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Assessment of Parental Capacity to Change where Children may be At Risk of Harm: Evaluation of the C-Change pilot project

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1. Introduction

In situations where parents have been involved in the maltreatment of a child, one of the most important questions for child protection agencies is whether those parents can turn their lives around, with appropriate help, so that the child is protected into the future. In order to make sensible plans for the children, social workers are effectively having to predict whether the parents can change things sufficiently and do so in a short enough time frame to meet the child's needs. Unfortunately, the practice methods available to social workers to assess parental capacity to change have hitherto been very limited and only one such approach has specifically targeted the requirements of local authority social workers in the UK (Research in Practice, 2013). None of the existing methods, as far as we are aware, has drawn on behaviour change theory to provide a substantive component of the assessment, something we regard as a significant failure to utilise available knowledge across disciplines. In work undertaken at the University of (anonymised for review), we set out to address these shortcomings.

The approach, entitled (anonymised for review), was developed as part of a project funded by the English Economic and Social Research Council's Knowledge Exchange Opportunity Scheme. Development of the approach was undertaken collaboratively with experienced social workers in three local authority Children's Services Departments in England. A description and analysis of the approach and its theoretical background (Authors' Own, 2016a) has been published, as well as a practice manual (Authors' Own, 2016b). The purpose of this paper is to present the results of a brief pilot evaluation of the approach, undertaken in 2015, and to explore the implications arising from the findings. To achieve this, we begin with a background overview.

2. Background and context

In the policy and practice context in England, assessment of parental capacity to change is becoming increasingly important. Expectations from the courts, where orders are considered to remove children into state care, have increased in the last few years. In particular, a recommended court report template (Association of Directors of Children's

Services, 2016, p.8) now expects social workers to assess whether a parental “capability gap” can be “bridged” - in other words, to consider the parents’ capacities to change.

This growing awareness of the importance of parental capacity to change is a response to practice issues such as lack of parental engagement with services; child deaths from maltreatment or neglect ; and so-called ‘disguised compliance’ (sic), where parents are said to be engaged with services but little change is actually occurring (Sidebotham et al., 2016; Wilkins, 2017). Research findings (Ward et al, 2012), have shown that social workers sometimes mistake superficial engagement by parents for a genuine desire to change.

As we and others have argued (Authors’ Own, 2016a; Macdonald et al, 2017), parental capacity to change has been neglected or even completely absent from social work assessments of children experiencing significant welfare challenges for many years in the UK. At the same time, evidence of capacity to change can be a key that unlocks an understanding of the potential future for a child should they remain in their parents’ or current carers’ care. As such, it can contribute significantly to decisions about whether that care is viable. Social work-orientated methods of assessing capacity to change are underdeveloped and theory for practice has not, until recently, drawn sufficiently from insights available via other disciplines. In this context, although the present study is simply a pilot, we consider it important to publish the findings as a contribution to the growing body of knowledge on the topic (see, for example, anonymised, 2020) and to support future research.

Central to these concerns is the need for professionals to maintain a focus on the child, rather than being distracted by the needs of the parents. The (anonymised) approach seeks to achieve a balance, by understanding the situations of the parents, whilst maintaining the centrality of the experiences and needs of the child(ren). The approach is comprised of two essential parts: (1) an assessment of barriers and facilitators to parents changing their behaviour, and (2) an assessment of actual changes that parents attempt to make when supported by appropriate therapeutic intervention.

Development of the (anonymised) approach (Authors’ Own, 2016a) drew on typologies of factors affecting behaviour change, and reviews of the literature on parental capacity to change, readiness to change and parental engagement with services. The two parts of the (anonymised) approach enable the social worker or other relevant practitioner to triangulate the information gathered on parental capacity to change, so as to bring together best evidence in the practice context. The first part, assessing *barriers and facilitators* of change, provides an understanding of the family and the context in which change is being attempted. It draws attention to what may or may not be achievable in terms of change. The second part, which involves assessing *actual changes* made by the parents, gives the assessment a more concrete basis in terms of whether change can be achieved in reality. The understanding of barriers and facilitators of change complements the assessment of actual change; it helps the worker to understand why change was or was not achieved, and to consider whether there is a likelihood of change being sustainable.

The first part, assessment of barriers to and facilitators of change, is based on five categories of factors affecting behaviour change in parents: 1) priority and relevance of the proposed changes for the parents; 2) current knowledge and skills of the parents; 3) motivation and intentions of parents; 4) habits and automatic responses; and 5) contextual factors (Authors' own, 2016a). It was developed by examining a number of integrated approaches from several key sources on behaviour change, on engagement with services, and on readiness to change (Cane et al, 2012; Olin et al., 2010; Ward et al., 2004). Details of the process of developing this approach is set out in our earlier paper (Authors' own, 2016a).

The second part of the approach, which assesses actual change made by the parents, builds on the tradition of giving parents an opportunity to resolve their difficulties before coercive actions such as removal of the children into care are attempted. Providing parents with appropriate and fair opportunities to make changes involves assessing progress both before and after a period of support or intervention. Such an approach has been systematised by Harnett (2007), making particular use of Goal Attainment Scaling. Harnett's procedure is incorporated into this second part of the (anonymised) assessment method.

As a means of addressing the lack of adequate practice approaches to assessing capacity to change, we worked with three local authority Children's Services Departments in England, to develop and evaluate relevant materials. The aim of the evaluation was to examine the impact of the (anonymised) approach on the practice of social workers in their assessment of parental capacity to change.

The main objectives of the evaluation were to explore whether:

- (1) The methods of assessment of parental capacity to change would be usable and valued in the social work practice context;
- (2) Training in, and application of the (anonymised) method would lead to improved understanding of parental capacity to change and improved skills in assessing parental capacity to change by participating social workers;
- (3) Application of the (anonymised) approach would lead to improved decision-making regarding interventions for children subject to child welfare concerns.

3. Methods

In this section, we present details of how the (anonymised) approach was implemented, and the methods used for the evaluation. The overall intention of the project was to design a new method for assessing parental capacity to change, and to establish initial proof of concept via a pilot implementation and evaluation. The funding source that supported the project was a knowledge exchange scheme and whilst a more extensive evaluation would have been desirable it would have taken the project bid beyond the funding ceiling. The particular funding scheme was chosen so that we could develop and test the workability of the assessment method before asking funders to risk more extensive funding for a larger scale evaluation. As such, the approach was seen as sensible and prudent, although it

meant that data collection was limited to brief questionnaires and a small number of qualitative interviews. Interviews with service users were not possible and whilst a comparison group was not used, the data collection included a comparison of 'before and after' data. Details of the methods used are as follows.

