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THURLOW HOUSE ASSESSMENT PROGRAMME FOR FAMILIES WITH PHYSICALLY ABUSED CHILDREN

ABSTRACT

A comprehensive assessment programme for families where physical child abuse has occurred is described in this paper. The programme is informed by a multifactorial understanding of child abuse. Programme staff are members of a multidisciplinary team based in a Department of Child and Family Psychiatry. The main function of the programme is to provide a sound basis for long term-planning in cases of non-accidental injury.

INTRODUCTION

Child care inquiry reports and the recent DHSS guidelines highlight the complex problems faced in the management of families where children have been physically abused. (DHSS, 1986; DHSS, 1982; Beal et al., 1985). They also draw attention to potential pitfalls professionals can make when dealing with these cases.

Eight distinct steps may be identified in the management of cases of child abuse:

1. detection;
 2. crisis intervention;
 3. first case conference leading to an interim plan;
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4. execution of interim plan;
5. comprehensive assessment leading to a long term plan;
6. second case conference;
7. execution of long term plan;
8. periodic review

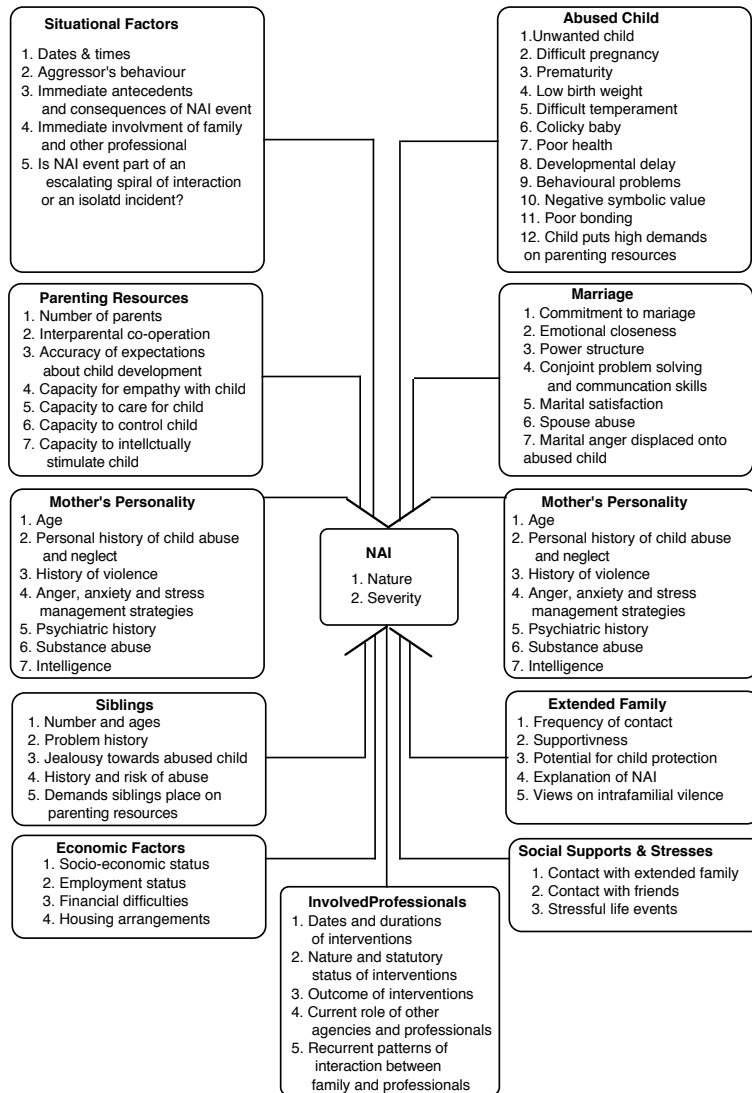
Errors in the handling of child abuse cases may be viewed as arising from failure to deal competently with each stage (e.g. poor crisis intervention) or omitting one or more steps completely (e.g. comprehensive assessment with an eye to long term planning).

The Thurlow House Assessment Programme for Families with Physically Abused Children evolved as a service to help avoid some of these pitfalls ,particularly those associated with long term planning. The programme was developed by the authors, who constitute the senior members of a multi-disciplinary team. The team is based in the Department of Child and Family Psychiatry of the West Norfolk and Wisbech Health Authority. The programme has been running now for four years. The purpose of the programme is to reach an independent opinion on whether it would be safe to return the child to the care of the parents, and if so, the specific conditions under which this should occur. Referrals are typically accepted from case conferences when there is difficulty making such decisions.

