Family for every child

Report of Consultation

Documenting Therapeutic Approaches

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This contents you are about to read are focused on the therapeutic interventions being offered by a proportion of organisations linked with Family for Every Child. There is much detail about: staff qualifications; therapeutic orientation; type of interventions being offered and how and where this takes place, means of assessment; measuring change and outcome; and the specific mental health difficulties or problems targeted.

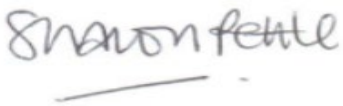
It was not possible to consider all the annual reports and other documents that each organisation has written over the years: this report is in the 'here and now'. Telephone interviews were carried out with key people but did not extend to other fieldworkers and clinicians. The perspective of people who had benefitted from an intervention was not included – but would be essential in an evaluation study. While these are limitations, the richness of the information made available, including many case examples enabled me to get the flavour of the work being undertaken. Furthermore, the circumstances in which most organisations are delivering important and much needed therapeutic interventions are difficult, the political economic and social context often problematic. The combined efforts to assist children and families around the world in a culturally sensitive manner is impressive and commands respect.

The numbers of children, parents and families reached by each project varied enormously – not only due to the size of the project itself and the number of people employed or volunteering in different positions, but in relation to the aims of the organisation, which may be specifically focused on one issue or have a wider remit. Information was not collated about numbers of children, adults, families intervened with directly, reached through community projects or the specific timeframe of therapeutic work. This is likely to vary considerably and will not mean one organisation is 'better' or 'more effective' than another – they all have different goals and need to operate in different contexts.

For readers from outside 'Family for Every Child' it is essential that you realise that organisations are providing input at many levels: community projects, teaching and training, social action and political lobbying. Therapeutic intervention is but one part of their work and may form a smaller or larger proportion of how they use their available resources.

Family for Every Child is a global alliance of local civil society organisations working together to improve the lives of vulnerable children around the world.

I strongly urge you to read more at **https://familyforeverychild.org/**



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INTRODUCTION

Context of the Consultation

Organisations were applying a variety of professional approaches such as Social Case Work, Community and Clinical Psychology, Family Therapy, and Therapeutic Counselling in extremely difficult contexts. Violence and abuse are universal phenomena, but both were particularly prevalent in some areas, communities or countries in which these organisations operate. Many contexts have had significant political and civil unrest and there was great variation as to the level of government provided medical/health, education and early childhood care services available. In some places, these were not easily accessible to all, especially the poor, or to those in marginalised communities.

Most of the professionals offering therapeutic interventions were Systemic Psychotherapists, postgraduate Psychologists, Medical/Psychiatric Social Workers and Counsellors – often supporting other staff or volunteers. Some senior people had completed training in Administration and Management which may have moved them away from direct service provision. Most, if not all, the organisations have had intermittent issues with funding, resources were often limited and the scope of problems challenging. Supervision and support was not always consistently available, and additionally - even during this consultation - there were staff changes occurring in key personal and gaps at senior levels.

Talking to senior people gave a clear sense that everyone was keen to understand and potentially draw on approaches that were being taken by other organisations, and to share best practice. There was a strong interest in learning from and helping others, and recognition that methods developed by other organisations might apply to their own context either as they were, or with adaptations. There was interest in the documentation of different approaches and the tools that were being used. There was appreciation of the likely value in pooling resources in relation to both knowledge and skills.

There was a strong wish to increase skills and expertise through additional professional training, on-line courses, workshops attended and/or significant relationships with Universities and Clinical Services in the UK or USA. There was a consistent recognition that interventions might need to be adapted to the cultural context, in order to offer sensitive interventions at many levels with young people and their families. There were strong existing links between some organisations.

I have written this report with the definition of therapeutic interaction from the Mulberry Bush School in mind. This recognises that it is not always a formal therapy that leads to change. The way children and families are approached, the care and respect with which they are treated when in distress or difficulty, the relationships that are nurtured and sustained involvement which demonstrates a commitment to care, can result in shifts without manualised or structured interventions.

Therapeutic interactions are therefore, those that contribute to

- a mental, physiological or emotional state being regulated more healthily
- a thought or feeling being more bearable
- something different happening in somebody's emotional life
- someone having a better story about themselves
- someone understanding themselves differently

- something being tolerated
- someone (re-)establishing contact with self and others
- an experience being taken in or used more healthily & a therapeutic relationship contributes to and change that lasts beyond the relationship ending.

However, although recognising these interactions as critically important, for the purpose of this consultation I have concentrated and emphasised the more formal interventions being offered.

Process

Initial reading was provided including Power Point presentations, and further information was gathered from various websites, published papers or evaluation studies provided by different organisations. Collating this and using detailed interviews with senior staff on Zoom added to the richness of the descriptions. These were followed by requests for additional documents which had been discussed during the conversations. In many instances, it seemed that the interviews led to some useful reflections or new ideas arose and I hope these were beneficial in themselves.

Some organisations primarily worked with individual children and their families, some targeted a proportion of their resources at the wider community and others have, or have had, a clear training/ development role for other professionals. In addition, a number placed an emphasis on influencing public policy, and pushing for long term changes. The organisations varied in complexity, both in the range of services they offer and the levels at which they intervention. Each has a rich history, which reflects social and political change. Many have been through periods of substantial development and periods of significant financial constraint. The task of this consultancy was to focus on the therapeutic work offered and it was not possible in this document to do justice to the range and richness of everything that each organisation does.

I am grateful to everyone who gave their time and thoughtful consideration to all my questions, and who offered comments and corrections on the draft report.

Summary of therapeutic work undertaken by each organisation

ABTH in Brazil

Like many other organisations ABTH has operated at many different levels. Reintegration work has been the core of their work, based on their systemic therapeutic approach: and reintegrating street children and those in institutional care to their original families has been a priority. They have offered both a preventative therapeutic approach in the favelas and a protective therapeutic approach with children from the streets, shelters or foster care.

This organisation operates in two favelas, areas which are known to be particularly violent and which many other services will not enter. Direct work is offered with the aim of preventing the removal of children from home. By working from a strong systemic theoretical background, they can have an influence on the extended family and interventions can have far reaching impact. They also involve a great number of young people through neighbourhood activities such as handicrafts, theatre and

football organisations. ABTH has also worked with children who were living in foster homes, or on the streets, and embark on new projects approved by more recent partners/donors. They have a strong profile offering training for professionals.

Having access to a series of slides written in English, a Report of Activity 2018, information available on the website and a number of documents e.g.: *Report on Social therapeutic Work with Families in Situations of Violence Encompassing the Use of Genograms in Social Practice ['trabalho socio terapeutico']* allowed clarification of the methodologies used with young people with their families in the Reintegration program. Many were translated from Portuguese by Tiago Bravo[1].

ABTH sees the system around each child as being of fundamental importance and uses Genograms* and Ecograms** to map relationships and identify significant people/community links. This captures the vast quantity of complex information relating to a three-generation extended family network and provides a visual map of the family's organisation. In addition, children are immediately seen in a wider context including health services, education, church, NGO's, and friends. The visual representation of relationships denotes whether connections are strong or weak, supportive or conflictual. Systemic interviewing [with explicit attention paid to non-verbal communication] explores relationships and alliances, family history, rules, and inter-generational patterns so that a story is co-constructed with the family. This process involves the active participation of family members and ultimately enables staff to hypothesise and clarify directions for therapeutic work as the professional work plan takes account of the wider psychosocial and cultural context.

The intensive family work is undertaken by a Psychologist and Social Worker as co-therapists, offering complementary knowledge and skills. They reflect on their own roles as part of the professional system and are encouraged to be self-reflective. There is an expectation that staff will explore their own genograms, and the organisation sees this as part of the approach which along with supervision, increases effectiveness and minimises 'burn-out'.

A recent reduction in funding has affected the amount of therapeutic work the organisation is currently able to undertake. They no longer work with foster families or reintegrate children but focus on preventative work with children living within families where the level of violence is high and there are other complexities. The organisation developed a 'Scale of Violence' for use during assessment and ongoing monitoring. The families are 'high risk', reside in the most violent communities where other professionals will not go and therapeutic work can be intense.

Interventions include 1:1 and family meetings, and the organisation may remain involved with a family up to two years working consistently towards change and then ensuring that this is sustained. They seek to improve relationships, using solution focused, strength-oriented techniques and encouraging reflection. The aim is to provoke change not only within the family but in the structure of the community so that violence is less prevalent. In addition to individual and household systemic interviews [using the tools above * & **], there are activities in the community such as jewellery and cooking workshops, a theatre group and community bazaar. A significant innovation has been the opening and sustaining of an Early Childhood Space where children's play and development is supported. Referrals are made to Psychiatry if someone is thought to be psychotic, suicidal or need a PTSD assessment, but this is rare.