3.1 Implementation of the (anonymised) approach in three English local authorities

The local authorities involved with this project were chosen pragmatically, based on geographical accessibility for the university project team, existing working relationships with colleagues and the willingness of the authorities to participate. One of the authorities was a rural county with no large cities. The other two were metropolitan district councils, one with a mix of city and rural environments, and one comprised of semi-rural towns and villages on the fringe of a large city. All three authorities were experiencing the effects of economic austerity and could be considered to have relatively comparable caseload sizes. All three authorities had predominantly white populations. Two of them had recently introduced the Signs of Safety approach (Turnell & Edwards, 1999) as a standard working method, and the (anonymised) approach was developed in such a way as to complement Signs of Safety. To achieve this, the approach to goal setting with parents in the (anonymised) approach builds on the use of safety goals in the Signs of Safety approach and we incorporated sample practice questions for use with parents, questions that utilised forms of language consistent with Signs of Safety.

As part of the development of the (anonymised) approach, a series of consultation sessions were held with experienced social work practitioners drawn from each of the three local authorities. A core part of this process was the preparation of a pilot Assessment Manual, and training materials. Five two-day training courses were then provided by two of the authors (initials anonymised) for social workers and other relevant practitioners from the three authorities. Each course covered identical material on implementation of the approach; each one was open to all three of the local authorities involved so as to encourage cross-fertilisation of ideas, and venues were chosen in a variety of geographical locations in order to accommodate a range of accessibility needs.

The training focused on knowledge and skills development, with workshop-style activities forming a large part of each day, interspersed with presentations and explanations. Fictitious case studies, video extracts from an existing source (BBC Television, 2012) and case examples from participants provided a 'real life' focus for discussions and exercises. At the end of the training, participants were asked to apply the approach in their own practice. To facilitate this, they were offered the opportunity for follow-up support and consultation, from the research team at the University, and from senior practitioners/consultant social workers in each of the three local authorities. The individuals, who were asked to provide in-house support in the local authorities, were those who had been involved in initial consultations about the development of the approach and had also attended the training in using it. Copies of the assessment manual and materials were posted on each local authority's intranet as a means of making them more easily accessible. We also provided a 1-day training course for managers, but its participants were not included in the survey sample for the present study because the format of the course was different.

3.2 Data collection

3.2.1 Surveys: Survey questionnaires were administered at three time points: 1) immediately before the start of each training course (Time 1: T1); 2) at the end of each training event (Time 2: T2) and 3) three months after the training event (Time 3: T3). Paper-based questionnaires were used at T1 and T2 because they could be handed to participants at the time of the training so as to maximise response rates, whilst T3 data were collected via the on-line software, Bristol Online Surveys. The reason for the on-line survey at T3 was to enable easy access to the questionnaires for participants in their own workplaces and thereby to maximise response rates.

3.2.2 Semi-structured face-to-face interviews: The data derived from the survey questionnaires were supplemented by qualitative interviews held at T3. A sub-sample of 12 participants was interviewed regarding their experiences of the (anonymised) method, using a semi-structured approach. The main focus of the interview was on an anonymised case example, drawn from their own practice, through which participants were asked to illustrate their experiences of using the (anonymised) assessment.

3.3 Sample

3.3.1 Survey sample: The survey sample was comprised of all the participants in the two-day training courses described above, a total of 107. Response rates in terms of questionnaire completion were 100% at T1 and T2, a rate that is unsurprising since these data collection points were at the beginning and end of each training course. Response rates at T3 (the three-month follow-up) were much more difficult to maintain, but after a succession of reminders and encouragement, we achieved 50% (53) of the 107 training participants.

3.3.2 Interview sample: Regarding the qualitative element of the evaluation, we recruited a sample of 12 participants, four from each local authority, by seeking volunteers at the end of each course (the actual interviews were held at the three-month follow-up point). A purposive element was introduced into this recruitment by explicitly asking volunteers to come forward with a range of opinions including those less positive. The intention of this request was to counteract the possible tendency for only the more enthusiastic participants to put themselves forward. We also ensured we had a balanced representation from each of the three local authorities; where one local authority had sent some unqualified family support workers on the training, we included a representative of this group in the sample; and we included one participant from each authority who was a team manager and had attended either the 2-day training programme or the 1-day training for managers. Their responsibilities included supervising practitioners who had been through the 2-day training, and therefore they were in a unique position to comment on the impact of the training on their staff.

3.3.3 Characteristics of participants

The 107 participants comprised 86 professionally qualified staff (in social worker, senior practitioner and consultant social worker roles), 4 student social workers, 10 family support workers (who were not qualified social workers), and 7 in various management roles. The three local authorities had 33, 34 and 40 participants respectively. Of the total, 92% were female and the group was dominated by 'front line' practitioners.

The amount of experience the participants had as qualified social workers was skewed towards the inexperienced end, with only 37% having finished their qualification more than 5 years ago. Qualification levels were mainly at undergraduate degree or diploma level, and 10% had no social work qualification. Approximately a fifth (21%) were holders of post-registration qualifications and 59% were trained in the Signs of Safety approach (Turnell & Edwards, 1999).

3.4 Measures

Measures were devised to gather data against each of the three objectives of the evaluation, as follows.

3.4.1 Objective 1: Measuring the usability and value of the (anonymised) approach in the social work practice context.

A fundamental principle in developing the (anonymised) approach was that it should be accessible and straightforward to use in a busy practice context. Its success was dependent not only on its intrinsic theoretical worth, but also on whether it was found to be useful and practitioner friendly. There were four aspects to the way we evaluated this outcome.

- First, participants were given a survey questionnaire at the end of each training programme (T2). Included in this questionnaire were items that required respondents to rate each component of the (anonymised) assessment on a Likert-type scale. The questionnaires were in the style of feedback sheets and were developed by the project team.
- Participants were then asked to indicate, via yes or no responses, whether they had children/families on their caseloads with whom they could use the (anonymised) approach following the training course.
- Subsequently, at the three-month follow-up point (T3), participants were asked to rate the materials again in the light of their experience in the intervening period, and to indicate briefly how they had used the approach (via a selection of multiple choice answers), and with how many children/families.
- Lastly, the usability of the (anonymised) materials was explored in more depth in the qualitative interviews at T3.