Referrals into the programme are accepted after the case has been conferenced and an interim plan developed and implemented. Such a plan usually involves the offending adult facing charges in court and the child being placed with foster parents under a care order. Thus entry into the programme may occur as late as three to nine months following the non-accidental injury (NAI) incident.

Within the programme the full range of factors which may have contributed to the occurrence of the NAI are assessed with a view to formulating a comprehensive hypothesis to explain how the incident occurred. In the light of this hypothesis, potential targets for change are sought. Where realistic targets for change can be identified, appropriate rehabilitative interventions are specified. Where such targets cannot be identified, access recommendations are made. Recommendations on monitoring and periodic review are made in each case. The comprehensive nature of the assessment allows the team to set out in broad strokes a five year plan (alongside specific immediate courses of action). A member of the programme staff attends the second case conference, responds to comments on the report, clarifies recommendations, and offers his or her services as a consultant at periodic review meetings.

Figure 5.1. Factors to consider in the assessment of families where a non-accidental injury has occurred.



In this paper the conceptual model which underpins our approach to the assessment of families with physically abused children will first be outlined. A description of the clinical and administrative procedures which constitute the assessment programme itself will then be presented.

THE MULTI-FACTORIAL MODEL

Evidence from a variety of sources suggests that child abuse is most fruitfully conceptualised as a multi-dimensional phenomenon (Belsky, 1980; Friedman et al., 1981; Lee, 1978; Garbarino, 1977; Mrazek & Mrazek, 1985; Parke & Collmer, 1975; Rosenberg & Reppucci, 1983). There is now some consensus within the literature as to which variables are important to consider in the etiology of physical child abuse. These are presented in Figure 5.1. However, controversy surrounds the way (or ways) in which these variables interact to cause non-accidental injuries. For this reason, at the outset of the evaluation of any given case, we simply assume that all of the variables listed in Figure 5.1 may have contributed to the occurrence of the NAI. This is represented in Figure 5.1 by linking, with unidirectional arrows, the various potential contributing factors to the NAI itself. Thus Figure 5.1 is a simple forcefield diagram.

This diagram offers a framework within which to categorise information gained from the various evaluation procedures described in the next section. In each case, once the relevant information has been gathered and located within the simple forcefield diagram, the team develops a specific hypothesis to explain the unique way in which the variables contained in Figure 5.1 interacted to lead to the occurrence of the non-accidental injury. Such hypotheses are usually quite complex (Calam & Franchi, 1987, p.187).

PROGRAMME STRUCTURE

We have experimented with a variety of staffing arrangements and team structures. For the purpose of this paper we shall mention the one which is most likely to be used for the foreseeable future. In a given case, two team members take on keyworker roles for the parents of the abused child. They develop close relationships with the parent, liaise with other involved agencies, collect background information, and solicit specialist evaluations from other team members as required. The keyworkers ensure that all meetings are scheduled and the final assessment report is completed within three months of the first day of the contracting interview. The core keyworker team are offered consultancy and supervision on request from a team chairperson. At this stage in the team's development, a number of members can competently take on this

difficult role. However, in the early stages of the project the team social worker was primarily responsible for fulfilling this function.

A chronologically ordered list of the clinical procedures which comprise the programme is set out in Table 5.1. Detailed comments on these procedures will now be presented.

Table 5.1. Components of the Thurlow House Assessment Programme for Families with Physically Abused Children

1. Contracting interviews with referring agent, family and foster family
2. Initial psychiatric evaluation
3. Client centred interview with parents
4. Marital interviews
5. Family of origin interviews
6. Foster parent interviews
7. Parent child interaction observational sessions
8. Records review and interviews with involved professionals
9. Psychometric evaluation
10. Residential review and planning conference
11. Residential family evaluation
12. Second psychiatric evaluation
13. Formulation conference
14. Report writing
15. Feedback session
16. Case conference

CONTRACTING INTERVIEWS

Separate contracting interviews are held with the area social worker responsible for the case, the parents of the abused child and the foster parents. Usually these occur one after the other on the same day and are followed by a joint session in which appointment schedules, access arrangements and transportation arrangements are clarified.

In the referrer's contracting interview, team members meet with the area social worker responsible for the case. Details of the programme are outlined and the responsibilities of the team and the area social worker for the duration of the assessment are specified. One point in particular, which is clarified at this meeting, is worth mentioning. The area social worker retains statutory responsibility for the child's protection throughout the assessment programme with the exception of the residential period during which the team social worker has this responsibility.