1 A Counselling Psychologist working in the UK, who also joined the interviews as an interpreter – his contribution was considerable and much appreciated.

There has also been a focus on teenage pregnancies as many girls under 18 become pregnant. There is a repeating pattern of infants being looked after by their grandmothers, often within a wider context of gender violence. Groups were established for the young mothers, these have a psycho-educational component focusing on issues such as attachment and bonding between mother & child, and care of self & baby. Sessions may include other professionals, such as lawyers who can provide information about the rights of pregnant women. Handicraft activities encourage young mothers to make items for their baby or to sell. Therapeutic work with the family takes place during home visits using systemic ideas and techniques. The aims include preventing adolescents becoming pregnant again within a short time - thus, interrupting the repeating pattern, and to improve the quality of care provided by teenage mothers to their infants.

CHALLENGING HEIGHTS in Ghana

The Social Worker interviewed was also covering the post of Shelter Manager as the previous incumbent had resigned. Challenging Heights rehabilitate children who have been trafficked and forced to work in the fishing community. They have a 'shelter', Hovde House, where children live and receive medical care, emotional support and education while their families are located and the potential for reintegration is explored. A range of issues are assessed [e.g. physical development, nutrition, developmental level for age and behaviour problems] and while in the House staff observe the young person's level of independence, behaviours, ability within the classroom and their communication with adults. Children stay around three months, occasionally for up to a year. The 'Behaviour book' and 'checklist' was provided, but there was no available outline of the parent training session.

Hovde House has clear rules, written as an extensive list with consequences for non-adherence [also provided] and in addition, there is a behaviour modification programme [based on Social Learning theory]. Young people receive small gifts/rewards on Sundays that serve to motivate [examples include sweets, biscuits, ice cream or a small toy]. Each young person's behaviour is recorded daily: positive behaviour such as making the bed and negative behaviours e.g. fighting. Points are awarded for the former and deducted for unwanted behaviour. Some items are not clearly defined such as 'good classroom behaviour' and some have a 5-point scale but no clear definition of the criteria for each score. Total scores are shared weekly but notification of these are not shared for some days. Distinctions are not made between the increase in positive behaviours and decrease in negative behaviours. Individuals in the group are ranked which may produce a degree of competition. Children are not given a copy of their charts, and although some are illiterate, they might benefit from a visual representation of their individual progress.

The shelter is staffed by five teachers, five shelter parents, an art therapist and a social worker who provides the counselling. It has no formal link with a psychologist, although a previous staff member had a psychology degree. The group work program is manualised and covers emotional literacy, social skills, and problem solving. Each of the topics is covered for a few days to ensure that each young person digests the content. Role plays are used and there is a sense that each young person must actively participate before moving on to a new topic. The group is very large [up to 65 children] and it is rare for any child to complete the whole program: most receive only part of it. It draws on Cognitive Behaviour, addressing thoughts feelings and behaviour and uses techniques that were completely new for many house staff. Most have at least a high school certificate, and a few have tertiary education. The Social Worker is unique in having a professional qualification.

A team from the USA came to provide a 3-day training before the implementation of the therapeutic program, and they conducted a workshop on how to use it. The team does not maintain contact to advise on ongoing issues following implementation or to consider changes that might be useful. The Social Worker that attended that training but has now left, as has the previous Shelter Manager.

In the school the children are divided into three classes: graded to accommodate those who have never been to school and are illiterate or innumerate, and those who have been to school and might have achieved grade 3.

Many of the children have had traumatic experiences, not only abuse but seeing dead bodies or almost drowning. Children are screened for PTSD in the first few weeks using the CRIES, [a well-established questionnaire] and the scores are noted in the care plan. Children with scores in the clinical range are offered counselling sessions with the intention of reducing their reported symptoms. The techniques used in counselling were drawn from Social Casework experience and no specific model of trauma-focused intervention was used. The Social Worker usually approached this task by focusing on the most traumatizing experience and encouraging the young person to talk about it ['*open up*'], recognising that some might need time to be able to do this. The counselling sessions often helped to reduce the PTSD scores and also focused on how children could behave better. If this was not successful, young people are referred to a psychologist externally [usually around three children each year].

The level of understanding about trauma was not consistent throughout the staff group. There was some recognition that aspects of the environment might be trigger for young people and if identified, staff tried to manage these. There was a component in the manual left by the Americans addressing anxiety, but this was not used in counselling. There was no assessment of Dissociation as a possible feature in those scoring highly in the PTSD assessment. It was considered that a group intervention might be less appropriate as children wanted their experiences, particularly of sexual abuse, to be confidential.

Some work was undertaken with parents in the form of a training session held twice a year. Parents might have to travel a considerable distance [funded by the organisation] which also created some time constraints. Within the day they discuss child trafficking, how best families could use their financial and other resources, and how to handle the child when they returned home. They do not draw on any evidence-based model of parent training but talk about the experiences they have within the shelter, how children were on admission and how they have been helped. They do not describe the use of behaviour charts but encourage parents not to shout or beat their children but rather to sit down and talk with them, and to motivate them. They discuss situations such as a child misbehaving and how a parent needs to talk calmly, and how the child's reintegration will be monitored by officers who visit weekly. There has been no consideration about running a regular parent training programme for parents who live more locally. Advice might be offered locally and/or group sessions held which would include parents who were managing their child's return home more successfully.

In terms of reintegration children who felt bitter towards their parents tend to have the problems most of the problems but there were not many meetings between parents and child before reintegration took place. This is likely to make is difficult to resolve issues.

Supervision of and consultation to staff could be patchy. However, while the manager post was vacant, assistance could be sought from the Vice President or President of the organization.

CHILDLINK in Guyana

Childlink operates in the context of investigations of reported child sexual abuse. It exists in 4 out of 10 regions of Guyana and there are hopes to expand into two more. It works with the national Child Protection system and related institutions providing a multidisciplinary service including a Forensic Interviewer and Trauma Counsellor. The team works together to ensure prosecutions of perpetrators and that the child's needs for therapeutic help are met. Staff can also be called to give evidence and support the young person and their family through the court process. Therapeutic intervention without delay.

There has been considerable input from various clinicians In the USA and consultations which have helped them develop a Children's Rights based approach. The model was adapted from the USA and clinicians were brought over to train the multidisciplinary teams. They partnered with JACONI with whom they visited and held joint conferences.

There is a clear trauma-focused assessment process which looks at the family context. Suicidality or substance misuse need prioritising and, in these circumstances, or if someone is thought to be psychotic, the case is returned to the Child Protection Officer to make a psychiatric referral to the hospital. Counsellors determine the level of traumatization. They rely on children over 7 reporting their symptoms, and those under 7 being involved in activities which may give the counsellor ideas about their presentation. Treatment goals are established, and efforts are made to engage families, and solve problems which create any barriers, including the use of motivational interviewing.

The assessment session aims to build a connection with parents and information is gathered about the child's behaviours and parental observations. There is no automatic link with schools but at times teachers' observations of the child's behaviours are incorporated. Information is also gathered from the Social Worker/Child Protection Officer who observed the child's forensic interview. No other screening tools [such as the SDQ or RCADS] are used, and there is no measure for parents. If there is physical abuse at home, this needs to be addressed before the counselling can start or, if disclosed later, it would be suspended temporarily. Considering a safety plan, offering strategies for children who tend to self-harm, and exploring ideas of normal sexual development and age/person appropriate boundaries were other aspects addressed.

Individual counselling starts with building rapport and the assessment continues within this context as the child may later refer to other symptoms. There are twelve modules primarily drawing on a CBT framework: psychoeducation, relaxation skills, affect modulation and cognitive coping skills aimed at building confidence and offering the child strategies to manage as they narrate their abusive experience. Children were seen weekly, but a module might need more than a week to be sufficiently understood. Children with phobic responses/avoidance are assisted through practice and a 'fear ladder' used to monitor their reactions. The focus is on helping the child talk about the abuse or find ways to express their feelings through writing a song or poem about it. At a later stage, efforts are made to help parent and child create a conjoint trauma narrative together.

Counsellors had access to a 'Tool Book' with worksheets and a range of creative ideas ['people in my world', how to use drawings, using colours to denote certain people or feelings]. The various modules might be used differently depending on the age and gender of the child and/or the type of abuse. There was a recognition that young people would process traumatic experiences at different speeds and that at times they might need a break. The session would be stopped and the child distracted

if they were becoming too distressed. The Decisional Balance Worksheet was not used as it was not considered relevant for a social context where many parents were illiterate.

Parents/carers were involved alongside the child, educated about trauma separately and encouraged to understand what they could do to help and support their child. They were made aware of the modules and taught some of the techniques. Parenting Skills training was offered by Parenting Officers in closed groups lasting eight weeks. The manual for this was currently under revision.