3.4.2 Objective 2: Measuring the understanding of the (anonymised) approach to parental capacity to change by participating social workers and their skills in assessing this capacity.

Self-efficacy is an approach that asks participants to assess their own competence and was inspired by the work of (Holden et al, 1999). The approach has achieved good reliability in the UK in studies of social workers' professional development (Chronbach's Alpha ranging from 0.961 – 0.950 and test-retest correlation $r=.80$, $p<.05$) (Authors' own, 2012 p.17), and has also been shown to be psychometrically robust by Parker (2006). Based on this methodology, outcome-focused objectives were developed for the training, specifying the skills and knowledge expectations at the end of training programme. These outcomes were used to create a self-efficacy questionnaire (see Appendix 1), incorporating Likert-style

items, through which participants undertook a self-assessment of relevant knowledge and skills. Participants were asked to rate themselves on ten items, using a five-point scale. A pre-test, post-test design was used, incorporating a second follow-up test. Thus, the questionnaires were administered at each of the three time points, T1, T2, and T3.

The data from this questionnaire were tested for reliability using the Cronbach's Alpha test, applied to the completed responses at each time point in the above sequence. The results were as follows:

Time point	Cronbach's Alpha score	Number of items
T1	0.90	10
T2	0.87	10
T3	0.95	10

Table 1, Reliability Statistics, Self-Efficacy Questionnaire

The self-efficacy questionnaire was considered to have a good level of reliability, based on a threshold score for 'good' of 0.8 (Cronbach's Alpha). Consequently, we considered that an overall mean score could be derived reliably from individual total scores across the 10 items.

To supplement the data collected on self-efficacy from the surveys, qualitative interviews included questions which enabled the participants to talk about their own understanding of the principles of assessing capacity to change, their confidence using the (anonymised) approach, and to indicate additional support or training that might be helpful.

3.4.3 Objective 3: Measuring decision-making capacity regarding interventions for children subject to child welfare concerns.

A key feature of the policy and practice context is an overall intention to improve the quality of decision-making in relation to children with complex needs. As a means of measuring this outcome, we identified five dimensions of decision-making quality, adapted from work by Turney et al (2012), namely

- i) a focus on the needs of the child;
- ii) clarity of analysis;
- iii) timeliness of decisions and avoidance of delay;
- iv) extent to which plans for the child address the child's identified needs; and
- v) the engagement of parents in negotiating goals.

Three descriptors for each dimension were developed based on the researchers' knowledge of practice, representing good, average, and poor quality decision-making respectively. Participants were asked to choose the descriptor that most closely resembled their own decision-making approach. A pre-test, post-test design was used, and the measure was applied at two time points, T1 and T3. To help reduce bias, none of the statements were explicitly identified as representing a particular standard of practice, nor were they presented in any consistent order. They were expressed in language intended to represent a preferred approach to practice rather than quality of practice.

In the qualitative interviews (held at T3), open questions were included to identify how participants felt the (anonymised) approach had been helpful or otherwise.

3.5 Data analysis

Quantitative data from the T1, T2 and T3 surveys were analysed using SPSS. Analysis of the qualitative data was thematic. Recordings of the interviews were reviewed by both members of the research team who were involved in the interviewing process and successive lists of themes and sub-themes were drawn up and refined until an agreed version was achieved. Data was coded against these themes and sub-themes. The qualitative data presented in this paper were selected so as to provide more detailed information and thereby to enrich the quantitative findings. Quotations were chosen on the basis that they fulfilled this function whilst representing the wider dataset identified through the coding process. Both confirming and disconfirming cases have been included deliberately (Patton, 2015), and the context and importance of considering each quotation is explained.

3.6 Ethics

Ethical approval was granted by the Research Ethics Committee of the Faculty of Social Sciences and Law, University of (anonymised), a procedure that complied with the requirements of the funding body.

This evaluation did not raise significant or contentious ethical issues. In setting parameters, we addressed two central aspects. First, with regard to the development of the (anonymised) approach itself, we were conscious that its focus on parents and their capacities to change carried an inherent risk that, in the practice context, professionals' attention might be diverted from the child towards the parent. We addressed this balance in the training sessions by repeatedly returning to the broad purpose of the approach, namely to find the right ways of meeting the needs of the child(ren) within an appropriate timescale.

Secondly, in the context of the evaluation, the primary concern was that the identities of participants and services users were kept confidential. All questionnaires were completed anonymously, and participants were instructed in how to devise a code, identifiable only to themselves, to enable the tracking of individuals from T1 through to T3. Where participants were asked to talk about service users, either in the training or as part of the evaluation, they were required to use pseudonyms or otherwise to anonymise the information.

Participation in all aspects of the project was voluntary. Consent was given by all participants for the use of their data for the purposes of evaluation and reporting of results. It was made clear to participants that disclosure of information indicating either risk to a child, or professional misconduct, would be reported through appropriate channels.

4. Results

In this section, we begin with an analysis of the work responsibilities of participants. Then we examine the study's findings in relation to each of the three main objectives of the evaluation.

4.1 Participants' work responsibilities

Participants were employed in a variety of work teams, but because of the different organisational structures and configurations of responsibilities (between the different organisations involved), it is not possible to provide meaningful numerical data on participants' detailed work roles. However, there was a balanced range of tasks and roles, including dealing with new referrals through a duty system; investigations and assessments of alleged child maltreatment; court-related work (the majority related to potential removal of children into care); working with children in the care system; working to return children from care to their families (reunification); and family support .

Participants were all asked to indicate whether they had assessed parental capacity to change previously, and the methods they had used. Fifty-four (51%) of the 107 respondents indicated that they had used various methods to assess parental capacity to change. The responses of those 54 individuals are set out in table 2.

Previous methods utilised to assess parental capacity to change	Proportion of participants using the method (n = 54) ^a
Practice experience	93%
Set goals and reviewed progress	69%
Stages of Change (Prochaska & DiClemente, 1986)	58%
Other standard tools (variable interpretation – e.g. Assessment Framework (Department of Health, 2000), Signs of Safety (Turnell & Edwards, 1999))	53%
Other (mainly different types of parenting assessments)	11%

^a the total here does not add up to 100% as respondents were asked to indicate all methods that they had used, and thus to tick all boxes that were applicable to them.

