EFFECTIVE STRATEGIES FOR WORKING WITH CHILDREN AND FAMILIES: ISSUES IN THE PROVISION OF THERAPEUTIC HELP

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This paper reviews the ability and effectiveness of different kinds of intervention in cases of child abuse. It gives an account of the kind of work carried out in Britain and considers the question of which professionals and which agencies become involved in providing therapy for children and families.

While local authority social workers are still very much involved in Providing Psychosocial help to children and families where abuse has occurred and are protagonists in the investigation of abuse, there is some evidence that social workers from voluntary agencies and some child psychologists are increasingly providing therapeutic input. Approaches include play therapy and family therapy as well as cognitive-behavioural therapy. Organisational issues, in particular the purchaser/provider split and changes in funding in the UK also affect the provision of therapeutic help.

A further issue concerns the organisation and content of training for therapeutic intervention. The experiences of multi-disciplinary teaching on a post-graduate training course are reviewed. We conclude that the extent and nature of child abuse, and more specifically child sexual abuse, necessitates skilled, planned intervention from a range of professionals. No one agency or discipline is identified as the ideal provider of therapy, though certain trends can be discerned.

Policies concerning child maltreatment have in the UK focused increasingly on that Part of the process which involves identification and investigation and the immediate Protect the child. This emphasis, symbolised in the shift of terminology from child abuse with its socio-medical connotation to the social-legal framework of child protection, has been well-charted by writers such as Parton (1991) and emphasised in such central government documents as the Guidelines for Assessment (1989) and the Memorandum of Good Practice (1992). Thus, although historically much therapeutic work has been undertaken by social workers (and practice), the role of the British social worker in local authority social services departments is becoming more that of case manager and less that of therapist.

We shall in this paper argue that the major changes in organising the provision of services which are embodied principally in the National Health and Community Care Act 1990 and the Children Act 1989 mark something of a watershed for British social work in general and child protection social workers in particular. These changes, as we shall demonstrate, suggest a much clearer demarcation between the purchaser of services, normally the local authority, and the provider of services, which will usually be those in the voluntary or not-for-profit sector. We shall maintain that even if social workers predominantly act as 'brokers' and purchase psychosocial help from others on behalf of children, parents and their agency, they need nonetheless to be well-informed about which approaches are appropriate with which problems and with which clients.

We shall develop this argument in three stages. First, by examining

the shifts in the role of the social worker in the statutory setting, and the implications that this may have for the way in which therapeutic services are organised. Secondly, by looking at which forms of psychosocial help have historically been provided, and by whom. And thirdly, by considering some of the knowledge, tasks and training that the social worker's new role may necessitate in relation to providing therapy for the abused child. In the context of this paper, we consider therapeutic help as those interventions directed towards bringing about change in the individual or family system, rather than those concerned with arrangements for the overall care of the child, such as the provision of substitute care in the form of fostering or adoption. This is not to say that such arrangements and tasks do not need to be carried out 'therapeutically'; on the contrary. We consider that they are, however, qualitatively different from planned, face to face practitioner-client sessions. This distinction is also clear, for example, in Rogers (1976) and in texts on the practice of fan-lily therapy in social work (e.g. Dale et al., 1983; Howe, 1989). For a fuller discussion of the distinctions between therapeutic work with children and play related communications and assessment see chapter one in a book on play therapy by one of the present authors (Wilson et al., 1992).

In a manner which so often characterises service provision in the M the existence or otherwise of a particular form of help in a locality has traditionally depended as much on the particular interests of individuals working in an agency as on any centrally devised policy and planning. In addition, the high cost and under resourcing of certain provisions such as the psychiatric service has meant that time-consuming and therefore expensive interventions (such as sustained therapeutic help) have often been undertaken by less highly qualified individuals, with professionals such as psychiatrists involving themselves to a greater extent in diagnostic activity. Therapy involving any one of the approaches discussed later may be offered by child psychiatrists, child psychologists, social workers or community workers, both of the latter probably but not necessarily having acquired some form of post-qualifying training in the particular approach offered. These professionals, in turn, may be working in the statutory or voluntary sector, and may be employed by either the NHS, the social services, or one of the voluntary organisations. Thus, a child or family when referred for help could be treated by any of the following agencies and professionals:

1. child guidance clinic: psychiatrist, psychologist or social worker;
2. social services, local team: social worker;
3. hospital based clinic: psychiatrist, social worker, specialist nurse;
4. voluntary, 'not-for-profit agency: social worker, psychologist;
5. family centre: statutory, voluntary and 'not for profit! agency: variety of workers.

