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All correspondence to:
The Editor
Social Work Now
PO Box 2620
Wellington

Email: bbannister@xtra.co.nz

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Editorial

acknowledging our realities and learning collectively

Debbie Sturmfels *examines what the baseline review will mean for frontline staff*

The Department of Child, Youth and Family Services has just been through a baseline review, and I was privileged to be a member of the review team.

I say privileged because it is not often in the life of an official that you get the opportunity to step aside from your day-to-day responsibilities and look at your department in its entirety. Or to do that within a multi-disciplinary team of people who bring a diversity of expertise, thinking, insights, perspectives and expectations. Consequently the dialogue was wide ranging and the debate often vigorous. There were differences of opinion, interpretation and method. There was more than one false start, many blind alleys and much agonising over describing the social work process to Treasury analysts.

The baseline review terms of reference covered defining Child, Youth and Family's outcomes to costing a baseline. From a "costing baseline" perspective the review didn't achieve its objective. We were unable to advise the Ministers what could be delivered in terms of quantity, quality and risk for given levels of investment. For a range of reasons, outlined in the review report, it wasn't possible to say what a sustainable baseline for Child, Youth and Family should be.

However, what the review team did do was something much less tangible and in some respects more far-reaching – it engaged us all in a learning process. In the context of the review, the learning process involved making sense of the information and data gathered and the pre-existing knowledge team members brought to the table. It occurred through the sharing of that knowledge, integration of new information, analysis and insights. Finally, having acknowledged that the review did not have all the answers and that many of the assumptions underpinning the recommendations required testing, the team took action and documented its findings and recommended package of initiatives in to a final report.

However, the process of learning is never final – the baseline review report is a starting point not an end point for Child, Youth and Family.

The **Stabilise**, **Learn** and **Improve** focus of the package of initiatives arising from the review is intended to **stabilise** operations, support it to become a **learning** organisation and **improve** the quality of its services. The learning theme is the one I believe poses the greatest challenge to Child, Youth and Family as it now faces the task of understanding the baseline review findings, integrating them into its day-to-day operations and learning from that process.

It is much the same challenge as that faced by anyone who has ever been through a learning experience, whether it be a training course, a conference or seminar, a review or an everyday event.

- How are the insights, new skills and knowledge gained integrated back into one's life and the workplace?
- How are new behaviours shaped and supported?
- How does the organisation accommodate the learning made by that worker, and support, nurture, challenge and learn from it?
- How does the organisation, being more than the sum of its workers, change its own behaviour?

Learning for human beings is both a survival mechanism and a developmental process. The same could be said for organisations. Nancy Dixon defines organisational learning as 'the intentional use of learning processes at the individual, group and system level to continuously transform the organisation is a direction that is increasingly satisfying to its stakeholders' (Dixon, 1994, p5). An organisation learns through the collective use of the capabilities of its members but becoming capable of this involves more than developing and training workers. Fundamentally, it is about the organisation being responsive to, and affected by, the learning of individuals and developing an environment where, collectively, this is actively facilitated.

Dixon describes a learning cycle that involves four circular steps – generating information, integrating that information into the organisational context, developing a collective interpretation of the information and having authority to take responsible action based on that interpreted meaning, which in turn leads to the generation of more information. 'When the steps of the organisational learning cycle are disconnected, collective learning is lost' (Dixon, 1994, p44).

The challenge for Child, Youth and Family is to develop that cycle and to create an environment where it can flourish. To do that we might need to learn to behave in different ways, take time to sit back and think strategically, consider information in the context of the whole system, value diversity and differences as opportunities for learning rather than obstacles and empower the workforce to participate actively in all aspects of the learning cycle.

But what does all this mean for the frontline?

The baseline review acknowledged the realities that frontline workers experience every day – unceasing demand for services, increasing public scrutiny, organisational and professional practice expectations that are at times irreconcilable and a deterioration of social work capability and capacity. It looked at what the data said about the organisation and sought input from frontline staff as to what this meant in practice, and found an alarming distance between national office and delivery staff.

However, it acknowledged that Child, Youth and Family's greatest asset is undoubtedly its frontline staff and that 'their experience and understanding of what drives their work should be brought to bear on the development and implementation of policy and the management of the organisation itself, for example in how managers allocate budgets and staff to meet client demand' (*Baseline Review Report*, 2003, p71).

The package of initiatives recommended by the review and subsequently endorsed by Ministers addressed those realities with significant additional funding focused on stabilising operations and rebuilding capability. Increased resources to implement social work plans, employ more frontline staff, improve management information and monitoring and evaluation systems, and maintain effective demand management strategies will all, over time, improve conditions for the frontline. The nature of the changes depends less on extra money than on the way Child, Youth and Family responds to the developmental challenge ahead of it.

Child, Youth and Family knows a lot about its business, but up until now we haven't collectively learned as much as we might from that knowledge. The baseline review gives us the opportunity to go beyond the knowing, to begin learning and start applying the lessons. We now have the time, the resources and central agency support to do that.

In order to stabilise and improve we must be able to learn from the review itself, from our experience of the implementation of the baseline review initiatives and to continue to apply that learning. The challenge facing the Department as it seeks to make greater *sense* of its world is to act upon that *knowledge,* to ensure that the distance between national office and the frontline is reduced and to become an organisation that is strongly focused on and able to learn from its service delivery.

When we achieve that, the question of what does the baseline review mean for the frontline will be self-evident.