Table 2, Previous experience of capacity to change assessment

Turning specifically to the (anonymised) approach, we examine the findings under each of the evaluation objectives.

4.2 Objective 1: Usability of the (anonymised) Assessment.

Of the 53 who responded to the relevant question at T3, 85% (i.e. 45 participants) reported that they had cases of their own or cases they supervised where they had been able to apply the (anonymised) method in the first three months after the training.

The numbers of cases to which individual participants applied the (anonymised) approach varied and details are shown in Fig 1. The variation in numbers of cases with which each relevant participant used the approach was explained partly by differing work responsibilities. However, it was also evident that some workers were more enthusiastic about using it and this may also help explain differing usage levels. Application of the

approach was not made mandatory by any of the three authorities and we considered it more appropriate to rely on professional judgement in individual cases for the decision about its application.

Figure 1, Numbers of cases per worker with which the (anonymised) approach was applied during first 3 months after training (n=45)

Participants used the approach with the following categories: children in need¹ (34%), children who were subject to child protection procedures (30%), in-depth parenting assessments (32%) and in a small number of other situations such as disputes over parent-child contact in divorce cases. In terms of the detailed work undertaken, this included reunification, working with foster carers, working with so-called 'stuck cases', supporting therapeutic work, pre-birth assessments, domestic violence situations, and assessing and planning contact arrangements between parents and children (where parents were separated or divorced, or the children were in the care system).

Participants (of which there were seven), who had not used the (anonymised) approach, were asked for reasons why they did not use it. The reasons included general lack of time; that it slipped from consciousness due to work pressures; insufficient time to assess capacity to change on top of the general children and families assessment; and lack of

¹ Children in need, in English law, is a defined category where there are concerns about the child's wellbeing, and services are needed to address those concerns but there is no reasonable evidence to believe that maltreatment has occurred.

confidence often brought about by constant change in local authority settings (e.g. re-organisations and new organisational initiatives). Three participants reported that they were unable to implement the approach because no suitable cases had come up since the training.

Although a majority of respondents at T3 indicated they had used the (anonymised) materials, the numbers give only a partial picture of how some social workers viewed the importance of assessing parental capacity to change. One participant in the qualitative interviews emphasised its significance for both worker and parent:

It's huge. And, I think, until I did this, although I've been practising for a long time, until I did this, you didn't actually sit down and actually think about it. ... The changes we are asking parents to make, for them, are so life changing. ... when it's their life, I don't know, it's like asking me to stop playing my guitar, isn't it. How would I do that? You know, it's alien to me, cos that's what I do. So when I'm asking them to stop using a substance which is their life, that is what they do, you know... you're not just asking them to change, you're asking them to change so much: their social circles ..., the places where they go, the way they lead their lives.

The survey questionnaires gathered feedback on use of all the key elements of the (anonymised) approach, and responses from participants are set out in figure 2. The individual elements were not treated as mandatory in all cases; rather it was left to the practitioner's judgement to choose which elements best suited the particular child and family.

For full details of these materials, please see Authors' own (2016b)

Figure 2, Elements of the (anonymised) approach used by participants and how they were rated (from data collected at T3)

Figure 2 shows that the most frequently used aspects of the (anonymised) approach were the framework of barriers and facilitators of change, the questionnaires and scales that were recommended to support the approach, the sample practice questions and the Goal Attainment Scaling chart. In terms of the helpfulness of each element, the overall ranking was similar to the usage pattern. Except for the pictorial scale (due to small cell counts) there was a positive relationship between the use of each element and appreciation of its usefulness in practice ($n=53$, all Chi-square analyses significant at $p<.01$)². This relationship is likely to be explained by both an enthusiasm on the part of the relevant practitioners to use the methods, and an appreciation of their value once they had tried them.

Evidence from both the quantitative and qualitative elements of the evaluation suggests that the extent to which the methods were applied varied, ranging from simple application of theoretical principles, to thorough incorporation of a range of materials into an assessment. Of the participants who responded at T3 ($n = 53$), 55% had used the (anonymised) approach as a two-part assessment of capacity to change (see discussion of the two parts of the assessment at the beginning of this paper), and this finding implies that some participants only used one part and not necessarily both.

Attitudes to and usage of the different components set out in figure 2 varied considerably between participants, and some examples from the qualitative interviews gave us an indication of how they were used. One social worker spoke about how she had identified barriers and facilitators to change which she had discussed with a single parent father, and the insight they gained into a deep-rooted problem in engaging with services helped him to move forward and make necessary changes. Similarly, several participants in the qualitative interviews welcomed the Goal Attainment Scaling process, and some comments indicated that the practitioner found it very easy to use. One interviewee described how she had used it with a mother with learning difficulties:

One of the things that was very apparent from the time when first we met her was her tone of voice – was flat. And it wasn't just the tone of voice, it was things that she said. So, she used a flat tone, unless she was angry and then she would show anger, but never praise or happiness, ... So, we talked to her a lot about that. And we actually had, we did one of these (i.e. Goal Attainment Scaling chart) for it as well. ... We did it for a month, ... and at the end of the month she did score a '3' because she was changing her tone most of the time. And she was also praising more and generally being more positive in the way that she was interacting with her little boy.

² Framework of factors ($\chi^2 (1) = 17.44$, $p < .01$.); Standard tools (questionnaires and scales) ($\chi^2 (1) = 15.24$, $p < .01$.); Practice questions ($\chi^2 (1) = 8.65$, $p < .01$.); Goal Attainment Scaling ($\chi^2 (1) = 21.16$, $p < .01$.); Written summary ($\chi^2 (1) = 14.35$, $p < .01$.); 2-part approach ($\chi^2 (1) = 9.60$, $p < .01$.); Balance sheet ($\chi^2 (1) = 9.83$, $p < .01$).

It is relevant to both these examples, however, that a small number of participants in the qualitative interviews drew attention to the difficulties of identifying specifically what needs to change. One interviewee, when asked if it was always straightforward to identify behaviour that needs to change, introduced a cautionary note:

It can often be something very clear. You know, (where) there's domestic violence or something like that, then it's often very clear that, actually, that clearly needs to change. I think it's when, you know, it might be much more, kind of, emotional stuff, I suppose, that's going on, and a lot of that goes on behind closed doors. You know something isn't right, but you can't necessarily find out exactly what that is. But you know there's a problem and identifying the problem can be a bit harder ... sometimes it is and sometimes it isn't (straightforward).