An important feature of the contracting interview with the family is underlining the participative nature of the assessment process. Much of the proceedings through which the parents will have gone until then will have been highly child centred. The team emphasises to the parents that the assessment programme offers them a chance to put their view on record, to be understood and supported. They are informed that they each will be allocated a key worker whose primary responsibility it is to ensure that this happens. It is also pointed out that throughout the process of assessment they will have a high level of access to their child so that their relationship with their child has a chance to grow and develop. The parents are told that if the assessment shows that they can understand their difficulties and begin to take steps to make changes in their lives which would prevent the recurrence of child abuse then the team will recommend that their child will be returned home under specific conditions. Failure to show insight and the capacity for constructive change, they are told, will lead to a recommendation that the child remain living separately from them. We point out to the parents that they cannot demonstrate insight and the capacity for change by turning up for scheduled assessment procedures and simply going through the motions.

In the contracting interview with the foster parents, details of access visits are clarified and the importance of these being very frequent despite the difficulties this may cause is emphasised. The team point out to the foster parent the important role that they will play in the assessment in offering direct observational data on the child and descriptions of the parent-child interactions on access visits.

PSYCHIATRIC EVALUATION

A psychiatric evaluation (comprising one or more interviews) is conducted following the contracting interview and also after the residential family assessment. Thus, the psychiatrist meets the family at the beginning and towards then end of the programme. He is, therefore, in a position to comment on significant changes in functioning displayed by the family over the course of the assessment. This, of course, is in addition to his comments, as a specialist, on the psychiatric and neurological status of each family member.

CLIENT CENTRED INTERVIEWS

Each parent is allocated a key worker from the team who conducts a series of client centred interviews with them. The purpose of the client centred interviews is to give each parent an opportunity to feel that their side of the story has been heard and understood and to clarify their individual perspectives on the NAI. In the sessions clients clarify their view of the marriage and their views of themselves as parents. The way

in which each parent sees their family of origin is explored. An inventory of current and past family stresses is also compiled by each parent. Genogram construction is a method we commonly use to aid this information gathering and relationship building process. (McGoldrick and Gerson, 1985). A genogram is a family tree annotated with significant information about family members. Genograms are useful for identifying patterns of family relationships both within a given generation and those that repeat across generations. This assessment method is particularly apt, since child abuse is a phenomenon that often occurs across a number of generations within the same family (e.g. Belsky, 1980).

In these sessions the therapeutic emphasis is on support rather than confrontation. Each parent's capacity to participate in, and benefit from, supportive client centred counselling is assessed during these interviews.

MARITAL ASSESSMENT

Once keyworkers have formed therapeutic alliances with the parents, the marital assessment is conducted. Both keyworkers meet conjointly with both parents for one or more interviews to assess the interactional characteristics of the marriage. The following are the major features of the marriage to which the assessors direct their attention: the couple's level of commitment to sustaining the marital relationship; the extent to which the partners can meet each other's needs for nurturance and emotional support; the power structure of the marriage; the couple's capacity for co-operative problem solving and clear communication; the way in which child care tasks such as nurturing and setting limits on the children are divided up and the impact this has on the couple's marital relationship; the major sources of marital satisfaction and dissatisfaction; and the presence of violent spouse abuse.

Information about these aspects of the marriage are obtained both by having the couple talk about them and by observing the couple interacting in the marital interview situations. Discrepancies between *what they do* and *what they say they do* are noted but not often commented upon. This information is presented at the pre-residential conference and may be used in a confrontative manner during the residential period. Although marital interviews may become highly emotionally charged events, by and large the keyworkers aim to keep them at a low key level with the focus being on insight rather than change.

FAMILY OF ORIGIN INTERVIEWS

The abused child's grandparents (i.e. the parents' families of origin) are interviewed by the keyworkers to assess their view of the facts

surrounding the non-accidental injury and to check on the historical accuracy of the social histories that have been taken in the client centred interviews. In addition, the way in which violence, anger, drug abuse, psychiatric problems and life stresses were dealt within each of the parent's families of origin is established. The grandparents are also assessed as child care role models for the parents of the abused child.

In cases where there is a possibility that the child might be placed with the grandparents as part of the recommended treatment programme, the grandparents' capacity to meet the child's needs in this situation are assessed through interviewing and grandparent-child interaction observational sessions.

PARENT-CHILD INTERACTION OBSERVATION SESSIONS

The team's health visitor attends selected access visits at the foster parents' home and observes the abused child interacting with his parents. Deficits in child management skills are noted and the parents are coached in more appropriate child management strategies. Their capacity to respond to this coaching is also assessed. These sessions are conducted in a matter-of-fact way without recourse to elaborate teaching aids.

