of MST CAN.

Table 7: Summary of strengths and limitations within studies

Authors (year) Country or origin	Strengths	Limitations
Brunk et al. 1987 USA	• Families randomly assigned to treatment, • Clear description of treatment interventions, including limitations detailed. • Used both self-reporting and observational methods to assess change. • Parent-child interactions across both treatment groups were marked by independently by two raters. They were blind to the group and treatment condition of the family.	• 10 non-completers (5 from each treatment group) are not included in final outcomes. • Neither MST intervention nor Parent Training programme were implemented as per written manuals (e.g. dosage of MST is usually more than 90 minutes a week over an eight-week period). • Neglected children and parents in MST group (9.8 & 36.2) were significantly older than the those in the Parent Training group (6.8 & 26.4). • Whilst supervision for MST group was listed as 1 hour per week this was not detailed for the Parent Training group, other than stating that they received supervision. • The families were court ordered to engage in therapy, therefore this external pressure may have impacted on engagement and self-reporting. • There was no measurement of re-abuse to support findings.
Swenson et al. 2010	• Randomly assigned to treatment this was computer generated.	• The measures taken to engage families in the EOT were 'above and beyond' that of treatment as usual. For example, therapists calling to remind of appointments,

USA	• Paper provides clear information about participants, including non-completers who were included in outcome data as intent-to-treat analysis. • The psychometrics used in the study have demonstrated strong internal consistency.	making home visits and providing transport vouchers. These measures are not necessarily generalizable to 'real world' interventions. • There was a high turnover of therapists in the MST CAN intervention, eight over a three-year period. • Supervision was jointly provided by a supervisor from the centre and an MST CAN developer, this is not generalizable to real world implementation of MST CAN. • The treatment element of EOT is unknown other than the chart data from other agencies, e.g. substance use.
Stallman et al. 2010 Australia	• Psychometrics used have good reliability and validity.	• Single design case study with no comparison. • Case study took significantly longer to implement that RCT or QE design, 15 months.
Shaeffer, et al. 2013 USA	• Cases were matched pairs based on date of maltreatment (within previous 180 days) and child victim age (6-17). • Re-abuse and placement data obtained independently for both groups. • Appropriate statistics used.	• Self-report measures could only be administered with those in MST-BSF condition. • Due to there being no control group the statistical power is low.
Kamphuis et al. 2015 Holland	• A real-world example of the diagnosed mental health of families referred to MST CAN.	• Case study design. • No control group to compare with. • No pre and post statistical data.
Hefti et al. 2018 Switzerland	• Psychometrics used had at minimum good reliability. • Real world implementation of MST CAN in European country.	• No comparison group was included in the study due to ethical reasons. • Missing data for non-completers/dropouts. • Potential selection bias with those that remained in the study. • Risk of participants giving socially desirable answers from the outset on the Parenting Stress Scale.

Discussion

The aim of this systematic review was to synthesise and review the evidence base for MST CAN. Seven papers met the inclusion criteria and were included in this review. MST CAN was shown to significantly improve both child and parental mental health, reduce the risk of re-abuse and significantly improve social supports for the family (see tables 5 and 6).

However, the review highlights that currently there is a lack of strong quality studies. The Early Intervention Foundation (2019) propose that in order for an intervention to be considered to have a strong evidence base (scoring a rating of 4+), there needs to have been at least three RCT/Quasi Experimental Design studies. This review has brought together all of the current evidence for MST CAN efficacy at addressing child maltreatment of physical abuse and/or neglect. Despite the limited number of studies, both the RCT and quasi experimental study indicate that MST CAN is a promising intervention to address active child maltreatment. There is currently no other intervention in England provided by one team that works to address the multiple factors of child abuse and neglect and reduce the risk of future maltreatment.

The findings of the studies included in this systematic review are considered below in a narrative synthesis organised by consideration of whether the

four overarching aims of the MST CAN model are achieved (see table 5 for an overview of the findings of each study) (Schaeffer and Swenson, 2018).

1. Keep families together safely.

The results from both the RCT (Swenson et al., 2010) and Quasi-experimental study (Shaeffer et al., 2013) demonstrated that children within the MST CAN groups were less likely to experience out of home placement. This was statistically significant in the Swenson et al. (2010) study (14% MST CAN vs 30% EOT). However, whilst this result was observed again in the Shaeffer et al. (2013) study, with the incidence and number of out of home placement being lower in the MST BSF group, it was not statistically significant. In the Swenson et al. (2010) study when children were placed out of the home, they experienced significantly fewer placements that the EOT group. These results indicate that MST CAN has demonstrated some efficacy in keeping families together with fewer days out of the home.

2. Prevent re-abuse and neglect.

The results from both the RCT (Swenson et al., 2010) and quasi-experimental study (Shaeffer et al., 2013) demonstrated that MST CAN was more effective than comparison groups in reducing subsequent maltreatment as evidenced by re-abuse data. However, in the Swenson et al. 2010 study this difference was observed (4.5% vs 11.9) but was not

statistically significant. MST CAN youths reported almost 50% less incidents of severe assault by their parent across the 16 months follow up period than those in the EOT group (4.7 vs 9.8 incidents). In the Shaeffer et al. (2013) study, MST BSF mothers were three times less likely to have another substantiated incident of maltreatment over the two year follow up period. The comparative youths in the MST BSF study (Shaeffer et al, 2013) experienced significantly more re-abuse incidents over the 2 year follow up period with a large effect size (d=.80). These findings indicate that MST CAN has demonstrated evidence of being able to reduce the likelihood of future maltreatment.

3. Reduce mental health difficulties experienced by adults and children.

The results from both the RCT (Swenson et al., 2010) and Quasi-experimental study (Shaeffer et al., 2013) demonstrated that MST CAN was significantly more effective than comparison groups in reducing youth mental health symptoms and parental mental health, as evidenced by a reduction in psychiatric distress. Improvement in parental mental health was also reported in three other studies included in the review, Stallman et al (2010), Kamphuis & Brand-De, (2015) and Hefti et al (2018).

4. Increase natural social supports.

A significant difference was identified between MST and Parent Training in the 1987 study by Brunk, Henggeler & Whelan. (1987) with Parent Training being more effective in increasing social support for parents than the MST

intervention. In the subsequent development of the MST CAN adaptation, increasing social support was identified as a targeted risk factor and an important element of treatment. In the RCT (Swenson et al. 2010) found that MST CAN was significantly more effective than EOT at improving natural social supports for parents. They also reported that the social support outcomes lasted beyond treatment at 16-month follow up.

Supportive findings for MST CAN have also been reported in two meta-analyses that have reviewed the evidence base of interventions to address child maltreatment (Euser et al. 2015 and Vlahovicova et al. 2017). Euser et al. (2015) found significant effect sizes for programmes which offered parent training, matched intensity to clinical need and aimed to reduce child treatment rather than prevent it. They cite MST CAN as one of the more promising treatments included in the study.

Limitations and future research

Despite the limited number of studies included in this systematic review, it highlights that MST CAN has the potential to be an effective intervention to both address the multifaceted factors of child abuse and/or neglect and reduce the likelihood of future re-abuse with parents who have become known to children services. However, the majority of stronger studies

included in the review (3) have been carried out in the USA. There are likely to be differences in the way in which children's services worldwide view and address child maltreatment. As evidenced by Benbenishty et al. (2015) who found significant differences between countries in their international comparative study of decision making in child protection.

This systematic review of MST CAN has provided an overview and examination of the studies to date. Further research on MST CAN application in England would be useful for commissioners and Local Authorities and add to the evidence base. Cost effectiveness of treatment interventions is essential at a time when Local Authorities are facing substantial budget cuts. Perraudin & McIntyre (2019) report that 133 out of 152 Local Authorities (88%) overspent in the area of Children's Services, they estimate that the figure of the overspend is £807M. A local evaluation report from the pilot study in Leeds (Watmuff & Ross, 2016) reported that for every £1 spent on MST CAN there was a £1.59 return. This is a more conservative figure than the saving of $3.31 for $1 spent reported by Dopp et al. (2018). However, Dopp et al (2018). did compare the cost of MST CAN with Enhanced Outpatient Treatment which may not be representative of treatment as usual in England. The EOT differed from treatment as usual in England as therapists were encouraged to increase attendance at appointments by sending messages, making telephone calls and going out and completing home visits. With the exception of texts reminders which are often used in practice by NHS, these additional steps to engage service

users are not generally provided by universal services in England. The responsibility of engagement usually lies with the services user.

Stallman et al. (2010) highlight some challenges in implementing MST CAN in real practice as it was in the clinical trials. The case study outlined was in treatment for 15 months, which is significantly higher than the recommended 6-9 months and would impact on the cost effectiveness of the intervention. In the trials, treatment lengths varied from between 2-12 months. Swenson and Shaeffer (2018), suggest that for some families with complex needs, and especially where there are initial challenges around engagement, 12 months' treatment may be required.

Conclusion

A review of the evidence base indicates that MST CAN consistently demonstrates that it can reduce the risk of further child maltreatment however, there are limited high quality studies evidencing this and those included are predominantly from the USA. The review also highlights how MST CAN is an effective intervention at addressing risk factors (including parental substance use, parental mental health and parenting skills) for child abuse and neglect. A benefit of the MST CAN approach is that it has shown that these difficulties can be addressed in a specified time frame that would fit with cases at the brink of entering Child Care Proceedings.

Further studies need to be carried out testing the efficacy of MST CAN in England.

The studies included in the review highlight that families with multiple difficulties benefit from a coordinated approach and home-based treatment that facilitates engagement by removing practical barriers that may otherwise prevent attendance. This is something universal and early help services could learn from as providing appointments at home which are attended is more cost effective than having non-attendance at a clinic.

The next chapter features a study of real life cases of families that have gone through care proceedings with the end outcome of either a Supervision Order or Care Order with the index child being between 6-17 mirroring the criteria for MST CAN. The study aimed to increase our understanding of the difficulties experienced by the families and what impacts on children remaining in parental care or not.

Chapter three - An exploration into the characteristics of cases eligible for Multisystemic therapy CAN intervention that result in a decision of child(ren) removal from families and those that do not, following care proceedings.

Abstract

This study set out to identify the similarities and differences in a sample of fifty cases within one local authority, that entered Care Proceedings under the categories of neglect, physical abuse and/or emotional abuse, with at least one child aged >6 between 2014-2018. The fifty cases were split into two groups, 25 whereby the outcome at the end of Care Proceedings was child removal and 25 whereby the outcome was to remain within the care of family. The findings demonstrated the striking similarities between the two groups especially the parental psychosocial difficulties and previous experience of being maltreated in childhood themselves. High numbers of parents presented with mental health difficulties, alcohol and/or substance use and previous experience of domestic abuse. Positive correlations were found between the outcome of Care Proceedings and perceived parental engagement with social care and interventions offered. There was also a correlation between outcome of Care Proceedings and where the child resided during proceedings. More specialist interventions need to be offered to families at high risk of causing significant harm to their children and these need to be matched in intensity to need and delivered in a way

that engages families and reduces risk factors and increases protective factors.

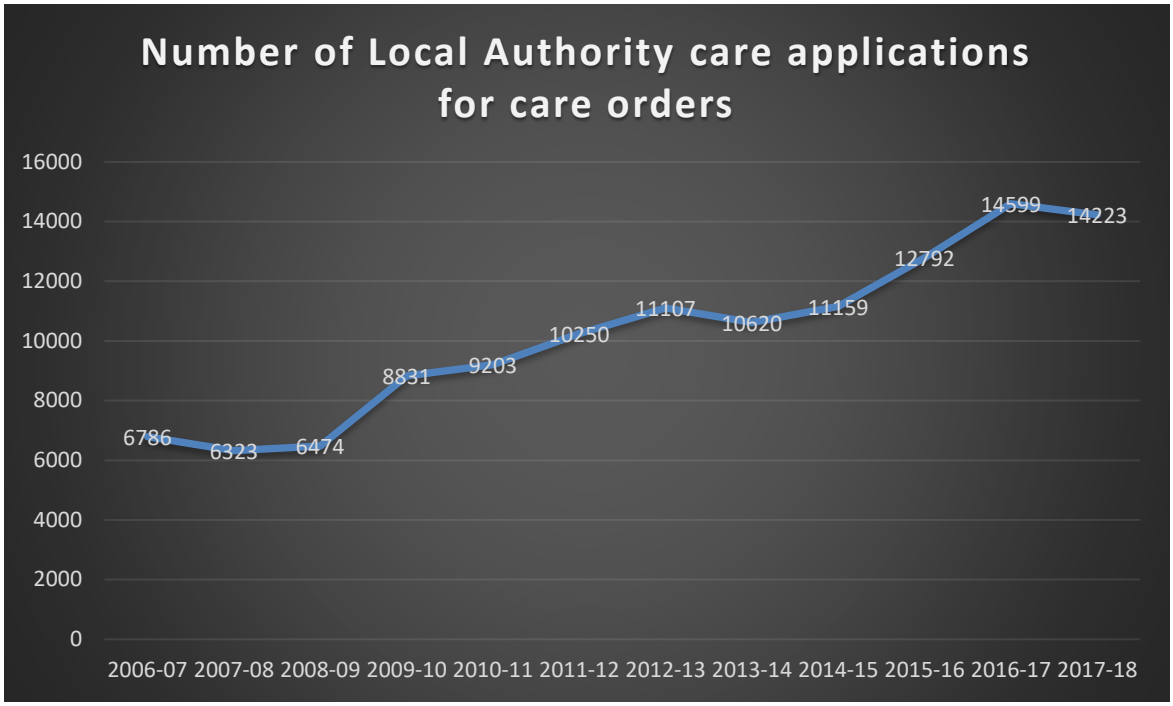
Introduction

As highlighted in chapter one, the number of children on Child Protection Plans (CPP) due to significant risk of child abuse and neglect has increased substantially over the past ten years. Similarly, the number of Care Order applications have risen with a dramatic incline occurring immediately after the Serious Case Review (SCR) into the death of Baby P (Macleod et al, 2010). This figure has continued to rise and is now more than double what it was 10 years ago, see figure 5 (Trowler, 2018).

There is an increasing need to identify 'what works' in addressing the risk factors identified in CPP concerns and ensuring children are safe and not at risk of harm. This area of research is considered a priority, given Local Authorities (LA) are facing increasing budget cuts and demand for foster care placements is higher than what is available (Brazier, 2018). Trowler (2018) argues that without services available that can address the multiple needs of families facing court proceedings, social workers end up with limited choice but to initiate proceedings. A limitation of services that are available exists alongside a lack of co-ordination or prioritisation of needs, and identification of which risk factors to target to minimise harm. Sometimes the number of issues present become a barrier to parents being able to access universal services, e.g. some mental health services

recommend situational factors such as, substance use or domestic abuse are addressed before accessing services. Despite the challenges parents face in accessing services, many CPP detail a number of actions parents should take to address concerns, e.g. access mental health services, engage in substance abuse treatment and attend a parenting course, sometimes without established links with these services to help support access. The number of identified actions can be overwhelming and unachievable for parents in the time frames given. There are often lengthy waits for specialist services such as, mental health support for complex trauma and these are not available in all LA areas. Similarly, engaging people in addressing alcohol and/or substance use can be time consuming and requires work around motivation to change and eliciting change statements before meaningful change occurs. Furthermore, when addressing alcohol and/or substance use there can be lapses and this is not always tolerated when families are within care proceedings. Chapter four will demonstrate the work involved in engaging a parent to change their problematic alcohol and substance use. Other issues like being homeless after fleeing domestic violence are also long winded and may not be resolved within the 26-week time frame of care proceedings.

Figure 5: *Care Applications 2006-2018 in England (Source: Trowler, 2018)*



The decision to enter Child Care Proceedings that may result in the removal of children from parental care, is one of the most challenging and complicated decisions faced by professionals in children's social care (Davidson-Arad et al. 2006). This decision-making process has progressively become subject to wider scrutiny in the wake of high-profile child deaths such as Baby P and Daniel Pelka. Missed opportunities to prevent further harm have led to professionals involved, especially social workers facing high levels of criticism and even public demands for loss of jobs (Care crisis review, 2018). In the case of Baby P, three social care professionals, the allocated social worker, the team leader for the social worker and Director of Children's Services were all dismissed for their role

in not identifying the significant harm Baby P was subjected to. A Paediatrician was also suspended from unsupervised practice for failing to recognise significant injuries to Baby P. Whilst investigations identified serious errors were made by both the police and several healthcare professionals the blame was predominantly targeted towards social care professionals. The significant impact of this case on social work has led to what has been subsequently called the Baby P effect with escalating numbers of children being placed on CPP and entering Care Proceedings (Macleod et al, 2010). The unintended impact of SCRs can often lead to escalated professional anxiety and an increase in defensive rather than defensible practice. This is characterised by a risk averse nature and reduction in confidence that change is possible, with activities carried out as a 'tick box exercise' for when the case is inevitably presented at court (Trowler, 2018 & Care crisis review, 2018).

Davidson-Arad & Benbenishty (2008) carried out a study to assess the impact of child protection worker attitudes on removal, reunification and duration of alternative care and perceived quality of out of home placements. Using vignettes and a 'child welfare attitudes' questionnaire they found that there were two profiles of workers 'pro removal' and 'anti removal' and these attitudes impacted upon decision making in the study. They found that those who were 'pro removal' were more likely to make higher risk assessments and recommend removal significantly more than

those workers who were 'anti removal'. This finding was replicated in an international study across four countries (Benbenishty et al. 2015).

Davidson-Arad et al. (2006) suggest that for the majority of cases open to Children's Services, the decision around whether there will be a need for child removal is not clear at the outset. There are generally only a small number of cases whereby significant risk of harm is imminent and requires immediate removal from parental care to ensure safety. For the cases that are less clear, decision-making often takes place after information gathering from a wide range of sources. Munro (1996) highlighted how the information gathered by social workers can often be equivocal and contradictory further muddying the waters in the decision-making process.

Recent publications in the media (e.g. Bulman, 2017) suggest that the growing number of children entering care in England is a direct result of financial restrictions placed on Local Authorities and Public Services (including mental health and substance use). This has resulted in the closing down of services and a reduction in universal support, all of which may have prevented cases from escalating to the tipping point of meeting the threshold for removal. In contrast, Trowler (2018) argues against this viewpoint suggesting that some of these services are not designed to meet the multiple and often complex needs of families entering proceedings. However, it could also be argued that these services, e.g. for mental health/substance use may be appropriate if they are provided in a more-

timely manner, referrals are followed up and supported when issues are first identified then later when they have worsened or more issues have arisen, e.g. substance use to self-medicate mental health difficulties.

