**Supporting families at risk: social workers experiences of a Family Safeguarding Model and the effectiveness of parent infant psychotherapy**

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

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| **Declaration and signature of candidate** |
| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  C:\Users\cuccch\Desktop\Char Sig.pngI confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.  Signed: Date: 27/04/2023 |

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# Thesis abstract

This thesis reviews and synthesises the evidence-base for parent-infant psychotherapy (PIP) and directly explores social workers experiences working with families in within a Family Safeguarding Model in child protection services.

Chapter one is a literature review, critically appraising the effectiveness of parent-infant psychotherapy. PIP was found to be effective in improving parental mental health and mixed results were found for child development and attachment relationship outcomes. Improvements were observed in those with complex trauma histories and in those with poor predicted prognosis (e.g. >4 previous traumas). To improve validity and reliability further research should focus on larger samples including fathers, other comparison groups and robust measurement. Clinical implications such as the importance of trauma-informed assessment and access to intervention are discussed.

Chapter two is an empirical paper designed to explore social workers’ experiences of working within the Family Safeguarding Model. Six social workers were recruited and engaged with semi-structured interviews. Interpretive Phenomenological Analysis was used to analysis the transcripts. Three group experiential themes emerged: fighting to work with families, feeling held and protected and we’re breaking at the seams. The results illustrate that when the model works as it’s intended that social workers feel able to connect with families, develop a shared understanding and feel less alone in managing risk. However, with increasing caseloads and a reduction in resources, workers are left feeling alone, powerless and hopeless. Clinical implications for family services are discussed.

Chapter three is an executive summary of the empirical paper written for professionals working within family safeguarding services, such as social workers or anyone else involved with this type of work. The aim of this is to make the research outcomes more accessible.

# Paper 1: Literature Review

# Effectiveness of parent-infant psychotherapy for infant development, parenting, parental mental health and the attachment relationship: A review of the literature

Word count: 7993

Target Journal: Journal of Infant Mental Health

Author guidelines can be found in Appendix 4, although further modifications will be made prior to submitting to the journal

# Abstract

Parent-infant psychotherapy (PIP) is a recommended treatment for maltreated children which focuses on maternal representations alongside the attachment relationship. This review aims to provide an updated synthesis on the outcomes of PIP for parents, children and their relationship. 8 databases were searched for literature and a total of 16 studies fitted the inclusion criteria. Studies were appraised using Crowe’s Critical Appraisal tool (Crowe, 2013). Most studies found improvements in parental mental health following PIP intervention. Mixed results were obtained for child development and the attachment relationship. Factors found to be associated with treatment outcome included; length of treatment, prognosis at baseline, education, and number of traumatic stressful events. Specifically, those with poor predicted prognosis and >4 previous traumas benefited more from PIP than those in comparison groups. Clinical implications include the importance of screening for trauma and supporting access to treatment for those with complex trauma histories and outlines the benefits for parental mental health, which may have longer term implications for parent-infant attachment outcomes. Treatment fidelity, small sample sizes and confounding variables may limit the reliability and validity of results. Further research with larger samples including fathers, other comparison groups and robust measurement, particularly for parent/infant outcomes is needed.

*Keywords:* Maltreated children, parent-infant psychotherapy, parent-child attachment, parental mental health

Key findings:

1. Specifically, those with poor predicted prognosis and >4 previous traumas benefited more from PIP than those in comparison groups which highlights the importance of screening for complex trauma histories at point of assessment.
2. Most studies found improvements in parental mental health following PIP intervention, illustrating the efficacy of PIP for parental mental health.
3. Improvements in adult mental health suggest the importance of ensuring that such clients have access to trauma informed therapies.

# Introduction

There are several interventions offered in clinical settings to treat parents and their infants with disrupted attachments or infant-regulatory difficulties (e.g. crying, feeding, digestion and separation difficulties) aiming to promote optimum development in infants. Evidence based approaches include parenting programmes, home visitation, Parent-Infant Interaction Therapy, and Parent-Infant Psychotherapy (PIP)(Barlow et al., 2015).

Attachment theory refers to the emotional bonds that infants develop with their primary caregiver, (Bowlby, 1969) and findings suggest that ‘insecure attachments’ impact negatively on a child’s social, emotional and cognitive development (Szaniecki & Barnes, 2016; Patrick et al., 2014). Factors found to impact on attachment security include; ‘maternal representations’, which refers to the mothers’ own internal working models, including her perceptions of parenting, and of her child (Rosenblum et al, 2019), ‘parental reflective functioning’; which describes a parent’s capacity to understand their infants’ internal feeling states and behaviour (Kelly, 2005) and ‘emotional availability’, which refers to a parents’ ability to interact and respond to their infant’s needs (Saunders e al, 2015).

Difficulties with aforementioned factors are often the consequences of parents own insecure attachments and ‘unresolved trauma’ (e.g. historical abuse/neglect) (Cicchetti, 2006), otherwise known as ‘ghosts in the nursery’ (Fraiberg 1975 as cited in Malone et al., 2010). Such unresolved trauma can affect the way caregivers relate to, and bond with their infants, increasing the likelihood of maternal mental health difficulties such as Post Traumatic Stress Disorder or depression (Collishaw et al., 2007). These difficulties increase the risk of threatening or insensitive parenting behaviour, which can result in child maltreatment (O’Donnell et al, 2015), resulting in the transmission of insecure attachments to infants (Madigan, 2006; Van ljzendoorn & Bakermans-Kranenburg 2019). Long term, this has implications on child development (Vameghi et al., 2015), regulation difficulties (Breeman et al., 2018; Patrick et al., 2014) and behavioural difficulties (Hemi et al., 2011).

Internationally, ‘attachment difficulties’ are commonly cited as the reason for parent and infant referrals into specialist services, (Keren et al., 2001) with a prevalence ranging from 12-16% (Briggs-Gowan, 2001), which is estimated to be significantly higher in contexts of extreme poverty and family displacement (Grantham-Mc Gregor et al., 2007). Perinatal mental health difficulties are estimated to have a long-term cost on society of £8.1 billion each year, in the UK and 72% of this cost relates to adverse impacts on the child long-term. Thus, a focus on early trauma and attachment relationships within clinical services, particularly for parents’ exposed to early deprivation and chaotic relationships is paramount. Despite this, in 2014 only 3% of Clinical Commissioning Groups (CCG’s) in England had a strategy to commission perinatal mental health services (Baur et al., 2014). However, the NHS long term plan (2019) has since sought to to address this by increasing access and available treatments for specialist perinatal mental health services by 2024 (Alderwick, & Dixon, 2019).

Parent-Infant Psychotherapy (PIP) is a psychodynamic intervention, which originates from Fraiberg’s (1980) work, whereby parent-child dyads are treated together. The aims of intervention centre on fostering the parent-infant relationship to promote attachment security and optimal infant/child development. The intervention supports parents to understand and be able to ‘mentalise’ their child’s emotional states with a focus on encouraging parental self-reflection and sensitivity to their child’s needs. This is an attempt to improve parental behaviours towards children by targeting the parents internal working models, born out of their experiences of being parented (Matheb et al, 2021).

PIP was later applied to children up to 5 years of age, which is referred to as ‘Child Parent Psychotherapy’.(Lieberman & Vanhorn, 2006 as cited in Lieberman et al, 2005). Thus PIP and CPP are broadly the same intervention utilizing the same theoretical underpinnings, but with different terminology to reflect the age of the child.

A review found that PIP is a promising model to improve infant attachment security, particularly in high-risk families whereby parental mental health difficulties were present, however found no evidence that this intervention is any more effective than any other methods of working with parents and infants together. They concluded that more research was needed on mediating factors including parental mental health, reflective functioning and the parent-infant interaction (Barlow et al, 2015).

## Rationale for review

Child Parent Psychotherapy (CPP) is recommended for ‘maltreated children’ such as those who have experienced neglect and/or abuse, between the ages of 0-5 years (National Institute for Health and Care Excellence [NICE], 2017). A review exploring the efficacy of this treatment for children and parents excluded studies that were not Randomised Controlled Trials (RCT) or quasi-experimental; and studies whereby infants mean age exceeded 24 months (Barlow et al, 2015). An RCT is not reflective of the current real world context in which such dyads are treated and thus lacks external validity. The recommendations specify this treatment as a suitable intervention for children up to 5 years old and the previous review excluded studies on the basis of the child being ‘too old ’, thus this review increases the scope of the previous review in evaluating the effectiveness of PIP in clinical practice for the age range specified in NICE guidance.

Aims

* To provide an update on the outcomes of PIP using a wider range of research design (not only RCT), since 2015. Outcomes will include the attachment relationship, children’s development and parental mental health, to inform evidence-based guidelines for use of PIP in children up to the age 5.
* To examine all studies previously excluded from Barlow’s (2015) review of PIP such as children up to age 5 and non-RCT designs.

Review question: What is the effectiveness of PIP for infant development, parenting and the attachment relationship for children up to the age of 5 years?

# Method

## Scoping searches

An initial scoping search was carried out using the Cochrane and google scholar databases to determine the viability of the review, which identified a previous review examining the efficacy of parent-infant psychotherapy (Barlow et al., 2015). Further published studies were found on the outcomes of PIP since this review was published and highlighted gaps in the previous review that warranted an updated synthesis of the evidence for the effectiveness of PIP.

## Search Strategy

Systematic searches to ensure replicability were carried out in April 2022 across the following databases: PsychINFO, PsyArticles, CINAHL, Education Research Complete, Medline, Scopus, Social Care Online, and ETHOS. Search terms were based on the terms that the previous review had used and included:

(“Parent-Infant” OR “Parent-Child” OR “Parent Toddler” OR “mother Infant” or “father infant” or “Mother Child” OR “Child Parent”)

AND

(“Psychotherapy” OR “Psychoanalytic therapy” or “Psychodynamic” or “Psychotherapy”)

Initial scoping searches demonstrated a lack of sensitivity to using ‘PIP’ or ‘CPP’ as search terms, and thus these broader search terms were more viable.

To determine which research papers were eligible for the review, inclusion and exclusion criteria were applied (see Table A).The review did not apply any date limiters given its aims were to capture any studies excluded from the previous review, as well as provide an update to this.

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Inclusion** | **Exclusion** |
| *Population* | Parent or caregiver child dyads or triads (fathers included)  Studies with infants 5 years or under. [[1]](#footnote-2) | Caregivers or children alone |
| *Design* | Any quantitative design reporting on outcomes and effectiveness of PIP  e.g. Pre-post analysis, pilot studies, controlled clinical trials, quasi-experimental, RCT or single case experimental designs. | Qualitative studies  Case studies  Commentaries  Process Studies |
| *Intervention* | Studies aiming to evaluate outcomes of PIP/CPP based on both Cicchetti (2006) and Lieberman & Vanhorn’s (2005) work originating from Fraiberg’s (1975) work and inclusive of one of the following components   * There is a focus on psychodynamic theory * focused on altering the attachment relationship * Explores maternal representations | Studies where the *primary focus* is other dyadic interventions focusing on different theoretical approaches |
| *Language* | Available in English |  |

Table 1. Inclusion and Exclusion criteria

## Publication Bias

To minimise publication bias including when journals only publish articles that display statistically significant findings or in non-English language (Montori et al., 2000), a search of the grey literature which included ETHOS and google scholar was conducted. This search identified five studies that appeared eligible initially but were screened out, as their primary focus was not psychodynamic. A further two were non-english, and after accessing the abstracts one did not report on outcomes (Bark et al., 2018) and the other had not concluded their trial (Eckert et al., 2020) and thus were excluded.

## Overview of the search

The search process is illustrated in Figure 1, showing that searches obtained 1744 results across databases. After duplicates were removed (671), 1070 studies remained, which were screened by title and abstract. After screening, 1042 studies were removed and 31 studies remained to be assessed at full-text level for eligibility against the inclusion and exclusion criteria, including 3 studies identified through citation searches within relevant articles. A total of 16 studies meeting the inclusion criteria remained.



## Quality Assessment

The Crowe Critical Appraisal Tool v.14 (CCAT) (Crowe, 2013) was used to critically appraise all studies, given its suitability in application to studies with different methodologies/designs. The CCAT evaluates 8 categories including; preliminaries, introduction, design, sampling, data collection, ethical matters, results and discussion. Each criteria is scored between 0-5, whereby 5 indicates a high level of quality and 0 a low level, with a maximum score of 40. This tool is reportedly more reliable than informal methods of appraisal, as it reduces rater effects and minimises bias (Crowe et al, 2011). No studies were excluded based on their quality rating given that the lower rated studies adopted non-RCT methods and were considered to be relevant to the review’s aims.

Narrative Synthesis was utilized, which involved reading over all relevant studies and inputting key information into a study characteristics table (appendix 2) whereby an initial preliminary synthesis was developed and quality appraisal carried out. Study findings were compared, and textual descriptions of included studies summarised. Study outcome measures were collated separately to support with mapping out conceptual findings to inform written synthesis (appendix 3) (Popay et al., 2006). Meta-analysis was not carried out, given that there were several different outcome measures used across the variables measured.

# Results

## Overview of the studies

16 studies met the inclusion criteria and were included in this review. The majority of the studies took place in the USA (N=7) and others in the UK (N= 4), Sweden (N=1), Germany (N=2), France (N=1) and Switzerland (1). All studies aimed to evaluate the outcomes of “parent-infant psychotherapy”, with their primary focus being on parent and infant mental health, parental reflective functioning, infant development and the parent-infant attachment relationship. Some studies focused on the predictive factors influencing outcomes. The majority of included studies were randomised controlled trials (RCT) or quasi-experimental (N =11), with the remaining five being service evaluations (Armstrong & Howaton, 2015; Cramer et al.1990; Hagan et al, 2017;Herve et al, 2009; Lavi et al, 2015).(See table 2 for extraction table).

*Table 2 Study Extraction table*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Author & year** | **Country & Setting** | **Aims** | **Findings & conclusions** | **CCAT**  **Score** | **%** |
| Armstrong & Howatson (2015) | UK | Evaluate a creative ‘art’ PIP group. | * Largest improvement in parent’s ability to think about their infant and interpret how they feel/what they need. * Parental responses were significantly more positive post intervention. * Highest change in ratings for mothers with post-natal depression. | 18 | 45 |
| Bain (2014) | Homeless shelters in Johannesburg | Efficacy of group PIP for high risk, diverse dyads. | Significant improvements:   * Infants’ speech development (p=0.024) and the mothers’ abilities to structure their interactions with their infants (p = .015).   Correlations:   * Positive correlation between number of sessions attended, improvement in the babies’ hearing and speech, (p = .01) and mothers structuring abilities, p = .006. * A negative correlation found between the mothers’ depression score and number of sessions attended (p = .048). | 26 | 65 |
| Cramer et al., (1990) | Switzerland | Compare effectiveness of PIP and interactional guidance. | Improvements across both groups:   * Infant symptoms – (e.g. sleep, feeding, digestion, separation & behaviour) * Interactions – Maternal sensitivity to infants’ signals significantly increase. * Maternal representations – several significant changes – (infant perceived as calmer, more affectionate, more independent and less aggressive in both groups). * Improvements maintained at follow up: Mothers increased sensitivity, decreased intrusive control & infants showed more cooperation, in both groups. * Cases that were seen as having a ‘poor prognosis’ improved more across both groups.   PIP Specific outcomes:   * Maternal self-esteem increases only in PIP group (p=<.002) | 20 | 50 |
| Fonagy et al., (2016) | UK | Efficacy of PIP on quality of parent-infant relationship and mothers’ mental health. | * favourable outcomes for PIP on maternal mental health (p=.002), parenting stress (p=0.018) and parental risk representations of the baby and their relationship. | 32 | 80 |
| Geog et al., (2021) | Germany | Efficacy of PIP for the treatment of early regulatory disorders. | Significant findings:   * PIP found to be superior to TAU in treating infants with ERD (P=.004), night waking disorders (p=.030), mothers psychological distress (p=.000) and depression (p=0.06).   Non-significant findings:   * Results showed trends for superior effects of PIP on increased maternal self-efficacy. | 34 | 85 |
| Gosh Ippen et al., (2011) | US | Efficacy of PIP for children who experienced multiple traumas. | * Statistically significant changes for those who had experienced 4 or more TSE’s, CPP group showing lower rates of PTSD than comparison group (p=<0.01). * Significant reductions observed in scores for poor maternal functioning for Comparison & CPP, however comparison group not significant if >4 TSE’s. | 26 | 65 |
| Hagan et al, (2017) | US | Effectiveness of PIP on parent and child PTSS symptoms and how this associates with pre PSTD/life stressors | Significant findings:   * PTSS decreased for both parents and children.   Associations:   * Parent and child improvement in PTSS was greater for those with fewer lifetime stressors. * Individuals who started with higher levels of PTSS tended to decrease PTSS symptoms more. | 21 | 53 |
| Herve at al., (2009) | France | Predictive factors for PIP outcome in young children presenting with functional or behavioural disorders. | * Post therapy 70% of children displayed favourable outcomes (child asymptomatic at final session) or partial improvement (e.g. less than 4 functional symptoms present such as sleep, eating, crying difficulties). * Mothers & fathers– reduction in depression/anxiety   Associations with unfavourable outcomes:   * Children: behavioural disorders/fears, higher symptom check-list score (sleep, feeding, digestion, behaviour, fear, shyness & separation) separated parents, mothers with high anxiety and father absent from consultations. * Mothers: separated from father, higher initial anxiety/depression scores & children had high behaviour difficulties. | 23 | 58 |
| Lavi et al., (2015) | US | Effectiveness of CPP on a perinatal sample on maternal functioning and mental health. | Significant findings:   * Decrease in levels of depression (p=<0.0001, large effect size .94), PTSS (P=<0.0001, large effect .99) and increase in positive child rearing attitudes (P=<0.0001, large effect .95) post CPP.   Associations:   * Women with low maternal-fetal attachment demonstrated the greatest improvement in depression, PTSS, and child-rearing attitudes. | 23 | 58 |
| Lieberman et al., (2005) | US | Efficacy of CPP for preschool-age children exposed to marital violence. | * CPP group had significant post-test reductions in traumatic stress symptoms (p=<.001), child behaviour scores, maternal PTSD & maternal mental health and comparison did not. | 27 | 68 |
| Lieberman et al., (2006) | US | Efficacy of CPP on child and maternal symptoms at 6 months follow up. | * Child functioning & maternal mental - showed a significant group x time interaction in only CPP group (p=<.001). | 27 | 68 |
| Mattheb el al., (2021) | Germany  mother-child facilities | Efficacy of PIP for mothers at risk and their children. | * PIP intervention had a small moderating effect (0.39) on sensitivity * At time 3 mothers receiving care as usual had significantly higher mental health difficulties compared with PIP p=.022; effect size = .096.   Predictors:   * Mothers with higher baseline sensitivity scores benefited more from PIP. | 25 | 63 |
| Salomonsson et al., (2021) | Sweden | Effectiveness of brief PIP on parental depression and infant social– emotional functioning/  associations with pre-treatment adversity factors | Mothers depression scores & infant functioning difficulties decreased significantly post therapy – (large effect 0.70 & moderate effects 0.40 respectively).  Predictors/mediators:   * Higher levels of depression associated with a higher number of sessions * Mothers whose child did not live with them had higher depression at baseline * Higher education level was associated with a steeper rate of change for depressive symptoms. | 30 | 75 |
| Sleed et al., (2013) | UK, homeless hostels | Effectiveness of clinic model using PIP in hostels | * Significant effect for cognitive capacities such as sensory, memory, learning, problem solving and verbal development in PIP group (P=<.04)) and motor scores (e.g body control, muscle coordination, fine motor skills) for infants. | 22 | 55 |
| Toth et al., (2002) | US | Efficacy of two interventions for maltreated pre-schoolers and their mothers | * Adaptive maternal representations, children’s self-representations, and quality of mother-child relationship scores increased significantly over time in all four study conditions - the most significant changes were observed in PIP. * A significant difference for negative self-representations only in the PIP group (p=<0.001). | 25 | 63 |
| Weiner et al, (2009) | US | Effectiveness of trauma focused treatments within a foster care program on child outcomes | * CPP African American youth experienced significant improvement in every Child and Adolescent needs and strengths domain (p=<.01) (e.g. behavioural/emotional needs, risk behaviours, life functioning, trauma experiences & traumatic stress symptoms).   Predictors:   * Predictors of change in traumatic stress were baseline traumatic stress symptoms (p=.000) and number of sessions. | 17 | 43 |

**Key:** TAU = Treatment as usual, TSS = Traumatic Stress Symptoms , PTSD = Post Traumatic Stress Disorder, CPP = Child Parent Psychotherapy, PIP = Parent-Infant Psychotherapy, ERD = Early Regulatory Disorders, PTSS = Post Traumatic Stress Symptoms, TSE’s = Traumatic Stressful Experiences,.

## Aims

14 studies aimed to measure the impact of PIP on a range of children’s outcomes including two measuring regulatory symptoms (e.g. sleeping, feeding, separation, digestion etc.) (Cramer et al., 1990; Georg et al., 2021) and five measuring developmental difficulties (e.g. hearing, speech, cognitive and motor function) (Bain 2014; Fonagy et al., 2016; Herve et al., 2009; Matheb et al., 2021; Sleed at al., 2013). Two studies measured behaviours indicative of early trauma (Toth et al., 2002; Weiner et al., 2009) and five measured children’s exposure to traumatic events, to see if this impacted on outcomes (Ghosh Ippen et al., 2011; Hagan et al., 2017; Lieberman et al., 2005; Lieberman et al., 2006; Weiner et al., 2009).

Seven studies aimed to measure the impact PIP has on the relationship between the parent and child, including parental reflectivity, (Bain, 2014; Georg et al., 2021; Matheb et al., 2021) maladaptive maternal representations, (Cramer et al., 1990; Fonagy et al., 2016; Toth et al., 2002) and changes in the attachment relationship (Fonagy et al., 2016; Matheb et al., 2013). The quality of the parent-infant interaction (e.g. parental sensitivity and infants’ responsivity) was measured in six studies, (Bain, 2014; Cramer et al., 1990; Georg et al., 2021; Fonagy et al., 2016; Matheb et al., 2013, Sleed et al., 2013).

All but four studies aimed to measure the effect of PIP on parental mental health (Armstrong et al., 2015; Cramer et al., 1990; Sleed et al., 2013; Toth et al., 2002), including depression, anxiety, post-traumatic stress symptoms and personality difficulties. Some studies aimed to measure impact of PIP on parenting stress (Armstrong et al., 2015;Georg et al., 2021; Matheb et al., 2021), self-efficacy (Armstrong et al., 2015 Fonagy et al., 2016; Georg et al., 2021) and child rearing attitudes (Lavi et al., 2015). Five studies additionally aimed to find associations with treatment outcome (Bain, 2014; Cramer et al., 1990; Hagan et al., 2017; Herve et al., 2009; Lavi et al., 2015).

## Sample

The majority of study participants were mother-child dyads ranging from 12 dyads (Armstrong & Howatson, 2015) up to larger samples of 199 dyads (Hagan et al., 2017). All but two studies (Georg et al., 2021; Armstrong & Howatson et al., 2015) reported dyads were from at risk populations, including parents experiencing mental health difficulties and domestic violence concerns. Several studies recruited participants, who had experienced early adversity, such as exposure to trauma, socioeconomic deprivation and poor access to education.

### Caregivers

Most studies specified exclusion of mothers with severe mental health difficulties such as psychosis or suicidality, with the justification that this would likely impact on engagement in therapy. Fathers were not explicitly excluded with one study including fathers’ data (Georg et al., 2021) and another reporting inclusion of non-biological caregivers (Hagan et al., 2017). Another was based in a foster care setting, however referenced that a parent or caregiver was necessary for treatment (Wiener et al., 2009), and another recruited when mothers were in their third trimester of pregnancy (Lavi et al., 2015), with the focus on the unborn child. The age of parents included across the studies ranged from mothers at 18 years to 43 years old, with a mean maternal age of 30.05 years.

### Infants

Recruited infants ranged in age from the gestational period (Lavi et al., 2015) up to 6 years in one study, which was deemed to meet the inclusion criteria given most infants were below 5 years old (Hagan et al., 2017). The majority of studies recruited children under 2 years old and the mean age across all studies was 25.6 months. There appeared to be equal weighting between females and male infants across studies.

## Recruitment

The majority of infants were recruited on the basis of initial referrals into clinical services which outlined concerns about the child’s behaviour, attachment/bonding difficulties with their parents and/or functional disorders including difficulties with sleep, feeding and emotional regulation. Sampling methods adopted were primarily purposive in nature as dyads were known to health services and were typically recruited through referrals from professionals. There were a small number of studies, which accepted some self-referrals (Georg et al., 2021; Ghosh Ippen et al., 2011; Lieberman et al., 2005; Lieberman et al., 2006).

## Study designs

All studies adopted a quantitative approach whereby the majority of studies were RCT’s or quasi-experimental, reporting on pre-post outcome measures. Randomisation and blinding methods whereby researchers and those coding outcomes were independent raters, were explicitly outlined in 10 of the studies (Bain, 2014; Fonagy et al., 2016; Georg et al., 2021; Ghosh Ippen et al., 2011; Herve et al., 2009; Lieberman et al., 2005; Lieberman et al., 2006; Matheb et al., 2021; Sleed et al., 2013; Toth et al., 2002;) Other studies were classified as evaluations (Armstrong & Howatson 2015; Cramer et al., 1990), ‘naturalistic’ (Salomonsson et al., 2021; Weiner et al, 2009), ‘open treatment studies’ (Hagan et al., 2017), or ‘pilot studies’ Lavi et al., 2015).

## Control and comparison groups

All but four studies utilized a control and/or comparison group (Armstrong & Howatson 2015, Hagan et al., 2017;Herve et al., 2009; Lavi et al., 2015). Within this, two of the studies compared PIP with other forms of therapy such as interactional guidance (Cramer et al., 1990) and other trauma intervention, but for older infants, (Weiner et al., 2009) and the remaining studies compared PIP with treatment as usual (TAU).

## Intervention

All interventions had a psychodynamic focus aimed at parent-child dyads, whereby main treatment goals were in line with parent-infant psychotherapy treatment recommendations (Chichetti, 2006). Ten studies named their treatment as Parent Infant Psychotherapy (PIP) and the remaining six, named treatment as Child Parent Psychotherapy (CPP), the latter based on similar psychodynamic principles, just reflecting the older age of the index child.

### Fidelity

12 of the studies outlined study fidelity through use of checklists, regular supervision, video rating and manuals. Four studies did not discuss treatment adherence (Armstrong & Howatson, 2015; Cramer et al., 1990; Herve et al., 2009; Sleed et al., 2013).

### Facilitators

All of the studies referenced that facilitators were trained licensed psychotherapists or therapists in relevant training with several years of intervention based experiences in relevant contexts.

### Duration

The number of sessions varied with a range of some studies offering four sessions over 12 weeks (Geog et al., 2021) and others offering more sessions over a longer period of time; delivering weekly sessions for up to one year (Ghosh Ippen et al., 2011; Lieberman et al., 2005; Lieberman et al., 2006; Weiner et al., 2009).

### Group sizes

Three of the studies were groups (Armstrong & Howatson, 2015; Bain, 2014; Sleed et al., 2013).Group sizes ranged from 3 to 16 mother-infant dyads (Bain, 2014). One group design offered a ‘drop in’ approach to improve access and managed to recruit 39 dyads within a 3-6 month time frame with a range of between 2-21 group session attendances (Sleed et al., 2013) and another offered the group creatively using art (Armstrong & Howatson, 2015).

## Outcome measures

Studies utilised a variety of child, parent and child-parent relationship outcomes (appendix 3). The majority of the studies completed outcome measures at pre and post therapy and three measured outcomes at follow up (Cramer et al., 1990; Lieberman et al., 2006; Toth et al., 2002).

### Parent focused

Across studies, 18 different measures were used to capture parent-based outcomes. Outcomes focused primarily on parent’s psychological symptoms, such as post-traumatic stress levels, anxiety, depression, and self-efficacy. Examples of outcomes measures whereby good reliability is reported include the Parenting Stress Inventory (PSI) (Georg et al., 2021), Clinician Administered PTSD Scale (CAPS) (Ghosh Ippen et al., 2011; Lieberman et al., 2005), and the Edinburgh Postnatal Depression Scale (EPDS) (Matheb et al., 2021; Salomonnson et al., 2021).

### Child-focused

Across all studies 14 different measured were used to capture child-focused outcomes. These looked at children’s behaviour and development using outcome measures such as the Trauma Symptom Checklist for Young Children (TSCYC) (Hagan et al., 2017), Bayley Scales of Infant development (Cramer et al., 1990), or the Griffiths Scales (Bain, 2014), all reporting high reliability and validity.

### Parent and child relationship focused

Across the studies, 18 different parent-infant measures were utilized. Parent-infant interaction was measured most often using the Emotional Availability Scales (EAS), which were coded after clinicians observed video recorded interactions (Bain, 2014; Fonagy et al., 2016; Georg et al., 2021; Matheb et al., 2021). Reflective functioning, including maternal representations was measured using self-report outcomes, for example the Mother’s Object Relations Scales (MORS) (Fonagy et al., 2016), narrative story stem methodology (Toth et al., 2002) and through clinical interviews (Bain, 2014; Fonagy et al., 2016). Changes in attachment was measured using video recordings coded based on the strange situation procedure (Ainsworth et al., 1978, as cited by Fonagy et al., 2016) and self report questionnaires (Lavi et al., 2015; Matheb et al., 2021).