Work was not done in groups as many of the children came from one community, but groups were offered to children with behavioural issues, or when individual work was completed as the groups played a role in increasing self-esteem and empowering children. If they were able to share experiences, this was seen as having the potential to decrease shame and their sense of isolation.

There was an awareness of secondary trauma for staff and a system of staff support in group sessions for Forensic Interviewers and Counsellors, and regular 1:1 consultations.

BUTTERFLIES in India

Butterflies has provided services for vulnerable children, especially street-connected and working children in Delhi since 1989. The Rights-based participatory and non-institutional approach aims to educate and impart life skills to vulnerable children so that they become skillful and emerge from the intergenerational cycle of poverty. To achieve this goal Butterflies implements programs with children, families, communities, legal systems and schools both at a grassroots level and through partner organisations, supporting the children and their families, communities and schools. Social Casework aims to promote the adjustment and development of individuals by improving relationships and enabling better use of resources which may have been restricted by certain factors. Butterflies take the view that denial of Children's Rights impacts on their development and survival and is closely related to protection and mental health issues. Children and families are seen as in need of more comprehensive assistance, which has the potential to address multiple factors.

Caseworkers can identify problems early and be proactive: they do not always wait for the client to approach the organisation. Information from various sources is collated and treatment can be extended to significant people in the child's life. Effective management of children's issues usually demands collective decisions and family involvement in addition to individual child-focused interventions. They facilitate any necessary modification in the family environment, build the parents' capacity to address emotional wellbeing so that they can attain more satisfying personal and social relationships.By utilizing resources better, Social Casework offers an method through which children's problems are dealt with alongside promoting overall development and adjustment, and the prevention of violence. Rigorous conversations, house visits and regular work within the community programs assist in the development of constructive interactions.

Social caseworkers meet the children daily and periodically conduct sessions on life skills, mental health, and issues related to child protection. Those in need of a mental health intervention are identified or are referred by street educators, parents or community members. Social Casework and Family Therapeutic Care [FTC], which is underpinned by Attachment Theory are utilized, and consideration is also given to a child's needs in a more comprehensive way, e.g. helping them to complete formal education and learn vocational skills.

Therapeutic skills are part of the Social Caseworkers professional training, and within FTC problem-solving and solution-focused models are adopted. The young person is encouraged to have a secure, reliable relationship with the caseworker, and to explore and develop a similar connection with other significant adults in their lives. All frontline staff undertake additional training offered by Butterflies which continues to build skills through monthly training sessions and ongoing supervision. The initial FTC training was provided by Juconi. The three stages are: i. working on attachment with the child and the family to create a sustainable relationship; ii. enabling children and families to gain insight by reflecting on the past and identifying potential solutions – generating hope; and iii. offering a process which is healing while working on behaviour, decision-making, and lifestyle. The focus on family bonding encourages positive and nurturing relationships and improvement in family communication. Cases are closed when treatment goals are achieved, usually within two years.

Many children have complex problems: anger management and emotional regulation issues; lack of interest in studies or daily activities; emotional distress; and dealing with major life transitions such as achieving independence. Some present with high risk behaviours such as gambling and stealing. Substance use is also observed in a few children: this might link with them being detached from family but mostly follows experiences of family violence and being influenced by peers. Issues such as physical abuse, forced work, neglect, early marriage and sexual abuse have also been reported. Different forms of violence are embedded within social norms and practices and community-based interventions attempt to address these.

The assessment format is to develop a socioeconomic profile and make a psychosocial study (history of the problem, family history, academic history, work details, social relationship history etc]. Five indicators assess the progress and are monitored at regular intervals. Where relevant data is collected in a systematic way following the indicators for Substance Abuse Disorder [DSM-5] enabling staff to assess dependence, use/abuse, and experimentation with substances including glue, cigarettes and tobacco [gutka], and alcohol. This results in a clear picture of the dependencies and their severity, detailed history of drug abuse/misuse and clarification of the resulting complications [physical, familial, psychological, legal, financial and occupational] and noting of high-risk practices such as sharing/reusing needles, and sexual health issues. Additionally, past attempts at abstinence [duration, what support was available, reasons for trying] and reasons for relapse are explored. Caseworkers assess the young person's motivation and intentions for the future. They have used motivational interviewing, e.g. when a child is out of school and reluctant to return.

The process of assessment, planning and review [which may include diagnosis] is seen as a dynamic process. The 'cognitive map' of each case is presented during clinical presentations to inform assessment and plan further treatment. This is also discussed in supervision and may result in a decision to bring in new people to address specific needs.

Case examples included a young person with anger management difficulties, a limited capacity for problem-solving and tobacco addiction. Another young adult with aspirations had been forced into early marriage and was struggling with family issues: intergenerational conflicts around expectations of her behaviour, an alcoholic father and abusive younger brother who was domineering. Intervention with her enabled her to exit the marriage and continue her studies. This illustrated the importance of the case worker being able to offer a comprehensive approach that includes, but is not limited to, therapeutic work, for example: mentoring; environment-modification; links with other organizations and services; and routes into education and skills development.

Most of the intervention takes place within the community: the organisation has a main base/office which has a short-stay home for boys - The Resilience Centre. The boys who stay for a short period at the Resilience Centre are children who access CHILDLINE [a 24x7 helpline services for children]. Most children are lost, missing, trafficked, exploited as child labour and/or abused and in the majority, efforts are made to return them to their families rather than to long-term institutionalized care. The first week constitutes an assessment phase, that is then discussed with the team. The Centre offers groups drawing from CBT using techniques/worksheets, and workshops that focus on behaviour such as managing anger/aggression or substance misuse. During their stay children access at least 8 sessions promoting understanding and behaviour change, and 10 sessions of life skills education [including communication skills, recognition and management of emotions, understanding and developing empathy, and greater skills in problem-solving and decision-making].

Genograms help clarify where a child feels safe or illustrate other aspects of child and family relationships. For those who may not be able to articulate their problems, its reasons, patterns of their relationships or emotions, they may use techniques such as 'visualization' to help the child reflect on their lives and experiences which may include traumatic events. Standardised tools to assess PTSD are not used; but within the psychosocial intervention, and an empathic listening approach is utilised rather than Trauma-Focused CBT or EMDR. Children identified as having a psychiatric illness are referred to psychiatrists in Government hospitals.

Sessions are held with parents and regular workshops that focus on the family and the community ensure the community's active involvement in providing a safe, caring and protective environment for children. These sessions are about positive parenting skills, emphasise the significant role that parents can play in a child's life, outline the effects of violence on children, suggest how to deal with adolescent risk-taking behaviour, and aim to improve family communication and bonding.

USK in Kenya

USK has strong links with Juconi: exchange visits were suggested and funded by Railway Children [funders]. Juconi facilitated training, advised on implementation and provided coaching. USK has also had links with an American psychologist [Dr Jenny Roberts] who has helped to provide activities to engage children and devised sessions for families. Visits from both have now ceased.

The main objective is to work with street children, many of whom have been exposed to violence, and it encourages reintegration and a safe return home. The organisation has a KPOS [Kenyan Place of Safety] where an initial assessment can be made, and a treatment plan developed. A case analysis format template assists in the gathering of information. An evaluation of the RRR program [Rescue Rehabilitation and Reintegration] 2016 recommended that more details about how the plan was implemented were recorded and better monitoring of changes could be done. The Intensive FT intervention showed that there was a benefit in school retention, increased confiding in parents, less physical chastisement and improvements in parent/child relationships.

Young people leave the streets voluntarily, and for those who remain out of their families, there is an 'association' model, which links individuals to a supportive peer group after rehabilitation. With increased life skills and positive influences these youths are more able to identify and 'rescue' others. Teaming up has advantages for finding safer accommodation, support when sick, increases the

propensity to develop business ideas and may provide a peer group that helps keep a young person away from crime and drug use.

Reintegration guidelines were followed which require comprehensive understanding of the family and the system around the child including school. There was a strong priority given to developing a relationship and maintaining an interest in a child through individual interviews. Staff use a variety of therapeutic tools and activities. A strength-based approach is favoured and the range of therapies includes Dance and Movement Therapy. These are recognized as be particularly valuable for less articulate and younger children for whom they offer a means of self-expression, and especially important with children who have been sexually abused. USK considers these are a unique way in which they empower the children they work with.

The Family Therapy intervention is offered to a proportion of families and is focused on improving relationships between parents and children through joint activities, decreasing the likelihood of physical chastisement and abuse. It aims to enhance parents' capacity to support school attendance and achievement, there is an emphasis on helping parents improve parenting skills. In conversations, a solution-focused orientation and future-oriented questions appeared to be favoured.