Research focussed on care proceedings

Increasingly, over the past decade, the process of care proceedings and outcomes have become an area of interest. This has partly arisen as a result of the changes implemented in the Children and Families Act 2014, specifically the reduction in the number of weeks' care proceedings should take. As discussed in chapter one this is now 26 weeks, which is almost half the time many cases previously took. Other changes also included the requesting of external reports and the renaming of Residence Orders to Care Arrangement Orders. The care crisis review was commissioned in response to rising care applications (see table 8) and provides feedback from all of those involved with the process of care proceedings and insight into the perspective of families. Table 8 also contains an overview of two of the largest studies on care proceedings in the last decade that are specifically looking at the use of supervision orders which relate to this chapter. These were large scale studies and the findings help to increase our knowledge and understanding of the prevalence, regional variations and difficulties experienced by the families presenting at court. Of interest is that despite this research and the increasing focus on the rising numbers of s31 applications and children entering care, there appears to be little focus on implementing the suggestions for change raised. Like healthcare options, for children and families known to social care their options of support can be a postcode lottery, defined by funding and prioritised spending (Care crisis review, 2018). Less regional variation and more generalised offers would be preferable for children and families.

Table 8: *A summary of recent care proceedings studies*

Authors, Year and Title	**Type of study and included population**	**Overview of findings.**
Harwin, J., Alrouh, B., Golding, L., McQuarrie, T., Broadhurst, K., & Cusworth, L. (2019). The contribution of supervision orders and special guardianship to children's lives and family justice.	Funded by the Nuffield Foundation. Sample size 175,280 sets of care proceedings issued between 2007 and 2017. Over 50% of applications were for children under the age of 5.	The study reviewed a significant number of care proceedings and focussed this specifically on the use of Supervision Orders (SO) and Special Guardianship Orders (SGO). The study was prompted by concerns around 'family orders' whereby children remain within the care of a parent, family member or friend raised by a number of SCRs and questions around the robustness and usefulness of SO and also a query around SGOs being granted without enough time to robustly assess appropriateness of identified caregivers. SO are time limited and provide the LA the opportunity to befriend, assist and support the caregiver initially for 12 months but can be increased to a maximum of 36 months. SGO are in place until the child is 18 years old. This is the largest and first study to date that has focussed on both SOs and SGOs specifically and another unique part of the research was examining the number of SGOs with an SO attached to them. The number of findings within this report are vast and greatly increase our knowledge and awareness of care proceedings, court outcomes and what happens in the longer term with these cases. Summarised below are some of the key findings: • The median length of care proceedings has almost halved when comparing cases from 2010/11 with 2014/2015 which occurred after the children's and families Act, 2014. • There has been a rise in the number of SGOs resulting from care proceeding applications. Alongside this rise in SGOs there has been a decline in the number of Placement Orders (PO) awarded. • Over time there was an increased use of SO attached to SGOs.

		• Use of SO alone has mostly remained static, 13.1 in 2010/11 increasing marginally to 13.8 in 2014/2015. • Most SO were attached to an original application to remove children on a Care Order not a SO. • 16% of SO were likely to return to court in 2016/2017 compared with only 10% in 2010/2011. • Regional variations were observed in the use of SGO, with a lower number of them in the West Midlands (14.4%) in comparison to outer London (25.2%). • There was also regional variation observed in the use of SO attached to SGOs with this figure being higher in the East Midlands (46.7%) compared to Inner London (20.4%). • The national average use of SO was 14%, however regionally there was a large difference observed, in the North West of England this was 8% whereas in London it was 23%. Conversely, whilst the average number of CO was 30% in 2016/2017, in the North West this was 47% and in London 28%. • The main factor that influenced the attachment of a SO to an SGO was geography, with 70% of children in the North of England having an attached SO compared with 30% in the South of England. • The age of children within the care proceedings were predominantly <5 (57.8%) compared with the smallest percentage of children being aged >10 (18.8%).
Masson, J. M., Dickens, J., Garside, L. B. E., Bader, K. F., & Young, J. (2019). *Child Protection in Court: Outcomes for Children*. School of Law, University of Bristol.	Funded by ESRC with DfE and Cafcass acting as research partners. Conducted across 6 LA in England and Wales.	The study aimed to examine the pre-proceedings process (PLO) and also outcomes of care proceedings pre and post reform arising from the Children and Families Act 2014. Key findings and recommendations: • They found that common features of the cases that they reviewed was the 'toxic trio' of mental health, problematic alcohol and/or substance use and

	Before reform S1, 170 cases relating to 290 children brought in 2009/2010 After reform S2, 203 cases relating to 326 children brought in 2014/2015. Information obtained from court files, LA data and children services files. 54 LA staff participated in an interview and there were 2 focus groups with judges.	domestic abuse. These difficulties were often observed together with poor engagement with children's services. • Overall, 20% of children that are subject to care proceedings were not looked after, before, during or after they had concluded. 10% were looked after with parental agreement on s20 during proceedings. • The number of SO used in S2 had increased by 8% to 19% compared with S1. Whereas the use of permanent removal orders (CO and P0) of children from their families had reduced from 60% in S1 to 44% in S2. • Cases whereby the outcome was a SO returned to court with a further s31 application for almost a third of cases in S1, this reduced in S2 (22%) however, this was only measured over a 2-year period in comparison with 6. • Of those cases diverted away from court using the PLO process, only 27% had not entered s31 proceedings after 12 months. • After 6 years 20.5% of those diverted from court had not entered proceedings, however they were often known to services and open either on Child in Need plans or CP plans. There was an identification of continued need for support when children remained within family care. • Outcomes of SO: 25% had additional s31 proceedings, which is worrying because they are now older and have experienced additional harm. • They did find however, that 75% of SO did not fail and children remained in family care. Though it is important to be aware that these families did require significant support and were often still open to Children's services with an ongoing cost to the LA. • They suggested that supporting parents outside of care proceedings, utilising the PLO process should not be seen as delaying proceedings but offer an opportunity to change.
Care Crisis Review. (2018). The care crisis review: Options for	Carried out by Family Action Group and funded by Nuffield foundation.	The care crisis review was prompted due to the increasing number of care application and the rise of children in care. Key findings:

change. London: Family Rights Group	The review consisted of an inclusive listening exercise with over 2000 participants which included LA, parents and children and young people, judicial representatives, social workers and managers. A rapid literature review.	• Many professionals in the review described feeling overstretched, overwhelmed, believe there is a lack of resources and increase budget cuts and that children and families are not receiving the support they need early enough as a result of this. • A recurring theme reported was how to engage families and change a risk aversive culture and minimise professional fears around 'getting it wrong'. • Many contributors within the review (parents and professionals) expressed how they felt that a culture centred around blame, shame and fear had developed which heightens a sense of risk adversity and mistrust. • That there is a need to utilise a 'whole family' approach to addressing the multiple difficulties experienced by families and supporting referrals to specialist services. • It would be beneficial to have multi-disciplinary teams with social workers more closely aligned with specialist adult workers in the areas of mental health, substance use and domestic abuse. • The review heard how it is essential that people have access to the 'right' service at the 'right' time and delivered at the 'right' level of intensity and for the 'right' duration. • Approaches such as Motivational Interviewing, Signs of Safety, Restorative Practice, Family Partnership Model and MST were cited within the review as helpful and effective practice. • There was recognition around how hostility can be more likely and partnerships difficult to build when cases move to CP and care proceedings become a possibility. • Supporting families to change requires skilled practitioners who can be open and honest about concerns and challenges but utilising a problem-solving approach and not setting people up to fail was expressed in the review.

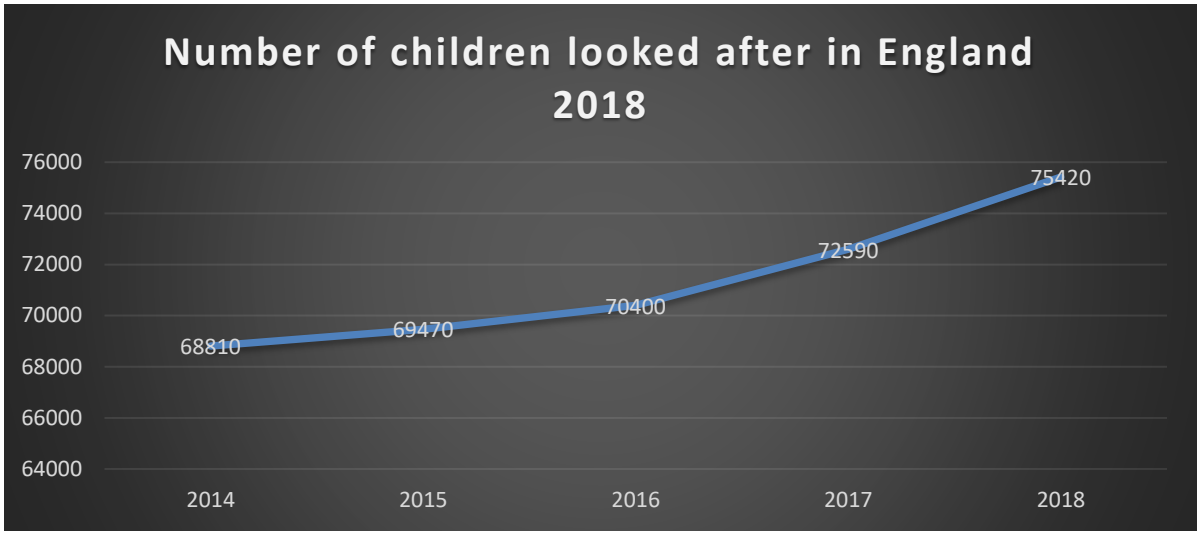
The cost of care proceedings and care placements.

The cost of entering care proceedings is high, Masson et al (2017), share that in 2015-2016 legal aid for children and parents in around 12,000 cases was £400 million, with local authority legal figures are on top of this. Both the costs and length of time that it takes to make decisions are of concern to those involved in child protection and the government. Given the known lack of funding available for early interventions that may have ameliorated this cost in the first place, alongside knowing what evidenced based support is available for families with high needs, a review of what support is needed and when, could be of value to policy makers, local authorities and healthcare providers.

With numbers in children in care reaching an all-time high of 75,420 in 2018 (DfE 2018) see figure 6 for more details, the cost of this is high and there is a higher demand for placements than there is available (Brazier, 2018). According to the National Audit Office (2014), the cost of providing both foster care and residential placements for children in care was 2.5 billion between the years 2012-2013. The average annual cost of a foster care placement is between £29000-£33000, with residential placements costing an average of £131000-£135000. Unfortunately, despite the evidence base indicating the negative impact changing placements can have, approximately 34% of children in 2012-2013 had experienced more

than one placement. The DfE (2013) reported, that of the data they had reviewed 11% of looked after children had experienced three or more placements.

Figure 6: Children in care figures 2014-2018 (DfE 2018)



Risk factors for child abuse and neglect.

The area of child abuse and neglect has been heavily researched in terms of its epidemiology (e.g. Gilbert et al. 2009), how to identify it (e.g. Sirotnak et al, 2004), the multiple factors that are potential predictors of the risk of child abuse and/or neglect (Swenson & Schaeffer, 2018) and the long-term impact of such abuse on children (Cyr et al, 2010). The risk factors that have been identified are best viewed using an ecological perspective (Bronfenbrenner, 1979) as they often include multiple systems including child, parental, family and community factors (Kolko & Swenson, 2002, Gilbert et al, 2009). The risk factors for child abuse and

neglect that have been identified within empirical research are summarised below in table 9.

Table 9: A summary of risk factors for child abuse and neglect across multiple systems

Child Factors	• Aggression • Noncompliance • Difficult Temperament • Age • Delayed Development • Physical disabilities • Learning disabilities • Twins • Two children with less than 18 months between them
Parental Factors	• Mental health difficulties including: depression, anxiety disorders and personality disorders • Overly anxious parenting style • Substance Abuse including: substance (including prescription drugs) and/or problematic alcohol use • Low Self-Esteem • Poor Impulse Control • Antisocial Behaviour • Poor awareness of Child Development • Negative Perception of Child • Low Involvement with Child • History of experiencing maltreatment as a Child • Young parent • Low engagement with services • Poor recognition or denial of concerns
Family Factors	• Marital Status-Single • Difficult spousal relationship, not feeling supported or feeling disconnected within the relationship • Domestic Abuse • Estranged from wider family
Community factors	• Social Isolation • Low availability or dissatisfaction with Social Supports • Low use of Community Resources • Limited Involvement in or access to Community Activities • Deprived area • Lack of family support

The importance of parental engagement

Parental engagement is an essential factor taken into account within care proceedings. The importance of parental engagement in both recognising and being willing to address the risk factors that have been identified as contributing child abuse and neglect has been reinforced by the findings of multiple Serious Case Reviews (SCRs). Many SCRs have demonstrated that a significant risk factor is caregivers concealing difficulties, engaging with services at face value and not implementing changes to reduce risk of harm. SCRs have provided examples of what 'disguised compliance' may look like and have highlighted the lengths that some parents who abuse their children will go to, in order to conceal this. For example, attending different hospitals for injuries, delaying treatment and hiding from sight. An infamous example being Baby P having what looked like chocolate all over his face, masking significant bruising. Parental engagement can vary from actively participating in parenting assessments, working with health professionals to address mental health difficulties by medication compliance and/or accessing talking therapy, working with alcohol/substance misuse workers, ensuring children are taken to appointment and actively addressing concerns e.g. home conditions. Given that engagement is a construct and can be interpreted differently by people, there is a risk of bias.

The DfE (2018) reported that the most common factors identified within referrals to Children's Social care in 2018 included: domestic violence (towards the child and/or other adults in the household), which was identified as the most common factor present in 51.1% of assessments. Followed by mental health at 42.6%, this can include the mental health of the child or other adults in the household. Alcohol and/or substance use comes in next with a combined total of 39.4% with drug use being slightly more prevalent at 21%. The risk factors of domestic violence and mental health have seen the largest increase in prevalence.

Growing concerns around the number of families entering Care Proceedings whereby parental substance and/or alcohol use is a primary factor, led to the development of the Family Drug and Alcohol Court (FDAC) approach being piloted in England from 2008. The intervention was implemented in an effort to increase reunification back to parental care by addressing parental substance and/or alcohol use. Cases heard by the FDAC have met the threshold for Care Proceedings the same as usual cases however, a key difference between the two procedures is that the FDAC court utilises a problem-solving approach to the factors identified as being key to the child abuse and/or neglect (FDAC National Unit, 2019), see table 10 for an overview of each process. The FDAC approach seeks to understand the reasons that led to Care Proceedings and utilises a multi-disciplinary team

who believe that parental change is possible and provide parents with a trial for change. This enables a more flexible approach to increasing both parental motivation and strength of belief that change is possible. The process is perceived as less adversarial than 'treatment as usual' because the process is more collaborative and family driven than traditional Care Proceedings (FDAC National Unit, 2019). Unlike traditional approaches within England to address substance and/or alcohol use, which is often harm reduction based, FDAC approach is to aim for abstinence (Harwin et al. 2018).

The majority of research on the efficacy of FDAC comes from America, though this deficiency is being addressed in England with emerging research into the application of FDAC and longer-term outcomes (Harwin et al. 2018). There are currently eight FDAC specialist teams in England with the majority of these in the south and only one in the North, leaving a wide deficit across the country for the thousands of families facing Care Proceedings whereby substance and/or alcohol use is a factor.

Table 10: *Comparison between FDAC proceedings and usual care proceedings (adapted from Harwin et al, 2009)*.

FDAC care proceedings	Usual care proceedings
Judges A team of specified judges oversee FDAC cases.	No dedicated judges or magistrates, reducing continuity of judicial process.
Specialist team FDAC process is underpinned by a specialist team that carry out assessment of need, interventions and referring to specialist support if the team cannot offer this. Regular meetings occur and progress is reviewed and treatment plans updated.	No specialist team.
Hearings Regular hearings occur without lawyers present	Reviews only take place with legal representation. Parents do not routinely have an opportunity to speak directly with judges or magistrates.
Guardians The FDAC team have a dedicated group of children's guardians, they are appointed straight away and appoint their own solicitors. This leads to a reduction in waiting time	Solicitors are often appointed prior to the children's guardians and there can be a delay in waiting for one to be allocated.
Assessment of substance use Carried out by the FDAC team and within 2-3 weeks of first hearing.	Parents solicitors are usually responsible for organising alcohol/drug testing, often hair strand testing and this can be delayed. Not all universal alcohol and drug services offer testing routinely and these are not always to the standard required by the court.
Use of expert reports Can be requested by the court, if required. However, the aim is for such assessments and reports to be carried out by the FDAC team. Parent's consent to assessment process and the first report is usually completed within 2-3 weeks of first hearing. Final report is prepared prior to the final hearing or when the case exits FDAC process.	Generally, tend to be ordered by the court. All legal representatives have to agree on instruction and requests can be length. Process can be time consuming with reports completed several months into proceedings. Expert report can lead to more reports being requested.
Co-ordination of services Interventions are co-ordinated by the MDT and offered in a timely manner, regular reviewing process ensures that these meet the needs of the family.	Little co-ordination of services, reviews generally take place as part of child protection review process.

Another intervention that also targets parental substance and/or alcohol use is Multisystemic therapy for child abuse and neglect, MST CAN which is recommended within NICE guidance, also aims to deal with multiple risk factors including parental mental health, child mental health and parenting strategies. All of these risk factors are identified and addressed collaboratively with the family by one team. This type of approach to address child abuse and/or neglect could be beneficial to families who find it difficult to engage with services and meeting different workers from various organisations. Despite the recommendation of MST CAN as an intervention to meet the high risk and multiple complex needs of families at the edge of Care Proceedings it is only currently offered in six local authorities in England. This is of concern given the criticism of early interventions as not being designed to meet the needs of such families by Trowler (2018). Similarly, to the evidence base for FDAC the majority of research on MST CAN, as summarised in chapter two, is from countries other than England, mostly America, indicating a need to evaluate its implementation here. MST CAN does not involve a different court process like FDAC and can be offered to families whereby there are concerns of child abuse and/or neglect pre-proceedings or alongside proceedings.

Aims

This aim of this study was to compare the similarities and differences between s31 Care Proceeding cases that have resulted in the permanent

removal of the children on a Care Order (CO) and those whom remain within the family on a Supervision Order (SO). It differs from other studies in this area due to a specific focus on care proceedings for children aged >6. An objective of the study was to examine the impact that parental engagement with services has on outcomes, increase awareness of what support is offered to parents to address concerns and the length of time that concerns have been present prior to proceedings. This study will also look at whether cases whereby children remain at home during proceedings are significantly more likely to be issued a Supervision Order at the end of the proceedings. A unique aspect of this study compared to others was that the information of children not looked after during proceedings could be identified.

Hypotheses

- Cases whereby children remain at home during proceedings are more likely to result in a supervision order as parents have time to demonstrate capacity for 'enough' change and 'good enough care' with the children present.
- Cases where there is perceived 'poor engagement' and not being accountable for concerns are more likely to result in removal from parental care.