The participants were also asked whether they felt supported within their organisation to implement the approach. Most (62%) of the survey respondents at T3 (n=53) indicated that they felt supported in the implementation. Where negative responses were given to this question, the reasons did not offer a clear pattern for analysis. The only theme that came up several times was a need to do further work on embedding the approach in practice. These findings were reinforced by feedback via the qualitative interviews. Here, a key theme was the importance of starting a capacity to change assessment at a sufficiently early stage, thereby allowing time for it to be completed and reducing delay or drift in decision-making. Organisational support for doing so would be important. One interviewee suggested that the approach was more easily assimilated in social work practice than some other new ideas had been in her organisation. Another said that it needed to become part of local authority policy and process, perhaps with prompts to use it at various relevant stages of assessment and review.

4.3 Objective 2: Knowledge and skills in assessing capacity to change.

As indicated earlier, participants rated their own understanding and competence in undertaking a parental capacity to change assessment via a self-efficacy questionnaire (Appendix 1) completed at T1, T2 and T3. On average, participants reported higher self-efficacy at T2 ($M = 42.2$, $SE = 0.53$) than at T1 ($M = 33.8$, $SE = 0.88$). This difference was statistically significant ($t(46) = 9.833$, $p < .001$, $r = 0.68$). The average self-efficacy scores fell between T2 and T3, but the scores at T3 ($M = 39.1$, $SE = 1.12$) remained significantly higher than they were at T1 ($t(46) = 3.907$, $p < .001$, $r = 0.25$). These changes in mean scores are shown graphically in Figure 3 below.

Figure 3, Changes in participants' mean score on the whole 'self-efficacy' questionnaire over time

Beyond the overall scores, the self-efficacy scores were divided into three sub-questionnaires. The sub-questionnaires were proposed on the basis of theoretical coherence, i.e. that the design had incorporated three distinctive groups of questions. These groups were then tested independently using Cronbach's Alpha, and each separate sub-questionnaire was shown to have good reliability. The details of the subscales are given below (see Appendix 1 for individual items within each sub-scale).

- i) Assessing barriers and facilitators of change (i.e. part 1 of the (anonymised) approach, see 2. *Background and Context*, above) (3 items. Cronbach's Alpha: 0.82 at T1, 0.64 at T2, 0.91 at T3)
- ii) Assessing actual change (i.e. part 2 of the (anonymised) approach, see 2. *Background and Context*, above) (3 items. Cronbach's Alpha: 0.81 at T1, 0.79 at T2, 0.89 at T3)
- iii) How the (anonymised) approach fits in with the overall child and family assessment (i.e. knowledge and skills in making the (anonymised) approach align with existing assessment-related procedures the worker is using, see *Fundamental Principles* in Ch. 2, Authors' own, 2016b) (4 items. Cronbach's Alpha: 0.76 at T1, 0.79 at T2, 0.85 at T3)

The changes in self-efficacy scores for each subscale are shown graphically in Figures 4 - 6, below. It may be noteworthy that the smallest decrease in subscale score between T2 and T3 occurred within the sub-scale 'Assessing actual change', which may suggest that this aspect of practice was easiest for participants to assimilate.

Figure 4, Changes in participants' mean scores: Assessing barriers and facilitators

Figure 5, Change in participants' mean scores: Assessing actual change

Figure 6, Changes in participants' mean scores: How the (anonymised) approach fits in with the overall child and family assessment

Turning to qualitative interview data in relation to this outcome, several interviewees talked about how the (anonymised) approach had helped their understanding of capacity to change. In response to a question about factors affecting capacity to change, one interviewee said:

"I never ever had broken it down like that before... Never to break it down to being five domains like Habits, Automatic Responses, you know, all of those Contextual factors. I didn't have any framework to hang that on. So it's helped massively".

Another interviewee said:

"I found it really positive, actually. I suppose, when you've been doing the job for long enough, and you've had the various bits of training and experience, and put them altogether, and I felt that is what this did a bit for me. It was a bit of a personal pulling everything together, and not necessarily learning things that are completely new, but it's all the familiar things in quite a structured, helpful way."

A very small number of participants were less positive. An example is the following comment:

Initially, I think, it did affect my thinking. But, you know, I've been so busy, that, actually, it probably has slipped out of my thinking in the last months. ... (And later in the interview) I don't feel confident using any of the screening tools in that kit (i.e. the practice manual), I'll tell you that now. If I did, then I would use them. The more I think about it, the more I think that that a practical training day on - this is how you'd use them, this is when it's appropriate to use this one - that would be really useful.

As the survey data demonstrate, however, participants with views of this kind constituted a minority (see results reported in 4.4 below, which give a quantitative indication of whether participants were positive about the approach).

4.4 Objective 3: Decision-making capacity

Participants in the 2-day training were asked at T3 to indicate, on a five-point scale, whether the (anonymised) assessment had contributed to improvements in their approach to decision-making. In answer to this, 81% reported some improvement, a good improvement or considerable improvement, whereas 19% suggested no improvement or a little improvement (n=52). This finding might be rather limited on its own, but it is supported by the decision-making scores submitted by respondents.

As previously indicated, participants were asked to rate their own decision-making practice on two occasions, first at T1 and secondly at T3. Fifty-one of the trainees who responded at T1 answered this question at T3. Differences between these scores were examined to identify whether changes had occurred since the introduction of the (anonymised) approach. The McNemar-Bowker test was used in relation to each dimension, and significantly more participants at T3 compared to T1 said that they could achieve decisions within the child's timescale where possible (McNemar-Bowker test) $\chi^2 (2) = 7.451, p < .05$, OR = 2.9). Details of the changes are shown in table 3. No statistically significant differences were detected (at $p < .05$) in respect of the remaining four dimensions of decision-making.

