Editorial: Working with complexities

Yoko Totsuka

So much has happened since I last edited Context (2012: 120). In one job, I had to compete for posts and I lost colleagues to redundancy. In my other job, the service is being ‘redesigned’, in effect losing everything that made it unique. The December issue said a lot about the current climate in public services, including the NHS, where many of us work. It is hard to think of a friend or colleague unaffected by some form of cuts or reorganisation. There are increasing demands, constraints and challenges, which I am sure many of you are feeling. It is also an interesting time; on the one hand, there are exciting opportunities for ‘innovation’ but, at times, it feels hard to hang on to where we come from and what we trained to do. Does the need for innovation mean our existing practice is somehow not good enough, perhaps old-fashioned, and has to be replaced with something else? Family therapists are good at taking a one-down position, and trained to be uncertain, collaborative and inclusive but, in this climate, could the very qualities that make us unique and creative count against us?

As families need both processes of negotiating changes and maintaining stability, I wonder if we need both the adaptability to evolve in the political and social context and the ability to maintain our traditions, history and values. In my recent experience in service development (Totsuka et al., this issue), I was conscious of the new, but often thought about what we inherited from our colleagues and how we were building on it. The opportunity itself came about on the back of their successes and hard work over many years. And yet, I fear our memories can be short and our past colleagues and their work easily forgotten or un-credited. In the context of the challenges we face, there is a temptation to re-package and reinvent wheels to make things look new. Of course, there is nothing wrong with innovation and we need to evolve. But is it possible that over-emphasising the new could result in losing touch with the roots of the theoretical thinking, good practice and innovation that have been around for many years?

It is, of course, both/and. I hope this issue offers something interesting (dare I say, innovative?) and familiar about working with complexity. Jenny Summer applies systemic ideas to network meetings. This article was often on my mind as I started working with social care. Arnon Bentovim provides an evidence-based framework for working with families presenting with risk, and complex and multiple-problems. Sally Wood and Rachel Watson share their practice as family therapists in children’s social-care teams. Chiara Santin’s article on being an ‘undercover’ family therapist is a unique and important contribution, which challenges us to think about the political context, power and the implications of concepts such as ‘troubled families’ to families and therapists. Danny McGowan offers an update on his work in a school, and it is encouraging to hear about his service thriving in the multi-agency context when so many services have been lost. Linda Staines tells about the parenting service and a ‘day out’ with families and young people under youth offending teams. Her team’s tailor-made, individual approach to building relationships with families was replaced with a parenting group at a huge cost, only to be abandoned later. Linda told me “My article was a way of putting to rest once and for all the work I loved so much, before I had no choice but to resign”. My colleagues and I have written about our experience in working with social-care teams (Totsuka et al.). It was not about creating something new, but we wanted to write about our experience, building on and honouring our organisational and collective memory of our service’s history and practice, and learning something new in the process.

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We at Context would love to hear what you think about the magazine. If you have a comment about any of the articles in Context, we are always keen to hear it. The AFT publishing committee welcomes new voices: contributors of articles, committee members and proofreaders. If you have an idea for an article or an issue theme, or would like to take part in the planning and proofreading of your association’s magazine, please get in touch. A list of planned issues is available on the website (http://www.aft.org.uk/about/view/about-context.html). Contact Brian Cade, general editor, on bcade@talktalk.net re content, or Louise Norris, publications co-ordinator re proofreading on l.norris@aft.org.uk.

Context offers an excellent forum for you to share your practice, thinking and development in your work. I recently spoke to some people who told me about ‘innovative’ services they had worked in many years ago and wishing they had written about them. It is never too late; we would like to hear these stories. It is more important than ever to document our history and achievements, to keep curiosity and hope alive. I always thought this phrase by bell hooks (1994) applied to learning and writing: “To emphasise that the pleasure of teaching is an act of resistance countering the overwhelming boredom, uninterest, and apathy” (p. 10).

My heartfelt thanks to the authors who found the time and energy to contribute in such a demanding time. These articles make me feel truly proud of my field. I dedicate the issue to colleagues Jackie O’Brien (who worked tirelessly in the multi-agency context in Newham) and Mary Swainson (my team is doing what her team would have done next), whose work I will never forget.

Reference

The application of family therapy principles in a professional and family network meeting

Jenny Summer

Introduction
This article will illustrate how ideas and techniques drawn from family therapy can be applied in a professional and family network meeting, held prior to a family attending an assessment and treatment programme at the Marlborough Family Service. The families who attend these programmes are usually those involved in legal proceedings where there are serious child-protection concerns. It is important to state that the ideas expressed in this article are not exclusive to court work. I currently work part-time in a role where I train and support social workers to implement systemic approaches to their work with families. These workers in various local authorities are based in teams or ‘units’ such as Access and Referral, Children in Need and Children with Disabilities. The ideas outlined are applicable with all families involved with social care, not just to those cases in court proceedings. Finding ways to engage families who have previously had negative experiences of so-called ‘helping agencies’ is essential to any professional working in social care or, indeed, in the field of mental health.

At the family service, all involved professionals and significant adult members of the family are invited to the initial network meeting. For simplicity’s sake, in the remainder of this article I will refer to these adult members of the family as ‘the parents’ but, of course, family structures are often more complex and the adults invited to the meeting can be partners of parents, step-parents, grandparents, aunts or uncles or any other significant adults in the children’s lives.

The context of the Marlborough Family Service
The parenting assessment service at the family service provides multi-disciplinary parenting and family assessments, carried out in a variety of different contexts. These are in public-law cases (care proceedings) and private-law cases (contact and residence issues). Independent reports are provided for the family courts as well as for various social-care departments and the clinicians appear as expert witnesses in court. The parenting-assessment service is asked to make recommendations to the court regarding the children’s permanency as well as issues relating to contact. The emphasis is on assessing and treating the whole family as a unit and identifying areas where change is needed.

The parenting-assessment service is used with families where there are serious child-protection concerns. These may be related to intra-familial violence or other serious relationship-difficulties, drug and/or alcohol abuse, adult mental health problems, factitious and induced illnesses, learning difficulties, a history and/or suspicion of emotional, physical or sexual child abuse and/or neglect, parents experiencing their children as ‘out of control’ and children presenting with major emotional and behavioural difficulties. Many of the families that attend the unit can be described as ‘multi-problem families’, with issues such as low income, unemployment, uncertain immigration-status and homelessness exacerbating difficult situations.

The approach taken by the service when undertaking the assessments is collaborative. Families are not assessed by purely being observed. The emphasis is on creating systemic interventions to try and effect change. Without interventions being put in place, the families would just continue ‘to do what they do’. The aim of interventions in the assessments is to offer the family a chance to do something different, therefore capacity to change is what is really being assessed. Families with entrenched difficulties, sometimes spanning many generations, cannot be expected to make dramatic changes in a relatively short period of time (three months). However, we are able to assess their ability and/or willingness to start a process of change, and we then have to consider whether the overall change needed is likely to take place in a timescale compatible with the child(ren)’s needs.

The systemic ideas used in the network meeting
The parenting assessment service uses the knowledge and skills developed in the field of family therapy as the basis for work. Ideas drawn from Milan systemic, structural, narrative and solution-focused brief therapy models are all used in this meeting. These approaches are based on the notion that the individual’s behaviour occurs within the context of its family and the wider system. This idea means that problems, even child abuse and neglect in families, are not seen as being located in isolated individuals but are viewed as part of interactional patterns between family members. This represents a shift away from linear (cause and effect) thinking towards a notion of circular causality (Cecchin, 1987). Systems thinking is based on the notion that the family is not a closed system. Rather, it is an open one which interacts with other individuals, groups, the community, professional systems and the wider social and political environment, all of which must be considered (James & MacKinnon, 1986). Based on this notion, the wider system is significant and relevant when working with families, and therefore systemic ideas can and, indeed, should be put into practice in a meeting, even where some family members are not present (the children are not invited to this meeting as issues may arise that are not appropriate for them to be party to).

Who comes to this meeting?
Inter-agency work is consistent with these ideas that individuals do not exist in isolation and the external system,
Finding ways to engage families who have previously had negative experiences of so-called ‘helping agencies’ is essential to any professional working in social care or, indeed, in the field of mental health

The meeting

The primary task of the network meeting is to establish who is currently involved with the family and what their involvement is. It is essential the therapist chairing the meeting ensures that the parents come away from the meeting with a clear understanding of this. The parents need to hear directly from the professionals what their concerns are – and what they believe needs to change in order for children to come off child protection plans, or be rehabilitated back home.

Quite often, in cases in legal proceedings, concerns about the family are expressed in professionals’ or experts’ meetings, to which parents are not invited. Even if parents are part of meetings such as child protection case conferences, these are often intimidating and stressful and can sometimes lead to parents feeling overwhelmed and unable fully to understand what is being discussed. The network meeting allows for the parents feeling overwhelmed and unable fully to understand what is being discussed. The network meeting allows for the parents feeling overwhelmed and unable fully to understand what is being discussed.

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The application of family therapy principles in a professional and family network meeting
**Working with resistance**

Most of the families who attend network meetings are doing so against their will and feel they have little choice about whether or not they come to the assessment service. This is sometimes the reality, as the assessment may well have been directed to take place by the courts. If they do not comply with this direction, the chances of them getting their children returned to their care become more limited. The parents also frequently disagree with the concerns that social care have about their family, and feel hostile towards the therapist, viewing them as yet another uninvited agency into their system. These families are usually unfamiliar with, and disinterested in, what therapy might have to offer. They are not voluntarily seeking the help of a professional but are usually connected to statutory agencies. They therefore fit into the category of ‘reluctant clients’ or ‘visitors’, as opposed to ‘customers’ (Berg, 1991; de Shazer, 1988; George et al., 1990).

Some might see resistance as the ‘fault’ of the client who is then labelled “difficult” or “unmotivated”. When viewed in this way, resistance is considered to be an individual problem. In taking a systemic approach, resistance can be seen differently; it can be viewed as a clash of two very different cultures or systems with an enormous imbalance of power (Lethem, 1994). Understanding resistance in this way encourages the therapist to evaluate his or her behaviour in relation to the client and, in fact, systemic therapies regard client co-operation as an issue for which the therapist should take responsibility (Berg, 1991; de Shazer, 1986; George, et al., 1990). Therefore, on meeting a family for the first time at a network meeting, one of the tasks of the therapist must be to attempt to engage or ‘join’ with the family in order to establish a working relationship (Minuchin & Fishman, 1981).

**Systemic techniques and approaches used in the meeting**

There are several techniques that are helpful for joining with a family in a network meeting. First, it is important the therapist arrives at the meeting with an unbiased and open mind and hears directly about the (usually contrasting) views of the family and the professionals. Frequently, at the point of referral, referrers send detailed past-reports written by various professionals about the family. The intention is usually to be helpful, and to be consistent with the principles of ‘Working Together’ (H.M. Government, 1990). Understanding resistance in this way encourages the therapist to evaluate his or her behaviour in relation to the client and, in fact, systemic therapies regard client co-operation as an issue for which the therapist should take responsibility (Berg, 1991; de Shazer, 1986; George, et al., 1990). Therefore, on meeting a family for the first time at a network meeting, one of the tasks of the therapist must be to attempt to engage or ‘join’ with the family in order to establish a working relationship (Minuchin & Fishman, 1981).
Carr (1997) and de Shazer et al. (1986) have written about some of the goal-setting ideas and techniques, many of which are used in the network meeting. De Shazer suggests the therapist must establish the client’s ‘position’ at the start of the work. If the client appears to be positioned as a ‘visitor’, then the focus of the therapy can be negotiated. For instance, a father told me he had only attended the meeting because he had been “forced into it by the social worker, who always tells me what to do”. In this case, I then negotiated with him what he might need to do in order to be able to get the social worker out of his life so that he could make more decisions on his own. Taking this approach rather than trying immediately to work on what everyone else considers to be ‘the problem’, means the goal is important to the family. Research has shown that when a person is committed to achieving a goal and that goal is consistent with the person’s values they are more likely to be successful (Berg, 1991).

Goals need to be small, specific, achievable and observable. Only small goals are necessary, because a small change in one person’s behaviour reverberates around the system resulting in different behaviour from everyone (de Shazer et al., 1986). The bigger the goal, the less chance there is of a co-operative client-therapist relationship and the more likely the goal is to fail. Specific goals lead to better performance than vague goals (Carr, 1997) and, in the network meeting, time is spent breaking goals down into components that can be described in terms of observable behaviours and interactions. For example, in a recent meeting when a social worker said she needed to see the mother disciplining the child “more appropriately” before the child came off a child protection plan, I asked her to give examples of what this would look like. One of the questions I asked, to help the mother understand what she needed to do, was “What would be happening that would tell you the mother was disciplining the child in such a way that would reduce your worry?”

**Conclusion**

In using systemic thinking the way I have outlined, the family is seen in the context of its wider system. This allows for useful observations and a greater understanding of the ‘family problem’. Using family therapy techniques allows the therapist to reframe the problem-saturated story, thus providing a more sensitive service to families who might ordinarily reject professional support. Emphasis is given to the therapist’s role in assisting the family to engage in the service offered. A strength-based approach is taken in relation to the problem. This is often a new experience for the family, whose previous relationships with professionals have usually been very negative. Establishing clear, observable and achievable goals in this meeting helps build the expectation that change will happen, allowing for greater chances of success.