## Ethical considerations

12 studies reported ethical approval with only 4 not explicitly stating this (Armstrong & Howatson 2015; Cramer et al; 1990; Toth et al, 2002 Weiner et al, 2009).

# Synthesis of main findings

## Child outcomes

There are mixed findings for the impact of PIP on infant development. Three studies reported that post PIP, infants displayed significant improvements regarding their early development including in their speech (Bain, 2014), cognitive, language and motor functioning (Sleed et al., 2013) and social and emotional development (Salomonsson et al., 2021). On the contrary, two studies found no significant effects of treatment on infant development (Fonagy et al., 2016; Matheb et al., 2021).

In regards to regulatory symptoms inclusive of; sleep, feeding, digestion, behaviour and separation; three studies reported a significant improvement post PIP treatment (Cramer et al., 1990; Georg et al., 2016; Lieberman et al., 2005), which were maintained in a 12 month follow up (Lieberman et al., 2006). Herve et al, (2009) documented that over 70% of their sample were asymptomatic (e.g. less than four functional regulatory symptoms present) or showed a partial improvement post treatment, and the remainder faired worse from treatment, however these findings are not based on statistical analysis.

Trauma symptoms in infants were found to significantly reduce in all four studies that measured this, following PIP treatment (Hagan et al., 2017; Lieberman et al., 2005), including when infants were exposed to 4 or more traumatic stressful life events (Ghosh Ippen et al., 2011) and across diverse ethnicities (Weiner et al, 2009).

## Parent outcomes

Significant improvements were reported for maternal mental health following PIP in 8 studies (Fonagy et al., 2016, Georg et al., 2021, Ghosh Ippen et al., 2011; Hagan et al., 2017, Lieberman et al., 2005, Matheb et al., 2021), two of which reported a large significant effect of PIP treatment (Lavi et al., 2015, Salomonsson et al. 2021). PIP was outlined as superior in comparison to treatment as usual in improving mental health symptoms in three studies, (Geoge et al., 2021, Lieberman et al, 2005, Matheb et al.,2021), and this was supported at follow up (Lieberman et al, 2006). The treatment remained effective for those with four or more traumatic stressful life events, when compared with treatment as usual, which was reportedly not effective for those with significant trauma histories (Ghosh Ippen et al., 2011).

Another study, reported that mothers’ depression and anxiety symptoms had reduced from 67% pre therapy to 49% reporting symptoms post-therapy (Herve et al., 2009). Only one study did not report improvements in parental mental health post PIP, whereby 72% reported symptoms had worsened (Bain, 2014), however this was understood in the context of defensive reactions to the loss of a group space upon the termination of treatment.

Of the two studies measuring parenting stress, one found no significant effect of treatment (Georg et al., 2021) and another only illustrated significantly higher levels of stress within the distress subscale post therapy in those receiving treatment as usual compared with PIP group (Matheb et al., 2021).

When PIP was compared with Interactive dyadic therapy, a statistically significant increase was found in the psychodynamic focused treatment only for maternal self-esteem whereby mothers viewed themselves as less controlling in their parenting behaviour (Cramer et al., 1990). Two further studies measured parenting self-efficacy, with one reporting no effect of treatment (Geog et al, 2021) and another reporting highly significant treatment effects (Fonagy et al., 2016).

One study measured personality dysfunction and found no significant effects of treatment over time (Matthe et al., 2021)

## Parent/child outcomes

Four studies found that parental representations (e.g. the parent’s experience of motherhood and the relationship between her and infant/how she perceives her infant), significantly improved post PIP (Armstrong et al.,2005; Cramer et al.,1990; Fonagy et al., 2016; Toth et al., 2002). Two studies found no effect of PIP treatment on parental reflective functioning (Georg et al., 2021; Matheb et al., 2021).

Mixed results were observed for the impact of PIP on parent-infant interaction. One study found participants to have significantly improved in several parent-infant interactions including mothers’ sensitivity and controlling behaviour, alongside the infants’ cooperation and happiness, with improvements maintained at follow up (Cramer et al., 1990). Two studies reported significance only with structuring (Bain, 2014) and sensitivity (Matheb et al., 2021). A further three studies found no effect of PIP treatment on parent-infant interaction (Fonagy et al., 2016; Georg et al., 2021; Sleed et al., 2016).

Both studies measuring attachment outcomes pre and post PIP reported no significant changes (Fonagy et al., 2016; Matheb et al., 2021).

### Predictors

Poor predicted prognosis including severity of infant’s disturbance, mothers’ mental health symptomology (Cramer et al., 1990) low fetal-attachment (Lavi et al., 2015), exposure to four or more trauma events (Ghosh Ippen et al., 2011) and a diagnosis of post-natal depression (Armstrong et al., 2015) achieved the greatest improvements post PIP. However, on the contrary, Hagan et al, (2017) found that PTSS improvement was greater for those with fewer lifetime stressors who engaged in fewer sessions.

Those with higher baseline depression scores engaged with more treatment sessions (Salomonsson et al., 2021) and more treatment was associated with increased improvement in infants hearing and speech, alongside the mother’s ability to structure interactions (Bain, 2014). However, the finding that the more depressed mothers were, the fewer number of sessions they attended, suggests that whilst they appear to benefit from treatment there is a difficulty for this group in accessing treatment (Bain, 2014). Furthermore, mothers who did not live with their child full time had higher depression at baseline and if separated from the infants’ father, were more likely to have an ‘unfavourable outcome’ (Herve et al., 2009; Salomonsson et al., 2021).

# Critical appraisal

Appendix 1 provides an overview of the total scores and subscales provided for each section rated within the CCAT. There was a range of scores from 17 (43%) (Weiner et al., 2009) to 34 (85%) (Georg et al., 2021), and a mean critical appraisal score of 25 (62.5%). This varied quality of included studies is illustrative of a range of methodological issues observed, which may affect the confidence in the overall interpretation of findings.

Some identified patterns across studies included that the lower rated papers were very limited in their study design, for example by not having a comparison group and thus it was unclear whether treatment effects were the result of other confounding variables (Armstrong & Howatson, 2015; Hagan et al., 2017; Herve et al., 2009; Lavi et al., 2015; Weiner et al., 2009). Sampling was somewhat unclear across studies with only a small number of studies specifically referencing the use of a power analysis to determine the sample size needed, making it likely that most studies were at risk of making a type two error. All but one study relied heavily on parental self-report measures (Toth et al., 2002), thus outcomes may be influenced by social desirability, particularly as the group of participating dyads who were experiencing adversity may already experience significant stigma. Precision of outcome (effect sizes) was reported in only a small number of studies and thus outcomes were often limited in regards to their overall size of effect, limiting the overall clinical utility of the findings.

On the contrary, those who yielded the highest appraisal scores were commonly RCT’s and utilized a control condition of standard care. Points were scored for studies that discussed group differences with baseline comparisons between treatment and control groups, which does reduce the influence of any potential confounding variables (Fonagy et al., 2016). However, as the study authors often had a strong involvement in the development of PIP, there could be an influence of bias and addressing this was unclear in all of the studies.

Overall patterns observed across studies for the highest sub-scoring sections was for introductions with most of the studies providing a clear and concise summary of the current knowledge base with clear aims and objectives. Most studies commonly scored lower in the ethics section, with some not referencing ethical approval at all, and generally there was little consideration for protection from harm, which is a vital ethical consideration when research is carried out with vulnerable groups. A final identified pattern across studies was that data collection methods were often poorly reported and thus this was a consistently low scoring area across most studies.

# Discussion

The aims of this review were to examine effectiveness of parent-infant psychotherapy, that represented real world clinical settings, for children up to age 5 years. The review partially met these aims, as the literature provides insights into the effectiveness of PIP on parent/infant outcomes, particularly in high-risk groups who present to clinical services. Despite widening the inclusion criteria in comparison to the previous review, to include children up to the age of 5 years as recommended, it is important to note most studies recruited children under the age of 2 years and therefore the results from this review remain limited for the older child age range. Including designs that are not RCT or quasi-experimental, yielded four previously excluded additional studies (Armstrong & Howatson, 2015; Cramer e al., 1990; Herve et al., 2009; Weiner et al., 2009), however it was clear that these designs were weaker, and thus the validity of these results may be limited. The remaining 12 studies were all studies published post the previous review and thus provided an update to this. Overall results suggest that PIP interventions significantly improve parental mental health symptomology and infant regulatory/trauma symptoms, however infant development and parent-infant relationship outcomes are less conclusive.

Overall of the 13 studies measuring infant outcomes, all but two studies (Fonagy et al., 2016, Matheb et al., 2021), highlighted significant effects over time on regulatory symptoms, development and infant representations of self and others. Matheb et al, (2021) did adopt a very small sample (N=36 dyads), and a young group of mothers (e.g. mean age 21 years), compared to other studies. Young maternal age does increase the risks for adverse outcomes in mothers and their child (Agnafors et al., 2019) and thus this group of participants may have different treatment needs, compared to the other high-risk groups.

Of the studies reporting on parent outcomes, all but two (Armstrong & Howatson, 2015; Bain; 2014) measuring parental mental health post therapy, reported significant improvements, including at follow- up (Cramer et al., 1990), and another showed it was effective for those with significant trauma-histories (Matheb et al., 2021). Those with significant trauma histories may represent differing treatment needs, given that a TAU group only became ineffective when dyads had experienced 4 or more TSE’s, suggesting the likely benefits of PIP for those with complex trauma (Ghosh Ippen et al., 2011). Of the two studies reporting non-significant findings both were groups and one noted trends of improvements (Armstrong & Howatson, 2015) with the other being a particularly diverse high-risk group from a homeless population with extensive trauma-histories (Bain, 2014), perhaps the non significance found in group intervention highlights the need for individual therapy for those with complex needs. Furthermore, when compared with Interactive dyadic therapy, PIP proved to be superior in improving parental self-esteem (Cramer et al., 1990).

Some promising results were highlighted for relationship-based outcomes, with six out of the eight studies reporting significant effects post intervention. Significant changes were illustrated for parent-infant interaction, (Bain, 2014; Cramer et al., 1990, Matheb et al., 2021), maternal representations, (Fonagy et al., 2016, Toth et al., 2002), and child rearing attitudes (Lavi et al., 2015). However, some studies reported unexpected outcomes where significant improvements post-intervention were observed in mother-infant interaction but not reported for reflective functioning (Bain, 2014). Others did not find any effect of intervention on parent-infant interactions, however noted improvement in ‘risk related representations’ such as ideas that relate to ‘helplessness’ and ‘hostility’ (Fonagy et al., 2016). Risk related representations measured by the Assessment of Risk Representations (ARR), (Sleed, 2013 as citied in Fonagy et al., 2016), are evidenced to mediate the relationship between reflective functioning and the parent-infant interaction. For those that unexpectedly found changes in interaction and not reflective functioning (Bain et al., 2014), it may be that experiences of hostility or helplessness affected such findings. For example, Bain (2014) reflected that the participants in their study were angry to be losing their group space after the research ended, which may have increased feelings of hostility or helplessness, likely influencing the feedback and their reflective capacities.

Four of the studies reported on the association with pre-treatment adversity factors and outcome such as those considered to have a ‘poor prognosis’ pre-treatment, and noted increased benefits in these groups after engagement in treatment (Armstrong & Howatson 2015; Cramer et al., 1990; Ghosh Ippen et al., 2011; Lavi et al., 2015). Such groups of people often report limited access to clinical services and limited interventions to meet their needs (Lamb et al., 2011), further supporting the need to evidence suitable interventions for this client group and improve their access and outcomes in clinical services. Whilst such findings highlight the potential effectiveness of PIP for high-risk groups, the prediction of a ‘poor prognosis’ was subjective and should be treated with caution.

## Limitations

All studies were affected by methodological issues such as small sample sizes; where often power analysis was not discussed. The majority of studies used self-report measures only, which in the context of parental mental health and child-maltreatment whereby stigma is high (Romangnoli & Wall, 2012) is likely to be highly susceptible to social desirability, given that parents may fear the consequences of rating the measures truthfully. Some designs were impacted due to the limited funding, whereby researchers had to cut corners by not including control groups as well as also act as clinicians (Bain, 2014) which may also impact on social desirability and the transference between participants and researchers.

There were a large number of measures used across studies to capture the effectiveness of PIP. Whilst measuring several variables adds to the effectiveness of PIP, George et al, (2021) acknowledged that this could have resulted in a biased participant group whereby such extensive assessment may have attracted more motivated care-givers, which is not very generalizable of at risk or diverse families (Lamb et al., 2011). Furthermore, the studies did not consistently measure the variables using the same outcomes and thus it makes it difficult to compare, or reliably report change. Some studies adopted multiple measures to illustrate the same construct (e.g. parental representations) and yielded differing results (Fonagy et al.,2016), highlighting limitations in the psychometric properties of current measures, highlighting the robustness of measures may be questionable. Further information regarding the psychometric properties of measures used across studies can be found in appendix 3.

## Limitations of this review

The CCAT is a subjective appraisal tool and given time limits; a second-rater was not utilized for the appraisal; meaning inter-rater reliability cannot be reported.

Parent-Infant Psychotherapy is an intervention, which originated in the early work of Selma Fraiberg, however it has since been developed and applied to parents with older infants (>5 years). Whilst both approaches focus on the application of psychoanalytic principles, in clinical practice is it not uncommon for such models to become more integrative in nature naturally. Some of the studies were transparent in how they had made the method more integrative utilizing behavioural processes alongside representational methods (Lavi et al., 2015), however treatment adherence procedure did vary and one study referenced the difficulty in measuring treatment adherence, given it’s not a model that follows prescribed sessional topics (Fonagy et al., 2016). Consequently, it is difficult to ascertain how much outcomes were explained by the original psychoanalytical techniques, and rather outcomes may be more reflective of integrative methods; a likely limitation of most intervention reviews that are less manualised.

## Clinical implications

The results suggest some effectiveness of PIP for those with significant trauma histories and maltreated children, highlighting the need to screen/identify dyads who have experienced early trauma, to signpost ‘at risk’ families to appropriate treatment. This is supportive of the research highlighting the need for trauma-informed interventions, for those with adverse histories (Johnson et al., 2018). Such findings highlight the clinical implications for dyads with complex histories when engaging in treatment incorporating psychoanalytic principles which may improve mother-child outcomes long-term. The small sample sizes, high drop out rates, and the association with those who are depressed attending less sessions highlights the need for clinical services, to be creative in supporting less privileged groups to access treatment which may be of benefit to them. Some findings outline that those with less extensive trauma histories benefit from TAU, and thus this level of treatment may be appropriate for this group, however further research is needed.

Furthermore, this review provides evidence for the efficacy of parent-infant dyadic therapy on parental mental health, even though this is not something specifically targeted through PIP. This suggests that parents who struggle with their mental health may benefit from dyadic treatment focusing on attachments, which long-term may have positive implications on infant development and social and emotional functioning.

Given that ‘brief’ therapy was illustrated as effective in contexts of high deprivation, the cost-effectiveness of PIP may be beneficial for services with limited funding and resources. This approach could be proactive in tackling replications of ‘Intergenerational trauma’ in future-generations (Bellis et al., 2014) thus reducing the need for future clinical services. However, consideration should be given to parents with significant adversities, who may benefit more from creative ways of accessing treatment for a longer duration of time as those with particularly sensitive trauma histories may be re-traumatised by the sudden cessation of helping services.

## Research Implications

Given that social adversities are evidently high in families in need of mental health services (Stepleton et al., 2016), research would benefit from consistently considering how such factors impact on treatment-outcomes. Studies should work to actively include fathers in their uptake, as the effectiveness of treatment when fathers are involved is unclear and they were largely under-represented across the included studies.

Future research should enhance their designs by ensuring that their sample is adequately powered to detect an effect and report the precision of their results to add to the clinical utility of the findings. Studies should aim to use consistent and robust measurement within their outcomes, which is more objective in nature. For example, scales such as the emotional availability scale, which requires training and yields high levels of reliability and validity may increase the robustness of findings.

Studies should aim to consistently measure outcomes at follow up to assess the longevity of the effects, and how improvements in parents’ mental health may impact on infant outcomes and the attachment relationship long-term. Studies should also aim to explore the efficacy of PIP on children aged 3-5 years, given this remain a gap in the research, despite recommendations of PIP for infants and children up to the age of 5.

# Conclusion

The review illustrates mixed outcomes for child and maternal mental health, alongside the attachment-relationship. There were several methodological and ethical limitations in some of the studies included which may limit the confidence we have in the overall findings. Despite this, the review adds to the existing evidence base outlining the effectiveness of PIP compared to treatment as usual and occasionally other dyadic interventions, particularly when applied to groups with significant trauma/maltreatment. Conclusions on the efficacy of PIP for children aged 3-5 years remains limited, given a lack of studies recruited children in this age range, thus the efficacy of PIP for pre-school children remains unclear and requires further research.

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# Appendices

## Appendix 1: Crowe’s critical appraisal scores across studies

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Author & Year** | **Preliminaries** | **introduction** | **Design** | **Sampling** | **Data collection** | **Ethical matters** | **Results** | **discussion** | **Total** | **%** |
| 1. Armstrong & Howatson, 2015 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 18 | 45% |
| 1. Bain 2014 | 3 | 4 | 3 | 2 | 3 | 4 | 3 | 4 | 26 | 65% |
| 1. Cramer et al, 1990 | 2 | 5 | 3 | 2 | 3 | 1 | 2 | 2 | 20 | 50% |
| 1. Fonagy et al, 2016 | 4 | 5 | 4 | 4 | 3 | 4 | 4 | 4 | 32 | 80% |
| 1. Ghosh Ippen et al, 2011 | 3 | 5 | 3 | 3 | 3 | 2 | 4 | 3 | 26 | 65% |
| 1. Georg et al, 2021 | 5 | 5 | 4 | 5 | 4 | 3 | 4 | 4 | 34 | 85% |
| 1. Hagan et al, 2017 | 2 | 5 | 2 | 2 | 1 | 2 | 3 | 4 | 21 | 53% |
| 1. Herve et al, 2009 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | 23 | 58% |
| 1. Lavi et al, 2015 | 3 | 5 | 2 | 2 | 2 | 2 | 3 | 4 | 23 | 58% |
| 1. Lieberman et al, 2005 | 3 | 5 | 3 | 3 | 3 | 2 | 5 | 3 | 27 | 68% |
| 1. Lieberman et al, 2006 | 3 | 5 | 3 | 3 | 3 | 2 | 4 | 4 | 27 | 68% |
| 1. Matheb et al, 2021 | 4 | 5 | 3 | 2 | 2 | 2 | 3 | 4 | 25 | 63% |
| 1. Salomonsson et al, 2021 | 4 | 5 | 3 | 5 | 2 | 3 | 3 | 5 | 30 | 75% |
| 1. Sleed et al, 2013 | 2 | 4 | 2 | 2 | 3 | 2 | 3 | 4 | 22 | 55% |
| 1. Toth et al, 2002 | 4 | 5 | 3 | 2 | 4 | 1 | 3 | 3 | 25 | 63% |
| 1. Weiner et al, 2009 | 3 | 2 | 2 | 2 | 1 | 1 | 3 | 3 | 17 | 43% |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Appendix 2. Study extraction table Salomonsson et al., (2021)  Short-term psychodynamic infant–parent interventions at Child health centers: Outcomes on parental depression and infant social–emotional functioning | Sweden | Effect of PIP on parent reported depressive symptoms and infant social– emotional functioning  &  Investigate associations between outcomes and pre-treatment adversity factors.  . | 100 Mothers and infants below 2 years  mothers had difficulties with parenting, marriage, wellbeing, contact with child and baby problems such as feeding, sleep and affect regulation.  Screening selection made by nurse and final decision made by the psychotherapist upon consent.  Exclusion: Severe parental mental health e.g psychosis, substance abuse | Design:  Naturalistic outcome study comparing a treatment group with one non clinical group which provided ‘norm data’  Intervention:  Short term psychodynamic PIP  Mean number of sessions 4.3 | 3 methods (Non parametric)  Multilevel growth modelling (MLM)  Reliable change index  Clinically significant change (e.g. from dysfunctional to functional population ranges) | Depression scores significantly decreased 3.60 points pre/post therapy - large effect 0.701.  Infant functioning problems decreased with an effect size 0.40.  Clinically significant change was observed whereby pre therapy 24% of parents worried about their babies beyond the cut-off and post therapy 9% were worried.  Number of sessions was associated with higher baseline depression Scores.  Mothers whose child did not live constantly with them had four more depression points initially compared with families where both parents were living together.  Higher education level was associated with a steeper rate of change over time for depressive symptoms. | No control group  Participants not randomly assigned – may be selection bias  Interventions fidelity low  Issues of bias not addressed in the design | 30  75% |  |
| Fonagy et al., (2016)  Randomised controlled trial of parent-infant psychotherapy for parents with mental health problems and young infants | UK, | To determine whether this model of working (PIP) can lead to improved outcomes directly for the baby, in the quality of the parent-infant relationship and the mother’s mental health. | Recruitment:  4 sites in UK  Referrals made by health and social care professionals  38 dyads in control group and 39 in intervention group | Methodology:  Design  RCT  Intervention: PIP  Data collected at 3 time points | Analysis:  Intent to treat statistical analysis & multilinear regression | No effect over time on infant development, parent- infant interaction or maternal reflective functioning. Favourable outcomes over time for PIP on maternal mental health, parenting stress and parental representations of the baby and their relationship.  Infant development: There was a marginal effect of time on the Cognitive scale (p = .07), with infants performing slightly better on this scale post-therapy.  Infant attachment: more infants classed as securely attached although not significant  Mothers in the PIP group reported lower levels of parenting stress over time relative to the mothers in the control group, p = .018. Substantial reductions in perceived relational difficulties between the PIP-treated mothers and babies. Marginally significant: trends of reduced Invasion, p = .051, and higher Warmth, p = .095 compared with control group.  Maternal mental health: Mothers in the PIP group reported superior improvements over time in terms of their depressive symptoms p = .002, and their overall sense of mastery, p = .006. There was a marginally significant Group × Time interaction for maternal general psychological well-being p = .059. | Randomised but no mention as to how  Control group specifies standard care but not clear what this involves specifically  Sample is adequate but small  High attrition rates  Does not consider the generalisability of the research | 32 |  |
| Mattheb et al., (2021)  Potential efficacy of parent-infant psychotherapy with mothers and their infants from a high-risk population: a randomised controlled pilot trial | Germany  Mother-child facilities | Efficacy of treatment alongside care as usual | 32 mother-infant dyads allocated to PIP group (N=16) or (TAU) Control group) (N=16)  Inclusion:  If they lived in mother-child facilities in Germany under permanent supervision  Mothers with acute mental health or substance misuse were excluded from the study  Recruitment:  Received monetary compensation  Recruitment took 30 months | RCT  PIP | Analysis  ANCOVA  Intent to treat analysis computed using linear mixed effects models for repeated measurements & t-tests | Motivation to participate and interest in the study was low  Results revealed improvement in sensitivity, mental health problems, stress and depression, showing evidence for efficacy of PIP  No significant difference between groups on attachment style, reflective functioning post intervention.  TAU members displayed significantly higher mental health difficulties at time 3 compared with PIP group.  Maternal stress revealed no difference between groups post intervention, the maternal distress subscale was higher at time 3 in the TAU group and was significant.  No significant effects of personality dysfunction.  The postpartum bonding results indicate difficult to severe bonding deficits in all mothers at 6 months. Neither care in Mother-Child Facilities nor 6 months of PIP intervention had a positive effect, despite the improvements on maternal sensitivity and reflective functioning. | Large amounts of missing data – only 13 of 32 post-intervention – underestimating true effects | 25 |  |
| Armstrong et al., (2015) | UK | Evaluation of the ‘Create together group’ based on parent-infant art psychotherapy | Group promoted to social work, health teams, early years workers and a nursing team  Recruited parents of infants under age 3 where professionals felt there were difficulties in interpersonal relationships.  Group 1:  6 mothers & 8 infants. Group 2: = 6 mothers & infants | Ran for 12 consecutive weeks within community spaces in UK rural towns | Paired t-tests | An overall improvement across all statements for all parents was observed of 8.2%  The largest improvement was observed in the parents’ ability to think about their infant and interpret how they feel or what they need.  Responses were significantly more positive post intervention.  Before : M = 40, SD – 7.8  After: M = 43, SD – 8.5  Those with the highest change in ratings was where referral was due to post-natal depression | Small sample size  No even distribution – should not use parametric tests then  No follow up data |  |  |
| Geog et al., (2021) | Germany | Investigate the efficacy of PIP for the treatment of ERD as superior to the treatment usually provided by the family paediatrician, according to current health practices | GPower analysis was used to determine sample size of 160 needed  190 parents expressed interest and underwent screening – final sample of 154 families  TAU N=73 and 52 families requested consultation with paediatrician in this time at least once  PIP N= 81 – (5 treatment dropouts) | Two arm RCT comparing 4 sessions of PIP and TAU | Analysis:  Group ANOVA  Intent to treat samples were used | Mothers in PIP were significantly more satisfied with their treatment  Significant effect was found for Infant regulatory symptoms showing a stronger effect of FPIP compared to TAU  The frequency of remitted patients from night time waking disorders was significantly higher in PIP, no differences in sleep onset, persistent excessive crying or feeding disorders.  Significant effect was found for distress measure with mothers in PIP reporting decreased distress in comparison to TAU.  Interaction effect was found, favouring PIP compared to TAU in terms of less depression.  FPIP found to be superior to TAU in treating infants with ERD.  No treatment effects on parental mentalizing, self-efficacy, and quality of parent–infant interaction. Results showed only trends for superior effects of fPIP on increased maternal self-efficacy (MSAS) and decreased prementalizing (PRF-PM). | Participation required extensive assessments  The generalizability to diverse/at-risk population limited  No Control means changes may result from factors unrelated to either treatments | 34  85% |  |
| 1. Bain (2014) | UK Study based in south Africa | To implement a 12 week group therapy intervention for infants with attachment difficulties and their mothers or caregivers in two Johannesburg shelters for homeless mothers and test the effectiveness of this by measuring infants global development and mothers mood, child responsiveness to mother, and mothers emotional availability and reflective functioning | Participants:  Homeless mother-infant dyads living in shelters  Between 2 months to 2 years  Mum’s ages – 18-43  Infants 9 days to 2.5 years  Group 1: 7 dyads. Group 2: 6 dyads  Group 3: 9 dyads but ended with 3  Group 4: (control group) 6 dyads  16 mother-infant dyads completed the programme and 6 in the control group  Majority of sample ‘poorly educated’ and ‘unemployed’  All mothers reported trauma | 3 experimental groups each received the group intervention and one control which did receive treatment at a later stage.  Pre and post testing was used &  randomisation was used to allocate | ANOVA’S were run to detect any significant treatment effects over time, and Pearson’s correlation coefficient was used to detect any significant correlations in the data | No significant effects of the program on maternal RF were found at post-testing; however, descriptive analysis of these findings was more useful. In the experimental groups, 31% of the mothers’ RF scores increased by 1 or 2 points, 25% of the scores decreased by 1 or 2 points, and 44% of the mothers’ scores remained the same.  Mothers’ abilities to structure interactions with their infants, as measured on the EA Scales, increased significantly in the mothers who attended the groups, as compared to those in the control group p = .015.  The number of sessions attended by each mother–infant dyad correlated significantly with the amount of improvement in the babies’ hearing and speech, p = .01, and with the amount of improvement made by mothers regarding their structuring abilities, p = .006.  There was a significant negative correlation found between the Kessler-10 pre-score and the number of sessions attended by the mothers and infants, p = .048, indicating that the more depressed the mother was at pretesting, the fewer sessions she attended. This suggests increased difficulty for severely depressed mothers to access, commit to, and internalize treatment. | Very small sample | 26  65% |  |
| 1. Lavi et al., 2015 | US | To explore the impact of CPP on a perinatal sample on maternal functioning and mental health. | Pregnant women  64 completed the CPP and were included in analysis 53% of the women were in their third trimester at this time and engaged until their infants were 6 months old. | Pilot study | ANOVA  Effect sizes: Cohen’s D  Moderation analyses  . | Decreases in depression and PTSS from pre- to post-treatment assessments, as well as an increase in positive child-rearing attitudes.  Women with low maternal-fetal attachment demonstrated the greatest improvement in depression, PTSS, and child-rearing attitudes compared to women with high maternal-fetal attachment.  Significant decrease in levels of depression (large effect .94) and PTSS (Large effect .99)  Significant increase in positive child rearing attitudes (large effect .95)  No sig interaction with any demographic factors over the course of treatment | Pilot study with a small sample and lack of control group  Attrition very high  Influence of social desirability as the clinician completed the measures | 23  58% |  |
| 1. Hagan et al., (2017) | US | Investigated whether parent and child PTSS symptoms similarly decreased during treatment and whether improvement was moderated by parent, child, and treatment characteristics. | Sample recruited from dyads referred for outpatient mental health services.  199 dyads participated in an open treatment study of CPP,  Children were between 24-72 months. | Open treatment study of outcomes and predictive factors | Groups were compared to check for significant differences in group characteristics. | Significant findings:  - PTSS decreased for both parents and children.  Associations:  - Parent and child improvement in PTSS was greater for those with fewer lifetime stressors.  - Those with higher levels of PTSS achieved greater change in PTSS symptoms post treatment. | Large drop out e.g did not complete treatment (over 40%)  All measures were parental self-report  No control group | 21  53% |  |