	Time 1	Time 3
Social worker's self-rating	n=103 %	n=51 %
I almost always manage to achieve decisions, about the future of a child I am working with, within that child's timescale, and, where this is not possible, it is usually due to factors beyond my control ^c	19%	41%
I sometimes find that decisions about the future of a child I am working with are delayed, but I work with the family and other professionals to keep to timescales where possible.	75%	57%
I find it very difficult to manage decision-making about a child's future within tight timescales, and sometimes delay making final decisions because of their complexity, and because it is best to give the parents plenty of opportunities to prove themselves.	6%	2%

^c McNemar Bowker test significant at $p < .05$ level

Table 3, Changes in decision-making in context of timescales, at Time 1 and Time 3

The direction of this reported change in practice was away from delaying decisions about a child's future, towards working together to keep to timescales where possible.

The qualitative interviews gave us some indication of how the (anonymised) assessment contributed to apparent improvements in decision-making. Early in the capacity to change assessment, the approach emphasises the importance of identifying specific behaviours or circumstances that are having an adverse impact on the child. In this context, one social worker described a situation where:

"You can identify the risk that she's using heroin, but what needs to change to make things better for that child? Because actually, he's meeting all of his milestones, doing really well. I can see no neglect issues. Biggest risk is her emotional availability."

Here the clarity and specificity that came from addressing the impact on the child enabled the social worker to see that despite the parent using heroin, and despite the fact that the services might reasonably be worried about it, there was no evidence of physical harm or neglect at this point in time. The worker then turned her focus onto what she saw as the bigger risk, that of emotional unavailability.

A team manager whom we interviewed talked about supervising a social worker in her team whilst using the (anonymised) approach. She expressed the view that:

... it offered a really good framework to phrase, if you like, and cement where those concerns (about capacity to change) sat in the assessment. I think, without that sort of template, the social worker could likely find themselves stating things like "my observations led me to believe da, da, da.." which of course when you're actually in court is sometimes upheld and other times not.

These comments suggest that the (anonymised) approach offered practitioners a more systematic approach to using evidence of capacity to change. This point, that the approach supports thinking and analysis, was reinforced by another social worker, who said

You might be thinking along the lines of you know this parent can't do it because there's this thing that's really getting in the way of... this barrier that's really hindering her or him, because they can't see past that. And you, kind of, know that's a problem, but then it helps you to think about why it's a problem, and what you might be able to do about it, and how big a problem is it.

Even though this social worker had not used the approach as rigorously as we might have preferred, it had been a notable influence on her thinking processes.

Turning to a more general question about the findings, we had one particular concern, about whether the T3 respondents could be considered representative of the sample as a whole since the T3 response rate was only 50%. Some of the attrition was caused by participants³ who moved to new jobs in other organisations between T2 and T3. The

³ Accurate numbers are not available for these participants, but a realistic estimate is approximately 10 people.

pressures of other commitments and likely reluctance to prioritise questionnaire completion over the needs of children on caseloads can reasonably be assumed to account for the remainder. A bias that would have concerned us most was that those who did respond at T3 might have been more enthusiastic about the approach than those who did not respond. It was certainly the case that respondents at T3, who said that that it had improved assessments, were more likely to have used it in the practice context, than those who were less positive at the same time point ($\chi^2 (1) = 28.37, p < .001.$). To test this concern, we examined whether those respondents, who rated the approach less enthusiastically after they had undertaken the training (i.e. at T2), were less likely to respond at T3, but there was no statistically significant difference on this dimension between T3 responders and T3 non-responders. More of the T3 non-responders (58%) had anticipated considerable benefits at T2, compared with 42% of those who did respond at T3. This finding gave us greater confidence in our findings from the limited T3 sample.

5. Discussion

In this section, we return to key aspects of the findings, to explore their importance in the context of the methods used, the limitations of the study, the availability of comparable data, and the current policy and practice environment in the UK. Since the (anonymised) approach is a new method in social work practice, there are no directly comparable studies against which to compare our results. However, the use of Goal Attainment Scaling (GAS) has been subject to a number of evaluations across a range of professional contexts (e.g. Ottenbacher & Cusick, 1990; Steenbeek et al., 2007). Positive results in terms of child outcomes and cost effectiveness have been obtained from studies of the Parents Under Pressure Programme (Dawe & Harnett, 2007), which incorporates the use of GAS, although the evaluations examined the overall programme rather than GAS alone (Barlow et al., 2015; Dalziel et al., 2015). Similarly, various elements of the (anonymised) barriers and facilitators framework have been examined through numerous studies in a wide range of contexts, and integrated typologies from this work were used to inform the design of the (anonymised) approach (Authors' Own, 2016a).

Around half (51%) of the participants reported that they had previous experience of assessing parental capacity to change before. Within this group, methods and techniques that they used were limited, with social workers often relying on models such as the English *Framework for the Assessment of Children in Need and their Families* (Department of Health, 2000) which were not designed to assess capacity to change, or the Trans-theoretical (Stages of Change) model (Prochaska & DiClemente, 1986) which arguably is not satisfactory for this purpose. This finding, although not derived from a random sample, supports earlier theoretical and empirical analysis (Authors' own, 2016a; Macdonald et al., 2017), that capacity to change is often missing from general assessment approaches.

Turning to our first objective, that the methods of assessment of parental capacity to change would be usable and valued in the practice context, we found that the (anonymised) approach was well used within the pilot study, based on responses at T3, although ways in

which it was used were somewhat variable, with regard to the different elements of the assessment approach. In one sense, this finding was unsurprising: during the training we had presented the materials as offering a menu of techniques within an overall framework, and that practitioners should choose the relevant components to suit the needs of particular family situations. The qualitative data indicated that practitioners appreciated this message, particularly in the context of their busy work environments. Indeed, some participants used (anonymised approach) as a framework for thinking rather than a method of collecting evidence systematically.

However, despite the central principle presented in the training that the (anonymised) approach had two essential parts within each of which some choice of components was appropriate, it became clear that some practitioners chose only to use one part. From both qualitative data again, and from anecdotal reports as the project progressed, it was evident that this was a pragmatic choice often determined by the worker's perception of time constraints. As we have argued above and elsewhere (Authors' own, 2016a & b), the first part of the approach (understanding barriers and facilitators of change) supports the practitioner in assessing the parents' capabilities, motivations, social and practical constraints and so forth when faced with making particular changes in their lives. It provides an essential level of understanding but it does not give the parent an opportunity to attempt the changes in question and to demonstrate their capacity to change in practice – which is the focus of the second part. The two parts, thus, complement each other, making the resultant combined two-part assessment greater than the sum of its elements. We are conscious, in making these points, that simply using one part may theoretically be much better than not using any methodology when it comes to assessing capacity to change, and we recognise the constraints on practitioners' time. However, completing the two parts will, we believe, make for a better-quality decision for the child, who is the ultimate focus of the assessment.