I would like to acknowledge and give special thanks to Eia Asen, child, adolescent and adult psychiatrist, for the development of these ideas, and for the training he gave me to implement them.

**References**


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Hope for children and families: An evidence based resource pack for frontline practitioners targeting abusive and neglectful parenting and impairment of children’s health and development

Arnon Bentovim

Introduction

There is a clear overlap between the clients of family intervention teams, and practitioners aiming to prevent the recurrence of the maltreatment and impairment suffered by children and young people. Factors associated with such maltreatment, including parental mental health concerns, parental conflict and alcohol and substance abuse, are often present in families worked with in family intervention services. What is characteristic of both is the limited utilisation of evidence-based approaches to intervention, of which there is no shortage, to target problems of the emotional and behavioural life of children and young people and their families. Chorpita & Daleiden (2009) have identified over 700 well-based interventions, yet they have limited use in practice. ‘Treatment as usual’ is the approach most commonly used, comprising a mixture of the approaches practitioners have been trained in, supplemented by support and consultation from colleagues. Research on treatment as usual has demonstrated its value, supplemented by making a good working relationship and working with intensity and high expectations. The addition of evidence-based approaches can significantly enhance the impact of a dedicated practitioner. The Hope for Children and Families approach (Bentovim et al., 2013), should be replaced by ‘developed by my colleagues and I (see acknowledgements) is aimed at making that difference.

The development of the Hope for Children and Families project

The development of this project is part of a two-year initiative on childhood neglect, funded by the Department for Education and run by Child and Family Training (see our web site http://www.childandfamilytraining.org.uk). This project builds on initial work, supported by the department, focusing on developing evidence-based approaches to assessment, analysis, planning interventions and identifying measurable outcomes with children and families to support the assessment framework and required locally-developed ‘assessment protocols’ (Department for Education, 2013); it includes the development of practice tools and accompanying training that many local authorities have adopted:

- Assessing parenting and the family life of children using the HOME Inventory (Cox et al., 2002) and the Family Pack of Questionnaires and Scales (Cox & Bentovim, 2000)
- Assessing families in complex child-care cases using the family assessment
- Communicating with children and young people using the ‘in my shoes’ interview
- Using the ‘attachment style interview’ in child care, fostering and adoption contexts
- Child protection decision-making using the ‘safeguarding assessment and analysis framework’ – evidence-based assessment and analysis of risks of future harm to a child and prospects for intervention.

Aim of the Hope for Children and Families project and resource pack

The project includes the development of a manual for practitioners – a resource pack designed for work with children and young people and their parents and carers to prevent abusive and neglectful parenting and the associated impairment of children’s health and development. The manual is aimed at all practitioners whose roles are to provide interventions to children and families where there are:

- Concerns a parent may harm or neglect their child
- Evidence of neglectful or abusive parenting before the child’s health or development is impaired, or where there is evidence of impairment
- Children or young people presenting with emotional and behavioural problems or other impairments in their health and development as a result of neglectful or abusive parenting.

Who might use the manual?

Practitioners who would be able to use the approach include:

- Social care, education, probation and health practitioners such as social workers, family support workers, teachers and education support staff, educational psychologists, school nurses, health visitors, CAMHS staff
- Those working in:
  - Children’s and family centres such as those involved in individual, family, group and community outreach work
  - Family intervention teams, multi-agency teams and ‘troubled families’ focused services
  - Schools and education support services
  - Looked after children services and residential and foster carers
• Youth offending and probation services
• Voluntary, community and independent services.

**Underpinning research and the evidence-base informing the development of the project**

The approach taken to develop the project follows the model provided by Barth *et al.* (2012) and Chorpita & DeLeiden (2009). This argues that there is a commonality of approaches demonstrated to be effective in preventing the recurrence of maltreatment and the associated impairment of children and young people. Chorpita & Daleiden (2009) distilled the common elements across the different evidence-based approaches, and described a common practice-element approach that conceptualises practice in terms of generic components that cut across many distinct specialist treatment-protocols and specific clinical-procedures and processes. Forty-seven distinct practice-elements were distilled from twenty-five random-controlled trials (Bentovim & Eliot, 2013) that successfully modified neglectful and abusive parenting and the resulting impairments to children and young people’s health and development. The outcome research that was examined included:

- Parent/child interaction therapy
- Alternatives for families combining CBT and multi-systemic therapeutic/systemic approaches to modify abusive attitudes and to improve relationships
- Trauma-focused CBT, combining elements to resolve traumatic symptomatology
- Multi-faceted in-home programmes to address neglect (e.g. Project SafeCare USA)
- Approaches to failure-to-thrive
- Promoting healthy parent/child interaction, tackling family conflict and approaches to promoting attachment.

In addition to the common practice-elements approach, there is also a common-factors framework, which asserts that the personal and interpersonal components of intervention (e.g. alliance, client motivation, therapist/helper/practitioner factors) common to

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**Figure 1.** The UK Assessment Framework for Assessment of Children in Need and their Parents

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all interventions are responsible, to a significant degree, for the treatment outcomes.

The manual for practitioners

Practice elements are integrated to form modules that provide step-by-step guidance, resources and tools to deliver an evidence-based intervention. The manual provides building blocks and a tool kit for foundation skills in intervention across a wide spectrum of levels of harm and risk of future harm; at various levels of severity and complexity of parenting problems and individual, family and environmental factors; and where there are impairments to children’s health and development as a result of abuse and/or neglect:

- Where there may be specific risk of harm to an unborn child – current parental difficulties, previous harm: the aim is to work with parents throughout the pregnancy, birth and early months, fostering attachment and good quality parenting
- Where there is evidence of abusive and neglectful parenting and potential or actual impairment identified by early intervention teams and early help assessments, health service surveillance, in a family centre, as a result of a child protection section-47 enquiry or by other professionals: the aim is to work with parents to modify abusive and neglectful parenting, and to ensure that children’s health and development is safeguarded and promoted
- With children where there is evidence of impairment of their health and development and who may display traumatic symptomatology or disruptive behaviour – at home or in alternative care: interventions use modules focused on various impairments, delivered by a variety of workers from social care, CAMHS, fostering and adoption services, youth-offending services or educational services in collaboration with a supportive carer
- Where there are significant problems in individual or family functioning or in relationships with the community, and for use by family intervention teams (or their equivalent) working with multiple problems (including those experienced by parents with physical or mental health or substance-abuse difficulties) to improve family functioning by delivering modules focused on aspects of parenting capacity, family and community relationships and impairment of children’s health or development.

Using a development of the assessment framework (Figure 1, previous page), it is possible to see that strengths in parenting capacities reinforced by positive family and environmental factors results in resilient functioning of children.

Whereas, as shown in Figure 2, where there are high levels of parenting difficulties, high levels of individual and family stress,
there is a higher likelihood of harm to children and impairment of their health and development.

Integrating the practice elements which emerged from the distillation exercise from over 20 evidence-based effective interventions to prevent and target abusive and neglectful parenting, as shown in Figure 3, helps to target parenting capacity of the associated aspects of family and environmental factors. This can improve the outcomes for children and young people, and can further reinforce the process of work with parents, family context and children and young people themselves. The integration of practice modules, and fitting them to the changing and evolving needs of children and families, represents a modular systemic intervention.

Forty modules have been developed across five areas and each module comprises information/resources outlining:

- Goals
- A briefing for the practitioner – the step-by-step approach to achieving the goals
- Materials to support the development of therapeutic work (worksheets etc.)
- Tools to assess the success of the intervention for the child
- Guidance on the skills required to deliver the module, and how the modules can be integrated to form a comprehensive programme of intervention.

We are in the piloting stage of developing ‘Hope for Children and Families.’ A number of agencies are piloting its effectiveness in enhancing the quality of their work and improving outcomes for children: in addition, when there is doubt about the outcome, assessing whether parents can be helped to make significant improvements to their parenting skills, whether individual and family factors can be modified, and whether children and young people are helped to develop coping skills and recover from the anxiety or traumatic response, or externalising angry or sexualised responses.

**Modules include the following:**

1. **Modules to promote engagement and hope**

   These initial modules introduce the approach to, and promote appropriate engagement with, the family (parents and children), separately and together. The goal is to give a message of hope, to set collaborative agreed goals, identifying targets for eradicating abusive and neglectful parenting, strengths to be built on and how children and young people’s health and development are to

*Figure 3. Targeting abusive and neglectful parenting and the associated impairment of children’s health and development*
be addressed. Criteria for success and failure need to be defined as well as the consequences. A care, protection and intervention plan for each child needs to be established.

2. Psychoeducation

Psychoeducation with parents and children, both separately and together, helps convey understanding about how abusive and neglectful parenting can influence children and young people’s development, psychologically and neurobiologically – their capacity to learn, to develop and regulate emotions and behaviour. Parents and children are encouraged to acknowledge the nature of abuse and neglect their children have experienced. Modules focus on helping parents understand the basic needs of children, society’s expectations and what is required of them to promote their development.

3. Modules focused on targeting abusive and neglectful parenting

These modules explore the way stress in parents’ lives, current and in the past, have had an impact on their capacity to meet their children’s needs, and led them to make negative attributions about children’s behaviour, justifying harsh treatments. Approaches are advocated to help manage potentially harmful effects. The development of positive parenting is encouraged, promoting secure attachment and the development of positive emotional responses, problem solving, communication and managing conflict. Neglectful parenting is countered by modules that promote good-quality care, health, positive nutrition and safety through active intervention, modelling and feedback in the home. Parents are encouraged to promote development, play and skills, again through the use of modelling and active intervention. Abusive parenting is targeted by directly tackling conflict cycles, punitive responses and coercive critical parenting. Alternatives are encouraged such as enjoyable one-on-one time and the use of praise and rewards as well as effective discipline, commands and effective instruction and, where appropriate, time out.

4. Modules supporting children, young people and their carers to address adverse emotional outcomes

These modules support practitioners to engage with children and young people, and to assist them to understand the way exposure to abusive and neglectful parenting, that results in significant physical, emotional and sexual abuse, can have an impact on emotional and behavioural functioning and can result in traumatic stress. Basic-skills modules include coping with the impact on their emotional life, being able to be safe, to relax, develop helpful activities, and manage traumatic symptoms and, where appropriate, anxiety and mood difficulties. Support from, and sharing with, a non-abusive carer is essential to targeting the range of responses associated with these impacts.

5. Modules supporting children, young people and carers to address adverse disruptive behaviour

A common response in older children, who may have been exposed to multiple adversities, is the development of disruptive responses that maintain the pattern of abuse and neglect through enactment with siblings and peers. The practitioner is encouraged to take a key role in promoting professional and community networks of formal and informal support to strengthen the team around the family. There are ‘flow charts’ to support practitioners to integrate modules, and approaches to record and measure change. In the future, it will be essential to develop a relevant training approach both at general and specific levels, and to assess the value of an approach that brings together so many effective elements of practice. Figure 4 demonstrates the process that has to be followed, as noted in the upper box, where initially there needs to be assessment and analysis of children’s developmental needs, parenting capacity, family and environmental factors.

A common response in older children, who may have been exposed to multiple adversities, is the development of disruptive responses that maintain the pattern of abuse and neglect through enactment with siblings and peers.
• Targeting abusive and neglectful parenting is achieved by selecting modules focused on providing good quality-care, ensuring safety, emotional responsiveness, a positive learning-environment, positive parenting, and managing disruptive behaviour.

• The associated impairment of children and young people is targeted through generic modules appropriate for all children and young people, and specific modules for significant internalising and externalising behaviour.

• The choice and sequences of modules is dictated by the context – e.g. whether families are together, or whether there has been a separation for protection purposes.

Case history

To illustrate the way the approach can be used, one of the Child and Family Training’s family and home assessment video-families will be used as an example. These were based on families we worked with; the roles taken by actors.

The Ward family (Figure 5, overleaf)

Moira Ward and Ian Ross have got together over the last 12 months. This followed Moira’s separation from her former partner, Gary Wills, who formed a relationship with one of her friends. She has two children by Bill, a former husband; Laura, aged 14, and Michael, aged 8. The children are not in contact with their father. Ian separated from his wife, and sees his son on a monthly basis. The family is a white English family, Ian works in the building industry; Moira is currently at home.

The school have referred Michael because of concerns about a recent marked changes in him. He has become anxious, distracted and has difficulty concentrating, is persistently late, has a neglected appearance and is often hungry when he gets to school, whereas, in the previous term, he was bright, cheerful and smartly turned out. Using the HOME Inventory, an initial assessment of parenting revealed significant concerns regarding Michael’s experience of care; the emotional climate was one of restrictiveness and punitiveness. Michael stated he had been hit by Ian.