It is within this somewhat piecemeal and haphazard style of provision that the two major pieces of legislation need to be understood. In the National Health Service and Community Care Act 1990, the government makes an explicit commitment to the independent sector, setting out as a key objective for service delivery the promotion of:

... the development of a flourishing independent sector alongside good quality public services ... social services authorities should

be 'enabling' agencies. It will be their responsibility to make maximum possible use of private and voluntary providers and so increase the available range of options and widen consumer choice (p.5).

Although this is less clearly spelt out in the Children Act 1989, there is also here an emphasis on the development of a mixed economy with local authorities using and co-operating in the provision of a range of services. For example the Act places a duty on the local authorities to `facilitate the provision by others (including in particular voluntary organisations) of services which the authority has power to provide' (17 (5) (a)).

Although it will still be possible for services to be provided from within the statutory agency itself, in practice both Acts are likely to enhance the purchaser/provider split, with the local authority and Health Service acting as purchaser or facilitator of services and a commensurate development in the private or not-for-profit sector. Under this legislation, the provision of care will thus be seen as pluralistic, involving a range of different kinds of help and support and the targeting of specific dimensions of family life.

'PURCHASING' AND 'PROVIDING

The new purchaser/provider split (most recently and more hopefully called a `system') will inevitably involve some prioritising of different activities. It is notable that the parts of the Children Act concerning prevention or family support are in general couched in more permissive terms than other parts of the Act. Thus, as what Tunstill and Stace (1990) describe as amore aggressive contracting-out culture develops, the provision of therapeutic help for children and families may well come to be regarded as a dispensable option, particularly in a period of financial constraint. Equally, because of the greater financial accountability of the two main statutory bodies involved, in areas where responsibilities have historically overlapped, such as therapeutic provision, we are likely to see a greater reluctance to fund on the part of each service. There is already some, admittedly anecdotal, evidence of the difficulty in organising therapeutic help, because neither health authority nor social services are willing to accept responsibility for funding it.

THE CHANGING ROLE OF THE SOCIAL WORKER

The social worker in the statutory setting has had, as key worker in child protection cases, a pivotal role in devising and managing what are described, in rather optimistically concrete terms, as 'care packages' for children assessed as maltreated and in need of further help. Changes involved in policy following from the new legislation do however signal an increased emphasis on the role of social worker as case manager, involving the dual role of assessor and enabler with the 'ability to make a proper assessment of need and to ensure that a range of services is available to meet that need' (James and Wilson, 1991).

As we suggest above, this role is not new. However, its emphasis does require greater clarification of the skills involved in undertaking it. In relation to working in child protection, we see these skills as involving

1. an understanding of the objectives for referral;

2. a knowledge of different services available;
3. an understanding of the basis on which a particular form of intervention should be selected.

Understanding the objectives of the referral

Although this might seem self-evident, it is apparent that some confusion exists as to what may be achieved in a referral for therapeutic work, and that on occasion referrals are made with the, often not articulated, purpose of gaining confirmation, or further evidence, that the child in question has in fact suffered abuse. This is clearly another example of the way in which pressures to undertake the initial investigative stage `correctly' so that evidence can be gained which can be used in criminal proceedings, may distort the stage of the process which is or should be directed towards helping the child. It is important therefore for the referrer, usually the social worker as key worker, to distinguish therapy from validation interviews or diagnostic interviews. It is true that both these may, sensitively conducted, provide some relief from what is burdening the child, and the acknowledgement of the child's feelings about, for example, an abusive experience may be a source of emotional strength. There are other similarities between these interventions and therapy: all must have a clear professional remit and purpose, be set within time boundaries and recognise the limits of confidentiality. Frequently, too, there are similarities in methods and approach, since both may utilise toys and Play to facilitate communication and diagnosis.