Method

Sample

This study included a sample of 50 families who had been involved in Care Proceedings in one Local Authority between the years 2015-2018. The LA that consented to the study is considered to be large, urban and in the north of the country. The cases were obtained from two lists of Care Proceeding cases, kept by the Local Authority Legal team, detailing those that ended on a Care Order and those on a Supervision Order. All cases included in the study met the criteria of social care threshold for removal under the categories of physical abuse, emotional abuse and/or neglect, with twenty-five cases having the final hearing outcome of removal from parental care on a Care Order and twenty-five cases having the final hearing outcome of remaining in family care on a Supervision Order. There were at least two children within these families including one child over the age of six. The rationale for this was in order to assess those cases that had gone through the court process that may have been eligible for MST CAN. Older children are often more difficult to find long term care placements for and are more likely to experience multiple placements (Department of Education DfE, 2013). Furthermore, only a minority of children experience permanency via adoption and the majority of these (74%) are aged between 1-5 (DfE, 2013).

There was 257 final care orders and 236 final supervision orders between 2014-2019 prior to the exclusion criteria being applied to the two lists held

by the Legal team. They were asked to work through the remaining list choosing every third case to be included in the study until there were 25 cases in each group, they were advised to return to the beginning if this was required. The legal team carried out this task in order to ensure compliance with GDPR and limit access to data that was not required for the study.

Exclusion criteria was those cases whereby the category of abuse was sexual abuse and those cases where there was not a child in the family aged over 6 years. The exclusion criteria were designed in order to match the referral criteria of MST CAN.

Ethical considerations

The study was granted ethical approval by the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee and permission was granted by the Corporate Director for Children and Adults services in the Local Authority.

Procedures

Information about the families was gathered by the author from the electronic case records containing initial core assessments, parenting assessments, minutes from Child Protection Conferences and Looked After Child reviews. Also reviewed were; minutes from Legal Planning and Public Law Outline (PLO) meetings, Chronology lists, Local Authority position

statements prepared for courts, parent statements, witness statements, reports from expert witnesses and any other services that contributed to the court proceeding process.

All of the information gathered was retrospective as the Care Proceedings had ended. The LA position statements, and Chronology Lists were the most valuable data source providing details that were beneficial to the objectives of the study.

For the purpose of anonymity each case was assigned a case number and no identifiable data was recorded. Variables were coded by whether or not they were present (yes) or not (no) and numerical values.

For the purpose of identifying and recording engagement in this study engagement was identified using thematic analysis. Engagement was assessed using court reports that documented parental engagement in the process, individual reports from other professionals, CPP reviews, key words included: medication compliance, attendance at appointments, observed changes in behaviour, negative screens for alcohol/substances and engaged with parenting assessment. Of course a limitation is whether or not these things were reported. In chapter one, the concept of confirmatory bias was introduced and how this could impact on how someone both interprets and reports something.

Table 11: Variables identified to collect from the case files

- Single parent or not
- Gender of parent/s.
- Status of parent – single/married/divorce/separated
- Age of parents.
- Social economic status of parents – working FT/PT or not
- Who is the suspected perpetrator of abuse
- What was the discipline of original referral to CSC
- Number of children in the household.
- Gender of children
- Age of children – birth order.
- Type of maltreatment – physical abuse/emotional abuse/neglect/combination
- Engagement with services – Yes/No
- Parental substance use – will be a yes/no and current or historical concern.
- Parental Alcohol use will be a yes/no as above current or historical concern.
- Parental mental health issues – diagnosis
- Number of years known to CSC – numerical recording.
- Whether children had previously been removed from parental care yes/no.
- Length of time from 'front door' to proceedings – numerical recording.
- Length of CP plan – numerical recording.
- Whether case was within Public Law Outline (PLO) yes/no
- Categories of harm – physical abuse/neglect/emotional harm.
- Psychological reports and whether these indicate support which is within the children's time frame
- The wishes and feelings of the children – preference to live at home or to enter care.
- The parental views of where the children should live
- Accountability of parents and recognition of the concerns – yes or no.
- The emotional, behavioural and mental health of the children
- Is there any child substance/alcohol use?
- Has the children engaged in offending behaviour and are they known to YOT?
- Were the children resided during the process – home or not.
- What CSC were recommending at the final hearing
- Were the parents in care as children themselves? Yes or no.
- Were parents subjected to abuse in childhood
- Length of time Social worker has been qualified – numerical value.
- Domestic violence yes/no
- Learning Difficulties both parental and child yes/no

Analysis of the data for each family centred on the index child and the parent that they resided with who was considered to be the perpetrator of child abuse and/or neglect.

Treatment of results

The database consisted of the two cohorts of families whereby children remained in family care or not at the end of proceedings. Data frequencies were obtained to develop the profiles characteristics of each group. These characteristics were then correlated with whether or not children remained in the care of their family at the end of proceedings. A chi-squared analysis was carried out on the data to identify any statistically significant associations.

Results

Tables 12 (parental) and 13 (index child) present the demographic and psychosocial characteristics of the families at the start of proceedings. The similarities between the two groups were noticeable prior to the application of statistical tests. The demographics of the groups were very similar with the majority of caregivers being female, white, unemployed and in their thirties.

Table 12. Profiles of the parents during care proceedings

Characteristic	Care order % (n)	Supervision order
Total number of families	N=25	N=25
Number of children in family 2 3 4 5 6	N=72 40% (10) 40% (10) 16% (4) (0) 4% (1)	N=70 44% (11) 40% (10) 8% (2) 8% (2) (0)
Number of children <2	4	12
Single mum	60% (15)	64% (16)
Single dad	8% (2)	4% (1)
Couple living together	32% (8)	32% (8)
Female age 20-29 30-39 40-49 50+	36 (23) Range 24-47 (4) (10) (9) (0)	33 (24) Range 22-51 (10) (10) (3) (1)
Male age 20-29 30-39 40-49 50+	39 (10) Range 26-59 (3) (3) (2) (2)	38 (9) Range 24-53 (2) (2) (4) (1)
Ethnicity of primary caregiver		
White (includes White British and White other)	68% (17)	84% (21)
Black (includes Black African, Black Caribbean and Black other)	20% (5)	4% (1)
Asian	0%	8% (2)
Mixed	12% (3)	4% (1)
Socioeconomic status		
Working	4% (1)	8% (2)
U/E	96% (24)	92% (23)
Identified Perpetrator		
Perpetrator Mother	68% (17)	64% (16)
Perpetrator Father	16% (4)	16% (4)
Perpetrator Both	16% (4)	20% (5)
Type of abuse		
Neglect only	32% (8)	20% (5)
Physical Abuse only	4% (1)	20% (5)
Emotional Harm only	0%	0%

Combination of at least x2 categories	64% (16)	60% (15)
Who made the referral		
Police	44% (11)	36% (9)
Health	28% (7)	48% (12)
School	20% (5)	8% (2)
Anon	8% (2)	8% (2)
Average length of years known to Children's Social Services	6.84 range 0-16 years	6.88 range 0-16 years
Cases open in Public Law Outline prior to proceedings	36% (9)	28% (7)
Children in care during proceedings *	84% (21)	48% (12)
Previously had a child removed	4(16%)	2 (8%)
Where the children resided post proceedings		
In care	100% (25)	0% (0)
Home with mother Home with father Home with both parents	0% (0) 0% (0) 0% (0)	44% (11) 4% (1) 24% (6)
With wider family members	0% (0)	12% (3)
Removed from primary carer and placed with another parent	0% (0)	12% (3)
Friend of the family	0% (0)	4% (1)
Parental psychosocial factors		
Parental Substance use	52% (13)	40% (10)
Parental Alcohol use	60% (15)	48% (12)
Parental Mental Health	84% (21)	76% (19)
Parent abused in childhood	76% (19)	48% (12)
Parent in care during childhood	8% (2)	28% (7)
Experienced of Domestic Abuse	68% (17)	92% (23)
Parental Learning Disability	12% (3)	8% (2)
Perceived engagement with social care and other services *		
Engage Yes	8% (2)	40% (10)
Engage No	92% (23)	60% (15)
Accountability	8% (2)	24% (6)

*denotes a statistically significant difference at <.0.01%.

Table 13. Profiles of the children during care proceedings

Child Characteristic	**Care order**	**Supervision order**
Number of families	N=25	N=25
Age of Index child	10 (72) Range 6-17	10 (70) Range 6-17
Ethnicity of child		
White (includes White British and White other)	60% (15)	64% (16)
Black (includes Black African, Black Caribbean and Black other)	20% (5)	4% (1)
Asian	0%	8% (2)
Mixed Heritage	20% (5)	24% (6)
Children with Emotional and behavioural difficulties	92% (23)	84% (21)
Children with reported * Physical health issues	4% (1)	8% (2)
Children with reported * Learning Disabilities	4% (1)	4% (1)
Child SU/AU	8% (2)	12% (3)
YOT	16% (4)	4% (1)

* care should be taken as the absence of reported difficulties does not mean they were not present.

There a number of similarities observed between the two groups of children, including age, presenting with emotional and behavioural difficulties and the majority being white. The main difficulty that was most frequently reported in the case files were emotional and behavioural difficulties. These difficulties included hyperactivity, attention deficit, challenging behaviours at school, attachment issues and anxiety symptoms. Although not statistically different there were more children placed in care that were from BAME communities, the children were more

likely to have emotional and behavioural difficulties and there were also a higher number of children in this cohort that were known to the Youth offending team.

Data Analysis

The chi-squared analysis (see table 14) highlighted the similarities between the two groups and also demonstrated positive associations between perceived parental engagement and the child remaining at home at the end of Care Proceedings ($p<0.01$, one tailed). There was also a positive correlation between the outcome at the end of Care Proceedings and where the child resided during them ($p<0.01$, one tailed).

Table 14: Chi-squared analysis of Risk factor variables

Risk factor variable	**N**	**Chi-squared Value (df=1)**	***P-Value (2-tailed)***	***P-Value (1-tailed)***
Engagement with services *	50	15.062	0.00	0.000
Residing in care during proceedings *	50	9.191	0.005	0.03
Substance use	50	.725	0.571	0.285
Alcohol Use	50	.725	0.571	0.285
Mental health	50	.500	0.480	0.363
Case in PLO prior to Care Proceedings	50	0.095	1.000	0.500

*Denotes statistically significant difference at <0.01%.

Discussion

Of interest is the high proportion of supervision orders placed in this LA during the review period in contrast to national data. Harwin et al. (2018) reported that the use of SO was on average 14%, unfortunately the study did not collect the data for all orders only SO and CO but these figures were very close, indicating that the final outcome of SO is higher in this regional area than others (CO = 257 and SO = 236).

A large number of caregivers (76%) in the CO group had experienced child maltreatment whilst growing up and whilst this figure was lower (48%) for the parents whose children remained within the family at the end of Care Proceedings, a higher number of this group had been in care themselves (28%). These findings replicate those of Harwin et al. (2018) who compared the profiles of mothers engaged with the FDAC court with those engaged in Care Proceedings as usual and found that 27.5% of mothers had experienced being in care in childhood. Another finding was that a larger number of people in the SO group had experienced domestic abuse 92% compared with 68% in the CO group. This is perhaps unsurprising as changing living circumstances by the perpetrator leaving the home can result in a quick reduction of concerns, particularly around emotional abuse.

Unsurprisingly for both groups there was the presence of the 'toxic trio', experience of domestic abuse, current substance and/or alcohol use and mental health difficulties. Interestingly all three categories were higher in

the group whereby children were removed from parental care, though these differences were not statistically significant.

The majority of children in each group were cared for primarily by their mother. There were also 32% in each group who were cared for by both parents. Across the two group there were three fathers who were the primary caregivers of children.

The results of this study found that the majority of referrals to Children's Social care came from the Police (40%), Health (38%) and Schools (14%). This mirrors national statistics as reported by the DfE (2018). It also highlights the lack of referrals received from agencies working with families to address difficulties such as substance use as identified by Forrester & Harwin (2007).

The majority of cases examined within this study had been 'known' to Children's Services' for a number of years prior to the care proceedings which were reviewed. On average this had been for almost seven years but was as long as 16 years for some. For those open for longer periods there tended to be other children that had been removed from parental care in the past and a higher rate of previous CPP. This previous history indicates a need to do something different than treatment as usual as previous interventions have not been effective or cases would not be re-referred. In addition, this finding indicates that there have been earlier opportunities to provide support. Masson et al. (2018) suggest that

extensive support is required post Care Proceedings and social workers should be cautious about closing too soon after the spotlight of the court process has ended. Maybe this suggestion could be generalised to the closure of Child Protection Plans (CPP) given the length of time the majority of families were known to Children's Social Care prior to Care Proceedings and 92% of the families (48) included in the study had at least one previous CPP.

An interesting finding was the number of children who remained in parental care during proceedings which was overall 60%. There was a much higher proportion of children in care during the process who were removed on a care order in the final hearing (84%). This was compared with only 48% of children who remained within the family at the end of care proceedings on a SO. These figures are much higher than those observed by Masson et al. (2019). This could be partially contributed to the fact that all of the proceedings within this study were initiated post changes arising in the Children's and Families Act 2014.

The high presence of psychosocial difficulties for parents in Care Proceedings in this study reinforces the findings of other studies (Harwin et al. 2018 & Trowler 2018). Sadly, the generational cycle of abuse is highlighted by the number of parents who experienced maltreatment as a child themselves with almost a third having experienced being removed from their parents and placed in the care system.

Surprisingly, very few cases in either group were subject to pre Care Proceedings using the Public Law Outline (PLO) process before entering the family court arena. This is an interesting outcome, especially for the cases where the children remained within family care on a supervision order at the end of proceedings. PLO was introduced as a tool to divert cases from care and studies have shown that it can be useful. However, in this LA it does not appear to have been utilised as much as it could have been with only 16/50 cases being subject to PLO prior to care proceedings. In line with recommendations by Trowler (2018), it begs the question of whether these cases could have been diverted from Care Proceedings and worked within Public Law Outline.

The importance of engaging families during Care Proceedings is demonstrated in this study as this factor was significantly associated with children remaining with their families at the end of Care Proceedings. The care crisis review (2018) highlighted how some family members find the care proceedings process adversarial and can feel like there is no hope and give up. This could have contributed to the perceived low engagement for this group. The finding of poor engagement alongside issues of domestic abuse, mental health difficulties and alcohol and/or substance use, replicated the findings of Masson et al. (2019). There is a vast amount of literature pointing out that due to the adversarial nature of Care Proceedings the relationships between parents and social workers is often

conflictual and at times hostile (e.g. Platt and Riches, 2016). Platt and Riches (2016b) have developed a C-Change Manual which could be useful for social workers to be aware of and implement recommendations to increase family engagement. Investment in training could be effective in supporting social workers to develop motivational interviewing techniques to increase parental awareness of the risk of harm they present and enhance motivation to change identified risk factors. Motivation to change is discussed more in depth in chapter five in a critique of the URICA and its use with adults who use alcohol and/or substances.

The other statistically significant finding, associated with children remaining in the care of their family at the end of proceedings, was where they resided during proceedings. Those who were in care at the start of proceedings were more likely to remain in care at the end of proceedings. This is not a surprising finding as it could be argued that those most at risk had to be removed from parental care and the lack of engagement with social workers and other services did not provide evidence of behavioural change or reduction in risk. In contrast, those with the children at home have more opportunity to demonstrate a change in behaviour and whether or not this can be sustained. One hypothesis around these findings could be that those parents whose children remain in their care during Care Proceedings are more hopeful about them remaining in their care and more willing to attempt change.

Limitations

One limitation of this study, is it having a small sample size, a small sample size can impact on statistical reliability and may prevent differences from being observed, increase the risk of error and can undermine the internal and external validity of a study (Faber & Fonseca, 2014). Another limitation is that the data collected from the files was carried out solely by the author which increases the risk of confirmatory bias. The study could have been strengthened by having another researcher review a subsection of files to check inter-rater reliability on identifying less measureable factors such as 'engagement'. Another factor to consider is that this cohort of care proceedings differs from other studies in that it focuses on those cases with children.

A limitation of all studies that rely upon past records is that they may contain information that is biased, there can often be missing information and may not provide the whole picture. Some information may not have been recorded or known to the writers of the reports for example, domestic abuse is not always reported. A learning point for the author was that the original list of variables to be collected was ambitious. Not all reports detailed the child's wishes of where they wanted to reside or even the viewpoints of the parents. The experience of carrying out the study illustrated how it is more difficult to collect qualitative information than

quantitative and the use of robust definitions is important to reduce risk of bias whilst collecting data.

Another limitation of the study is that it is only focussed on the outcomes of Care Proceedings of one Local Authority which again could limit generalisations, given the regional differences in the use of SO (Harwin et al, (2019). Despite these limitations, it was reassuring to see that the findings replicate those reported by Harwin et al. (2018) and the DfE (2018).

In hindsight, the study could have been strengthened if the original application for S31 were recorded and whether these differed from the final care order outcome.

Conclusion

This study, whilst limited to one local authority, has demonstrated that the majority of cases presented at court for Care Proceedings have a significant number of needs and risk factors. Distinguishing between those cases that are likely to engage in services and address the risk factors associated with child abuse and neglect is a challenge for those working in the arena of Child Protection. There were only two significant differences identified between the two groups in this study and these were perceived engagement and where the children resided during Care Proceedings. For the majority of the characteristics analysed there were no significant

differences between them. This finding has been observed in other studies comparing family characteristics between groups at the start of proceedings (e.g. Harwin et al, 2018). However, a number of difference were observed whilst not statistically different which provide some insight into the historical difficulties experienced by parents who find themselves known to children services. Many of them have experienced multiple traumas and these have been throughout their lives from childhood. Adverse childhood experiences have been shown to significantly impact many people in adulthood (Bellis et al, 2015). Increased awareness of this and services being trauma informed, is a step in the right direction however, for this awareness to impact on practice more work is required to help teams view families through a trauma informed lens whilst engaging them in a process that is itself traumatic.

The findings of this study highlight the need for timelier interventions for high need and high-risk families that are able to address the multiple difficulties effectively. Two emerging interventions in England that are designed to address substance and/or alcohol use alongside other factors are the FDAC and MST CAN, unfortunately these interventions are currently limited in England and not on offer to families in many local authorities. There are plans to increase the offer of specialist support to families (FDAC National Unit, 2019) under the heading of Supporting Families; Investing

in Practice. This is a welcome investment in the arena of supporting families to live together safely, if possible. However, it is essential to ensure that investments are made to provide evidenced based interventions that work and address the risk factors and minimise future risk of harm. Lessons could be learned from the substantial amount of literature in the area of 'what works' in addressing offending behaviour (e.g. Craig, Gannon & Dixon, Farrell, 2013). Broadhurst and Bedston (2017) point out that the family justice system lags behind the criminal justice system in its awareness of reducing 'recidivism' and investing in services to achieve this. Recidivism is an important factor in care proceedings due to the high number of women who are repeat clients in the English family court system. Similarly, to custodial sentences having little impact on recidivism for the majority of offenders, the devastating consequences of having children removed do not necessarily lead to a change in behaviour or reduction in original concerns (Broadhurst & Bedston, 2017). For some women they lose multiple children through the system and fail to be offered or engage with the right help at the right time. Within this study 6/50 women had previously experienced having a child removed from their care.

