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**JOURNAL FULL TITLE:** Journal of Biomedical Research & Environmental Sciences

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BRIEF REPORT

# Joint Parent-child Therapy for Children in Vulnerable Families

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## Abstract

Three inter-related topics have attracted renewed attention; early intervention therapy for vulnerable children, joint parent-child therapy for vulnerable children, and therapy for court-involved families. Commentators recognise that the three forms of therapy introduce complexities that do not arise when clinicians provide treatment to one client with a diagnosed condition, including ethical dilemmas. This article briefly reviews recent publications on joint parent-child therapy for families where children are vulnerable and identifies topics that require further research.

## Introduction

There has been growing interest in provision of early intervention therapy for children who live in families where the parenting a child receives is inadequate to meet their needs and suboptimal rather than being abusive. Research indicates that children who receive inadequate parenting are more likely to develop a mental disorder [1,2], and possibly are more likely to experience maltreatment due to inappropriate parenting [3]. Families that are involved in either a Family Law court or a Child Protection court are called court-involved families and children who live in these families are more likely to receive inadequate parenting compared to peers who live in other families [4]. A family-oriented court will make decisions both about whether a family or child is required to participate in early intervention therapy to improve family functioning, where the child should live, who the child will have contact with, and who will make decisions about the welfare of the child.

The aim of this brief report is to summarise recent advances regarding submission of treatment reports to family-oriented courts. A treatment report is a report written to be submitted to

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DOI: 10.37871/jbres2308

Submitted: 16 June 2026

Accepted: 23 June 2026

Published: 24 June 2026

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### Keywords

- Inadequate parenting
- Court-involved family
- Early intervention therapy
- Resist / refuse dynamics
- Cumulative harm
- Dual involvement children
- Ethical dilemmas

VOLUME: 7 ISSUE: 6 - JUNE, 2026



**How to cite this article:** Tustin RD. Joint Parent-child Therapy for Children in Vulnerable Families. J Biomed Res Environ Sci. 2026 June 24; 7(6): 6. Doi: 10.37872/jbres2308



a family-oriented court that describes progress made by a client on topics of concern to the court.

This report summarises developments on four topics that are relevant to clinicians who provide treatment reports to family-oriented courts. The topics are: (a) types of early intervention therapy; (b) parent-child relationships when a child resists spending time with one parent despite a court order, called resist/refuse dynamics; (c) impact on a child of increasing numbers of risk factors that require therapy, called risk of cumulative harm; (d) the plight of children who are removed from parental care and then offend, called dual involvement children; (e) impacts on children of not providing early intervention therapy; and (f) ethical dilemmas that can arise when a clinician provides simultaneous and coordinated therapy to two members of a family.

Literature is cited that summarises developments on each topic.

## Types of Early Intervention Therapy

Early intervention therapy is therapy that is provided at an early stage of a person developing a disorder, including before a person meets all criteria for exhibiting a mental disorder. Carr [5,6] distinguished two forms of early intervention therapy that can be provided for children who receive inadequate parenting; treatment for an individual child, and joint parent-child intervention, where therapy aims to produce simultaneous and coordinated changes in the behaviour of both parent and child participants to reduce dysfunctional interactions that occur between the pair and that result in a disorder. The second form of therapy is also called systemic parent-child therapy as the therapist aims to change one component in a family system.

Parenting is described as inadequate if parenting practices do not meet all of a child's

needs, but practices do not amount to abuse or neglect.

## Resist / refuse Dynamics

././..0003/000000000000000000 inadequate parenting for children. Mechanisms that transmit malfunction were identified in the review that concluded the inadequate parenting practices appear to be treatable.