Some group counselling takes place. Cognitive Behavioural techniques are used with older children if their developmental level allows and they can utilise the concepts. A small proportion of cases are deemed 'non-intensive' – weekly sessions may become less frequent, and work may be completed within 6 months. More complicated cases require longer term intervention: e.g. when parents are resistant to a child's return, parents have drug/alcohol problems or are themselves affected by early trauma. In these cases, there may be many visits a week with workers demonstrating that they can be persistent and committed to helping the family work towards change.

An assessment of the level of violence in the family was made and reviewed after 6 months, improvements in this were linked with the move towards 'graduation' from the programme. This event provided an opportunity to talk about achievements and positive change, and often led parents/ families to continue to meet or visit one another. Other aspects were clearly significant: such as economic empowerment; helping parents to interact with others; capacity-building and reducing disengagement.

Psychoeducation about the negative effects of drug use, alcohol and crime were undertaken, and some longer-term aims to increase the number of people engaged in productive activity. Psychosocial therapeutic counselling was aimed at enhancing young people's sense of self-esteem and identity, to change their attitude to life, and promote behaviour change. Much of the therapeutic work is undertaken by staff in pairs, dividing of roles [perhaps with one taking the child, the other working with parents]. A male co-worker is particularly helpful in engaging fathers and attention is paid to the relationship building and gender/power issues.

The case study provided showed how the work with an individual teenager, who spent some weeks in the Place of Safety, led to contact with his family, changes in the lives of his siblings and his mother's parenting. After almost three years of involvement with the organisation his mother has a successful small business, his siblings were in school, 'T' had completed his education and was doing well. Another showed how a young man was helped to process his past experiences and identify his strengths in order to move forward

JUCONI in Mexico

Juconi was established thirty years ago and is firmly underpinned by the systemic approach, taking into account the connections with school/teachers, neighbours, community and employers. It has developed a model aiming to reach children missed by governmental and other voluntary organisations: those who work on the street, or who work there but still live at home, or with families where children are at risk of street life. Juconi developed guidelines for Reintegration of children, extensive preparation, intervention at multiple levels, and follow-up, offering support through all stages and working in collaboration with Child Protection services. It runs two residential homes [one for males with a focus on Reintegration, the other for those making the transition to independence], a day centre and local offices. It also seeks to promote change at a national level, through an income generating Training Institute. It has a strong link with the Tavistock Clinic in London, UK.

The objective is to reintegrate children back into a **safe** family environment, using Juconi House, if necessary. The approach has a firm base in Attachment theory both in terms of promoting healthy family relationships and in the therapeutic relationships it strives to develop and maintain. It aims to break the cycle of violence through therapeutic interventions directed at individual parents, children and whole families - much of the work taking place during home visits. It privileges engagement, sometimes making strenuous efforts to persuade family members of its' intentions and making a commitment to work with them towards change. Staff consistently convey the message that they are important and that Juconi will not give up on them. It embodies the intention to approach parents with respect and appreciation: reframing, seeking out strengths and avoiding criticism. In 90% of families there is a long history of violence, and adults may need time to talk about their own childhood experiences. Child sexual abuse is also common.

The comprehensive assessment includes a family genogram, clinical history form and a Family Functioning Scale alongside the Strengths & Difficulties Questionnaire [SDQ] and Child Care Index. A cognitive assessment is carried out on every child. Assessment of parents is focused on the home environment and their ability to care for the child.

Interventions can be individual, family and/or group oriented and include parent training, dealing with trauma, helping people understand and improve emotional regulation, cognitive understanding and increase social skills. Where appropriate helping individuals and families to process narratives around difficult emotional experiences to enable them to move forward.

In groups there are workshops on Child Development and early childhood issues, health and nutrition topics, self-care including sexual health. They actively take up parents' ideas but do not run any evidence-based parent training but sometimes run sessions on limit setting and discipline. Video Interactive Guidance is used with some parents.

CBT is provided for the child and family: concentrating on developing an emotional vocabulary, and emotional literacy [making use of a 'thermometer' with colours red, yellow and green to denote mood states] and creating a plan, so that individuals have ideas of what to do when someone is upset. Strategies may be discussed in family therapy sessions, breathing/calming techniques practised, drawings made to facilitate sharing, and problem-solving skills developed. Co-therapists may be assigned to large families and different subsystems worked with simultaneously.

They also base their work strongly on the work of Crittenden but do not use the Adult Attachment Interview or Story Stem Assessment Profile. Weekly psychoanalytical-oriented play therapy with children ['special time'] is provided with the aim of helping educators and staff in the homes to understand the child's inner world and the behavioural consequences. Where families are supportive, this may be continued on a non-residential basis. Supervision is provided by the Tavistock Clinic.

Traumatic experiences are explored as part of the history taking, and intergenerational trauma patterns recognised, but there is no formal assessment or distinction made regarding PTSD. Digital storytelling is undertaken with older children facilitated by Social Workers and Family Therapists: this provides an intensive but containing structure to explore and narrate a powerful experience following a format of questions starting with *'When did you feel part of your family?'*. Recently young people wanted to share these. The original is given to the author and usually there is no copy made.

A more recent development is a Day Care Centre close to the market where children can be left safely. This context promotes play and age appropriate development rather than the child helping with their parents work and/or being subject to minimal supervision. School support is available for older children.

Referrals are made to the Juconi House by other agencies, sometimes families who have been helped refer/recommend people or the organisation reaches out to young people who are known to be absconding, using drugs or not attending school. There may be an initial refusal from parents, but workers are persistent. A stay in the house might be lengthy, particularly if adults need time to recover from their own trauma history before a child returns. The organisation reflects on when reintegration has failed or is 'sabotaged', for example by a teenager running away. Progress is evaluated every six months and there is a focus on four areas [family relationships, behaviour, life results and sustainability] with defined positive change indicators.

Most recently Juconi has been involved in using attachment-based ideas in developing foster care for the first time in Mexico. This is specifically for unaccompanied children/refugees who have left their own countries due to violence.

ENFOQUE NINEZ in Paraguay

Enfoque Ninez is anchored firmly in a systemic model: the organisation has strong links with services in Scandinavia and significant relationships with Family Therapists/Systemic thinkers such as Tom Andersen. It is heavily based on the social constructionist approach, and therefore seeks to work in a collaborative way with *'families living in situations of social injustice'*. It eschews the prevailing medical model, does not use forensic or psychometric assessments, and the use of psychological or psychiatric diagnoses are avoided. Therapists aim not to be prescriptive.

It is linked to the Child Protection system and yet represents a rare alternative innovative practice in the Paraguayan professional context aiming to guarantee safe and effective Reintegration for children and families. The model not only addresses significant issues of violence, abuse and neglect **within** families but also each family's economic situation so that they are strengthened in the longer term. The organisation views the client as an "expert" in his / her life and the therapist as a learner. It follows that the therapist then invites the client into a partnership taking a position of genuine curiosity and uses this to facilitate change.

The main role of Enfoque Ninez is to offer social and therapeutic work to children, adolescents and their families referred by the judicial system: to promote reintegration; run a family home placement program and to work collaboratively with children, adolescents and their families. In addition to this, Enfoque Ninez takes an advocacy role with the intention of influencing public policy. and offers training for professionals. The team is comprised of Community and Clinical Psychologists, Social Workers and lawyers. Other professionals such as an Educational Psychologist or Psychiatrist may be drawn into the network for any necessary evaluations.

All cases are in legal proceedings following maltreatment, neglect or child sexual abuse. The most difficult cases in legal proceedings are referred to Enfoque Ninez, who are then obliged to file regular reports about their work.

Relationships with children/adolescents and the conversations between them and their therapists are considered some of the most important aspects of their work. Family Therapy, individual counselling and psychotherapy are integrated. Meetings usually take place in the family home and/or in the community rather than an office. The main goal is reintegration and a concerted effort is made with the biological parents and extended family to see if return is possible. Relationships are made long term and rarely are cases held for less than 18 months, with some young people known by therapists for years. Alternatively, children may move into alternative family care and potentially leading to adoption.

The assessment process endeavours to clarify why children were separated from their parents and a genogram/community map is used to represent the family, their relationships and connections with the external professional system visually and gather historical and current information. The priority is to establish a relationship with the family or relatives, taking this, more collaborative, stance. Adults and children are invited to be part of the therapeutic process directed towards recovery without labelling and the family's own language and narratives are prioritized.

Reports are written to the Judge about the working relationship and this is done with the family's knowledge. The system incorporates neighbours and community, school and all voices are considered important, and everyone is heard using a dialogic approach. A case example was shared in which a young mother with a learning disability was enabled to move into another family with her infant also drawing on the support of the community rather than the child be adopted. No formal parent training takes place, but this is done 'within conversations' and also in the family sessions, where m ore positive parental approaches are explored. Given the commitment by Enfoque Ninez to working with families over time, there was a recognition that progress was not always consistent but could be fluid and variable. The organisation found it difficult to find any measures that represented the reality experienced by the families that could track this usefully.