Overall, then, we found evidence that, with some limitations, our first objective had been achieved, that (anonymised) would be usable in practice. Our main proviso in relation to this is that further work appeared to be necessary to embed the approach fully in practice. Perceptions of the approach being time-consuming should also be monitored.

Our second objective was that training in and application of the (anonymised) methods would lead to improved understanding of parental capacity to change and improved skills in assessing parental capacity to change. Here, we found moderate improvements in participants' self-efficacy ratings, and these improvements were maintained at a slightly reduced level at the three-month follow-up, particularly regarding participants' abilities to assess actual change. There is, of course, the possibility that the changes were affected by other factors unconnected to the present project. Two such factors were identified in this regard (through consultation visits following the training). In the largest of the three authorities, there was greater uptake of follow-up consultations, and the same authority was undertaking other work in relation to training for decision-making within timescales that meet the child's developmental needs. There were also two authorities using the Signs of Safety approach, and because participants were familiar with its goal-setting approach

they may have felt more confident to take up goal attainment scaling as a practice method. We noted in the findings above that there was some indication from the data that assessing actual change (of which goal attainment scaling was a central part) may have been more easily assimilated by practitioners. There were, however, equivalent improvements in self-efficacy in the authorities where these additional factors were not in place so there is little to indicate that outcomes were affected by local authority-specific factors. Consequently, we have a fair degree of confidence that many of the reported improvements can be attributed to the introduction of the (anonymised) approach.

Regarding the third objective that the use of the (anonymised) approach would lead to improved decision-making, our data gave us some indication that this is achievable. We had not expected that there would be significant changes in social workers' reported approaches to decision-making within three months of introducing the approach. However, there were small but significant improvements reported in relation to decision-making within the child's timescales, although not in relation to the other dimensions of decision-making. The data are not conclusive, and our position is simply that the (anonymised) approach may support improved decision-making but that further evaluation is necessary.

Before setting out our final conclusions, it is important to be clear about the limitations of this study. They were as follows:

1. The evaluation was part of a small-scale pilot of an approach to assessing parental capacity to change. Its objectives were limited to giving a broad indication of the value of the approach.
2. The measures used were based on social workers' self-evaluations of their own knowledge, skills, and decision-making competence. Whilst this approach has been shown in other studies to be robust (Parker, 2006), it is partial, relatively subjective, and open to bias. It is no substitute for evaluation of objective outcomes for children.
3. Whilst responses to questionnaires at T1 and T2 were 100%, the response rate at T3 fell to around 50%, and the attrition may have skewed the results. However, this response rate is better than a recent study with which we were involved, where response rates ranged from 24% to 42% at an equivalent 3-month follow-up point (Authors' own, 2012). See also discussion above (this section).
4. The evaluation was undertaken by the team who developed the (anonymised) approach, and consequently an element of bias is likely. There were seven local authority staff who took part in the initial development work for the approach who subsequently became participants in the evaluation. The steps that we took to overcome potential bias were that <authors 3 & 4> took a semi-independent role in overseeing the evaluation and undertaking the quantitative analysis. Regarding the local authority staff, knowing the nature of the workforce, we were confident that many of these practitioners would be able to take a critical approach to completing questionnaires. However, we do not consider these biases to have been eliminated completely, and our conclusions are therefore presented cautiously.

5. Finally, the sample choices may raise some legitimate questions. The geographical areas chosen for the work were based on pragmatic decisions and did not offer sufficient ethnic diversity. Similarly, because of funding limitations, no data were collected from service users. Both these issues should be addressed in future research.

6. Summary and conclusions

The study reported here cannot give definitive conclusions on the (anonymised approach) since it was small in scale, the evaluation was conducted by the team that developed the approach, and data collection used self-report measures. However, the findings are indicative that the pilot achieved its three objectives.

1. Regarding objective one, the approach was well-used by social workers and their supervisors.
2. For objective two, there were significant improvements in participants' self-reported knowledge and skills in assessing capacity to change.
3. and regarding objective three, there was some limited evidence that (anonymised) may support improvements in decision-making.

There was also evidence that an approach of this kind is needed, based on shortcomings in knowledge, experience and available methods, amongst participating social workers prior to undertaking the (anonymised) training.

Despite apparent enthusiasm amongst a good number of participants, several aspects should be addressed for future implementation.

1. Firstly, the training alone was unable fully to embed the approach within routine practice, a finding that occurs regularly across a wide range of professional training contexts (Horwath & Morrison, 1999). A more systemic, whole system approach to implementation, that addresses the contextual and organisational drivers to support its application in practice, would be necessary for (anonymised) to achieve its potential. Key elements of this, in our view, would be to make use of the approach mandatory in relevant, defined circumstances and to embed it within existing in-house assessment protocols and in regular supervision processes (see also point 2 below).
2. Secondly, some of the more systematic aspects of the approach, particularly achieving clarity over what a parent needs to change and analysing the information gathered from the assessment, may be challenging to apply in some circumstances. Implementation may consequently require a structure of supervisory, mentoring, or similar support to enable such challenges to be overcome. For instance, in training that has subsequently been offered in the use of the approach in the UK, sessions of follow-up or 'booster' training form part of our standard package.
3. Thirdly, results of the pilot evaluation indicate that some practitioners took a 'pick-and-mix' approach to using the (anonymised) materials. In part this was intentional,

since the (anonymised) manual offers a range of methods within a core framework for practitioners to choose from, and no one assessment tool will be appropriate to every situation. However, with the benefit of hindsight it gave us cause for concern that the fundamental principles, in particular the two-part approach, may not have been applied consistently by practitioners. The data were insufficient to reassure us on this point, and it would be necessary to monitor usage more fully in any future study.

