The ‘toxic trio’ - working with children and families where there is domestic abuse, parent substance misuse and / or parent mental health issues

Katy Burch, Principal Researcher Institute of Public Care
Institute of Public Care

- For well led, evidence-informed public care.
- Oxford Brookes University.
- Social care, health, education, youth offending, housing.
- Analysis, implementation and development.
- Performance management, commissioning, managing practice quality and change.
- Central, regional and local government, NHS, private and voluntary sector.
What I do (with colleagues at IPC)

- Research and development projects relating to:
  - Preventative social work with children and families
  - Preventative ‘family support’ services e.g. parenting programmes, youth intervention teams, multi-disciplinary prevention teams
  - ‘Systems’ designed to promote better outcomes for families with multiple needs e.g. Team around the Family
  - Improving outcomes for children in care
Mainly the yellow and purple ‘bits’
It’s all about ‘What Works’

“We can never know enough about what works”
What I’d like to talk about today

1. What is the toxic trio and why do we need to talk about it in relation to preventative social work with children and families?
2. Impact of toxic trio issues on parenting and outcomes for children
3. New prevalence rates – from recent studies
4. What are the barriers to effective support for these families?
5. What works – new innovations
How did we begin to refer to ‘toxic trio’ families?

- Domestic Violence & Abuse
- Parental Mental Health
- Parental Substance Misuse
Cleaver et al and other research summarised in our rapid research review (2015)

Hampshire County Council
Working with Families where there is Domestic Violence, Parent Substance Misuse and/or Parent Mental Health Problems
A Rapid Research Review
December 2015
The particular effects of **domestic abuse** on parenting and families

- Creates an *inconsistent and unpredictable environment* for children
- Carers may demonstrate a lack of emotional warmth and / or higher levels of aggression
- Alternatively, children may undermine a more nurturing environment because they sense and respond to the ‘fear and anxiety’ of the adult being abused
- There is also a well established link between domestic abuse and the physical abuse of children
- There is ‘gathering evidence’ of the link between domestic abuse and sexual abuse of children
The particular effects of **substance misuse** on parenting and families

- It is not inevitable that substance misuse will affect parenting capacity
- However, it is a significant feature in cases where children have been seriously harmed or killed
- Alcohol dependence linked with depression is particularly associated with poorer, less consistent parenting
- There has been some small scale research to date suggesting an association between parent alcohol misuse and child sexual abuse
The particular effects of parent mental health problems on parenting and families

- Parent mental health problems are also a strong feature of cases where children have been seriously harmed.
- Even conditions such as depression can inhibit a parent’s ability to respond to their child’s emotional cues and offer consistent care.
- It can cause a parent to be either ‘intrusive and hostile’ or ‘withdrawn and disengaged’.
- Research has only just begun now to consider the effects on parenting of the more serious mental health conditions.
Does anyone set out to subject children to toxic issues? – How does it happen?
One thing leads to another …

Research suggests for example that:

- Adults with mental health problems are more likely to abuse drugs or alcohol
- People who abuse drugs have a markedly increased lifetime occurrence of diagnosable mental health issues
- There are strong links between intimate partner violence and both ‘drinking in the event’ and ‘problem drinking’ more broadly
The cycle of abuse / ‘inherited’ toxic trio issues

In a recent IPC study of Child in Need or Child Protection Plan families working with Intensive Support Services

37%

Included at least one current parent / carer with a history of childhood abuse or neglect - including resulting from toxic trio issues.

In some cases, it was both parents / carers

This is likely to be an under-representation
Outcomes for Children
What is it about the ‘toxic trio’ that’s so significant for child and family social work?

The combination has been clearly linked with increased risks of abuse and neglect of children and young people.

“Time and again, it seems that the combination of problems is much more likely to have a detrimental impact on children than a parental disorder which exists in isolation” Cleaver et al (2011)
The significance of child resilience

- Some children cope relatively well – resilience factors include child characteristics as well as high levels of extended family and community support / moving to a safer more secure environment.

- However, Velleman and Templeton (2007) suggest caution in relation to an unrestrainedly positive view of resilience in children. They argue that the processes that allow children to become resilient in the short term may result in later problems – particularly in making healthy relationships.
Prevalence of Toxic Trio – existing and new findings
<table>
<thead>
<tr>
<th></th>
<th>Overall Population</th>
<th>Child Protection</th>
<th>Care Procs</th>
<th>Serious Case Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td>3 – 13%</td>
<td>25%</td>
<td>43%</td>
<td>63%</td>
</tr>
<tr>
<td><strong>Substance Misuse</strong></td>
<td>5% - 7% (alcohol)</td>
<td>25-60%</td>
<td></td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>3% (drugs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domestic Abuse</strong> (partner abuse)</td>
<td>3 – 4%</td>
<td>40 – 50%</td>
<td>51%</td>
<td>53%</td>
</tr>
</tbody>
</table>
Prevalence Rates – Families with a CIN or CP Plan (Baseline Area A 2015)

<table>
<thead>
<tr>
<th>Toxic trio issue</th>
<th>Prevalence rates in statutory cohorts from existing studies</th>
<th>Area A prevalence rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic abuse</td>
<td>40 - 50%</td>
<td>74%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>25%</td>
<td>46%</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>25 - 60%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Why domestic abuse prevalence is so significant

“Although there is substantial evidence showing that a combination of (toxic trio issues) increases the risk to children’s safety and welfare, the best predictor of adverse long-term effects on children is the co-existence (of a range of family issues) with family disharmony and violence”.

