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Evaluating Service Provision for Physical Abuse and Neglect in England and Wales: Feasibility of a Pilot Multisystemic Therapy Trial

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ABSTRACT

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is an intensive, trauma informed intervention for families where children are at risk due to physical abuse or neglect. Adapted from MST, which targets antisocial youth, MST-CAN offers a broader, systemic approach addressing both child and caregiver needs. This mixed-methods pre-pilot study explored the feasibility of conducting a randomised controlled trial (RCT) of MST-CAN in England and Wales. An online survey mapped the availability of 'service as usual', the existing statutory and commissioned children's social care provision for physical abuse and neglect, across England and Wales, revealing significant variation and limited access to MST-CAN (3% of local authorities). While many services aimed to be family-focused, provision was often fragmented and constrained by resources. Semi-structured interviews with senior and frontline professionals highlighted challenges, including inconsistent multi-agency coordination and uneven access to evidence-based, trauma-informed interventions. Qualitative analysis identified six key themes, including clear distinctions between MST and MST-CAN, the diversity of current interventions, and the importance of relational, flexible practice. Findings indicate that MST-CAN offers a more integrated and consistent model than typical provision. The study concludes that a pilot RCT is feasible and recommends a small-scale internal pilot with process evaluation to assess implementation, acceptability and inform progression to a definitive trial.

1 | Introduction

Protecting children from significant harm is one of the most complex and demanding responsibilities of the state. In England and Wales, the Children Act 1989 places a statutory duty on local authorities to safeguard and promote the welfare of children in need and, where possible, to support their upbringing within the family (Children Act 1989). Where children are suspected to be suffering, or at risk of suffering significant harm, local authorities are required to initiate enquiries under Section 47 of the Children Act 1989 to determine what action, if any, is necessary to promote their welfare.

Child protection legislation is devolved within the United Kingdom (UK), and statutory frameworks therefore differ across the four nations. This study focuses specifically on England and Wales. In England, statutory child protection duties are primarily governed by the Children Act 1989 and associated guidance, including the requirement to undertake Section 47 enquiries where there is reasonable cause to suspect significant harm. In

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Wales, child protection operates under the Social Services and Well-being (Wales) Act 2014 alongside the Children Act 1989, with Section 47 duties applying in broadly comparable ways. Although policy frameworks, terminology, and service structures differ between England and Wales, the legal threshold and purpose of Section 47 enquiries are substantively similar across both jurisdictions.

Intervening effectively in cases of physical abuse and neglect requires adaptive, evidence-informed approaches. Research indicates that families involved in child protection systems often experience multiple and co-occurring risk factors, meaning that no single intervention model is sufficient for all (Thoburn 2009). In response, there has been a growing emphasis on the use of evidence-based programmes (EBPs) in child and family social work, as these offer structured and tested ways of improving outcomes (Sundell et al. 2023; Ward et al. 2014). However, the availability of EBPs in social care settings in England and Wales remains limited, and many interventions in use have not been subject to robust evaluation, particularly randomised controlled trials (RCTs) (Euser et al. 2015).

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) is an intensive EBP, developed to support families where there are recent concerns of physical abuse or neglect, often involving statutory child protection intervention and elevated risk of family breakdown or out of home placement (Hefti et al. 2020; Buderer et al. 2020; Swenson et al. 2010). Delivered in the family home and community, MST-CAN is time-limited and involves frequent therapist contact, with a focus on enhancing caregiver capacity, reducing risk of maltreatment, and improving child safety and wellbeing. The model is an adaptation of multisystemic therapy (MST), an established intervention that primarily targets adolescents involved in antisocial behaviour. MST uses a systemic family- and community-based approach to address drivers of risk across multiple ecological domains. While both MST and MST-CAN are grounded in systemic theory and use intensive, family-focused interventions, MST-CAN expands on standard MST by integrating additional components, including trauma-focused interventions for children and caregivers, structured safety planning and close collaboration with statutory child protection services, to address the specific dynamics of child maltreatment (Hefti et al. 2020; Buderer et al. 2020).

At a practical level, MST-CAN also differs from standard MST in several key delivery and structure features, including smaller caseloads (3–4 families), extended treatment duration (6–9 months), broader child age range (6–17 years) and a primary partnership with children's social care rather than youth justice (Swenson et al. 2010). Delivery is supported by 24/7 therapist availability and a multidisciplinary team structure, including a full-time supervisor and regular consultation, enabling intensive home-based intervention within complex safeguarding contexts.

International studies have shown promising results for MST-CAN. RCTs and evaluations in the USA, Australia, Germany and Switzerland report reductions in children's mental health symptoms, parental psychological distress, maltreating behaviours and out-of-home placements, alongside improvements in social support and school attendance (Swenson et al. 2010; Herbert et al. 2014; Hefti et al. 2020; Buderer et al. 2020; Bauch et al. 2022). MST-CAN was also one of only five programmes identified in a meta-analysis as reducing child maltreatment (Euser et al. 2015), and a US-based cost analysis suggests it may offer substantial net savings compared to enhanced community services, including reduced costs associated with out-of-home placement, mental health service use and wider societal costs (Dopp et al. 2018).