## Risk of Cumulative Harm

Tustin [10] reviewed research about risk factors for children who live in court-involved families and identified five common risk factors for children who live in families involved with a family law court or a child protection court. The common risk factors are: (a) parental difficulty in managing the child's behaviour; (b) some parental mental health issues; (c) some parental substance misuse; (d) some exposure to domestic violence; and (e) co-parenting difficulties. Tustin [10] drew attention to the concept of risk of cumulative harm which indicates that risks to a child increase with the number and severity of risk factors a child is exposed to. However, research has not yet identified assessment instruments that identify thresholds to distinguish between families where it is safe for a child to live with their parent while therapy is provided, and families where a child is at an immediate risk of unacceptable harm and needs to be removed from parental care [11]. The lack of assessment instruments that set objective thresholds is significant for family-oriented courts that are required to make decisions that impact significantly on children who live in court-involved families, and may contribute to the unnecessary removal of children from parental care, where child removal becomes a method of first resort rather than last resort. Tustin [10] and Greenberg, et al. [12,13] hypothesised that early intervention therapy is effective in changing inadequate parenting practices in families where children experience



a moderate number of risk factors that are present at a moderate level of severity, provided therapy is based on a careful assessment of risk factors and is delivered by practitioners who are well informed about both psychological models of intervention and relevant legal principles. However, it is difficult to assess this hypothesis about treatability in the absence of objective measures of risk factors for children.

Introducing an objective instrument to assess number and severity of risk factors for children would help courts to distinguish between families where early intervention therapy is safe for children, and families where the risk of harm is unacceptable, so it is necessary to remove a child from parental care. Stating standards expected for adequate parenting on each of the risk topics above will assist therapist to aim therapy at achieving clear goals.

## Dual Involvement Children

Tustin [14] discussed research findings that a proportion of children who are removed from parental care and placed into long-term state care later become involved with the juvenile justice system following their offending. These children are called dual-involvement children or cross-over children [15,16] as they become involved with both a child protection court and a juvenile justice court. Tustin [14] reviewed research about psychological interventions that are effective with court-involved children and identified fifteen evidence-informed psychological models that promote the healthy development of vulnerable children. The review summarized effect sizes associated with each intervention model and found that no single model achieved sufficiently high effect sizes to be considered a predominant model to guide selection of interventions. Tustin [14] proposed a framework for assessing risk factors that grouped risk factors as parental risk factors, childhood risk factors and peer risk factors. Tustin [14] concluded that an effective system of

intervention for vulnerable children requires a tier of interventions commencing with universal interventions that are available to all families that are supplemented by targeted interventions for families where children are at heightened risk due to a higher number of risk factors and different types of risk factors.

Tustin [14] drew attention to several parenting topics that are under-researched including: (a) limited research into parenting practices to teach children to manage emotions that emerge during the mid-childhood years; (b) limited research into the assessment and appropriate parenting of children who display distinct temperaments; (c) limited research on effective parenting when a child displays a disorganized attachment pattern; and (d) limited research about parenting and therapy for children who display co-existing internalizing and externalizing behavior disorders. Tustin [14] also identified some potential therapies as being under-developed including application of principles from attribution theory that analyze how parents explain their child's misbehavior, models that promote parental reflection about parenting practices they use, and differential therapy for children's reactive aggression and proactive aggression.

## Implementation of Early Intervention Therapies

Macvean, et al. [17,18] reviewed evidence about parenting programs for vulnerable children and identified 81 published parenting interventions for children aged up to 6 years that appeared relevant for court-involved children who are vulnerable both to a risk of being maltreated and to developing a mental health disorder. They found the most effective interventions were delivered both in a clinic and in the family home and were delivered by qualified professionals who operated independently of the child protection agency that prosecutes families. Macvean, et al. [17]



identified 17 common components of effective parenting interventions.

However, Wade, et al. [19] found there was only low use of evidence-based early intervention programs for vulnerable children in Australia. They discussed possible explanations for the low use of early intervention programs with vulnerable children who live in court-involved families. One explanation involves a shortage of practitioners who are qualified to provide interventions. Another explanation is that research indicates that effective interventions are individualized for each family based on an assessment of risk factors, but authors of some universal parenting programs require their programs to be implemented in a standardized way to meet fidelity requirements to facilitate scientific research.

## Ethical Dilemmas

Two further explanations of why clinicians are reluctant to provide early intervention therapy for children who live in court-involved families can be identified. One explanation is there is limited research and education about legal concepts clinicians must understand when they provide testimony in court including by writing a treatment report [20]. Legal concepts that clinicians need to understand when providing therapy for court-involved families include parenting capacity and definitions of emotional abuse and neglect used in the child protection system.