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| Gosh et al., (2011) | US | To explore if child–parent psychotherapy (CPP), is efficacious for children who experienced multiple traumatic and stressful life events (TSEs). | See Lieberman 2005 for full methodology  Traumatic and stressful events (TSEs). were calculated by summing across 8 categories that correspond  with Adverse Childhood experiences (ACE’s)  Data sources included family history and diagnostic interviews, DHS reports, and the Screening Survey of Children’s  Exposure to Community Violence | RCT Reanalysis (Lieberman et al, 2005) | Descriptive statistics used to measure prevalence of TSE’s  GLM model repeated measures analyses were conducted to investigate treatment effects by level of child TSE exposure  Split into <4 and >4 TSE’s | | **Baseline**  Children with 4+ TSE’s showed significantly greater impairment across all child symptoms  Mothers of children with 4+ TSE’s did not differ from those with <4 TSE’s on any maternal symptom measure at baseline  **Treatment effects**  Significant PTSD reductions observed in CPP group for those with both under and over 4 TSE’s compared with comparison group.  Significant reductions in the number of symptoms of depression and diagnoses for only the CPP 4+ group.  Significant reductions observed in poor maternal functioning for Comparison & CPP if less than 4 TSE’s but only CPP if more than 4 TSE’s  CPP mothers with 4+ TSE’s significantly less likely post treatment to have a diagnosis of PTSD  Maternal depression significantly decreased in CPP in those with less than 4 TSE’s and 4 or more but comparison group did not yield sig results if more than 4 TSE’s.  Findings give support for the efficacy of CPP with pre-schoolers who have experienced 4 or more TSE’s. | Small sample  Relied on maternal self report | | 26  65% |
| Herve at al., (2009) | France | To determine efficacy and predictive factors for a population of young children presenting functional or behavioural disorders following PIP based intervention. | *Participants*  49 infants and toddlers aged 3–30 months presenting functional or behavioural disorders | Design  Non RCT, Quasi Experimental  . | | Chi Squared or Fischer tests used for categorical variables and non parametric Kruskall Wallis or Mann Whitney for Quantitative variables  Multivariate step wise logistic regression | 29 children, or 59.2%, had a favourable outcome. Six children, or 12.2%, had an intermediate outcome. Unfavourable outcome concerned 14 children, or 28.6%. For the mothers 24 (49%) presented anxious or depressive symptoms at the final assessment. Of these 24 presented anxious symptoms compared to 33 at the initial assessment; 5 presented depressive symptoms compared to 12 initially.  Nine fathers (25.7%) presented symptoms at the time of the final assessment (8 presented anxious symptoms compared to 13 at the initial assessment, and 3 had additional depressive symptoms compared to three also in initial assessment).  Predictive factors included parental separation, type of disorder in child, presence of father in consultations, intensity of disturbances in relationship and initial psychological condition of the mother. | No control group  Small sample size  Self-assessments | 23  58% | |
| Sleed et al, (2013) | UK, homeless hostels | Aimed to see if the clinic model to address specific needs for infants in temporary accommodation (hostels) was associated with more positive outcomes than mainstream services. | *Participants*  59 Mother baby dyads – high risk & hard to reach population  30 in intervention group  29 in comparison hostels. | Design  Quasi-experimental pre/post comparison trial | | Demographic characteristics compared using t-tests for normally distributed data, chi-squared test for categorical data and Kendal’s S-statistic for data in ordinal categories.  Data from the Bayley tests were compared using a 2x2 ANOVA. | The indices of mental and motor development of infants in the intervention hostel were significantly improved over time in relation to infants in the comparison hostels. No significant differences were found in the quality of parent-infant interaction between the two groups over time. | Brief video taped rated sessions may be insufficient in capturing the overall quality of parent infant relationship.  Researcher was not blind to assessment. | 22  55% | |
| Toth et al., (2002) | US | To evaluate efficacy of two competing interventions for maltreated pre-schoolers and their mothers | 122 Mothers & maltreated pre schoolers  4 groups  Preschool parent psychotherapy (PPP) (PIP)  Psychoeducational home visitation (PHV)  Community standard care  & Non Maltreated comparison group | RCT | | ANOVA – to compare baseline and post intervention group differences  GLM repeated measures used to determine overall main effects of study condition and time | Main effect of time emerged for adaptive maternal representations and decreased maladaptive maternal representations.  Levels of positive self-representations increased significantly.  Highly significant decrease in maladaptive maternal representations in the PPP intervention group – the most dramatic decrease in this occurred in PPP compared to other conditions, although all did decrease  Significant decrease in negative self representations occurred only in PIP group.  Children in all four conditions exhibited more positive mother-child relationship expectations over time but the most dramatic increase was in the PIP group  Children in the PPP intervention evidenced more of a decline in maladaptive maternal representations over time than PHV and CS groups, and displayed a greater decrease in negative self-representations than CS, PHV, and NC children. | Measures focused exclusively on factors expected to improve from PPP/an attachment based intervention rather than what we might expect to improve from a direct parenting intervention | 25  63% | |
| Weiner et al., (2009) | US | Does the implementation of trauma focused intervention (including PIP) within a wraparound foster care program improve child outcomes and how does this differ across racial subgroups. | 216 participants across 3 groups,  CPP – mean infant age 3.7 years  CPP – 65 Participants | Design:  Non-RCT pre/post trial  6 agencies, two delivered each EBT including Child Parent Psychotherapy, Trauma focused cognitive behavioural therapy & Structured psychotherapy for adolescents responding to current stress | | Chi-squared  T-tests  ANOVA | All 3 interventions are effective regardless of race  For CPP, African American youth experienced improvement in every CANS domain.  Biracial youth experienced significant improvements in “Traumatic Stress Symptoms,” “Strengths, Behavioral/Emotional Needs,” and “Risk Behaviors.”  Hispanic youth experienced significant improvement in “Traumatic Stress Symptoms,” “Life Domain Functioning,” and “Behavioral Emotional Needs.”  White youth improved significantly in “Life Domain Functioning.  For CPP, the only significant predictors of change in traumatic stress symptoms were baseline traumatic stress symptoms (β= .475, p= .000) and number of sessions. | Limitations  No control group  Treatment fidelity difficult to track for nature of CPP  No treatment specific measures utilized  Validity compromised due to small sample. | 17  43% | |
| Lieberman et al., (2005) | US | To compare the efficacy of Child-Parent Psychotherapy (CPP) with case management plus treatment as usual for pre-school age children exposed to marital violence | PPS  39 girls and 36 boys aged 3-5 and their mothers  Referred due to concerns with the child’s behaviour or parenting after child witnessed or heard marital violence | RCT  Randomly assigned to (1) CPP or (2) case management plus community referral for individual treatment.  Weekly CPP sessions over 50 weeks  Measures taken pre and post | | ANOVA repeated measures  Cohen’s d for effect size  Treatment outcome analysis included 66 dyads that completed the outcome assessment  The original 76 dyads are included in the intent to treat analyses | CPP group had significant post test reduction in number of PTSD symptoms and comparison group did not.  Child behavioural and emotional difficulties significantly improved in only CPP evidencing significant changes, post intervention.  Maternal PTSD symptom scores significant changes for “avoidance” but only in CPP group.  Total maternal PTSD scores - both the CPP and comparison group showed significant reductions  Re-experiencing and hyper arousal significant effect of time but no effect of group x time.  Global severity index measuring maternal distress/functioning difficulties only CPP group showed significant reductions.  No significant difference in PTSD scores however there was a reduction in scores in both treatment and comparison group. | Small sample size  Reliance on mothers self-reporting | 27  68% | |
| Leiberman et al (2006) | US | To find out If CPP is still efficacious after 6 months post treatment (follow up of Lieberman 2005) | The final 6-month follow-up sample included 22 girls and 28 boys ages 3 to 6 years mean = 4.04; 27 in the treatment group and 23 in the comparison group. | RCT Follow up study  (Same design as Lieberman et al 2005) | | General linear model repeated measures  Effect size  ITT analyses | Child behavioural and emotional difficulties showed significant reductions over time for CPP group at follow up.  Maternal PTSD symptoms as measured on the global severity scale illustrated significant improvements maintained only for CPP group | Small sample size  Reliance on maternal self-report | 27  68% | |
| Cramer et al, (1990) | Switzerland | To examine change in brief psychotherapt for mother –infant dyads and compare  with interactional guidance therapy. | 38 mother-infant dyads  Engaged with pre and post testing | Not RCT but an evaluation with pre/post outcomes  Outcomes completed before treatment and at 1 week, 6 months, and 12 months after therapy | | Descriptive statistics & t-tests | Significant decrease in symptoms  Increase in maternal sensitivity.  No significant changes in representations but raw data does show positive changes  Improvement were maintained at 6 months.  Mother infant interactions continues to increase their sensitivity to infants at 6 months.  Looking at difference between two groups over time:  Equivalent improvements occurred in both types of therapy,  negative correlation between predicted poor prognosis and evaluation of improvement . | No control group  Small sample size | 20  50% | |

**Key:** TAU = Treatment as usual, TSS = Traumatic Stress Symptoms , PTSD = Post Traumatic Stress Disorder, CPP = Child Parent Psychotherapy, PIP = Parent-Infant Psychotherapy, ERD = Early Regulatory Disorders, PTSS = Post Traumatic Stress Symptoms, TSE’s = Traumatic Stressful Experiences,.

## Appendix 3: Outcome measures broken down by type of outcome and study

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| **Parent focused measures** | **Measuring** | **Validity & reliability** | **Studies** |
| Kessler-10 | Depression & anxiety symptoms | Good sensitivity and specificity in detecting depression (0.66), post-traumatic stress disorder (0.69) panic disorder (0.71) and social phobia (0.76) (Bain, 2014). | Bain 2014 |
| Beck Depression Inventory | Depression symptoms | Reliability  on average alpha co-efficient higher than 0.75, high content validity, moderate to high convergent validity 0.58 – 0.79 (Richter et al, 1998). | Cramer et al., 1990 |
| Center for Epidemiological Studies (CES-D; Radloff, 1977 as cited in Fonagy et al, 2016) | Depression scale | (Cronbach’s  α = .91) (as cited in Fonagy et al, 2016) | Fonagy et al, 2016  Lavi et al., 2015 |
| The Brief Symptom Inventory (BSI) | Maternal self-reported psychological symptomology. | High internal consistency – between .74 & .89 (Asner-self et al, 2006).  High Validity (.91 - .96) (Derogatis, 2001). | Fonagy et al, 2016 |
| The Self Mastery Scale (Pearlin & Schooler, 1978) | Mothers’ sense of mastery over their life’s chances | Original paper does not state reliability/validity (Pearlin & Schooler, 1978). | Fonagy et al., 2016 |
| The German Parenting Stress Inventory (PSI) | Self-reported characteristics of stress in parents and in child | Cronbach’s a of global score was excellent (0.93) (Geog et al., 2021). | Georg et al., 2021  Matheb et al., 2021 |
| The German  Symptom-Checklist (Symptom-Checklist-90R-S, SCL)25 | Self reported psychological distress and depression | Cronbach’s a GSI = (0.95) and subscale depression (0.86). Test–retest reliabilities from .78 to .90  (Derogatis, 1994). | Georg et al., 2021  Ghosh Ippen et al., 2011  Lieberman et al., 2005 |
| Symptom Checklist (SCL-K-9)  (Short version of above) | Mental health severity | Alpha = .91, inter-item means and convergent validity satisfactory (Imperatori et al., 2020). | Matheb et al., 2021 |
| The German translation of the  Maternal Self-Efficacy Scale (MSES) | Perceived behavioural competence in parenting. | Cronbach’s a (0.76) (as cited in Georg et al., 2021). | Georg et al., 2021 |
| Clinician-Administered PTSD Scale (CAPS). | Maternal PTSD | The interview has excellent test–retest reliability and convergent validity (Lieberman et al, 2005). | Ghosh Ippen et al., 2011  Lieberman et al., 2005 |
| The Post-Traumatic Stress Scale Interview | Maternal PTSD | Post Traumatic Stress Interview (PSSI) Cronbach’s Alpha = .88 (Hagan et al., 2017). | Hagan et al., 2017 |
| Davidsons Trauma Scale | Maternal PTSD | Davidson Trauma Scale (parents) - Cronbach’s a = .82 (Davidson et al., 1997). | Hagan et al., 2017  Lavi et al., 2015 |
| Life stressors Checklist Revised (LSC-R), (Wolfe, Kimerling, Brown,  Chrestman, & Levin, 1996) | Mothers lifetime exposure to stressful events | Endorsement of one or more stressors is significantly associated with a PTSD diagnosis/no other reliability/validity stated (Wolfe et al, 1996). | Hagan et al., 2017  Lieberman el al., 2005 |
| Life Stressor Checklist (LSC; Gray et al,, 2004) | Interpersonal trauma e.g. did you ever see violence between family members (abuse/neglect) | Reliability – mean kappa .61 and test retest correlation .82, strong convergent validity with other trauma specific measures (as cited in Lavi et al., 2015). | Lavi et al., 2015 |
| Hospital Anxiety and Depression Scale | Mothers depression and anxiety symptoms | High internal consistency (0.75-0.89) Sensitivity = 85% and specificities >78% (Kjaergaard et al., 2014). | Herve et al., 2009 |
| The Mini International Neuropsychiatric Interview  (M.I.N.I.) | Presence of psychiatric disorders based on DSM IV and ICD-10 | Good or very good Kappa values, only drug dependence scale below 0.50. Sensitivity 0.70 or greater for all but dysthymia, OCD & current drug dependence. Specificities were 0.85 or higher. Inter-rater reliability ‘acceptable’ – 0.45-0.59. Low inter-rater reliability (below 0.45 for diagnoses with high comorbidity (Sheehan et al, 1998). | Matheb et al., 2021 |
| The Edinburgh Postnatal Depression Scale (EPDS) | Symptoms of maternal postpartum depression | Adequate sensitivity .86 and .96 (Murray & Carothers,1990) and specificity .78 and .81. Internal consistency reported at .896. | Matheb et al., 2021  Salomonnson et al., 2021 |
| Inventory of Personality Organization (IPO‑16) | Severity of personality dysfunction | IPO - 16 - Personality inventory – reports it is a standardized and validated (Matheb et al., 2021). | Matheb et al., 2021 |
| Total outcomes = 18 |  |  |  |

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| **Infant focused measures** | **Measuring** | **Validity & reliability** | **Studies** |
| Griffiths Scales | Infant development | Several studies highlight its adequate reliability/validity which has been further supported cross culturally where strong construct validity cross culturally was illustrated (Luiz et al, 2001) | Bain (2014) |
| Bayley Scales of infant development (BSID) | Infant development  Evaluates a child’s cognitive, language, and motor functioning. | Bayley Scales - good test-retest reliability for mental and motor index scales (0.83 & 0.77) (Bayley, 1993 as cited in Cramer et al., 1990)) good concurrent validity with other measures of physical and cognitive function (Provost et al, 2000; Voigt et al., 2003). | Cramer et al., 1990  Fonagy et al., 2016 (revised version BSIDIII) (Bayley, 2006)  Sleed et al., 2013 |
| Symptom check list (SCL) | Infant regulatory symptoms  sleep, feeding, digestion, behaviour, fears and shyness, and separation | Symptom Check List (SYX) -designed for this study)  validated  in a clinical population and a general control population (Herve et al., 2009) | Cramer et al., 1990  Herve et al., 2009 |
| The Ages & Stages questionnaire (ASQ-SE) | The Ages and Stages Questionnaire: Social-Emotional (ASQ) was used to assess parents’ reports of the infants’ social and emotional functioning. | Test retest reliability reported at 0.94 and Cronbachs alpha for internal consistency for babies 3-14 months at .69 and .67.(Fonagy et al, 2016). | Fonagy et al,, 2016  Salomonsson et al., 2021 |
| Structured clinical interview to assess regulatory disorders | sleep onset disorder, night waking disorder, feeding  disorders, and regulation disorders of sensory processing | Good to excellent inter-rater reliability on the levels of current and lifetime regulatory problems (k = 0.77–0.98) high inter-rater agreement correlation co-efficient= 0.86–0.97) (Popp et al, 2016). | Georg et al., 2016 |
| The Questionnaire for  Crying, Feeding and Sleeping (QCFS) | Infant regulatory symptoms  (1) crying, fussing, and sleeping, (2) feeding, (3)  dysfunctional parental co-regulation, | Cronbach’s a was good (0.81) (as cited in Georg et al., 2021) | Georg et al., 2021 |
| The 96- hour behaviour diary | The diary of crying, sleeping,  and feeding behaviour is similar to widely used parental  diaries of infants’ behaviour. Parents record the frequency  and duration of each behaviour in 15-minute intervals on 4  consecutive days. | No psychometric studies conducted or clinical cut-offs reported. | Georg et al., 2021 |
| Screening Survey of Children’s  Exposure to Community Violence: Parent Report Version | Assesses children’s exposure to a  range of stressful and traumatic events (Richters & Martinez, 1993). | None reported in original study (Richtners & Martinez, 1993) or other literature | Ghosh Ippen et al., 2011  Lieberman et al., 2005 |
| Semi-structured interview for diagnostic classification DC: 0–3 for clinicians (Scheeringa et al,1995)  DC: 0–3 interview) | Assesses diagnoses and symptoms regarding the number of Post Traumatic  Stress Disorder (PTSD) and depression symptoms the child was experiencing. | Measure of internal consistency for dichotomous variables was .77 for PTSD  and .69 for depression ( as cited in Lieberman et al., 2005) | Ghosh Ippen et al., 2011  Lieberman et al., 2005 |
| Child Behavior Checklist (CBCL 2/3 and 4/18). | Child functioning | Shown to be valid for use in cross-cultural samples and to have good reliability,  stability and predictive validity (Scheeringa et al,1995) | Ghosh Ippen et al., 2011  Lieberman et al., 2005  Lieberman et al., 2006 |
| Traumatic Symptoms Checklist for Young Children (TSCYC) | Hyperarousal (e.g., being easily startled), reexperiencing (e.g., bad dreams or nightmares),  and avoidance (e.g., not wanting to talk about something bad  that happened) | 1. Traumatic symptoms Checklist for Young Children (TSCYC) - Demonstrated reliability and predictive validity (Briere et al, 2001 as cited in Hagan et al., 2017) | Hagan et al., 2017 |
| Traumatic Events Screening Inventory-Parent Report Form (TESI-PRR) | Children’s lifetime  exposure to traumatic events | Good face validity reported regarding participant Adverse Childhood Experiences (ACE’s) and objective violent crime occurrence (Choi et al, 2019) – no other validity/reliability yet reported | Hagan et al., 2017 |
| German  developmental test ET6-6-R | Motor activity, cognition, language skills, and  socioemotional development. | None reported in Matheb et al., (2021) or other literature | Matheb et al., 2021 |
| Child and Adolescents Needs and Strengths (CANS) | Behavioural/emotions needs, care giver needs and resources, cultural factors, life functioning, risk behaviours and strengths | CANS is used universally across the department of children and family services to document treatment needs and track progress - it has high interrater reliability 0.81 (Anderson, 2003 as cited in Weiner et al., 2009) | Weiner et al., 2009 |
| Total = 14 | | | |

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| **Parent/infant focused measures** | **Measuring** | **Validity & reliability** | **Studies** |
| Parental Developmental Interview | Parental reflective functioning  Fonagy et al., 2016 - used the PDI to assess parental Representations. e.g. the parent’s experience of motherhood, and her child and the relationship between them. The transcripts were coded on two coding systems: Parental Reflective Functioning and the Assessment of Representational Risk. | The RF scale showed high inter-rater reliability, internal consistency, and  criterion validity (Sleed et al, 2020) | Bain, 2014  Fonagy et al, 2016 |
| Emotional Availability Scales | Mothers sensitivity and infant’s responsiveness  Georg - Four dimensions of parental  emotional availability (EA; sensitivity, structuring, non-intrusiveness, and non-hostility) and 2 child dimensions  (responsivity and involvement) | Significant cross context reliability (Bornstein et al, 2006) | Bain 2014  Fonagy et al., 2016  Georg et al., 2021  Matheb et al., 2021 |
| Indication criteria questionnaire | Used to predict prognosis of parent/infant | None reported in Cramer et al., (1990) or other literature | Cramer et al., 1990 |
| Improvement scale | Improvements in infants and parents overall rated by therapists | None reported in Cramer et al., (1990) or other literature | Cramer et al., 1990 |
| Maternal representations interview | Maternal representations | None reported in Cramer et al., (1990) or other literature | Cramer et al., 1990 |
| Ainsworth Sensitivity Scale | Mother-infant interactions/sensitivity | Scale was not successful in predicting later attachment relationship when measured at 4 weeks (Yorgason et al., 2015)  Sensitivity scores found to be robustly related (r=.65) to secure/insecure classifications (Perderson et al, 2014 as cited in Cramer et al., 1990) | Cramer et al., 1990 |
| Mother’s Object Relations Scales (MORS) | Mothers’ internal working models of their infants.  Two subscales for the mothers’ representations of their  infant: Warmth and Invasion | Strong validity and internal consistency – reported to have the necessary psychometric properties for infants between 6 weeks and 12 months (Oates et al, 2018) | Fonagy et al., 2016 |
| Crittenden Experimental Index of adult-infant relations | Mother-infant interaction | Cohen’s Kappa for inter-rater reliability .85 for infant categories and .80 for mother categories (Moioli et al, 2014) | Cramer et al., 1990 |
| Kiddie-Infant Descriptive Instrument for emotional states (KIDIES) | Mother-infant interaction | Construct and predictive validity adequate in predicting infant attachment (Raine et al, 1990) | Cramer et al., 1990 |
| Coding Interactive Behaviour Scale (CIB) | The CIB is a detailed rating system for assessing multiple aspects of parent–child interactions  e.g. dyadic attunement, parental positive engagement, and  child involvement. | Good concurrent and discriminant validity and sensitivity to treatment change (Feldman & Eidelman, 2003; Feld man, Eidelman, & Rotenberg, 2004; Feldman, Eidelman, Sirota,  & Weller, 2002; Ferber & Feldman, 2005; Ferber et al., 2005) as cited in Sleed et al., 2013). | Fonagy et al., 2016  Sleed et al., 2013 |
| Strange Situation procedure | Childs attachment behaviour coded and considered if secure, insecure avoidant, insecure resistant or disorganised. | (Ainsworth et al., 1978 as cited in Fonagy et al., 2016)) | Fonagy et al., 2016  Matheb et al., 2021 |
| The German Version Patient Satisfaction Questionnaire (ZUF-8) |  | Cronbachs a of total  score was good (0.81) (Georg et al., 2021) | Georg et al., 2021 |
| The Parent–Infant  Relationship Global Assessment Scale (PIR-GAS;DC:0-3R) | Used to assess parent–infant relationship  dimensionally from 0 to 10 (documented maltreatment) to  91 to 100 (well adapted) Three aspects of the parent/infant relationship are evaluated in order to classify a disordered relationship: the behavioral quality of interactions, affective tone, and psychological involvement. | One study has attempted to establish predictive validity.  Aoki et. al. (2002) describe their PIR-GAS scores as predictive of mothers reporting child internalizing symptomatology four months later, contributing to the predictive validity of the PIR-GAS measure. | Georg et al., 2021 |
| Parental reflective functioning questionnaire (PRFQ), | (1) interest and  curiosity in mental states (IC), (2) certainty of mental states  (CMS), and (3) prementalizing (PM), which signifies deficits in parental reflective functioning (PRF) | Cronbachs a was low for scales relating to parental reflective functioning and Interest and curiosity  (0.59; 0.50), and acceptable for certainty of mental states (0.73) (Georg et al.,2021) | Georg et al., 2021  Matheb et al., 2021 (PRFQ-1) |
| Maternal Fetal Attachment Scale MFA; (Cranley, 1981) | women’s bond with her unborn child (e.g., I imagine myself taking care of the baby). | Good internal consistency Cronbachs alpha .87 (Lavi et al., 2015) | Lavi et al., 2015 |
| The Adult-Adolescent Parenting Inventory-2 (AAPI-2; Bavolek & Keene, 2001 as cited in Lavi et al., 2015) | Child Rearing Attitudes  (e.g., Strict discipline is the  best way to raise children). The inventory includes five subscales:  inappropriate expectations, empathy, corporeal punishment, role reversal, and power independence. | Child rearing attitudes scale pre and post Cronbachs .93 & .95 (Lavi et al., 2015) | Lavi et al., 2015 |
| Parental Bonding Questionnaire (PBQ) | The quality  of attachment relationship. | None reported in study used in review or literature | Matheb et al., 2021 |
| Mac Arthur narrative coding manual (MNCM-RR) & Bickham and Fiese's child narrative codebook as cited in Toth et al., 2002 | Infants representations of self and others | Narrative story stem methodology found to be a valid and reliable method to evaluate children's perceptions of parent-child relationships, parenting behaviour, child's socioemotional development and behavioural adaptation (Toth et al., 2002) | Toth et al., 2002 |
| Total = 18 | | | |

*Appendix 3 Key:*

TAU = Treatment as usual, RCT = Randomised Controlled Trial, RF = Reflecting functioning, ACE’s = Adverse Childhood experiences, TSS = Traumatic Stress Symptoms , PTSD = Post Traumatic Stress Disorder, CPP = Child Parent Psychotherapy, PIP = Parent-Infant Psychotherapy, ERD = Early Regulatory Disorders, EA = Emotional Availability, PTSS = Post Traumatic Stress Symptoms, TSE’s = Traumatic Stressful Experiences, PHV = Parental Home Visitation, CS = Community Standard, NC = Non-maltreated-Control group.

# Chapter 2: Empirical paper

# A fight to work with families, rather than against them: exploring social workers’ experiences of working within the Family Safeguarding Model (an IPA analysis)

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# Abstract

The Family Safeguarding Model is a strength-based framework within Child Protection Services in the UK. Given the emotional toll of traditional social work practice that seems to work ‘against’ families, it is important to understand how social workers experience this way of working. To date there has not been any research exploring social workers’ experiences working within this framework. This qualitative study explores social workers’ experiences of working within this model and what this means for them in their roles. Semi-structured interviews were completed with six social workers, who had worked within this model for at least 6 months. Interpretive Phenomenological Analysis (IPA) was used to analyse the data. Three Group Experiential Themes (GET’s) were identified: fighting to work with families, feeling held and protected and breaking at the seams. Social workers valued the secure base offered to them by the model enabling them to build therapeutic relationships with families and feel more confident in managing risk. However, when service demands increased, and crucial resources were reduced and they were disempowered to meet the needs of families. Clinical implications include getting back to ‘working under one roof’ to enable trauma-informed care and support for social workers, even when demands are increasing. Further research is required on social workers who have worked in other strengthening families frameworks.

# Introduction

Children’s social services in the United Kingdom (UK) have learnt lessons from its historic adversarial approach, which can work against families as opposed to empowering them (Ayre, 2001). A phenomena referred to as the ‘invisible child’, illustrates social workers struggling to be ‘child-focused’, when they become emotionally overwhelmed with the complexity and resistance of families (Furguson, 2017). Social workers’ in safeguarding contexts can be perceived by parents as dehumanising (Dale et al., 2005). The inherent stigma attached to child protection work can be challenging, particularly when coercive systemic processes may inadvertently perpetuate harmful narratives about social workers (Gibson, 2015).

Contemporary social work approaches have been criticised for being too risk oriented rather than focusing on individual needs, resulting in workers feeling fragmented from other agencies (Westwood, 2012). Evidently, there is too much focus on ‘protection’, rather than ‘prevention’, diminishing the quality of relationships between workers and families (Higgins, 2017; Vyvey, 2014). Managing risk and simultaneously building therapeutic relationships results in tension for social workers who reflect on the challenges of balancing the duality of this role (Stevens et al., 2018). Social workers value opportunities to build relationships with families (Morazes et al., 2010), however acknowledge the emotional labour this has (Rollins, 2020). The impact of early relational trauma, often inherent in this client group, and the role this plays in building trust is a further challenge (Rollins, 2020). Further, such relationships are challenged by social workers’ own sense of safety and fears when families are complex and high risk (Murphy et al., 2013).

The Covid-19 mandate to work from home, decreased opportunities for professionals to build working relationships with colleagues and clients. Working in a silo within emotionally charged contexts with a lack of resources and increasing caseloads, increases stress (Antonopoulou et al., 2017; Morazes et al., 2010), reduces wellbeing and directly impacts services available to families, through lost working days due to workplace stress, anxiety and depression (as cited in Ravalier et al., 2021).

This illustrates the need to advocate a shift in culture to ‘working with families’ rather than ‘doing things to them’. This would enable social workers to fulfil what they view as ‘true social work functions’ (Morazes et al., 2010, p. 243) and reform social work practice, with an emphasis on increased support for social workers (Stanley et al., 2006) and families (Higgins, 2017).