However, as one of the present authors argues elsewhere (Wilson 1993) the differences are considerable. Diagnostic or validation interviews are usually brief, and their focus is normally decided by the practitioner, whose main purpose is to obtain information and make a decision. In therapy, by contrast, the aim is to help the child resolve difficulties in his or her current functioning, many of which have arisen because of distortions in early primary relationships. During the process, issues concerning the specific event of abuse, or the child's wishes and feelings for example concerning future placement with the abuser or other carer, may or may not emerge directly, although it is of course highly probable that during therapy the therapist will gain information about these things, and may help the child address them. It is a mistake therefore:

... to refer the child for therapy with the expectation of confirming or refuting allegations of abuse: these may or not be the concerns which are uppermost in the child's mind, may or may not emerge during therapy, and are certainly not its purpose (Wilson, 1993).

It is also vital, when making a referral, to ensure that someone, usually the key worker, retains the overall management of the case, and the social worker needs to distinguish this management role from that of the therapist. We are not arguing here that social workers should not undertake therapeutic work, but simply that difficulties may arise if the two roles are vested in one person. There are, invariably, a range of tasks, from initiating court proceedings to planning placement and arranging support services for therapy, which need to be undertaken by the case manager. In addition, and most importantly, where for example different modes of therapy are offered to the family, there needs to be someone who can co-ordinate and manage what has been described as the constant tension between and interdependence of personal intrapsychic feelings and expression of

feelings within relationships' (Glaser and Frosh, 1988) while at the same time maintaining confidential boundaries between the various therapeutic relationships. Braverman et al. (1984) for example describe graphically some of the problems which may arise in the private sector where work undertaken in family therapy is unwittingly undermined by the individual play therapist. Problems which might have been avoided had there been someone in the role normally taken by the key worker in statutory settings who could have anticipated and explained these divergences to the different therapists.

A knowledge of the range of services available

Although practitioners may not be undertaking therapeutic work themselves, they need to know what kind of approaches and services are available and where, which theories and research underlie them and how (even whether) the work will be evaluated. It is stoking today, in a climate of value-for-money, that agency managers are often prepared to pay considerable sums to finance interventions which they are ill-equipped to judge undertaken by another agency over which they have little or no direct control. We review some of the more widely practised and purchased therapeutic services, briefly considering their focus and place in effective child protection work.

PLAY THERAPY

Individual work with children which utilises play as the principle medium through which change is achieved has been practised in the UK for many years by professionals in a range of settings. A number of different approaches have been used, which include the psychoanalytically derived methods, the structured approaches described by Oaklander (1978) and the non-directive methods derived from Rogers (1976) and Axline (1947). However, the underlying principles and differences of these methodologies are often not well-defined, reflecting the somewhat eclectic approach which so often characterises practice in the UK There has also been, in contrast, say, with the behavioural approaches, a lack of systematic evaluation of the effectiveness of play therapy. Although studies are currently being undertaken at the Institute of child Health and at the Tavistock Clinic, it seems unlikely that these will produce any systematic evaluation, since the studies are not differentiating between the different methods of play therapy.

A further problem in the development of the practise of play therapy has been the absence of appropriate training courses in the UK.

The increasing importance, nonetheless, which is being attached to play therapy is reflected in the formation, last year, of the Association of play Therapists in order to provide a forum for communication, support and the development of professional training and practice. A number of publications (West, 1992; Wilson et al., 1992; Jennings, 1992) on play therapy published in the last eighteen months are a further indication of growing interest in the field.

In our view this approach holds much promise for the future, both because it is a relatively short-term intervention, and because, since it ensures that the child is respected, listened to and not intruded upon, it is well-suited to work undertaken in a statutory context.

Particularly where children have been the victims of abuse, the

resolution of the trauma inherent in the experience frequently
requires the formation of the kind of intensive sustained
relationship with the therapist, which is available in individual
therapy. In this, as Glaser and Frosh suggest, the child can focus
'not only on the abuse and sexuality, but also on other experiences,
relationships and the child's view of herself (1988. p.147). The
individual relationship created between child and therapist provides
the privacy and time required to enable the child to address deeper
levels of experience and to allow negative and angry feelings, as
well as more positive or ambivalent ones, to emerge. Although
treatment which addresses patterns of interaction between family
members is also often indicated, especially in cases of incestuous
abuse, it may be argued that as a general rule such intervention
should be in addition to, rather than instead of, individual work
with the child.