Debbie Sturmfels *is the National Manager, Programme Implementation for Child, Youth and Family.*

REFERENCES

Dixon, N M. (1994) ***The Organisational Learning Cycle – how we can learn collectively,*** **McGraw-Hill Book Company, London.**

Department of Child, Youth and Family. (2003) ***Baseline Review Report.***

Children's voices

optimising the opportunities for inclusion

Jill Goldson *examines methods used to ensure children's participation during parental separation and divorce*

Research and practice evidence suggests children whose parents separate or divorce are more likely to experience better long-term wellbeing if family relationships remain as stable as possible, regardless of what the final structure of the family winds up being. I suggest that children's involvement in discussions at the time of separation, if managed and facilitated, may help everyone involved in the process.

No one would deny that parental separation and divorce is painful for children. Such an experience during childhood is cited as one of the key variables contributing to a compromising level of vulnerability in the lives of young adults (Wallerstein and Kelly, 1980). However, research convincingly argues that it may not be the divorce or separation that causes future problems for children. It may stem from the way parents deal with it in their interactions with their children. More recently, extensive studies of children of divorced or separated parents also revealed that ongoing and unresolved conflict between parents is highly relevant in later maladjustment for young people (Pryor and Rodgers, 2001; Robinson, 2003; Hetherington, 1999; Amato, 1993; Carr, 2002).

Separation and divorce in New Zealand is common: 10,000 children experienced the breakdown of their parents' marriage in 1995 and a further number experienced the breakdown of their parents' de facto relationship (Statistics New Zealand, 1995). With such numbers, it seems urgent that evidence from research is used to enhance support services and interventions offered to families with children during the process of separation.

There are as many types of divorces as there are marriages and, although society's responses may lag behind social change, overall there is a shift away from the concept of divorce as a form of deviant behaviour that generates pathological outcomes for children (Smart, 2003). For practitioners of counselling and social work, a common task is helping families stuck in the distress of family reorganisation. Often the family's distress is manifested in the behavioural and emotional problems of its children and young people. It would seem timely that we, as practitioners, review our interpretation of such symptomatic behaviour. Research-based understanding of the genesis of this behaviour may well lead to more effective intervention.

The main defining feature of a nuclear family may no longer be co-residence (Morgan, 1996). Rather than seen as disintegrating, the family may simply be viewed as having suddenly scattered across more than one location. It will still have kin and, potentially, step-kin. The inherent challenge to practitioners is to help the family accept the change while retaining the essential relationships between parents and children.

The concept of family is currently being transformed and redefined. Family law and social practice, and those involved with them, have a professional obligation to move with the current changes and adapt accordingly. Likewise, policy must also reflect the shift from the centrality of marriage and spousal relationships towards the centrality of parenthood and parent-child relationships. Particularly in family law, the welfare perspective is of a child for whom there is concern but a preference that he or she is not seen or heard during the process. Increasingly, in other domains children are being placed at the centre of issues affecting them and, rightly, are being allowed to play a part in decisions about their own lives in the present (James and Prout, 2002).

Children's voices

This perception of the centrality of the child resonates in New Zealand through the Children, Young Persons and Their Families Act, 1989. There is provision, under the Act, for the child or young person to take part in decision-making through a family group conference. This provision is consistent with the philosophy of Article 12 of the United Nations Convention on the Rights of the Child (UNCROC), which was ratified by New Zealand in 1993. However, this does not impose legal obligations on signatories. In ratifying, New Zealand has assumed an international obligation to ensure that its laws, policies and practices comply with UNCROC. It is not a legally binding obligation but more a statement of intent. The Convention would need to be incorporated into domestic law for it to be legally enforceable and this has not been done. These rights do entitle children to information, adult support and an appropriate context to form and express views on matters that affect them. A recommendation was made that 'all aspects of government policy, administrative practice and legislation having an impact on children' be reviewed to take account of UNCROC. It seems incongruous, then, that in the area of family law in New Zealand, these principles are, arguably, barely adhered to.

Under the Guardianship Act, 1968 (section 23), the welfare of the child is paramount but it would seem that, within the context of family law, the rights of children to contribute to the processes that concern them are only minimally recognised (Tapp and Henaghan, 2000). This lack of recognition seems to be highlighted in our dispute resolution processes. Although children's voices are elicited via specialist reports written by psychologists, and also via representation from counsel for the child, disputes have usually reached the stage of irresolvable conflict between the parties. Hostility and anxiety compound a polarised situation in which the children are entrapped. There will always be situations of dispute that are not able to be resolved out of court. However, it is possible that even some of the more intractable situations, had they been encountered early enough and in a way that was family-inclusive, might have reached conciliation without the court's involvement.

Research

As a Family Court counsellor since 1986, I have frequently questioned the lack of provision for children's involvement in counselling provided under sections 9 and 10 of the Children, Young Persons and Their Families Act. On numerous occasions parents have requested that I see their children but, from a policy point of view, the right to do this remains vague and ambiguous and fraught with misgivings about whether this is fair to the child.

I have embarked on a small-scale research project involving the children in 12 cases of parental separation in the early weeks of disputes being heard through the Family Court.

First, I see the parents several times, within the counselling context of the Family Proceedings Act, 1980. Then, with the respective consent of parents and children, I talk to the children and subsequently to the family as a whole. This project is consistent with the recently published *Law Commission Report into Dispute Resolution in the Family Court* (March 2003) that includes recommendations about children's access to counselling.