CPTSCA in Philippines

CPTSCA was established 25 years ago and draws heavily on the Traumagenic Dynamics model. The organisation is primarily focused on working with young people who have been sexually abused and it accepts referrals from other organisations, community workers and self-referrals. Various adaptations have been necessary to create an approach appropriate to the specific context of a Catholic country where strong family/cultural/religious beliefs prevail and organise family responses. Their approach involves both individual, group and family therapy: addressing the impact of CSA; working on family

relationships; and enhancing resilience. They also are one of the few organisations in the country working with young people who commit sexual offences.

The model starts with an Intake session with child and carer to gather basic information using a standardised format. This information is discussed with the Treatment Response Team comprised of a Clinical Social worker, Psychologist, Psychiatrist, police and a lawyer.

This moves into an assessment phase lasting 4 sessions - exploring each of the four aspects of the checklist [betrayal, stigmatisation, traumatisation and powerlessness], and considering whether the child is safe physically, emotionally and psychologically. The assessment of the external environment is crucial and home visits are made to validate the information that is given. During this early stage a genogram is used to understand relationships in the family particularly in relation to sexual activity and violence. The plan for involving the family and continuing work with them is seen as a crucial goal as part of assessing the support system around the child in the short and long term. This needs to take account of their extended family members and include the community and identifies both the risk and protective factors. This is an essential component in the clarification of whether there is a need for the child to be removed into a kinship placement or protective custody, even if this is for a finite period until there is a significant change in the family. It also considers the relationship/position of the perpetrator and victim. Arrest and prosecution may follow, and support and preparation for court hearings is an integral part of the organisation.

The interviews follow clear guidelines with some formulated questions. Aspects of behaviour such as sleep, food intake and mood states including suicidal thoughts are considered and addressed through an individualised treatment plan. There are some questionnaires/forms for children to complete and if it is apparent that a young person is experiencing PTSD symptoms, a referral is made to Psychology/Psychiatry.

A co-therapy approach is used especially for the group work which spans 10 sessions [each lasting 90 minutes]. The group is closed and follows a clear CBT programme, this includes psychoeducation; exercises using art and drawing, poetry and other writing activities; and for those with high anxiety – relaxation techniques. Additional components involve a special spiritual counsellor. The order of individual therapy and joining the group varies but they can be simultaneous.

Therapeutic work with families [and individuals] tends to use a solution focused approach. Work with parents and families may also cover the issue of stigma as this links to the belief system of the family. Many are very religious and take different views about girl children who may be seen as ‘ruined’ by the abuse, and boys who abuse but might be seen in a less critical or judgemental way by their parents and/or the community. There may also be differing views between the parents as to whether a prosecution case should be filed.

Considerable effort is made to involve fathers [this is a requirement], and if they are not at home when therapists visit, a specific request is made that the father attends the next session. This can be problematic as there is a cultural tendency for men to assign such issues relating to childcare and abuse to mothers, men are often the principle or only wage earner. Some fathers are in custody. As yet, the organisation has not undertaken work between fathers and sons. There is no male Clinical Social Worker but the male Psychologist might become involved to help engage a father. Home visits may need to be made at night in order to facilitate the father’s presence. The staff have debated the

influence of the therapist's gender and whether a significant positive difference might follow if fathers were offered a male role model who demonstrated a different way of behaving.

Training has been provided within Family & Child courses at universities and by the Society for Filipino Family Therapists. Some staff completed their certificate level training, and many were trained in Trauma Informed Care and Psychotherapeutic Approaches through an American programme. These people now train others providing Continued Professional Development for Social Workers and others. Workbooks, worksheets and suggestions have been gathered from many sources and countries, but the organisation is also developing local materials based on their experiences.

Individual counselling tends to draw on approaches such as Beck, Rogers and Ellis: children are positive about these but want the activities to be more 'interesting and fun'. Towards the end of therapy techniques address relapse prevention, and sessions take a strong future oriented stance, focusing on education and achievable goals. They may use Gestalt techniques for those who are 'stuck' to help with 'unprocessed/unfinished business'.

Work with young perpetrators [under 15] aims to keep them in the community while providing a diversion programme as under this age they will not be prosecuted as an adult. They are placed in a transition home. The House of Hope provides interventions and education. Individual, group and family therapy interventions take place within this context. A 10-week group focuses on the following: accountability, addressing those who deny the offence, external blame, empathy building, impulse control, anger management and decision making. There may be a second phase addressing specific issues e.g. those who deny the offence. Cognitive distortions are challenged.

A different worker will address issues with the family and community but work closely together with staff at the House of Hope. This is integral to the rehabilitation plan. The organisation is interested in some of the root causes and looks for issues within the family, for example marital discord and/or substance misuse. Many parents will externalise blame onto their wider community or the child rather than seeing aspects for which they themselves may be responsible. Families have often given up and present feeling impotent and powerless. Staff often see a lack of empathy in parents and note their experiences of stigmatisation within the community. They approach families with compassion despite the work being long and sometimes frustrating. They have linked with the other organisations in Latin America to discuss some of the challenges in this work.

For some young people return home is not possible either because the community is toxic and would not accept this, and/or their parents will not engage in the change process. There is an independent living programme supervised by a Government Social Worker. Young people may be offered a scholarship and return to school, younger children are usually moved to a foster home. Parent support groups [mainly attended by mothers] are formed after the parent CBT group: these are facilitated at the beginning and then become self-sustaining. Parents who have successfully completed the program are considered as a resource. Occasionally there is a Family Day event – usually taking place in October ['Children's month'].

External supervision and consultation was provided by a hospital in Seattle, and Dr Tilman Furness [a Child & Adolescent Psychiatrist formerly in London, and then based in Munich]. All staff have a mentor or coach and receive support both within and from outside the office. Reflective practice is strongly encouraged.

UYISENGA NI IMANZI in Rwanda

This organisation also follows the Rehabilitation Reunification and Reintegration model aiming to work with street children, providing Transit Centres and Rehabilitative Centres in three districts. They have links with USK in Kenya. It is a family-based model which aims to help children and families through a healing process and helps develop sustainable community mechanisms. Many of the families are characterised by conflict, poverty and hunger, violence, sickness, drug misuse, may have been homeless and many comprised of only one parent. The organisation also offers advocacy and training.

UNI identifies and assesses children and then offers both individual and group interventions. The staff comprises of Psychologists and Social Workers and includes a trained counsellor. Assessment may also include some screening tools [these are carefully translated and incorporate Rwandan terms] and results in an individual support plan. There are very few standardised measures used with parents. The PTSD checklist is not used with all children, but they take a more ethnographic approach. If they suspect a psychological or psychiatric problem [e.g. PTSD] they collaborate with the nearby mental health centre where medication may be offered. UNI does not have a specific trauma focus. Children may stay in the Centre for different lengths of time but while there they are organised into groups of around 10.

UNI provide psychosocial support, therapeutic healing sessions and training for families on the effective care of children. Staff link closely with schools to encourage and support return for children who have dropped out of education, recognising that completing school will improve the young person's life chances. Reunification and graduation are the goals. In addition, young people are encouraged to join the scouts, an organisation which has positive values, helps children develop more self-respect and become good citizens within the context of a peer group.

The philosophy gives parents a clear message that children need both 'cash [their physical needs to be met] **and** care'. They see key steps as promoting parents' sense of responsibility [sometimes triggering guilt at what has happened]; working towards mutual forgiveness; parents developing greater skills in rule setting and maintaining boundaries; and role modelling. Trust needs to be re-established within the family and communication channels developed. The family may need some financial support and economic empowerment for changes to be sustained. Parents who have successfully completed the programme may became peer supports/buddies.

In stage 2 they focus on dealing with the identified problems: work is often done in small groups exploring questions such as, *'how did I live my life? what did it create in me? what should I call it?'*. They also use the Tree of Life [Ncube] helping children identify aspects of themselves and others in their lives from 'roots to fruits'. They evaluate some paintings and drawings using projective methods. They favour activities that reflect Rwandan culture and traditional songs and work actively with children and parents to promote the attachment relationship in a culturally appropriate way. They explore why children left home and moved to the street, promote positive parenting and parental responsibility, and offer both material and emotional support. At times within family work, they use an empty chair technique to encourage members to look at each other, talk about what they see and share their feelings about each other. When appropriate they work with different subsystems. The model used is more structural than social constructionist.

The individual support plan allows for 8 - 12 sessions with the child and 4 - 6 with the parents and/or family. If required there may be individual sessions with a parent. In the groups with parents' problems can be identified, they challenge parents about the issue of adult responsibility as many parents have accused the child of 'being the problem'. Later they may offer a 'healing session' which includes the child. In the last session they focus on developing a vision for the future and promoting the confidence of everyone. Then the process of reunification starts – this may take 3 - 12 months.