This study has highlighted how parental engagement was positively associated with children remaining within their families at the end of Care Proceedings. Engagement is important especially as it has been highlighted in several SCR as a significant risk factor associated with child deaths. More

research needs to be carried out looking at how barriers between families and social workers can be reduced and how to increase engagement with social care and the support being offered.

Another area of interest is the most common approach to addressing alcohol and substance use in England is harm reduction (Harwin et al. 2018). However, this may not best meet the needs of families in Care Proceedings due to the restricted time scale and the urgency around change being demonstrated. Abstinence may be a better approach and is often what social workers are recommending, however this recommendation is setting parents up to fail is support in doing this is not offered routinely or available in some areas.

The next chapter describes the work of a family referred to MST CAN to address the risk factors of parental alcohol and substance use, parental mental health, child behavioural difficulties and parenting techniques. The family psychosocial profile is similar to those included in this study, with multiple traumas being central to the parental presentation.

Chapter Four - A case study of addressing Child Abuse and Neglect risk factors utilising Multisystemic Therapy-Child Abuse and Neglect (MST CAN)

Abstract

With increasing numbers of children being placed on Child Protection Plans in the categories of Physical harm, Neglect and Emotional Harm, there is a renewed focus on ensuring that families are offered evidence-based interventions to address these concerns and reduce risk of harm to children in their care-givers care. Multisystemic therapy for child abuse and neglect (MST CAN) is the only intervention recommended within National Institute of Health and Care Excellence (NICE) guidelines to address multiple risk factors of child abuse and/or neglect by one team. This single case study design presents a single parent family with five children aged between two and fifteen, referred to MST CAN, to address the child protection concerns raised by Children's Social Services. The children were subject to Child Protection Plans under the category of neglect. This intervention targeted the identified risk factors that were perpetuating the neglect, including substance and alcohol use and mental health difficulties. At the end of the intervention, the family had achieved significant change as evidenced by; improved school attendance, no further episodes of children going missing, parental abstinence from alcohol and substances, improved parental and child mental health and improved family functioning. The family were no longer subject to Child Protection Plans at the end of the intervention and this was sustained eighteen months later.

Introduction

The number of applications into public care proceedings due to concerns around significant risk of harm to children has more than doubled over the past twelve years (Trowler, 2018). With increasing numbers of families entering the court arena there has also been an increase in the use of Supervision Orders at the end of care proceedings with children remaining in either their parents or extended family members care. Trowler (2018) suggests that for those families whereby the decision to remove a child from their caregivers could go either way, consideration should be given to whether they should be diverted away from court from the outset. In a review of care proceedings in four Local Authorities, Trowler (2018) reported that 34% of court disposals resulted in Supervision Orders, this figure has increased threefold since 2011. The need for evidenced based interventions that support the whole family is a key message from the paper. Currently, in England the majority of Local Authorities are reliant upon families accessing treatment to address risk factors which perpetuate abuse (e.g. mental health difficulties and/or substance use) from universal services. This can be problematic for a number of reasons. For example, there is increasing demand for support with mental health difficulties (Baker, 2018) and there have been a number of budget cuts which have impacted on the provision of support for those with alcohol and substance

use issues. A BBC analysis found that budget cuts to drug and alcohol services since 2013 were 18% (Rhodes, 2018).

MST CAN offers Local Authorities and commissioners a bespoke intervention which is tailor-made to meet the multiple needs of the referred family in order to minimise risk of future physical abuse and/or neglect. It is the only intervention currently offered in the UK that addresses the multiple risk factors. This is carried out by one team who work alongside the existing ecology of the family and Children's Social Services. More traditional approaches to address these needs have involved scattergun type referrals to multiple agencies to address identified parenting needs, substance use and/or mental health. This approach is often unsuccessful, in part due to the lack of co-ordination and communication between services caused by issues such as different IT/recording systems, service demands and non-attendance at assessments resulting in discharge.

The aim of this chapter is to present a single design case study of MST CAN and examine its effectiveness in addressing the multiple parental factors that contribute to the overall risk of significant harm of child abuse and neglect.

In the wake of serious case reviews there is an increased understanding of the escalation of risk of significant harm presented to children whereby the 'trilogy of harm' is present in the home. The toxic trio which is shared with

professionals working with adults and children in safeguarding training includes parental mental health difficulties, parental substance abuse and domestic violence (current or historical).

De Bortoli et al (2013) report that parental substance misuse is significantly associated with physical abuse and neglect even when controlling for other known risk factors including parental mental health, deprivation and household size. They summarise that parental substance use of illicit substances is associated with an increased risk of child removal from parental care. In their study of Australian child protection cases that were being presented at court they found the most commonly misused substances were alcohol and cannabis. This finding was also reported by Kamphuis et al (2015) in their study of MST CAN.

What is MST CAN

MST CAN is one of several adaptations of Standard MST. Standard MST is an evidenced based intervention that aims to address teenage antisocial behaviour and conduct difficulties. The intervention was developed in the late 70's (Henggeler et al, 2009), has over sixty-two published outcome studies and over one hundred and twenty published articles (MST Group, 2017). MST standard is recommended within the NICE guidance (2013) as

an intervention for conduct disorder that can be an emerging indicator for the later development of Anti-Social Personality Disorder. There are some similarities and differences between the two: both interventions follow the MST theory of change and offer a range of evidenced based interventions that are too vast to detail here (please see Henggeler et al., 2009) for more information). The differences between the two include: Standard MST is aimed at young people aged between eleven and seventeen and the majority of work is carried out with the caregiver to address the multiple factors for the young person's difficulties. Whereas, in MST CAN the majority of work carried out with the adult caregiver is to address the risk factors for child abuse and neglect that is linked to their behaviour, e.g. parental substance use, parental mental health or parenting skills.

The four overarching aims of the MST CAN model are (Schaeffer and Swenson, 2018):

1. Keep families together safely.
2. Prevent re-abuse and neglect.
3. Reduce mental health difficulties experienced by adults and children.
4. Increase natural social supports.
5.

In both versions of MST, individual interventions with the child/ren will take place if clinically appropriate and systemic interventions with some or all

family members may be offered. The two interventions differ in length with Standard MST being between 3-5 months' duration whereas MST CAN is 6-9 months. For both interventions the number of weekly sessions match clinical need, so could be daily and telephone support is available to families 24/7.

In addition to the Standard MST range of interventions, MST CAN offers additional evidenced-based interventions including; family safety planning; functional analyses of physical abuse incidents; Reinforcement Based Therapy (RBT) for substance/alcohol misuse; Trauma Focused Therapy for both adults (Prolonged Exposure; Foa et al, 2007) and children (Trauma-Focused Cognitive Behavioural Therapy for Children; Cohen et. al, 2006) to address Post Traumatic Stress Disorder (PTSD); Anger Management a 12-session programme (Novoco, 1975) and family communication training. Lastly, a clarification process that involves the parent taking responsibility for their behaviour and admitting to their children the reasons for them being open to Social Services as well as what has changed and how it will be maintained. Each intervention is individually tailored to meet the needs of the referred family.

Theoretical basis

The underpinning of the MST theory of change is Bronfenbrenner's (1979) theory of social ecology. An assumption of this theory is that individual behaviour is multi-determined, that is a number of systems influence and impact on the behaviour of individuals. Henggeler et al (2009), point out that in contrast to other family systems theories the ecological theory is much broader in its way of conceptualising this. They advocate that in MST assessments, consideration for the possible contributions to behaviour problems occur both between and within systems. For example, childhood neglect can be driven by many factors such as social isolation, mental health difficulties, substance/alcohol use and poverty. MST and MST CAN are licensed interventions that are quality assured at local, national and international levels.

Similarly, to MST, MST CAN interventions involve therapists and families working collaboratively through the analytical process (aka 'the MST do loop') and following the nine MST principles (see table 15) in order to effect change. Within MST the analytical process is the underpinning of assessment, formulation and treatment planning. Once difficulties are formulated, interventions can be tailored to address the issues. The initial focus within MST CAN is on addressing safety concerns and then working through the referral behaviours in a systematic way, prioritising drivers and

developing interventions, testing them out and then reviewing the advances and barriers of these.

Table 15: MST Principles Henggeler et al (2009) page 15

9 MST principles *
1. Finding the Fit – the purpose of assessment is to find the 'fit' between the referral behaviours and their broader systemic context.
2. Positive & Strength Focused – therapists should be strength focused and use family strengths as levers for change.
3. Increasing Responsibility – interventions should be designed to promote increased responsibility and decrease irresponsible behaviour amongst family members.
4. Present-focused, Action-oriented & Well-defined – interventions should be well defined – SMART and measurable.
5. Targeting Sequences – interventions should target sequences of behaviour within and between multiple systems, which maintain the problem.
6. Developmentally Appropriate – interventions should be developmentally appropriate and fit the developmental needs of the youth. They should also be appropriate and fit the needs of the parent.
7. Continuous Effort – interventions should require daily or weekly effort by the family members.
8. Evaluation and Accountability – success of interventions is evaluated using the perspectives of multiple systems.
9. Generalization – interventions should promote treatment generalisation and long-term maintenance of change by empowering caregivers to address difficulties across multiple systems.
* Fidelity is assessed by therapist and supervisor adherence to these principles

How MST CAN is implemented

MST CAN is implemented by a team comprising of a supervisor (this was the role of the author of this thesis), three therapists, a crisis support

worker, Psychiatrist (one day a week) and consultant. Each therapist holds a small caseload of three to four families as all family members are the focus of then intervention. On average five people within each family are offered treatment (Stallman et al, 2010).

Treatment length is between 6-9 months and families are seen as much is needed to match clinical demand. Initially this can be daily and tapers off towards the end of treatment. Services are offered usually within the home or other places that match the needs of the family. The team work flexibly to meet the needs of the family, offering early or late appointments if necessary. The family also have access to support 24/7.

Comparable to accredited offending behaviour programmes, treatment integrity and fidelity to the model is an essential part of the delivery of MST CAN. It is a licensed intervention that is overseen by MST Services. To ensure that MST CAN is delivered as closely to the clinical trials of its evidence base, the team attend Standard MST training, MST CAN training and specific training on delivering the Trauma focussed interventions. Quarterly booster training is provided for the team by the MST CAN consultant. The supervisor engages in weekly supervision with the consultant to ensure there is convergence on the weekly intervention plans.

The whole team have weekly face to face supervision with the MST CAN supervisor and group teleconsultation with the MST CAN consultant. Families complete a monthly telephone interview completing the Therapist Adherence Measure Revised for (TAM-R) that measures therapist adherence to the model. Therapist's complete a Supervisor Adherence Measure (SAM) on a bi-monthly basis. The whole team complete a Consultant Adherence Measure (CAM) on a bimonthly basis. These quality assurance processes help to identify the strengths and needs of the team and promote development of an effective service for families.

Engagement

For many universal and specialist services, attendance at appointments is the responsibility of the service user and non-attendance at appointments can often lead to discharge and withdrawal of treatment. Non-attendance at recommended treatment appointments can increase the risk of children being removed from their parents in cases where there is child abuse and/or neglect (Shaeffer & Swenson, 2018). In MST CAN non-attendance is considered systemically and the team are responsible for understanding the reasons behind disengagement and address these as part of the intervention.

For families engaged in child protection processes they may have difficulties engaging in services due to low trust, poor past experiences and a fear of being honest resulting in removal of children (Wilkins, 2017). Collaboratively identifying and working through these barriers is the responsibility of the MST CAN team. Engagement with services is an important aspect to consider within the area of child protection as it has been highlighted as a significant risk factor in numerous serious case reviews in the UK and child fatalities in the USA (Platt & Riches, 2016). Platt and Riches (2016) suggest that parental engagement with services can have a significant impact on decision around child protection and whether or not a child should remain in parental care. However, engagement alone does not represent a reduction in risk. This is evidenced by behavioural changes that are observed as well as self-reported and evidenced from a range of sources involved in the family ecology. In the UK there has been increased concerns around the concept of 'disguised compliance' whereby a family appears to engage with services or 'pretends' to make changes, however, fails to sustain any change and there is little if any reduction in the concerns. In serious case reviews disguised compliance has involved parents actively attempting to deceive professionals and hide significant harm. There has however, been an

overuse of the term used to describe parents who present with some resistance or ambivalence around change (Wilkins, 2017).

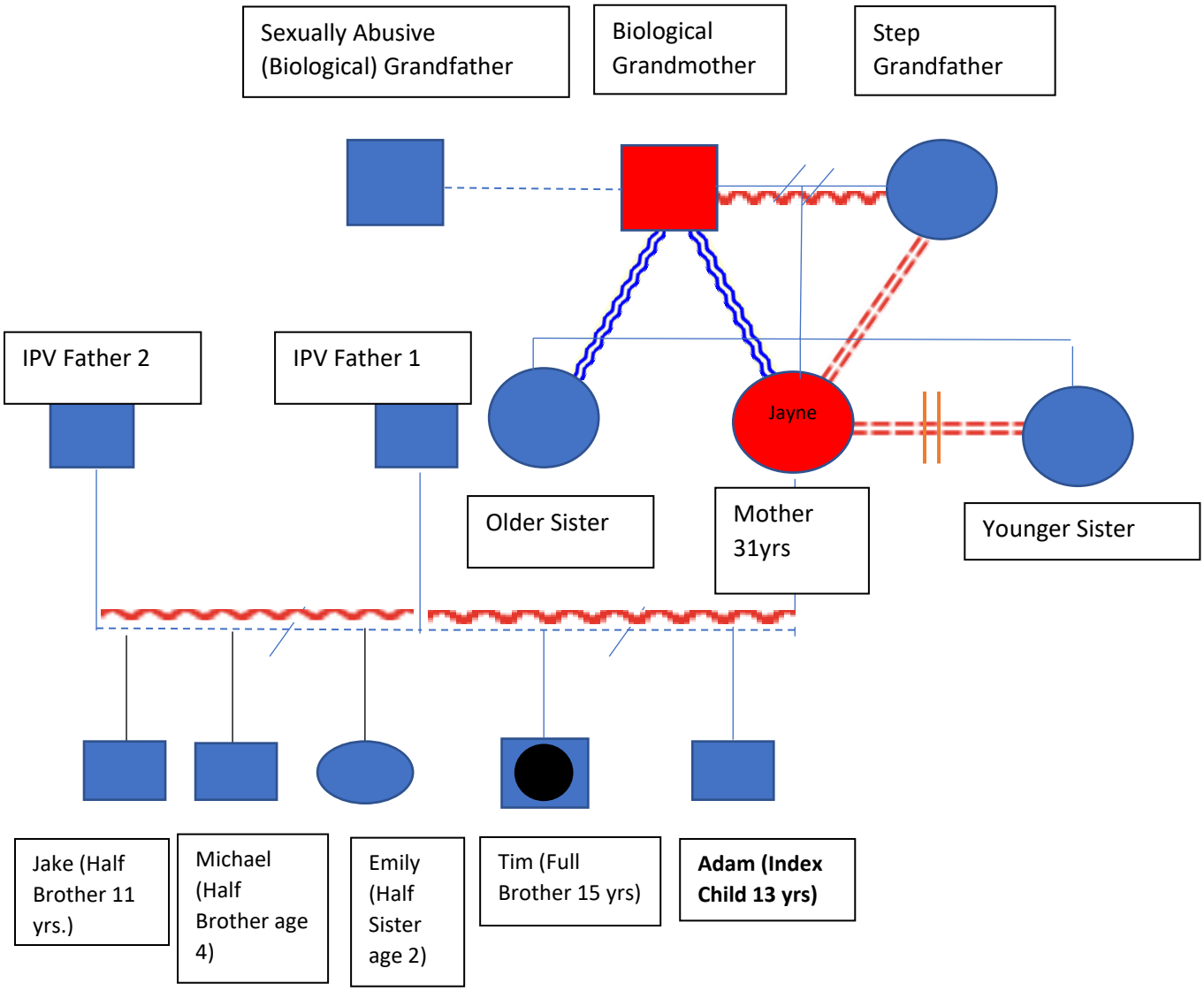
The case-study

Ethical considerations

This single design case study summarises the work carried out with the pseudonym 'Jayne' and her family. During the course of the intervention with Jayne, the author ensured that the British Psychological Society ([BPS], 2009), British Association of Cognitive and Behavioural Psychotherapists (BABCP) and Health and Care Professionals Council ([HCPC], 2016) code of ethics and conduct were adhered to. Full information was provided to the service user about the author engaging in a programme of doctorate study and consent was obtained in order for the family intervention to be written up as a case study for research. It was emphasised that they could withdraw their consent immediately or at any time and this would have no impact whatsoever on the interventions and support they were receiving from the team. The consent form can be seen in Appendix D. All work carried out with Jayne and her family was overseen by the external MST CAN consultant.

To ensure anonymity all references used throughout the case study for the family are pseudonyms. Thirteen-year old Adam and his family were referred to MST CAN after an escalation in concerns about the care and protection of the children. A Section 47 (S47) inquiry led to all five children in the family being placed on a Child Protection Plan under the category of neglect. Prior to referral to MST CAN the family had been accessing support from another intervention service offered within the Local Authority (LA) for families at the edge of care. However, gains had not been sustained and concerns actually increased with the family moving upwards from a Child in Need Plan to a Child Protection Plan. The significant harm concerns included low supervision and monitoring of the children, verbal aggression towards at least one of the children (Jake) and poor school attendance (including late arrival). There were also concerns around parental substance abuse. Jayne (mother) was in her early thirties and a single parent to five children aged between three and fifteen years old. There was very little involvement of the children's fathers as both had been perpetrators of domestic abuse and there were concerns about the children being unsupervised in their care.

Figure 7: Genogram of the family



Assessment

Background history: Jayne shared that she was the middle of three siblings (all females). They had resided with both biological parents until Jayne was approximately aged thirteen. Jayne described how both herself and her eldest sister were subjected to penetrative sexual abuse (incest)

from their biological father for around seven years, Jayne was aged between six and thirteen at the time of the abuse.