In no way do I suggest that the process of dispute resolution through the New Zealand Family Court is not effective. In fact, the vast majority of cases that pass through counselling and mediation do not proceed to court. What is arguable, however, is the adequacy of the sense of justice produced by such intervention. Along with justice, there needs to be an ethic of care factored into dispute resolution. This ethic, which is an integral part of justice, can be facilitated by family dialogue, given the right circumstances. If the post-separation period is seen, primarily, as a time for dividing children and assets between parents, however well intentioned the parents are, there is a very real risk of the children being seen inadvertently as chattels in a bargaining process. If the children feel like chattels there may be an attendant distress caused by divided loyalties and an untenable sense of being in a double-bind situation in relation to their parents. In such a situation, the child needs an agent to act on their behalf.

Along with justice, there needs to be an ethic of care factored into dispute resolution

The results of my work-in-progress are consistent with those of other researchers in the field. Children state very clearly that they want to know what is happening (Mitchell, 1983; Smith, Taylor and Gollop, 2000). Out of 106 children interviewed by Smith, Taylor and Gollop, half did not know why their parents had separated and 67 per cent were not asked about their views. The argument that children are better off not knowing too much ignores their rights and needs to mature as part of a social and cultural process. Children are more likely to learn to cope with a situation if they are given the opportunity and helped to do so. Focusing on what they can contribute to the process and allowing them to have a voice, rather than presuming immaturity and incompetence, may contribute to their ability to cope. Children I interviewed have stressed their motivation to be involved in the counselling process, but they do not want to be asked to make major decisions. Obviously it is important here to discern between children's rights and children's responsibilities. Following the initial disequilibrium commonly experienced by all members of the family when a parental

relationship breaks down, children, too, need the opportunity to participate in negotiations about new domestic arrangements. To deny this opportunity is to slow down the adjustment process for the child after the separation has taken place. For a child experiencing an event of such significance as separation, feeling a degree of involvement and control gives them the power to deal with its disruptive effect. Participation in mediated discussion with their family may result in a sense of being an effective agent in their own life, cancelling out the worst excesses of uncertainty and neglect in the process (Pryor and Rodgers, 2001).

The issues raised by the children I have interviewed to date are not necessarily matters that are the subject of dispute between the adults. The children interviewed have made frequent comments about the level of parental conflict, their anxiety about the parent who has vacated the family home, worries about pets and concerns about arrangements for Christmas and birthdays and summer holidays. By hearing these concerns, and helping the children convey them to parents in a negotiated context, the child-centred details remain visible and significant. Smart and Neale (2002) argue that the question "what matters" must precede the question "what works".

The assumption that working with the parents on their own will benefit the children in a "trickle down" effect assumes an equanimity that parents frequently do not possess at such a time. Inevitably any distress they feel can compromise the ability of the best-intentioned parent to hear their children. Frequently, children experience the parents' distress, leading them to misbehave. This is often the crisis point of intervention for social work or counselling services. Parents have reported in our sessions their difficulty in maintaining discipline and boundaries during times of relationship stress. This factor often leads to further conflict between the parents and it is this ongoing conflict during a transition of this nature that has such negative outcomes for children.

Conclusion

I contend that including a child in discussions about family reorganisation:

- helps the child to respond as positively as possible to the situation
- can help reduce the likelihood of negative behaviours developing later on
- can be an effective and democratic way of enhancing and consolidating mediated solutions.

It is important to note that both my own and larger research studies suggest that children prefer to discuss problems within the context of their families, if they are supported to do so. They are emphatic in their response that they do not want to tell all the family's secrets and problems to a stranger who does not know their family. Children are not looking merely for the opportunity to air their distress. Although this may be moderately reassuring in some instances, it can leave children with a sense that they have betrayed the parents they love but gained no sense of real relief from their anxiety. Primarily, they are looking for some form of resolution.

For distressed parents the fact that their children are coping can only relieve them of some of their own distress, giving them a greater capacity to provide positive parenting. This, in return, further reassures the children, making them less inclined to act out their distress with difficult behaviour. Such is the reciprocity of systemic family dynamics.

Given the assent of all family members, and predicated on reasonable levels of adult conciliation, I strongly suggest that including children in facilitated discussions should be a significant part of any intervention. ▫

Jill Goldson *is a Research Fellow at UNITEC and a Family Court Counsellor.*

REFERENCES

Amato, P. (1993) "Children's adjustment to divorce theories and empirical support". In *Journal of Marriage and the Family.* Vol 55. Pp22 – 38.

Carr, A. (2002) *Depression and Attempted Suicide in Adolescence.* Rouledge. London.

Hetherington, E. (1990) *Coping with Divorce. Single Parenting and Remarriage. A Risk and Resiliency Perspective.* Lawrence Erlbaum Associates. New Jersey.

James, A and Prout, A. (2002) *Children, Law and Society: The Cultural Politics of Childhood.* McMillan. London.

Mitchell, A. (1983) "Adolescents experience of parental separation and divorce". In A Smith, N Taylor and M Gollop, *Children's Voices. Research, Policy and Practice.* Pearson. New Zealand. Pp134–135.

Morgan, D. (1996) *Family Connections.* Polity Press. Cambridge.

Pryor, J and Rodgers, B. (2001) *Children in Changing Families. Life After Parental Separation.* Blackwell. Oxford.

Robinson, M, Butler, I, Scanlan, L, Douglas, G and Murch, M. (2003) "Children's experience of their parents' divorce". In A Jensen and M McKee, *Children and the Changing Family. Between Transformation and Negotiation.* Routledge Falmer. London.