Cleaver et al (2011)
Toxic Trio (All Three) Prevalence in Child in Need or Child Protection Plan cohorts – Area A (2015)
Toxic Duo (Two out of the Three) Prevalence in Child in Need or Child Protection Plan cohorts – Area A 2015

29%
In Area A, many families with toxic trio issues had a significant history with social care services
% of toxic trio / duo cases with poor or cursory parent engagement with the social service-led intervention
% of toxic duo / trio families with clearly positive outcomes for children remaining at home
In Area A, the case file analysis showed family engagement and outcomes were generally better where

- Toxic trio / duo issues weren’t chronic
- The key including toxic trio issues were identified early and with reference to the full referral history
- A robust plan of intervention addressing the key risks and issues was put in place without delay
- The overall intervention was ‘gripping’ of the family (intensive) in the initial stages at least
- The social worker played some active part (beyond monitoring and case coordination)
- The lead social worker remained in post throughout
Simon and his family
Danny and Family
Grace and Mum
What were the barriers to effective support for these families?
Access to Support for Toxic Trio in Area A – worker responses
The unexpected findings from talking with social workers and team managers in Area A

- Parent motivation (to change) was perceived to be the most significant factor influencing the accessibility of SM, DA and MH support – more so than the literal ‘availability’ of a local service.

- Other factors influencing accessibility are: being too busy to make the referral; providers not offering exactly what you need for the family.

- Not having access to the ‘right resource at the right time’ can be a major barrier because its impact on parent motivation (to change) as time passes / drifts.
What Works?
Our recent rapid research review focused on

1. The DfE summary ‘Rethinking Social Work’ (overall work with children with a statutory plan)
2. What works regarding the domestic violence ‘element’
3. What works regarding the substance misuse ‘element’
4. What works regarding the mental health ‘element’
It also recognised some of the broader factors

“Knowing the specific method of helping families to change is useful but, whatever the method, the worker needs to be able to engage and form a trusting relationship with the child and family members” Munro (2011)

“Helpers who are cold, closed down, and judgmental are not as likely to involve clients as collaborators as are those who are warm, supportive, and empathic” (Gambrill, 2006)

“A key finding from a review of evidence on what works in protecting children living with highly resistant (often toxic trio) families was the need for authoritative child protection practice. Families’ lack of engagement or hostility hampered practitioners’ decision-making capabilities and follow-through with assessments and plans. Practitioners became over-optimistic, focusing too much on small improvements made by families rather than keeping families’ full histories in mind” (C4EO 2010)
Emerging models in brief

- Integrated
- Specialist
- Generic
- Arms Length
Recent Innovations in Hampshire
Hampshire are in the early stages of developing

- Family Intervention Teams (FITs)
- Each comprising
  - A domestic abuse worker
  - A mental health worker
  - A substance misuse worker
- Working with teams of child in need / child protection social workers who continue to case hold
- Aiming to address toxic trio issues swiftly
Hampshire Experience so far (just a few months into the pilots)

- Individual Family Support Team workers (DA, SM, MH) have been useful / very useful in:
  - Working closely with the case holding social worker doing joint visits, providing advice and ‘consultancy’ support, and some direct work with families on toxic trio issues
  - Making swift, potentially more effective referrals to specialist services for medium to longer-term interventions relating to toxic trio issues
  - ‘Holding the baton’ in the meantime with family members – doing ‘warm up’ work with them to keep momentum, interest, and supporting small steps of progress
Challenges for a FIT model (in Hants and elsewhere) have included:

- RECRUITMENT (of enough workers with experience of working with toxic trio issues to the FIT)
- Workers who have an established idea of what they do and don’t do in relation to their specialism (DV, MH, SM) and who may be more experienced at diagnosis/triage or group work than one to one direct work
- Workers who have no previous experience of going into family homes (previously clinic based) and don’t have skills in working with all family members
- Workers who are flummoxed by the ‘multiple issue and whole family’ nature of the social work intervention or who have ethical barriers to working with the whole family
- The whole social work team culture still needs to change
Innovations in Newport – a local authority and voluntary sector partnership arrangement
Family Assessment and Support Service (FASS)

- Provided in partnership between Newport City Council and Barnardo’s
- Part of a bigger partnership model (and vision) for evidence-based family support services across the continuum of need
- The overall partnership model relies on core funding from both NCC and Barnardo’s - and Welsh Government grant funding (for the preventative stuff)
- This is a more established model – been running now for about 2-3 years. Those involved would say it began to achieve its potential after 18 months – 2 years.
- Social workers refer families in crisis / on the edge of care to the service – not lower level family support presentations
Key Attributes of FASS

- Staff are mostly qualified, but not all as social workers – teaching, psychology, systemic practice, nursing and social work. Plus some experienced family support workers.