- Relationships: Jayne has a small support network. At the time of referral, she was in contact with her mother, stepdad and the eldest of her two sisters. Jayne described how she had been in two long-term intimate relationships with males. Her first long term partner was fifteen years her senior when they engaged in a relationship. Jayne was sixteen when this relationship commenced, and they had two children together. Jayne later had a second long-term relationship at age twenty-one with a male who was closer in age to her, they had three children together. Both partners were perpetrators of domestic abuse to her. These relationships had impacted on Jayne having no friendship network as both partners were controlling. Jayne separated from her second partner after nine years (aged 30). Jayne had been single approximately eighteen months at the time of the referral to MST CAN.
- Education/Employment history: Jayne described how she had truanted from school and struggled at times with her education due to the abuse she both experienced (sexual) and witnessed at home (domestic violence). She did sit some exams and described how she had enjoyed art and cookery. Jayne described how her role has

mostly been as a homemaker since working age and she had little employment history.

- Physical health: Jayne had a diagnosis of Fibromyalgia for four years prior to referral and described how she would often experience fatigue and pain.
- Mental Health: Jayne had a diagnosis of Depression from her GP and presented with symptoms indicative of PTSD, including avoidance of thoughts, people and places, hyper arousal for danger and flashbacks of her abuse.
- Substance use: Jayne described how she had started smoking tobacco aged eleven. She tried cannabis in her teens and from her mid-teens had regularly drank alcohol. At the start of the assessment, Jayne shared that she smoked cannabis daily to manage her pain and occasionally drank alcohol.
- Forensic history: There had been a number of referrals to Children's Social Services during the previous fifteen years, with concerns around domestic violence, parental substance use and neglect. Other than the referrals to Social Services and Child Protection concerns, Jayne did not have a forensic history.

Pre-intervention psychometrics

Jayne completed self-report measures, commonly used in England to assess mental health. The clinical scores given by Jayne at the start of

treatment were indicative of someone experiencing severe depression, severe anxiety and PTSD Symptoms. The results were as follows; Patient Health Questionnaire 9 (PHQ9) Score 25. Generalised Anxiety Disorder 21 (GAD7) Score 15. Impact of Events Scale – Revised (IES-R) score 83. The symptoms described by Jayne met the criteria outlined by the Diagnostic and Statistical Manual for Mental Disorders, fifth edition (DSM-V) for PTSD.

Formulation and identification of target areas

Predisposing factors

- Jayne was raised by her mother and father until she was thirteen. Her father left the family home to escape justice after she had disclosed to a teacher that he had been sexually abusing her for several years. Jayne described how she had experienced a challenging childhood with significant trauma. She reported recollecting her father beating her mother on many occasions and once witnessed him holding her mother over a bridge whilst threatening to kill her. Jayne shared that her father was an alcoholic and his behaviour was unpredictable. She shared how she was often anxious in her childhood and liked to spend as much time as possible away from the home.
- Jayne described a difficult relationship with her mother and her youngest sister. She shared how she felt it was unfair that her youngest sister had experienced what she believed was a much

easier life than her and she was angry with her mother for not protecting her when she first disclosed that she was being sexually abused.

- Jayne described how her relationships with both her partners had been domestically violent and the three eldest children had witnessed this spousal abuse.

Precipitating factors

- The ending of a long-term violent relationship and becoming a single parent.
- Difficulties in meeting the needs of five children of varying ages. Having to take the children to three different locations to attend education each morning. Struggling to manage fibromyalgia and depressive symptoms and not taking medication as prescribed. When she was tired Jayne was more likely to shout at the children or be lenient. For example, not following through with curfew times or not getting up with the children in a morning.
- Once a therapeutic relationship had been developed with Jayne, she was able to honestly share the level of her alcohol and substance use. Both were identified drivers for neglecting to meet the children's needs.

Perpetuating factors

- Alcohol and substance use.
- Jayne was socially isolated with little support and was reliant inappropriately on support from teenagers in the community. Jayne behaved as a friend with local teenagers rather than as an appropriate adult, as evidenced by her fracturing her arm when 'play fighting' with a teenaged male.
- Jayne did not take medication as prescribed to manage her pain or depression, this led to an escalation in symptoms which in turn made the situation worse.
- Felt guilty about the situation and wanted to make things better often by permissive parenting.

Protective factors

- Jayne wanted support for the family and wanted to be able to meet the children's needs. Jayne wanted to overcome difficulties in effectively managing the children's behaviour. She wanted to move away from the friend role that she had engaged in with her children to a parental role with clear boundaries and expectations of them.
- Jayne ended her past intimate relationship when concerns were raised about the risk of violent harm presented to the children.

MST CAN assessment

The initial stages of the MST CAN intervention include eliciting the family strengths, needs (see table 16) and individual goals of treatment. This then informs the collaborative development of overarching goals with the family (see table 17). Once these goals are developed, the fit of each problem area is developed, identifying the drivers that keep this problem going (see figure 8 for an example of this).

Table 16: Family Ecological Strengths and Weaknesses

System	**Systemic strengths**	**Systemic areas of need**
Index Child Adam aged 13	• Is bright and capable of achieving GCSE's • Academically gifted	• Isolated at school due to displaying sexualised behaviour two years earlier • Engages in self-harming behaviour – has cut superficially upwards of 50 times in one sitting • Recent bereavement of close friend • Smokes cannabis
Child Tim Age 15	• Engaged well and has accessed support from CAMHS • Able to express self creatively – enjoys art • Will ask for help	• Highly anxious and this can impact school attendance • Has engaged in self-harming behaviours • Has taken a young carer role in the home • Spends a lot of

		time isolated in bedroom when not looking after siblings
Child Jake aged 11	• Can be humorous and kind	• At risk of exclusion from school • Verbally and physically aggressive in school and at home
Child Michael aged 4	• Meeting developmental milestones • Happy at nursery	• Starting to present with some aggressive behaviour towards siblings
Child Emily aged 2	• Meeting milestones • Presents as happy	
Parent Jayne	• Warm towards all of the children • Ended relationship to safeguard the children from further harm witnessing domestic abuse	• Substance use • Mental health • Permissive parenting style • Not managing pain with prescribed medication and pain management strategies
Extended family	• Some contact with extended family (mother and older sister) • Stepfather helps with practical difficulties	• Rarely asks family for any support • Has estranged relationship with younger sister
Friend – Adam	• Has one prosocial peer	• Association with negative peers • Peers smoke cannabis • Peers are known to YOT
Community	• The area does have a nice park • There is a library	• Current house is damp and overcrowded • Low level of activities available in the area • Children attend schools in different area

Table 17: Overarching goals collaboratively developed with the family

1. Jayne to abstain from the use of alcohol and cannabis as evidenced by negative screens.
2. Jayne to manage her symptoms of depression using adaptive coping strategies rather than self-medicating. As evidenced by self-reporting, observation and negative screens for substances.
3. Jayne will keep the children safe by increasing her monitoring and supervision, evidenced by knowing Where, Who, When and What they are doing. Also, by monitoring what they are watching and sending on social media/mobiles/play station. As evidenced by no missing reports, observations when in the home and self-reports from the family.
4. Jayne will use appropriate strategies to manage the children's behaviour, as evidenced by self-reporting, reports from the children and observations.
5. Jayne will ensure that the children attend school daily and on time, unless they are unwell. As evidenced by school attendance records.

Formulation and development of target areas

Engaging Jayne in addressing cannabis and alcohol use

As evident in the 'fit' (principle 1) of the problem below in figure 8, there were several drivers maintaining Jayne's use of cannabis. One of the most powerful drivers was the belief that this was an effective pain relief for her Fibromyalgia. Jayne expressed that she would "rather be stoned than exhausted and in pain". We prioritised increasing other ways of managing this pain, including a review of medication with the GP, providing psychoeducation of the 'boom and bust' cycle, reviewing routines, prioritising tasks and scheduling regular periods of rest. However, whilst these interventions did not lead to abstinence initially, they did lead to a reduction in self-reported pain.

We then moved on to addressing some of the unhelpful beliefs maintaining the substance use. This was done by utilising motivational interviewing techniques (Miller and Rollnick, 2014) including; completing decisional balances on both changing behaviour or staying the same, using Socratic questioning to elicit change statements, completing measures to assess whether usage was problematic and then finally shared this utilising the 'confidential feedback report', which aims to summarise the issues.

Figure 8: The 'Fit' of Jayne's cannabis use

During this time, it was essential to motivate and support the therapist to continue to work on the issue and align Jayne to the intervention of RBT. The therapist had expressed concerns that she was repeatedly going over something that Jayne was reluctant to work on and was concerned about the potential impact on therapeutic alliance. However, addressing Jayne's cannabis use was prioritised as essential. It was a powerful driver to the neglect the children were experiencing. Jayne's eldest child was taking on a carer role when she was outside smoking and morning routines were disrupted, with things often being chaotic which led to her shouting at the children. The chaos in a morning was particularly difficult for Jake who would often present as challenging and aggressive at school.

As part of the RBT process 'motivation to change' was assessed using the University of Rhode Island Change Assessment (URICA) (Diclemente & Hughes, 1990). Jayne's initial answers indicated that she was in contemplation about change, this was shared with her as part of the confidential feedback report. This session appeared to lead to a shift for Jayne and she stated that she was willing to engage in RBT for her cannabis use and wanted to aim for abstinence. It was at this point she also disclosed that she was drinking every evening. As RBT is an abstinence-based model rather than reduction, we repeated the process of assessment focussing on alcohol use. Jayne was initially in precontemplation about changing this behaviour, with some pro use beliefs such as 'everyone does it', it's not

illegal', 'it's a treat' so we worked collaboratively with Jayne using the motivational interviewing techniques described earlier to elicit change statements and increase awareness of the unintended consequences of use. We were then able to move towards action around her alcohol consumption.

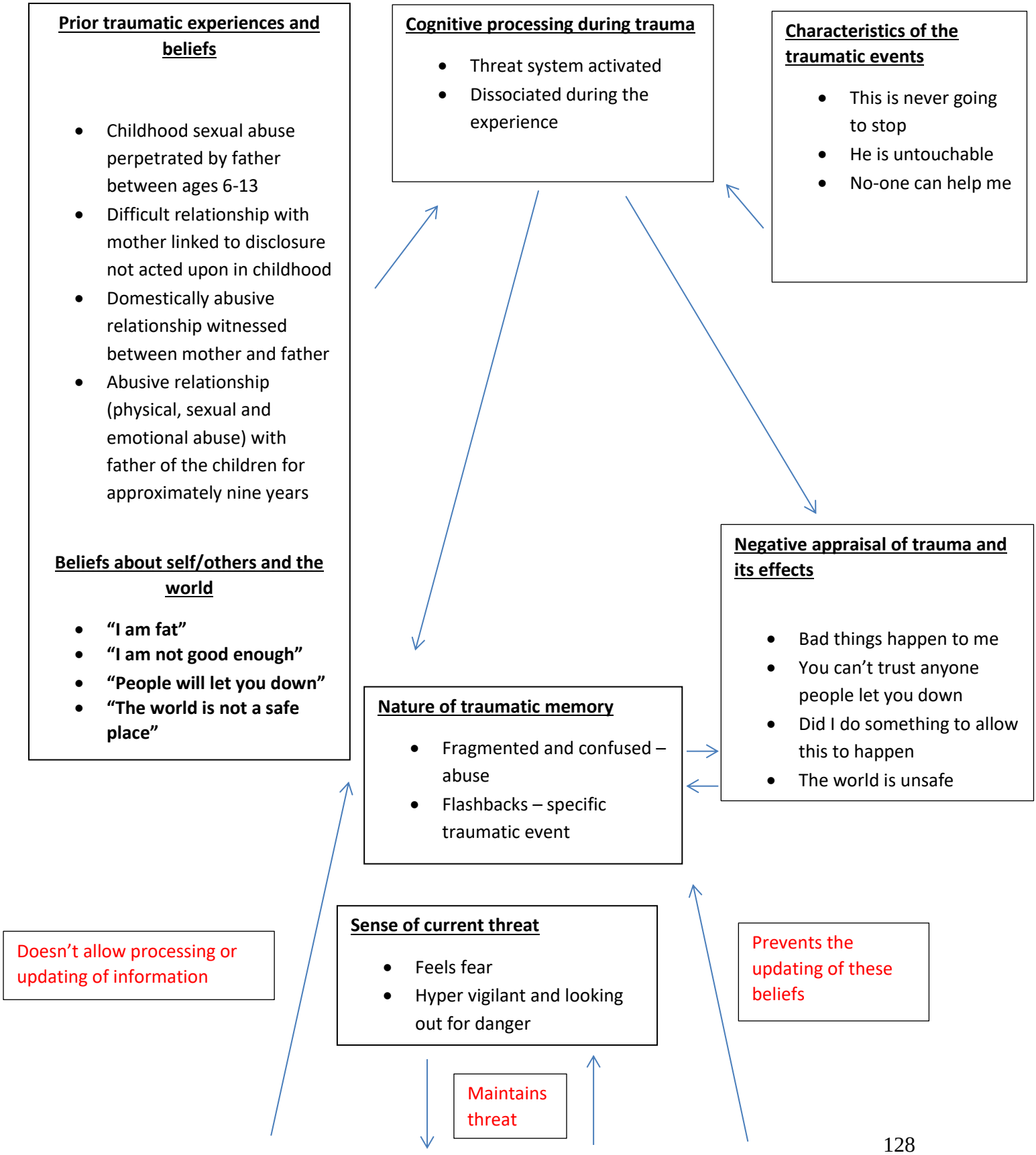
Engaging Jayne in Prolonged Exposure to address symptoms of PTSD.

The use of Functional Analysis to understand Jayne's cannabis and alcohol use highlighted that a trigger was symptoms of PTSD (see figure 9 for formulation), such as flashbacks, nightmares and unhelpful thoughts. These were predominantly linked to the sexual abuse Jayne experienced in her childhood. Jayne reported that after a nightmare and being unable to return to sleep she would use cannabis. In order to minimise the risk of nightmares she would drink alcohol before going to bed on an evening.

Prolonged Exposure treatment is an evidenced-based intervention recommended within NICE guidance to reduce the following three main factors that prolong trauma-related difficulties:

- Avoidance of trauma-related situations, places and people.
- Avoidance of trauma-related thoughts and images.
- The presence of unhelpful or inaccurate cognitions.

Figure 9: Formulation of Jayne's Post-Traumatic Stress Disorder



Understandably the thought of reliving and exposure was anxiety provoking to Jayne. However, she was tired of feeling how she did and after the rationale for treatment was shared, she became hopeful that it could be effective. A key message was that the process would not be creating any new memories but would be processing those that are already present and causing distress.

Intervention and outcomes

Several interventions were implemented with the family to address the overarching goals defined at the start of the therapy; these are summarised in table 18. Treatment outcomes were measured by observation, parent, child and extended family reports and the use of clinical outcome measures. A successful outcome was determined by evidence of a reduction in risk factors and an increase in protective factors. Reduced risk factors included: negative screens for substances use, improved mental health. Increased protective factors included; the family having a wider informal support network, increased supervision and care, as evidenced by no missing episodes and increased attendance at school on time and with no reports of negative behaviour.

Table 18: Summary of treatment interventions

Goal	Treatment	Overview of Treatment	Length of treatment
Substance use Cannabis and alcohol.	Reinforcement based therapy	Random drug/alcohol screens and alcohol breath tests, voucher reward system.	RBT process commenced one month into treatment after Jayne disclosed

		Assessment of motivation to change (URICA) and use of motivational interviewing techniques such as decisional balance, costs and benefits analysis and a feedback report summarising first use to current. Functional assessment of use, non-use and lapse, graphing of use and engagement in other activities which are protective factors. Relapse prevention planning – including how to manage triggers and future setbacks.	substance use. First month Jayne refused to consent to weekly testing. Rolled with this resistance over four weeks until Jayne agreed to engage in abstinence programme. 7 months of testing, with these being x3 per week at start of RBT for cannabis and alcohol use, reducing to once a week for cannabis when abstinence was achieved.
Mental health • Depression	GP medication review Antidepressant medication	Monitoring medication compliance	
	Behavioural activation for depression	Monitoring activities and impact on mood, scheduling in rewarding activities, increasing problem solving skills and assertiveness such as asking for help and saying no to others.	1 session a week for 12 weeks.
• PTSD	Trauma Focussed CBT	Prolonged Exposure for PTSD which included psychoeducation about PTSD and DSM-V criteria, development of in-vivo exposure hierarchy, reliving, cognitive restructuring and relapse prevention planning.	1 session a week for 12 weeks.
Managing physical health	GP review Medication	Monitoring medication compliance	

	CBT	Providing psychoeducation on pain and the 'boom and bust cycle'. Pain and activity diaries. Scheduling in rest each day. Increasing awareness of focus of attention and body scanning. Increasing skills in being proactive rather than reactive in pain management.	1 session a week for 6 weeks.
Improving parenting	Systemic interventions.	Increasing awareness of positive behaviour management. Development of Behaviour management plans for each of the children. Increasing knowledge of parental and child button pushers and not getting drawn into conflict. Increasing awareness of family structure and supporting Jayne to be at the top of the hierarchy and reducing older siblings taking parental role.	Weekly parenting sessions.
Improving family communication	Family communication module	Family problem solving training, communication training (completing family communication assessment, modelling skills, behavioural rehearsal and feedback), cognitive restructuring of unhelpful beliefs which maintained family conflict.	Family communication module was delivered between months 6-9, weekly session totalling nine sessions.
Reducing risk of self-harming behaviours by eldest two children	Psychoeducation Safety planning	Increasing parental awareness of how to look out for risk factors of self-harm, including carrying out sweeps of the home, eliminating risk, increasing communication and observing behavioural changes.	This was carried out over three sessions at the start of the intervention and reviewed weekly.
Reducing risk of missing episodes for Adam	Safety planning	Increasing parental expectations of curfew, supporting parent to	This was developed within the first two

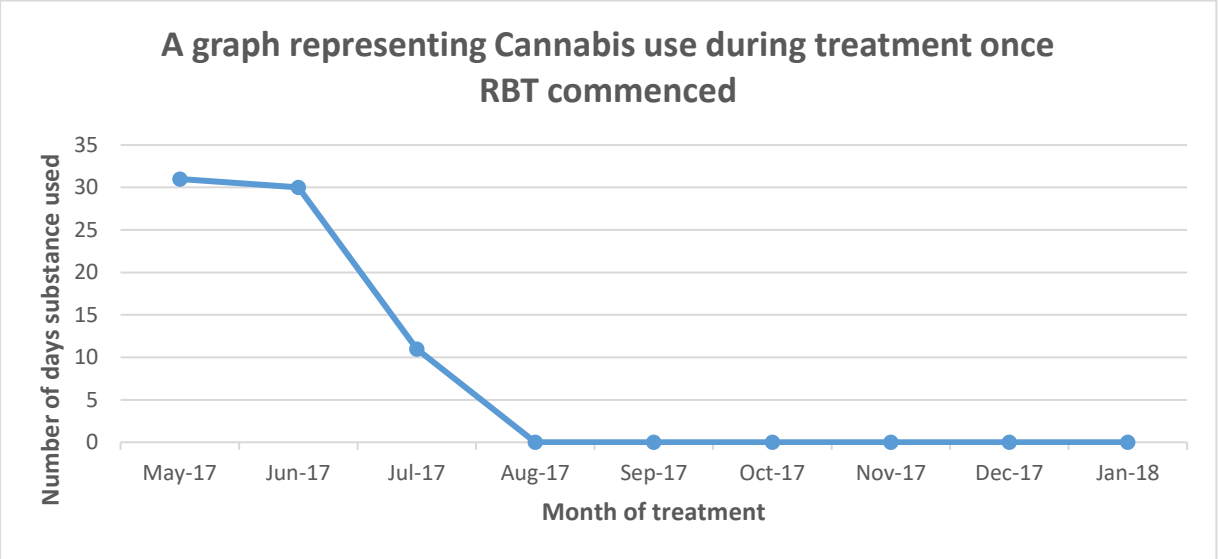
	Development of boundaries and curfew	develop curfew and having a clear plan to follow if this was not adhered to, including reporting to the police, increasing network of communication with Adam's peers' parents and utilising telephone support.	weeks of the intervention and monitored weekly.
Abuse clarification process	Abuse clarification	Provided rationale for the clarification process which includes clarification of the abuse, parent taking responsibility for the abuse in letter format and demonstrating awareness of the impact that this has had on the children. Eliciting from children any concerns they have and what they want from the meeting.	Clarification preparation sessions and clarification meeting. Total of 8 sessions.