Finally, the positive findings from the evaluation give a good indication that further evaluation would be worthwhile. Such evaluation should be conducted by an independent research team, should utilise more objective measures of the effects of the approach and should incorporate a stronger comparative element using appropriate independent comparison or control groups. Larger sample sizes would be necessary and objective measures should be developed for examining the effectiveness of decision-making. These measures should include, for example, an evaluation of the match between decisions made and the needs of the child, as well as the manner in which timescales were managed to reduce delays in ensuring the child's needs were met within a realistic developmental timescale. The predictive capacity of the (anonymised) assessment would also be an important component of an evaluation and an assessment of its cost-effectiveness in practice would help to show whether our anticipated time savings arising from better quality decision-making can balance out any additional time involved in using the approach. An evaluation of the service user experience should be undertaken, for example through parent interviews or observation of parent/professional interactions.

Appendix 1

Knowledge and Skills in Assessing Parental Capacity to Change - Self-Efficacy Questionnaire Items

-
1. I can explain to a colleague how a capacity to change assessment fits in with other processes when working with children and families

 2. I understand the factors that may affect a parent's capacity to change

 3. I understand how to gather information to assess factors affecting a parent's capacity to change

 4. I can weigh up the effects of different factors affecting a parent's capacity to change

 5. I am generally confident about creating opportunities for parents to change, and using the outcomes to inform my assessment

-
6. I am confident about establishing measurable goals for an intervention to help a parent change their behaviour

 7. I am skilled at writing down my detailed expectations of the extent to which parents must achieve each goal for change

 8. I consider myself able to use standardised tools or questionnaires in my assessments

 9. In my assessments, I know how to write an analysis of a parent's capacity to change

 10. I understand the effect a parent's capacity to change has on decisions about a child's future
-

Subscale composition:

1. Assessing barriers and facilitators of change: items 2, 3, &4.
2. Assessing actual changes made by parents: items 5, 6 & 7.
3. Knowing how the capacity to change model fits with the overall assessment of a child and his/her family: items 1, 8, 9 &10.

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References

- Authors' own (2012)
Authors' own (2016a)
Authors' own (2016b)
Association of Directors of Children's Services (2016). *Local Authority Social Work Evidence Template (SWET)*. <https://adcs.org.uk/care/article/SWET> [accessed 04.06.2020].
Barlow, J., Dawe, S., Coe, C., & Harnett, P. (2015). An Evidence-Based, Pre-Birth Assessment Pathway for Vulnerable Pregnant Women. *British Journal of Social Work*, 46 (4) pp 960–973, <https://doi-org.bris.idm.oclc.org/10.1093/bjsw/bcu150>.

- BBC Television (2012), Protecting Our Children. Used with Permission.
- Cane, J., O'Connor, D., & Michie, S. (2012). Validation of the Theoretical Domains Framework for use in Behaviour Change and Implementation Research. *Implementation Science*, 7, 37.
- Dalziel, K., Dawe, S., Harnett, P., & Segal, L. (2015). Cost-Effectiveness Analysis of the Parents under Pressure Programme for Methadone-Maintained Parents. *Child Abuse Review*, 24(5), 317-331.
- Dawe, S., & Harnett, P. (2007). Reducing Potential for Child Abuse among Methadone-maintained Parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*, 32(4), 381-390.
- Department of Health (2000). *Framework for the Assessment of Children in Need and their Families*. London: The Stationery Office.
- Gilmore, L., & Cuskelly, M. (2009). Factor Structure of the Parenting Sense of Competence Scale using a normative sample. *Child: Care, Health and Development*, 35, 48-55.
- Harnett, P. (2007). A Procedure for Assessing Parents' Capacity for Change in Child Protection Cases. *Children and Youth Services Review*, 29, 1179-1188.
- Holden, G., Barker, K., Meenaghan, T., & Rosenberg, G. (1999). Research Self-efficacy: A new possibility for educational outcomes assessment. *Journal of Social Work Education*, 35(3), 464-476.
- Horwath, J., & Morrison, T. (1999). *Effective Staff Training in Social Care: From theory to practice*. Abingdon: Routledge.
- Macdonald, G., Lewis, J., Ghate, D., Gardner, E., Adams, C., & Kelly, G. (2017). Evaluation of the Safeguarding Children Assessment and Analysis Framework (SAAF): Research Report. In. London: Department for Education.
- McConaughy, E., Prochaska, J., & Velicer, W. (1983). Stages of Change in Psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice*, 20, 368-375.
- Olin, S., Hoagwood, K., Rodriguez, J., Ramos, B., Burton, G., Penn, M., . . . Jensen, P. (2010). The Application of Behavior Change Theory to Family-Based Services: Improving parent empowerment in children's mental health. *Journal of Child and Family Studies*, 19, 462-470.
- Ottenbacher, K., & Cusick, A. (1990). Goal Attainment Scaling as a Method of Clinical Service Evaluation. *American Journal of Occupational Therapy*, 44(6), 519-525.
- Parker, J. (2006). Developing perceptions of competence in practice learning. *British Journal of Social Work*, 36, 1017-1036.
- Patton, M.Q. (2015), *Qualitative Research and Evaluation Methods*. California: Sage, 4th ed.
- Prochaska, J. O., & DiClemente, C. C. (1986). Towards a Comprehensive Model of Change. In W. R. Miller & N. Heather (Eds.), *Towards a Comprehensive Model of Change*. New York: Plenum Press.
- Research in Practice (2013), *Assessing Parents' Capacity to Change: Frontline Briefing*. Dartington: Research in Practice.
- Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., . . . Sorensen, P. (2016). *Pathways to Harm, Pathways to Protection: A triennial analysis of serious case reviews, 2011 to 2014, Final report*. London: Department for Education, <https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014> [accessed 06.07.2020]
- Steenbeek, D., Ketelaar, M., Galama, K., & Gorter, J. W. (2007). Goal Attainment Scaling in Paediatric Rehabilitation: A critical review of the literature. *Developmental Medicine & Child Neurology*, 49, 550-556.
- Turnell, A., & Edwards, S. (1999). *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection Casework*. New York: W.W. Norton & Co.
- Turney, D., Platt, D., Selwyn, J., & Farmer, E. (2012). *Improving Child and Family Assessments: Turning research into practice*. London: Jessica Kingsley Publishers.

- Ward, H., Brown, R., & Westlake, D. (2012). *Safeguarding Babies and Very Young Children from Abuse and Neglect*. London: Jessica Kingsley.
- Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The Multifactor Offender Readiness Model. *Aggression and Violent Behaviour, 9*, 645-673.
- Wilkins, D. (2017). We need to re-think our approach to disguised compliance. *Community Care*(16 March).