- All trained in evidence based approaches to strengthening family engagement and motivation (e.g. Motivational Interviewing Techniques and Solutions Focused Approaches) + other key areas such as domestic abuse work; parenting skills / programmes; CBT.

- Strong emphasis (reinforced through senior managers, practice manager and practice standards) on workers applying:
  - Their knowledge of key theoretical underpinnings (attachment theory, change theory, positive parenting) to assessment and ongoing work with families.
  - A therapeutic approach to working with family members combined with practical supports, tips and suggestions.
  - Key principles from the generic family support literature such as: strengths based; outcomes focused; evidence based; holistic (whole family).
The ‘golden combination’ of therapeutic and practical approaches?

<table>
<thead>
<tr>
<th>Therapeutic</th>
<th>Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Confident exploration of the past</strong> (cycles of behaviour &amp; relationships and impact of childhood experiences &amp; parenting approaches)</td>
<td><strong>Parenting tips</strong> – reference to evidence based programmes that can be delivered 1:1 – including suggesting, ‘modelling’, ‘doubling back’ when problems arise</td>
</tr>
<tr>
<td><strong>Theraplay</strong> and other playful approaches to strengthening attachment</td>
<td><strong>Providing information e.g.</strong> about how inter parental conflict affects children / how to de-escalate conflict</td>
</tr>
<tr>
<td><strong>Ongoing support for motivation to change</strong> including to reach out to external supports for DV, SM, MH</td>
<td>Basic financial and housing <strong>advice and support</strong></td>
</tr>
<tr>
<td><strong>Support for depression and anxiety</strong> - CBT ‘approaches’</td>
<td><strong>Advice</strong> about how to keep children safe</td>
</tr>
</tbody>
</table>
This is what the Newport families said

- Got us all together to play games and do therapy
- Saw us as a family, me and my husband together and separately (very good, important to us)
- We used cards to do with routines and safety
- We played, did games
- Encouraged my partner to see himself as a parent – gave him permission to get involved
- She did relationship counselling with us
- Helped me see how arguing affects children
- He was really clear about what was normal and what was not
- She demonstrated how to discipline children positively, how to respond to people in the community if they are rude
- He helped to sort out appointments for the children
- Helped my husband find numbers to ring about sorting out benefits
- She was like a counsellor, said it’s trial and error, try this and persevere with it
I really liked these ones…

Taught us that when things go wrong, don’t let it all go wrong

Somebody coming from outside seeing how our family worked. Not someone just coming in and telling us what to do, showing us instead
Other key Attributes of FASS

- Very intensive in the first few weeks (3 - 4 visits per week) to explore family issues further and to achieve the ‘gripping’ initial phase
- Not overly long interventions (but longer than some) – 60% cases closed before 32 weeks, 32% before 42 weeks
- The service doesn’t draw in lots of additional services, particularly in the first few weeks – keeps the Team around the Family ‘tight’
- Male as well as female workers – can work effectively with Dads
- Use of highly visual ‘distance travelled’ tools with families
% Newport families with highly successful outcomes including children remaining safely at home
Overall Newport has seen

- A recent dramatic (22%) drop in the number of children coming into care
  - 165 in 2014-15
  - 129 in 2015-16

- An increase (16%) in the number of children stopping being looked after (including those rehabilitated home quickly)
  - 250 in 2014-15
  - 290 in 2015-16

- Re-referral rates have declined significantly

- Recruitment and retention of social workers in CIN/CP Teams has improved
Costs / Cost Benefits of Newport FASS
BIG LEARNING

- Empower People
- Inspire People
- Leadership
- Lead Change
- Shared Vision
BIG FACTOR – The VCS effect?
It takes time to establish effective solutions

The real advantage of a partnership model is the capacity to grow over time – grow people, staff who deliver the services. Continually starting from scratch can be the enemy of evidence based practice.

Newport Senior Manager
Continual refinement not reinvention of the wheel
Ongoing challenges and questions

- How to impact on the hardest to budge cases – predominantly families with chronic issues and long standing Domestic Abuse perpetrators
- Even if they’re not actively doing most of the motivating of families and direct work – do the case holding social workers need a ‘good grounding’?
- To what extent should social workers be encouraged to ‘float’ across case holding and this service (the Partnership covers both)?
Further reading / resources

- [http://ipc.brookes.ac.uk/](http://ipc.brookes.ac.uk/) For all our publications on this theme and others e.g. how useful are volunteers with social care clients? How useful are ‘personal assistants’ in social work teams?


- [https://www.rip.org.uk/](https://www.rip.org.uk/) Research in Practice publications such as ‘Engaging resistant, challenging and complex families’

- [http://www.eif.org.uk](http://www.eif.org.uk) Early Intervention Foundation including for ‘What works to enhance inter-parental relationships and improve outcomes for children’

Contact me

- kburch@brookes.ac.uk
- Colleagues at ipc@brookes.ac.uk
- Tel: 01225 484088