Addressing substance use as a risk factor

As can be seen in Figure 10, Jayne reduced her cannabis use over the first two months of RBT, with abstinence occurring Mid-July 2017. However, this did not show as a negative screen until September 2017. This is quite a typical period for cannabis to leave the body after such heavy usage as indicated by NHS. Jayne remained abstinent from cannabis from this point until closure as evidenced by three screens per week. Once Jayne was abstinent from substance use her ability to implement effective parenting strategies increased. As evidenced by the children attending school on time, having breakfast before leaving the house rather than picking up something on the way (that further compounded the issue of late arrival).

The household appeared more relaxed during visits after school and the older children shared how they found their mother to be less irritated and shouting less.

Figure 10. Cannabis use during the treatment of RBT



Addressing mental health as a risk factor

Initially, time was spent on increasing Jayne's understanding of her symptoms and providing psychoeducation on PTSD, Depression and Anxiety. Analogies were used to increase understanding of how the body responds to trauma and also how the brain processes it and how this is different for people experiencing PTSD symptoms to those who do not. Time was also spent socialising Jayne to the Cognitive Behavioural model, specifically Prolonged Exposure and what the treatment entailed.

An in vivo hierarchy was developed collaboratively with Jayne and it was something for her to engage in between sessions. The function of the

hierarchy was to reduce avoidance and increase her ability to tolerate distress. The in vivo hierarchy is detailed in table 19, along with self-reported pre and post scores. As Jayne developed skills in regulating her emotions within and between sessions, she started to engage in activities that had previously been avoided.

Imaginal exposure to traumatic event, processing of the 'hot spots' of the trauma. Certain elements of the trauma narrative were initially avoided; sessions took place whereby we focussed on these elements of the trauma and fully developed the narrative with repeated exposure.

Table 19: Pre and post scores on the In-vivo Hierarchy.

In-vivo Hierarchy	Pre	Post
To smile at someone that looks like my father.	100	10
To remain in a shop when I see someone that looks like my father.	80	0
To be alone with male relatives.	70	10
To hug male relatives.	70	10
Watch the Steven King movie IT.	50	0
Listen to songs from my childhood.	30	0

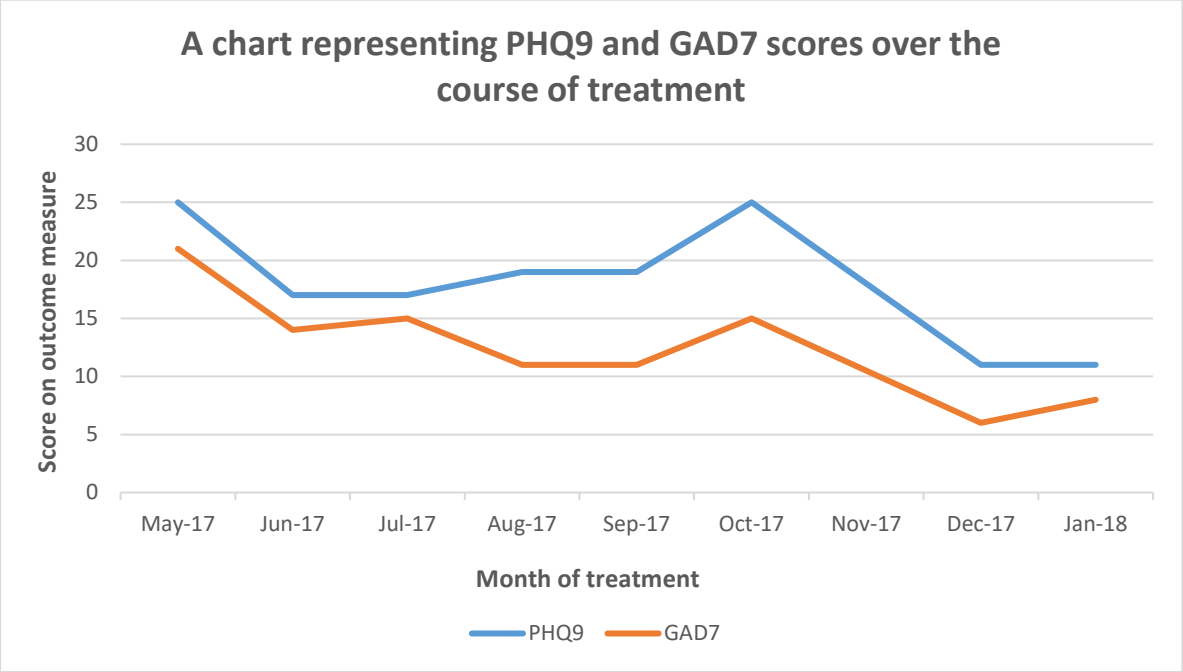
Jayne self-reported an improvement in her mental health and a reduction in PTSD symptoms; she stated that she was no longer experiencing panic when out in public places and was not avoiding things that she used to. Jayne reported that she no longer feels the need to use alcohol and/or cannabis to manage her symptoms and can manage effectively by utilising strategies such as breathing when she does experience physical symptoms

of anxiety. The Impact of Event Score – Revised (Weiss & Marmar, 1996). had reduced from a score of 83 at the start of intervention to a score of 8 post treatment this score indicates recovery and is not indicative of PTSD.

Both depressive and anxiety symptoms improved as can be seen in figure 11. At the end of the intervention anxiety symptoms were scored as 7/21 on the GAD7 indicating a move into recovery. Depressive symptoms reduced from severe 25/27 into the mild range 11/27 as scored on the PHQ9. At the time of closure there was a slight increase in anxiety symptoms. However, this was linked to environmental factors that included the youngest child being diagnosed with a genetic difficulty that will be a lifelong condition and Adam being diagnosed with Autistic Spectrum Disorder. Understandably, Jayne was initially worried about what this means for her children and the impact these diagnoses will have on their future. These challenges did not lead to a lapse or the use of maladaptive coping strategies and increased her confidence that she would be able to sustain gains post MST CAN involvement.

Throughout the course of treatment, it is essential to work on sustainability of what is working and to increase awareness of identifying potential risk and how to cope with any lapses. A sustainability plan was developed with Jayne clearly stating how she would maintain gains and what she wanted to continue to work on in the future.

Figure 11: Clinical Scores over the course of therapy



Discussion

This case study has demonstrated that following the model of MST CAN within a local authority can successfully address the numerous factors associated with child abuse and neglect within the six-nine-month timeframe. The advantages of this approach include the family being able to access a service in their own home or place of choosing which minimised barriers around attending services. One team leading all clinical interventions meant that there were not numerous people involved for the family. There was a close link between Children's Social Care, the family and MST CAN team ensuring that there was a shared understanding of progress and areas of need throughout the intervention. Regular reviews took place in addition to statutory meetings. The intensity and frequency

at the start of the intervention facilitated 'quick wins', which helped to build a therapeutic alliance and increased sense of hope in change being possible. The consistent quality assurance process minimised the risk of drift and ensured adherence to the model and this enabled timely problem solving of identified barriers to treatment. The therapist adherence score for the therapist working with the Smith family was consistently above the recommended minimum point for an adherent therapist of 0.61. Treatment fidelity and therapist adherence to the model has been linked to successful Standard MST outcomes (Henggeler, 2011).

As many of the interventions utilised within the MST CAN model all have their own independent evidence base, this case study highlights the success of bringing them together in a tailor-made approach to meet the often-complex needs of families who present with significant risk of harm. The overarching goals developed at the start of therapy were successfully achieved and sustained by Jayne.

The four MST CAN model aims were achieved as described below.

1. Keep families together safely – At the end of the intervention the family were safely living together with no reported missing episodes, increased supervision and care of the children.
2. Prevent re-abuse and neglect – no further reports of abuse. The

progress of Jayne during the nine months of MST CAN involvement led to the Child Protection Plans under the category of neglect being closed. At eighteen months follow up the children remain unopen to Children's Social Care and there have been no further reports or concerns raised.

3. Reduced mental health difficulties experienced by adults and children, as self-reported by Jayne and the children and evidenced in observations and feedback from wider systems such as school, community police and other professionals.
4. Increased natural social supports, as evidenced by Jayne attending activities in the community, working through challenges in relationship with mother and accessing support from others when needed by asking for help.

Study limitations

A limitation of this study is that it is a single design case study, criticism of these include; their lack of scientific rigour in contrast with a RCT, the results are only for one case and this limits generalisability, and risk of the researchers own bias in reporting. This family were at an earlier point in their journey with Children's Social Care and did not present with hostile views of social workers and were keen to engage with MST CAN and access support, not all families who are offered MST CAN are this receptive from the outset. Many of the measures used in this study were self-report. A

limitation of self-report measures is that people can answer in a way that they believe to be socially desirable. The author of this report was the supervisor at the time the intervention occurred, this could be perceived as a limitation due to potential biases with reporting a case that has been successful. Of course with any intervention there will be cases that are considered successes and failure. However, given that the gains experienced by the family and changes made by Jayne remain at two year follow up, this case is a real world example of how offering the right intervention at the right time can have a sustained positive impact for the family continuing years post intervention which cannot be manipulated. Another measure that helped to mitigate bias was the rigorous methods used within the intervention such as drug and alcohol screening three times a week and regular collection of standardised measure of depression, anxiety and PTSD, these were not carried out by the author but members of the team.

Whilst this case study has some limitations, it is an example of how MST CAN works in a real-world setting, rather than in a clinical trial.

Conclusion and recommendations for future research

This case study highlights how, despite numerous previous referrals to Children's Social Services and recommendations and signposting to universal services to address factors such as substance use or mental health difficulties, these were not accessed or successful for this family.

There are numerous reasons for this such as but not limited to; level of motivation to address these areas at the time of the recommendations; lack of statutory involvement to follow through whether they were followed up and the challenges faced by a victim of domestic abuse whilst still in that environment. Although, the success of the intervention has been highlighted and there is evidence of improved family functioning, parental mental health, abstinence from substances and positive individual child achievements. For example, Jake completing primary school after being on the brink of permanent exclusion. He then went on to successfully transition to secondary school with no reports of aggressive behaviour and improved behaviour in the home. It is also evident that the environment the children were growing up in had a significant impact on the behavioural, emotional and mental wellbeing of the eldest three children for many years despite concerns being raised.

MST CAN is one intervention that can be offered to families where there is child abuse and/or neglect and Children's Social Care want to support the family to remain intact. However, given that there are 152 Local Authorities (HM government, 2018) in England and MST CAN is only available in six of them, there is a significant deficit in supply meeting demand. The intensive nature of MST CAN and small caseloads held by the team means that each team will work with between fifteen and eighteen families per year. Therefore, alongside increasing the provision of MST CAN there is a need

to look at other ways in which we can offer early interventions to address parental drivers of child abuse and neglect. It would be advantageous to consider the lessons to be learned from MST CAN around increasing engagement by offering evidenced based interventions such as Trauma Focussed CBT or RBT in a more accessible way and with a strong link with Children's Social Care. Further research is required evidencing the effectiveness of MST CAN in the UK and given the challenges around budgets, further data on the cost effectiveness of MST CAN in the UK would be useful for the Local Authorities to make informed decisions. As there are health interventions offered as part of MST CAN a contribution from health services is something to consider. As reported in chapter two, a local evaluation study by Watmuff and Ross (2016) reported that for every £1 spent on MST CAN there was a £1.59 return. This figure does not take into account the longer term savings of stabilising life for children and improving family functioning and mental health.

A common theme throughout the thesis has been around parental alcohol and/or substance use, engagement and motivation to change. The next chapter is a critique of the University of Rhode Island Change assessment (URICA) psychometric tool and its use with adults who use alcohol and/or substances.

Chapter Five - University of Rhode Island Change Assessment: A critique of its use with adults who use alcohol and/or substances

Abstract

The University of Rhode Island Change Assessment (URICA) has been used as a measure of motivation to change across a wide range of problematic behaviours including, addiction, offending, obesity and psychotherapy. More recently the psychometric tool has been recommended within social work practice as a way of measuring motivation to change problematic behaviours that contribute to child protection concerns. The reliability and validity of the tool differs across the areas in which it has been applied. Given the widespread application of the tool this critique set out to examine the psychometric properties when utilised with adults who have problematic alcohol and/or substance use. This is of particular interest given that one of the high-risk-factor concerns in child protection is parental substance and/or alcohol use and this is an area which can heighten the risk of child removal from parental care. The findings of the critique are that the URICA has good reliability and construct validity in assessing stages of change for those who use alcohol and/or substances in outpatient settings. However, the URICA does not have good predictive validity and should not be utilised as a predictor of treatment outcomes.

Introduction – Measuring 'motivation to change' in Forensic Psychology

Motivation to change is often referred to as an important factor in the assessment and treatment of risk and recidivism in the field of forensic psychology. It is identified within the Risk, Needs and Responsivity model as an essential factor to examine when targeting change (Andrews, Bonta & Hoge 1990). Child abuse and/or neglect, though more often presented at family court than criminal court, is an area whereby the concept of motivation to change can heavily impact upon decision making (Platt & Riches, 2016). Perceived lack of engagement or motivation to change, often termed as 'disguised compliance', has been identified as a key risk factor within Serious Case Reviews (SCR) (Sidebotham et al. 2016). A number of risk factors have been identified as increasing the risk of child abuse and neglect, however specific consideration is given to three factors commonly termed as the 'trilogy of harm' or 'toxic trio'; Mental Health, Substance/Alcohol use and Domestic Abuse (Donovan, 2016). In particular, Substance and/or Alcohol abuse has been identified as one of the most likely behaviours, if not addressed, that increases the risk of child removal from parental care (De Bortoli, Coles & Dolan, 2013).

The Transtheoretical Model of Change

The Transtheoretical Model (TTM) was developed by Prochaska and DiClemente in the late seventies whilst they were working with individuals who wanted to stop smoking. Over the past four decades the model has been utilised as a way of conceptualising change when working with a number of behaviours. The model has been further developed in response to the numerous studies testing its concepts in practice, there has been over 1500 studies testing the model (Diclemente, Schlundt & Gemmell, 2004). The TTM is commonly applied within areas of targeted behaviour change such as smoking (e.g. Diclemente & Hughes, 1990), substance and/or alcohol use (e.g. Field et al, 2009), offending (e.g. Serin & Kennedy, 1997), psychotherapy (e.g. Mander et al, 2013) and exercise (e.g. Lerdal et al, 2009). There are some criticisms around the appropriateness of the use of the TTM and its application in the areas of offending (e.g. McMurran, 2009) due to poor construct validity; and diet and exercise (Mastellos, et al. 2014) due to the risk of bias and imprecision. However, the model is generally considered to be appropriate and applicable to substance and alcohol use (Kennedy & Gregoire, 2009).

The TTM describes change as being characterised by five stages and individuals can move both forwards and backwards through these stages

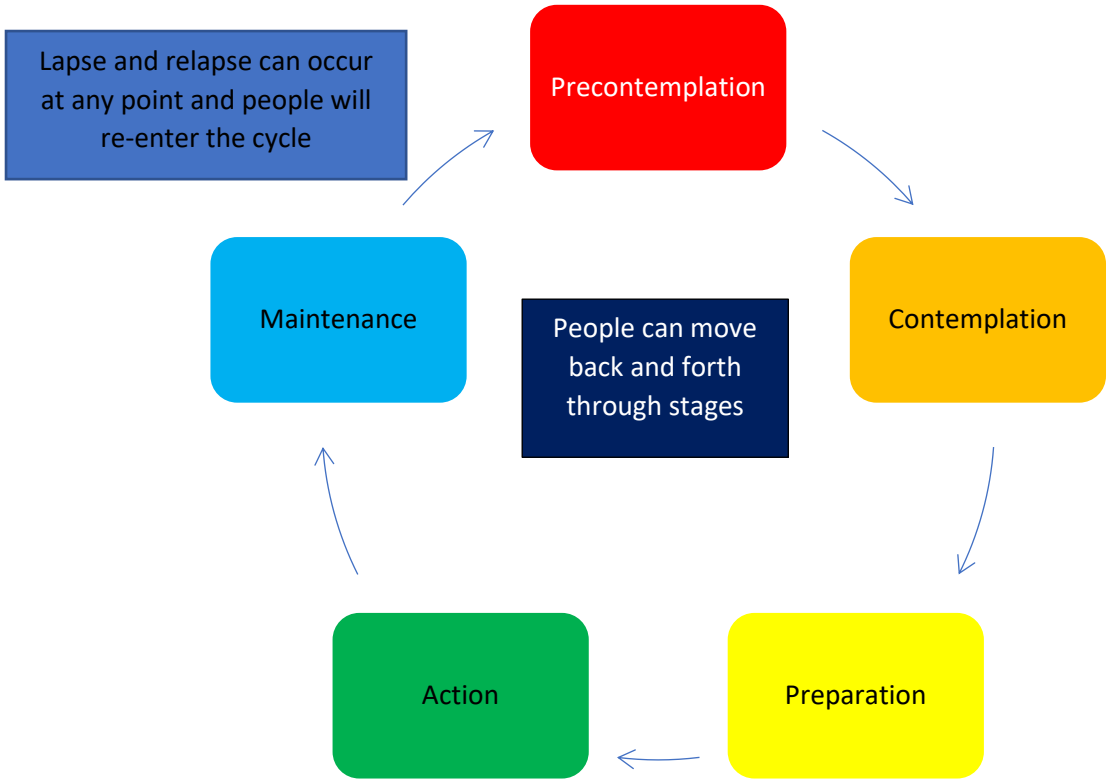
whilst trying to modify their behaviour. These stages are summarised in table 20.