MULBERRY BUSH SCHOOL in United Kingdom

The Mulberry Bush school is a rare resource in the UK offering residential therapeutic schooling to children between 5 and 13 who are the most damaged in the country. They have usually had extensive experiences of abuse and/or neglect, and usually have had a series of failed placements with foster carers, in residential settings or a combination of both. Children usually spend some weekends and holidays with alternative carers or their families. MBS went through a reorganisation in 2008 due to significant financial constraints: there were redundancies. This process resulted a timetable change facilitating reflective practice groups and accommodating a regular weekly meeting of the whole school where the children's achievements could be recognised, and compliments given.

The school has a strong psychodynamic ethos which places a great value on staff consistently reflecting on the impact on themselves of their work with these troubled children: they talk about this as a way of understanding the child's experience and inner world. There is also a high priority placed on staff relationships - how staff recognise and resolve conflict and manage their own feelings. All behaviour is seen as a communication about how the child feels and how this relates to their experiences. The 'therapeutic milieu' is a fundamental aspect of the organisation: much happens in the daily connections between staff and the children; staff try to stick closely to the child's feelings; are continuously curious about these; and help the child make sense of them. At a deep level this is an experience of re-parenting, offering children an ongoing experience of attunement. This process links closely with, and is underpinned by, Attachment Theory.

When children are first admitted they stay in the intake house [Rainbow] for a while. All children are seen for two sessions of non-directive play and a Story Stem Assessment Profile [a play-based assessment is completed. This gives information about the child's attachment relationships, expectations of adults, and a range of other information. These processes assess the child's ability to remain in the room, degree of curiosity, level of play and provides a sense of what they can tolerate in this 1:1 context. Children who have few words and are developmentally immature are more likely to have Music Therapy. Those who show symbolic play but are not able to talk about feelings are directed to Drama Therapy and those who can verbalise or express their feelings may receive individual Child Psychotherapy. For some children all of these may be overwhelming. All therapies can be provided initially for a shorter period [30 mins] and this can be extended as the child's capacity to manage improves. Individual therapeutic input can be weekly or more frequent. Around 65% of the children in the school have 1:1 therapy of some kind.

Various assessment tools are used as baseline measures in addition to the SSAP including the Boxall Assessment Profile, the MB Social & Emotional Adjustment Scale, British Picture Vocabulary Scale and Parental Reflective Functioning Questionnaire. These are completed annually. MBS did not find the ACC to be useful for the children it serves.

A Family Therapist is a member of the staff team but Family Therapy is co-worked by a variety of staff whose training in different models may vary, thus enriching the process and enlarging the pool of ideas to draw on. This may include the House Manager or someone else who lives alongside the child on a daily basis. Who undertakes each piece of work is considered separately. Marital work may be offered, and home visits made.

Parents often feel blamed by professionals that have been involved previously and the process of engagement can be difficult. The starting point is to ask, *'What do you want help with - with your child?'*. Sometimes the therapeutic work is specifically to promote emotional attunement and sensitivity in a dyad or within family relationships. It may include video feedback [which is also used school staff and pupils] to help parents/carers reflect on how they manage behaviour: many will have had Triple P or Incredible Years training in the past. Families may become part of a multi-family group [incorporating two or more families] or attend a family weekend which involve many families. MBS also has groups for adoptive parents and another for foster carers: meetings with agendas and a reflective space.

Life Story work is started when children begin to ask about their history. Sessions can be weekly over a period of 18 months, beginning with the child and extending to include the parent or carer. It may continue after a child has left the school. This intervention, which works backwards from the child's arrival in the school, is led by a senior staff member with specific training in this aspect of working with children who live outside their families. It can be taken at a slower pace to fit the child's development and capacity to process. It does not need to follow the frequency that is offered in other services, e.g. Family Futures in London.

Trauma focused interventions such as EMDR and TF-CBT are available through the local Child & Adolescent Mental Health Service [CAMHS]. Other interventions including CBT are often supported by a Clinical Psychologist who links with MBS staff. Issues approached in this way include self-harm, helping young people learn to keep safe and exploring safe touching, body work and body image, and identity issues. Some children are on medication: there is a fast track to assessment at the CAMH clinic, and a clinic held on site to review medication twice a year.

Therapeutic Care Practitioners and other staff draw together the jigsaw of experience and understanding of each child in a six weekly Case Conference although if there is a need, this can be called more often. This happens if there are a series of incidents or a significant event in a child's life, such as the death of a parent. Senior staff regularly review the statistics on physical incidents and review academic progress, taking an overview of the whole group.

MBS sits within a Child Protection/Social Care system. There is a Partnership Manager, a senior member of staff who maintains a link with the Local Authority [LA] responsible for the child's placement. Each child has an allocated Social Worker, but in practice these people may be inexperienced and have little connection or relationship with the child, or his/her carers. If necessary, matters are escalated to a Team Manager as there can be splits and differences about long term goals which need to be addressed and resolved for the child's sake. There are currently no written expectations as to the role of the LA when a child is placed. Any disclosures of abuse are referred to the MASH team [Multi Agency Safeguarding Hub), which includes CAMHS and Police representatives. There is also an Outreach Service offering training and intervention advice to mainstream and special schools about working with children at risk of exclusion.

FOST in Zimbabwe

FOST currently operates in two provinces and covers seven districts. Funding constraints and government policies have led to staff changes and affected the reach of the organisation, but it has maintained its core business. Strategic partners and donors shift and at times, activities have been scaled down in line with available resources. A conference advocating for Deinstitutionalization attended by FOST and others from Family for Every Child in Africa led to the realization that millions of children were in institutions and alternatives that could provide better care and protection were needed. Most African practitioners were suggesting foster care but FOST were part of a smaller group that considered believed that kinship care was being practiced but received no support from most governments. The majority of children supported by FOST are looked after by their grandparents/other relatives. Some are at risk of exploitation, isolation and/or being drawn into criminal activity. FOST aims to improve their resilience, capacity to cope and sense of social connectedness. It improves psychosocial support in schools through training teachers adding to the safety net for those with AIDS, living in conflict and/or poverty. Teachers are encouraged to think of psychological needs: consider children's thoughts, feelings and understand their behaviour. FOST strongly advocates for play as a vital factor in enhancing development and social skills.

With support from the alliance FOST has conducted two national studies on Kinship Care, and Sexual Violence in Boys which have created much interest. FOST has created strategic partnerships and collaborations to enhance its impact and now has greater influence at national level.

FOST Programme Officers live in the Districts and are part of the communities in which FOST works. They link with volunteers, many of whom are unpaid, and some of whom are qualified teachers and health workers. Many FOST staff are experienced and have completed additional training in Zimbabwe e.g. Counselling with CONNECT, and/or community-based work with children through the University of Kwazulu Natal. Psychological services are extremely limited and mainly available through the Ministries of Education, and Social Welfare. FOST builds capacity of paraprofessionals to bridge this gap.

Most children have experienced trauma: some caring for dying parents, others experiencing abuse. FOST recognizes that these children and their families have educational, nutritional, health & social needs which they find difficult to access due to their vulnerability. Programme Officers offer emotional support children and their families through home visits at least every three months, with monthly visits by volunteers. At the initial visit the POs use a Household Profile Form which collates the background of the family: household composition; a vulnerability ranking capturing the physical, emotional, social and psychological needs of all members; and the support that is, or could be, available from FOST. In follow-up visits the POs will complete a Profile Update Form which captures stories of change/impact, alterations in the household composition and updates on previous recommendations. This helps to build a story about each household. The PO is a scarce resource and skill sharing is essential, so they have to justify to HQ if a child needs a more specialist intervention from them as there are both lay and peer counsellors available. No standardized measures used. In the past FOST used a form completed by teachers each term about a child's academic and psychosocial progress. This was not favoured by teachers [who are poorly paid] as they were lengthy, and the task was not part of their employment mandate: thus, they had to be completed on a voluntary basis.

FOST creates opportunities where social needs can be better met through support groups and clubs. The Education Assistance and Enhancement Programme facilitates access to schooling through grants covering school fees. This has improved school attendance. Some children still struggle with attention and concentration difficulties due to challenges they face at home and in the community.

Sessions are provided for bereaved children to help them process their loss[es] through creating memory books and boxes so that they can treasure memories of close relative[s]. They also use the Tree of Life [see Ncube] with children, their families/carers to develop a narrative, and drawings to help children and families talk together about feelings. Sessions may be with a child together with grandparent(s) to discuss issues and can be followed up by a volunteer. During meetings, generational differences have been noted, especially when adult expectations of behaviour are not met by young people and the imposition of discipline creates conflicts and challenges within the family. Self-Help Groups established by FOST, enable women to meet regularly [weekly or monthly] to discuss issues affecting them and their households and provide moral support. Each S-HG identifies a person who takes the issues discussed to a Cluster Level Group that looks at matters at a community level, considering the effects on children, families and communities. Ideas are pooled about what interventions/ workshops would be helpful – as yet, structured parenting interventions have not been offered. The groups for caregivers have also helped financially by encouraging saving and providing a platform for small scale borrowing and lending. This enables adults to generate income through investment in small businesses/market stalls which increases the economic stability of family units.