Smart, C. (2003) "Separation and children". In the *Independent*. May 23.

Smart, C and Neale, B (2002) *Good to talk? Conversations with children after divorce.* Young Voice. East Molesey.

Smith, A, Taylor, N and Gollop, M. (2000) *Children's Voices. Research, Policy and Practice.* Pearson. New Zealand.

Tapp, P. and Henaghan, M. (2000) "Family law: conceptions of childhood and childrens' voices – the implications of article 12 of the United Nations Convention on the Rights of the Child". In A Smith, N Taylor and M Gollop, *Children's Voices. Research, Policy and Practice.* Pearson. New Zealand.

Wallerstein and Kelly. (1980) *Surviving the Breakup.* Basic Books. New York.

Motivating change

__Ricki Tan__ describes the use of the Relapse Prevention Model for treating antisocial behaviour in adolescents

What is Relapse Prevention?

Relapse Prevention (RP) is a treatment approach that is specifically designed to help people maintain new behaviours they have learned following treatment. It was originally developed as a maintenance strategy for use in the treatment of addictive behaviour problems such as substance abuse and dependence. RP is a self-management strategy that focuses on enabling a person to refrain from engaging in undesirable or problematic behaviours, and so maintain, once treatment has ceased, the new behaviour pattern.

This article does not provide instructions for using RP to reduce recidivism among adolescents with antisocial behaviour problems. The aims are to:

- describe how antisocial problems can be viewed from an RP perspective
- discuss the rationale and benefits of applying the RP Model to the understanding and treatment of antisocial behaviour in adolescents
- outline the potential application of RP treatment techniques to antisocial adolescents.

Antisocial behaviours are relatively common among adolescents referred to the Specialist Services of Child, Youth and Family in Christchurch. A proportionally high number of these adolescents have been referred for clinical assessment and/or intervention for a broad range of disruptive behaviours and criminal offending.

High rates of prevalence and clinical referral indicate the significance of antisocial behaviours as a clinical and social problem. Alongside this, research findings indicate that antisocial behaviour:

- often portends major dysfunction in adulthood (eg criminal behaviour, substance-related problems)
- predicts similar behaviour patterns in the next generation
- is fairly persistent over the course of the adolescent's development (Kazdin et al, 1989; Shamsie and Hluchy, 1991)
- can have significant consequences, ranging in degrees of severity, for the victims.

Over the years several approaches to treating antisocial behaviour in children and adolescents have been applied, including diverse forms of

individual and group therapy, family therapy, behaviour therapy, residential treatment, pharmacotherapy, and community-based treatments. Nevertheless, there has been ongoing controversy over the success of these various methods. Although a few treatments have been shown to modify antisocial behaviour in clinical samples, none have been demonstrated as preventing poor long-term outcomes for the children and young people treated (Shamsie and Hluchy, 1991).

Certain treatment approaches, such as cognitive-behaviour therapy and contingency management, appeared successful only in improving outcomes for adolescents but not in reducing recidivism.[1] These findings are consistent with research studies in current psychological literature. Short-term success in modifying antisocial behaviour patterns has been documented. However, improvement following most treatment approaches has not lasted long enough to reduce the rate of recidivism. This trend appears to highlight a need to incorporate strategies into intervention and management plans for maintaining post-treatment changes.

Ensuring that therapeutic change and treatment effects are maintained is in itself an essential part of the intervention

Antisocial behaviours are learned responses, influenced by an adolescent's perspective, previous life experiences and current social environment. Here, the assumption is that previous social learning could influence the adolescent's behavioural and emotional reactions to subsequent life events and experiences. Therefore, ensuring that therapeutic change and treatment effects are maintained is in itself an essential part of the intervention.

Using the Relapse Prevention Model to understand antisocial behaviours

Alongside the potential to help adolescents avoid recidivism, another rationale for applying RP is its emphasis on self-management. As such, the antisocial adolescent is seen as responsible for his or her own solution. Through this approach, therapeutic gains such as increased control and long-term behaviour changes that resist the effects of unsupportive environments can be attributed to the adolescent's efforts. This can enhance an adolescent's feelings of personal competence, foster independence and generate improvements that they can attribute to their own self-control as opposed to external factors, which are often only temporarily maintained.

Its application is also supported by the following RP's theoretical assumptions about how problematic behaviours are acquired and maintained. Antisocial behaviour patterns can be precipitated by a combination of factors including: the adolescent's past experiences, social learning processes such as modelling of such behaviour by adults, the situations in which they find themselves at a given time and, in some cases, certain biological influences. More adaptive coping responses for managing life stressors and dissatisfaction are not used by the adolescent, and instead antisocial behaviour has been maintained by:

- emotionally and socially reinforcing outcomes (such as short-term immediate gratification, peer acceptance, increased sense of self-efficacy and elevated mood states)

1 From meta-analysis conducted by Whitehead and Lab (1989).

- erroneous attitudes and beliefs that legitimise and rationalise these behaviours
- lack of prosocial skills to manage emotional and interpersonal experiences.

The two central objectives of RP treatment are:

1. Identifying and responding appropriately to early warning signals that may directly or indirectly steer the antisocial adolescent towards the high-risk situations.
2. Teaching the adolescent skills to cope effectively with unavoidable high-risk situations that may lead to antisocial activities.