Ian had a very different idea about what was to be expected of the children compared to Moira’s laissez-faire attitude. There was now considerable conflict as Moira was attempting to comply with Ian’s views. She had moved away from her former home because of stress at the breakup of her former relationship. Michael was seen in a negative light by Ian because of a significant difference between Michael and Ian’s own ‘sports loving’ son, whom he only saw on a monthly basis. There was a significant degree of neglect of care, an absence of appropriate food and clothing, and there were concerns that Michael’s weight seemed to be going down and he was expected to fend for himself. The use of a series of questionnaires indicated Michael was really very unhappy. He described himself as feeling lonely in the playground, not able to assert himself, and was bored because he had no-one to play with.
Because of the recent onset of very concerning problems of school attendance, and evidence of neglect, a family assessment was carried out, and it was revealed there was a very unhappy climate in the family. Laura, Michael’s older sister, clashed a good deal with Ian over the expectations he brought into the family. She also revealed there had been violence between Ian and Moira when both had been drinking heavily. Moira demanded he leave the family. Ian stated he had literally had to beg to return. Laura also revealed that her mother had been drinking heavily as a stress-management device, triggered by having to mediate between Ian’s expectations and the children’s feelings as articulated forcefully by Laura, and through withdrawal and unhappiness by Michael.

The interview schedule for the family history revealed Moira had a controlling father. She had witnessed violence to her mother, who had died when she was eight years of age, indicating a significant loss of a nurturing figure, and experiencing a rejecting stepmother. She had left school early, had a series of violent relationships and periods of quite heavy drinking. There had been a volatile relationship with the father of Laura and Michael, domestic violence and drinking, again stress related. However, she had, generally, managed to protect the children from her drinking, using extended-family members who could be supportive at those times.

In his family of origin, Ian was the unfavoured sibling. His father was in the army and a strict disciplinarian. Ian often suffered physical punishment following his father’s drinking sessions. Ian’s previous marriage ended after a violent episode and he only saw his ten-year-old son from this relationship once a month. He worked well and was a good provider, although there were concerns about misuse of funds through Moira’s alcohol consumption.

When Michael was seen alone, he indicated his significant distress at the separation from Gary, mother’s former partner, and his extensive fear in relationship to Ian, who had kicked him when he kept missing the ball in football. He had also been hit when a letter had come from school stating he was not attending regularly or on time.

Some weeks later, there was a further incident. Michael was found wandering the streets late at night; Laura had left home after an argument; Michael had bruising on his legs and back where Ian had hit him; Moira was drinking heavily. He was accommodated in a foster home and a protection conference was called.

**Systemic analysis**

Figure 6 indicates that the systemic analysis of the information shows the predisposing factors in the family – exposure to violence in the family of origin, separation from the family context and loss of paternal figures, and a vulnerability to authoritarian figures. Precipitating trigger-factors and processes were Ian’s increasing expectations and demands, and Moira’s increasing withdrawal and alcohol misuse. The result was physical harm and bruising, neglect, poor nutrition, poor physical growth, increasing anxiety, distress and withdrawal, depressed affect with a significant impact on education.
and self-esteem. Further harm, physical abuse and failure to thrive were predicted; an escalating pattern of family violence, increasing alcohol misuse and increasing isolation and family breakdown has been observed.

Harmful maintaining-factors were alcohol-use as a coping mechanism, Laura’s opposition and increasing conflict, Ian’s withdrawal and Michael’s increasingly negative, withdrawn behaviour. Protective factors were a history of better care and, despite alcohol use in the past, children’s care being adequate; Laura was supportive through disclosures and Ian is a good earner and the home is well kept.

It was evident this was a context where there was significant risk. The family’s attitudes to concerns expressed by professionals indicated there was a degree of doubt about achieving change, uncertainty whether change could be achieved or not within Michael’s timeframe. It was uncertain whether Ian could take responsibility for his punitive action, Moira for her neglect and alcohol misuse, and there was uncertainty about the potential for collaborative work. Laura was independent and far more able to protect herself, for example, by going to stay with a friend.

So the questions are:
1. What collaborative goals would need to be established in the engagement phase, considering there is a degree of doubt present?
2. Which modules from the parenting and family areas are most likely to assist the parents and what sequence would be most effective?
3. Which modules from Working with Children and Young People would be most effective to assist Laura and Michael?
4. Which measures would help assess the effectiveness of intervention?
5. What is the likelihood of achieving sufficient change within the child’s timeframe?

Initial stages of work

1. Engagement and hope
The initial phase is to motivate Moira and Ian to demonstrate they are able to provide better quality care for Michael and Laura. The practitioner offering to work with the family needs to meet with family and the child protection team, to clarify the nature of concerns, and to establish a supportive approach. The challenges the parents have had to face would need to be recognised – the significant changes in the family over the last 12 months, painful separations, establishing themselves in a new environment, being isolated and affected by stress and withdrawal, with a risk of repeating problems from the past. The aim would be to establish a team around the child that would include the practitioner, foster carers looking after Michael, the family caring for Laura; and to create a protection, care and intervention plan, including a commitment to avoid violence – between parents, or to children.

2. Establishing collaborative goals
Collaborative goals require a commitment from the parents and children to work with the practitioner including the following:

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Figure 6. Ward family systemic framework

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Hope for children and families: An evidence-based resource pack for frontline practitioners targeting abusive and neglectful parenting and impairment of children’s health and development

1. That Michael and Laura would be able to return home safely to Moira and Ian.
2. That the care of the home and the children would be satisfactory, and that concerns, such as growth or failure to attend school or any neglect in the home, would be addressed successfully.
3. That Ian and Moira needed to acknowledge and take responsibility for the extensiveness of harm to the children, the impact of exposure to violence, confused expectations, punitiveness, and to acknowledge and address the harmful role of alcohol.
4. That the team would help Ian and Moira find alternatives to punitive care and other means to cope with stress than to use alcohol, linking with the specialist practitioners for alcohol services to assist Moira in achieving abstinence. At an appropriate time, harmful actions would need to be acknowledged to Michael and Laura.
5. To ensure Michael was protected; that he would be helped cope with the inappropriately punitive responses he had suffered from Ian; to recover from traumatic symptoms and depressed affect; to support his school attendance and help him achieve his potential.
6. To improve emotional responsiveness and relationships with the family and to enable them to function up to their potential rather than the increasing anger and disruption affecting all in different ways.

3. Psychoeducation about the impact of harm

The third module associated with engagement and hope is to provide psychoeducation about the impact of abuse, using a Socratic, reflective and circular-questioning approach. The aim is to help the parents consider the responses of Michael and Laura, and to understand them as a response to the family context of abusive action; to establish which responses the parents had noted, how they explained them and help them understand the impact on immature children and young people and the effect on brain functioning. The parents would need to think about the issue of responsibility for violence, whether Ian had the courage to acknowledge his discipline was punitive and harmful, and Moira’s retreat to alcohol-misuse led to increasing neglect. Socratic, and reflective questioning helps the client arrive at more accurate and helpful thoughts, examining the basis of thinking, challenging and using a variety of ways of finding an alternative approach; for example, why Michael was withdrawn, fearful and Laura angry and challenging?

Working with parents targeting abusive and neglectful parenting

1. Providing good-quality basic care

Given that both Michael and Laura are living separately, it is important to begin to work with parents and children separately. Parenting modules include a module which helps parents develop a capacity to identify and understand children’s physical and emotional needs, factors which influence children’s development and how children might have been affected; what are the appropriate expectations given Michael and Laura’s age and developmental stage using developmental charts and a variety of ways of attempting to help them understand the children’s responses. Because of the concern about the quality of care being provided to Michael, it would be essential Moira and Ian be helped to provide better quality of care. This module achieves this goal by establishing a profile of the patterns of care and home conditions, gaining a clear picture of the pattern of care over a 24-hour period, deciding on goals to improve the quality of care, and initiate a plan of intervention and assessing effectiveness.

The process is to help Moira and Ian think about adequate basic care, including adequate clothing, nutritional care, stimulation, promoting development, education, providing adequate boundaries. It is essential to establish what improvements are required, to establish what are the obstacles and hassles to providing adequate care, and establish a collaborative context of better care. An essential obstacle Moira needs to overcome is her use of alcohol as a way of managing stress. The isolation of the family is a further factor and the module on support networking may be relevant to create a more supportive community network.

2. Ensuring safety and preventing harm

A second key-area of intervention is to ensure a context of safety and prevent future harm. This module requires a review of harmful events in the home and environment, including exposure to harmful influences relating to Moira’s alcohol misuse and Ian’s punitive responses, and exposure to violence between the couple. A key to help ensure safety is the module – Parents coping with stress and the link with abusive and neglectful parenting. This module considers the way stress can arise and affects parents’ behaviour and capacities to provide good quality care. Factors are examined which play a part in increasing parenting stress, for example, children’s temperament: the significant difference between Michael’s gentle temperament and Ian’s son’s physical sporting style. Factors that affect the parent as an adult including personal health and relationships, losses, separations, which of course have played such an important role for both Moira and Ian, conflict between parents about expectations, views of what is appropriate for children. Parental responses to family of origin, stresses both past and present, are important given both Ian and Moira had a past history of punitive paternal figures and exposure to violence and a heavy-drinking culture. The fact Moira had an absent protective figure herself meant she has considerable difficulties in protecting the children against Ian’s significant demands.

The fact Moira had an absent protective figure, herself, meant she has considerable difficulties in protecting the children against Ian’s significant demands.
cycle that leads to stress, and introduces relaxation techniques. Closely linked to stress management and abusive parenting is the module *Helping parents cope with negative perceptions of their children*. Ian’s perception of the differences between Michael and his son means he becomes angry and punitive at what he perceives to be Michael’s failures, expectations of an eight-year-old’s independence clash with Moira’s more laissez-faire perceptions. These need to be explored using CBT approaches to identify challenging thoughts and practice differences.

3. Working with the children’s emotional and traumatic responses

In parallel to the work with parents, which it would be helpful to complete before the return of the children, there are a series of generic modules that are helpful for all children aged six years and upwards who have experienced maltreatment. These include:

- **Psychoeducation on the effects of maltreatment** to help Michael understand the impact of neglect and exposure to conflict between his parents, and help him correct any misattributions or misperceptions that it was his fault, and helping him develop a coherent story of what happened and why, taking him through the process from Moira and Ian’s conflict, his mother’s drinking, Ian’s demands and expectations and his own responses.

- **It would be important to help him with managing personal safety** when there are risks in the environment, particularly when he is going to school, or when playing outside. He needs to develop a plan to ensure he is safe in the present and future and to learn how to follow the safety plan. Given Laura was also going out late, it is important to help her think about the risks she may be taking.

- **Modules focusing on coping skills**, to recognise and manage the difficult emotions in adaptive rather than maladaptive ways, to help manage Michael’s withdrawal, his introverted responses and to help him find a repertoire of more-appropriate coping skills.

- **Relaxing and calming** is a helpful module, managing uncomfortable feelings, self-calming and positive imagery.

- **Describing and monitoring feelings** so he can understand factors affecting him and how they can be influenced. A ‘feeling thermometer’ is helpful, learning the CBT process of thinking, feeling and doing to describe his own and other’s feelings. **Activities to manage low mood, assertiveness skills, problem solving and social-skills training** may also be valuable.

- If Michael shows persistent anxiety, mood difficulties or specific traumatic symptoms, modules describe approaches to **anxiety, depressed mood** or such as **trauma-focused work** can be utilised. Work with traumatic symptoms include psychoeducation on traumatic responses, managing feeling states, creating a trauma narrative, stressing that remembering on purpose in a safe environment lowers distress, allowing the trauma to become part of the past. The role of a supportive parental figure is essential to successful completion of such work.

4. Working with families, clarifying, sharing and reconciling the impact of abusive and neglectful parenting

This is an important module since it is to be hoped, in his work on coping with stress, managing conflict, and looking at alternatives to punitive parenting, Ian may come to recognise his response to Michael. Similarly, Moira may need to appreciate that the impact of alcohol misuse has meant there has been significant neglect and inappropriate expectation. The process of **clarifying, sharing and reconciling the impact of abuse and neglect** is a helpful way of bringing families together to help them forge a new identity and a new future for themselves, maximising their potential. It is helpful for family members to construct a timeline of episodes of abusive and neglectful parenting they would wish to clarify, share and take responsibility for. It would be necessary to work with Michael, Laura, Moira and Ian about their respective experiences, the harmful impacts and developmental consequences being understood. **A family meeting for the children, supportive caretakers and those responsible for abusive action, needs to be convened to take responsibility, to apologise, to answer questions and consider the future. Laura’s role in drawing attention to the violence and her mother’s drinking would need to be positively connoted. A broader appropriate discussion of abusive events and traumatic loss may be appropriate for all members of the family, sharing, planning future protection, care and support.**

Given the way in which Ian, Moira and Laura get into conflict resulting in Michael’s withdrawal, introducing **helpful techniques to manage conflict and dysfunction** provides a helpful approach to deal with difficulties within the family in addition to the individual work on stress responses. There are a series of practice skills necessary to deal with conflict during the work – understanding the feelings of all family members, establishing the importance of listening, hearing, responding, and emphasising the damaging effects of anger, conflict and dismissal. Related to this is a further module on **developing family communication**, which introduces a model for discussing difficult topics and for problem solving.