Table 20: The stages of change identified in the TTM

Pre-contemplation: at this stage, individuals are generally happy with their behaviour and do not see it as problematic or any reason to change it. For example, someone using substances only identifying the positive effects of their substance use and are unable or unwilling to consider the negative aspects. They may minimise negative effects or express cognitive distortions around substance use.
Contemplation: at this stage, individuals are beginning to recognise the negative aspects of their behaviour alongside the positives. They can often feel ambivalent and unsure about change. For example, someone may enjoy having alcoholic drinks on a Friday night but dislike feeling hungover after overindulging and feel guilty about not doing activities with their family on a Saturday. This is an appropriate time to carry out a decisional balance, paying attention not to the quantity of items listed but the importance of them, in order to be able to decide about what they want to do. Individuals can remain in the contemplation stage for a prolonged period.
Preparation: at this stage, an individual has made the decision to start addressing their problematic behaviour. For example, for someone using with an alcohol difficulty may have gathered medical advice about how they can stop drinking, have chosen a date to stop drinking and enrolled with a local service.
Action: at this stage, the individual is actively addressing their problematic behaviour and may need support at the beginning of this phase. For example, engaging on an alcohol/substance misuse programme and accessing support in identifying and coping with triggers or other difficulties.
Maintenance: at this stage, an individual has made progress in addressing their problematic behaviour however continuous effort is required to sustain their progress and avoid potential lapse or relapse.

In addition to the five stages outlined above consideration is given to the possibility of lapse or relapse. A lapse involves an individual momentarily behaving in the way that they are avoiding for example having a couple of alcohol drinks. Whereas a relapse is a return and continuous engagement in the avoided behaviour. Prochaska and DiClemente (1983) suggest that an individual may relapse and reprocess through the stages on numerous occasions before they have fully extinguished the desired behaviour (see figure 12).

Figure 12: A diagram of the TTM



Motivation to change as a concept

Miller & Rollnick (1991) propose that motivation should not be viewed as static, it is dynamic and can fluctuate and change over time. They also suggest that the stages of change can be applied to both self-change and therapy assisted change. Ginsburg (2000) supported the concept of the TTM and summarised that behavioural change involves progressing through the identified stages in both clinical and non-clinical populations.

Viets, Walker and Miller (2002), further broke down the concept of motivation and suggested that it could be viewed in six key points (2002, p17):

1. Motivation is *modifiable*, like overt behaviour it can be increased or decreased via lawful principles of human nature.
2. Motivation is a matter of *probabilities*: how likely is the person to initiate and persist in a particular action? It is about initiating and directing action (Pertri, 1986). Therefore, interventions to influence motivation are those that effectively increase or decrease the probability of an action (Miller, 1985).
3. Motivation is an *interpersonal* phenomenon, something that occurs and changes with the context of human relationships.
4. Motivation is often quite *specific* to a course of action. A person may be unmotivated for one type of treatment or change but quite ready to participate in other. This is often observed when someone engages in poly substance use.

5. Motivation is *intrinsic* as well as extrinsic. Although it is possible to coerce behaviour change when one has control over external contingencies, intrinsically motivated behaviour change is more likely to last.
6. Intrinsic motivation for change is engaged by *eliciting it from* rather than installing it in the person.

Viets, Walker & Miller, (2002), suggest that a useful way of looking at motivation, is in terms of three distinct components, which are 'ready, willing and able'. They argue that in order for behaviour change to occur, all three of these components must exist at the same time. For example, abstaining from substance use would be very difficult if someone was willing and able but not yet ready. They propose that the more each of these components exist the more likely behavioural change will occur. These components fit nicely within the TTM.

'Readiness to change' refers to how much an individual desires change, views a need to change and is able to change. For example, a dependant alcohol user may want to change, know they need to but as they are physiologically dependent upon alcohol, change may be life threatening and require medical support.

'Willingness to change' can be considered as when an individual becomes aware of the discrepancy between where they are and where they want to be (contemplation). For example, a parent within Child Proceedings

wanting their child to remain in their care but recognising that they cannot do this and sustain their current substance use due to the risk of harm presented.

Measuring motivation to change

Diclemente et al. (2004) acknowledge that whilst they have identified five stages that are involved in people changing a targeted behaviour, measuring the stages has been problematic. Psychometric tests designed to measure the stages of change include the University of Rhode Island Change Assessment (URICA) (Diclemente & Hughes, 1990) and the Stages of Change, Readiness and Treatment Eagerness Scale (SOCRATES) (Miller & Tonigan, 1996) and the Readiness to Change Questionnaire (RQT) (Rollnick et al, 1992). A difference between the three tests is that the URICA is non problem specific whereas the SOCRATES and RQT were initially designed to assess motivation to change alcohol use. Later studies identified that a 'readiness to change' score can be derived from the URICA.

The URICA is a 32-item self-reporting questionnaire that was designed to assess the stages of change process that individuals progress through when engaging in behavioural change, either self-change or therapy assisted. There is also a 24-item version. Despite initially being designed to assess

change in smokers the URICA items are non-specific which enables the user to apply the questions to the desired problematic behaviour they want to change. The majority of research on the URICA has been in addiction treatment targeting specific substance use e.g. alcohol use, cannabis use or cocaine use (Diclemente & Hughes 1990 and Pantalon et al., 2002).

Due to the general nature of the questions in the URICA it has also been used in research to assess behaviour change with regards to offending behaviour (e.g. Yong et al., 2015), weight and health related difficulties (e.g. Lerdel et al, 2009). The URICA has recently been recommended to assess motivation of parents to change when they are open to Children's Social Services (Platt & Riches, 2016b). However, currently there is little research testing the validity of the tool with this client group.

Examples of the statements people rate in the URICA include: 'As far as I'm concerned, I don't have any problems that need changing', 'I am doing something about the problems that have been bothering me' and 'Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me'. Item responses are based on a Likert-type scale ranging from 1-5, with one being strongly disagree to five being strongly agree. Whilst there are five stages of change identified in the TTM, the URICA targets four areas that have been validated across a number of studies (e.g. Diclemente & Hughes, 1990). There are eight items for each

of the following areas of change: pre-contemplation, contemplation, action and maintenance. Scales scores range from 8-40. Diclemente et al. (2004) suggest that to determine a score you subtract the precontemplation score from the average of the other three area scores. A score of under 8 indicates pre-contemplation, a score between 8-11 indicates contemplation and a score of 11+ is indicative of preparation.

Normative data

In contrast to other psychometric tools that have been initially tested with university populations (e.g. the URICA-E2, Lerdal, et al, 2009), in the original study of the URICA with alcohol use (Diclemente & Hughes, 1990) the data included 224 adults who were entering outpatient treatment for alcohol use, participants were aged between 18-65, of these 65% were male and 79% were Caucasian. The URICA was originally developed in English however, it has been shown to have reliability and validity in other languages including Arabic (Khalil, 2011), Chinese (Chen et al, 2019) and Norwegian (Lerdel et al, 2009).

Psychometric properties - Reliability and Validity

Reliability is concerned with how often a test can produce similar and consistent results over time, repeated application and in similar

circumstances. Once reliability is established then validity can be tested. Validity is how well the test measures what it states it is measuring. When dealing with things such as personality or motivation which are constructs it is important to test the construct validity of each of the sub scales within tests such as the URICA.

Predictive validity is the ability of a test to predict the likelihood of a future event/behaviour. A working example of this is SAT scores for primary school and their ability to predict outcomes at GCSE levels.

The reliability and construct validity of the use of the URICA with people who misuse alcohol and/or substances has been demonstrated to be in the acceptable to good range in a number of studies using Cronbachs Alpha Coefficients, some of these studies are summarised in table 21.

There have been considerably more studies assessing motivation to change with people who have problematic alcohol use than drug dependence (Diclemente et al, 2004). Nonetheless, the studies researching motivation to change and the application of the URICA to measure substance use have also demonstrated moderate to good construct validity.

Construct validity

The majority of studies have found that there is a tendency for the areas of contemplation, action and preparation to score more highly than the area of precontemplation (Field et al, 2009). One explanation for this could be

participants attempting to answer the questions in a socially desirable way. This is a known risk of self-reporting questionnaires and involves individuals either over reporting perceived 'desired' behaviours and under reporting 'undesired' behaviours. This finding has been shared by Diclemente et al. (2004), who reported differences between individuals who had psychiatric and/or substance use difficulties and those who smoked. These differences included; not being as open about their reasons for change, underestimating the extent of the problem, not recognising their ambivalence towards change and overestimating their readiness to change or saying what they think providers want to hear in terms of where they are with regards to the stages of change. Given that people are often mandated to engage in alcohol/substance use treatment e.g. offenders who have committed offences whilst under the influence or parents who have neglected or abused their children as a result of alcohol/substance use, it is unsurprising that they give responses that are socially desirable. Diclemente et al. (2004) suggest that accurate self-assessments were also more difficult to obtain from people in inpatient or restricted settings not just as a result of social desirability but a genuine challenge for individuals to accurately report their motivation to change when they had restricted access to alcohol/substances. They found that the URICA is more reliable when used with outpatients.

Table 21: Studies demonstrating the Construct Validity of the URICA

Reference	**Population studied**	**Behaviour version**	**Version length**	**Reliability Cronbach's Alphas**
DiClemente & Hughes (1990)	N=224	Alcohol	32 Item	Precontemplation (.69) Contemplation (.79) Action (.82) Maintenance (.80)
Carney et al. (1995)	N=414	Alcohol	32 Item	.80-.84 for each of the 4 subscales
Carbonari & Diclemente (2000)	N=1183	Alcohol	32 Item	.68-.85 for each of the 4 subscales
Grencavage (2001)	N=63	Alcohol	32 Item	Precontemplation (.80) Contemplation (.67) Action (.83) Maintenance (.86)
Pantalon et al. (2002)	N=106	Alcohol & Cocaine	32 Item	Precontemplation (.75) Contemplation (.79) Action (.83) Maintenance(.78)
Siegal et al. (2001)	N=235	Substance use	32 Item	Precontemplation (.79) Contemplation (.67) Action (.85) Maintenance (.76)
Field et al. (2009)	N=831 Alcohol use N=336 Substance use N=495	Primary Alcohol or Substance use	32 Item	**Primary Substance use** Precontemplation (.81) Contemplation (.88) Action (.86) Maintenance (.85) **Primary Alcohol use** Precontemplation (.79) Contemplation (.90) Action (.87) Maintenance (.87)

Predictive validity

Tentative support for predictive validity of the URICA was evidenced by Field et al. (2009) who found that the 'readiness to change' score derived from the URICA was significantly correlated ($p<.01$) with fewer days' substance use. They also found that committed action was associated with

a lower retention rate for those with a primary difficulty of alcohol use. However, the majority of other studies utilising the URICA have found weak predictive validity (Diclemente et al., 2004). Given these outcomes, the predictive validity of the URICA has faced criticism for example, Bergly et al. (2014) advised that the predictive validity of the URICA with individuals who use substances is low and should be used with caution. This is due to the majority of research finding that the subscales identified at pre-treatment did not predict outcomes at the end of treatment.

The limited predictive validity of the URICA could be attributed to the theoretical assumptions underpinning the TTM. The TTM views change as not being a static process, it is dynamic, and it is argued that the process can be cyclical for some and people may cycle through the stages several times before they achieve the desired goal, e.g. abstinence. This has been observed in people who smoke, a study in Toronto (Chaiton et al, 2016) found that smokers attempted to quit up to 30 times before they were successful in abstaining from this behaviour for a year.

Another possible explanation for the limited predictive validity of the URICA in predicting treatment outcomes could be attributed to the number of other factors involved in 'successful outcomes' not just 'motivation to change'. Mair, Haug & Schaub (2016) studied treatment outcomes and

their predictors with service users across five outpatient alcohol treatment centres. They found that an initial treatment goal of abstinence rather than reduction of alcohol use was correlated with positive outcomes, as was treatment retention, higher life satisfaction, lower illness severity and lower levels of depression and anxiety. A surprising finding was that the likelihood of non-problematic drinking was less likely for those who were higher educated. A limitation of this study was the lack of a control group however, it is one of the only studies investigating factors associated with positive treatment outcomes. Given the multiple variables involved in successful outcomes of alcohol and substance misuse treatment it would seem somewhat unrealistic to expect the URICA as a standalone tool to predict outcomes based on one variable.

The limited predictive validity of the URICA has implications for how the tool should be utilised. Given these limitations it should not be used as a way of predicting treatment outcomes which is important especially for those who have been mandated into treatment.

Conclusion

The usefulness of the URICA as a tool to assess motivation to change for those who use alcohol and or substances is unquestionable. It has been

demonstrated across a range of studies to have good reliability and construct validity of the four stages of change and can be used in order to direct treatment as appropriate to the individuals' current stage of change. Being able to tailor treatment to the needs of the client is more likely to need to better alignment and engagement with treatment goals and potentially have a positive impact on treatment outcome. In contrast, treating all clients as the same is likely to impact on engagement, drop out, perceived resistance and poorer treatment outcomes.

The risk, need, and responsivity (RVR) model has a strong empirical evidence base and is commonly used to guide offender assessment and treatment (Andrews, Bonta & Wormith, 2011). The use of the URICA could help to inform treatment in line with the principles of this model.

- Risk Principle – Match level of programme intensity to current risk level. For those with high dependency and likely to relapse, treatment interventions to address alcohol and/or substance use may need to be frequent, positively reinforcing and outpatient based. A limitation of inpatient interventions is generalising the skills when based back in the community. Reinforcement Based Therapy (RBT) for substance and/or alcohol use utilises this approach, as described in chapter three with 'Jayne'.

- Need Principle – Target Criminogenic needs or those needs that are functionally related. Interventions for alcohol and/or substance abuse should be systemic and recognise the impact of community factors, accessibility and skill base of the client e.g. refusal skills, association with other users.
- Responsivity Principle – Match the style and mode of intervention to learning style and abilities. Utilise the information gleaned from the URICA to identify methods of working that will be effective with the client, e.g. rolling with resistance, providing psychoeducation about use and eliciting 'change statements'.

Using the URICA to determine current stage of change is important, as Norcross, Krebs & Prochaska (2011) point out, treating all individuals as if they are in the 'action' stage can lead to a small number of individuals accessing treatment or remaining in therapy. They also highlight that treating someone in precontemplation as if they are in action, skipping psychoeducation, increasing awareness and engaging in decision making may lead to radical behaviour change without insight. A criticism of this type of change is that it is likely to lead to temporary change. For those in precontemplation there is a need to 'roll with resistance' and help them to examine the pros of change and consider how this may be positive for them. Attempting to move someone into action before they are ready is likely to

lead to treatment being ended early or the individual being labelled as resistant to change (Norcross et al, 2011).

Bearing in mind the lack of evidence of predictive validity the URICA should not be used as a predictor of treatment outcomes, as treatment outcomes are dependent on a range of other variables not just the stage of change. This critique has highlighted how individuals are more likely to score higher in the areas of contemplation, action and maintenance and lower in the area of precontemplation, this could lead to false positives when predicting treatment outcome.

Given the limitations of the URICA highlighted in this review, recommendations to utilise it to assess parental motivation to change neglectful or abusive behaviour should only be implemented alongside awareness that the tool is an indicator of current stage of change only and is a tool to think about how to develop treatment, not a predictor of outcome. This viewpoint was suggested by Platt & Riches (2016) who proposed that for the purpose of assessing change with parents who are abusing and/or neglecting their children, the URICA is a tool that can be useful in identifying factors affecting change rather than focussing on an outcome score.

Chapter 6 – Conclusion

As a mature student and practitioner with almost twenty years of experience working in the fields of; the Prison and Probation services, Mental Health and Children's Services, the aims of this thesis were influenced by my passion for providing early intervention for people and increasing access to 'what works' in a timely manner. The overarching aims of the thesis included: increasing our understanding of Care Proceedings and consider whether there are cases that can successfully be diverted away from care proceedings and if there are factors which indicate this. Increasing awareness of the treatment options that are available to address the multifaceted risk factors of child abuse and/or neglect and consideration given to whether or not these are effective in an environment of increasing budget cuts. Lastly, attention has been given to how we work with families, specifically focusing on engagement in treatment and working with motivation to change.

This journey of study has been a steep learning curve for me. Combining study, being a mum to four children and working full time in a demanding role that required being on call 24/7 has meant managing a number of competing demands. The balance of these challenges alongside learning more and more about the intricacies of Child Protection, decision making and s31 care proceedings has been interesting and further served to increase my passion about children and families and ensuring the right

support is offered at the right time. All too often, in my experience, at the point of seeking legal advice, social workers have come to the decision that the best outcome for the children they are working with is to enter care and to elicit any shift from that stance is challenging and requires a lot of evidence against their original beliefs and multi-disciplinary working to ensure that risks are addressed. This is not generally how other agencies (e.g. health, substance abuse services, schools etc.) tend to work with Social Care, their remit around co-working is more often limited to providing update reports at CP reviews. The transition from being an accredited and experienced clinical practitioner to developing an academic approach and viewing things more scientifically and ensuring that I am not being biased due to my own thoughts, feelings and experiences is a strength and something that I will utilise in future practice. The development of this skill has supported me in being able to work at a more strategic level within services, developing them and using research to shape how to best meet service user, stakeholder and commissioner's needs. I have included personal experience as working on the front line means that you experience the challenges first hand and can see opportunities to change however, these are often considered anecdotal without research and evidence to support your views.

Each chapter of the thesis has aimed to provide consideration to how we improve and increase access to 'what works' for families who are within the

process of Child Protection and at the edge of care or within Care Proceedings as a result of child abuse and/or neglect. They have also considered how we minimise the risk of significant harm to children who are innocent victims of their childhood circumstances. This chapter will consider what has been learned through this journey of study and how this learning could help in real world practice.

The systematic review of MST CAN (chapter two) is the first to be carried out to date and was viewed as necessary given its relatively recent implementation in England and its recommendation within NICE guidance to address child abuse and/or neglect. The results of the Systematic Review were that MST CAN consistently demonstrates that it can reduce the risk of further child maltreatment by addressing the risk factors identified at referral. However, currently there are limited high quality studies evidencing this and those included in the review were predominantly from the USA. Another factor to consider is the research to date has predominantly been carried out by the developers of MST CAN and this may increase risk of bias in reporting. Therefore, this highlighted a need for further studies, preferably independent of the developers, to be carried out testing the efficacy in England. MST CAN is an expensive intervention, which provides extensive support to families, on top of staffing costs there are also license fees to consider. MST CAN has been

shown to yield savings of £1.59 for every £1 invested (Watmuff and Ross, 2016), a greater saving was evidenced in America of almost double this (Dopp et al. 2018). Cost effectiveness of interventions is an important consideration given the current climate and budget cuts LA face. However, these estimates may be conservative when considering the long term impact of child abuse and neglect and how these may be mediated by an intervention that minimises future re-abuse and has been shown to improve mental health of both parents and children within families. Another potential financial benefit of this intervention, as evidenced in Chapter four, is families developing skills that reduces the need for involvement of children's services in the future. A factor that is important to consider given the number of families, whereby the children remain at home post proceedings, requiring significant ongoing support as reported in the study by Masson et al. (2018).