In essence, the primary goal is to increase the adolescent's understanding and repertoire of skills so they can react more appropriately to high-risk situations. For the purpose of this discussion, a high-risk situation is broadly defined as any situation that may precipitate, and/or increase the probability of, an adolescent engaging in antisocial behaviours. From the RP perspective, the likelihood of an adolescent engaging in inappropriate behaviours following treatment is highly dependent on his or her ability to cope with high-risk situations.

Risk recognition and identification

For adolescents to learn how to handle high-risk situations in constructive and adaptive ways, they must first be able to identify and anticipate how these situations might arise. Therefore, the first step of RP intervention is learning to recognise high-risk situations and, through such recognition, gain warning that there is a need to change behaviour or to take alternative action.

It is also important to note that often, when urges develop to reoffend, defensive processes such as rationalisation, denial and minimisation may mask them. The adolescents can hide their true intention and make choices that are commonly known as 'seemingly irrelevant decisions'. In order to counteract this process, the adolescent must learn to recognise this and acknowledge that certain decisions can pave the way to high-risk situations.

Although each adolescent may have a unique set of situations that are high-risk, extrapolation on the basis of clinical experience suggests that recidivism, in many instances, is triggered by the following situations:

- negative emotional states, or situations in which the adolescent experiences unpleasant feelings (such as anger, anxiety and depression)
- interpersonal conflict, or situations in which the adolescent experiences relationship difficulties
- social pressure, or situations in which the adolescent experiences direct or indirect pressure from others to engage in antisocial activities.

However, it is important to note that identifying high-risk situations should be an individualised process. That way, informed psychological formulations can be made about the specific types of situations that are most likely to challenge an adolescent's efforts to make long-term behaviour change.

Specific skill training

In many instances, simple avoidance of particular situations is not possible or realistic. Acquiring adequate coping skills that will enable the adolescent to respond appropriately to unavoidable high-risk situations is a keystone of RP treatment. After these situations are identified, RP intervention focuses on alternative coping skills training, which is intended to counteract the habitual tendency of an adolescent to respond by engaging in antisocial

activity. As a prerequisite to the skill training, it is important to determine areas of deficit as well as competence.

This enables the clinician to tailor goals and interventions according to the adolescent's specific needs. Depending on assessment findings, the therapy process may include: mood management, relationships and broader interpersonal skills (including empathy, mutual respect, effective communication and conflict resolution), problem-solving skills (such as generating alternative solutions, thinking about consequences and taking the perspective of others) and strategies for impulse control.

Coping with lapse

Despite training in coping skills and risk identification, it is possible that the adolescent may experience a slip, or lapse. When applied to antisocial behaviour, the term lapse refers to any occurrence of an urge or thought about engaging in antisocial activities. It also refers to any formulation of a plan to carry out antisocial acts. Any actual occurrence of an antisocial behaviour will constitute a relapse.

The adolescent's cognitive and emotional reaction following such a lapse is a critical point in the RP model because it determines the likelihood and/or degree of escalation from a single isolated slip to a relapse. The adolescent may perceive the lapse as evidence of irreversible failure on his or her part or may attribute the cause to such traits as personal weakness (for example, no willpower). As a result, a relapse may occur via an almost self-fulfilling prophecy caused by the adolescent's expectation that they are likely to continue to fail.

If an adolescent is unable to cope effectively and believes a situation is beyond his or her capacity to manage, feelings of hopelessness and decreased self-efficacy may result. As a consequence, these cognitive and emotional responses, in combination with the reinforcing outcomes that a young person perceives he or she is able to derive from offending, can collectively and independently lead to recidivism.

Lifestyle intervention techniques

Helping the adolescent to recognise the influence which his or her lifestyle can have on recidivism is another aspect of RP. The majority of adolescents referred to our service have had extensive exposure to stressful and traumatic life experiences. The resultant or associated emotional distress frequently reported by these adolescents, such as feelings of rejection, inferiority, powerlessness and being unfairly deprived, can become especially acute if there is, at the same time, a relative shortage of self-reinforcing, pleasant activities in the adolescent's lifestyle. The imbalanced lifestyle can generate heightened desire for immediate gratification. These desires can manifest as urges to engage in antisocial behaviour and can, in turn, lead the adolescent to enter or set up a high-risk situation that can provoke a lapse and promote relapse.

Psychological wellbeing is an integral part of the RP intervention

Teaching adolescents to achieve and maintain a balanced lifestyle that will enable them to cope effectively in this situation and, at the same time, promote physical as well as psychological wellbeing is an integral part of the RP intervention. As the adolescent comes to recognise and appreciate that lifestyle imbalance contributes to the likelihood of re-offending, he

or she is encouraged to develop prosocial interests and participate in constructive activities.

In contrast with antisocial behaviour, which despite initial gratification will produce long-term negative consequences, positive activities such as sports and recreation (eg martial arts training, meditation and basketball) can yield long-term benefits. These may serve as avenues for increasing a young person's sense of self-adequacy, promoting goal-directed behaviours, generating positive emotional experiences and establishing a network of prosocial peers in the community that will support a non-offending lifestyle.

Conclusion

The RP conceptual framework and its treatment techniques offer a promising approach for preventing recidivism among adolescents with antisocial behaviour problems. The interventions outlined in this article are oriented towards teaching adolescents to refrain from engaging in antisocial activities, and to build a balanced lifestyle that is resistant to psychological stress and maladaptive habit patterns.