FAMILY THERAPY

family therapies have mushroomed over the last 20 years. In many ways
the literature formalised and gave theory to much family work already
being carried out by Practitioners. It also stressed the importance
of seeing the individual in the context of a family system within
multiple relationship systems (Satir, 1967). models of family therapy
quickly became popular in social work in a number of countries
including the UK where many social workers have practised some form
of family therapy since at least the early seventies (see Street and
Duncan, 1988. for a review of family therapy in Britain). The
development of the `Milan' school in Italy influenced practice. In
the UK, as we suggested earlier professional demarcations have been
less marked than elsewhere, and some of the leading practitioners,
for example Burnham, (1986), are social workers by training.

Despite its undoubted popularity as a method of intervention, at
least among professionals, there has been criticism of mechanical
methodologies associated with some forms of family therapy on the
grounds that consumers have found the approach bewildering and 'user-
unfriendly, that it is costly in terms of workers' time and that it
has not been evaluated for effectiveness (Vetere, 1988; Howe, 1989.)
Where families are selected for suitability, some forms of family
therapy which concentrate on problem-solving have been found to be
effective in bringing about positive change in abusing families
(Haley, 1976; Falloon, 1988).

Care must certainly be taken to give sufficient protection to the
child in any family approach, desirable though the latter might be
(Parton, 1985). Inquiries into errors of mismanagement in child abuse
cases resulting in the death of a child have underlined the
importance of the question 'who is the client' (e.g., the Beckford
Report, 1986; Bentovim and Jacobs, 1988). The Children Act 1989
reinforced emphasis on the child's interests being paramount, (in
this echoing the Children's Act 1975) while at the same time
stressing the need for professionals in child care to work in
Partnership with each other and with parents. Family therapy is
changing to take these lessons into account (Bagarozzi and Anderson,
1989). Organisational changes outlined elsewhere have resulted in
Some not-for-profit agencies (e.g. the NSPCC) specialising in
providing both the Practitioners and the facilities for the practice
of family therapy.

BEHAVIOURAL AND COGNITIVE-BEHAVIOURAL APPROACH TO CHILD MANAGEMENT

AND PARENT TRAINING

Many social workers and others use a vaguely behavioural approach without being conscious of the fact. Lack of knowledge can produce some basic errors. The approach is much more effective, and lends itself to assessment linked to evaluation, if properly learned and applied. (Sheldon, 1982). The principles of operant beaming and social learning theory are particularly relevant to much work with families where there are child behaviour problems, poor parenting and risk of neglect or physical abuse, especially where behavioural intervention is within an 'ecological' approach taking into account individual, family community and societal factors. (Gambrill, 1983a; 1983b).

Teaching parents how behaviour is learned, reinforced and maintained; showing them how they can make mealtimes, play, bedtimes and shopping expeditions pleasurable instead of being stressful and aversive experiences can, as part of a carefully planned programme, be very effective (Hudson and Macdonald, 1986. See also the literature of the Centre for Fun and Families, Leicester - an introduction to the work of this Centre is given in the Behavioural Social Work Review, 1990,12(1), pp.20-24). An example of intervention in a family within the natural home setting where there were problems of defiance, aggression and nocturnal wanderings is given by Bunyan (1986), while Bourn (1993) presents a study of Family Centre based intervention after a child's name was placed on the Child Protection Register following over-chastisement by the mother. Both authors are social workers; both carefully evaluate their work.

Some parents have never acquired the skills of setting reasonable limits to their children's behaviour, praising them, paying attention to 'good behaviour' with social reinforcements rather than rewarding a child just because they (the parents) happen to be in a good mood. Others put their children in danger because they cannot control their anger. A cognitive-behavioural approach (which may include social skills training with feedback and self-talk UK strategies) is useful in such cases. Scott has devised training programmes for groups of parents, with follow-up at one, three and six months. The results are encouraging. (Scott, 1989). A social beaming approach with parents of failure to thrive children has also yielded promising results (Iwaniec et al., 1985).

Social workers and health visitors often work with people who not only have in aversive environments but whose interactions are characterised by a high intensity and frequency of mutually punishing behaviour. Encouraging new, desirable behaviours through programmes which include modelling, role-rehearsal and positive reinforcement helps protect the child (Herbert, 1978; Herbert and Iwaniec, 1976). It is to be hoped that television programmes such as the BBC QED Special and the accompanying Radio Times article (Brompton, 1994) will help to convey both the warmth and the effectiveness of behaviour-based therapy to a wider audience.