Youth leaders [teenagers and young adults aged 16 to 25] run the 'kids clubs.' These are open to all children up to the age of 18, not only those who are vulnerable or orphaned. Children can take their younger siblings to the club with them if they have a caring responsibility. The club times vary but are usually held at least weekly and sometimes at weekends. They operate within a community space such as a village hall or school. The club meets social needs through activities such as ball games [soccer and netball]. They also provide an opportunity for children/teenagers to talk about topics such as sexual and reproductive health and rights, or relationships. Leaders learn basic skills about running a club, how to provide psychosocial support and have access to a FOST Psychosocial Support manual. There are regular refresher courses for the leaders who have mentors from the group of teachers and healthcare workers associated with FOST, and can call on the PO to assist. Other professionals [such as a local nurse or teacher] might be invited to help with the exploration of special topics, e.g. relating to health. This is part of capacity building in the locality and strengthens the families and communities in which children live. They do not use any structured groupwork programme to help young people develop life skills or greater emotional literacy.

CONCLUSIONS & RECOMMENDATIONS

Assessment

Template/history

Basic documentation varies considerably, but all organisations referred to striving to adhere to a framework which integrates the available information, aspects of assessment [either by interview alone or with the use of screening tools and other measures] and leads to a plan for intervention – which may include actions in addition to therapy. Some used templates to ensure that all necessary areas were covered such as Butterflies. Organisations looking to further their skills in relation to the assessment of specific issues should consider approaching Butterflies to understand more about how they assess substance mis/use, and ABTH for more information about the Scale of Violence

It may be advantageous for organisations to share what they are using, and consider the formats used in other organisations. This process may stimulate ideas for enhancing the early part of the process and increase the efficiency and effectiveness of the time spent during the assessment phase. It may also improve goal setting and assist in the monitoring of progress.

Note: *Frameworks which use Likert scores [such as 0 – 5 categories] need clear definitions of the points on the scale to increase consistency between rates and over time, and are best completed by the same person at different time points if used as a monitoring tool.*

Use of Standardised measures

Some organisations use standardised tools to augment the assessment process and to assist with monitoring progress [Juconi & MBS]. It would be beneficial for those organisations to share their experiences and outline the advantages of using these [whether a general screening – e.g. SDQ, or issue specific – e.g. CRIES], describe any difficulties and explain how these have been overcome. There may be benefits to having this kind of outcome data for existing funders, annual reports and when seeking new donors.

Perhaps consideration could be given to the possibility of deciding on some core measures that could be used such as the SDQ, RCADS, and CRIES – if these are deemed to fit culturally. All are easy to administer, and some may be already translated into the appropriate language. Many have versions for parents, teachers and self-report [for older children] and these can be read to children and adults who are illiterate. It is often useful to look at the differences between how children present in different contexts, and between how they see themselves in contrast to how perceive they are perceived by others – this gives an indication of insight.

There could be an advantage to looking at the value of the Assessment Checklist for Children, Boxall [https://boxallprofile.org/] and the MB Social & Emotional Adjustment Scale as these measures are based on observations by staff, carers or family and provide a richness of information about social and emotional behaviour.

Other measures might also be useful to assess parental/carer stress, family functioning and change. *Please see below.*

Specific areas

Traumatic experiences are frequently reported in many of those with whom the organisations work. It is the focus of CPTSCA & Challenging Heights in particular. Assessment might be improved by the use of a Life Event Checklist [for both young people and adults] and the use of the Child Dissociative Checklist [Pullman] as these may help direct clinicians to different treatment options.

- In relation to interventions, most organisations dealing with this specifically are using models derived from Trauma-Focused CBT [TF-CBT]. This can be effective with some young people but may also run the risk of re-traumatising children through rehearsal and repetition of their traumatic experiences. Exploring the possibility of training in the use of techniques such as Ericksonian Traumatic Memory Work and/or Eye Movement Desensitisation & Reprocessing [https://www.emdr.com/what-is-emdr/] may be beneficial, particularly for projects trying to meet the needs of younger children.
- Assessment of PTSD in children under 6years is more difficult and the DIPA [https://www.midss.org/content/diagnostic-infant-and-preschool-assessment-dipa] would be particularly useful for organisations dealing with sexual abuse and maltreatment of small children.

Systemic theory and practice is the foundation for much of the work in most organisations. Not only with families and the wider community but in the understanding of where the organisation sits in the wider culture, the current political situation and governmental structures, and in relation to other NGOs in the area.

There is a considerable wealth of clinical expertise in systemic work [particularly clear in ABTH, Enfoque Ninez & Juconi] and a variety of models used explicitly and implicitly. Some take a clear and committed social constructionist approach, others such as FOST appearing to operate in a more structural way. Not all projects use Genograms or Ecograms: and those that do not are likely to find it interesting and valuable to understand more about these. Finding a way to demonstrate the process of drawing them would be a helpful way of sharing both techniques which are useful during assessment, treatment planning and throughout therapeutic interventions.

The Tree of Life [Ncube] is also being used effectively as a systemic tool by UNI & FOST. Another 'seminar' demonstrating how this is used, sharing the results and describing cases in which it has been useful will be interesting for other Psychotherapists, Psychologists, Social & Medical Case Workers, and Counsellors. They will then be better able to consider using these, seek further training if needed and integrate ideas into their work. Solution Focused, problem-solving and narrative approaches were mentioned often [Butterflies, ABTH, USK & FOST]. https://dulwichcentre.com.au/the-tree-of-life/

Attachment theory also plays a powerful role in how organisations operate. This is embodied in the importance placed upon engagement and the development of the meaningful relationships with clients and their families. The Mulberry Bush School differs from other organisations in offering long-term placements within a therapeutic residential school and it specifically assesses each child's attachment relationships using the SSAP. While I doubt that this is likely to be something that other organisations would consider – I think it would be valuable to share information about this process. Similarly, perhaps more exploration of the Child Attachment Interview and Adult Attachment Interview[2]

2 https://www.psychotherapynetworker.org/blog/details/17/the-adult-attachment-interview-how-it-changed-attachment

might help counsellors and clinicians use some of the ideas in their work and raise the profile of this important aspect of the work undertaken.

Studies in the 1990s [Reder & Duncan] focused on fatal child abuse illuminated how parental scripts about children could distort relationships in complex ways that could lead to maltreatment, abandonment and ultimately fatalities. The concept of *'the meaning of the child'* has been built on with the development of a semi-structured interview. This assesses the 'meaning of the child to the parent', and the transcript can be analysed according to parental sensitivity and likely risk to the child. This leads to a more systemic and inter-subjective understanding of parenting representations.

- The Meaning of the Child Interview: A new procedure for assessing and understanding parent-child relationships of 'at-risk' families. Grey B & Farnfield S Clin Child Psychol Psychiatry. 2017 22(2):204-218. doi: 10.1177/1359104516633495

Considering ways to promote attachment and resolve attachment difficulties is a key task in reuniting children with their parents/families, placing children in foster care homes and/or caring for psychologically damaged children. MBS provide child &parent/care work 'Promoting Family Attunement' and this together with a focus on 'mentalising' approaches would be a way of strengthening what organisations currently offer. Going a step further, Dyadic Developmental Psychotherapy is a therapeutic training offering a way of working with children with marked attachment difficulties and their parents/carers simultaneously [https://ddpnetwork.org/library/dyadic-developmental-practice-ddp-framework-therapeutic-intervention-parenting/]. This entails a significant time commitment and may not be interesting to all organisations.

Reflective practice, supervision and consultation was referred to by most organisations. Clearly MBS has this at the core of its' practice and has already begun to share this with other organisations, some of which appear to be integrating this into practice. Issues relating to supervision and consultation varied: and at times were difficult due to changes in personnel especially when people who were trained and skilled in an approach moved on. Given the intensity of the work being done, and the extreme nature of some of the children's presentations, self-care and professional support is key to avoiding burnout and experiencing secondary trauma. This might be a topic that organisations can share and develop some appropriate guidelines. MBS is also the only organisation to explicitly use psychodynamic constructs.