It would be shortsighted and unrealistic to assume that RP alone could effectively manage the myriad problems presented by hard core youth offenders referred to our service. Issues of comorbidity must be considered carefully as young persons with multiple problems (including low levels of cognitive functioning, significant substance-related problems and major psychiatric disorders) require a well-structured programme with many approaches – no single approach is able to meet all their needs.

Finally, an effective application model requires a young person to be motivated to change. Therefore, an important precondition for applying RP interventions is to encourage these young people to acknowledge personal responsibility for their antisocial behaviour and to recognise the need to change.

Ricki Tan *is a registered psychologist in Specialist Services at the Department of Child, Youth and Family Services, Christchurch.*

REFERENCES

Kazdin, A E, Bass, D, Siegel, T and Thomas, C. (1989) "Cognitive-behavioural Therapy and Relationship Therapy in the Treatment of Children Referred for Antisocial Behaviour". In *Journal of Consulting and Clinical Psychology,* 57(4). Pp 522–535.

Shamsie, J and Hluchy, C. (1991) "Youth with Conduct Disorder: A challenge to be met". In *Canadian Journal of Psychiatry,* 36, No.6. Pp 405–414.

Whitehead, J T and Lab, S P. (1989) "A Meta-Analysis of Juvenile Correctional Treatment". In *Journal of Research in Crime and Delinquency,* 26. Pp 276-295.

‘Building Resilient Lives’

including families in residential intervention

Melanie Pearson *examines issues of family involvement in residential intervention such as Children’s Health Camps*

The popularity of residential interventions for children and youth has fluctuated, both around the world and over time. Such interventions, although relatively infrequently used in New Zealand, have the potential to significantly improve the quality of life of both the children they serve and their families, when the child returns home. In this article the literature on one factor, family involvement, is summarised. That is almost unanimously agreed to be of great importance in enhancing the probability of long-term change. The notion of families as treatment partners is then demonstrated by a description of Children’s Health Camps, a unique and innovative cluster of interventions attempting to ‘build resilient lives’.

Here, family is broadly defined as parents, caregivers, or significant individuals in the child’s life. It is acknowledged that the concept of family is culturally determined, and that the Māori notion of whānau and the concept of a nuclear family are far from synonymous.

A review of the literature

The great majority of residential outcome research has been conducted in the United States, involving long-term stays (typically six months to two years) and children or youth who were admitted to the residential programme as a ‘last resort’ with diagnoses as varied as conduct disorder and mental retardation. Very little outcome research has been conducted in New Zealand, with our relatively short-term residential programmes (usually between four weeks and three months in duration) and unique population and interventions.

Research indicates that children often display positive behavioural changes in the residential environment. However, follow-up studies of children placed in out-of-home care indicate that, generally, these changes are not maintained when the intervention has ended (Jenson and Whittaker, 1987, 1989). How they respond to treatment in residential centres does not necessarily indicate what the child’s adjustment will be like post-discharge (Burks, 1995). In fact, children and adolescents, on discharge into an environment that has often altered very little from the point of admission, commonly return to former behaviour patterns and fail to generalise changes by not incorporating the new behaviour on their return home (Finklestein, 1981; Jenson and Whittaker, 1989).

It is reasonable to expect that the level of positive behaviour change would tend to decrease over time. As the time since discharge lengthens, it is increasingly likely that the effects of the residential programme will exert less influence over the child's life (Hooper et al, 2000). However, the decomposition of treatment effects tends to be sufficiently rapid so that the process usually cannot be attributed solely to the effect of the passage of time.

When focus is on the isolation of those factors that encourage the maintenance of positive changes, a consistent observation has been that family involvement in the residential intervention improves generalisation post-discharge. In fact, Chamberlain (1999) goes so far as to assert that 'failure to include parents in youngsters' treatment may be the single largest barrier to generalisation of treatment effects from residential care to living at home' (p502). Thus, if parents and/or family members are involved with the child during their residential stay, the propensity for maintenance of positive changes will be increased. Emphasising this, Whittaker (1981) notes that any approach to treatment for children in need, including residential treatment, 'will succeed according to its ability to influence the total ecology of the child's world: most notably the family' (p68).

Jenson and Whittaker (1989) confirm the importance of family involvement with their statement that 'parental involvement and family support in the treatment process for children and youth removed from their homes are among the strongest predictors of a child's ability to adapt to the community successfully following placement' (p210). The authors argue that although parents are perceived, on occasion, by professionals as unable to care for their child, several powerful reasons exist for pursuing their involvement in the child's residential placement, including the strong empirical evidence establishing the importance of this involvement.

Few evaluations of interventions with a focus on family involvement in the residential setting have been attempted, but specific factors such as the frequency of visits from parents have been examined (Borgman, 1985). Jenson and Whittaker (1987) reviewed such studies and concluded that the frequency of parental visits during placement is 'positively associated with a child's successful return to his or her biological family' (p155). This conclusion is also supported by a study of 608 boys in a North American residential centre, for whom a successful outcome was associated with, among other factors, the number of face-to-face contacts between family workers and family members (Savas, Epstein and Grasso, 1993). Day, Pal, and Goldberg (1994) found significant improvements in behaviour were maintained at six-month follow-ups with children and youth with conduct disorder following discharge from a residential setting that emphasised family involvement. At this centre, parents participated in mealtime and bedtime activities, attended parent training groups and weekly family therapy sessions.