5. Positive parenting – managing difficult behaviour

Moira’s laissez-faire parenting means she has had relatively few problems in managing Michael and Laura. She was able to provide good-enough care in the past when her drinking was more contained. The children’s development was fostered well enough. With Ian’s very different approach, there has been a good deal of open opposition by Laura, refusal to comply on Michael’s part and withdrawal. It would be helpful if Ian was willing to consider a **positive parenting approach to managing difficult behaviour**, rather than use angry, punitive, fierce, threatening responses. Participating in direct-parent interaction work, he and Moira would have to learn the importance of **praise**, the use of **positive attention and ignoring**, giving **effective non-punitive instructions** and the use of rewards in **managing challenging or difficult behaviour**. These approaches rely on promoting parent-child interactions, through role playing, tasks and homework.
6. Promoting attachment, responsiveness and positive emotional relationships

In any ‘re-constituted family’, the issue of managing attachments and emotional relationships can be challenging. In the Ward family there have been extensive disruptions, disorganisation and destabilisation of relationships, separations for both Moira and Ian from their respective partners, for the children from their father, and a partner who provided positive emotional responses. There are risks of Moira’s secure bond with the children being undermined, and any possibility of a positive emotional relationship with Ian being frustrated. The module promoting attachment, responsiveness and positive emotional relationships reviews the development of attachments, and approaches to promoting attachments in older children. This includes tackling the avoidance and distance between Michael and Ian through a ‘one-on-one approach’. This is an interactive approach that encourages a parent to observe, to learn to comment positively, and be encouraging about a child’s activities. This helps boost Michael’s self-esteem, and promote the making of an emotional bond.

7. Conclusions – promoting stability and resilience

In working to prevent the recurrence of maltreatment by parents and the associated impairment of children’s health and development, it is helpful to have a set of modules available, which can fit with the needs of the family. The construction of the Hope for Children and Families intervention resource pack, including the set of modules and working documents and techniques, will give practitioners ways to meet the often complex needs of parents responsible for abusive and neglectful parenting, and the associated impairment of children and young people. It would be essential to have clear criteria for success or failure, and well-established approaches to measuring what has been achieved. The overall aim is to promote stability in the family, and a variety of approaches to seek alternatives to abuse, or neglect, to transform hopes for a brighter future for children into a resilient reality.

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References


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Child and Family Training is a not for profit organisation working to promote evidence-based assessment, tools, analysis and interventions with children and families.
Cambridge Safer Families: The experience so far

Sally Wood and Rachel Watson

Our working context
Cambridge Children’s Social Care has introduced a new model for safeguarding practice: ‘Social work: working for families’. The model is based on the claiming systemic approach to safeguarding. Rather than working individually, social workers now work collaboratively in ‘units’ of one consultant social worker and two social workers, who are supported by an administrative ‘unit co-ordinator’ and a half-time clinician. Providing systemic training for our consultant social workers, supported by Morning Lane Associates and The Institute of Family Therapy, has enabled a more systemic approach to social work practice, which has also been supported by Cambridgeshire’s recruitment of an experienced clinical team, made up of systemic family therapists, psychologists, and mental health practitioners. A half-time clinician has been allocated to each unit.

This model is congruent with the recommendations from Eileen Munro (2011) in her recent report following the death of Baby P. We have reflected on the opportunities and challenges this new approach has presented for providing effective interventions for families, and we are now in a position to focus attention on developing robust clinical models of intervention where children or young people may be at risk of significant harm, using a new framework: Cambridgeshire Safer Families. We are advocating a robust, but integrated, approach to enable us to address the needs of as wide a range of families in difficulty as possible. We are using a collaborative design which involves the social work unit, the child and the family. This article describes this developing approach.

The impact of systemic training and practice in Cambridgeshire
Our initial experience of the impact of the training was that it led to an improvement in engagement with our families. The staff were more ‘curious’ about the families they were working with and were developing a range of hypotheses about families’ presenting concerns. They were also using the range of questioning and interviewing techniques that had developed from their training. They felt more motivated and engaged in their work and there was a great deal of energy and creativity generated within the units. Although this was an important process, by reflecting on our progress we became aware we may have introduced too much flexibility for our practitioners and OFSTED commented on our variability of practice. This may have been compounded by the challenge presented by having to cover a large geographical area, including small towns and a more rural population, unlike denser urban local authorities. This presents an added challenge to developing consistency and coherence between practitioners. We considered this feedback and concluded that providing too much flexibility was as much of a problem as providing too little. We began to talk about the importance of an organisational context which offered creativity within structure. The development of this model of intervention is an important part of that process. Our aim is to provide a clear framework for practitioners to think about their interventions with families who may present with complex challenges, while retaining their own individual presence as practitioners, and developing areas of particular skill and interest.

Defining principles
As an organisation, we hold a belief that manuals do not provide the intervention: it is the activity of practitioners that is the intervention. However, we do need to provide a framework for thinking to enable practitioners to plan with the family the most effective activity. This comes in the form of an ‘intervention design kit’. We find our units need help in thinking about the focus of their intervention, so that they do not get caught up in the issues a family under stress may present as the particular concerns for that week. We have looked at our local evidence in relation to best practice, as we are committed to developing our practice in relation to addressing the needs of our local communities. We are integrating this with what we know from national and international research, and working to improve outcomes for Cambridgeshire’s children and young people. We are aware a focus on outcomes demands fidelity to a model of intervention. Our model includes the following features:

• Generalist-workforce competency rather than specialist teams.
• Outcomes: our aim is to focus on reinforcing the importance of collecting outcome data for families. We are aware that, if practitioners perceive outcomes as a performance management tool, this can lead to a belief that poor outcomes mean you are a ‘bad practitioner’. Clearly, this may be a possibility and would need to be addressed, but we hold in mind that poor outcomes may mean workers require access to an alternative approach. We needed to create an organisational culture which encouraged practitioners to be interested in measuring the outcomes of their interventions with families.

We began to talk about the importance of an organisational context which offered creativity within structure
Outcome measures are thought about as a way of supporting their work with families rather than being a process just designed to meet organisational need. We use measures of children’s wellbeing (including SDQ: Kidscapre); measures of adult well-being (including parenting stress index; parenting hassles questionnaire); measures of family functioning (currently SCORE 15); and goals-based measures measuring specific ‘SMART’ goals linked to definable risks.

- **Systems**: we have tried to develop a multi-systemic approach to our work to ensure engagement with all our key partners and stakeholders. Inevitably, this has been challenging and we are sure some of our partners would argue they have not been involved as effectively as they would have hoped.

- **Improvement orientated professional culture**: staff have been encouraged to share their successes. We have supported this by ‘learning circles’ and ‘practitioner groups’. Eileen Munro supported a recent conference event in Cambridgeshire, and stayed for the day to hear units present their work to one another. We still have a way to go in encouraging staff to share their failures as something we can all learn from. We are aware it takes time to create an organisational culture that can tolerate reflecting on things that have not worked; and that this is taking place against a background of media discourse that is very quick to apportion blame. We are realistic about the challenge this presents, but know that to ‘make families safer’ and to achieve safer practice, we need practitioners to be able to be more open about their concerns and the interventions that they may view as failing. Supervision in the unit meeting, and individually for all practitioners, is an essential component of our model to ensure we create space for focused reflective-thinking and thought-through action. Cambridgeshire Safer Families then provides a framework for thinking about the complexity of the issues within families and planning our interventions.

- **Developing local supports to train and sustain best practice**: following start-up training provided by Morning Lane Associates and The Institute of Family Therapy, we will be taking on future systemic training from within the clinical team, working together with experienced practitioners. We have developed a clear systemic training-pathway for our workforce. We are working hard to integrate systemic theory into robust statutory social work practice.

### The context for the model of clinical intervention

We are influenced by our experience and also by the appropriate evidence-base. We know that no one model of intervention can meet the needs of every family; but we also know that practitioners who follow a model of intervention improve outcomes for families. Chorpita and Daleiden (2009) recommend using elements of existing evidence to create services most likely to meet the needs of particular client-groups in particular local contexts. In developing our model, we have looked at the effective components of approaches and interventions that reduce the risk of maltreatment. We are using an overall systemic-frame within which to apply specific models of intervention, including parenting interventions underpinned by behavioural approaches incorporating social learning theory, developmental and attachment perspectives, and socio-ecological frameworks. Research supports the view that an integrative approach that incorporates these elements delivered within a systemic framework provides an effective way of intervening with ‘high risk’ families (Bentovim & Elliot, 2012), and so we are proposing a focused approach to the integration of a number of evidence-based treatments.

### Core structure of ‘Safer Families’

In working with families under pressure, we are focused on issues of safety where social workers are accurately assessing the levels of risk within a family in a comprehensive and timely way supported by the common assessment framework. We are working towards all our practitioners being able to utilise fully what Eileen Munro describes as both their intuitive and analytic skills (2011), which are required to provide thorough assessments of risk. Safety is our highest context-marker.

The model relies upon a clear assessment and formulation of the family’s current presenting difficulties and an agreed plan with the family. This ‘family plan’ is a programme of intervention using goals-based outcome-measures to track effectiveness. Changes to the plan are in line with the changing needs of the family, with the needs of the children being paramount.

Our framework sits within a socio-ecological context. We need to address housing difficulties, families living in extreme poverty, and families experiencing community hostility or discrimination. We know that systemic family work will not address these issues and will not provide an effective intervention if the family’s basic needs

<table>
<thead>
<tr>
<th>Safer Families Unit process</th>
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<tr>
<td>Assessment and analysis of the family’s presenting difficulties and strengths leads to a clear formulation/hypothesis.</td>
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<tr>
<td>Plan agreed with the family: ‘family plan’ to meet the needs identified in the assessment.</td>
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<tr>
<td>Intervention offered linked to clear goals and timescales: by whom and when (concrete and specific) agreed with the family and shared with other professionals around the family and, where helpful, in the wider context.</td>
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<tr>
<td>Evaluation: intervention reviewed at regularly agreed intervals, goals may be changed following review, or the family may have completed the work agreed and their case may be closed or stepped down to locality or voluntary sector agencies, or escalated to care proceedings when necessary.</td>
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are not being addressed. We need to focus our initial attention on physiological and safety needs.

**Systemic approaches**

Alongside the ‘usual suspects’ from our systemic repertoire such as using structural approaches (Minuchin, 1974) to emphasise hierarchies, and using ‘safe uncertainty’ (Mason, 1993) and relational reflexivity (Burnham, 2005) to manage the impact of our own ethical position, we would highlight the following as a particularly useful combination in this context:

1. **Addressing issues of power:** The nature of social-care assessment and intervention increases stress on parents and their families. Systemic models give social workers and clinicians tools to address the ongoing impact of the interventions and assessments of safety, and the possible perceived threat of these on the parenting that it is attempting to support. We are developing a capacity in our practitioners to enable them to form a working alliance from a position of power, and to think about how to use their ‘authority’ respectfully and effectively to facilitate change in families. Using authority is seen as an effective leverage for change. How this core subject of power operates, and how this can be dealt with in this context is currently the subject of further research.

2. **The domains framework** (Hill et al., 2011): the model attends to achieving clarity in the domains of family functioning and communication. Those are: safety, attachment, discipline/expectation, and exploration; contrasted with emotions expressed, the role of certainty versus uncertainty, and the degree of hierarchy in any given interaction. These areas of attention within the family give a framework for understanding and intervening in relationships in order to support safer parenting.

3. **Mentalisation-based treatment for families** (Keaveny et al., 2012): Both parents and children are supported in working to gain greater affect-regulation and increase their capacity for mentalisation of themselves and each other; parents learn to ‘read’ themselves and their children and so provide safer care.

**Case example:** This has been anonymised and serves to give a flavour of what the work can entail, rather than any ‘true’ description.

**Unit assessment and analysis:** Donna has two children, a girl, Aisha (three), and a boy, Charlie (two). The family are white-British. Previous risks that brought the family to the attention of services were parental drug-use and drug dealing and domestic violence. Donna is currently split from the children’s father and is living on her own, although she did return to live with him recently for a short time and left again due to incidents of domestic violence. She has worked with the unit and local drug-services to remain clean from drugs for three months. She has many strengths as a parent, such as an ability to carry out effective parenting strategies, and love for her children that she is often able to demonstrate to them with warmth, care and kindness. She has a wider family and, while her relationships with them can be volatile and difficult, at times she is able to approach different family members for support. She is often low in mood and struggles to maintain relationships with friends and wider family.

The current risks to Aisha and Charlie include emotional abuse and neglect, and lack of stability, security, and physical safety. Under stress, Donna can lose her abilities to parent effectively and be inconsistent and harsh. She has little confidence in her abilities and can ‘give up’ and leave the children too much to their own devices; and they have poor attendance records at nursery. She also struggles to manage her feelings and can behave harshly towards them, and misattribute to them characteristics belonging to their father, or to herself. She can experience Charlie as ‘bad’ and overly aggressive, or weak and pathetic; and she feels easily hurt by Aisha, who she experiences as “just like me”. Donna struggles to cope with her feelings when not in a relationship; there is a pattern of her returning to the children’s father, returning to drug use that makes her unavailable to the children, and then leaving following domestic violence the children have witnessed. The unit are in a dilemma as they see a pattern over time. If the children are managed under child protection, involving conferences and the public-law outline, then Donna’s parenting and their experience improve. However, these improvements do not seem sustainable without this overarching context. We were concerned to come up with a plan that would either help Donna parent more safely and consistently, in a way that would be sustainable, or for us to be prepared to describe in detail to the court why care proceedings may be the best outcome for the children.