Despite this emerging evidence base, MST-CAN has yet to be robustly evaluated in England and Wales. Existing studies, though positive, have been critiqued for potential bias, unclear primary outcomes and limited generalisability (Hastings et al. 2022). As such, there remains a critical need to explore whether MST-CAN is a feasible and appropriate model within the context of children's social care in England and Wales.

2 | Methods

2.1 | Aims

This pre-pilot consultation aimed to assess the feasibility of conducting a future pilot trial of MST-CAN within the UK context, specifically in England and Wales. The goal was to explore the key parameters needed to inform the design and implementation of a larger, pilot randomised controlled trial. The consultation addressed four exploratory questions:

1. Are MST and MST-CAN significantly different service provisions?
2. What constitutes 'service as usual' in children's social Services in England and Wales?
3. Is MST-CAN significantly different from 'service as usual' in England and Wales?
4. Is a pilot efficacy randomised controlled trial (RCT) of MST-CAN feasible in England and Wales?

2.2 | Survey

An electronic survey was distributed to 168 local authority children's services departments across England and Wales. The initial invitation was sent to heads of children's services, with requests to share the survey with colleagues who had knowledge of local service provision for families experiencing physical abuse and neglect. Further recruitment occurred through snowball sampling and opportunity sampling, including consultation interview participants and MST-CAN practitioners (see below). Although no specific professional role was required, recruitment was targeted towards practitioners and managers with oversight of, or familiarity with, local intervention pathways and 'service as usual' provision.

The survey posed a single question regarding the types of intervention currently available for families meeting the target population criteria for MST-CAN. Specifically, it focused on families where:

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- There were confirmed concerns about physical abuse and/or neglect, resulting in a child protection plan or the child being taken into care (with targeted work for reunification).
- At least one child in the household was aged between 6 and 17 years.
- There was no reported active sexual abuse, no reported active domestic abuse, and no reported active parental psychosis (i.e., ongoing or current at the point of referral or assessment).

Respondents were asked to identify available family-focused, parenting-focused and child-focused interventions from a predefined list, with an open text box allowing them to specify additional approaches not listed. These categories were used as broad descriptive groupings to capture the range of interventions available within children's social care and did not denote any specific intervention models. The list included both MST-CAN and other MST-derived programmes, alongside a range of non-MST interventions (e.g., parenting and therapeutic programmes). Emotional abuse was not included as a specific eligibility criterion in the survey, as the study was designed to align with the formal eligibility criteria of MST-CAN, which focuses on physical abuse and neglect. As such, the findings should be interpreted within this defined scope.

Surveys were administered using the survey platform Qualtrics between May and September 2023. In total, 76 responses were received, representing 58 unique local authorities (a response rate of approximately 35%). Where multiple responses were received from the same local authority, data were consolidated.

2.3 | Consultation Interviews

In addition to the survey, in-depth consultation interviews were conducted to further address this study's aims. Nine senior managers and frontline practitioners across five local authorities in Wales, the North of England, and the Midlands contributed. Participants were recruited via opportunity sampling, drawing on the authors' existing professional contacts both within local authorities planning to collaborate with the study and from wider professional networks beyond the immediate project remit. Snowball sampling was then used, with initial participants identifying relevant colleagues. Consultations were conducted online via Microsoft Teams and lasted between 30 and 60 min.

The purpose of the consultation was to provide a more in-depth understanding of the nature of 'service as usual' for families subject to Section 47 enquiries, including not only what types of intervention were typically offered, but how provision was experienced and delivered in practice, alongside perceived strengths, gaps and implementation challenges.

2.4 | Ethical Considerations

As this stage of work was classified as a consultation and service mapping exercise to inform the feasibility of a future trial, rather than research intended to generate generalisable findings, formal ethical approval was not required (Health Research Authority 2025). Advice was sought from both the Health Research Authority and the University of Kent Social Science Ethics Committee, which confirmed that this phase did not meet the threshold for formal research ethics review. Nevertheless, ethical principles were rigorously applied.

- All participants were aged 18 or older and provided informed consent.
- Survey participants were presented with an online information sheet before completing the survey.
- Consultation participants were provided with an interview brief and consent form, which they signed and returned.

All consultations were conducted by trained academic researchers ($n = 5$) experienced in qualitative data collection. Participants were given contact information for the consultation team and were assured of anonymity and confidentiality. Data were anonymised, securely stored and handled in accordance with standard data protection principles.

2.5 | Analysis

Survey data were analysed using simple frequency counts in STATA 18, categorising interventions by type (family-focused, parenting-focused, child-focused).

Consultation data were video recorded, transcribed verbatim, anonymised and analysed using applied thematic analysis (Braun and Clarke 2006; Ritchie and Spencer 2023). This inductive, phenomenological approach began with line-by-line coding of each transcript, followed by the development of themes through comparison and synthesis across cases. Coding and theme development were conducted collaboratively by the research team to improve validity and rigour.