## Strengthening Families Protecting Children: The Family safeguarding model

Following concerns and serious case reviews the Department of Education (2019) launched the Strengthening Families Protecting Children Framework, which advocates for reducing bureaucratic burden and working collaboratively with other systems of care. The aim is to enable early support when working with complex cases (Munroe, 2011), reform child protection services to ones that build resilience and enable social workers to manage risks confidently (Department for Education, 2019) and ultimately reduce the number of children entering care.

Initially implemented within local authorities deemed to ‘require improvement’, it has three main ‘innovators’, who developed models to meet these aims, including: Hertfordshire’s: ‘Family Safeguarding Model (FSM)’, Leeds: ‘Family Valued’, and North Yorkshire who developed ‘No Wrong Door’ (Department of Education, 2019). Hertfordshire were the first to roll out the FSM in April 2015, which advocates for having ‘all professionals under one roof’, to improve joined up working and shared communication systems (Forrester *et al*., 2017). Practitioners addressing parental mental health, domestic abuse, and substance misuse difficulties were employed directly within social work teams to work therapeutically, or to provide consultation/training to the team. The model utilises evidence-based approaches (Forrester *et al,* 2017; Forrester *et al*, 2013; Wilkinson *et al,* 2016), including multidisciplinary collaboration (NHS England, 2014) motivational interviewing (Hohman, 2011) and team formulation (Johnstone, 2017), aiming to empower social workers to support parents to make sustainable changes to benefit their children.

Since its implementation there have been substantial cost savings, a reduction in families accessing emergency services and evidence of collaborative working through wider perspectives shared on family issues in group supervision and the shared workbook system (Forrester et al., 2017). These successful outcomes have led to 16 local authorities using the model currently and many more expressing an interest in adopting the approach (Clarke, 2022).

## Rationale for the study

The Family Safeguarding Model is a children’s social care model that advocates for a holistic family approach and shifts in oppressive practice (Rodger et al., 2020). There is no current research exploring social workers’ first-hand lived experiences of working within this model and how it influences their experiences and approaches when working with complex families.

This project aims to contribute to psychological research and build on existing literature around the impact of having multi-disciplinary professionals such as psychologists embedded in Children’s Social Care. The research is unique as it explores social workers experiences of working in psychologically informed ways. This can inform recommendations for clinical practice and future research around social workers working within child safeguarding settings.

## Research Aims

The aims of this study were to:

* Explore social workers’ lived experiences of working within the Family Safeguarding Model within Child Safeguarding Services
* Explore social workers’ experiences of applying tools adopted by this model

## Research Question

1. How do social workers’ experience working within a Child Protection Service that utilizes the Family Safeguarding Model?
2. What does the model mean for social worker’s relationships with parents and the wider team?

# Methodology

## Design

The research design was qualitative as this is suited when questions are exploratory and interested in exploring an in-depth account of ‘how’ a group experience a phenomenon (Isaacs, 2014). Semi-structured Interviews were used, allowing flexibility for the participants to discuss experiences freely. The interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA). IPA was the chosen methodology, as the emphasis on exploring the depth of person’s lived experiences, and meanings attached to this were relevant to the aims (Smith, 2017). Social workers roles within child protection was considered an emotionally demanding job, and thus fitted well with the IPA approach that values exploring complex and emotive phenomenon (Larkin *et al*., 2021). Other qualitative methods such as narrative or discursive methods were not used as they would be less advantageous in capturing the depth of social workers lived experiences, that IPA encourages through the double hermeneutic approach. Furthermore, IPA emphasises the importance of reflexivity, which was key given the researchers unique insider perspective, having worked in the team previously.

## Ethics

Ethical approval was received from Staffordshire University ethics committee, and Hertfordshire County Council Children’s Services research and development team (appendix 2 & 3). Informed consent was obtained from all participants prior to them engaging in the study interview (appendix 5).

The interviewer discussed with participants how the interview would be managed if topics caused distress. A plan of action was discussed prior to conducting the interviews and resulted in participants acknowledging they would inform the researcher if they were finding questions too difficult. All participants were given the opportunity to debrief before the end of the interview. None of the participants raised they found the interview distressing.

## Recruitment

Purposive sampling was used when recruiting participants, in line with the analysis chosen to explore a person’s experience of a specific phenomenon (Larkin *et al*., 2021). The advert (appendix 7) and participant information sheet (appendix 4) were circulated to social work teams and promoted by the researcher at team meetings. As outlined in the inclusion and exclusion criteria (appendix 4), those who volunteered were required to have worked as a social worker within this model for at least six months, to ensure they had been embedded in the model for long enough to enable them to describe and reflect on their experiences. Given that the Hertfordshire team were the first to implement the model it was felt the most appropriate area to recruit from. Further, focusing on multiple sites would have been impractical within the timeframes of the research.

Social workers emailed the researcher to express interest in the study and were asked to complete and return the consent form and demographic questionnaire (appendices 5 & 6).

Once consent forms and questionnaires were received, the researcher arranged a date and time to complete the interview via Microsoft Teams. Recruitment began during May 2022 and completed by October 2022.

## Sample characteristics

Six participants participated in the study which included five females, and one male, four were White British and the sample ranged in age from 27 to 51 years. Other ethnicities have not been detailed as this may identify the participants. Four of participants held over 5 years of experience within the FSM. Experiences ranged from under one year up to its inception, which was between 7-8 years.

Table 1. Participant demographics

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Participant** | **Stacey** | **Shona** | **Kelly** | **Natalie** | **John** | **Nicky** |
| **Gender** | Female | Female | Female | Female | Male | Female |
| **Years working in model** | < 2 | >5 | >5 | >5 | <2 | >5 |

## Procedure

Individual interviews (appendix 9) were conducted once verbal consent was rechecked. The interviews ranged between 41 and 78 minutes, with an average interview time of 68 minutes. In line with Smith and colleagues (2022) guidance a flexible interview guide was developed with support from the researchers’ academic and clinical supervisors who had experience of IPA and the model. This supported the researcher to develop questions relevant to the FSM and aims of the research question.

All interviews were audio recorded and transcribed verbatim initially via teams, with amendments made by the researcher to ensure accuracy.

## Data analysis

The transcripts were analysed using Interpretive Phenomenological Analysis (IPA), following guidance outlined by Smith *et al*., (2022). The philosophical basis of this method is shaped around clarifying an event, process or relationship (phenomenology) and exploring how this is experienced by a person within their context and their own individual meaning making (Eatough & Smith, 2008). The approach allows exploration of components that make a phenomenon unique or distinguishable (Pietkiewicz & Smith, 2012). IPA aims to ‘make meaning intelligible’ through interpretation (Eatough & Smith, 2017) and what is termed the ‘double hermeneutic’ whereby the researcher is trying to make sense of the participant, who is trying to make sense of their experiences (Smith *et al.,* 2022). The approach is idiographic in nature; as the researcher studies a homogenous group and is interested in moving between different themes, comparing and contrasting those, with emphasis on each person’s unique experience (Pietkiewicz & Smith, 2012).

As little research exists in this area, qualitative research was deemed suitable as it enabled exploration of this model from the perspectives of social workers who had been fully immersed within it. IPA allows for identification and exploration of social workers shared and unique lived experiences within the model.

## Steps of analysis

Each interview recording was transcribed verbatim, and the researcher listened to the recordings several times, alongside reading transcripts, allowing the researcher to fully immerse themselves in the data before generating themes. The researcher kept a reflective log of exploratory comments about the content, language and non-verbal communications and key pieces of text were highlighted and copied onto a spreadsheet, alongside the exploratory notes. To decode the participants meaning making (Smith, 2015, Pietkiewicz & Smith, 2012), the quotes and exploratory notes were interpreted by the researcher into personal experiential statements.

A range of methods was used allowing the researcher to identify patterns across the data (Larkin et al., 2021). Initially the statements were collated into a word document and the researcher clustered the themes using colour coding. The personal experiential statements were printed and cut out, allowing the researcher to tangibly move them, searching for links across each participant. This process led the researcher to visibly group together similar statements (appendix 8) and generate Personal Experiential Themes (PETs). The same process followed for each participant until the researcher was able to group PETs across participants and generate Group Experiential Themes (GETs). Within each GET, subthemes were identified, and this was collated into a table. The GETs and subthemes were collated into a master table and all supporting quotes collated across participants (appendix 13). The GET’s and subthemes were heavily represented across participants and there were not any identified unique themes.

## Researcher position and reflexivity

The process of analysing data using IPA relies on the double hermeneutic whereby the researcher attempts to make sense of how the participants interpret their experiences (Smith, 2015). Given the influence of the researcher on interpreting this data, it is important for the researcher to remain reflexive and self-aware of any assumptions or bias that may affect the interpretation of the data (Shaw, 2010). The researcher’s ontological position was constructivist, acknowledging that stories are formed from multiple social realities and refuting the idea that there is a single truth (Galbin, 2014), which felt appropriate to the research when exploring how different social workers may experience the model. The researcher’s epistemology utilised an interpretivist approach, recognising that knowledge is intersubjective and produced through processes of interactions between participants and researcher (Hiller, 2016). This was relevant to the double hermeneutic process when interpreting social workers lived experiences and making sense of the meanings behind this (Smith *et al.,* 2022).

The researcher has worked within the FSM alongside social workers in this context. Hence, it was important for reflexivity to remain from the point of research design, throughout analysis and write up. The researcher noticed a strong bias when considering her own beliefs on the positive impact this model may have on social workers and the families they work with. Given the researchers role as a trainee clinical psychologist and having worked previously as an adult worker within the team, a bias towards the influence of this support was noted. This allowed the researcher to make a conscious effort to take a wider perspective when interpreting social workers experiences that comprises all the tools adopted by the model and not only unconsciously focusing on how social workers experienced the adult workers in the team. Given the researchers background, it was considered whether social workers felt able to be honest about any less helpful experiences they had with adult workers. Biases such as this cannot be eliminated, however the process of keeping a reflective log, using peer supervision and participant quotes to demonstrate fidelity to their personal meanings allowed the researcher to manage biases and refocus on the social workers experiences. These strategies increased the trustworthiness and credibility of the themes that emerged, managing potential assumptions made by the researcher.

# Results

## Overview of Group Experiential Themes and subthemes

## 

The aim of the study was to explore the participants’ lived experiences of working with the Family Safeguarding model in children’s child protection services. Table 2 shows the three GETS and nine subthemes identified within the data. The themes will be described below, with supporting quotations used to illustrate.

Table 2: Themes

|  |  |  |
| --- | --- | --- |
| **Group Experiential Themes** | **Subthemes** | **Present in participant(s)** |
| 1. **Fighting to work with families** | 1. Connecting with families | 1,2,4,5,6 |
| 1. Shared understanding and empathy | 2,3,4,5,6 |
| 1. Allyship and hopefulness | 2,3,4,5,6 |
| 1. **Feeling held and protected** | 1. Feeling confident and empowered | 1,2,3,4,5,6 |
| 1. Managing frustration/surviving in the role | 1,2,5,6 |
| 1. Less alone: Safe uncertainty | 1,2,3,4,5,6 |
| 1. **Breaking at the seams** | 1. Unappreciated: not good enough | 2,3,4,6 |
| 1. Letting families down: powerlessness | 1,2, 3,4,6 |
| 1. Professional isolation: feeling alone | 2,3,6 |

All themes incorporated social workers experiences of the Family Safeguarding model in its entirety, unless where a specific tool in the model is identified (e.g., adult workers) whereby this is explicitly outlined.

## 

## Group Experiential Theme 1: Fighting to work ‘with’ families

This theme reflected social workers feeling able to work collaboratively alongside families. This included showing understanding and empathy for parents’, resulting in families feeling like they are valued and hopeful for change.

### Connecting with families

Participants reflected on their experiences of spending time with families, being one human being to another, and letting them know “I’m here to support you” (Stacey).

*“when parents feel that we're really wanting to support them that scariness… starts to go away a bit and they see it as children’s services can be helpful and can be supportive” (Natalie)*

Natalie talks about this experience as being about ‘children’s services’ rather than how families identify her as a professional, which may be an attempt to distance herself from this identity. The language that children’s services ‘can be helpful’ rather than ‘are helpful’ may implicitly highlight the stigma attached to being a social worker in child protection and the emotional toll that being viewed as a ‘scary’ measure has.

For Stacey this approach resulted in her feeling supportive to parents.

*“She said it's because you took the time to get to know me. She said no one does that. And we ended up growing a really good relationship and I was able to support her” (Stacey*)

Despite the intention to be supportive, John reflected on this experience being challenging.

*“When I sit down and have discussions with parents It's like, oh boy, you're telling me off… No, I'm not. That's not the intention at all. I'm getting your experience…But because it's come from a social worker all she’s hearing is you’re telling me off…” (John).*

This was corroborated by Natalie’s that “there's like this real fight to work with them under a child in need plan”. The word ‘fight’ highlights the struggle social workers can experience when trying to connect with families and illustrates how effortful it can feel to show families they are there to support and not “catch families out”.

Social work on its own was experienced as ‘intrusive’ but with the flexibility of the framework, social workers felt supported in building meaningful relationships with families.

*“I find this very intrusive, social work on its own..”* (John)

*“Where I was before they felt I was the one coming in and asking all the questions and I was the one that was intruding into their lives. When effectively I am \*\*laughs\*\*. But it's to be able to reflect on then a model” (Stacey)*

Building a positive relationship with parents left workers feeling ‘relieved’ and ‘less worried and anxious’, enabling them to feel able to do their ‘best work’.

“*When you get to a point where you've got a positive working relationship with a parent….Like it feels good… you feel relieved. You feel able to go and do your best work because you…feel clearer. You know, worrying so much less, less anxious…the whole experience is just a much more pleasant experience” (Natalie)*

### Shared understanding and empathy

Social workers worked ‘with’ parents by exploring what may have happened to them historically, resulting in a shared understanding as to the reasons ‘why’ parents may present as they do.

*“OK look I don't know your understanding, I want to know. What makes you, you?” (John)*

*“…It's like a puzzle. I need to put it together…you're the only person that could do that for me….you've got these puzzles, you've got these pieces in your hand. Without those pieces, I cannot complete this whole picture …” (John)*

John describes the power in having that opportunity to reflect with parents on their experiences first-hand. There is a real sense of relinquishing control and sharing responsibility when working with parents, influencing John’s understanding of families.

A curious and non-blaming approach was outlined by Nicky.

*“Instead of just saying. You know, so and so used again [drugs]. It's like, tell me what was happening for you that week…What led you to that? And that's different to the conversations that we would be having before.” (Nicky)*

The shift to exploring the ‘why’ behind such behaviours implicitly conveys a sense of hope, less judgement and more empathy towards parents, which appears different to approaches before where workers may have felt quite hopeless.

Increasing insight into parents’ experiences resulted in a transformation in the perspectives social workers had on families and the approaches taken in their work.

*“From the outside looking in, it's like, Oh my God, this mum can't cope. She's in crisis at all the time. And actually for me, I'm thinking, but she's not…..she's like, oh, I'm rubbish. I can't remember anything. And then she just gets herself into a state. So if I were someone coming in that didn't know this family, I may think she cannot cope with these children… this is gonna be a disaster, but actually. My work with her is more around supporting and building her.” (Shona)*

Based on her understanding of this mum Shona recognises how her mind set has shifted from panicking that this mum ‘can’t cope’ versus the need to provide ‘support’ and ‘build her’. Having skills to identify parents’ internal world appears to reduce the sense of threat for workers, enabling a transformation of how she approached this mum with support.

This insight resulted in workers reflecting on how their approaches shifted to what was described as ‘soft but firm’ (Kelly) and feeling empathetic towards parents.

*“helped me begin to understand this person's experiences and… to try to work differently, even if it's kind of empathizing more with their change in presentation” (Shona).*

*“But my view of them is.. you know what Mum had no chance of being a half decent parent because she had a really crap childhood and her parents abused her or neglected her”. (Kelly)*

*“We're not supposed to be judgmental, we're not supposed to blame. But I'm still human. So I think what it does, it probably softens my approach to them, my view rather, it, my view cause my approach is usually soft but soft but firm” (Kelly).*

Kelly reflects on the importance of being both ‘soft and firm’ together outlining the important duality of their roles in this framework, to be supportive and simultaneously manage risk.

### Allyship and hopefulness

Social workers appeared to experience a sense of shared humanity with parents. This meant they were now more like allies to parents, feeling trusted that they were “not here to remove your child” (Nicky) creating hope in being able to provide help and keep families together,

*“I am here to safeguard and to help you safeguard” (Nicky).*

The language to ‘help you safeguard’, places some onus onto the parent and represents a rebalancing of power and shared responsibility between workers and parents.

Parents were able to be honest when things went wrong, and implicitly this may have resulted in social workers feeling like a trusted source.

*“Parents not being afraid to say, you know what? I messed up over the weekend and I did some cocaine” (Nicky).*

Social workers’ recognition of parents not being ‘afraid’ conveys the sense that social workers are feeling more like allies to families.

This allyship extended to adult workers who Natalie described provided a comforting experience, which illustrated a wider systemic ‘coming together’, enabling workers to feel supported themselves.

*“they have been able to have conversations with families [adult workers]…about like, what social workers do to try and support families so…they're providing a reassuring message to adults that they're working with rather than feeding into this, like scary narrative that, you know, social workers are evil and scary and come and take away children” (Natalie)*

*“obviously it feels quite comforting…and I think that like the repercussions of that is that we just have more trust with parents” (Natalie)*

John felt hopeful that his practice within this model was challenging historical ways of working in social practice.

*“I'm hopeful that eventually society will wake up one day and be like... They're there to help, they are not there to take my child…You know, it makes me feel. One day at a time, we're ticking the box where society will start believing social work are here to support” \*\*laughs\*\* (John)*

The laughter suggests that whilst he remains hopeful that the model is enabling him as a social worker to feel like a supportive measure, that as a society we may be a long way off viewing social workers as wholly supportive.

There was value in transparency and equality whereby it appeared to enable social workers to feel safer in managing risks.

*“All of my service users know that if I am concerned about something, I will share that. But at the same time, I'm human. I'm fair..” (Shona)*

*“I think it does help build relationships, which of course helps with managing risk because they're more likely to be open…and listen to you and not think that you're against them …” (Kelly)*

*…. It's about helping families to understand that in life we all, professionals as well, have lives that go like that…” \*\*gestured up and down with hands\*\* (Nicky)*

## Group Experiential Theme 2: Feeling held and protected

A further group experiential theme outlined how the model enabled social workers to feel confident, able to manage frustration and feel less alone, resulting in a sense of safety and protection in their roles.

### Feeling confident and empowered

The model enabled workers to feel confident in knowing they were meeting families’ needs and keeping children safe.

*“so having adult workers that can give you them tools, but also that you can go out and do joint visits with helps you to stay skilled in that area of work..” (Shona)*

*“It's just another example of why the adult workers are absolutely vital for my practice, for my learning, for parents to make improvements, for children to be safer and develop” (Kelly)*

The language ‘absolutely vital’ suggests how paramount this worker feels the adult workers are in enabling her to do her job effectively.

Others talked about feeling a sense of ‘purpose’ and ‘focus’ and noted how their skill sets had ‘significantly improved’ due to the model.

*“It was more I was going in with purpose. And it gave like real focus for the family as well as for me” (Natalie)*

*“it’s helped me become a more confident practitioner. And I think that my skill set and my knowledge base is significantly improved because of it” (Natalie)*

*“Your work is up for scrutiny….It's just so reassuring…. You just know that you're going to be able to back up your report… But also just confident I suppose in the decisions and the recommendations that you're making…” (Natalie)*

Support from adult workers and resources such as the workbook/parenting modules enabled them to ‘back up’ their decisions and workers felt reassured they were making helpful evidence-based decisions for the family. Knowing they were ‘held’ by a wider system and their work was informed by experts in the field, seemed to empower them in feeling confident in their recommendations for families. There appears to be an overall sense of containment and safety allowing social workers to cope with the daily challenges of their role, and able to confidently make a difference to the lives of families.

### Managing frustration and surviving in the role

The adult workers and group supervision appeared to be vital in supporting participants to manage stuck points and feel able to ‘survive in the role’.

*“I think to be able to survive in this job. I think you need that support which the model offers…” (Stacey)*

*“sometimes you feel like, I'm doing a really crap job \*\*laughs\*\* basically, and you feel like you’re just on that conveyor belt and it's going really quickly...” (Stacey).*

The metaphor of ‘being on a conveyor belt’ highlights the pressure that this social worker feels, resulting in her judging herself as ‘doing a crap job’. The laughter following this, could be reflective of the ‘emotional walls’ that professionals build when working in such environments, perhaps as a way of coping with frustration and the emotional toll of the work (Lyth, 1988).

Another worker reflected on how sharing her ‘internal frustration’ about a parent with an adult worker had been helpful.

*“If I was to be honest in myself, I found myself getting internally frustrated with this mum. It was so helpful to be able to sit amongst professionals in that field. So mental health workers and for them to educate me in respect of parents with EUPD” (Emotionally Unstable Personality Disorder) (Shona).*

The preamble of ‘if I was to be honest’ implicitly implies how difficult it may be to acknowledge frustration with parents. However, noticing this frustration and having space to share it with psychologists seemed to enable her to feel supported in working with this parent.

Social workers were ‘grateful’ to have time to reflect on cases and have opportunities for personal supervision to help them cope within the role.

*“Quite supported here and there is more of that personal supervision to look after yourself” (Stacey).*

*“I'm so grateful for that manager has always been very big on reflecting…which I find so useful because it makes you take that step back.” (John).*

Having the time to ‘step back’ and to reflect on cases provided a sense of support to social workers, allowing them to feel able to ‘look after themselves’ and manage the internal frustration when working with complex families.

### Less alone: Safe uncertainty

All the participants referred to how the model allows them to share responsibility with other professionals, allowing them to feel safer in managing risk in uncertain situations.

*“….if we're all sitting together and we're all talking and we're all sharing and we're saying, today, when I went out, I noticed this. It allows you to build them, patterns of behaviour or develop that discrepancy between your world. Like, why was Mum saying that with you? But she said this with me. I think that it helped a lot more in respect of managing the risk” (Shona)*

*“I felt less worried, because we had more than, it was, not just me” (Shona)*

*“… Everyone's responsible for safeguarding. I felt that within the family safeguarding. I wasn't the only one within the department that had eyes on the family...”(Shona)*

It seemed that this approach resulted in workers feeling more comfortable ‘sitting with risk’ and trying to step cases down.

*“ I do think that it has made me more confident in like, sitting with risk or unknown or uneasy situations, I do think that I feel more comfortable and confident in doing that” (Natalie).*

*“ we want to get you back to where you’re able to tap into those resources and understand that these resources are there for you without children’s services, involvement” (John).*

*“…it's like a joint consensus about really rethinking our like, thresholds and where we feel comfortable, how comfortable we feel, managing more risky situations…” (Natalie).*

Social workers feel safer managing risk with the support the framework provides. Another worker reinforces this when discussing the consequences of a lack of multi-agency working.

*“I think where you start getting those serious case reviews, it's because there wasn't that multi agency working. There wasn't that opportunity for them to reflect” (Stacey).*

Being able to follow through with providing support of adult workers meant participants felt they were more of a supportive rather than oppressive measure.

*“You would be able to follow through with your promises. So you say as part of this plan, you're gonna do some domestic abuse work because that's the key area of concern. You would then be able to bring a DV [Domestic Violence] worker on almost straight away” (Shona)*

*“Once you start implementing some of those professionals [adult workers] to help them….it can make that working relationship better, and they can see you as like more of a supportive measure rather than… like an oppressive measure” (Natalie)*

## Group Experiential Theme 3: We’re breaking at the seams

Social workers reflected on the challenge of increasing service demands, which were beyond service resource, resulting in a shift to how they experienced the Family Safeguarding Model. This appeared to occur during the Covid-19 pandemic alongside high staff turnover, resulting in the model becoming more ‘diluted’ (Nicky). Thus, the implications of increasing caseloads and less availability to adult workers meant their experiences of the framework shifted from what was previously experienced as a protective framework to one of feeling powerless and unappreciated. There was a sense of duality between feeling held and protected and simultaneously experiencing such challenges within their roles, which appeared to relate to day-to-day pressures and realities of working as a social worker in this context.

### Unappreciated: not good enough

Increasing caseloads resulted in social workers feeling as though they were having unrealistic expectations placed on them.

*“…if my caseload was halved, definitely could do it but you know when, when you're just putting out fires all the time. The parenting modules, they fall by the wayside”. (Kelly)*

‘Just putting out fires’, represents a reactive way of managing their role, versus being proactive as they could do previously. Consequently, it appears they became focused on managing risks rather than highlighting strengths and providing support as the model originally intended.

One worker discussed how many social workers have to work outside their working hours.

*“I don't know one social worker that doesn't work outside of their working hours to get all of their work done. And that's just that's just the reality of getting everything that you are expected to get done, done” (Natalie).*

*“…the reality is... when you're overworked and you know it's extremely tiring. It's also, it's draining. You know, there's lots of tears, sleepless nights, you know early mornings trying to get everything that you need to get done”. (Natalie)*

Natalie talks about how being ‘overworked’ is impacting on her own wellbeing. The word ‘extremely’ emphasises the sense of overwhelm that increasing caseloads and unrealistic expectations have on her. In contrary to previous reports, the participants felt unable to look after themselves when service pressures were so high.

A discrepancy between expectations and reality is further highlighted;

*“…we get communications being like this needs to be done, this needs to be done, this needs to be done. And actually, you know, I don't think as a social worker we'd ever not want to get it done”. (Natalie)*

*“…because people…get further and further removed from the actual practise…they don't understand actually what we're doing in the reality and like how much work and effort and time it takes to do these good pieces of work and as a social worker, it can feel very, quite demotivating and quite devalued”. (Natalie)*

*“…it almost feels like nothing we do is ever, like good enough” (Natalie)*

These unrealistic expectations appear to result in social workers feeling unappreciated and ultimately ‘not good enough’.

Another worker emphasised that for the model to work, everyone at all levels within the framework should be given a clear induction into the programme so expectations can be managed.

*“if you've got a new manager who isn't very clear on the Family Safeguarding Program themselves and then you're asking them to manage a team and guide, that team. So for me, I, I don't see why we wouldn't be doing an induction for managers as well”. (Nicky)*

### Letting families down: Powerlessness

The increasing caseloads, longer waitlists and lack of resources were impacting on how much difference social workers felt they could make to families. With some referencing pivotal points of change were being missed.

*“They're just so stretched as a service at the moment [adult workers]… they can offer basic psychological support. Most of the parents coming in now are way past that!” (Stacey)*

*“I just worry that by the time that service comes in [adult workers] that point of change is missed.” (Shona)*

This was described as impacting on whether they felt able to move cases forward, as they would like.

*“We're waiting for practitioners to become available and I think that sometimes can…delay moving cases on. (Kelly)*

*“It feels like we're having to hold cases open longer than we would want to because we're waiting for that specific piece of intervention to take place” (Natalie)*

One worker talked about how they share the frustration that parents feel about this.

*“you're saying they need to do this piece of work and I'm still on the waiting list four months later and you're like, yeah, that is really annoying and do you know what? I share that with you..”(Natalie).*

Given the lack of resources participants were feeling powerless in meeting families’ needs which meant that the Family Safeguarding Model was not being delivered as it was originally intended, resulting in a sense of letting families down.

*“We were delivering a program to help that family make change and when that was gone [adult workers], it meant that caseloads started to increase, which means that you can't. You can't deliver the program in a meaningful way..” (Nicky)*

### Professional isolation: Feeling alone

Participants discussed how connections between them and adult workers felt ‘disjointed’, which they felt was primarily due to the adult practitioner services “breaking at the seams” (Shona).

*“I think since Covid family safeguarding isn't what it was, and I think we're losing services. So for example, drug and alcohol services are now very much based from their units, they don't work directly in the teams anymore and that makes it really difficult to do collaborative work” (Shona)*

*“So I feel like sometimes the connections are becoming more disjointed” (Shona)*

*“…it got to a point where with mental health workers.., we weren't told when people change [leave their roles]... So there seemed to be a bit of a disconnect when new people were coming in…” (Nicky)*

The proximity of adult workers, no longer being under one roof, is directly affecting social workers opportunities to work collaboratively to support families and they are left feeling ‘disconnected’ and unsupported by the wider system. This resulted in social workers being uninformed when adult practitioners were replaced, and they were unaware of the resources available to them.

There was a sense of professional isolation impacting on how much strength-based work they felt able to do, and how many families were falling through the cracks.

*“It's really hard to focus and get them strengths because you're constantly trying to address the risks as a lone worker.” (Shona)*

*“How many families are we not reaching because we're thinking in silo and I think the family safeguarding program can’t be delivered in Silo” (Nicky)*

# Discussion

## Key findings & implications

This study was the first to explore experiences of social workers working within the Family Safeguarding Model, thus providing a unique contribution to the literature. Given the small scale of this study, caution should be applied when changes are offered to practice. Regardless, the results have implications for clinical practice in child protection services, the welfare of social workers and the families they are supporting.