This situation is rather familiar in this context, where parents and the units are in a complex relationship. While the plan is negotiated with the unit and the details of the content of the plan is as collaborative as possible, there is an overarching context of the power social care has, and the consequences, should the family not work with the plan towards change to minimise the risk for the children, could be that children may not remain in their family. The impact of this aspect of relationships in this context is subject of further writing and research.

**Family plan:** Donna has agreed to continue to work with the drug services and services for women affected by domestic violence. She has also agreed to the following plan. The unit clinician, working with some time-limited input from other clinicians, will work with the family for 12 weeks. Donna and the children will have a minimum of two appointments per week in a combination of the following evidence-based interventions:

- **Individual work with Donna:**
  - Using a domains-based approach to develop clarity in family communication across the domains. For example: attending to safety when needed, attending...
to comforting a child when needed, and not confusing those two things
- Using a mentalisation-based approach to help her to learn to ‘read her children’ and respond helpfully more of the time, and use of elements of reflective parenting programmes (Slade et al., 2005)
- Using a combination of mentalisation and CBT, allowing a focus on developing regulatory capacities, methods of managing stress, and understanding negative attributions and the impact of her family and relationships
- Using psycho-education to know what ‘good enough’ care is for her children. We provide clear information about what this looks like, including safety, and information about the impact of maltreatment
- Using social-learning-theory-based parenting-skills programmes, techniques to embed positive child-management to counter abusive parenting. These will include consistency, rewards, praise, ignoring negative behaviour and appropriate sanctions.

**Work with Donna and her children:**
- Using video-interactive guidance to work with parents to identify clearly defined and measurable goals. We are clear about our expectations of what Donna will need to be both saying and doing to reduce the risks to her children. This approach adopts a strengths-based approach to identify moments of effective, warm parenting and play, to build on them and to enhance the parents’ ability to notice the children’s responses. This helps to strengthen their attachments, increase their ‘attunement’ to each other and develop more positive emotional-relationships.

**Working with the family and wider system:**
- Managing storms in families
- Managing relationships with social services, school, GPs etc.
- Reconciliation and planning a safer future, including understanding risky patterns and the meaning of these within the family
- Enhancing support – from family, friends, neighbours, etc.
- Developing safety plans held by the wider family and in the community.

**Evaluation:** We are evaluating the work session by session, using the goals-based outcome-measure and satisfaction ratings. We are using strengths & difficulties questionnaires to provide a measure of the children’s wellbeing; Score 15 for family functioning; and the adult wellbeing measure. We review the interventions with the unit in weekly unit meetings, and punctuate the programme with regular joint reviews with Donna.

This trial of therapeutic intervention attends to the children’s timescales and can be seen as part of the move towards reducing the reliance on ‘expert’ reports for court (occurring over much longer periods of time by professionals known to the family). This approach is part of our journey towards embedding expertise within the service and giving parents such as Donna a chance to make changes before social care decide to enter the court arena. Donna has expressed frustration about how difficult and challenging she finds the work. She has also expressed frustration she has not had these opportunities before. She expresses a great deal of commitment to the programme and has said she realises this is an opportunity to access services she has not had before that may lead to changes she wants for her and her children. Investing in clinicians in this kind of context stands some chance of mitigating the problems being stored up for the future for complex families who do not reach current thresholds for treatments, and who unfortunately can only access help by demonstrating greater and greater risk.

We would be interested in hearing from anyone developing a similar approach. We hope that the collaboration that we aim for with families who have complex needs can be replicated among those of us attempting to provide a useful service to families in a social care context.

**References**
Sally Wood is professional lead for systemic practice, and Rachel Watson is a clinician and systemic family therapist, in Cambridgeshire Children’s Social Care.
A troubled family therapist undercover: Some reflections on working with ‘troubled families’ in a statutory agency

Chiara Santin

After working with children and their families in social care for ten years, whilst training as a systemic and family therapist and supervisor, I now work as an independent systemic psychotherapist undertaking post-adoption support work for the local authority. Whilst working in a statutory setting, I progressively felt like I was working under cover as a systemic thinker and family therapist; my therapeutic skills were never fully acknowledged and formalised into a proper therapeutic role within the organisation. There were too many dilemmas for a statutory organisation to handle whilst striving for certainty in professional judgments in courts and safeguarding practices; too few resources to meet the huge amount of needs; the fit (or lack of it) between therapy and statutory services; the tension between parents’ empowerment and social control; and the imbalance of power between ‘troubled families’ and workers.

I used to like the challenge of using my skills in this context; I felt valued by some managers, who gave me ‘the cases’ where they felt there was some hope and potential for change. However, in an environment of defensive rather than reflective practices, my dilemmas and ethical questions were not welcome and I felt silenced as an uncomfortable voice. This led me to disengage further from my organisation and explore dilemmas in external clinical-supervision rather than sharing them with my colleagues and managers. This is why I describe this experience as a ‘family therapist under cover’, which eventually led me to leaving this post. In this article I will share some of these dilemmas and reflections with a wider systemic audience.

The ethics of therapy for undeserving clients: Is it cost effective? Is therapy a political act?

Reflecting on my experience, with a small dose of irreverence towards organisations (Cecchin et al., 1992), can be useful here, although I have to acknowledge my own bias toward this possibly typically Italian stance wherever politics is involved! At times of particular pressures and lack of positive outcomes in the therapeutic work, I was irreverent in simply wrestling with the uncomfortable questions/dilemmas that may be underlying policies and organisational choices about the best use of resources. Is it worth investing in ‘hopeless clients’, ‘troubled families’ where change is difficult to achieve, often making us feel ‘hopeless workers’, possibly ‘troubled workers’, unable to create change? No doubt good outcomes make us feel like good therapists.

I have sometimes wondered whether a hidden yet powerful professional discourse about the usefulness, or effectiveness of therapy in statutory agencies is influenced by the belief (or prejudice?) that the most disadvantaged people in our society “have to sort themselves out” and use the support available to them, possibly to make professionals feel good about themselves as helpers. Interestingly, when working collaboratively with clients by trying to identify their own therapeutic goals, I often heard: “I need to sort myself out”. The use of language here seems a reflection of these dominant professional-discourses that, in turn, reflect the wider socio-political discourse and social expectations, which may have been internalised by clients.

At its worst, any suggestion that ‘troubled families’ deserve political action, hence the need for a specific funding to support them, without recognising our part in perpetuating the myth of personal/individual as opposed to social and collective failure to care for the most vulnerable people in society, may reinforce the discourse that they are to blame due to being unable to “sort themselves out” even when supported. The boundaries between “personal troubles” and “public issues” (Wright Mills, 1959) can become blurred. Based on the principle of mutual influence, systemic thinkers believe that personal troubles and public issues are intertwined and therefore personal troubles are public issues, and vice versa. I would argue that the Government initiative for ‘troubled families’ may further reinforce the process of ‘othering’ by creating the sense of ‘us and them’ in the society, increasing the families’ sense of exclusion from social benefits that they deserve and interfering with their sense of belonging to a society by defining them in this derogatory way. It could also reinforce and convey the idea that families ‘deserve troubles’ more than they deserve support.

During my experience as a leader and supervisor of the Family Therapy Service, I realised the importance of keeping alive a political dimension in the clinical practice by trying to challenge some of the most hidden and shameful prejudices which are mirrored in the room (Hare-Mustin, 1994), particularly the idea of “undeserving clients”. I hypothesised that some clients’ missed appointments were a reflection of the internalised discourse of
Clients in this context are often implicitly blamed for not taking responsibility for addressing their personal problems embedded in their disadvantaged position in society. People have no control over their personal troubles, and the family could take a risk and open up yet again to another professional, positive outcomes were achieved by helping the family develop a different story about themselves, their children’s needs and their family history.

I was mindful of the need to acknowledge my own power in my professional role, e.g. my position as a therapist, a job, an income, knowledge and skills which confer social, professional and economic status, the mandate to be involved in people’s lives, the ability to ask questions, to manage personal information, the intimacy in conversations, the distress we witness to name a few. On a more personal level, I was overwhelmingly privileged in many respects compared to all my clients, for example, financial rewards and a family I can rely on. Furthermore, in a climate of cuts and redundancies, a job can be regarded as a privilege in itself. I often felt that managers were keen to convey the message that I should be grateful for having one rather than being “difficult” by raising concerns about safe practices.

I am also aware that my own childhood experience of being part of “a troubled family” (although not in the current political sense) and my experience of being silenced in professional contexts (e.g. due to my foreign accent or being an “unqualified social worker”) have made me sensitive to power imbalance and marginalised and dominant/voices. Having worked in this statutory setting without a recognised role as a family therapist, I often felt like a marginalised systemic voice within the dominant social work culture. My difference seemed to represent a reminder of the marginalised lives of the client group we, as a service, were supposed to empower and help find a voice. I felt like an outsider within my own organisation to the point that I had to resign to gain a voice and stand up for more ethical and anti-oppressive practices which would emphasise concerns as well as personal and family strengths. In my view, some assessments in such an organisational context run the risk of becoming abusive, unless they are balanced with a therapeutic and ethical stance of respect and co-constructed hope for change.

Anti-oppressive and collaborative practices

In my clinical work, I value engagement skills with this client group who often lead chaotic lives, fail to prioritise appointments, can unconsciously put up barriers around their scrutinised lives, make choices about what to disclose and what to “hide” to protect their sense of privacy in a context where confidentiality cannot be ensured.

In the statutory setting, some clients have no control over their lives and the decisions about their children are in the hands of professionals whom the parents have to work with and prove themselves to. Such dynamics further disempower them into the inevitable belief that change is not possible. I found it useful to reframe clients’ apparent “reluctance” to engage as “acts of resistance” (White, 2002) against the power imbalance and their attempt to maintain a sense of control in their lives. I used to ask...
them what they still had control over, e.g. coming to sessions and talk about difficult issues. This seemed to help them identify their strengths and counter the powerlessness. By giving them another chance despite many missed appointments, I attempted to maintain and honour the tenuous link with the possibility of change and keep a sense of balance between safeguarding concerns and family strengths.

In order to facilitate families’ engagement, I tried to make the teamwork and the reflecting team processes as family friendly as possible. Having no screen meant a less visible barrier and more transparency. We introduced the idea of ‘talking chairs’ in the middle of the room and ‘listening chairs’ for the reflecting team in the corner. In order to make reflections more accessible and simple for clients with low self-esteem and often poor educational backgrounds, we used small pieces of paper with a key word or message, which was explained in the reflecting conversation and left on the table for the family to take or leave. This was designed to give them a sense of agency and choice over what they regarded as potentially useful.

I found it useful to conceptualise my therapeutic position as sometimes ‘walking ahead’ when attending to statutory concerns, and ‘walking alongside’ when privileging collaborative practice, helping clients to see, notice and amplify any small changes, and giving them credit whilst standing behind them. White & Epstein (1990) suggest: “The therapist can achieve this standing-behind position posture by taking up a position at the ‘base line’, against which all of the changes in the person’s life can thrown in to sharp relief” (p. 149).

Case example (the details have been changed to preserve anonymity).

When we started working with a mother of four children, mostly teenagers, who were referred for extreme aggression and violence between them, the trainee therapist felt overwhelmed due to the level of chaos and conflict in the room. We reflected that it was difficult to have any conversation and that laughter was used to avoid talking about more uncomfortable topics e.g. how to get along better. In one of my interventions as a supervisor, I asked the oldest children to be part of the reflecting team and make notes about what was being said or write any other comment. One of the children wrote, “Mum loves her kids”, and, “laughter can sometimes hurt”. Another wrote, “My sister was sad when they were calling her fat and made her feel bad about herself”, showing empathy with her sister who was blamed for causing arguments in the family. Another note read, “Everybody needs to stop talking so people can talk one at a time”. By empowering them to write and to notice each other’s behaviour rather than imposing ‘order’, which could have been perceived as abuse of our power as therapists, we enabled them to find a voice and start communicating in a different way. The trainee therapist managed to achieve some level of “controlled chaos” where some profound words could be uttered in precarious moments of silence, and a listening mode – a different experience from their daily arguments.

When I was asked to write a report for a child protection conference, I had to take the position of assessor of risk and explain what changes were necessary to reduce the conflict and aggression. I shared the report with the mother, being open an honest with her about my concerns whilst trying to reframe her family situation as “having lost hope that things could be different”. She agreed that this was the case. This could be seen as an example of “walking ahead”, required by the statutory role in attending to safeguarding concerns, whilst trying to walk alongside the family by being transparent and acknowledging their stuck position.