3 | Results

3.1 | Survey

The survey explored the prevalence and type of interventions used by local authorities with families subject to Section 47 enquiries. A total of 76 responses were received from 58 local authorities (35% response rate). The results are summarised in Table 1.

Family-focused interventions were the most often reported interventions ($n = 42$; 72%), followed by parenting-focused ($n = 26$; 49%) and child-focused ($n = 19$; 33%). Percentages exceed 100 because some local authorities reported offering more than one type of intervention; however, most local authorities reported offering interventions in one domain rather than across all three.

Three forms of multisystemic therapy (MST) were reported: generic MST (17%), MST-Building Stronger Families (2%) and MST-CAN (9%). However, as some MST-CAN sites were included through opportunity sampling, their proportion is inflated. The (true) national prevalence of MST-CAN was 3% (5 of

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TABLE 1 | Frequency of different interventions reported for families with Section 47 concerns.

Intervention type	Intervention	*N* (%)
Family-focused	Multisystemic Therapy (MST – generic)	10 (17%)
	MST – Building Stronger Families (MST-BSF)	1 (2%)
	MST – Child Abuse and Neglect (MST-CAN)	5 (9%)
	Functional Family Therapy	4 (7%)
	Parent/Child Interaction Therapy	1 (2%)
	Strengthening Families	13 (22%)
	Family Solution-Focused Therapy	3 (5%)
	Family Safeguarding Support	3 (5%)
	Family Therapy	1 (2%)
Parenting-focused	Incredible Years	11 (19%)
	Empowering Parents	4 (7%)
	Conflict Management	3 (5%)
	Solihull	2 (4%)
	Triple P	4 (7%)
	Points on Parenting	1 (2%)
	Peer Support	1 (2%)
Child-focused	Trauma-Focused Cognitive Behavioural Therapy	11 (19%)
	Youth Support	1 (2%)
	Direct Social Work/Social Work Assistant Support	4 (7%)
	Signs of Safety	2 (4%)
	Edge-of-Care Crisis Intervention	1 (2%)

Note: Due to opportunity sampling, MST-CAN services were over-represented. The true prevalence is 3%, i.e., 5 of 168 local authorities.

168 local authorities) at the time of the survey. The qualitative consultations explored key distinctions between MST and MST-CAN; however, it is important to note that MST (generic) is typically delivered to a different target group—adolescents at risk of offending or substance misuse—rather than those experiencing child protection concerns.

The most common family-focused intervention was Strengthening Families (22%). This approach focuses on identifying risk and promoting protective factors through activities aimed at strengthening family functioning and coping. Although widely implemented (including through government support), its evidence base is relatively weak, particularly outside targeted versions such as Strengthening Families 10–14, which have shown short-term benefits for adolescents and parents (Segrott et al. 2022).

Among parenting-focused interventions, Incredible Years was the most frequently reported (19%). It aims to enhance parent–child interaction and promote prosocial behaviour in children aged 2–10 years. Although moderate evidence exists for its effectiveness in improving behavioural outcomes (Gardner et al. 2017), it does not target the same population as MST-CAN, nor does it offer systemic, multi-agency support.

In terms of child-focused interventions, provision of trauma-focused cognitive behaviour therapy (TFCBT) was reported by 11 local authorities (19%). TF-CBT is a skills-based, time-limited therapy for trauma-exposed children and adolescents, often delivered over 16 weeks. Although it has some promising applications, its evidence base for use with children who have experienced neglect is limited, with systematic reviews citing a lack of rigorous evaluations in this population (Leenarts et al. 2013).

Overall, the range of interventions, over and above usual social work and social work assistant (where social work assistants provide practical support to children and families under the supervision of qualified social workers) practices, offered to children and families where there are section 47-related concerns, is broad and often focuses on only one element: the family, parent or child. There is little evidence that the intervention approaches offered provide a holistic systemic approach to meeting the needs of children and families experiencing concerns that led to section 47 enquiries.

TABLE 2 | Themes identified during consultations.

Theme 1: Clear distinction between MST and MST-CAN
Theme 2: Establishing family needs
Theme 3: Good practice intentions
Theme 4: Evidence-based programmes
Theme 5: Collaboration, referral and coordination
Theme 6: Range of interventions

3.2 | Consultation Interview Findings

Six overarching themes were identified during consultation interviews, offering an insight into the nature of 'service as usual' in child and family social work. These themes illuminate the diverse ways in which families are assessed, supported and engaged with by services. The themes are summarised in Table 2 and explored below.

3.2.1 | Theme 1: Clear Distinction Between MST and MST-CAN

Participants consistently differentiated between MST and MST-CAN, noting variations in focus, methods and suitability for

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different family contexts. MST was largely associated with older children and adolescents displaying problematic behaviours that could lead to care, with outcome tracking focused on education, employment and offending. As Participant 008 explained, 'We monitor whether [young people are] at home at the end of treatment, whether they're in education or employment, [and] whether they've had any new arrests'.