Social workers expressed the usefulness in ‘working with’ and exploring families’ backgrounds through questions such as ‘what has happened to you’ and emphasized the importance of parents describing their experiences first hand, as an important ‘piece of the puzzle’. The Power Threat Meaning Framework (PTMF), advocates for such approaches outlining the power in understanding complex behaviours in the context of surviving painful past experiences (see reference for more information) (Johnstone & Boyle, 2018). Professionals who begin to understand their clients’ experiences using psychological formulation, feel they, and clients, have more control over their problems, reduce their levels of blame towards clients’, and become more optimistic about being able to move forwards (Berry *et al*., 2009). The findings support this idea as it became possible for social workers to hold in mind two perspectives; that behaviours are concerning *and* that they are equally understandable.

By exploring families’ backgrounds and how power may have operated in their lives, social workers increased their awareness of the psychological impacts of austerity (McGrath, 2016), and were united with families in exploring the source of their distress. Further, there was an implicit recognition of the power social workers held themselves in their roles. Social workers reflected on the tensions of building relationships with families whilst working within the pressures of statutory services, and the mistrust families have of them (Gorman, 2018). There was an emphasis on challenging the stigma and oppressive processes that can overshadow their personal values to the work, illustrated through collaborative and non-hierarchical language (e.g., ‘walk alongside, sit down with etc.). Such approaches challenge the historical misuse of power in statutory services, which can be central to the development and maintenance of distress (Boyle, 2022).

Feeling held by the wider system and having increased multi-agency support in-house enabled social workers to develop what can be referred to theoretically as ‘a secure base’ (Bowlby, 1979), operating from a secure-base leadership framework (Coombe, 2010). Thus, social workers felt able to connect with families, take positive risks, sit with uncertainty and manage their own professional anxiety. When resources were readily available to them, and when working with professionals ‘under one roof’, they felt protected, enabling them to feel confident in their roles and adequately meet the needs of families.

The importance of physical MDT physical presence was highlighted further when social workers described the impact Covid-19 had on staffing and service pressures. The mandates to ‘work from home’ during the Covid-19 pandemic, resulted in a service that was originally positioned as ‘having all professionals under one roof’ (Forrester *et al,* 2017), working in a silo. The sense of professional isolation and social workers back to ‘putting out fires’, illustrates a reactive approach to such work, rather than one that enables positive risk taking and hope. Reductions in resources are known to decrease overall job satisfaction in such settings (Stand & Dore, 2009), thus it is unsurprising that social workers appeared despondent and reported feeling they were letting families down again. When social workers felt unable to meet the needs of their families, there was a loss of direction in their work, and the benefits of the model that initially enabled them to put the child at the centre of what they do became lost (Zell, 2006). Social workers described family safeguarding as ‘not being what it was’ highlighting the need to get back to managing risk together as a multi-agency, which has been consistently reported as paramount when protecting vulnerable children in complex families (Coates, 2017, Munroe, 2011). To ensure adult workers are accessible and reduce silo ways of working, the new blended approach following the Covid working from home guidance, may warrant review. Physical presence of multi-agency working seemed pivotal in enabling connections and a secure base to enable social workers to effectively support complex families. Thus, virtual ways of working, an approach now often adopted by therapeutic services, including in clinical psychology (Hayden et al., 2021), may not be as useful in high-risk services, where collaborative working is key.

Further, given the increase in mental health difficulties following the Covid-19 pandemic (Khan at al., 2022), current service pressures have moved beyond service resource. This calls for changes to be made at government level and funding to be increased in line with service need. This will enable social workers to proactively focus on the strengths of families they are working with, making the model and their roles as social workers more sustainable.

Changes at policy level advocating for trauma informed care that prioritise building therapeutic relationships in statutory work would support with prioritising the time social workers have to sit alongside families. As adult workers were referenced as pivotal in shaping their practice and enabling them to feel confident in their work, social workers would benefit from consistent multi-agency support in-house to allow shared responsibility for complex cases. This would enable social workers spaces for consultation, supervision and continued development of their skills to continue understanding the ‘why’ behind family difficulties. As discussed, this will enable them to operate from a ‘secure base’ and inform the way they work with families to meet their psychological needs, resulting in stronger therapeutic relationships and improved outcomes in the long-term (Ritter et al. 2022).

## Methodological strengths and limitations

Although overall sample size was small, a strength of the interviews was the rich data collected allowed an in-depth analysis of participants’ experience. This is a strength of the study as the depth of interview data is prioritised over the breadth in IPA (Smith, 2015). The sample were predominantly female and employed by one local authority who may have been known to the researcher from having worked in the team previously. Further, the researcher’s clinical supervisor who supported with recruitment is one of the adult workers where participants were recruited. This may have influenced a selection bias whereby those who had particularly meaningful experiences or who had built relationships with adult workers may have been more likely to participate, and females are typically more open to sharing emotive experiences. Thus, the study may have benefited from recruiting across local authorities, as there may be differing experiences across areas and less selection bias. Despite this, there was a large range of experience between participants, with some part of the team since its inception and others less than 1 year.

Research being conducted in the aftermath of a pandemic may have influenced the findings, highlighting a need to replicate this study when full-service resumes. Nevertheless, some important messages about the presence of the MDT and limitations of agile working are illustrated.

## Future Research

Future research could aim to recruit social workers across several regions that adopt this approach, to determine whether there are any differences in how this model is experienced. It may be useful for there to be a comparison of the other Strengthening Family Protecting Children approaches, for example seeing how social workers experience the ‘No Wrong Door’ and ‘Family Valued’ initiatives. Further research focused on the contribution psychologists make when embedded in children’s social work teams is needed to further the evidence base for psychology within social work.

# Conclusions

This study provides a unique contribution to the literature in exploring how social workers had experienced working within the Family Safeguarding Model in Child Protection Services. Six participants were interviewed, and transcripts were analysed using an IPA methodology. Three Group Experiential Themes were identified: fighting to work with families, feeling held and protected and breaking at the seams. These results are relevant to the field of clinical psychology as they highlight the importance MDT working under one roof to enable a secure base, building therapeutic relationships and using psychological formulation to understand why families present as they do. The implications of the pandemic further highlighted the importance of multi-agency presence, given this resulted in increasing service pressures and adult workers being outsourced or unavailable, and social workers left feeling hopeless and that they were letting families down again. Government policy should consider the changing needs of families living in the UK so appropriate funding can be provided to tackle increasing caseloads/staff shortages in such circumstances. Finally, to ensure the sustainability of the model, where possible it is crucial for adult workers such as clinical psychologists to remain in-house working alongside social workers. Child safeguarding services should not underestimate the impact that such support has on social workers feeling able to make a meaningful difference to the lives of vulnerable families.

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# Chapter 3: Executive summary

# A fight to work *with* families, rather than *against* them: exploring social workers’ experiences of working within the Family Safeguarding Model (an IPA analysis)

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Word Count: 1969



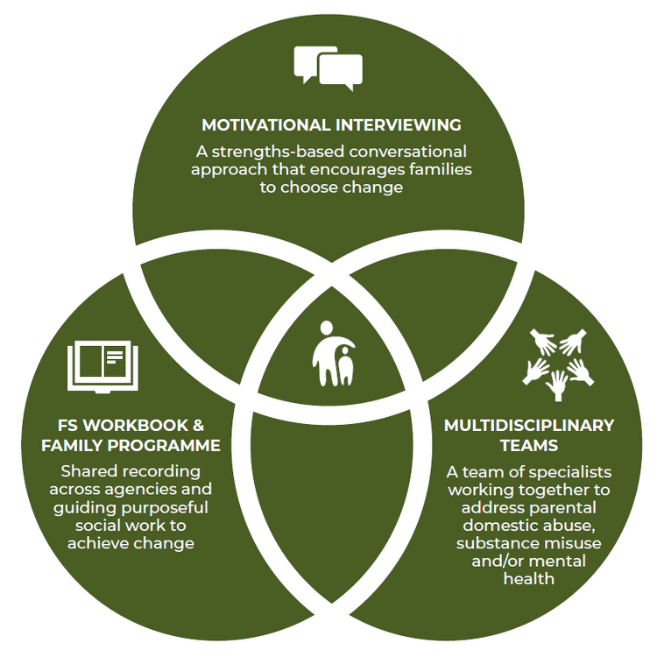
A fight to work *with* families, rather than *against* them: exploring social workers’ experiences of working within the Family Safeguarding Model (an IPA analysis)

*For social workers and professionals working in child protection services.*

**The research project**

The research set out to explore how social workers experience working within the Family Safeguarding Model. This document is a summary of this research and the findings and has been designed for social workers and professionals who are interested in understanding how frontline social workers in child protection experience their role when the Family Safeguarding Model is applied.





**The research aims**

The aims of this study were to:

* Explore social workers’ lived experiences of working within the Family Safeguarding Model within Child Safeguarding Services
* Explore social workers’ experiences of applying tools adopted by this model

**Why was the research done?**

Social workers in child protection services work to manage risk and simultaneously build trusting professional relationships, which can be challenging (Stevens et al., 2018) and emotionally effortful (Rollins, 2020). Trusting professional relationships can be challenged by social workers own sense of safety and fears when families are complex and/or high risk (Murphy et al., 2013). Working in a silo within emotionally charged contexts with minimal support, lack of resources and increasing caseloads, increases stress (Antonopoulou et al., 2017; Morazes et al., 2010), reduces wellbeing and directly impacts services available to families, through lost working days due to workplace stress, anxiety and depression (as cited in Ravalier et al., 2021).

The Family Safeguarding Model (see box below for more information on this) is an innovative social care model that advocates for a holistic family approach and a shift in traditional social care culture and practice (Rodger et al., 2020). There is no current research exploring social workers’ first-hand lived experiences of working within this model and how it influences their felt experiences and approach when working with complex families.

The components of the Family Safeguarding model (Social Care Institute for Excellence, 2021)

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**The Family Safeguarding Model**

Initially implemented within local authorities deemed to ‘require improvement’, it has three main ‘innovators’, who developed models to meet these aims, including: Hertfordshire’s: ‘Family Safeguarding Model (FSM)’, Leeds: ‘Family Valued’, and North Yorkshire who developed ‘No Wrong Door’ (Department of Education, 2019). Hertfordshire were the first to roll out the FSM in April 2015, which advocates for having ‘all professionals under one roof’, to improve joined up working and shared communication systems (Forrester *et al*., 2017). Practitioners addressing parental mental health, domestic abuse, and substance misuse difficulties were employed directly within social work teams to work therapeutically, or to provide consultation/training to the team. The model utilises evidence-based approaches (Forrester *et al,* 2017; Forrester *et al*, 2013; Wilkinson *et al,* 2016), including multidisciplinary collaboration (NHS England, 2014) motivational interviewing (Hohman, 2011) and team formulation (Johnstone, 2017), aiming to empower social workers to support parents to make sustainable changes to benefit their children.

Since its implementation there have been substantial cost savings, a reduction in families accessing emergency services and evidence of collaborative working through wider perspectives shared on family issues in group supervision and the shared workbook system (Forrester et al., 2017). These successful outcomes have led to 16 local authorities using the model currently and many more expressing an interest in adopting the approach (Clarke, 2022).

**Participants**

Participants had all worked as a social worker within the Family Safeguarding Model for at least 6 months. There were six participants in total, who were mostly white British. Four of the participants had over five years of experience working within the Family Safeguarding Model.

**Ethical Approval**

Ethical approval was received from the Staffordshire University ethics committee, and Hertfordshire County Council Children’s Services research and development team.

**How was the research carried out?**

Semi-structured interviews using an interview guide were conducted with participants. Interviews lasted on average 68 minutes. All interviews were audio-recorded and transcribed verbatim. Interpretative Phenomenological Analysis (IPA) was used to analyse the interview data. IPA Is a type of analysis used to help the researcher make sense of and interpret the participants lived experiences of a particular phenomenon (e.g. The Family Safeguarding Model).

**The Findings**

The researcher identified three group themes and nine subthemes that summarised the social workers experiences of the model.

**Group theme 1: Fighting to work with families**

Social workers felt the model enabled them to try and work collaboratively alongside families and they were open about the challenges in this.

*“When I sit down and have discussions with parents….It's like, oh boy, you're telling me off… No, I'm not. That's not the intention at all. I'm getting your experience…But because it's come from a social worker all she’s hearing is you’re telling me off…” (John).*

**Subthemes:**

1. **Connecting with families**

Participants reflected on their experiences of spending time with families, being one human being to another, and letting them know “I’m here to support you” (Stacey).

*“when parents feel that we're really wanting to support them… that scariness sort of like starts to go away a bit and they see it as….. children's services can be helpful and can be supportive” (Natalie)*

1. **Shared understanding and empathy**

Social workers worked ‘with’ parents by exploring what may have happened to them historically. This resulted in a shared understanding as to the reasons ‘why’ parents may present as they do.

*“Instead of just saying. You know, so and so used again [drugs]. It's like, tell me what was happening for you that week…What led you to that? And that's different to the conversations that we would be having before.” (Nicky)*

1. **Allyship and hopefulness**

Participants reflected on feeling trusted by parents that they were not there for the sole purpose of removing children and instead felt hopeful in being able to provide help. There was a new sense of shared humanity between social workers and families.

*“I think it does help build relationships, which of course helps with managing risk because they're more likely to be open…and listen to you and not think that you're against them …” (Kelly)*

*…. It's about helping families to understand that in life we all, professionals as well, have lives that go like that…” \*\*gestured up and down with hands\*\* (Nicky)*

**Group theme 2: Feeling held and protected**

The model enabled social workers to feel confident, able to manage frustration and feel less alone, resulting in a sense of safety and protection in their roles.

**Subthemes:**

1. **Feeling confident and empowered**

Social workers felt that the model enabled them to feel confident in knowing they were meeting families’ needs and keeping children safe.

*“It was more I was going in with purpose. And it gave like real focus for the family as well as for me” (Natalie)*

*“Your work is up for scrutiny….It's just so reassuring…. You just know that you're going to be able to back up your report… But also just confident I suppose in the decisions and the recommendations that you're making…”(Natalie)*

1. **Managing frustration/surviving in the role**

The adult workers and group supervision appeared to be vital in supporting participants to manage stuck points and feel able to ‘survive in the role’.

*“If I was to be honest in myself, I found myself getting internally frustrated with this mum. It was so helpful to be able to sit amongst professionals in that field. So mental health workers..and for them to educate me in respect of parents with EUPD” (Emotionally Unstable Personality Disorder) (Shona).*

1. **Less alone: Safe uncertainty**

All of the participants referred to how the model allows them to share responsibility with other professionals, allowing them to feel safer in managing risk in uncertain situations.

*“… Everyone's responsible for safeguarding. I felt that within the family safeguarding. I wasn't the only one within the department that had eyes on the family...”(Shona)*

**Group theme 3: We’re breaking at the seams**

Since the Covid-19 pandemic the rise in service demands were beyond service resource resulting in a shift to how social workers experienced working within the Family Safeguarding Model. This seemed to occur alongside high staff turnover, resulting in the model becoming more ‘diluted’ (Nicky) and challenging to apply. Social workers described feeling unappreciated, alone and the sense they were letting families down in their roles. Thus, the implications of increasing caseloads meant their experiences of the framework shifted from what was previously experienced as a protective framework that enabled hope to one of feeling powerless and unappreciated. There was also a duality in generally feeling ‘held’ by the model but simultaneously feeling the day-to-day pressures of the reality of social work in child safeguarding settings.

**Subthemes:**

1. Unappreciated: not good enough

Increasing caseloads resulted in social workers feeling as through they were having unrealistic expectations placed on them.

*“…it almost feels like nothing we do is ever, like good enough” (Natalie)*

*“…if my caseload was halved, definitely could do it but you know when, when you're just putting out fires all the time. The parenting modules, they fall by the wayside”. (Kelly)*

1. Letting families down: powerlessness

The increasing caseloads, longer waitlists and lack of resources were impacting on how much of a difference social workers felt they could make to families. With some referencing that pivotal points of change were now being missed.

*“I just worry that by the time that service comes in [adult workers] that point of change is missed.” (Shona)*

*“you're saying they need to do this piece of work and I'm still on the waiting list four months later and you're like, yeah, that is really annoying. And do you know what? I share that with you..”(Natalie).*

1. Professional isolation: feeling alone

Participants discussed how recently connections between them and adult workers feel ‘disjointed’, which they felt was primarily due to the adult practitioner services “breaking at the seams” (Shona).

*“It's really hard to kind of really focus and get them strengths because you're constantly trying to address the risks as a lone worker.” (Shona)*

**Recommendations for future research**

* Recruit social workers across several regions that adopt this approach, to determine whether there are any differences in how this model is experienced across the UK in different contexts.

A comparison of the other Strengthening Family Protecting Children approaches, for example seeing how social workers experience the ‘No Wrong Door’ and ‘Family Valued’ initiatives and how this compares to this study.

**Implications of the research?**

* Social workers should have easy access to ‘adult workers’ working under ‘one roof’ as the model intends. That physical presence of multi-agency working ‘under one roof’ seemed pivotal in enabling a ‘secure base’ and supportive systems for social workers to effectively manage risk.
* Changes at policy level for more trauma informed care principles to be embedded when completing statutory work, may support with prioritising the time social workers have to sit alongside families to build meaningful relationships.
* Social workers referenced how time to reflect with adult workers was useful in shaping their practice, and thus it would be of benefit for social workers to be provided with regular training on trauma informed practice including adult mental health, domestic violence and substance misuse.
* Social workers would benefit from opportunities for individual consultation and reflective practice spaces to discuss complex cases. This will enable them to work with families in understanding the source of their distress and the factors perpetuating this, in order to consider strategies to influence meaningful change.
* The reported lack of resources calls for changes to be made at government level and funding to be increased in line with service need, particularly since the increase in mental health difficulties following the Covid-19 pandemic (Khan at al., 2022). This may enable the model to be sustainable long-term and support social workers to stop ‘putting out fires’ and again focus proactively on the strengths of families they are working with, as the model aims to do.

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# Appendices

## Appendix 1. Hertfordshire county council ethical approval

|  |  |  |
| --- | --- | --- |
| **Children’s Services** |  | |
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|  |  | |
|  |  | |
|  | **Learning and Development Team** | |
|  | **Hertfordshire County Council** | |
|  | **SROB125** | |
|  | **Robertson House** | |
|  | **Six Hills Way** | |
|  | **Stevenage, Herts SG1 2FQ** | |
|  | **www.hertfordshire.gov.uk** | |
|  |  |  |
|  | **Tel:** | 01992 555 105 |
|  | **Email:** | [CSResearchGovernance@hertfordshire.gov.uk](mailto:CSResearchGovernance@hertfordshire.gov.uk) |
|  | **Date:** | Thursday, 13 July 2023 |
|  |  |  |



To: Charlotte Cucciniello

This letter is to confirm that Hertfordshire County Council Children’s Services has approved the research proposal for Charlotte Cucciniello in relation to the research project entitled:

**“An exploration of social workers experiences of working within a Family Safeguarding model alongside ‘Adult Workers’ in Child Protection services”**

Your service sponsor is Ross Williams from the **Family Safeguarding East Service** and you may contact them via [Ross.Williams@hertfordshire.gov.uk](mailto:Ross.Williams@hertfordshire.gov.uk) .This person will coordinate support for you to carry out your research project.

Once you have completed your research, please confirm the date of completion by sending an email to [CSResearchGovernance@hertfordshire.gov.uk](mailto:CSResearchGovernance@hertfordshire.gov.uk)

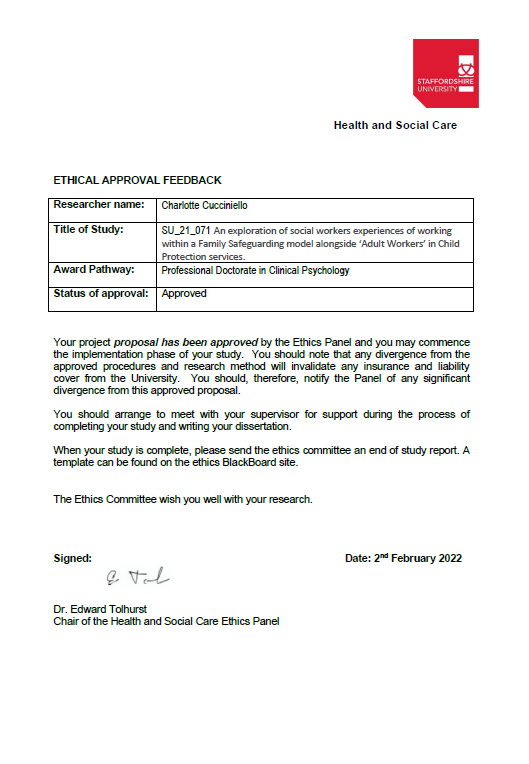
Where suitable, copies of your final findings may be requested by Children’s Services to share results and learning.

Regards,

Mohan Ballard

Assistant Learning and Development Office

## Appendix 2: Staffordshire university ethical approval



## Appendix 3: Participant information sheet

**INFORMATION SHEET FOR PARTICIPANTS**

*Project Reference Number:* SU\_21\_071

**Title of study**

An exploration of social workers experiences of working within a Family Safeguarding model alongside ‘Adult Workers’ in Child Protection services.

**Invitation Paragraph**

I would like to invite you to participate in this research project which forms part of my Doctorate in Clinical Psychologyresearch. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take the time to read the following information carefully and I encourage you to ask any questions or seek clarification as required.

**What is the purpose of the study?**

The purpose of this study is to explore social workers experiences of working within the new and innovative Family Safeguarding model adopted across several local authorities currently within Child Protection.

I am carrying out this study in order to understand the impact of this model on Child Protection practices from the perspective of the social workers working within it. I will aim to explore how social workers experience the adult workers and tools adopted by this new and innovative approach to child safeguarding. A secondary objective will be to explore social workers first-hand experiences of how the model may have affected their relationships and work with families.

The Family Safeguarding model is one of three developing models currently utilized across safeguarding contexts within the Strengthening Families framework in the UK. Therefore the findings of this research may be helpful to inform other services who adopt this approach, of ways they may implement processes or tools to improve its clinical utility for professionals working alongside families in need.

**Why have I been invited to take part?**

All social workers currently employed by a local authority within a child safeguarding context that currently adopt the Family Safeguarding model are being invited to take part in this research. To be eligible you must have at least 6 months of experience working within this model as a qualified social worker where you have held Child Protection cases.

**What will happen if I take part?**

If you agree to take part you will be contacted by the researcher via email to arrange an interview at a time and date that suits you.

You will be contacted to complete a short background questionnaire prior to the interview. During the interview you will be asked questions about your experiences of working as a social worker in the context of Child Protection working within the Family Safeguarding model.

The interview will take place over Microsoft Teams and will last approximately 1 hour. Interviews will be audio recorded with your consent and the researcher will let you know prior to starting the recording. The interviewee will be given the option to turn their camera off whilst recording on teams if this is there preference. Both interviewer and interviewee will be expected to complete interviews virtually in a quiet and confidential space, such as a private room.

Recording of interviews is necessary for the research so that all data can be transcribed verbatim and analysed accordingly. All recordings will be stored in a safe, secure and encrypted One Drive university account and will be safely destroyed once all the interviews have been fully transcribed.

**Do I have to take part?**

No, participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

**What are the possible risks of taking part?**

The study is not expected to pose any potential risks, however the questions may prompt participants to reflect on sensitive topics which may cause some distress. If this happens you are reminded that you do have the right to withdraw at any time before, during or after the interview or pause/postpone your interview if you need a break. You will also be offered a chance to debrief after the interview and be signposted to relevant services who may be of further help if requested. You will have the right to withdraw the information you shared within the interview and short questionnaire for up to two weeks after the interview has been completed.

**What are the possible benefits of taking part?**

There will be no direct personal benefit from taking part in this research. The research may however benefit wider safeguarding services through enabling recommendations to be made to developing the family safeguarding model. There may also be some reflective benefits in having the opportunity to talk about your own first-hand experiences of your role as a social worker within this context.

**Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). All transcribed data and background questionnaire will be anonymous. Audio recordings, transcripts and the background questionnaire will be stored securely and confidentially on the researchers’ secure university One Drive, and will only be used for research purposes. Transcripts may be shared with the research team including second and external markers and will be retained by Staffordshire University for 10 years, after which they will be deleted and destroyed securely. Confidentiality would only be broken if you were to disclose a risk to yourself or other people e.g. harm to self and/or others, at which point the researcher would let you know of the need to share information with relevant persons to protect yourself and/or others.

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a ‘task in the public interest’. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

**What if I change my mind about taking part?**

You are free to withdraw from the study without having to give a reason. Withdrawing from the study will not affect you or your rights in any way. You are able to withdraw your data from the study up until two weeks after the interview has taken place, after which withdrawal of your data will no longer be possible due to the processing of the data and analysis of this will have started by this date.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study.

**What will happen to the results of the study?**

The results will form part of my thesis, submitted for assessment within my doctorate in Clinical Psychology. This may also be submitted for publication whereby if accepted may be included in research journals. Material from the research may be used for teaching/training purposes or presentations at conferences, with use of anonymised quotes.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please do not hesitate to contact me using the following details: Charlotte Cucciniello [c025000k@student.staffs.ac.uk](mailto:c025000k@student.staffs.ac.uk). You may also contact my research supervisor; Dr Yvonne Melia ([Yvonne.Melia@staffs.ac.uk](mailto:Yvonne.Melia@staffs.ac.uk)).

**What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the research director of the Staffordshire University Ethics Committee for further advice and information on [Tim.Horne@staffs.ac.uk](mailto:Tim.Horne@staffs.ac.uk)

**Thank you for reading this information sheet and for considering taking part in this research.**

## Appendix 4: Consent form

Centre Number:

Study Number:

Participant Identification Number for this trial:

**CONSENT FORM**

Title of Project: An exploration of social workers experiences of working within a Family Safeguarding model alongside ‘Adult Workers’ in Child Protection services.

Name of Researcher: Charlotte Cucciniello

Please initial box

1. I confirm that I have read the information sheet dated 30/05/2022 for the  
   above study. I have had the opportunity to consider the information, ask questions and have  
   had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw up to two weeks

after the interview has taken place without giving any reason.

1. I understand that the interview will be recorded via Microsoft Teams, and I will have

the opportunity to turn my camera off if this is my preference.

4. I understand that all information shared will be entirely anonymous and confidential,

unless a risk to myself or others is disclosed where the researcher deems it necessary to share information with relevant people to protect myself and others.

1. I agree to take part in the above study.

Name of Participant Date Signature



Charlotte Cucciniello

Name of Person Date Signature

seeking consent

## Appendix 5: Questionnaire

**Demographic Questionnaire**

**Study Title: An exploration of social workers experiences of working within a Family Safeguarding model alongside ‘Adult Workers’ in Child Protection services.**

Demographic questionnaire

*Please select an answer for each of the following to help inform the demographics of the study sample. If you would prefer not to answer simply omit this item.*

1. What is your Gender identity?

Male ☐ Female☐ Other☐ Prefer not to answer☐

1. What is your age?
2. What is your ethnicity?

White ☐ Asian ☐ Black African/Caribbean ☐ mixed or multiple ethnic groups ☐ Other ☐

**Thank you for completing.**

**Please return this form electronically to the researcher on** [**C025000K@student.staffs.ac.uk**](mailto:C025000K@student.staffs.ac.uk)

## Appendix 6: Study Advert



## Appendix 7: Interview schedule

**Semi-structured interview schedule**

An exploration of social workers experiences of working alongside ‘adult workers’; within a Family Safeguarding model in Child Protection services.

Introduction to me

* Name and role
* Check can hear and what happens if internet drops
* Remind will be recording on MS teams
* Discuss the limits of confidentiality/anonymity – refer back to participant information sheet and consent form
* Reiterate reason for the interview as per the participant information sheet and their right to withdraw even after data has been collected

Establish a plan regarding ceasing interview if questions become distressing for any reason.

How will I know this interview is causing you distress? What can we both notice? Agree on a plan of action if distress were to occur with the interviewee prior to beginning the interview.

***Go through demographic Questions if not already completed first***

***Short information gathering Ice Breaker:***

How long have you been qualified as a social worker and have you worked anywhere else in children’s social work?

How much experience have you had working within the family safeguarding model?

Have you worked alongside any other models in children’s safeguarding?

I am now going to ask you some questions about your experiences of working within the Family Safeguarding Model. If for any question you feel you have nothing to say or would simply prefer not to answer, just let me know and we’ll move on. Do you have any questions at all before we begin?

1. ***Overview: (strengths and drawbacks)***
2. Can you describe your experiences of working within the Family Safeguarding model in Child Protection?
3. What have you found to be of particular value to you when working within the Family Safeguarding Model? (strengths)

*Prompts around specific tools to add to above questions if not already covered:*

- What did this mean for you in this role? What sense did you make of this? Can you tell me some more about x or y?

-What about your experiences of adult workers, theoretical models (MI, formulation), group supervision and core group meetings?

1. What have you found to be more challenging since working within the Family Safeguarding Model?

*Prompts around specific tools to add to above questions if not already covered:*

- What did this mean for you in this role? What sense did you make of this? Can you tell me some more about x or y?

- Is there anything you would like to add about adult workers, theoretical models (MI, formulation), group supervision and core group meetings?

1. ***Impact on work/role as a social worker in this context? (self and systems meaning making)***
2. How does this way of working impact on your work? What does this mean about you as a social worker in this context?