We invited the mother on her own to view a five-minute clip of a session to help her see the family interactions from a different perspective. After the initial reluctance and embarrassment, she became reflective and noticed how she was behaving like “a teenager” or “older sister” herself, expecting the therapist to be “in charge of the kids” and giving up her authority. This meeting enabled this mother to imagine and wish a different role she could take within the family, which we started witnessing in subsequent sessions e.g. when she was firmer and taking a leading role in family conversations. This could be seen as an example of “walking behind”, when clients become more reflective and hopeful for the possibility of change. Keeping flexible positioning was at the heart of our therapeutic work; trying to move between different positions to maximise therapeutic potential and navigate the fine line between therapy and a statutory role.

Powerlessness and reasonable hope in the interrelated systems

I noticed in my work how typical emotions such as hopelessness, helplessness and disappointment with the lack of change were isomorphic processes (Liddle & Saba, 1983) i.e. reflecting emotions present in the various systems. Families who were experiencing powerlessness in their lives in relation to a powerful legal system, and therefore not attending sessions, seemed to create disappointment and hopelessness not only in their social worker but also in other professionals including us therapists: we were working so hard to “give them hope” but often failing to engage them in the process of change.

I wondered if this is an example of internalised hopelessness in professional systems, which reflects clients’ vulnerability and hopelessness. It was helpful for us as professionals to reframe “hopeless clients” as “clients who lost hope”, who could not believe things could be different in their lives. Like in the clinical example above, it became our aim to help families to shift this entrenched belief and explore with them exceptions, more positive, yet realistic scenarios of “reasonable hope”, i.e. co-construct hope together by identifying resources, strengths and signs of resilience (Weingarten, 2010).
Equally, as professionals, it was crucially important to promote “critical hope” (Freire, 1992, p. 2) as a way to cultivate hope in clients as well as taking a political and ethical stance by being a critical voice against oppression and injustice.

Conclusion

Being irreverent to myself (and my story) leads me to conclude that perhaps I have written this article for myself hoping for a catharsis. Furthermore, this is only one side of the story, my own biased story. Systemic and non-systemic colleagues, managers and clients will all have different stories to tell.

My story would not be my lived story if it did not incorporate personal feelings of hopelessness and painful dilemmas about the use or misuse of power in organisations, particularly statutory services, and my place in it. In a context where defensive rather than reflective practices prevailed, it has been hard not to carry a sense of personal failure i.e. failing to make a difference in public services and to contribute to changing its defensive, potentially unsafe and abusive practices further impacting on ‘troubled families’.

I would like to express my gratitude to all my clients who have taught me so much about the mystery of suffering, various forms of oppression as well as strengths and resilience hidden in every human being. For me as a therapist under cover, this shared experience of resistance in the face of perceived oppression became a source of renewed commitment to therapy as a social and political act. Freire (1992) states “My hope is necessary, but is not enough. Alone, it does not win. But without it, my struggle will be weak and wobbly. We need critical hope the way the fish needs unpolluted water” (p.2).

References


After working for ten years in social care, I now work as an independent systemic and family psychotherapist for an adoption agency within the East Sussex County Council offering post-adoption support to children and their adoptive parents. I have been a tutor and trainer for the certificate in systemic practice at IFT for four years and now at the Tavistock Portman and NHS Trust, London, as part of an agency-based training course in local authorities in London. I am a trainer and supervisor for a small organisation which runs two children’s homes in East Sussex and I am a committee member of the Sussex Association of Family Therapy and national representative for Sussex.

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Newbridge revisited: Working in partnership with Wigan CAMHS and Newbridge Learning Community

Danny McGowan

My colleagues and I wrote previously in Context (Alty, et al., 2010) about our experience of working together at Newbridge Learning Community – Wigan’s specialist educational provision for pupils with a statement of special needs for emotional, behavioural and social difficulties. I work as a Tier 3 specialist CAMHS-based family therapist and have had one-day-a-week allocated to work with the school. This is a brief update, connecting with the theme of this issue on working with families with complex needs.

While not formally connected to the ‘troubled families’ initiatives, children and families in our client group do experience considerable challenges and often require some innovation in our attempts to support them. Since our original article, austerity and cuts have also begun to bite, and this has resulted in the school losing resources. However, there has also been a positive move by the local authority to develop a mental health strategy informed by a ‘social model’ of mental health, acknowledging the contextual factors that lead to young people’s distress and difficulties in functioning. Denise McCarthy has been a key person in this, as a mental health champion both within Newbridge and with a cluster of local schools too.

I have also accepted an invitation to be a school governor for the school, with a lead role in promoting mental health within the governing body. While there are some identified conflicts-of-interests in this role, I felt this was an opportunity to support the ‘school as the therapist’ and learn about successes across the system, such as the very good academic results achieved by a number of pupils. Following the completion of my systemic supervision course, I have also been delivering systemic supervision to staff throughout the school, including managers, administrators, teachers and pupil family partnership workers. This has been an enriching experience, and the personal and professional contributions everyone makes in this goal are now shared in my approach.

Newbridge is a hub for multi-agency input due to the high proportion of pupils who are in care or otherwise known to social services, youth offending teams and other agencies. Our success has led my trust and local commissioners to create a new family therapy post to work specifically with emotional, behavioural and social difficulties, and the school’s head teacher, Elaine Kucharski, is involved with us in the interviewing for this.

I felt her introduction of me as “the school’s family therapist” to be very generous and it helped me feel part of the school system. I still run my clinics in school and value the support the pupil family partnership manager and staff provide in this, as co-workers and in engaging with the families with skill and consistency. Engagement remains the central task, working with families where trauma, poverty, historic family issues and previous experiences of professional help that have not always felt helpful predominate. We have had some straightforward successes but also have had scope to allow families to re-engage with us when attempts to work together have not worked out the first time, and where there is ambivalence about help.

While locating myself within ‘social constructionist’ thinking, I am also open to using resources and ideas that may be useful tools in particular situations. I am guided by a dialogue between attachment theory and structural family therapy, and find taking the position of holding ‘nurturing boundaries’ remains helpful in this. Pupils often have a complex combination of longstanding behaviour-problems and traumatic experiences, often shared by other family members. Parents can alternately feel the guilt, try to be sympathetic and give their children everything to compensate: when this does not work, they try to impose discipline, which doesn’t work either as they alternate between these two positions.

I start from a position that children need to feel safe in the relationships between them, the parents, and us before we can take risks in our exploration of change. We share an understanding that things have often gone wrong in the past, and services like ours, and therapists like me, may not previously have been able to help. But we also have some ideas to offer to where things are now. Confidence that this might work and make life better can help establish this safe base too, alongside mobilising resources and finding evidence of marginalised resilience. Often re-establishing structure – routines and boundaries – is helpful to establish a degree of stability and parental influence from which to explore traumas safely. In turn, feeling safe and understood can re-direct behaviours in a positive direction.

Pupils often have a complex combination of longstanding behaviour-problems and traumatic experiences, often shared by other family members.
It is crucial, however, that there is a ‘fit’ between my clinical orientation of sensitive persistence and the efforts of the school staff. This includes the practical and emotional support from the pupil-family-partnership workers and the educational strategies of teaching staff that, in combination, help families to engage and pupils to achieve. The school also has an experienced and highly regarded school counsellor, and strong relationships with other professionals and agencies. ‘Joining’ with this system is inevitably greater than simply a stand-alone clinical intervention in a school setting would be.

Rather than simply react to referrals, we have also offered screening with strengths and difficulties questionnaires to gain a better understanding of the mental health issues of pupils. Initially, we offered this to the whole school-roll with responses from pupils, families and school staff returned. This identified most pupils as at high risk of ‘behavioural disorders’, which was no surprise, and the school has appropriate strategies to support them with this. Given the high rates of a diagnosis of ADHD amongst pupils, fewer than expected were considered as at risk of ‘hyperactivity disorders’. A very small number were identified as at ‘high risk’ of ‘emotional, behavioural and hyperactive disorders’. Targeted intervention at this group has led to disclosures of child-protection issues, referrals to the early intervention in psychosis team, and re-engagement with CAMHS through myself.

We had a very positive therapeutic intervention with a pupil, whose externalising behaviour in school would not have drawn attention to high levels of internalised anxiety and trauma. After a series of family therapy sessions, which explored historical experiences, family dynamics and strategies to manage anxiety, we repeated the strengths and difficulties questionnaires, as we would routinely do before closing cases, and noted scores of ‘low risk’ in all three domains.

Supporting pupils with statements of special needs for emotional, behavioural and social difficulties, transitioning from primary school to Newbridge, has been a recent focus of my work. This involved me meeting with the main feeder primary school, which had similarly offered the strengths and difficulties questionnaires to pupils, families and staff, to screen for mental health issues and signpost for referrals. Resources permitting, we plan to continue evaluating this year group.

We always work systemically within wider systems. Making sure we have a pathway through the new CAMHS single point of access systems has also been helpful, recently. I am looking forward to working with the new CAMHS family therapist commissioned to work specifically with this group of children, and with my colleagues at Newbridge, who continue to make a difference to the children and families with whom we work together.

With thanks to Elaine Kucharski, headteacher, Michelle Alty, pupil-family-partnership manager, and Denise McCarthy, assistant pupil-family-partnership manager, Newbridge Learning Community.

Reference

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Between 1998 and 2009, I was the parenting coordinator of the youth offending team in Somerset, a largely rural county in the West of England. In 1998, following the Crime and Disorder Act, the Labour government introduced such teams as multi-agency organisations to tackle anti-social behaviour and offending, as well as school exclusion and non-attendance. The teams consisted of members of the probation, police, education, youth and health service, and what was at that time, social services.

In this article, I will give a brief history of the work I did with parents, with a small group of colleagues in the team, whose company made me glad to go to work every day. I would also like to acknowledge the families we were privileged to meet, whose feedback helped us to understand how to be more effective parenting workers. I also offer a few findings from my masters research dissertation (Staines, 2008), which is based on a day at the seaside with mothers known to us in the team. The research findings prepared us to develop our work further.

The first chapter

My role as parenting coordinator was to work with parents to reduce offending and anti-social behaviour. “Relate”, the organisation offering counselling for couples, families, young people and individuals, piloted and evaluated a parenting programme with my first cohort of parents, who were referred by social services. The parents told me, informally, that what was missing in the twelve-week course was the chance to talk about the emotional impact of the intrusion by various professional agencies, such as social services and the police, into family life following the young person’s offence. After two years in the job, an assistant joined me. When we meet now, we still talk about driving to villages and towns, and about the families we met, of every socio-economic status and class, and about the dogs, cats, snakes, parrots and fish, which were intrinsic to the experience. Many referrals came from social workers, and were often vague. But there was a need ‘out there’ and we tried to offer something in response. We did not have hard quantitative data on whether this preventative work with over 600 families was successful or not, as there was no dedicated post for an evaluator within the team at that time. But we were supported by the Trust for the Study of Adolescence, which was working hard to provide information on evidence-based practice, research, evaluation and training. The trust organised a national monthly-forum for all those in youth offending teams who worked with parents, in an atmosphere that was collaborative, stimulating and humorous.

My own ethnographic observation and reflective recording identified a range of recurring themes: the son’s role as the ‘man of the house’; the changing use of gender-based language by young people, for example “slag” and “whore”; aggressive physical behaviour towards parents by their young; discrimination based on culture, race and ethnicity, for example against travellers, gypsies and newcomers to Somerset.

Right from the start, my colleague and I decided to look for strengths and not deficiencies in families and to validate intentions to improve things even when they were not working. We had ongoing meetings with magistrates, where we argued the case for working voluntarily with parents rather than under a statutory parenting order, which they inevitably perceived to be a judgement on them as ‘bad’ parents. The strength of our argument depended on the extent to which magistrates were influenced by the latest government directives. We built connections with other agencies.
such as Somerset’s Committee for Racial Equality, Somerset’s mediation service and CAMHS. Long before I understood what was meant by the word “systemic”, it made sense to work with more than just the young person or the parents. We once held a meeting in a living room with the parents and siblings of a 12-year-old boy, as well as the neighbours and friends. He had been charged with setting fire to cars and we invited our police officer to join us. We sometimes called upon the expertise of our educational psychologist, literacy teacher, drugs worker and youth worker. These meetings, which brought together the various systems, were invaluable in promoting better communication and helping reduce unhelpful processes between the families and professionals, and also between professional systems. Every week, I accompanied families with whom I had built a relationship in their homes to the family therapy clinic to work with Rudi Dallos, who was at that time the consultant psychologist in the youth offending team.

By 2008, the number in our team had increased to five, two male and three female, one of whom was part-time. Sensing a push towards more short-term targeted work, I organised two days of training in solution-focused brief therapy with Chris Iveson from the Institute of Family Therapy. These ideas fitted well with our commitment to seeing people rather than simply their problems. The focus of the approach on strengths and resources helped us grapple with the new demand to meet ‘SMART’ (specific, measurable, attainable, realistic, timely) targets. As time moved on and we were required to set short-term targets for complex family situations, I thought back to years earlier when my colleague and I had had a long conversation with a single father in his home, which ended with his comment: “That really helped – I’d never thought of those things before”. I thought that setting as a target: “to introduce new thinking” was attainable and had the capacity to be useful and meaningful.