FAMILY CENTRES

The therapeutic interventions described above often take place in family centres which have over the last ten years grown in number. Pioneered by the voluntary sector, often funded by a mixture of public and private finance, some were being run directly by local authorities towards the end of the last decade.

Initially they were developed as an informal place for parents with small children to go where the atmosphere was relaxed, children could play safely and freely but support was available if needed (Phelan, 1983). There was typically a blurring of boundaries between paid staff, volunteer workers and users who, in many centres, had a say in how the centre was run (Wilmot and Mayne, 1983).

SSDs were not slow to realise the potential of these centres for providing monitoring and support for families 'at risk', or where neglect or abuse had taken place. A debate ensued, still not concluded today, as to whether it was possible to mix 'referred' families, with ordinary families from the community (Goldberg et al., 1986); whether centres would be stigmatised and therefore devalued in the community by being labelled as 'places where you go if you batter your child' (Cannan, 1986); and whether, in a climate of scarce resources, they should target only those families known by SSDs to need intensive help and resources.

Many researchers have highlighted the value of a warm, comfortable place where young, isolated parents (usually mothers) can take their children, make friends and have a break from the often confined spaces in which they had no choice but to live (e.g. Ryan, 1986). Others, for instance Cigno (1987; 1988) have pointed to the dangers of swamping centres with too many needy families because of the demand for this kind of resource, and making them as a result no longer attractive places to go. The current trend seems to be for family centres, whether in the statutory or voluntary sector, to take `referred' families in need of a stimulating but informal environment where their children can have access not only to a wide variety of experiences, toys and games but also where they and their parents can be assessed and monitored for evidence of 'good enough' parenting and where parenting skills are taught (Dale et al., 1986). This is now the objective of many centres even where the opportunity to have fun is stressed.

Thus, attendance at a Family Centre may now be part of a `contract' with a family and agency as part of a Court requirement. In this case there is obviously a coercive element involved in attendance. As there are far more Family Centres in the voluntary than in the public sector, they provide an instance of the purchaser-provider split in obtaining resources for children and parents. The local authority pays for places and/or therapy and delegates the provision of skilled intervention to practitioners employed in the private or voluntary sector. Family therapy, play therapy, child management and parent training (often in groups) all take place within the auspices of a centre. Very often, the local authority social workers are capable of undertaking therapeutic intervention themselves, but are increasingly unable to do so because of organisational factors and increasing legal and procedural duties involved in case management.

Family Centres are likely to play an important role either as a venue for various kinds of therapeutic intervention with selected families where there is a statutory obligation to protect the children; or as a safe, informal place (sometimes implicitly geared to preventing abuse, as Meacher, 1982, has noted) where local people with young children can go to relax when they want to. It seems, however, unlikely that both functions can be sustained by the individual centre. Disagreements over focus will go on but the need for a partnership between agencies and between parents and agencies

(identified before the Children Act 1989 - see, for example, De'Ath, 1985; Olsen, 1986; Whittaker, 1986) will continue.

Selecting the appropriate form of intervention

No one approach can be identified as the approach in families where child abuse has occurred, or is thought likely to occur. The question therefore to ask is not which approach is to be used but which approach is most appropriate with which problems and with which clients? In some cases, for example, it is argued that it is essential to keep the case manager and therapist roles apart. (Wilson et al., 1992). In others, this is not necessarily so, because the objectives of the intervention are different. This need to select the appropriate therapeutic approach means that assessment skills of a high order are required in the kind of work under discussion, together with a clear view of what constitutes ethical and anti-oppressive practice: there should be no place for the predilections of the individual worker or agency determining the intervention. Proper emphasis should be given to needs-led assessments. This is, of course, difficult in a climate of economic restraint, but it is only part of the story. Quite apart from available resources, practitioners need to be clear about what the objectives of the intervention are and to be familiar with research on effectiveness (Sheldon, 1986; MacDonald et al., 1992).