Prompts; benefits and drawbacks?

1. How has the family safeguarding model impacted on your experiences when working with the wider system? What did these experiences mean for you in regards to the wider system?

Prompts; with external agencies such as first steps, universal services, schools and families, legal processes etc.

1. ***Changes***
2. How do you feel your experience of the family safeguarding model compares with previous professional experiences you’ve had?

Prompts: Was this way of working experienced any differently for you and if so how?

1. ***Attitudes/relationships with families & colleagues (others meaning making)***
2. How does this model impact on the experiences you have when working with complex and/or high risk families?

Prompts; perspectives on families, own bias/prejudice views, positive risk tasking etc., knowledge of toxic trio.

1. How does this way of working change your own practice and experiences working with families? Please can you explain your answer?

Prompts; changes in decisions around assessment, escalation, relationships with families, case load?

1. How did you experience working alongside your colleagues/team within this model? Prompts: peer support, supervision etc.

*Generally prompts about experiential elements in particular emotional experiences: e.g. confidence, connectivity with family, understanding, empathy*

1. ***Closing question***
2. Is there anything you would like to add about your experiences of working within this model that we have not talked about so far?

Thank you for participating, do you have any questions?

## Appendix 8: Debrief form

Research debrief information

Thank you for your participation in our study, your participation is greatly appreciated.

Purpose of the Study:

An exploration of social workers experiences of working within a Family Safeguarding model alongside ‘Adult Workers’ in Child Protection services.

This research aimed to explore social workers lived experience working in the field of Child safeguarding utilizing the Family Safeguarding Model. As this model is a new and innovative model still in development, little research has been done on it to date. Previous literature and serious case reviews have highlighted the need for new and innovative processes in child protection. Currently no research exists on how social workers experience this new approach. Here, our interest was in exploring social workers first-hand experiences of being immersed in this approach, alongside what this meant for their work with families, children and the wider system.

The research adopted an exploratory approach and thus the method of data collation was through individual interviews. For each interview completed the researcher will immerse themselves in the data before transcribing and generating themes identified, which can may be useful in informing this approach and future research within it.

Confidentiality:

You may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted please contact us within two weeks after the date of your interview.

Final Report:

If you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact us.

Contact Information:

If you have any further concerns or questions please do not hesitate to get in touch with the research team on the contact details below:

Charlotte Cucciniello: c025000k@student.staffs.ac.uk.

You may also contact my research supervisor; Dr Yvonne Melia - Yvonne.Melia@staffs.ac.uk.

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the research director of the Staffordshire University Ethics Committee for further advice and information on Tim.Horne@staffs.ac.uk

Further Reading(s):

If you would like to learn more about the previously utilized models in children’s safeguarding services please see the following references:

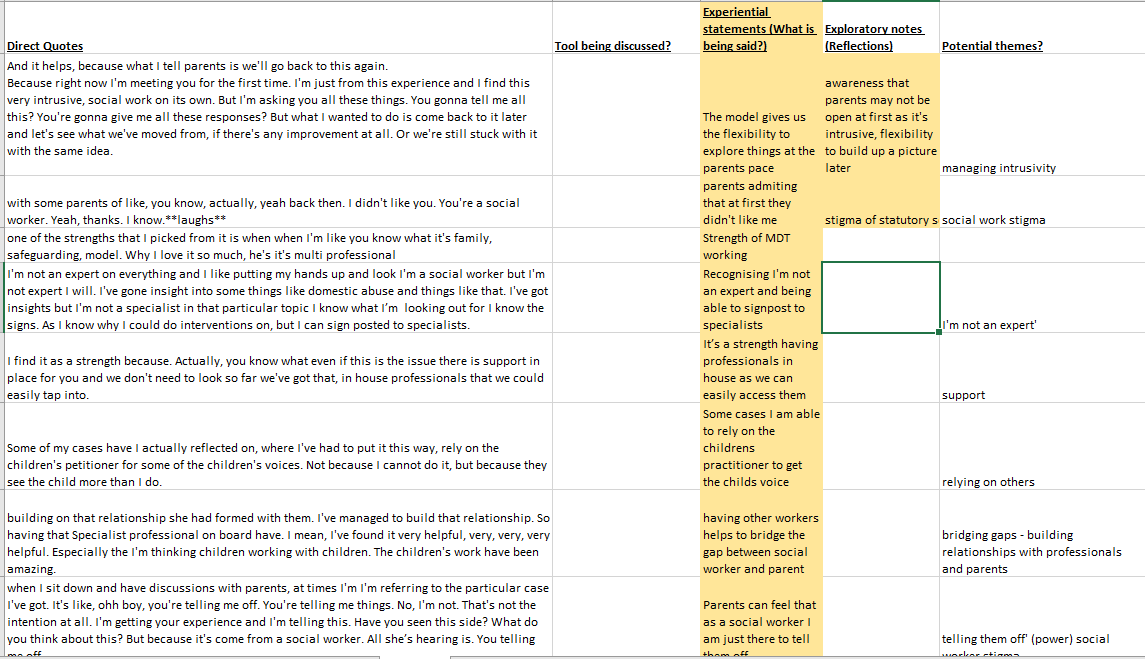
Cambridge Children's Services (2010) Social Work: Working Together for Families. Downloaded [www.cambridgeshire.gov.uk](http://www.cambridgeshire.gov.uk)

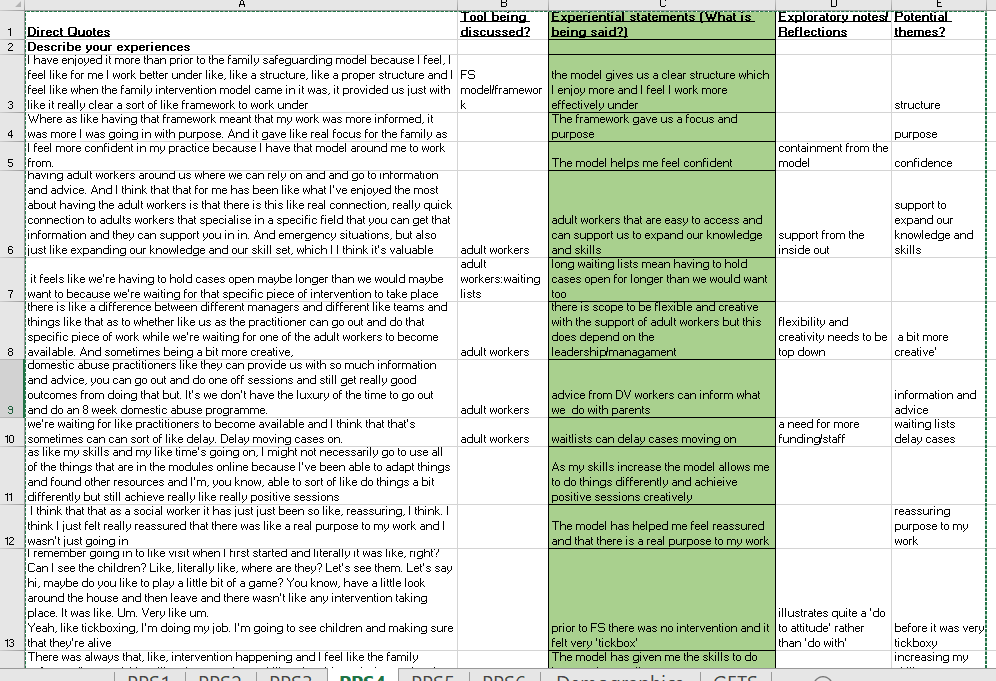
Forrester, D., Lynch, A., Bostock, L., Newlands, F., Preston, B. & Cary, A. (2017). Family Safeguarding Hertfordshire Evaluation Report. Children’s Social Care Innovation Programme Evaluation Report 55. 1-94.

Hackney (2008) The Way We Do Things Here, City and Hackney Child and Adolescent Mental Health, downloaded from Http://www.cityandhackneycamhs.org.uk

Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study

## Appendix: 9 Examples of transcript analysis: Generating experiential statements





## Appendix 10: List of experiential statements and initial clustering

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| **Experiential statements: Stacey** |
| The workbook gives a structure |
| Comparing FS to other ways of working, it does have more structure and we don't have to go straight to a parenting assessment anymore |
| A pro of the FS model is that the modules allow you to get to the deeper issues and the potential safeguarding concerns for that child |
| The model can be complicated, which can take a while to understand. There are not as many sections in comparison to other models but they are in depth |
| The sections of the workbook can be quite intense, meaning work needs to be split |
| Parents may experience it as intrusive as we would only usually get to exploring these things when a PA is needed |
| it can help to uncover other things they might need support with that aren't on the referral |
| The workbook allows the sw to see the parents progression over time, instead of it feeling forced into a small time scale as it would historically with getting a PA done |
| When you have to complete a PA in a short period of time then parents cannot be honest but with workbook you are working over a period of time |
| The structure of the model helps us to remember key areas to cover |
| The workbook specifies what we need to be asking and its very much like the rulebook |
| The workbook helps it feel as though I'm not directly being intrusive on a parents life as its more because of the workbook |
| We are able to say we want to discuss this as this is part of the model, and it's less me asking questions because I want too and more part of the process |
| It helps the parents as they can see the gaps through the model, rather than them thinking this is just the social workers opinion |
| Where there was no structure you would build up trust but then they would think we are using things against them |
| We can have that trusting relationship with parents and still safeguard the children |
| The model helps keep my work and the relationship I have with the family separate |
| Maintaining trust and professionalism together |
| Hearing what parents have been through makes me want to support them |
| My approach is to come alongside families and tell them I am here to support you |
| I can be creative in the ways I get the childs views |
| By taking the time to get to know families, we can build really good supportive relationships |
| Able to respond to individual needs of families |
| Disparity between adult workers in different LA's |
| It's useful having adult workers assigned to our team so we can work together |
| Having adult workers as part of the team is useful as their structure will be the same as ours |
| Long waiting lists/larger case loads for psychologists and only basic support offered mean that needs are being missed |
| Parents need secondary care input given the complexities, however this results in another waiting list |
| Missed opportunities for change due to long waits |
| The model works well when we have the staff but when we can't offer the support that’s needed, that’s when we end up in court |
| changes to social context e.g Covid have not been condusive to the model |
| We can identify the problems now however we don't have resources to offer support again |
| The role can affect sw's mental health and here we are quite supported with personal supervision to look after ourselves |
| Having separate time for personal supervision helps to protect us as workers |
| In this role within this framework I do feel I am making a difference and giving a voice to children who don't |
| Getting a range of experiences in one room to discuss and reflect on stuck points with families is really helpful |
| Serious case reviews are likely due to not having that multi-agency approach and lack of opportunity for reflection |
| Having several perspectives on a families situation can help us to think outside the box |
| When things are feeling really pressured and frantic we have the support of colleagues for validation |
| To survive in this role we need support which the model offers |
| The model allows us to know eachothers cases |
| The model helps us to identify the bigger picture and protect ourselves |
| Having easily accesible communication systems makes information sharing better, which helps to manage risks |
| Working together as a multi agency helps us see the bigger picture |
| where there is not a central location for all information to be recorded risks can be missed |
| The model helps us to have clear referral processes |
| The model helps us to explore everyones perspectives in the family |
| the modules help us to explore grey areas/hunches |
| Reflecting on concerns with complex cases and questioning our thoughts |
| The modules helped me to identify patterns and signs of abuse |
| The framework helped me evidence concerns and potentially avoid a serious case review |
| Being a social worker is a high risk job and the model helps us protect ourselves |
| Being a social worker is a high risk job and the model helps us protect ourselves |
| Being a social worker is a high risk job and the model helps us protect ourselves |
| The model allowed me to evidence strengths for families and identify the real concerns |
| The model allowed me to evidence strengths for families and identify the real concerns |
| I was there to support families |
| I was able to support and being transparent from the start |
| The modules also help to identify where there is no safeguarding concerns |
| dads views now included on the modules |
| The framework helps us to see what work has been done and what are the gaps |

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| **Experiential statements: Shona** |
| The model felt positive when everyone was very enthusiastic and when we had adult workers in house |
| A strength of the model was having adult workers available to work alongside you |
| When caseloads were smaller workers were adult to just respond, which alleviates stress for social workers |
| since covid services don't work under the same roof as us |
| Connections in the model have become disjointed |
| resources are being pulled and are limited which impacting on the pressures in the service and on us |
| since covid things in the FS model haven't worked as well |
| when adult workers were under one roof you could then provide the support that was needed to parents |
| previously we were able to catch parents at that pivotal point of change |
| waiting lists means that point of change is likely missed |
| Having a range of workers around the table was really good before |
| Outsourcing that support again is a real struggle as I can't get hold of the workers |
| The amount of legal work being requested means there is no capacity for strength based work |
| Since covid there has been an increase in CP and children in care |
| When the model works I am able to do what I was trained to do and build a rapport with families |
| the limited resourced in house means I am just chasing risks not building relationships as we should be |
| Lone working means always addressing risks and not focusing on strengths |
| staffing means that families aren't getting the services they need |
| Changes in resources mean I now have no time to do the things that I love to do with families |
| Previously you would have spontaneous reflection at your desks with other workers |
| working from home means we are not sat with our colleagues in the office |
| The only stability currently is with psychologists and DA workers |
| not knowing which resources are availalble to tap into due to lack of communication |
| Not knowing who Is in the service to tap into |
| The model doesn't work when we don't know who to refer into in-house |
| lack of communication from leadership means there is a disconnect/lack of clarity of what services are available |
| Communication from top down can be limited |
| difficult maintaining relationships in covid |
| differences in opinion with management meant that relationships with families became fractured |
| Being able to follow through with what we said we would help to build my relationship with families and change their views of SS |
| Having a multi-agency way of working helps me to share responsibility and feel safe in that I wasn't the only one managing the risks |
| Sitting together and sharing information helped to build up patterns or develop discrepancies which enabled me to feel more comfortable |
| Having mental health workers helped me to manage times I felt stuck with parents |
| Having mental health workers enabled me to empathise more and work differently |
| Speaking with a psychologist in house enabled me to take a step back and see this was part of her personality disorder |
| Having adult workers in house helped me to understad service users from a different perspective |
| reading the psychological assessment helped to shape perspective and way of working with a family |
| The framework allows us to complete person centred work |
| Rather than veiwing something as a crisis, I look at how to support and build parents |
| Sometimes it can be hard to clarify which service the parent should receive the service from |
| The framework allows us to see what the adult workers are working on and develop patterns or discrepancies |
| The modules keep us focused and really look into the risks of harm |
| We need to build relationships with parents first before we expect to explore parents earlyexperiences |
| The modules allow us to be creative in how we go about our work |
| This way of working means we are continually questioning what this family needs are |
| We are thinking of the bigger picture |
| sometimes its just about spending time with parents listening to them |
| It's just about being one human being to another |
| Having that time to be one human being to another |
| When caseloads are high we lose the abiity to just sit and get to know families |
| I can't imagine working in any other framework now as this is structured and it keeps you focused |
| Although there are delays in work, I have been able to develop skills to deliver things |
| Even with the struggles in FS I still think our throughout for families is greater than other LA's |
| Liasing with adult workers in house was really helpful as I was able to then work to meet parents needs |
| Having guidance on how to work with parents to meet their needs is very helpful |

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| **Experiential statements - Kelly** |
| I saw different professionals sitting together in the office and this resulted in better lines of communication |
| it felt like families were supported and children safer as professionals new what was going on |
| When people are not coming together and communicating, Information can be lost |
| Workbook can mean duplication of work and I am really behind with this |
| Difficulty summarising in the workbook, in case we are questioned, and information is needed for court |
| Questions in the modules can feel awkward to ask |
| the modules are idealistic not realistic to get done |
| getting good quality work done during home visits is tricky when there is lots of chaos |
| caseloads impact on ability to follow the programme as it was intended - if it was halved I could do it |
| having adult workers helps social workers feel supported and to keep children safe. |
| lack of clarify of documenting information can increase workloads |
| Its easier to build relationships with adult workers under the same roof/same team as us |
| Having adult workers in house helps them to acknowledge the bigger picture of risks/safeguarding concerns |
| By building relationships with parents, they are likely to trust us, be more open and not think we are against them |
| Understanding parents’ history can increase our insight into their difficulties |
| Having open exploratory conversations with parents can increase their insight and indirectly reduce risk |
| the approach softens my view of them |
| I am able to see how Mums struggle to parent based on their own past difficuties |
| Your behaviour makes sense and you also have a choice/holding both sides in mind |
| The psychologists helped me to understand a childs behaviour was linked to mums’ difficulties with boundaries |
| adult workers are vital for my learning to support parents and keep children safe |
| The model helps me understand why parents, parent the way they do and increase my empathy |
| knowing how their parenthood affects their parenting often leads to requesting psychological assessment and this explains a lot |
| understanding parents’ history can increase our insight into their difficulties and help in court |
| working is more effective having all professionals on one team, but this can also go against us in that parents may think we are all against them |

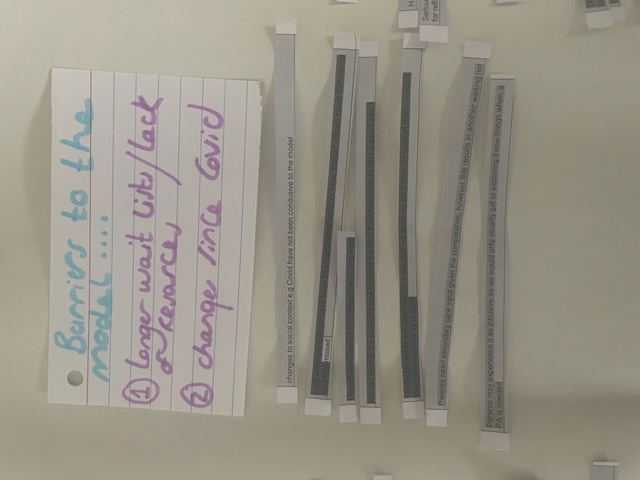
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| **Experiential statements: Natalie** |
| the model gives us a clear structure which I enjoy more and I feel I work more effectively under |
| The framework gave us a focus and purpose |
| The model helps me feel confident |
| adult workers that are easy to access and can support us to expand our knowledge and skills |
| long waiting lists mean having to hold cases open for longer than we would want too |
| there is scope to be flexible and creative with the support of adult workers but this does depend on the leadership/management |
| advice from DV workers can inform what we do with parents |
| waitlists can delay cases moving on |
| As my skills increase the model allows me to do things differently and achieve positive sessions creatively |
| The model has helped me feel reassured and that there is a real purpose to my work |
| prior to FS there was no intervention and it felt very 'tickbox' |
| The model has given me the skills to do interventions well |
| the adult workers have been able to give me really valuable advice |
| The advice given to me by adult workers has really helped my to tailor my work especially for those with learning needs |
| Able to develop transferable skills with lots of cases |
| Not feeling alone in holding all the knowledge for a family feels safe and reassuring and has helped me to provide a better service to families |
| knowing the ethos of the service has good intentions and containing me helps me to provide a better service and feel 'held' |
| The intention of the model is to do really good pieces of work |
| changing terminology from assessment to intervention helps make it more collaborative, less oppressive |
| We want to work with parents rather than tell them what to do |
| The process is longer and it's more work but the outcomes for families are better |
| The reality is that social workers do often work outside their working hours |
| Great pieces of work but difficulty finding time to document it |
| admin can be repetitive, which feels overwhelming |
| Most social workers are overworked and its tiring and training trying to get everything that needs doing done |
| narratives from leadership result in social workers feeling nothing they do is good enough - when leaders are too far removed from what we are actually doing this can impact on their understanding |
| as above |
| waiting lists for interventions are a challenge |
| when I am undervalued I start to resent my work |
| discussing the impact of waitlists on her personally - it can be tiring and frustrating having to explain this to parents |
| the model has significantly improved my knowledge and confidence |
| If I have to go to court now I feel reassured that I have been the expert and able to evidence my practice |
| as above |
| This way of working is reassuring and it helps me have the confidence in the decisions I'm making |
| My recommendations are so much more informed |
| Being able to draw on lots of different expertise feels safer |
| Since the model has been introduced I am able to do parenting assessments for court |
| I'm not sure that external services such as schools know much about the family safeguarding model |
| Other professionals outside the team might not understand the depth of the work we do |
| It’s incredibly helpful to have other professionals inform my work |
| Relying on mental health practitioners for assistance and sign posting |
| Having adult workers has helped parents feel supported by children's services |
| Having adult workers can help the relationships we develop with parents because they feel supported and listened too by someone that isn't us |
| When parents realise children services can be supportive and we show we want to work with them, it helps build up that relationship with parents. |
| Being able to introduce parents to adult workers makes our working relationship better |
| It feels good to have a good working relationship with a parent and I feel relieved and that I can do my best work |
| The change of language from assessment to intervention helps to build better relationships |
| It has changed our way of working with parents where its not so much of a fight anymore |
| I'm thinking more around the problem now, rather than the problem alone |
| I'm less judgemental |
| It's made me explore things more in a kinder and empathetic way |
| It's made me a better social worker in that I can think about things now from other perspectives |
| A shift from not escalating cases |
| I'm more confident and comfortable to sit with risk now |
| I now think about the impact of putting a child on a protection plan and what this might mean for them long-term |
| ensuring cases her escalated for the right reasons rather than professional anxiety or just safeguarding ourselves |
| It's meant that we are really rethinking our thresholds |
| Parents can really see that we want to work with them collaboratively and we don’t want to escalate cases |
| It's not about trying to catch families out so we can escalate cases |
| I think both us and adult workers learn from each other |
| I feel reassured that adult workers know what safeguarding concerns look like and what to do about it |
| It's really helpful to have that shared understanding between us, parents and the adult workers about the service being their to support parents |
| Having adult workers on board in comforting and in turn we have more trust with parents |
| Social workers have bad press and the more we can work like this the more we can get across this supportive narrative |
| It likely helps parents feel more reassured that these people are here to help you, rather than work against you |
| Its helpful to have a whole system working together to better meet the families needs rather than overwhelming them |
| It's helpful to have a structured piece of work |
| Having an open dialogue with the adult practitioners will help with our work with families |
| I become aware of what are the triggers for families and how I can try to manage it |
| Although there can be lots of admin, in practice what this means for families is much better |
| We are now tailoring interventions to meet families needs and it is very individualised |
| Genuinely meeting families needs and having better outcomes most of the time |
| It took some time to get used to the workbook but now it's just embedded I our practice |
| I enjoy having nice conversations with families and I think it's a better way of working |
| I think we could improve on sharing of resources |
| Sharing resources might just give it a new lease of life |

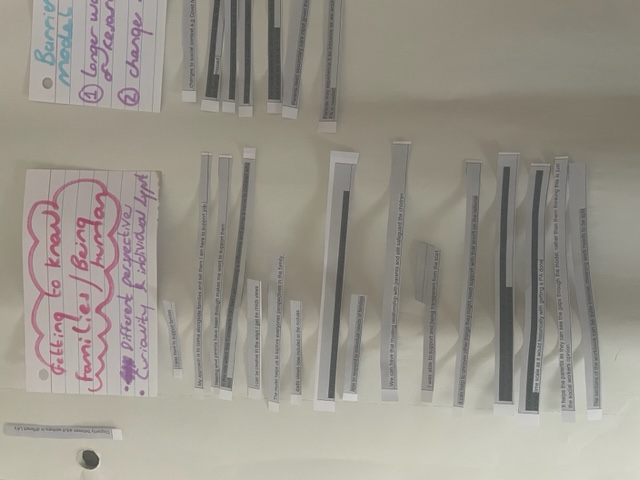
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| **Experiential statements: John** |
| The model gives us the flexibility to explore things at the parents pace |
| parents admitting that at first they didn't like me |
| Strength of MDT working |
| Recognising I'm not an expert and being able to signpost to specialists |
| It’s a strength having professionals in house as we can easily access them |
| Some cases I am able to rely on the childrens practitioner to get the childs voice |
| having other workers helps to bridge the gap between social worker and parent |
| Parents can feel that as a social worker I am just there to tell them off |
| An adult practitioner could say the say things to parents as us but it's received differently from them |
| Appreciative of the relationship parents have with adult practitioners |
| I acknowledge that it must be hard for parents to open up to social workers due to fears we may take there child, so Its helpful they are able to talk to adult practitioners |
| Having lots of professionals on board is benefical |
| Parents fearful we are going to take their children |
| I try and share my understanding of the processes with parents |
| Having other professionals on board who they feel safe to talk to |
| Having other professionals on board who they feel safe to talk to |
| Understanding that parents can access support through other professionals and that's ok |
| The model utilises the best people for the right job |
| Parents are going to struggle to be open and honest with social workers so there are limits to what we can do in our role |
| working together to support the family rather than passing the buck |
| The model encourages us to get to know parents |
| The build a bigger picture only the parents can help us understand what makes them who they are |
| The model helps us to put together the whole picture and gives parents the opportunity to reflect |
| Recognising the trauma and turmoil parents have been through |
| The model has the power to tap into other services |
| The model gives us the flexibility to explore things at the parents pace |
| Able to recognise trauma and refer to specialists to support this |
| The model gives us the right people for the right job |
| We are all humans and there is not a one fits all approach |
| Without the wider support from the team I am unsure if I would have achieved what I have with families |
| I had lots of support around me from other professionals |
| Its great to have resources to tap into directly |
| Able to rely on other professionals to work with me in supporting a family |
| working together |
| The opportunities for reflection on adverse experiences |
| Try to develop an understanding of parents |
| The power of being able to encourage parents to reflect |
| Helps parents see we are not picking on them |
| Helping parents understand there early experience is powerful and can help to step cases down |
| The opportunities to reflect helps us to develop shared concerns with parents |
| Regurgitating information onto workbook - hard to know is this just social worker or the FS model |
| The difficulties of evidencing MI in my write ups |
| Translating what I do into the paperwork is more challenging |
| There are several admin processes and it's difficult to know which is unique to the FS model |
| FS on its own not challenging |
| It’s the statutory bureaucratic approach that makes the work challenging |
| The FS model helps with court reports |
| The FS model gives me a head start when I am asked to do a PA in court I can track the progress |
| Having to record everything we do is overwhelming |
| It's overwhelming and I am appreciative of being in an understanding and supportive team |
| The model enables me to feel able to work in statutory services |
| With support and understanding from the team I am able to manage this type of work |
| The model has kept me working in this type of service |
| There are shared opportunities for us and parents to reflect on experiences |
| Opportunity to understand several perspectives |
| We have to all come together to support families |
| We have to all come together to support families |
| Coming together to manage risk effectively |
| Helps other professionals understand what safeguarding actually is |
| Building relationships with other professionals can be the bridge for parents to rebuild relationships |
| Coming together to support parents to cope without children's services involvement |
| Building supportive relationships with services that can continue once we step away |
| The model supports an alternative narrative that social workers are here to support |
| The model does challenge the societal stigma attached to social work |
| The model highlights risk and complexity, it helps us support parents to really hear their children |
| Reflection supports in unpicking complexity and break it down |
| sharing our concerns with parents |
| Understanding the function/the why of a parents behaviour |
| It helps us to explore parents motivation to change |
| I've had opportunities to make sense of family experiences intergenerationally |
| The model helps us to analyse information openly with parents |
| parents probably think we are going to make orders but instead we are exploring with parents what went wrong |
| Considing where parents are at on cycle of change and where the gaps are |
| Getting the feel of the complexity of cases |
| Able to recognise that despite concerns being there, the bigger picture shows that the safeguarding concerns are diminishing |
| Reflecting on cases helps me to step back and consider the main concerns in complex cases |
| The model has the child as the centre and at each part we are considering the impact on the child |
| Able to track change and see progress for families |
| Supporting parents to feel heard and move forwards |
| Being honest with parents can also have it's challenges |
| Remain flexible to revision |
| Using the parents perspectives to shape our understanding |
| Building better relationships |
| Building relationships with professionals in house influences the way I practice as I can tap into their knowledge |
| Using adult practitioners to inform my own practice |
| It can be perceived as intrusive but I view this as understanding |
| We need to understand parents experiences to be able to support in a meaningful way |
| It increases families and professionals understanding of the concerns and results in meaningful work |
| Giving parents the opportunity to result and consider the concerns |
| The model gave us the opportunity to unpick parents understanding and explore issues |
| Until we reach a shared understanding with parents we are stuck |
| Trying to understand where parents are coming from reduces that power imbalance |
| supervision gives us further opportunity to reflect on our own thoughts and feelings |
| The model cannot be faulted |