> The success of treatment is contingent on parental involvement

Krona (1980) agrees that, to a large extent, the success of treatment is contingent on parental involvement, but goes further, suggesting that it ought to be an ethical premise to involve parents. He then suggests three reasons why

programmes without parental involvement are unlikely to effect lasting change:

1. The behaviour of the child is maintained by its effect on, and interaction with, the environment, most notably the family. The new behaviour patterns of the child, established in the residential environment, can be maintained most effectively by the actions and support of individuals in the child's usual environment.

2. Before the residential intervention, parents may have felt overwhelmed and unable to cope with their child's behaviour. These feelings, along with possible guilt, anger and resentment, may cause further family dysfunction if not addressed during the residential intervention.

3. Where family dysfunction is related to the child's difficulties, feelings of guilt and self-blame may place additional stress on an already unsteady family situation if these are not addressed during the period of the residential intervention.

Wells et al (1991) support this last point and, importantly, note that among the sources of social support available to youth following discharge, family support is related most strongly to post-discharge adaptation. Specifically, they found that family support was significantly correlated to three indices of adaptation: self-esteem, mastery and psychopathology.

Although the literature evaluating family-centred residential treatment programmes is scarce due to the relative rarity of such facilities, the empirical evidence strongly suggests that such programmes are desirable. In fact, studies are distinctive in their almost unanimous agreement on the significance of this factor. In the words of Baker, Blacher and Pfeiffer (1993), a lack of family contact 'leaves a void that even the highest quality treatment program cannot presume to fill' (p565). Let us now examine a service that is attempting to prevent that void from occurring in its residential programme.

Te Puna Whaiora – Children's Health Camps

Children's Health Camps are a group of seven facilities located throughout New Zealand. The history of this movement is interesting, unique to New Zealand and can be found in the enjoyable publication *Children's Health, the Nation's Wealth: A History of Children's Health Camps* (Tennant, 1994). The structure and function of the camps has altered dramatically from the early days of underweight, malnourished children confronted with lashings of milk, matrons and fingernail inspections. The modern Health Camps are more likely to serve children and families who have been referred by Public Health Nurses, social workers, school staff, counsellors and medical and/or cultural professionals for a variety of reasons. These include psychological aspects of functioning (such as emotional and behavioural needs), social aspects (including poor peer relationships), physical aspects (for example, poor management of asthma, diabetes, obesity or skin conditions), and environmental aspects (these can be poor self-care skills or lack of hygiene). Most commonly, referrals to the Health Camp service are to address a combination of these needs. Referrals are accepted for children aged 5–12, and represent a wide range of cultures, socio-economic levels and living situations, although the most common referrals relate to children living in solo-parent households.

Following referral, a trained and experienced multicultural team of fieldworkers carry out a thorough assessment. An appropriate

intervention is devised, with collaboration between the family, referral agent and Health Camp staff members. Historically, this intervention has involved a five-week residential stay at one of the purpose-built facilities, but several other interventions are now available. These include an individualised and specific mentoring programme. However, for the purposes of this article, the focus will be on the residential intervention.

Family involvement in practice

The Children's Health Camps encourage families to be involved with their child during the residential intervention in a number of ways. At least two three-day parent workshops are offered during each five-week residential intake and family/whānau members are encouraged to participate. They can even stay on-site, if they reside some distance from the facility, in comfortable, private bedrooms. Meals, childcare and laundry services are provided to encourage parents to relax, build social networks with other parents and spend considerable time with their children. Trained and experienced facilitators work with groups of parents, covering topics such as self-esteem and behaviour management, and the parents are invited to presentations on the types of programmes their child may be undertaking, in order to further aid generalisation of concepts to the home environment.

Each of the seven facilities has a strong team of experienced and multicultural fieldworkers. These staff members work extensively with the families of children before, during and after the residential intervention. They assist parents to strengthen networks with other professionals, coach them on the child's likely reaction to returning home and provide specific parenting advice in the home setting. This approach is supported in the literature, as evidenced by Small, Kennedy and Bender's (1991) assertion that 'perhaps more useful than family therapy would be a clinical case management approach that can help families to connect with outside supportive services which they would not otherwise pursue' (p336).

Several practical strategies are employed by residential staff members to encourage family members to be involved with their child while he or she is in residence. These include meeting with the child and family before the intervention, a pōwhiri to welcome the child and family into the 'Health Camp family' and weekly phone calls outlining the child's progress during their stay. Families are encouraged to visit their child, and are often provided with a meal if they happen to visit at dinnertime. Families have been observed going on outings with the dormitory group (these can include accompanying the child, staff and peers for a swim) and are encouraged to attend special occasions such as birthday parties and regular talent quests and award ceremonies.

Families have been observed going on outings with the dormitory group

An ongoing study at the Pakuranga Children's Health Camp in Auckland is examining the influence that family involvement has on outcomes for children, utilising a brief behavioural screening measure, the Strengths and Difficulties Questionnaire (SDQ), as one of the measures. This questionnaire is increasingly used in New Zealand, Australia and the United Kingdom and incorporates five domains:

- Emotionality.
- Conduct Problems.
- Hyperactivity.
- Peer Problems.
- Pro-social Behaviour.

Results indicate that the Health Camp residential intervention is rated as useful in the short-term, as evidenced by a decrease in the 'total difficulties' score on the SDQ at two-week follow-up. The influence that family involvement has on outcomes in this setting is currently being determined. This study is also attempting to examine staff attitudes towards family involvement, because the literature identifies this as a potential barrier (Baker, Heller, Blacher and Pfeiffer, 1995). Initial feedback suggests that some residential staff members see the benefits of family involvement when the child is still in residence. Comments exhibiting this awareness include 'staff/caregivers/child can create a system of working towards their objectives together' and 'if parents are involved (eg parent workshop), they will be able to help children maintain progress made at camp at home'. Verbal feedback sought, on a regular basis through a client satisfaction survey, also indicates that families have generally felt very welcome at the camp and make positive comments about their interactions with staff members.