In contrast, MST-CAN was described as more appropriate for younger children and for families where abuse and neglect were central concerns. Participant 002 noted that MST and MST-CAN were offered as two distinct interventions within their local authority, with MST-CAN specifically designed to address 'parental factors that contribute to child abuse and neglect'. They added that MST-CAN tracked different outcome domains, such as whether children enter care either during or after the intervention, as well as longer-term goals like family reunification and independent living.

MST-CAN was also seen as more explicitly trauma-informed than MST. While both models used structured tools to assess outcomes, MST-CAN was perceived as offering a more intensive, wraparound approach that addressed underlying trauma and parenting challenges. Participant 007 described the model as 'more trauma-informed ... and you were working with the parents and the children, not just focused on outcomes'. This shift—from a problem-solving model primarily addressing adolescent behaviour to a therapeutic, holistic response—was welcomed by professionals.

However, participants acknowledged that embedding trauma-informed practices within statutory social work services remained a challenge. The expectations and timescales of statutory child protection frameworks were sometimes seen as at odds with the relational and therapeutic ethos of MST-CAN.

In summary, while both MST and MST-CAN aim to support families in complex situations, they differ in emphasis. MST tends to focus on adolescents at risk of entering the criminal justice or care systems, with behavioural outcomes as key markers of success. MST-CAN, by contrast, concentrates more directly on child protection and family preservation, incorporating a strong trauma-informed lens and tracking broader outcomes related to family stability and child welfare.

3.2.2 | Theme 2: Establishing Family Needs

Establishing the needs of families emerged as a complex and dynamic process, shaped by the evolving evidence base, contextual knowledge and professional judgement. Participants highlighted the importance of grounding interventions in EBP, while also remaining responsive to individual family circumstances.

Several participants raised concerns about the consistency and clarity of the evidence used to inform decisions. Participant 007 questioned the reliability and transparency of the published literature, asking, 'Is it a clear evidence base or not? I think sometimes it could be questioned ... sometimes what's been published or not been published [i.e., whether all relevant evidence is publicly available], for instance'. This highlights a broader tension in EBP between the aspiration for rigour and the realities of limited or selective publication.

Despite these concerns, practitioners emphasised the importance of maintaining an iterative and flexible approach to intervention design. As Participant 007 explained, services need to be adaptive: 'We trial it and then change it and shift and move it as we go along'. They added that while there are 'really positive areas of practice', there is always scope for reflection and improvement. This mindset was echoed by Participant 008, who stressed the importance of 'working with families in a way that's fluid and responsive', particularly when needs change mid-intervention.

Tailoring interventions to the unique learning needs and challenges of families, including differing levels of readiness, engagement and capacity to absorb and apply content, was considered key. Rather than rigidly delivering predefined sessions, professionals spoke of a more bespoke approach. As Participant 007 put it, 'People will pick and choose the sessions they feel are gonna [going to] be most appropriate for the learning needs of the families and parents and so forth'. This customisation was felt to be particularly important for high-risk or high-need cases, such as those undergoing court proceedings.

Participant 009 elaborated on the role of targeted support, particularly in school and community contexts: 'It is part of universal services, but [...] we do have things that are more targeted'. This dual approach—balancing universal provision with more intensive, specialist responses—was seen as essential in addressing varied levels of family complexity.

Collaboration across sectors also emerged as a critical component in identifying and responding to family needs. Participants frequently referenced the importance of drawing on third-sector organisations and community-based expertise. Participant 007 described how their team worked alongside services such as 'Caring Dads, and Women's Aid', using service-level agreements to ensure access to timely and relevant interventions.

In summary, participants described a nuanced and evolving process of need identification. Although EBP remains important, there was a clear emphasis on flexibility, critical engagement with the research base, and tailoring support through multi-agency collaboration. The challenge, as participants framed it, is to balance structured frameworks with the agility required to meet families 'where they are'—acknowledging that no single model or intervention fits all.

3.2.3 | Theme 3: Good Practice Intentions

Participants consistently emphasised the importance of good practice when supporting families—particularly through individualised, flexible, culturally sensitive, collaborative and trauma-informed approaches. Interventions were seen as most effective when tailored to reflect a family's specific needs, cultural context and lived circumstances. However, participants also noted that delivering such bespoke support was often hampered by limited resources, time pressures and fragmented service landscapes.

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Tailoring interventions was viewed as central to effective support. Participant 006 stressed the importance of flexibility, 'It's whatever works best for that family'. They described how some families needed intensive, wraparound services, while others benefitted from targeted, practical support—such as introducing boundaries and routines. As Participant 006 put it, families do not always need 'really intense services', but still require responses that are carefully adapted to their situation.