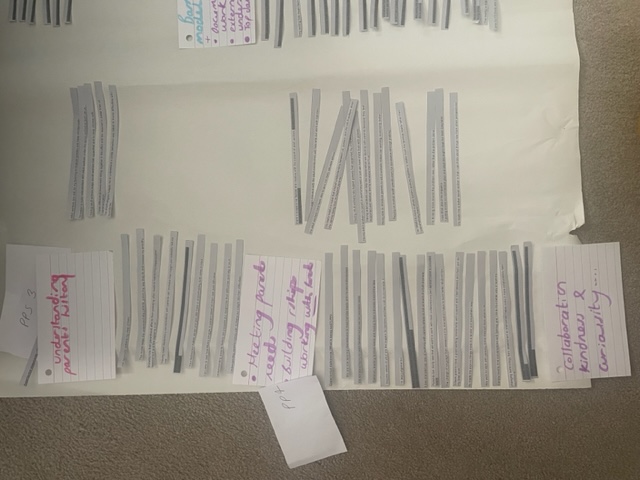
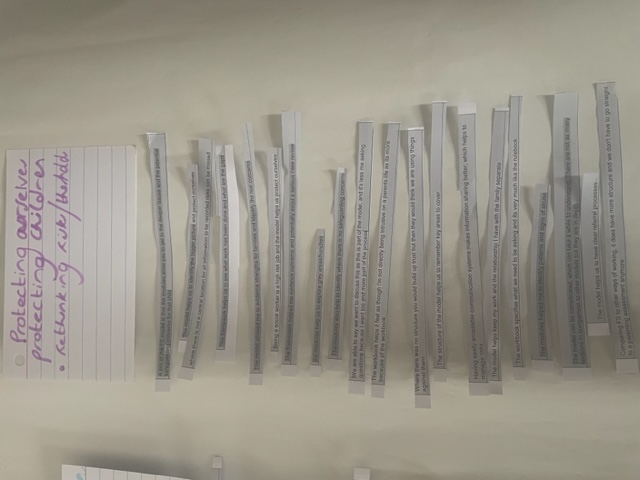
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| **Experiential statements: Nicky** |
| A limited time frame meant we had to 'build bridges as we walked across it' |
| Navigating new frameworks did have 'teething problems' |
| starting afresh with a new team was a privileged position to be in |
| Working alongside other professionals was brilliant |
| The loss of good workers had a negative impact on the model |
| New leadership resulted in loss of direction, understanding and enthusiasm |
| When enthusiasm top down is lost it becomes difficult |
| Manageable caseloads result in effective programme delivery |
| poor programme adherance equals higher caseloads and further difficulty implementing the programme |
| Frustration and high staff turnover |
| When caseloads increased and staff turnover increased the power of working together was lost |
| the power of leadership for facilitating the model |
| Getting back to working in line with the model and challenging resistance |
| The challenge of working with colleagues embedded in old cultures/ways of working |
| The model has created valuable changes to social work practice |
| The model means parents are not afraid to speak up/honestly |
| Helping parents get back on track, rather than situations being veiwed as a crisis |
| having that understanding and walking alongside parents to help them support themselves |
| The model helps us to support/empower parents to find their own way |
| The model creates a sense of achievement for social workers |
| Parents show their appreciation for social workers support |
| The FS model stops that revolving door, as cases can be managed at the front door now. |
| The need for strong connections and building relationships with adult workers |
| Overtime the availability of adult workers and those connections/relationships were lost |
| Lack of communication/sharing of resources can make connections with adult workers disjonted and impact families |
| Frustrations with inconsistent workbook recording across professionals - managers can't see the throughout |
| When the programme is being delivered as intended it has a positive impact |
| Having information for families all in one place helps to safeguard children efficiently |
| We started noticing what was going well for families, turning negatives into positives |
| It was hard to get schools on board with our approach - initially they thought were were being to easy on parents |
| Giving out packs with information on FS to external agencies was helpful |
| Getting schools on board with our new way of working was hard at first |
| The model encourages workers to understand the 'why' behind the concerns |
| Understanding the reasons behind parents behaviour |
| Tensions with schools did exist and maybe we could have communicated our new ways of working earlier |
| Family safeguarding model is a better way of working compared with old models |
| Before FS we were just going round in circles |
| Family safeguarding model is a better way of working compared with old models |
| Old ways of working were stressful and ineffective |
| The model works better for complex families as long as it's adhered too as its intended |
| Psychologists help to guide us on how we can work with parents |
| understanding the history and background of parents is key |
| The shift to exploring past experiences |
| Its finding out what someone has been through |
| The model helps workers consider care environments as last resort and recognises this can cause emotional harm |
| The importance of explaining to families what the FS programme is |
| Being hopeful for change as opposed to illustrating concerns only |
| The model allows for creativity and time to explore and get to know parents |
| The model unlocks the opportunity to be a change agent for families |
| The model allows opportunity for reflection on own practice |
| The model allows room for professional curiosity |
| The model allows room for professional curiosity |
| MI supports with professional curiosity |
| The importance of top down role modelling curious language and approaches |
| Having a manageable amount of cases is paramount for every staffing level |
| The model does not work when social workers have high case loads |
| The model is ineffective if people are not provided with the training and guidance they need for it |
| as above |
| The issues with workers not knowing how to deliver the model |
| It's difficult to admit that you don't know how to deliver the programme |
| Need for better training processes into the FS model |
| Need for better training processes at the start even for managers |
| lack of support for workers result in frustration and drift |

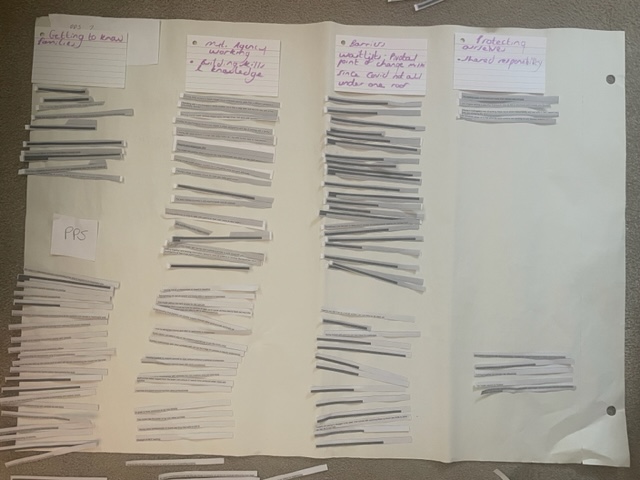
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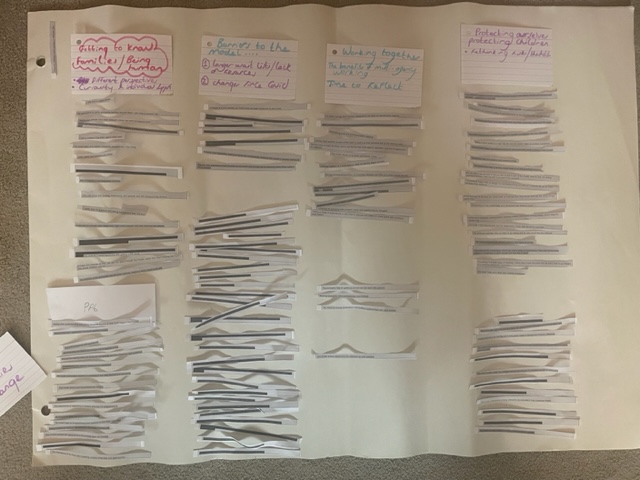
## Appendix 11: Clustering Experiential Statements and emerging Personal Experiential Themes

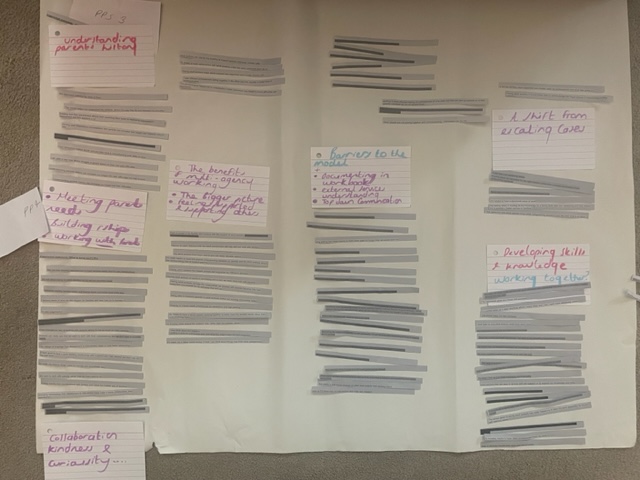












## Appendix 12: Initial and final GETS/PETS

1. **The intensity and depth of the model**
2. Getting to deeper issues and potential safeguarding concerns
3. Recognising individual needs of families

**Final GET 1: Fighting to work with families**

Final Subthemes

1. Connecting with families
2. Shared understanding and empathy
3. Allyship and hopefulness
4. Identifying the bigger picture through modules
5. Unpicking those grey areas
6. Identifying strengths and risks
7. **The benefits of working over a period of time**
8. Encouraging honesty and building trust
9. Able to see progression
10. Building supportive relationships/being human
11. Longer process, better outcomes
12. **Creating collaborative working processes**
13. Coming alongside families to hear and support them
14. Exploring everyone’s perspectives in the family
15. Increasing insight and empathy towards parents

**Final GET 2: Feeling held and protected**

Final subthemes

A) Feeling confident and empowered

B) Managing frustration and surviving in the role

C) Less alone: safe uncertainty

1. Feeling supported working under one roof with adult workers
2. Thinking outside the box/taking a step back to reflect
3. Accessible communication and information sharing (at all levels)
4. Working together helps us to identify the bigger picture
5. Adult workers bridge the gap between parents and social workers
6. **The safety of using the model**
7. It’s not just the social workers opinion (Structure and guide)
8. Separating the work and the relationship
9. Knowing each others cases
10. Feel protected by the model
11. Multi agency working creates shared responsibility in managing risks
12. **Managing wellbeing/surviving in the role**

a. Personal supervision is protective

b. Feeling I am making a difference

c. Support and validation from colleagues ‘feeling held’

d. confident in the decisions I am making

1. **A shift from escalating cases**
2. Comfortable sitting with risk
3. **Challenging ‘traditional’ Children’s Services ways of working**
   1. Fears that we will use information against them
   2. Fears of removing their children
   3. Building alternative narratives: ‘social workers are supportive’
4. **Experienced barriers to the models application**
5. **Long waiting lists and large case loads**  ‘Missed opportunity’ – ‘not catching at that pivotal point of change’
6. Higher caseloads increases social worker stress
7. proximity of workers/connections disjointed (covid)
8. Requests for legal work decreases capacity for strength based work
9. No time for spontaneous reflection

**Final GET 3: We’re breaking at the seams**

Final subthemes:

1. Unappreciated: not good enough
2. Letting families down: powerlessness
3. Professional isolation: feeling alone
4. Differences in opinion with management
5. Duplication of work (workbook)
6. The modules are idealistic not realistic
7. External services may lack understanding of the model