STRATEGIES IN THERAPEUTIC PRACTICE: SOME CONSIDERATIONS
The social worker as case manager or service provider

As we argue above, recent legislative changes have major implications for the organisation and delivery of social work services in the UK. The clearer distinction between the role of purchaser and provider may signal for the local authority social worker an enhancement of their role as case manager, and a diminution of that of provider of therapeutic services. Currently, as we have shown, there is a diversity of agencies and practitioners involved in intervention. We should want to keep this diversity, considering it to be in the clients' interests. We do, however, question the desirability of local authority social workers becoming case managers only, important though this role undoubtedly is. Social workers, by nature of their training experience of offering an active role in intervention. It is, moreover, arguable that experience of offering at lest one of the methods of intervention provides the kind of practice wisdom essential for the effective case manager. Once social workers lose their therapeutic role, it will be very difficult to reclaim it at a later stage.

Training for therapeutic work

As qualifying courses become increasingly specialist in their approach towards social work training, it is likely that competence in assessment, which has been highlighted as a task of central importance (Department of Health, 1988) will be emphasised. Skilled assessment does, however, demand some knowledge of the alternative forms of treatment, available, and it remains questionable to what extent qualifying courses are able to impart this. Such evidence as there is (for example, the CCETSW guidelines on the child care curriculum for qualifying course, CCETSW, 1991) suggests that courses may in fact be expected only to impart limited knowledge concerning the understanding, recognition, investigation, policies and procedures in child protection, let alone much on therapeutic

interventions.

It is clear therefore that Professionals involved in cases of child abuse need training, over and above what has been offered during their previous qualifying courses Some of this training will be provided on an agency basis, but following the introduction of CCETSW's framework for post-qualifying training, encouragement is being given to the development of sustained periods of post-qualifying training, based in the educational institutions. At present there are only a few such courses in the UK and successful completion of such courses is intended to signal that a high level of competence has been reached in the specialist area of child protection practice. Although such courses can, inevitably, only provide an introduction to the range of therapeutic methods available, they should at the least enable students to acquire sufficient knowledge of these to make appropriate referrals. Furthermore, as modularisation and credit accumulation and transfer become standard practice, it is possible that individual courses will develop specialist modules in particular forms of therapy. Thus, for example, the post-qualifying course at the University of Hull, on which the present authors both teach, has since its inception four Years ago taught non-directive play therapy and supervised students in practising it. In the future, it may be possible for students who have a particular interest in play therapy and who have completed their foundation modules elsewhere to come to Hull for further training, while at the same time Hull students may seek alternative specialist courses elsewhere. In this, it is to be hoped that the skills and understanding derived from initial training for undertaking therapeutic work will be developed, and that there will be a continuing expectation that it is appropriate for social workers, by dint of their experiences and professional roles to undertake this work, providing that they receive the appropriate further training and continued supervision.

CONCLUSION

Protecting children and providing them with therapeutic help needs highly skilled practitioners. We argue that a variety of professionals are well-placed to provide therapeutic help and that this diversity works to the benefit of clients and should be maintained. Nonetheless, case managers in local authority services should not be so divorced from therapeutic practice that they are ill-equipped to assess, choose and evaluate purchased therapy for children and their carers. Multi-disciplinary training is one essential strategy in ensuring that children get the quality of service they need.

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based intervention strategies for children with. ADHD including behavioral intervention s, mod-. iï¬cations to academic instructi on, and ho me-. school communication programs. Also discussed. are approaches to developing partnerships among. school professionals including methods to faciliÂ intervention for ADHD, at least in the research. literature, is the u se of contin gent positive rein-. forcement in the form of teacher praise or token. reinfor cement (DuPaul & Stoner, 200 3). In such. programs, students gain access to praise or token. reinfor cement when they exhibit speciï¬c target. behavio rs (e.g., completio n of assigned work). Token reinforcers (e.g., poker chips, stickers, points) are exchanged later in the day or week. This report is based on research conducted by the Vanderbilt Evidence-based Practice Center (EPC) under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. 290-2012-00009-I). The findings and conclusions in this document are those of the authors, who are responsible for its contents; the findings and conclusions do not necessarily represent the views of AHRQ.Â Anyone who makes decisions concerning the provision of clinical care should consider this report in the same way as any medical reference and in conjunction with all other pertinent information, i.e., in the context of available resources and circumstances presented by individual patients.Â Appendixes Appendix A. Search Strategies Appendix B. Screening and Quality