Several good practice principles emerged in relation to 'service as usual'. Cultural sensitivity was highlighted as essential, particularly in work with migrant families or those requiring interpreters. Participant 008 asked, 'Is it regarded as acceptable within their culture?' This comment reflects the importance of recognising and respecting diverse norms and values. Collaboration—both with families and across professional disciplines—was another good practice principle raised in consultation. Relationship-based practice remained central in participants' minds. Participant 006 noted the limits of digital engagement, 'Parents don't wanna [want to] do it online … it doesn't sync in as much as when you build a relationship one-to-one'. Meanwhile, Participant 001 underscored the value of a multidisciplinary model in MST, 'We have people … from psychology, mental health, social work, education or youth justice'. This collaborative model was seen as critical to delivering holistic, coordinated support. Trauma-informed practice was also widely recognised as a marker of good practice, though its application was not straightforward. Participant 008 described its benefits in creating safety and promoting resilience. However, Participant 007 took a more critical stance, 'I think trauma-informed is just a key buzzword […] trying to work in a trauma-informed way is very difficult and sometimes goes against some of the statutory legislation that's in place'. This highlights how statutory procedures, which often prioritise risk management and legally mandated actions, can conflict with trauma-informed approaches that emphasise pacing, choice, and relational engagement.

While participants described a range of good practice examples, they also acknowledged significant systemic challenges in meeting them. The support landscape was frequently characterised as fragmented and conditional. Participant 005 explained that access to MST is limited to families already open to children's services: 'You don't have to be on a child protection plan, but you do need to be open to children's services'.

Other options, such as family group meetings, operated outside of statutory frameworks.

Participant 005 explained that while these non-statutory interventions can still be coordinated, the families involved are not formally 'open cases' with children's services (i.e., they do not have an active allocated worker or case plan). Cuts to preventative and youth services were viewed as a major loss. Participant 005 reflected, 'Youth clubs don't exist anymore […] kids vaping, drinking energy drinks on street corners and nobody's there for them to just have a chat with'. They also highlighted the poor availability of mental health services and the structural divide between health and social care, 'It's extremely poor … it's more of a health specialism rather than a social care specialism'. Timeliness also emerged as a barrier to effective delivery. MST008 flagged ongoing delays in accessing support, stating, 'Times, for example, are not good'. Such lags in service responsiveness were seen to undermine even the best intentions.

> In summary, participants described a shared commitment to personalised, trauma-informed and collaborative practice. Yet despite these aspirations, the delivery of good practice was often shaped — and constrained — by issues of access, service fragmentation, policy limitations, and the complex needs of families.

3.2.4 | Theme 4: Evidence-Based Programmes

Participants consistently underscored the importance of using EBP when supporting families, particularly within family centres and wider multi-agency settings. These approaches were seen not only as best practice but as essential to delivering effective, accountable interventions.

As Participant 008 explained, EBP is embedded in their day-to-day work, 'The evidence-based parenting approaches that we use within our family centres'. This emphasis on proven models reflects a wider professional commitment to ensuring that support is grounded in research and has demonstrable outcomes for families.

Trauma-informed care was also frequently highlighted as a recognised and evidence-supported approach. Participants described its application across a range of interventions, including domestic violence programmes that address both victim and perpetrator needs. Participant 007 described the breadth of this work, 'We do use domestic violence programmes both in terms of for women and men, both in terms of victims and perpetrators'. This example reflects a holistic understanding of trauma and its systemic impact—not only on individuals but on relationships and family dynamics.

While participants valued trauma-informed practice, several acknowledged its implementation was not always straightforward. Challenges around service availability, funding, and variability across sectors were noted. Participant 003 described a need for flexibility and shared problem-solving when services are lacking, 'How can we work collectively together to make sure we get the best outcome?' This comment speaks to a resourceful and collaborative ethos—where professionals strive to deliver trauma-informed support even when systems fall short.

The role of education in trauma-informed practice also emerged as a crucial factor. Participant 004 highlighted schools and early years settings as key partners in safeguarding, 'The importance of schools, nurseries and schools being involved in child protection plans'. However, there was variability in how trauma-informed practice was embedded across schools. As Participant 004 reflected, 'Some schools are more trauma-informed and more understanding of children's situations than others'. This observation underscores a perceived

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need for more consistent training and awareness across educational settings, particularly given the amount of time children spend in these environments.

In summary, participants conveyed a strong commitment to evidence-based and trauma-informed models of intervention. These approaches were seen as critical for supporting families effectively, promoting emotional wellbeing, and addressing complex needs in a coordinated and research-informed way. However, the delivery of such approaches depended heavily on interagency collaboration, the availability of appropriate services, and a shared understanding across professional domains.

3.2.5 | Theme 5: Collaboration, Referral and Coordination

Effective child protection and family support rely heavily on collaboration and referral systems that enable services to respond holistically and in a timely way. These processes require not just communication between professionals but the alignment of systems, priorities, and timelines—often across complex organisational boundaries (Munro 2011; Department for Education 2023).

Participants emphasised the importance of collaborative working as a cornerstone of child and family practice. Participant 005 noted that while information may be shared across adult and children's services, actual multi-agency engagement can fall short, 'We get communication and reports from adult services, but they don't always attend core groups' (i.e., meetings of key professionals responsible for implementing a child protection plan). This observation underscores a gap between information-sharing and true collaboration, where consistent participation from all involved agencies is essential to informed planning and decision-making.