As a parenting team, we used the skills and resources we had as individuals within the team, in the same way in which a family therapist uses the resources in a family. For example, a colleague who had worked individually with young people in the youth justice system for over thirty years came to join our parenting team because he wanted to work more systemically. He and I visited a boy who had been given a reparation order by the court after being charged with assault on another young person. His brother was waving a golf club at their mother. There was a consensus that school holidays were a “nightmare”. After some time, I asked when they had last done something outside the home all together as a family. The father turned around from where he was sitting at his computer and everyone became silent for a few moments. The mother then started to recall, in great detail, how they had all walked slowly through the water as they followed the course of a local river. The atmosphere in the room was transformed as each of them returned to the memory of that shared experience, and hope became tangible. This episode aroused in me the idea of working with families in natural surroundings, which then led to the regular organisation of days out.

At some point during the next few years, my colleague and I spent one unforgettable day on a beach in Cornwall having a barbecue with forty-two family members from four generations (this was in the ‘good old days’ before we became constrained by the demands for health and safety). We subsequently heard the children were still talking about it, years later. On another occasion, we walked slowly along the seafront in the autumn with a small group of distressed parents who, by the end, had made new friends and felt calmer. One spring, we climbed five hundred feet up the face of the Mendip Hills to bungee jump down again (well, I didn’t, I took the photographs) and saw how a son, reluctantly at first, held the rope for his large muscle-bound – and terrified – father, helping him make it to the top. Shouts from another father to his son of: “Oi! Come on, you girl!” later opened up useful conversations about gender.

The research

For my research dissertation at the Institute of Family Therapy, I chose to look more closely at one particular day out and how it was experienced by four mothers, who spent the day with eight other families at a seaside on the south coast of England. All were mothers of young people defined by the Youth Justice Board as a “young offender”. This was someone between the age of 10 and 17 who had received a final warning from the police for an offence, the first step on a ladder to a criminal record (the highest rung being custody).

Method

Of the eight mothers who attended the day at the seaside, I asked five of them, after the event, if they would be willing to talk to me about it. My colleagues had been with them, but I had decided not to go, in case my presence as their parenting worker inhibited our conversation about it afterwards. Four agreed to talk to me and the fifth told me she “wouldn’t know what to say”. After a short while, it seemed unethical and disrespectful to pursue my request any further as she seemed reluctant to talk, and I was not sure why at that stage. This interaction on the telephone was a pivotal moment in the research process, and made me aware that speaking about the experience may present more difficulties for the participants than I had anticipated. It helped remind me of the need for sensitivity during the interview process. All of the four women had experienced physical violence from partners and/or their young person. All lived in local authority housing and were not in paid employment. Three were single parents and all were
under the age of 45. I used a qualitative method and conducted semi-structured interviews with the mothers in their home, each of which lasted approximately one and a half hours.

**Analysis**

I was interested in understanding how the women made sense of their experience. I chose to use narrative analysis, which focuses on the way people “tell stories about” their lives, and it seemed particularly fitting as a way of discovering stories which may be more hopeful than those they were used to hearing. People in positions of power had typically told their stories; for example magistrates in the youth court, social workers and the police. This method of analysis is concerned with a sense-of-self and with wider socio-political conditions and the cultural assumptions represented by language. I wanted to find an alternative to the “soft on crime” discourse, which says that professionals reward bad behaviour with a day out. Narrative analysis focuses on the way language is an expression of social and personal relationships and, as I already had a relationship with my interviewees as their parenting worker, this fitted well. I was also interested in how meaning would become ‘co-constructed’, an idea proposed by feminist writers such as Goldner (1985). I was also a mother myself, and I had a memory of my mother having fun playing rounders with other people in the street where we lived, when I was ten. Why was that memory still so vivid and so painful? Would those who were on this day out want to ‘bottle’ what they experienced, if it was positive? Finally, not exclusive to a narrative analysis, but appealing to me: “Metaphors and images act as bridges between sensory processes, cognitions and feelings, thus connecting us with ourselves (and others) on many levels” (Etherington, 2004, p. 135). I still recall vividly that, as I became immersed in their stories over months, the sea was present throughout, soothing as well as stormy.

**The theme of freedom**

A ‘day out’ is a powerful metaphor. Being displaced from everyday life, for example on holiday, can produce some kind of ‘unique outcome’, to use a term from narrative therapy. In systemic terms, a change of context can change thoughts, feelings and actions. As I started on the analysis and my own self became entwined into the process, I found each mother’s narrative included something which spoke to me of freedom: freedom from the stress of organisation, freedom from economic considerations, freedom from taking responsibility for their children, freedom from the constraints of their community back home, and freedom, or not, to talk about powerful memories of childhood and to enter into the experience. Byng-Hall (1995) talks about family rituals, as “symbolic enactments which provide opportunities for change” (p. 25). One woman’s narrative included memories of their “happy family” at the seaside together, ending suddenly when her parents divorced. She told me how she had come to terms with it and about her plans to study psychology so that she can help other people who have struggled. Her story moved through past, present and future. She wanted to do things differently for her own children, reversing the painful aspects and repeating the happy aspects, what Byng-Hall calls “corrective and replicative scripts” (1995, p. 233).

**Studies relating to crime by West and Farrington (1973) have shown that families are often disconnected and poorly attached**

Two out of the five women found it difficult to talk. One told me she remembered being at the seaside as a child with her mother and with “someone else”, but said that she didn’t “want to mention him”. Crittenden’s work on the link between attachment experience and memory being held in different systems – procedural, visual, semantic and episodic – sheds light on the way memories become integrated so that we can make sense of our lives (2008). She says: “Telling the stories of our lives is crucial to understanding ourselves and understanding ourselves is crucial to our relationships, especially...
those with our children” (2008, p. xiii). Painful memories were likely to make it difficult for many of the parents we worked with to create coherent narratives of their own and help their children to do the same. According to Dallos (2005) this ability is a skill. This is particularly relevant in a youth offending team, where young people are expected to talk about the effects of their behaviour on victims, without having learnt the skill. The work of Fonagy et al. (2002) on reflective self-functioning – the ability to think about our own and others’ internal states – is also relevant for these young people and their parents.

The memories will live on

At exactly the same time as I qualified as a family therapist in 2008, Somerset’s youth offending team was robustly re-organised. There was a move towards delivering a one-size-fits-all parenting programme across the county, specifically the Triple P programme (Sanders & Ralph, 2002). This meant we were no longer able to tailor our work to match the unique needs of parents. However, one thing which remained was a belief that days out with families should continue. Anecdotal evidence consistently showed positive outcomes: parents and children saw each other in a new light; workers modelled consistency and respectful behaviour; workers were seen as human beings, which created a good working relationship; parents saw their young people take responsibility; people made friends and their confidence grew; and it was fun.

My research with four women revealed useful insights, which could potentially have been useful for mothers, fathers and young people. From one woman, I heard her hopes for the future, which she linked to memories of her troubled past. What makes it possible for some people, and not others, to make those connections? Is it possible to somehow ‘bottle’ a sense-of-self which is competent, free, proud and at ease, and take it back to an environment where you feel constrained by your circumstances and by the language of those in a more powerful position? I heard from one mother that she and her husband had left their son in the care of the parenting team as parenting coordinator until her resignation in 2008, and wondered if she had done the right thing. How do our attachment experiences affect the way we care, for ourselves and for others? What are the implications for young people in the youth justice system whose parents have never been cared for themselves?

Had our parenting team been given the chance to develop, we would like to have found a way of using the deeper insights gained through the research, to tailor the work we did with parents to be even more effective, by building on ‘exceptions’ and trying to influence the professional systems involved with young offenders and their families. Unfortunately, at that time, the word “systemic” was not part of the common language, as it is now, and the ideas were, perhaps, not ‘smart’ enough. They will remain as a special legacy of a community of families and professionals who were challenging some negative professional discourses within the youth justice system. Our interventions were a very careful response to feedback from parents. We remained hopeful that they could find the freedom to enjoy being parents in all their different contexts, and help their children to flourish. I trust that these ideas and memories will live on in another time.

References


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“On I do like to be beside the seaside”: Working systemically with families in the youth justice system
Bridging CAMHS and social-care teams: Experience in a ‘troubled families’ project

Yoko Totsuka, Jessica Muir, Sylvia Metzer and Bella Obi

This article is based on our work as a team of CAMHS clinicians in the Families First pilot project, London Borough of Newham’s ‘troubled families’ initiative. The ‘troubled families’ program (Casey, 2012; Department for Communities and Local Government, 2012) is a government initiative aiming to ‘turn around’ 120,000 families defined by poor school-attendance or exclusion, worklessness and anti-social/criminal behaviour (families are identified as ‘troubled families’ if they meet two criteria). We, a small team of clinicians, were also given a role to work closely with the children’s social care teams, as part of the department’s drive to introduce systemic approaches to social work (Goodman & Trowler, 2012). We will describe our work from three perspectives; our client families, social-care colleagues and ourselves. We will first describe the context of our work, our practice and experience, and then present a summary of a qualitative analysis of feedback we received from social-care colleagues and families.

Context of the service

The Newham Child and Family Consultation Service has been developing accessible and responsive services for over a decade (Aggett & Ryall, 2012; Aggett, 2012). It is jointly funded by health and social care and we have strong connections with the multi-agency network; outreach work takes place in many parts of our service. Dedicated CAMHS clinicians work with the local authority services (e.g. looked-after-children teams, Early Start) and in the education-outreach service in mainstream schools and special-education provisions (e.g. Metzer, 2012).

The pilot gave us an opportunity to further develop our relationship with the local authority. Our role was to be embedded and integrated members of three social-care teams to provide a range of CAMHS input, including a liaison role, consultation, teaching and training, and therapeutic input to families known to these teams. Our model was based on our service’s ethos of providing accessible, responsive and flexible CAMHS input to children, young people and their families who are often described as ‘hard to engage’ for a range of reasons. The plan for our project was informed by the developments in the borough, where training on systemic therapy and social-learning theory were being rolled out to all social workers. This meant there was an expectation for us to work jointly with social workers, with a hope this would provide a learning opportunity to build on the training. We also saw it as an opportunity for mutual learning, given this was the first time in Newham we had a chance to work closely with social-care teams.

Our practice

Cases referred to us often involve ‘hard-to-engage’ families, risks in relation to child-protection issues and mental health, possibility of, or ongoing care-proceedings, complexities in terms of multiple problems and complex needs in children, young people and often in parents, too. Our theoretical orientations are parenting interventions based on systemic therapy and social-learning theory. We used different venues, flexibly, to maximise the impact of our work. We have seen young people and their carers at their home, foster-care homes, care homes, schools, social-care offices, clinics, and even in a park, cafes and job centres. Sylvia, whose young client took her on a dog walk in a park, sometimes had to travel a long way to meet young people and carers who lived out of the borough, where many of her clients known to youth intervention (social care) teams experienced disruption to their lives, e.g. going in and out of care, moving to live with other relatives or carers due to placement breakdowns. However, we did not define our work by home visit or ‘outreach’ per se, recognising the importance of flexible approaches. Our ethos is ‘crossreach’, a “term to describe working across, with and in multiple contexts; purposefully working flexibly across contexts using a range of venues; working with and within the multi-agency network; working with the ‘family-helpers relationship’ (Imber-Black, 1988, p. 131), supported by the clinician’s ability to reflect on and negotiate with clients on the most helpful approach, depending on the aim of the work at any given time” (Totsuka, 2012, p. 1). For example, Yoko suggested meetings at a social worker’s office when the family were unable to acknowledge the local authority’s concerns and the seriousness of the court-mandated work. In this case, we thought the social worker’s office might symbolically communicate the nature and the purpose of the work.

Although we tried to co-work with social workers whenever indicated, we quickly realised the best approach was to keep seeking feedback from the families and social workers as to what is most helpful. For example, we did not realise, until we met with a parent alone, how terrified and petrified she was of the social-care department’s involvement, which was causing her to walk out of meetings, creating an impression she was not ‘engaging’ or cooperating. Some families seemed more able to talk openly without a social worker being present, particularly those in or at risk of care proceedings. Bella, who worked with a social work team, where most cases were in or near proceedings, in some cases found meeting with parents individually before attempting to bring the social worker and family together was a helpful approach. Whilst some families seemed to benefit from seeing social workers and clinicians work together, we were aware of the risk that joint work with social workers could make us...
We try to work with the network as a resource to create changes for the family. However, some families where children were on child-protection plans find the process extremely stressful. The fear of, and anger with, the local authority's 'intrusion' often makes it hard for them to work with their social workers that, in their view, have the power to take their children away. It was helpful to reflect on the dynamics within the network and common pitfalls such as a sense of powerlessness (for both professionals and clients); expectations of chronicity and timelessness (i.e. the network losing a sense that things can be better, or things used to be different) and power relationships within the network; and we often try to work on the relationship between the family and social workers, for example, by explaining the system to the family and explaining the family to the system (Aggett et al., 2007).