## Appendix 13: Master table of themes

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| **Group Experiential Themes** | **Subthemes** | **Supporting quotes** |
| **Working ‘with’ rather than ‘against’** | Connecting with families | **PPS 1: Stacey**  I've had parents tell me they've been raped and go into real big detail or they've had a miscarriage or things like that. And you wanna be there for them.  What I do is I come alongside them. Well, I'm here to support you.  She said it's because you took the time to get to know me. She said no one does that. And we ended up growing a really good relationship and I was able to support her and yes, she got me a beautiful card, saying thank you for saving me.  I think what it was, was I said that I was there to support her. She would hear from core group meetings, things like that, that I would keep going back at the school saying, OK, so you had that incident, how did you communicate with mum  So we built that trust up. So I think that was a lot of it. I didn't discriminate her.  it's then we're referring to the model, than it's me coming into your lives and asking loads of questions, even though I am. I can refer to the fact that this is the process.Because I think where I was before they felt I was the one coming in and asking all the questions and I was the one that was intruding into their lives. When affectively I am \*\*laughs\*\*. But it's to be able to reflect on then a model.  **PPS2: Shona**  When it works It It allows me, as a social worker, to do the things that I trained to do \*\*laughs\*\* so to do the direct work. So actually being able to sit down and see the children and do that direct work, that if I was doing domestic abuse work and I was addressing drug and alcohol concerns and I was sitting and doing kind of safety plans around mental health, that would take away my time to really sit down and really build that rapport with the families.  Kind of doing that sitting down, encouraging that attachment. That's. That is the part of social work that really feeds into what I love to do. And you just don't have time to do it.  Sometimes I go out to my parents and I sit down on the sofa and I say tell me about your week. And they will just. Talk to you and sometimes it's just about sitting and listening  I think that we are really the modules allow us to be really interactive. So getting on the floor using diagrams using. Games, activities, things like that.  I feel like you need a relationship with a parent in order to explore what their childhood was like. Otherwise you're just gonna get. Yeah, it was great. It was fine. But if you know that this parent has had trauma going in and sitting down with someone after one session and say tell me about your trauma No, I think that as professionals, we need to recognize that that's not a good time.  And basically you come back and you record your journey with the family, you record your reflection. Do you feel like parents are at that stage of wanting to make change? What needs to happen? What do I need to do as a worker? Do I need to tap into adult workers in our team? Do I need to tap into external services?  You can see the progression of the parent getting to where they are instead of right. You've got a month to do all these sessions and you've got to write an assessment on it.  **PPS 4: Natalie**  I think in turn has helped some of the relationships that we've had with parents because they feel supported in their own right, they feel they've been listened to in their own right now, someone that they can go to but to talk to if something's going on for them that is away from us  I think that when parents feel that we're really wanting to support them, like, so we're saying, right, this is an identified need, but this is the support service that you can go to get that support and we want to work with you while you're accessing that support. I think we just. That sort of like scariness sort of like starts to go away a bit and they see it as more of like a supportive measure and that children's services can be helpful and can be supportive and an in turn, it's sort of like helps us build that relationship with that parent.  When you get to a point where you've got a positive working relationship with a parent. Like it feels good. Like it feels good. Like it feels, you feel relieved. You feel, um, able to go and do your best work because you like you feel clearer. Um, you know, worrying so much less anxious.Like the whole experience is just much more pleasant experience  since we've actually changed our terminology from you saying we're completing a parenting assessment to we're completing family intervention or the intervention model, like I do think that that has also helped build better relationships with the parents because they don't feel like they're coming in and just assessing them  I do think that that has changed our way of working with parents and our relationships. The way that we just even use that language differently. Because this, yeah. It doesn't feel so much of a fight. You know, we're coming in to, like, observe you and to assess you. No matter how nicely you put that, like, it must not feel very nice for a parent.  When we changed the terminology from like, saying, parenting assessment, but actually parenting intervention. I think it makes it feel like more of, like a collaborative piece of work. And it doesn't feel as like, yeah, oppressive, really.  It's like, actually we want to come out and we want to support you, we want you to learn, and we want to teach each other about what life looks like and where where things can be different and and how it can be different and why that's important. It just feels more. Um. Like, it's just, yeah, like less sort of like we're coming and telling people what to do. It's like much more of a collaborative approach, which I think is better.  I think the thing that like like benefits that is that they can really see that we really try and to work with them like. Like collaboratively and we don't wanna get to that point, wherever it's in a way more forced or  I think that they can see sometimes that there's like this real fight to work with them until under a child in need plan rather than escalating the case. And I think that also happens under child protection. I think that they can see that even when the case has gone to trial protection that there is this real strong like desire to step the case down and it isn't the other way. It's not. Trying to catch families out to like further escalate  The the got the easier the job is, but also like the better outcomes because this just stops that like that months of sort of like resistance which. And it probably helps parents feel like way more reassured as well, to be honest. Like they must feel so much more reassured to, like, hear from multiple professionals. Actually, these people are here to try and help you like they're not here to work against you.  we are working in like a more collaborative way with parents and I think that we're doing, we are. Um, tailoring our intervention like to meet their specific needs and I think it's very individualised to that family.  when I come in to plan my intervention and to do my sessions, I can be aware of like, well, these, this is the trigger point. And how can I, how can I do that in a really reassuring and supportive way  **PPS 5: John**  When I sit down and have discussions with parents, at times, I'm referring to the particular case I've got. It's like, oh boy, you're telling me off. You're telling me things. No, I'm not. That's not the intention at all. I'm getting your experience and I'm telling this. Have you seen this side? What do you think about this? But because it's come from a social worker. All she’s hearing is. You telling me off  one of things I do with parents I I draw like the processes of children's services to try and share that understanding that look everything it's a process and for us to be here this is  what we're doing  And it helps, because what I tell parents is we'll go back to this again.  Because right now I'm meeting you for the first time. I'm just from this experience and I find this very intrusive, social work on its own. But I'm asking you all these things. You gonna tell me all this? You're gonna give me all these responses? But what I wanted to do is come back to it later and let's see what we've moved from, if there's any improvement at all. Or we're still stuck with it with the same idea.  **PPS 6: Nicky**  The change to social work practice is what I've found the most valuable, so even.  And and that I guess erm unconditional positive regard that social workers can have for families. That I see this model, and particularly with MI, helps them have  Having that understanding actually that that the model is about walking alongside someone, albeit there will always be children that have to be removed. That's that. We're never gonna get away from that. There's always gonna be families where, no matter the situation is too high risk. But, UM, they're also those families that so long as you can ensure that the child is safeguarded and you can walk along with that parent and support them in finding their own strategies In order to support themselves, should, should you know, should things dip and what you're not seeing is a revolving door to social care. You're not seeing families just like. Three months after case, you know, child is closed, that it comes back again because this has happened again, etcetera. It's about helping families to to understand that in life we all professionals as well have lives go like that \*\*gestured up and down with hands\*\*  it's about supporting families in terms of finding their own way. And I think that was the value that is the value of the model  So what do we, what do we do? What do I need to do to help you get back on track. And you know that can't so so long as you know that the child is has been safe.  parents would often start bringing things to a social worker and to say like, oh, thank you, you know, and it's, it's a really good ending  if they said something negative, I would like you know erm still try to find the strength in that and kinda say OK, that's not going so well, but this is going well. |
| Shared understanding and empathy | PPS 2: Shona  I find the models are so good they prevent drift. They allow you to focus on pieces of work. They allow you to pull out insight and understanding, and it allows you to really analyze the risk of harm.  From the outside looking in on a lens, it's like, Oh my God, this mum can't cope. She's in crisis at all the time. And actually for me, I'm thinking, but she's not. She is in crisis all the time. But we have to balance that with the risk of harm to the children so she gets herself into crisis because she forgets something like she forgets where she put her keys and then all of a sudden everything just flows back to her. But she's like, oh, I'm rubbish. I can't remember anything. And then she just gets herself into a state. So. If I were some one coming in that didn't know this family, I may think like she cannot cope with these children like this is gonna be a disaster, but actually. My work with her is more around supporting and building her.  It just helps you, well helped me to begin to understand this person's experience is and in order to try to work differently, even if it's kind of empathizing more with their their change in presentation,  And for me working and talking to these professionals within this context helps me to understand service users a bit more from a different perspective, whereas sometimes in social work you can be quite tunnel vision and even though you work with so many factors and we have all this training around managing drugs alcohol, we're not experts in their area, we need them experts in their area to guide us  when I sat down and I kind of read a lot of research and I sat down with the psychologist and we spoke enabled me to kind of take a step back and think, OK.This this is part of her personality disorder  And I suppose reading that assessment, a lot of my based on what I had read and based on the information I saw, I flipped the script in my work. So a lot of my work focused around the parent and child. So doing work with mum around how she sees her child, what are the positives that she sees with her child, what are the difficulties?  So it's about kind of thinking outside. Outside of the box, if that makes sense  PPS3: Kelly  It gives us a window into what kind of parenting they had and what they experienced, which in turn then sort of increase our insight into their parenting  opens up discussions with the parent of so you kind of experienced this and do you see any patterns of how your parenting now... and all of those discussions can indirectly reduce risk because if you don't have discussions, you don't have people on the same page, you don't have parents increasing their insight. That's when the risk starts gradually getting higher  But my view of them is sort of like well, you know what Mum had no chance of being a half decent parent because she had a really crap childhood and her parents abused her or neglected her.  So it's almost like it's excusing their behavior, but at the same time, we always remember you still have a choice here is all the support and the intervention we can offer you. You can learn so much from it. We're pointing out the risks. Let's make some changes, not overnight, but we'll work with you. And so is that fine balance between we know why you are the way you are. But then again, your children are suffering  That knowledge of how your parenthood affects your parenting, I think that's probably. Part of the decision around asking for a psychological assessment on parents which explores their history, their support, the though they're way of coping they're triggers, and then attachments with their parents and attachments with their children. And that really explains a lot.  ‘that's why Mum does this and Dad reacts like that’ And then the the child is this. And it not only sort of makes us feel like, yes, that's what we're trying to say, but it also is really useful in court.  We're not supposed to be judgmental, we're not supposed to blame. But I'm still human. So I think what it does, it probably softens my approach to them, my view rather it my view cause my my approach is usually soft but soft but firm  Yeah. Empathy and awareness um and understanding for sure. I mean the the depth of um reasons why a parent, parents the way they do. And then of course the children behave a certain way, whether it's school, eating too much, getting into alcohol, drugs themselves, what not. Yeah, it's just increasing awareness. Yeah, empathy, definitely.  At first we're thinking, what is wrong with this child, you know? And of course, we know that the child's behavior really stems from the parents parenting. But it's difficult to see because we're seeing Mum trying her best.  But it meant the psychology team coming in and saying actually, yes, Mum needs to make the changes. This is why the child is is responding the way she is because she doesn't respect her mum and she's needing and wanting boundaries and And more firmness and more confidence from mum. So yeah, so it really is very interesting.  PPS4: Natalie  you don't just look at the the problem or the behaviour or you know, the outcome, you're thinking about like all of the things around it that like approach about, like exploring all the different things that are around the family, they're makeup, and like how that impacts on them as individuals, as parents, as women, as men, as you know their children like you just look at the whole system altogether and I think. Yeah, I think it has sort of changed my. My view of families as a whole, I think.  to be totally honest with you, I think I'm just less judgmental.  it's just really made me yeah, like, not just jump to my first decision, my first conclusion or. You know, it's really made me double think and triple think and explore things in such a in such a better way, I think in, in, in in a much nicer, kinder, more empathetic way, I think.  I think it just makes makes me a better social worker and it makes probably just makes me a nicer human being. Yeah, I think like. And I think it helped. I mean, it's definitely made me like, learn more. Like I feel like I've had to expand my like my knowledge and like my understanding of situations more. Because. What I know, or what I think that initial thought is that judgmental side, isn't it? And so actually having to think about other things from other perspectives all of the time.  PPS 5: John  The opportunity to actually reflect because I remember using one of the models and one of the work that I did with the parents was using ACES Video as a tool and that was the point where I actually got the parents. This was a parent that was very challenging.  But it helps to shape there understanding. that, look, I'm not picking on you as a social worker, and this is why understanding your earlier experiences, earlier experiences makes a difference. So. Like I said, that particular case, that was the point where I got the mum. Where I was like she actually broke down in tears, crying like, Oh my God, this is what my experience was.  It’s works for us as professionals to give us that understanding into parent's lives and experiences. And at the same time it gives parents the opportunity to reflect on the, their experiences and also tap into the right resources, when needed.  Actually, why do you do it? What? What's?  The motive round this? Well, you know when I've had a stressful day. OK, and that tells me actually you're not using this as a social. No, I'm I'm not saying I'll call. You shouldn't drink alcohol. Actually using it as a de-stressor.  Using the ACE video and things like that, where parents could actually pause in the whoa, I didn't think that was always going on. So what you're telling me is because I saw my parents lived through all these DV and I meant for my house to houses. That's why I'm now a perpetrator. There's a link, there's a possibility. So are you telling me my child would be? That makes sense. That's why he's been shouting at the sister like that. That's why it's been. And it starts to get them in a position where they start to reflect.  PPS6: Nicky  And actually, there's probably so much rumbling behind the background, it could be mental health. It could be drug and alcohol. It could be domestic abuse. It could be depression. It could be 101 things. As to why Mum can't get up and get that child to school everyday. – 10  PPS2:Shona  it's not just about going out and doing your job, it's about going out and part of MI I think it's just. I it's just about having a conversation. It's just about allowing them to talk, allowing them and sometimes I can't find solutions  PPS5: John  I'll rather you at least have someone you could talk to rather than the view that ohh yeah you not engaging with professionals because I understand it could be very difficult for people with the knowledge that. Ohh yeah Bob, with the societal view that well so social workers if I tell you anything you had to take my child.  Having the professionals on board and having these models where actually we go back, we breakdown the basics. Back to the basics to say OK look I don't know your understanding, I want to know. What makes you, you?  What makes you, you. I've heard all this things. I've read all these reports. That's all. It's like a puzzle. I need to put it together. Together. You're the only person that could do that for me.We need to form this picture and parents? I guess that at times it works. When I use that, it's suppose you've got these puzzles, you've got these pieces in your hand. Without those pieces I cannot complete this whole picture and I guess it gives parents the opportunity to reflect on their own upbringing  There's a lot of turmoil there. There's a lot of trauma that has been unaddressed. I'm not the right person to address that with you. I can listen.  This this is our children's voices. Let's take a break. Pause here and actually hear what your child is saying.  I'm thinking it and I'm thinking. Wait a minute. What's what's happened there? What's going wrong here? What's what's changed? What's. What, what was good during this period where we did not have any children services involvement? I'm thinking all this so the only person that could give me all the information is you  But that opportunity for her to be able to actually reflect and unpick that work was up through doing the models and say actually what's your understanding of this what's what's the issues around there what's and the children's view  PPS6: Nicky  I think initially when we changed the way that we were approaching families, I remember going to meetings with social workers like child in need meetings erm I would always start with the the family, like how how were you and tell me what's changed for you  But it's shifted that so. OK, So what what's happened to you? What have you been through? And and let's take it from there. Let's learn from that. So it's it's really finding out what someone has been through to come to the point where they are, and why they are there and then whether they can in that child's time frame, can they be supported in making those changes.  start with OK a change plan with the family. What? Why do you think I'm here? And what do you wanna change? So there's these are your goals. And if you understand what behaviours are worrying us and what behaviours are impacting on your parenting.  We can. We can look at helping you change those behaviors and having those first conversations as opposed to, OK, so we got this referral from the assessment team and we're very worried because the home conditions are a mess.  They're back again, right? So we need to think about what we can do differently this time because obviously you know it got to a point and that's the MI bit. It got to a point where we were satisfied enough to close. So what was that point and what has happened? So we know that that a parent can make the changes because we've been there before, so they can make the changes again, but we just need to know what's happened that's made this case come back. So is that having those conversations.  Be professionally curious as opposed to ohh not this family again. So it's that it's language  Instead of just saying. You know, so and so used again. It's like, tell me what was happening for you that week. What? What? What led you to to that? That and that's different to the conversations that we would be having before. – 17  So it really helps workers to kind of think a little bit more. OK, what's happening for a parent at this time? And that's what we use supervision for as well. Is it just a a lapse or relapse or is this a difficult time for a reason? And do we need to be more professionally curious? - 17 |
| Allyship and hopefulness | **PPS 2: Shona**  All of my service users know. That if I am concerned about something, I will share that. But at the same time I'm I'm human. I'm fair. I we will build their relationships. I'll sit down. We'll have a chat. Sometimes we'll take the kids to the park.  **PPS3: Kelly**  I think it does help build relationships, which of course helps with managing risk because they're more likely to be open maybe and listen to you and not think that you're against them. For example, the module around parental history childhood. Because it not only gives them sort of a one whole session where they're telling you their history of where they came from, which builds rapport and trust.  **PPS 5 John:**  I'm hopeful that eventually society will wake up one day and be like, you know, well actually. They're there to help, they are not there to take my child.  You know, it makes me feel. One day at a time, we're ticking the box where society will start believing social work are here to support \*\*laughs\*\*  We'll break it down.  through different tools and out forms. Again, the ability for the present actually reflect or actually shared our views on what the thing that concerns are  What the model then does is give us again is the chance to be able to analyse all this information and from what work we've been doing so far and this is this is what I find powerful when I analyse where parents and I think this is, where I'm always open and honest with you if I see something and I always say it's apparent I think the the first time I say it's pretty just look I'm like yeah right. What I'm saying to you I'm gonna write it down. – what was powerful?  **PPS 4:**  I think that they have been able to have like conversations with families and adults within families about like, what social workers do to try and support families so that, like, they're providing like a a reassuring message to adults that they're working with rather than feeding into this, like scary narrative that, you know, social workers are evil and scary and come and take away children. So I think like, it's so it's so helpful to have like. Like that? More like shared understanding about like what all services do, really.  it's obviously it feels quite comforting, like, and I think that like the repercussions of that is that we just have more trust with parents.  it's yeah, reassuring and I think. And I think it's needed. I think it's needed like more widely like I think it needs to be known more widely and I think. That social workers have such bad press, like such bad press and I think. The more people that can like share this like more supportive narrative to parents like.  **PPS 6: Nicky**  Parents not being afraid to say, you know what? I messed up over the weekend and I did do some cocaine  Does that child have to come out to care to care environment, or can that child come out to a a wider family member whilst we work with the parent? If if, if that's the level so that the the push is also to look at Family group, conference friends, etcetera, have really good contingency plans. So if a child does have to come out, does it have to be into the care system where getting that child back Into the home's gonna be harder. Or can it? Can it be to family members, whilst we do work with parents so.  I think the model looks more at that, whereas before it would very much be you know, we need a foster placement  That first interaction. And that explanation of OK, so first of all, this is what the family safeguarding programme is, this is what we're hoping to achieve. I'm not here to remove your child. I am here to safeguard and to help you safeguard. |
| **Feeling held and protected** | Feeling confident and empowered | **PPS1: Stacey**  this is the work. But this is my relationship with you. And I try and keep them separate. And actually the, the, the, the model helps you do that. I've had parents where we've removed their children at in court and afterwards the month ran up to me and gave me a hug and says I need to talk to you about this because you're the only person I can trust.  The mum was in tears by the end because she didn't even realize how many strengths she had, but because of them the the module, yeah, it was able to go for everything. And I said there's no concerns.  **PPS2: Shona**  when there's been delays in work, and I've delivered that work. So I feel like actually it also allows us to not be deskilled. As social workers,  so having workers In family safeguarding and that can give you them tools, but also that you can go out and do joint visits with helps you to stay skilled in that area of work as well.  And X was working with Mum to do stabilization therapy leading up to the hearing and and kind of, X would liaise with me about things that mum was struggling with or I would provide X information. So it's just really helpful. To have them people that you can bounce off for staff and X would kind of say to me mum really struggles with this and it would help me when I then go out and do work with mum in respect of making sure that my work meets her needs  we can consult with X to make sure that we're using the right tools or we're approaching things at the right level for a parent and but quite often we get guidance outside of the cognitive assessments that tell us how to work with families, which we can then use in our work. So it's just a it, it's just all very helpful.  So I think the fact that what's good about the, the model is that it is structured.And you know, and then you don't then forget, as a social worker that. Ohh, no, I didn't cover emotional support  We're having to do that work ourselves, which is causing it's almost better for someone else to have someone else doing that work. And because I feel like when previously when people had domestic abuse workers going in early on, they were catching parents at that pivotal point of change and they were able to start that. And having that separate person different from the social worker gives them.I I don't know. I just feel like they see the process very differently.  And I think for me It does kind of flip my way of working because I think sometimes the social workers we go in with this agenda of right, we need to do the modules and we need to do this and actually family safeguarding is shifting now so before we would go in and it would be like we would have to do the modules to inform a full parent and assessment and we'd have to do every module and we would have to do this. We're not doing that anymore. So we're being really focused. So we're looking at parts of the modules that we need to do for that family. So what is the imperative part of the module that we need to focus on  In respect to the family safeguarding model that didn't impact at all. I felt like that still was very positive and we were still working with the workers at that stage and parents felt positive about the the consistency of the attendance of the adult workers, so they were turning up when they said they would. They were involved and things like that and I felt like that helped build my relationship, but also their view of social services like we're following through with what we're saying we're gonna do.  **PPS 3: Kelly**  Families were supported, more professionals, new sort of what was going on in the case and they could utilize different expertise.  it's just another example of why the adult workers, absolutely vital for my practice, for my learning, for parents to make improvements, for children to be safer and develop  Just summarize in the workbook, just summarize, Don't write essays in there. And we were saying, the social workers were saying, well, we can't summarize because we're gonna need that information for court One day. . We need a lot of information. What mum said. What dad said, what we said because we will be questioned and it's the detail that is needed.  Like I said, bringing the professionals together does really help. It gives a lot of support to the worker because we may have the DAP worker or a member of the psychology team sitting next to us one day, and because they're brought in from the family safeguarding model, we have them physically there, which really does help. It helps build relationships to. And then of course, them sitting in supervision, giving their update. So it it, it's just it's it's a really good idea. I think it's vital for us to to do our job effectively. And you keep children safe.  for example, a CGL workers having having that relationship with them, which is built by seeing them in the office being in supervision, having a laugh with them. Them hearing other areas of the case that they wouldn't hear if they weren't in supervision. It's sort of jogs their memory of ohh yeah yeah this happened. And and this is why this is happening. And by the way have you thought about this and we wouldn't get that. Just by them sitting in a core group or conference and we wouldn't get that by an e-mail or just a a phone call for an update.  **PPS4: Natalie**  Where as like having that framework meant that my work was more informed, it was more I was going in with purpose. And it gave like real focus for the family as well as for me.  I think that that as a social worker it has just just been so like, reassuring, I think. I think I just felt really reassured that there was like a real purpose to my work and I wasn't just going in.  There was always that, like, intervention happening and I feel like the family safeguarding model has like given me those skills to be able to do that and to do that well.  I found with the adult mental health um service. I found it really helpful in terms of thinking about like parents that have like additional like additional needs and learning needs and being able to go and ask for like information and advice to help me plan for sessions, especially those that are in court and having like erm feedback provided to me so that I can be really reassured that I can actually tailoring my work to meet an individual's needs.  I think I've felt quite held by X. I don't I, you know, I don't wouldn't say that like you know certain reasons and things that happening. I wouldn't say I always feel like that. But like times of the family intervention model, I do feel like it's been really like helps me as a practitioner feel really held by X. Like like they're really looking after me like wanting to provide like the best service.  It helps us become like I do feel that it is helped me become like a more confident practitioner. And I think that my skill set and my knowledge like base is like significantly improved because of it.  I feel like when I when I go into like court obviously, I mean obviously the idea is that we don't go into the court arena. But when I have gone into the court arena, I felt so reassured that like the work that I have done is like. I suppose that I have been the expert in that field  I've been able to like evidence like my practice, why I've been doing the work that I've been doing, what I've been able to achieve or what hasn't been able to be achieved. Been able to use other professionals to inform my practise. And I felt really confident that like with all of that, like I'm, I'm the expert  It's just so reassuring. Going into court is like, I mean I quite like the court arena, but when you're in court and you're you're work is up for scrutiny it feels so when you know that you have been, you have pulled on all of these resources and you know that all of your work is informed. It's like. It's just so reassuring cause you just you just know, like. You just know that you're going to be able to back up your report or. Um. But also just confident and I suppose the decisions and the recommendations that you're making,  Just generally. I think that your recommendations in your analysis are just so much more in like it's just so much more informed.  when I've gone to court since and like that people have put forward like applications for like, like independent social workers and then I'm like, no, I can do this. Like I don't. We don't need it to be an independent social worker because I know I can write this parenting assessment  It genuinely does. Meet their needs and then that that means that we all having, I do believe quite strongly that we are having better outcomes for children, you know, most of the time  Have nicer conversations with families. I enjoy it more. And I don't moan as much about the admin. I suppose you just get on with it now, but like. Yeah, I'm I'm quite a big advocate for this model for working. I I think it's, I think it's a better way of working  **PPS5:John**  I've had all that support and I've got that understanding and. I'm I'm doing it somehow so somehow I'm doing it, I'm managing it  **PPS6: Nicky**  it means that I know the families are being safeguarded. I know that I can go up to a workout or look in a workers electronic tray and know exactly where a family is at it it so it has a positive impact on me because if that worker is off sick. Umm. I. It means that I can direct another worker to to pick up and know exactly where that worker is and would that family. So the the impact when this program was delivered is is really positive. |
| Managing frustration and surviving in the role | **PPS1: Stacey**  But then, once a month we would have group supervision and that will be as a team with the domestic abuse worker that's assigned to our team as well. And someone will come and present a case. So maybe it's one that they're struggling with or they're just thought, yeah, I just don't know where to go with it or I'm really struggling with this mother. What can I do next? So they’ll present a case and then the team would work together on how we can move forward with it. And again, then you get everyone's different experiences and things and things like that. So again, I think that. That works as well.  (Referring to personal supervision)But the fact here that they do have them separate I think does protect people with regards to their mental health  I believe that they're quite supported a bit here and there is more of that personal supervision to look after yourself  Because sometimes you feel like I'm doing a really crap job \*\*laughs\*\* basically, and you feel like you just on that conveyor belt and it's going really quickly. I'm not getting much done. But then I'll mention it to a colleague and they’ll go. It's that time of month or something like we're all doing it like we're leading up to the summer holidays, so you'll get more teachers coming out with disclosures and things because they're going in summer.  I think to be able to survive in this job. I think you need that support which the the model offers, but also it's the working environment you're in and so far.  X been one of the best councils that I've worked with in that regard.  They want to work, what I've found so far, so you want to work as a team.  **PP2: Shona**  like if I was to be honest in myself, I found myself getting internally frustrated with this mum.it was so helpful to be able to sit amongst Professionals in that field. So mental health workers, psychologists, and for them to educates me in respect of UK parents with EPD  **PPS 5: John**  I'm so grateful for that manager has always been a very, very big on reflecting. She's always, always bigger reflection which I find so useful cause it takes makes you take that step back. I've got all the cases so complex I've got all this concerns. But pause thinking, take a breath, go back to you. What is your main concern here? What without losing sight of the child  **PPS6: Nicky**  Ohh has it gives you that further opportunity to say actually I'm thinking this and I mean I've the this week cases where I'm like ohh my gosh what am I gonna do now this is just so frustrating and it sit down and take you back are you really everything like ohh actually no it's not that frustrating let's go back to it  I think and and when those techniques are used Well, I and and work is really understand the the motivational interviewing. I think that that's what helps workers to kind of think like hey, is this parent being resistant or my expectations might be be helps you look inwards a lot more of your own practice  I I like to use the psychologist that was on our team, like to look at this, look at this history, this, this, this.difficult history. How best do you think it's we should work with with this parent? In terms of the psychological profile, how are we likely to bring about change?  it's it's really helping social workers understand that complexity has many different sides to it, and I think that's what the model does as well, because the first part is around why are we involved? And then the next things your your family history and your that's the second part of the module. And I think if social workers do that bit well. It's key to everything moving forward. |
|  | Less alone:  Safe uncertainty | **PPS1: Stacey**  I think where you start getting those serious case reviews, it's because there wasn't that multi agency working. There wasn't a that opportunity for them to reflect. With colleagues, with the manager. As such, it a lot of them, sadly, probably weren't even assign cases.  And I think that's the whole point of our job was we're have to hypothesise had to process that quite a lot and analyze and.  And if it's just one set of opinion. Is that really benefiting the the child because we try not to, but there could be stuff in my past and I'm thinking I knew that happened with that family. So that's what's potentially in the back of your mind. You could think that's what's happening. But actually having that really objective conversation with a colleague about something, they could go. well, actually, I had a similar situation and this was the outcome and it was totally different. And I think it benefits the family and the children more, but also it benefits yourself.  The only way to get that bigger picture is to work as a multi agency.  Because you've got that supervision and that time, there's other professionals, you get their input. You can then get a bigger picture as such and. So yeah, so I think then that helps those complex cases actually drill down to is that just the social workers opinion or is it a fact?  What's good about here is yes, we have got a domestic abuse worker assigned to our team who comes to all our team meetings. The days that we're in the office, she's there. If we have a party or birthday she's present. And I think that's really good because she does feel like she's a valued part of the team.  Say a teacher was concerned about something and I was on holiday. For example, I was, on annual leave, but they had a concern. They could still come to any social worker in the team, so ring in and they will be able to look at my workbook and because the workbook gets pulled through, which is the, the model gets pulled through every month. It wouldn't have to be. Let's say I've just started a new one and then I've gone on annual leave. They'll still be able to see if there was any risks of any concerns. So they'll be able to go on those modules, click on them, and if I've still got, if I've got any information in there, they'll be able to see it and then they'll be able to still move, move on and refer.  **PPS2: Shona**  So the Council that didn't have it, you'd only actually get probably as deep as that when you started doing a parenting assessment. And sometimes you wouldn't do that on a child in need case. So you never really got to the full safeguarding concerns for a child. So that's what I would say is pro and the family safeguarding model.  the risk of missing risk is reduced and I think for me. I felt more comfortable, comfortable as a worker. Working with that family because and and actually, if we're all sitting together and we're all talking and we're all sharing and we're sent out today. When I went out, I noticed this. It allows you to build them, patterns of behaviour or develop that discrepancy between your world. Like, why was Mum saying that with you? But she said this with me. I think that it helped a lot more in respect of managing the risk.  before it was really good, we would have workers, we would have at meetings, we would have a an array of different workers sitting around the table. We would have different people from domestic abuse, mental health and they would sit together and we would all talk and put together support, supportive plans of families.  I felt less worried, because we had more than it was, not just me. That was over. So even though we work as a multi agency way of working, so the school are responsible, everyone's responsible for safeguarding. I felt that within the family safeguarding. I wasn't the only one within the department that had eyes in the family  we *had* so many different people sat at the desk and you would have a situation or you would have a case and you would be able to talk and reflect at the desk and you'll be able to get the points of other people and kind of. Have you tried this or no, actually, I think you could do this  so the strengths are that you could tap into different expertise in the service. So we had workers. If I just use drug and alcohol for an example, you had workers in the office that if you needed someone to come out with you for And swab analysis or breathalysing in there was people available.  Similarly with mental health. When we were in the office, if there was someone that was in the midst of a mental health crisis at that stage, people didn't have massive caseloads, so people would be able to just respond. Come out. there would be very short time scales and respect of waiting for services. And so the strengths work that you would have the expertise of different people, but also it would kind of at alleviate the stress for the social workers of previously doing that whole role before or making all them referrals out to all them services and having to chase all them services and getting feedback from them services. \*\*reeled off quickly and then a big breath\*\*  When the family safeguarding model first begun. I think that it was really, it was really positive. Everyone was really enthusiastic. We had lots of kind of new innovative roles. So we had the psychologists had domestic abuse workers, we had lots of CGL workers that were actually working in the office with us  **PPS3: Kelly**  So I think what the the model does is it brings sort of the family of professionals around a case closer and sometimes parents see that as we're all on one team and they can't trust any of us. But what it does is and what it's supposed to do is. Umm, just make working more effective and seamless.  **PPS 4: Natalie**  having adult workers around us where we can rely on and and go to information and advice. And I think that that for me has been like what I've enjoyed the most about having the adult workers is that there is this like real connection, really quick connection to adults workers that specialise in a specific field that you can get that information and they can support you in in. And emergency situations, but also just like expanding our knowledge and our skill set, which I I think it's valuable  When we first get parents like, they're normally like really hostile and confrontational, hate us going into their home. Can be, you know, really quite defensive. You know what in quite a lot of conflict, but like once you start implementing some of those professionals to help them. Like that does usually go it does it just, it doesn't go completely because I think people. People can still dislike you, but it can make that working relationship better, and they can see you as like more of a supportive measure rather than. I don't know would I saying like an oppressive measure.  The thing I found the most valuable in terms of the adult workers has actually been has been the advice that they've been able to provide to me.  Just feels really, really safe. Like it just feels really safe and really reassuring. Like I don't feel like I'm having to hold like all of the knowledge and all of the skill set, you know, I don't. I don't have to be like amazing at it all because I've got all these other people that can help me, help me do better or do my best. Um. And I think it's just helped, helped like me provide better service, I think, to to families I think  I suppose it feels safer again. I think we go back to the like that safe feeling. It feels safer being able being able to like draw together lots of different.Professionals, expertise, all in the one place, I suppose.  Again I would go back to that like sort of like that safe like that sort of like safety network  Being able to rely upon mental health practitioners that are working with parents and then if they have suicidal with intention or their mental health starts taking a dip, being able to sort of like call upon the mental health worker that's built that relationship with that parent to be able to call them and see if they can provide any assistance or assign posts them to somewhere to get that immediate assistance  The other workers have been able to provide parents who dislike children services, especially those in like some of the more complex cases with a professional that can work with just them. And I think that that has helped lots of parents feel supported by children's services  You know there's this huge shift isn't there for us like not escalating situations  I do think that it has made me more confident in like, sitting with risk or unknown or on or uneasy situations, I do think that I feel more comfortable and confident in doing that  I suppose, like I've just thought more about like. Long-term. What can managing risk on a lower level plan provide to this family? Like long time? And actually I think if I think about it from like a child's perspective when they become an adult, I think. You know, to find out that you might have been on a child protection plan and like, was it really necessary? I don't know. I just think about like when you think about like a child's identity when they're when older and I just think that there is. It's really changed my my view on my escalating cases and making sure that when we escalate cases like they are for the right reasons and they're not because of like, professional anxiety or, you know, like, like, yeah, like trying to like, safeguard ourselves,  it's like a joint consensus about really rethinking our like, thresholds and where we feel comfortable, like how comfortable we feel, managing more riskier situations..  I think I feel more reassured because I feel like they understand now, like if there is a safeguarding concern, like what that might look like and what to do about it.  And I think like why it's it's also really positive because there will be conversations that parents are having with the adult practitioners that we won't might not necessarily be Privy to. And although we might not be Privy to like every single detail actually like having that open dialogue about things that they have discussed or things that are important for us to be aware of just. That just helps then in our work with our in our intervention and feeds into that intervention.  **PPS 5: John**  The models help in highlighting, in what the risks are. And the complexity of cases.  One of the strengths that I picked from it is when I'm like you know what it's family, safeguarding, model. Why I love it so much, it's multi professional  I'm not an expert on everything and I like putting my hands up and look I'm a social worker but I'm not expert I will. I've gone insight into some things like domestic abuse and things like that. I've got insights but I'm not a specialist in that particular topic I know what I’m looking out for I know the signs. As I know why I could do interventions on, but I can sign posted to specialists.  I find it as a strength because. Actually, you know what even if this is the issue there is support in place for you and we don't need to look so far we've got that, in house professionals that we could easily tap into.  But when it comes from a professional domestic abuse worker would say the same thing. Ohh yeah, it's different. I'm like it's it's that separating the work. And I find I find this very beneficial.  I'll find when we have. Like I said earlier, I've been someone like the chip on board. They find it. Well, your not a social worker, so I can talk to you.  I noticed the health visitor had a relationship with the mother but yet expected me the social worker to do something, wait a minute. No. We need to tap into this, we working together. You're the health visitor. She's got a relationship with you. I do not mind if she comes to you for that support because that support is still being given  so with the family safeguarding model, I find it very interesting because it's all that approach of putting. How do? How would I put itt, I say to me manager ones, it's actually utilising the best people for the right job  if I have a professional that has that relationship with the family. That's what we all there for, to support these family and until we get to that, understanding that actually we're all there, we all play a very significant part and it's not just Um, pass the buck system. It's the social worker. Let the social worker deal with it. Then it becomes really. How would I put it, challenging.  that's the power of this model that we have. I can tap into psychologist team during consultation and make a referral  we've got that leeway to make those referrals within these model. So those are the things that I found beneficial using from the safeguarding model. So things like that, having that resources in place, like I said, having that right person, the right tool for the right job.  I've not achieved all this work by myself. I mean the the judge was like, ohh well done the social worker, social worker, you did that, and I have like, yeah, I had support from everyone. It's like without that support maybe I would not have reached where I reached maybe or maybe not.  But the facts that remains Is the support, the CHIP that pitched in, the domestic abuse worker that tried to do work and the psychologist when I had the consultation that was giving me advice. And I’m like without all that, without those specialists, without these people Yeah, probably a different result  when I'm working with this particular model again tapping into the the one of the professionals that you that that I rely on the most, the chips and the domestic abuse workers. It it makes it amazing.  the fact that we will come together and everyone is included in in all these approach. I think it works well cause it gives opportunity to actually understand the other person's view and professionals view and. All our views.  I think it helps you. Build, I wanna say build that knowledge but I'll say it's a refresh that knowledge of what safeguarding actually is  but I find working together with with school and build that relationship.It helps, cause what then that does is Parents will be able to rebuild relationships with school  I think coming together and retracing that look, we're only we're all there together to support. It goes a long way and for parents times where they will be able to rebuild those relationships, especially universal services relationships, PSo it's always good to have universal services on board  And I tap into the expertise. That's because they're there and I've formed a relationship already. So the the model I guess it brings together different professionals and because we already we co-worked a case before.  Ohh, we're still co working the case. We've got that relationship going already, and it makes it easier to be able to tap into that expertise.  Ohh, which then influences the way I practise the way I work cause not all my cases that I've got adult workers involved or children and practitioners working with me, but I still tap onto their knowledge.  we need to understand each other and this is where this model offers that opportunity to be able to reflect and of course within all these, I love the supervision.  **PPS 6: Nicky**  I think it's better for working with complex and high need cases.So long as it's the right social worker and the right workers adult workers around and even understanding and having the psychological input, even if you're running a case past one of our in-house psychologists and say how best should I work with – 13 |
| **‘We’re breaking at the seams’** | Unappreciated: Not good enough | **PPS 2: Shona**  But actually if that expectation is unrealistic because that service isn't available we  need to know that and I just feel like sometimes the communication from the top down isn't great.  **PPS 3: Kelly**  what I'm finding with the workbook for example is I'm duplicating a lot of work, so at the end of the month, well for example I'm I'm for the past month I've been working on December, January, February workbooks which is way behind.  And module 4 which is I think there's two parts, it's around the child's voice. I mean, a lot of questions it it's. It just be a little bit awkward to ask them really.  it was that module was was made or or produced or consulted with social workers, one of them was in my team actually, so it's ideal, but it's not realistic all the time.  there's a service manager that says. Well, do some really good quality work at each of your home visits, and then you'll get the modules done. That sounds great, but sometimes the home visits are so chaotic you know there's children running from room to room. You can't sit down and say, you know what makes you scared \*\*laughs\*\*  I could complete that work if I saw every child at school every couple of weeks or every month. But it just does not happen.Yeah, I think if my caseload was halved, definitely could do it.but you know when, when you're just putting out fires all the time. The the parenting modules, they fall by the wayside.  some of the modules, the way they're formatted and and the questions that are asked and the UM. Sort of. The lack of clarity of what goes where, case notes, modules, etcetera.That does that can add a lot of time, a lot of work to us.  **PPS4: Natalie**  there is like a difference between different managers and different like teams and things like that as to whether like us as the practitioner can go out and do that specific piece of work while we're waiting for one of the adult workers to become available. And sometimes being a bit more creative,  domestic abuse practitioners like they can provide us with so much information and advice, you can go out and do one off sessions and still get really good outcomes from doing that but. It's we don't have the luxury of the time to go out and do an 8 week domestic abuse programme.  Like I don't know one social worker that doesn't work outside of their working hours to get all of their work done. And that's just that's just the reality of getting everything that you are expected to get done done.  The hardest bit comes in to play is like finding that you can go out and do these great pieces of intervention, but it's finding the time to write it all up  There is repetitive sections on our system and you know in terms of like administration, it can feel really, really overwhelming  Like the reality is, is that like when you're over, when you're, when you're overworked, which I think most social worker is probably are, but when you're overworked and you know it's extremely tiring. It's also doing, it's draining. You know, there's lots of tears, sleepless nights, you know early mornings trying to get everything that you need to get done, done  We get communications being like this needs to be done, this needs to be done, this needs to be done. And actually, you know, I don't think, I don't think as a social worker we'd ever not want to get it done and it feels like sometimes the message like because people are like get further and further removed from the actual practise. They don't they they don't understand actually what we're doing in the reality and like how much work and effort and time it takes to do these good pieces of work and as a social worker, it can feel very quite demotivating and quite and devalue devalued. I don't know if that's a word, but like undervalued, because it almost feels like nothing we do is ever, like good enough  think it's just like from higher up you know, the communication side and other so you know higher up managers that aren't no longer like working face to face with families and think that that's where there's this real lack of understanding about like actually what life looks like on the ground for social workers.  When I'm feeling like that. (undervalued) It just doesn't make me want to do a good job. It makes me resent to my job  I do think it's quite frustrating at times because I think that they that other professionals sometimes feel like we're not really doing that much, we're just coordinating a plan. I think it would be good if they understood like exactly sort of the in depth.  **PPS 6: Nicky**  there's always that push because we have a surge like now at the moment. Of course surge from the front door and it's like workers just have to take it. Workers just have to take it. But we need to be professional, professionally responsible. As well as to say.OK, we need another plan because. The family Safeguarding programme does not work if workers have got high case loads |
| Letting families down: powerlessness | **PPS1: Stacey**  *They're just so stretched as a as a service at the moment [adult workers]… they can offer basic psychological support. Most of the parents coming in now are way past that!” (Stacey)*  ***PPS 2: Shona***  *I just worry that by the time that service comes in [adult workers] that point of change is missed.*  ***PPS 3: Kelly***  *We're waiting for like practitioners to become available and I think that that's sometimes can…delay moving cases on.*  ***PPS 4: Natalie***  *It feels like we're having to hold cases open longer than we would want to because we're waiting for that specific piece of intervention to take place*  *you're saying they need to do this piece of work and I'm still on the waiting list four months later and you're like, yeah, that is really annoying. And do you know what? I share that with you.*  **PPS 6: Nicky**  *We were delivering a program to help that family make change. Erm and when that was gone [adult workers], it meant that caseloads started to increase, which means that you can't. You can't deliver the program in a meaningful way*  A lot of workers knew what the model was, knew what the aim was, but actually one of the question was, do you know how to actually deliver that that module in the home with the family and a lot of those came back saying no - 19  So I think that would be the only thing is that there needs to be a better induction into the model when people come in.  I think the same applies to managers. I think if you've got a new manager who isn't very clear on the family safeguarding program themselves and then you're asking them to manage A-Team and tell that guide, that team. So for me, I, I I don't see why we wouldn't be doing an induction for managers as well - 20  So when a worker sits in. In supervision and says I'm really struggling. I don't know how to record in the family safeguarding work, but what will her answer be? Because we haven't helped her. That thing is key to staff turnover. Frustration, drift. It's huge, and it's such a little thing. Just give people a bit more time and a bit more training. |
| Professional isolation - aloneness | **PPS 2: Shona**  I feel \*\*emphasized\*\* in the past and It’s probably linked to COVID as well. I think since COVID family safeguarding isn't what it was, and I think we're losing services. So for example, drug and alcohol services now very much a base from their units, they don't work directly in the teams anymore and that makes it really difficult to collaborative work.  I made a CGL referral several months ago and was chasing was chasing and I only found out for him the other day that dad had been having sessions over CGL worker, but they hadn't fed into any of my child protection work or anything like that. So I feel like sometimes the connections are becoming Or disjointed  And domestic abuse officers at the moment are being pulled out of family safeguarding and being back into probation services because of Job crisis, I suppose, in respect of recruitment.And psychologists are extremely overworked. They're a long waiting lists which are eating into PLO timescales, and I've got a case at the moment where PLO was stretched to 20 weeks because we haven't got the psychology in house psychological assessment filed yet. And so I feel like at the moment we're kind of breaking at the seams  It's really hard to kind of really focus and get them strengths because you're constantly trying to address the risks as a lone worker.  Now there's lots of flexible working. So we're not in the office as much.I think that also plays a role in being able to actually sit with your adult workers and your counterparts, because we're all working from home  I'm going to be honest with you. I don't even know if X and X still work for us. I don't know. See, that's the disconnect  I feel like family safeguarding is so disjointed at the moment that I don't know who is still in the service  I'd honestly don't know. And this is where the disjointed is, because if we don't know who we can refer to how does the model work?  We do have domestic abuse officers and I do have domestic abuse officers and some of my cases. But in the last three weeks, a lot of them are leaving because they're being pulled back to probation. I've only heard that through colleagues in domestic abuse. I haven't heard that from up above. So again, there's no communication down to us about the difficulties because actually, as workers, we're still being told you should domestic abuse were officers. But if there aren't domestic abuse officers to use, then we need to know that as a service because we need to outsource.  **PPS 3: Kelly**  the CGL worker. When was asked by the conference chair. You know? Do you think this meets threshold for significant harm? She said no because she was coming from drug and alcohol where dad was engaging. I do think if if she had been part of the family safeguarding team she would be able to say yeah. Actually I do see the concern says a lot of domestic abuse, the impact and the children, etcetera, etcetera. So there's so many professionals out there who, you know, just think about their role  **PPS 6: Nicky**  Although they they were replaced. As as they were replaced, sometimes the family safeguarding model got diluted.  For example the CGL manager was part of the journey with us. And then when that manager changed and the new manager came, there wasn't the same emphasis on completing the workbooks  was that passion at the the top and the understanding of the model at the top, I think we lost some direction. I'm with new managers coming in new workers it we lost some direction and didn't not to do with the model but to do with how to deliver the the the family safeguarding program that how to I think. We lost the leadership of that for a bit.  we lost the that enthusiasm top down, enthusiasm, understanding and expectation wasn't there and it was difficult  When those relationships are not built, cause I I think. For me, it got to a point where even with mental health or psychologists, we weren't told when. When people change, when people were. So there seem to be a bit of a disconnect when people were coming in.  I knew the mental health worker at at. erm at x, even though I was at x, so I might pick up the phone and say, didn't do, you know, what can you just? I know that you're really busy and you're. I can see that you've got a lot of cases, but have you got time for a quick consultation on on this one just to have a quick chat. And I think those those erm connections.Umm that got lost along the way somewhere.  How many families are we not reaching because we're thinking in silo and I think the family safeguarding program can’t be delivered in Silo depending on where you're based. So we are not sharing resources if that makes sense. |

## Appendix 14: Author submission guidelines for Journal of Public Child Welfare

**Preparing Your Paper**

**Structure**

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

**Word Limits**

Please include a word count for your paper. There are no word limits for papers in this journal.

**Style Guidelines**

Please refer to these [quick style guidelines](https://authorservices.taylorandfrancis.com/publishing-your-research/writing-your-paper/journal-manuscript-layout-guide/?_gl=1*4n0x2n*_ga*MzkyMTc1MzI4LjE2NDU1NDU4NzE.*_ga_0HYE8YG0M6*MTY4MTkxNTc4Ny4xMi4xLjE2ODE5MTYyODcuMC4wLjA.&_ga=2.234754846.1636802250.1681898179-392175328.1645545871) when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

**Formatting and Templates**

Papers may be submitted in Word format. Please do not submit your paper as a PDF. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

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1. Hagan et al., (2017) included due to mean age below 5 years, M=49.14 months [↑](#footnote-ref-2)