Chapter three detailed an empirical study designed to compare the similarities and differences between cases that were in s31 Care Proceedings which resulted in the permanent removal of children and those who remained within the family, not always with the primary caregiver, on a supervision order. The study highlighted how there are many similarities between the two groups which demonstrates the challenges faced by social work teams in 'knowing' which cases to divert from court and illustrates

how the search for 'clear blue water' as proposed by Trowler (2018) is immensely difficult for those in the arena of Care Proceedings. Although not statistically significant there were also some important differences to consider that could help to shape future practice. Caregivers that had their children removed were more likely; to have experienced child maltreatment, to have mental health difficulties and engage in problematic alcohol and/or substance use. Indicating that these areas are a priority to offer support and interventions for.

An interesting finding of the study was that both groups (those who were removed and those who remained within their families' care at the end of Care Proceedings) had been known to Children's Social Care Services on average for almost 7 years prior to current Care Proceedings and the majority (N=48) had previous Child Protection Plans open. This suggests that there had been multiple opportunities to engage families in appropriate support that may have ameliorated ongoing concerns. More research is needed that focusses on how cases drift and why children are remaining in homes where there are significant concerns for many years without these issues being addressed and sustained.

Another important discovery of the study was the significant finding that those families whereby the children remained in parental care at the end of

Care Proceedings were assessed as being more engaged in the process and more actively demonstrated change. This factor could be utilised as a way of considering whether or not cases should enter the court arena, Platt and Riches (2016) have developed a toolkit which could be of use to those in child protection with the responsibility of making these life changing decisions. They recommend the use of the URICA to assess motivation in order to inform ways of working with parents to effect change which was examined in chapter five. The Crisis review (2018) highlighted as a summary message the need to develop good relationships within and between families, agencies and practitioners. Demonstrating that the challenges observed in this study are not new or original, engaging families in addressing child protection concerns is well established, it seems we need to focus more on how to address it.

Chapter four presented a case study of a family at the edge of care, subject to Child Protection Plans for a second time within two years under the categories of Neglect and Emotional Harm. The case study highlighted how the 'toxic trio' of parental Mental Health, Parental Substance Use and a long history of Domestic Violence were core risk factors at the time of referral to MST CAN. These risk factors were prevalent in many of the cases included in chapter three and have been demonstrated with an increased risk of removal (e.g. Forrester & Harwin, 2008, De Bortoli et al. 2013).

Historical attempts to address these risk factors with Jayne (mother) in an uncoordinated approach had proved unsuccessful in minimising concerns and increasing protective factors. The chapter demonstrated that MST CAN had been a successful intervention for this family, in terms of addressing identified risk factors and increasing protective factors. An essential element of this success was the approach employed by the MST CAN team in taking responsibility for engaging Jayne in treatment and providing the intervention at home and within the community. Working through the stages of change identified in the TTM, proved successful in engaging Jayne in addressing her alcohol and cannabis use. Initially, Jayne was in precontemplation about changing either her substance or alcohol use, as assessed using the URICA. Both forms of abuse were utilised in order to self-manage both PTSD and Fibromyalgia symptoms. Working collaboratively with Jayne to understand her use and identify other ways of managing her symptoms, e.g. increasing awareness of the 'boom and bust' cycle of pain management and offering a specific treatment, as recommended by NICE for PTSD, resulted in abstinence from both cannabis and alcohol. This treatment was delivered alongside increasing family communication and addressing child risk factors for abuse such as aggression, which triggered memories of domestic abuse. The case study highlighted how the coordinated approach of MST CAN targeting the multiple risk factors presented, in a sequential way was successful. The outcome of this case study provides additional support for the results

described in chapter two, a systematic review of MST CAN. Success has been observed with this family in multiple ways, not only in improved child and adult mental health, abstinence from alcohol and substances and improved family communication but also by closure to services and this being sustained two years post intervention. This is an important point given the findings of Masson et al. (2018) that most families who continue to care for their children after care proceedings do so with significant support from services.

The aim of chapter five was to critically evaluate the use of the URICA with adults who misuse alcohol and/or substances. This was identified as relevant to the thesis as substance/alcohol use has been identified as a high-risk factor associated with child abuse and/or neglect (e.g. Forrester & Harwin, 2008). The review highlighted the limitations of the URICA in terms of predictive validity, the stage of change identified at assessment stage has not been found to have a significant relationship with the outcome of treatment. If this was a risk predictor tool like the HCR-20v3 (Historical Clinical Risk Management-20 Version 3; Douglas et al, 2013), this finding would suggest that it should not be used. However, the URICA is not designed to predict risk or outcome of treatment, it is designed to assess an individual's current stage of change. Given that an assumption of the TTM is that people will recycle through the stages of change and that the process is dynamic, and lapses will occur this finding was not a surprise.

The URICA is more usefully used as a way of assessing an individual's current stage of change in relation to the identified problem and adapting treatment in relation to this information. A case example of this was illustrated in chapter four whereby Jayne was in precontemplation about changing her alcohol and cannabis use at the start of treatment however, through the process of RBT which utilises Motivational Interviewing techniques she progressed to the stage of maintenance and this was sustained at one year follow up.

From research to practice

Within the findings of this thesis there are a number of considerations for real world practice in the area of Care Proceedings and addressing child abuse and/or neglect. The first is that early intervention is essential in ensuring that children are not subjected to adverse life circumstances that are outside of their control and will likely have a significant impact on their future development as evidenced by the ACEs literature. The two groups in the empirical study had been known to Children's Social Care for seven years on average (range between 0-16 years) before Care Proceedings began. This highlights a number of missed opportunities to successfully intervene at an earlier point and ensure that appropriate support is accessed in a timelier manner before an issue becomes more entrenched. Whilst early interventions for some may have initially been successful in reducing concerns for many they resurfaced. One way of addressing

concerns earlier could be by ensuring that instead of recommendations simply being made e.g. 'Parent to access Mental Health services' and cases closed at the point of referral to Children's services (front door) with recommendations, these are followed through and cases are only closed when engagement with recommended services is evident. Even better would be for these referrals to be made through developed pathways with services such as Improving Access to Psychological Services (IAPT) or Secondary Mental Health Care. p

Another change that could be implemented is offering families, especially those with multiple children or practical barriers to accessing support, interventions in the community or at home to increase engagement and access to services. The initial cost of travel and time is cost effective if it leads to appointments being attended and a reduction in concerns.

Another practical issue for both families and professionals involved in Care Proceedings is limited access to 'what works' for example, MST CAN which has demonstrated success as an intervention to address child abuse and/or neglect, is currently only available in 6 out of 152 Local Authorities in England. Whilst it is good that there is access to an evidence-based intervention, there is not enough supply to meet demands with the growing cases of children entering care annually. Similarly, though not the focus of

this thesis, another intervention which supports families with multiple needs is the use of the Family Drug and Alcohol Court (FDAC), an alternative approach to Care Proceedings. The difference between FDAC and usual Child Proceedings is the court process which is supported by a specialist team and uses a problem-solving approach to the difficulties that have led to Proceedings and is more inclusive of parents. Similarly, to MST CAN, this method of working with cases whereby there is abuse and/or neglect, has limited representation currently in England with only 9 specialist FDAC teams, serving 12 courts across 20 local Authorities in England (FDAC national Unit, 2019). Increasing access to 'what works' for families could lead to a reduction in children being removed and placed in care and break the cycle of intergenerational abuse and/or neglect and the longer term personal, economic and societal costs.

Another option to consider, given the high levels of trauma that parents within child protection and care proceedings have experienced, as evidenced in chapters three and four, would be for LA along with health commissioners to consider developing specialist trauma teams within local authorities, offering support at the earliest opportunity rather than during proceedings. These 'trauma teams' could comprise of registered psychologists and psychotherapists and work collaboratively with social workers to increase their understanding of the parental presentation, provide consultation to increase engagement and address trauma

symptoms alongside more universal interventions to improve parenting, if required. To alleviate cost, the setting would be a good placement for Psychologist and Psychotherapy trainees with appropriate supervision. There is a need to recognise families within the child protection arena and that current provisions do not meet their needs. There has been Public Health initiatives to increase support for women's perinatal mental health and recognition of the need to increase access to mental health services for adult offenders, this area of law (family) seems to have been forgotten.

There is also a need to think about how to better support social workers in managing the demands of caseloads, pressure driven by fear and monitoring and challenging potential confirmatory bias. One option would be to look at having support within social care from psychologists attached to teams providing; supervision which feels safe and whereby issues such as confirmatory bias could be explored in a safe space, consultation to discuss cases that are not progressing and also utilising an MDT approach within social care to managing complex cases.

Other examples of change to improve outcomes would be those recommended by the care case review highlighted in Table 8, such as having MDT teams, utilising methods such as Motivational Interviewing but providing adequate support, such as having an identified specialist to support its implementation.

Limitations of the thesis

Like the majority of studies, the chapters in this thesis have limitations and they should be considered. Chapter two is the first Systematic Review of MST CAN and brings together all of the research to date on its implementation. However, this is limited and there are only two high quality studies one being an RCT and the other a Quasi Experimental design. Another limitation and issue around the generalising of the results is that the majority of research was from America and conducted by the developers of the intervention.

In chapter three the empirical study, the data collection process was incredibly time consuming for one researcher which limited the number of cases included in the study to 50. Small sample sizes may prevent differences from being observed, increase the risk of error and can undermine the internal and external validity of a study (Faber & Fonseca, 2014). The data was from only one Local Authority (LA) which may limit generalisation of the findings across England, especially given the regional variations found in the use of CO and SO, for this LA the figures of SO were much higher than national averages. The data was collected and analysed by the author, to have ensured the data was more robust this could have been reviewed by a second researcher. Reports can be subject to bias and notoriously have information missing, as discovered within this research. This reduced the amount of data that was reported in the study compared

with the original variable list. It also highlighted that it is more difficult to collect qualitative information than quantitative and the use of robust definitions is important to reduce risk of bias. Another limitation is not recording the original application to court compared with final recommendation which would have indicated whether the order was judge led or social care led.

The primary limitation of chapter four is that it is a single design case study and whilst case studies can provide rich qualitative data it is hard to generalise the results as you would with a study with multiple participants.

Final thoughts

Overall, despite the limitations listed, this thesis further contributes to our understanding of the characteristics of families involved in Care Proceedings. The study into care proceedings further evidences the challenges faced by social workers in the area of Child Protection and Care Proceedings. It highlights the strengths and weakness of a promising intervention for child abuse and neglect, MST CAN and demonstrates the implementation of this intervention in a way which is accessible for professionals in the field of Social Work. The length of time

some families are known to services without sustained change being evidenced, highlights that what is currently being offered to them to address the risk factors for child abuse and/or neglect is not working. We need to understand more about these families. There is a need to review our approach to families where there is significant risk of child abuse and/or neglect and how we engage them in treatment. There is a lack of family friendly material documenting Care Proceedings, how to address concerns or normalising how difficult it is to make changes, but it is possible. Quite often the process involves professionals identifying what needs to change and families agreeing without any work carried out assessing their motivation to change and what support they need in order to do that. Future research looking at whether assessing parental motivation to change and increasing their confidence in their ability to change has any impact on parental engagement in services would be useful. Especially, given that in the majority of LA in England families do not have access to specialist interventions for child abuse and/or neglect such as, MST CAN or FDAC. The thesis highlights that it is not all doom and gloom, some families can and do change, they just need the right support at the right time and the mirror should sometimes be turned on the professionals to think about how we support this in order to gain positive outcomes for the children central to the concerns.

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Appendix A Search terms used in Systematic Review

Key words searched included: (MST CAN) OR (Multisystemic Child Abuse and Neglect) OR (MST Building stronger families) these terms were also combined with (therap*) OR (treat*) or (interven*) or (compar*) or (program*) the term NOT (MST) was used to reduce inclusion of standard MST studies.

Appendix B PICO

Inclusion Criteria Checklist (adapted from Chou, S. (2016). *Methodology of systematic reviews.* Retrieved from moodle.nottingham.ac.uk

Inclusion Criteria	**Criterion met?**	**Comment**
Study design: Does the study discuss the implementation of MST CAN, RCT, cross sectional, quasi experimental or case study? Not narrative or descriptive.	Yes Unclear Discuss No	
Population: Is the population children who have experienced child abuse and/or neglect aged between 6-17 AND Caregivers who perpetrate child abuse and or neglect.	Yes Unclear Discuss No	
Outcomes: Has the risk of child abuse and/or neglect reduced as evidenced by no further reports? Has the parental mental health improved? Has parental substance/alcohol use been treated? Has child mental health improved?	Yes Unclear Discuss No	
Intervention: Has an intervention taken place? AND What intervention is the comparator(s)?	Yes Unclear Discuss No	

Appendix C – Quality Assessment Tool

REDUCTION OF SELECTION BIAS			
Criteria	**Yes**	**No**	**Other**
1. Were eligibility/selection criteria for the study population pre-specified and clearly described?			
2. Was the sample size sufficiently large to provide confidence in the findings?			
3. Are the individuals selected to participate in the study likely to be representative of the target population?			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

STUDY DESIGN			
Criteria	**Yes**	**No**	**Other**
1. Was the study question/objective clearly stated?			
2. Indicate the study design: a. Randomised controlled trial b. Controlled clinical trial c. Cohort analytic (two group pre + post) d. Case control e. Cohort (one group pre + post) f. Interrupted time series g. Other specify _____ h. Can't tell			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

BLINDING			
Criteria	**Yes**	**No**	**Other**
1. Were the people assessing the outcomes blinded to the participants' exposures/ interventions?			
2. Were the study participants aware of the research question?			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

DATA COLLECTION METHODS			
Criteria	**Yes**	**No**	**Other**
1. Were the outcome measures pre-specified and clearly defined?			
2. Were the outcome measures valid?			
3. Were the outcomes measures reliable?			
4. Were the outcome measures assessed consistently across all study participants?			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

MANAGEMENT OF WITHDRAWALS AND DROP-OUTS			
Criteria	**Yes**	**No**	**Other**
1. Were sufficiently rigorous methods used in order to retain participants?			
2. Were participants who completed the study sufficiently comparable to those who withdrew/ dropped out?			
3. Were missing values appropriately dealt with?			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

INTERVENTION INTEGRITY			
Criteria	**Yes**	**No**	**Other**
4. Was the intervention clearly described and delivered consistently across the study population?			
5. Is it likely that participants received an unintended intervention (contamination or co-intervention) that may influence the results?			
Component Rating **STRONG** 1	**MODERATE** 2		**WEAK** 3

Analyses			
Criteria	**Yes**	**No**	**Other**

1. Were appropriate statistical tests completed?			
Component Rating	**STRONG**	**MODERATE**	**WEAK**
	1	2	3

SUMMARY OF RATINGS FOR THIS PAPER

Component	Reviewer #1 Rating	Reviewer #2 Rating
Reduction of Selection Bias		
Study Design		
Blinding		
Data Collection Methods		
Management of Withdrawals and Drop-Outs		
Intervention Integrity		
Analyses		

If there is a discrepancy between the two reviewers with respect to the ratings, please indicate a reason for this:

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

Appendix D MST CAN case study consent form

The Centre for Forensic and Family Psychology, Division of Psychiatry

http://www.nottingham.ac.uk/research/groups/cffp

The University of Nottingham

CONSENT FORM FOR CASE STUDY

- As part of the requirements for the doctorate in forensic psychology, I am required to produce case study examples of work. Case studies are helpful as they contribute to research areas and also provide further evidence to the 'what works' literature.

- There will be no identifiable information detailed in the case study included in the thesis, it will be anonymous and will share data such as scores on questionnaires, an outline of initial difficulties and reason for referral to MST CAN, initial problem definition and treatment targets, an overview of the treatment offered and outcomes.

- I agree to consent to the work completed with our family to be used as part of an anonymous case study. I am aware that this may be published however, there will be nothing detailed which would make it possible to identify who we are.

Thank you for agreeing to this.

Sebrina Turner

Name

Signature

Date:

Appendix E URICA: University of Rhode Island Change Assessment

Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel **right now**, not what you have felt in the past or would like to feel. For all the statements, answer in terms of what you write on the "Problem" line below. There are FIVE possible responses to each of the items in the questionnaire:

Problem:

_____

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing. _____

2. I think I might be ready for some self-improvement. _____

3. I am doing something about the problems that had been bothering me. _____

4. It might be worthwhile to work on my problem. _____

5. I'm not the problem one. It doesn't make much sense for me to be here. _____

6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help. _____

7. I am finally doing some work on my problem. _____

8. I've been thinking that I might want to change something about myself. _____

9. I have been successful in working on changing but I'm not sure I can keep up the effort on my own. _____

10. At times my problem is difficult, but I'm working on it. _____

11. Being here is pretty much a waste of time for me because the problem doesn't have to do with me. _____

12. I'm hoping that this place will help me better understand myself.

13. I guess I have faults, but there is nothing that I really need to change. _____

14. I am really working hard to change. _____

15. I have a problem and I really think I should work at it. _____

16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem. _____

17. Even though I'm not always successful in changing, I am at least working on my problem. _____

18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it. _____

19. I wish I had more ideas on how to solve my problem. _____

20. I have started working on my problems but I would like help. _____

21. Maybe this place will be able to help me. _____

22. I may need a boost right now to help me maintain the changes I've already made. _____

23. I may be part of the problem, but I don't really think I am. _____

24. I hope that someone here will have some good advice for me. _____

25. Anyone can talk about changing; I'm actually doing something about it. _____

26. All this talk about psychology is boring. Why can't people just forget about their problems? _____

27. I'm here to prevent myself from having a relapse of my problem. _____

28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. _____

29. I have worries but so does the next person. Why spend time thinking about them? _____

30. I am actively working on my problem. _____

31. I would rather cope with my faults than try to change them. _____

32. After all I had done to try to change my problem, every now and again it comes back to haunt me. _____

Precontemplation items 1, 5, 11, 13, 23, 26, 29, 31

Contemplation items 2, 4, 8, 12, 15, 19, 21, 24

Action items 3, 7, 10, 14, 17, 20, 25, 30

Maintenance items 6, 9, 16, 18, 22, 27, 28, 32