Collaboration was described as more than just working alongside others—it required different disciplines bringing their expertise while maintaining shared accountability. MST-005 explained, 'We've worked in collaboration with our partner agencies who are part of the child protection plan. We do a joint piece of work, but in actual fact [we're] coming at it from completely different angles'.

Referral pathways were equally central to how participants navigated service systems. These processes ensure that families are matched with the right expertise at the right time—though several respondents raised concerns about thresholds, exclusions, and the delays associated with overloaded systems. Participant 008 highlighted the limits of family support services can safely manage, referring to MST-CAN eligibility criteria and indicating the need for targeted referrals for higher-risk cases: 'Exclude family support where there is active sexual abuse, active [ongoing] domestic abuse, and active [ongoing] parental psychosis'. Here, 'active' was used by the participant to refer to current, unresolved risk at the point of referral, rather than historical concerns or risks already being managed within specialist safeguarding or treatment pathways. Such comments reflect a safeguarding-led approach to referral, where clear risk boundaries guide decision-making—but also signal potential service gaps for families with complex, overlapping needs.

Participants also reflected on the systemic constraints that disrupt effective coordination. Participant 008 spoke candidly about delays in service provision and how these can clash with children's developmental needs: 'There are waiting lists for services... and for me that means that the timeliness of those interventions is not within the child's timeframe'. They added that efforts are made to mitigate these challenges through interagency planning: 'We do try to work closely with partners to try and prioritise that, if obviously that's something we need to do'.

Taken together, participants described collaboration and referral not just as best practices but as structural imperatives for managing risk, aligning support and ensuring families receive timely and appropriate help. However, their reflections also pointed to persistent gaps in coordination, often caused by siloed services, resource limitations and misaligned timescales.

3.2.6 | Theme 6: Range of Interventions

The interventions embedded within child protection plans are wide-ranging, and they address multiple domains in a child's life to promote safety, stability and wellbeing. Participants described a mix of statutory, community-based and therapeutic approaches, all aiming to meet the individual needs of children and families.

Community-based provision emerged as a key component of local support strategies. MST-008 highlighted how informal spaces can be used creatively to support engagement: 'There are organisations that engage with families in community settings, such as adventure play areas and playgrounds. These spaces not only provide opportunities for children to engage in play but also involve parents and other stakeholders in the process'. This kind of intervention was seen not just as recreational but as a platform for building trust and involving families in meaningful ways. Participant 008 added: 'They know, these families, that it's very key [that partnership working is important], that they're part of the delivery of those child protection plans, and that partnership working is really important that we do that'.

Participants also stressed the importance of consistent, statutory engagement with families. This involved both the legal mandate to monitor progress and a commitment to relational practice. Participant 007 explained, 'We're primarily dominated by our legislation. Obviously, that's statutory requirements — which is a minimum requirement of seeing the children every 10 working days, interacting with the family and [...] support[ing] the wellbeing and achieving positive outcomes for those families'. Such regular contact enables professionals to monitor risk and build rapport, although the focus on compliance with timescales may also limit deeper relational engagement in overstretched systems.

The type and intensity of services provided often depended on the specific needs identified in the child protection plan. Participant 005 described the division between school-based

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and specialist interventions: 'School nurses can offer certain services, but for more intense emotional support, there's a preference for referring to services like the Young People's Counselling Service'. This reflects a tiered approach to support, where universal services are complemented by targeted mental health and therapeutic input. However, there was variation in how family-focused work was embedded in plans. Participant 007 noted that while some family-led interventions exist, such as family group meetings, they are not consistently prioritised: 'There are some initiatives like family group meetings, but the focus on family elements is limited'. This suggests that although family involvement is widely recognised as good practice, implementation remains uneven, potentially reflecting local policy differences or resource constraints.

Overall, participants portrayed child protection plans as multilayered frameworks that aim to balance statutory requirements with responsive, relationship-based interventions. While there was evidence of creative and community-oriented work, much depended on local capacity, inter-agency coordination, and the availability of specialist services. The diversity in practice highlighted both the strength and fragility of current systems—strong, where professionals could draw on a wide menu of options and work collaboratively with families; fragile, where services were fragmented, under-resourced, or narrowly focused on compliance. These accounts underscore the importance of maintaining a flexible, child-centred approach within the constraints of statutory frameworks, and ensuring that families are not only included but meaningfully involved in shaping and delivering their plans.