Cognitive Behaviour Therapy is used in many organisations, some following manualised programmes that they have adapted for their own use. The discussions clarified that others were providing CBT/skills-based components, CBT worksheets and tackling issues relating to maladaptive thoughts, linking thoughts feelings & actions, and developing improved listening, compromise and problems solving. Group work programmes vary, but PRISM [Wexler] was successfully introduced into a residential in-patient setting where young people attended the group every day from immediately after admission. One of the advantages of an open group is that as the cycle of the programmes continues, teenagers were able to demonstrate their greater proficiency with the ideas and could be helpful to others. Being present, watching and listening even if not overtly contributing can be of value, even in the first few days. It was also run as an out-patient group with a group of teenagers with a variety of presenting problems. There is a workbook was designed for troubled adolescents covering techniques such as self-assertiveness, active listening, peer pressure, cue therapy and self-talk, and includes self- soothing, and developing adaptive ways of self-expression.

- The Adolescent Self: Strategies for Self-Management, Self-Soothing, and Self-Esteem in Adolescents Wexler D. B. (Norton Professional Books) 1st Edition & The PRISM Workbook. A program for innovative self-management Wexler D. B.

The implementation of individual TF-CBT was described by organisations such as Childlink & CPTSCA.

Using 'buddies' is an effective way of capacity building in some organisations. Given the limited resources and high numbers of families requiring assistance, FOST], for example, use 'graduates' from their programmes as peer supports for other families, or train young adults to lead clubs for children. These people could also be trained to assist in the context of group work with parents and/or young people. This may also serve to provide a degree of encouragement and lead to further skills development that may be useful or lead some to commit to further education. How young people are actively training as leaders would be a worthwhile aspect to explore. Finding a way to share and build on these ideas and develop them further could be advantageous for many organisations, not only those who were part of this consultation.

Parent training: organisations work with parents on many levels from economic empowerment to enhancing parent/child communication, through to helping with ideas for ways to set limits and provide discipline which does not include physical chastisement. Workshops and groups were referred to and it was not always apparent whether these had been derived from an evidence-based programme that had been adapted for the local context. Two well researched programmes are Triple P https://www.triplep.net/glo-en/home/ and Incredible Year for 3 – 8 years https://pb4l.tki.org.nz/Incredible-Years-Parent. Obviously, these would have to be considered carefully and adjustments made so that they were culturally relevant. Information about utilisation with a wide variety of socio-economic groups and by NGO's in many countries and both websites are highly informative. More research data can be found here https://www.gov.uk/government/publications/evaluation-of-the-national-academy-of-parenting-practitioners-training-offer-in-evidence-based-parenting-programmes.

The Solihull Approach has a broader remit and has been established as being widely applicable in different contexts. It offers resources for professionals and parents, and many of their trainings have dedicated Skype places to encourage participation from professionals based at a distance. https://solihullapproachparenting.com/

Video guidance/feedback was used by at least two organisations [Juconi and MBS]. An online seminar could share the experience of using this and cover the strategies and techniques for helping adults look at their part in interactions. More information can be found at https://www.videointeractionguidance.net/aboutvig. This approach can provide considerable benefits for parents and carers who are enabled to observe their own interactions. It is well researched and known to enhance sensitivity in parents of children who are at risk of poor attachment outcomes due to a range of difficulties [see https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012348.pub2/full Cochrane review, November 2019. In the context of a Multi-Family Groups adults may comment on one another, and this is sometimes perceived differently to the same comment coming from a 'professional'.

'Relationship to help': This concept offers a useful lens through which to look at 'difficult to engage' individuals and families. Exploring and being curious about what help has been offered

previously, how it was offered and who by, and the client's response to this can be enlightening, allow professionals to understand why the process might be so problematic and this conversation may – in itself – be a step towards freeing up clients from this pattern.

- Relationship to Help: Interacting Beliefs about the Treatment Process, Reder P & Fredman G Clinical Child Psychology & Psychiatry [1996] https://doi.org/10.1177/1359104596013012

Multi-family groups are being used on occasion by some organisations including MBS. In resource restricted times, groups of many kinds may be a cost effective and efficient way to use limited staff. The ideas of getting families and the sub systems within them to work in a different way, helping each other – has been used in many different contexts. For many years these were also part of an assessment programme for families where children were at risk or had suffered maltreatment and neglect. The interventions could be intense but often other parents were able to communicate with their peers in a clear, direct and at times forceful manner and parents were better able to hear comments from them than therapeutic staff.

- Multi-Family Therapy: Concepts and Techniques [Asen 2010] https://www.annafreud.org/mental-health-professionals/our-help-for-children-and-families

Motivational interviewing links to a theory of change and offers a technique to explore the ambivalence often displayed by individuals during both the initial assessment of their issues and their treatment. Butterflies & Childlink referred to this. Although some ideas and guidelines were first proposed for alcohol abuse issues, a later collaboration refined this, and its' application widened to substance abuse generally. Further refinements that have resulted in the technique being used for numerous other purposes. https://www.recoveryfirst.org/motivational-interviewing/. The Stages of Change Model outlines movement through five stages from an individual who is barely considering change through the time when s/he has made a commitment to changing behaviour, accepted responsibility for doing so, and taking actions in relation to a stated goal. Finally in the last stage, change is seen to be happening and is maintained for at least 6 months. Links for support may be maintained long after the formal intervention has ended.

Resilience was not mentioned in most of the interviews, but this is an important concept when considering the emotional and psychological health of young people. Firstly, because there are children who are naturally resilient and may present as managing in the face of adversities to a greater extent than those around them, including siblings. Young people who have a clear direction forward, can meet challenges and cope with difficult experiences, are able to adapt when circumstances change, hold on to a balanced perspective and see both good and bad, will fare better as adults. Secondly, resilience building is an obvious additional goal for any therapeutic work and can be measured easily.

https://www.corc.uk.net/outcome-experience-measures/child-and-youth-resilience-measure-child-version/ https://positivepsychology.com/3-resilience-scales/ and https://www.resiliencecenter.com/resilience-scale-for-children-rs10/

Being your own resource

Developing a series of on-line seminars: Many of the above topics lend themselves to one or two organisations leading a seminar that focuses on an approach that they use to a high standard, sharing how they apply this to their specific population, how and why it works and discussing the limitations. It would be equally applicable to creative therapies such as Dance & Movement Therapy [USK], and Music & Drama Therapies [Mulberry Bush].

Some organisations referred to a 'tool box', worksheets, or a book of ideas that had been gathered over time to provide ideas of different exercises might be used in the engagement phase, or later in the therapeutic/counselling encounter. These may be applicable with individuals and/or groups, and others may be more appropriate to orient new staff to the organisation's way of working [such as USK]. Creating an on-line file accessible to all projects would be one way of sharing resources: they could be helpfully categorised for different uses. Organisations and projects could then connect with one another to ask how they were being used.

Other useful resources

- **Child Outcomes Research Consortium** https://www.corc.uk.net/
  An online resource with information and measures, easily accessible and full of details about ways to measure children and young people's mental health and wellbeing. This website gives access to research papers relating to a range of measures and screening tools including the Strengths and Difficulties Questionnaire [translated into more than 60 languages and with parent, teacher and self report versions] and the Revised Childrens Anxiety and Depression Scale which has a version that includes items relating to Child Sexual Abuse.

- **SCORE** is a self-report outcome measure for families.
  This was designed to be sensitive to the kinds of changes in family relationships that systemic family and couples therapists see as indications of useful therapeutic change. The Association for Family Therapy UK https://www.aft.org.uk/view/score.html?tzcheck=1 is in the process developing it in other languages and there might be the potential for some collaborative work with AFT [UK].

- **Parenting Stress Index** [various versions]
  Designed to evaluate the magnitude of stress in the parent–child system. The 4th edition of the this is a 120-item inventory focusing on three domains: child/parent characteristics, and situational/demographic life stress, but there are other shorter ones which may prove useful.

- **Young People and Mental Health**
  For those projects wanting more information, training and updates about different aspects of child mental health, or resources for young people these two UK based organisations may be useful https://www.acamh.org/ and https://youngminds.org.uk/

- **Sexually abused and abusing Young People**
  Those working with Child Sexual Abuse, Child Sexual Exploitation and/or young perpetrators,

these websites may be useful. https://www.nspcc.org.uk/, http://www.swaay.co.uk/ and https://www.lucyfaithfull.org.uk/expert-child-sexual-abuse-and-exploitation-training.htm

Alternative approaches

- **Choice and Partnership Approach** http://www.capa.co.uk/
  Some organisations may be interested to read more about CAPA. This is a service transformation model that combines collaborative & participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management. It brings together: active involvement of clients, demand and capacity ideas/Lean Thinking, a different approach to clinical skills and job planning.

  It is flexible and has been tailored to fit individual services in different contexts. I can easily connect people to Dr Annie York one of the people who developed this model for further discussion if this would be useful at some point.

- **The Signs of Safety** https://www.signsofsafety.net/downloads/
  Organisations may gather useful ideas from The Signs of Safety approach in Child Protection. This is an innovative, strengths-based, safety-organised approach to child protection casework. The model was developed in Western Australia [Turnell & Edwards] and has been implemented elsewhere.

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