A second explanation of the reluctance of clinicians to provide early therapy for court-involved families involves the lack of Practice Guidelines that inform clinicians about best practices to manage ethical dilemmas that arise when they provide joint parent-child therapy. Carr [5] and the AFCC [21] drew attention to the observation that different ethical principles apply when a clinician provides therapy for one person or provides joint therapy for two

members of a family. When a therapist has two clients who are members of the same family, it is possible for an ethical dilemma to arise if an intervention that is in the best interests of one family member is not in the best interests of the second family member. Authorities recognize that this ethical dilemma is likely to arise if a clinician identifies a risk to a child that was unknown to a court, as this can raise a dilemma between breaching confidentiality concerning information provided by a parent and prioritizing the safety of a child. Although legislation in many jurisdictions prioritizes the best interests and safety of a child, Greenberg and Gould [22] and Tustin [20] note that a parent who is dissatisfied with a treatment report might perceive that the clinician has acted contrary to the interests of the parent and might lodge a complaint about unprofessional conduct to a clinician's regulatory authority.

The AFCC [21] has provided generic principles for clinicians to consider when they provide joint parent-child therapy for children who live in court-involved families. However, it appears that few authorities have provided Practice Guidelines that provide clear advice about what are best practices for clinicians to follow that are endorsed in their jurisdiction to manage ethical dilemmas that arise when providing joint parent-child therapy. The lack of clear Practice Guidelines deters many skilled clinicians from providing therapy for children in court-involved families due to a concern that a complaint might be lodged with their regulatory body that the clinician did not follow what a lawyer considers to be an unwritten best practice to manage an ethical dilemma.

Further research is needed about what are considered to be best practices by clinicians for managing ethical dilemmas in each jurisdiction to guide clinicians who make professional judgments about how best to manage ethical dilemmas that arise while providing and reporting joint parent-child therapy.



## Conclusion

The findings of this brief review are summarised. Joint parent-child therapy that aims to change dysfunctional interactions and that is provided before either a parent or child has developed a mental disorder is established as an effective form of intervention. Joint parent-child therapy can be applied to court-involved families where a child resists spending time with one parent despite a court order to do so. The risk of harm to a child increases with the number of risk factors in a family, and this complicates provision of joint parent-child therapy. A proportion of children who are removed from parental care go on to commit offences and are called dual-involvement children as they are involved in both a child protection court and a juvenile justice court. Children who have potential to become dual-involved are prime candidates to receive parent-child therapy before they are removed from parental care. Research finds that despite the availability of effective parent-child therapies, delivery of these therapies to court-involved families is not high. Recent research highlights ethical dilemmas that can arise when a clinician provides joint parent-child therapy to two members of the same family and highlights a need for jurisdictions to provide Practice Guidelines that clarify best practices to be used by clinicians who provide joint parent-child therapy for court-involved families.

The lack of Practice Guidelines that provide certainty to clinicians about best practices for managing ethical dilemmas that arise when providing joint parent-child therapy for court-involved families is an obstacle that inhibits skilled clinicians from providing effective therapy for very vulnerable children. One consequence of the reluctance to provide effective therapies while families are intact is that children are removed from parental care under a court order, then become more distressed and progress to offending. It is likely

that analyses of costs will find that the cost to taxpayers of providing custody for children who are been removed from parental care before effective early intervention therapy was provided will greatly exceed the cost of providing early intervention therapy, especially if children are placed in accommodation with rostered staff rather than in foster care.

In conclusion, the efficacy of joint parent-child therapy for children who are vulnerable due to inadequate parenting practices highlights the fact that several significant topics are under-researched. Further research is required on three inter-related topics: the nature of interventions in joint parent-child therapy for court-involved families; the efficacy of specific interventions; and best practices to manage ethical dilemmas that arise to meet the legal and professional requirements in a jurisdiction.

## Conflict of Interest

No conflicts of interest.

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