4 | Conclusions

4.1 | MST Versus MST-CAN

MST-CAN is an adaptation of multisystemic therapy (MST), grounded in the same core principles of ecological, family-centred intervention; however, consultation data strongly supported the consensus in the literature (Bauch et al. 2022; Buderer et al. 2020; Hefti et al. 2020; Herbert et al. 2014; Swenson et al. 2010) that MST-CAN and MST are fundamentally distinct interventions. The most notable distinctions relate to target population, presenting concerns, and scope of intervention. While MST primarily serves adolescents exhibiting antisocial behaviours, often within a youth justice context, MST-CAN supports a broader age range (6–17 years) and is specifically designed for families where there are substantiated concerns of physical abuse or neglect. Although research has linked early maltreatment to later externalising behaviours (Pan et al. 2024; Esposti et al. 2020; Duprey et al. 2017), MST's primary focus remains the adolescent's behaviour, with parents engaged as part of a wider ecological system. In contrast, MST-CAN places greater emphasis on the behaviours, functioning, and support needs of caregivers, with the overarching goal of reducing maltreatment and improving child safety and well-being. This model embeds a strong trauma-informed lens, recognising how past trauma, loss and attachment disruption influence current family dynamics. These conceptual and practical differences were clearly echoed in participant consultations, which consistently distinguished between the focus, intensity and aims of the two programmes.

4.2 | Service as Usual

The consultation highlighted the complexity and variation in what constitutes 'service as usual' across English and Welsh children's social services. A key theme was the commitment to establishing family needs and delivering flexible, tailored interventions. Practitioners reported drawing on a broad range of EBP across both universal and targeted services, guided by local evaluations and practitioner experience. This aligns with research that advocates for personalised, relationship-based practice to meet diverse family needs (Ferguson 2016; Forrester et al. 2012). Many participants described good practice intentions, particularly the blending of trauma-informed care, strengths-based approaches and multi-agency coordination, with MST approaches often cited as exemplars of person-centred and ecologically grounded working. However, participants contrasted these accounts of good practice and MST-informed working with experiences of fragmented provision, characterised by differing service thresholds, resource constraints and the erosion of preventative support. MacAlister (2022) raised similar concerns in his independent review of children's social care, highlighting how current structures fail to accommodate the messy, human realities of family life—leading to fragmented response and inconsistent support. Participants raised concerns about the decline in community-based services such as youth clubs and early help provision—a trend reflected nationally and often attributed to prolonged austerity (Webb 2022; Cummings 2018; Ellison and Renton 2018; Featherstone et al. 2014). Accessibility remains a challenge, with inflexible service hours and inconsistent implementation of inclusive practices, such as interpreter access and cultural responsiveness, hindering equitable engagement.

Participants also underscored the importance of EBP within a trauma-informed, ecological framework. Yet, access to these services was variable and often limited, requiring frontline professionals to take a creative and resourceful approach to meeting children's needs, echoing the tension described by Hingley-Jones and Ruch (2016, 245) between the emotional and procedural dimensions of social work. These qualitative insights were supported by quantitative data that showed that while 72% of surveyed local authorities reported delivering family-focused interventions, only 49% did so for parents and 33% for children. This imbalance highlights not only variation in focus but also potential gaps in service provision for individual children themselves.

Finally, while multi-agency collaboration, referral and coordination were widely recognised as essential for delivering comprehensive support, in line with the Working Together to Safeguard Children document (Department for Education 2023), participants often described these partnerships as underdeveloped or inconsistent. Accounts suggested that professionals frequently approached family needs from differing disciplinary perspectives and organisational priorities, reflecting both the potential strengths and coordination challenges of multidisciplinary working. These accounts

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mirror national reviews identifying similar systemic tensions in child protection (Dickens et al. 2022; Neil et al. 2019). Despite this, professionals conveyed a strong commitment to working relationally and holistically, even in the face of structural and resourcing challenges.

The broad range of interventions delivered, from statutory safeguarding responses to school-based and community-led supports, demonstrates this commitment. Nonetheless, concerns persist about inconsistencies in the balance of child-, parent- and family-focused interventions, and about the continued reliance on US-based models, which may not fully reflect the complexity of family systems or cultural contexts in England and Wales (Brown 2021).

Taken together, these accounts highlight several fundamental systemic constraints shaping service delivery, including fragmentation across services, threshold-based access to support, resource pressures, and variability in the availability and continuity of preventative and evidence-based interventions. These constraints were evident across all domains of service provision and were seen to shape the nature and consistency of support offered to families.

4.3 | MST-CAN Versus Service as Usual

The consultation findings indicate that MST-CAN represents a significantly different model of service delivery compared to 'service as usual' within children's social services in England and Wales. While both share commitments to supporting families through a range of interventions, MST-CAN operates within a highly structured, intensive and time-limited framework with specific fidelity requirements. In contrast, standard services often deliver more fragmented and less intensively resourced support, shaped by local authority priorities, statutory thresholds, and resource availability.

One key difference lies in how intervention is conceptualised and delivered. MST-CAN's model is embedded in a systems-based, trauma-informed framework that offers daily clinical oversight, home-based delivery and 24/7 on-call support—features rarely found in standard statutory or early help provision (Swenson et al. 2010; Herbert et al. 2014). Moreover, MST-CAN requires integration across mental health, social care, and youth justice, ensuring comprehensive case formulation and coordination from the outset. By contrast, our consultation found that multi-agency coordination in 'service as usual' was often inconsistent or dependent on individual relationships rather than embedded processes (Neil et al. 2019; Dickens et al. 2022); despite good intentions for collaborative working.