As part of this work, Yoko started to encourage parents to mentalise (e.g. Asen & Fonagy, 2012) their social workers. She asked them if they have heard news about child abuse or death (many parents know about 'Baby P') and explained that social workers see hundreds of families and, if one of them turns out to be like these cases on the news, they would be vilified, lose their career and have to live with the guilt for the rest of their lives. After the question, “Imagine you are a social worker. How would you make sure the family you are working with is not one of them?” another question “What can you do to show your social worker that you are not one of these families on the news?” seemed to have a different meaning and spur the families into thinking more positively how they can demonstrate their strengths to their social workers. After this discussion a parent, who was complaining about the social worker’s unannounced visits, was fully convinced these visits were necessary to keep children safe and could see that the social worker was “just doing her job”. We try to help families build on small positive changes and credit them for the changes by emphasising that they ‘earned’ it; for example, positive feedback at a child-protection conference or fewer unannounced visits.

Our experience and learning

We had the privilege to work closely with dedicated and compassionate social workers and to witness the difference good social work makes. For example, a parent who kept denying physical abuse to her child, resulting in an impasse in therapeutic work, was able to acknowledge her responsibility after realising that the patient and helpful social worker was not there to take her children away. The parent then engaged with therapeutic work with us, jointly with the social worker, to think about how she could repair the damage caused to the child’s emotional wellbeing and their relationship. The biggest learning for our team was the insight we gained into the challenges social workers face; for example, their caseload of extremely complex cases, engaging families who may or may not want their input (and some families who may be overtly hostile), the changing demands on their roles, the sheer number of professionals they have to keep on board and the tight timeframes in their work, sometimes dictated by courts. We realised the network (including ourselves, before this experience) do not always appreciate this. For example, when decisions on rehabilitation were made in court, against the local authority’s recommendations, the network meeting was quick to question their plan without appreciating their dilemma and the power of decision-making being out of their hands.

Summer (2013), a clinician working within a local authority, encourages her social work colleagues to make purposeful use of statutory visits by thinking in advance about the situation and ‘taking hypotheses’ with them. As none of us have social work backgrounds, working jointly with social workers helped us understand their roles and widen our perspectives. For example, when we tagged along with the social worker’s meeting with younger siblings that we were not directly working with, the fact they were happy and doing well at school seemed to indicate the strengths of the family (which we can highlight as ‘something the parent is doing right’), despite difficulties in other areas of their life. Hearing the younger children talk affectionately about their older sibling, who had serious difficulties, provided a different perspective on the young person.

Once we built relationships with social workers, we started to hear their views and about their experience of our service. A common theme in their comments was that we were not responsive and accessible, partly due to waiting lists (although our recent service-re-design addressed this). We repeatedly heard social workers say they hardly see CAMHS clinicians coming out on home visits, in particular, with social workers. From our perspective, this did not seem entirely accurate, given all our colleagues offer an outreach service in response to a high level of mental health risk, and the multi-agency work is valued by the whole service. However, it was important for us to realise that there continues to be such perceptions of our service. In this sense, we tried to provide a bridge between CAMHS and social-care teams; for example, by explaining how we make decisions on urgency or the need for outreach work in the context of significant cuts to our service in recent years. We also wondered if this highlights the importance of the personal relationship with social workers, and making it possible for them to contact one of us as opposed to the ‘service’ (over the years, we had noticed that the availability of named or dedicated clinicians seemed to help change schools’ perceptions of our service). In our role, working alongside social workers, we also provided consultation on a wider variety of cases we were not directly involved with, and we hope that such input would support the integration of therapeutic approaches and preventative work. We also encourage our local authority colleagues to attend child-mental-health training (known as ‘Tier 1 Training’) provided by our CAMHS.

The ‘troubled families’ initiative means elaborating clear and defined goals we were expected to help the families achieve. Whereas we had some successes, we were also conscious of the reality that many of the parents were unable to seek or find a job, due to physical or mental health problems or learning disabilities. We were also aware of the limitations of our team and the need for a joined-up approach with other CAMHS colleagues. Liaison with the CAMHS clinician in the young-off ending team has been particularly important. Although our focus is child and adolescent mental health, we were often bringing in adult-mental-health perspectives to the network and signposted for referrals, especially...
in cases where adult-mental-health services were not yet involved, in order to better understand the parents' difficulties and capacity.

Feedback from social workers
As part of the evaluation of our project, clinicians who were not directly involved with them interviewed social workers and families. Seven individual or focus group interviews were conducted with social workers and managers, using a semi-structured interview. One manager offered written feedback. Transcripts were analysed using thematic analysis. We will describe the main themes, with examples.

1. Shifting perspectives
Social workers felt consultation with the clinicians helped them think differently about cases and reflect on their practice in new ways, which moved their work forward.

"It is shifting perspective slightly away from immediate concerns and addressing child protection plans, and looking slightly more in a wider context, and shifts focus slightly which I thought was helpful."

Social workers frequently cited the clinicians' acknowledgement of the families' past and use of systemic and strengths-based approaches as helpful in expanding their own thinking. The different therapeutic theories appear to function as transferrable 'tools' or frameworks they can continue to draw on in various aspects of their future work. They described how they have used therapeutic approaches in different stages of their work such as assessments, hypothesising and interventions.

"I am employing different approaches and attitude towards interventions with this case and others. Developing transferable skills."

2. Moving forward together
The direct work, jointly conducted by social workers and clinicians, has helped social workers move their work forward. They indicated there were a number of facets to the support provided by the clinicians that facilitated this. Flexibility and accessibility emerged as one of the key themes. The embedded role of clinicians made it easier for social workers to discuss, develop and implement intervention strategies with them.

"It has been good to have that consistency. X (clinician) has been able to see how cases have progressed rather than it gets missing."

Social workers found the accessible and integrated clinicians in their teams helped work to progress at a quicker rate. They felt the willingness of the clinicians to see families in their homes or social care offices, rather than only in clinic settings, was a crucial factor in kick-starting therapeutic work with hard-to-reach families.

"You have to make arrangements for the family to go and see them (at clinic), and a lot of families won’t do that, you have to bring it to them. So, the fact that she goes out is really beneficial."

"This way it also makes the family feel more comfortable. A family had not attended (clinic) appointments and saying they didn’t receive letters but X (clinician) was coming to visits I had already arranged so it was a lot more helpful than them coming all the way to the clinic as they were comfortable because they knew me and it was in their own home."

Social workers indicated that outreach work was appreciated by families and facilitated positive outcomes; for example, in engagement and helping families gain different perspectives on the issues they were facing.

"Parent totally shifted her perspective; she was engaging more, seemed to be more insightful, more self-aware... Really good outcomes achieved for that family."

"From my opinion it’s more helpful if they are more involved as X (clinician) was coming into the family home to support the social worker – a fresh pair of eyes on the whole situation rather than just listening to the social worker’s opinion."

Social workers also mentioned that families often found it easier to share information with the clinicians in response to therapeutic styles of communication. Families were less fearful when disclosing information to clinicians who were regarded as less threatening or likely to enforce unwanted measures.

Linking therapeutic theory and practice: Social workers felt joint visits with the clinicians enabled them directly to see therapeutic techniques. This in turn helped them to develop confidence in drawing on their own theoretical knowledge and using therapeutic skills in new ways. When asked which stage of support was of most value, a social worker commented:

"Joint working, as I also learned something from her especially talking with the service user. She takes time to build relationships and work systematically."

"Some questions that X (clinician) asked that I never thought about, that helped me with my other cases."

3. Challenges
One of the barriers identified by social workers was the clinicians' limited capacity. Whilst consultation was described as useful, some felt more involvement of the clinicians would have been helpful.

Social workers highlighted the differences in therapeutic work and social work, in terms of timescales and focus of the work.

"We are coming from a perspective of 'change needs to be brought about'; we have timescales to do that, and we need to progress things, whereas the perspective of more therapeutic input is more ongoing and less emphasis on timescales."

"It appears as though Mum, something happened in the past, it is why she is stuck... I found that a bit worrying because I thought from my perspective, it’s time this individual moves on. The same case can’t be open forever dwelling on the past."

Feedback from families
Three families were interviewed. All the interviews involved mothers of children who were known to social-care teams and currently or previously subject to child-protection plans. One interview involved a 19-year-old sibling. Two families had previously attended the clinic. We will describe the main themes with examples.

1. Taking time
The importance of the clinicians 'taking time' came up in different ways. Families noted that therapists would take the time to listen, explain and share information. Families appreciated how much time the clinicians and social workers spent listening to them, leading to a sense that someone was truly trying to get to know them and thus understand the factors affecting them.

"They listened and spoke to me and A (son) separately and they took the time to know me and A."

Families felt the clinicians and social workers took time to explain processes and systems involved in the work, which made them feel supported, particularly at the early stages of the work.
“In the beginning I thought it’d be really hard. But X (clinician) made it much easier. She breaks everything down.”

“She was really supportive, right from the start. They explained everything to me, everything (laughs) and she did what she said she would do.”

Taking time to explain things, to be interpreters of information, seems to break down the barriers and create alliances between workers and families. This indicates that families may have felt alienated in the past by professional terminology, and anxious because they were unsure how the social-care systems that they were embroiled in worked.

“X (clinician) can help explain all the big professional words the social workers use.”

“It really helps having X there to explain things to us, as social workers just say ‘this is going to happen next’ whereas X breaks it down and explains ‘they can only do that if this and this happens first.’”

**Taking time to share information and be transparent:** One family emphasised how much they valued the time the clinician and social worker took to share their reports for meetings.

“They told me what they were putting in the reports before meetings and everything was right and it wasn’t unfair, I wouldn’t need to change anything.”

This contrasted with earlier experiences where this mother felt workers were taking events out of context and adding them to reports without prior discussion, leading to her fear her children would be taken away.

### 2. Flexibility and responsiveness

A second theme, interrelated to the first theme, is the importance of worker flexibility and responsiveness. Families valued the clinicians’ and social workers’ willingness to meet in places where they felt comfortable, such as their own home.

“It’s not as uncomfortable as it is at the clinic. There it feels like you’re being judged. But X comes to our home and she doesn’t judge us” (sibling).

“X comes to my home and asked how I was feeling. But I preferred to go to the office. I felt, what’s the word, not safe, exactly, but more able to talk … She’s very understanding, willing to help.”

“They called out to the home at different times of the day and evening, so they could see how things were at different times, such as when he was tired, which was helpful.”

The families also commented on the flexibility, responsiveness and accessibility in relation to communication, and who was included in the work.

“She was always there for me if I needed someone to talk to. If I was losing confidence or just needed someone to check in with about how something was going. She wasn’t just there for my kids – she was there for me too.”
3. Not being judged
The combination of taking time to get to know families and a flexible, responsive approach appeared to generate a sense within families that the therapists and social workers were understanding them and not judging them. It is clear families have felt judged negatively in the past by professionals but, in contrast, they felt viewed positively by the clinicians.

“It’s so different from the clinic. There, I feel like we’re being judged by everyone – even the receptionists… With X, she sees how things really are in our own home, and I can ring her whenever I need to for support.”

“She’s not stuck up. She sees that everyone has their own problems. When we talked about mum and drugs she said ‘That’s something people go through in life’, she didn’t judge us” (sibling).

“I really liked X, she is understanding for one, and for two, she doesn’t make her own judgement, she is fair, she says it as she sees it.”

“They did not make me feel like I was a bad parent; the previous workers asked me too many questions about me and not A (son) and didn’t see what was really going on, as they met me and A at the clinic A would often refuse to come. This meant that A was seeing no one.”

The parent who made that last comment felt professionals in the past ‘were judging without being there’. When asked what she would say to other families, she said, “They can help you without judging you. People should know that you can’t change if you don’t think staff are fair”.

4. The benefits of different perspectives
All families spoke of how they valued gaining different perspectives provided by the clinicians and social workers in joint work.

“It was good to have a new social worker and psychologist together. They both saw what was going on and they were both from other places … you are not being judged by just one person.”

“It’s not good cop bad cop but X will explain, whereas social services are more blunt. [Having a therapist working alongside a social worker] takes the scare factor away”.

5. Solid Outcomes
Families spoke of positive and tangible outcomes they achieved which improved their wellbeing.

“X helped me to think about how I talk and act in front of the kids.”

“If I hadn’t seen X, my daughter would probably be in care right now.”

“My daughters are a lot calmer and so am I. My little one behaves better, attends school regularly- and usually on time too!”

Moving forward
Our team has expanded since the pilot, with new developments in the local authority services. The recent changes in the wider context have included the reduction in expert-witness assessments and a tighter timeframe for care proceedings. In response, we are looking at ways effectively to support the ‘front-loaded’ work the local authority needs to undertake before initiating care proceedings. Such work will inevitably bring challenges; e.g. confidentiality, consent, clarity about our role as therapists, likely requests for reports on our work for courts and the potential impact of this on the therapeutic relationship (Santin, this issue, discusses these dilemmas), the need to work within timeframes to test parents’ capacity to change (which was identified as a challenge in the aforementioned social workers’ comments). However, we also see this as an opportunity to further develop our practice and partnership working, aiming to reduce risks to children and young people.

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