It appears that the Children's Health Camps are responding well to the recognition of the importance of family involvement in the research literature. The camps are translating this into practice, with positive results. They continue to seek ways of achieving their motto of 'Building Resilient Lives' by moving forward with families.

***Melanie Pearson** has been employed by the Pakuranga Children's Health Camp for four years. She is currently completing a Doctorate of Clinical Psychology at the University of Auckland.*

REFERENCES

Baker, B L, Blacher, J and Pfeiffer, S. (1993) "Family involvement in residential treatment of children with psychiatric disorder and mental retardation". In *Hospital & Community Psychiatry,* 44(6). Pp561–566.

Baker, B L, Heller, T L, Blacher, J and Pfeiffer, S. (1995) "Staff attitudes toward family involvement in residential treatment centres for children". In *Psychiatric Services,* 46(1). Pp60–65.

Borgman, R. (1985) "The influence of family visiting upon boys' behaviour in a juvenile correction institution". In *Child Welfare,* 64(6). Pp629–638.

Burks, J. (1995) "Edgewater Childrens' Centre outcome study 1991/1992". In *Residential Treatment for Children and Youth,* 13(2). Pp31–40.

Chamberlain, P. (1999) "Residential care for children and adolescents with oppositional defiant disorder and conduct disorder". In H C Quay and A E Hogan (eds) *Handbook of Disruptive Behaviour Disorders.* Kluwer Academic/Plenum Publishers. New York. Pp495–506.

Day, D M, Pal, A and Goldberg, K. (1994) "Assessing the post-residential functioning of latency-aged conduct disordered children". In *Residential Treatment for Children & Youth,* 11. Pp45–52.

Finklestein, N E. (1981) "Family-centred Group Care: The Children's Institution, from a Living Centre to a Centre for Change". In A N Maluccio and P A Sinanoglu (eds) *The Challenge of Partnership: Working with Parents of Children in Foster Care.* Child Welfare League of America. New York. Pp89–105.

Goodman, R. (2001) "Psychometric properties of the Strengths and Difficulties Questionnaire". In *Journal of the American Academy of Child and Adolescent Psychiatry,* 40(11).

Hooper, S R, Murphy, J, Devaney, A and Hultman, T. (2000) "Ecological outcomes of adolescents in a psychoeducational residential treatment facility". In *American Journal of Orthopsychiatry,* 70(4).

Jenson, J M and Whittaker, J K. (1987) "Parental involvement in children's residential treatment: From preplacement to aftercare". In *Children and Youth Services Review,* 9(2). Pp81–100.

id. (1989) "Partners in care: Involving parents in children's residential treatment". In R D Lyman, S Prentice-Dunn et al (eds) *Residential and Inpatient treatment of Children and Adolescents.* Kluwer Academic/Plenum Publishers. New York. Pp207–227.

Krona, D A. (1980) "Parents as treatment partners in residential care". In *Child Welfare,* 59(2). Pp91–96.

Savas, S A, Epstein, I and Grasso, A J. (1993) "Client characteristics, family contacts and treatment outcomes". In *Child and Youth Services,* 16(1). Pp125–137.

Small, R W, Kennedy, K and Bender, B. (1991) "Critical issues for practice in residential treatment: The view from within". In *American Journal of Orthopsychiatry,* 61(3). Pp327-338.

Tennant, M. (1994) *Children's Health, the Nation's Wealth: A History of Children's Health Camps.* Bridget Williams Books and Historical Branch, Department of Internal Affairs. Wellington.

Wells, K, Wyatt, E and Hobfoll, S. (1991) "Factors associated with adaptation of youth discharged from residential treatment". In *Children and Youth Services Review,* 13(3). Pp199–216.

Whittaker, J K. (1981) "Family involvement in residential treatment". In A N Maluccio and P A Sinanoglu (eds) *The Challenge of Partnership: Working with Parents of Children in Residential Care.* Child Welfare League of America. New York. Pp67–89.

Book Information

Instead of a book review in this issue, Social Work Now *is featuring information on two recent publications by Jessica Kingsley Publishers.*

Information and Communication Technologies in the Welfare Services
Edited by Elizabeth Harlow and Stephen A. Webb
224 pages ISBN 1 84310 049 5 pb £17.95 US$27.95
Information technology is changing not only the role, responsibilities and practices of social care professionals but policy and management decision making. Leading British academics discuss the application of new information technology in health and social care and the impact on issues such as child abuse and the Internet, computer mediated self-help and collaborative learning.

Children's Unspoken Language
Gwyneth Doherty–Sneddon
176pp ISBN 1 84310 120 3 £16.95 US$25.95
Developmental psychologist and mother of two young children, Gwyneth Doherty-Sneddon, examines the way in which a child's developing personality and intelligence can be displayed through non-verbal communication. This is an accessible text that takes an in-depth look at four of the channels of non-verbal communication: hand gesture, facial expression, eye gaze and touch.

Further details for these books can be found on the JKP website: http://www.jkp.com/catalogue. Books can be ordered online from this page.

Social Work Now

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the baseline review

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involving families in residential intervention

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