Another major contrast between MST-CAN and 'service as usual' in children's social care in England and Wales is the focus on carers' behaviour and capacity to parent safely. While mainstream social work increasingly draws on trauma-informed and strengths-based approaches (Ferguson 2016; Toros and Falch-Eriksen 2021; Asmussen et al. 2022), MST-CAN delivers manualised interventions specifically targeting parental mental health, substance misuse, and trauma history as direct pathways to reducing child maltreatment (Swenson et al. 2010; Buderer et al. 2020). This contrasts with the more varied and sometimes reactive nature of family-focused interventions available through standard services, where support may be less intensive or less targeted depending on thresholds and resourcing.

Finally, MST-CAN's focus on fidelity and outcome monitoring distinguishes it further. While many services in England and Wales strive to implement EBP, they are not always supported by the infrastructure to measure adherence or long-term outcomes systematically. The MST-CAN model requires rigorous outcome tracking and clinical supervision, contributing to its evidence base but also requiring a level of organisational capacity that may not be mirrored in routine provision (Brown 2021; Hefti et al. 2020).

4.4 | Pilot Efficacy

While MST and MST-CAN share a theoretical foundation rooted in ecological systems theory, their differing target populations and therapeutic focus support the need to evaluate MST-CAN specifically in England and Wales. MST targets adolescents with histories of antisocial behaviour, whereas MST-CAN is designed to support families where children aged 6–17 years are at risk of abuse or neglect, through a trauma-informed and multi-agency approach (Swenson et al. 2010; Herbert et al. 2014). Existing trials of MST conducted in England within a UK policy and funding context (Fonagy et al. 2018, 2020) focus closely on young people in the youth justice system and do not address the broader maltreatment-related needs that MST-CAN is designed to meet.

Our findings suggest that a pilot RCT of MST-CAN is *feasible*, but only with careful planning, robust infrastructure, and sustained collaboration between delivery teams, commissioners, and research partners. Given the complexity of the intervention and its potential impact on high-risk families, we recommend an internal pilot across three sites to assess implementation processes, fidelity and stakeholder acceptability. This approach would allow researchers to determine whether progression to a full-scale RCT is warranted, following clear stop/go criteria in line with guidance on feasibility trials (Eldridge et al. 2016).

The primary outcome of any future trial should align with MST-CAN's core aim of reducing physical abuse and neglect, using appropriate indicators of maltreatment recurrence, severity or risk. Key secondary outcomes should include improvements in parenting capacity and child–parent relationship quality, alongside mental health outcomes for both children and carers. Given the established links between maltreatment, behavioural difficulties and later offending (Pan et al. 2024; Esposti et al. 2020; Duprey et al. 2017), downstream child behavioural outcomes may also be included as secondary outcomes. These may include externalising behaviours measured by the Strengths and Difficulties Questionnaire (SDQ). A detailed process and implementation evaluation should accompany the trial to explore contextual barriers and enablers, examine fidelity to the model, and assess perceptions of usefulness and accessibility among families, practitioners and commissioners. This mixed-methods process is crucial for interpreting trial outcomes and adapting MST-CAN for delivery within England and Wales (Craig et al. 2018; Moore et al. 2015).

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5 | Limitations

It should be acknowledged that this study was based on a relatively small sample of professionals, and while care was taken to include different roles and regions, it may not reflect all perspectives across England and Wales. Additionally, the sample included an overrepresentation of participants who had prior familiarity with MST-CAN, either through training, delivery or evaluation, which may have introduced a positive bias in how the model was perceived or contrasted with existing services. The focus on practitioner viewpoints also limits insight into lived experience. Future research, including any pilot RCT, should include the voices of children and families directly (Izzidien et al. 2024). Finally, while participants were encouraged to reflect candidly, social desirability or institutional positioning may have shaped how they reported on service quality and intervention needs (Featherstone et al. 2014).

6 | Summary

In summary, MST-CAN is a distinct and structured intervention that offers a more integrated and intensive approach than the current service-as-usual provision in England and Wales, particularly for families with entrenched safeguarding concerns. While promising, its suitability and effectiveness in England and Wales require rigorous evaluation. A carefully designed pilot RCT represents the most appropriate and ethical next step in this trajectory.

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Ethics Statement

This study was conducted as part of a wider feasibility and consultation exercise and was not classified as research under the Health Research Authority. As such, formal ethical approval was not required. However, all work was carried out in accordance with recognised ethical standards for working with professionals in child protection and care-experienced communities, including informed consent, voluntary participation and secure data handling procedures.

Consent

All participants were provided with clear information about the aims and use of the consultation, and gave informed consent prior to participating.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that supports the findings of this study is not publicly available due to confidentiality agreements with participating local authorities and ethical restrictions relating to the sensitivity of child protection case data. Anonymised excerpts from qualitative interviews may be available from the corresponding author upon reasonable request, subject to approval by the relevant ethics committee.

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