FOSTER PARENT INTERVIEWS

The key workers obtain the foster parents' observations of the abused child's behaviour and the developmental appropriateness of the child's responses to nurturance and structure in these interviews. The foster parents' observations of the child's behaviour during access visits are also noted and any change in this behaviour over time. The match or fit between the foster family and the abused child is noted and the suitability of the foster home as a long term placement is assessed.

INTERVIEWS WITH OTHER PROFESSIONALS AND RECORD REVIEW

Available documentation from social services, the general practitioner (GP), the paediatrician, health visitor, home help and other involved agencies are obtained and reviewed. Following the record review, involved professionals are contacted and interviewed if keyworkers deem it necessary.

PSYCHOMETRIC ASSESSMENT

The team's psychologist uses psychometric assessment procedures to furnish standardised information on the abilities and personalities of family members and on certain aspects of family functioning such as marital satisfaction (Snyder, 1981) or family stress (McCubbin et al., 1982).

THE RESIDENTIAL ASSESSMENT PERIOD

Prior to the residential assessment period, the team meet to pool their information and come up with a preliminary hypothesis. This hypothesis is a tentative explanation as to why the NAI occurred when it did.

The residential assessment period lasts 26 hours from 10.00 am on the morning of the first day until noon on the second day. It is attended by both parents and all of the children including the abused child. The assessment is conducted by a senior occupational therapist with specialised training in psychotherapy. A child keyworker and the team social worker attend this assessment period also. A self-catering cottage is rented as a venue for this part of the programme.

The goals of the residential assessment are to check out the psychodynamic validity of the team's hypothesis about family functioning and to assess the parents' capacity to make constructive personal and interactional changes through engaging in emotionally intensive insight oriented psychotherapy. We have given a detailed account of residential family assessment in a previous publication (Irving et al., 1988).

FORMULATION CONFERENCE

All team members meet for a formulation conference after the residential assessment period . The conference, for which an entire working day is scheduled, is usually held in a room equipped with a whiteboard large enough to contain a summary of all available assessment information. The goals of the conference are to condense the information that has been gathered and locate it within the forcefield model set out in Figure 5.1, to synthesise this information into a comprehensive hypothesis, and to outline a series of recommendations and a practical plan of action which follows from the hypothesis.

Two features of the information brought by the team to the conference deserve mention. First, all team members have some knowledge of all aspects of the family. Thus most facts may be double checked. This ensures that the hypothesis is based on fairly reliable information. Second, each team member has a particular circumscribed area in which his or her knowledge is authoritative. This authority is acknowledged by the team, the case conference and, indeed, the courts. Thus, the information on which the hypothesis is based is not only reliable, but also authoritative.

At the hypothesis formation stage, initially all team members brainstorm a variety of partial hypotheses. Then one member attempts

to synthesise these into a unified comprehensive explanation. This is altered and refined by other team members.

A hypothesis is a brief explanation, based on information contained in the forcefield diagram, which shows how the family and the wider social network within which it is embedded functions, and how this relates to the occurrence of the NAI. A hypothesis has the following characteristics:

1. it is stated in specific rather than vague terms;
2. the statements within the hypothesis are logically connected;
3. it is comprehensive and so takes account of most available significant information;
4. it contains statements about predisposing and precipitating factors
5. it identifies factors which continue to place the family at risk for further child abuse such as *vicious cycles* of social interaction
6. it points to a clear action plan and also suggests courses of action that should be avoided. (We have previously presented a full account of this approach to hypothesis construction in Carr, 1987).

Once the hypothesis has been formulated, a set of recommendations which follows from it are listed and prioritised. First, a statement must be made as to whether the family and its network display sufficient flexibility for change to permit the child to be returned to the care of the parents. If it is decided that this can occur, the conditions under which this would be possible must be set out. The practical steps that need to be taken for these conditions to be met must be clarified. This is the action plan. It contains details of resource allocation and the role of our team in the future rehabilitation of the family. In practice we have found that primary care services (in the form of support, monitoring, and child management training) are best provided by community based workers such as the area social worker, the health visitor, the GP, Home Start workers, or volunteer counsellors. Members of our team may provide a backup consultative service to these workers, and if necessary specialist primary care services such as individual psychotherapy or family therapy.

If the assessment reveals that the child cannot safely be returned to its parents' care, then the plan of action must specify placement arrangements, monitoring and intervention services for the child and the services to be offered to the parents to help them to cope with the loss of their child and related problems.

The conference is facilitated by a designated chairperson. This is an exacting role, requiring the following skills and attributes. Team members must trust the chairperson and respect his or her judgement. That is, a team must invest the chairperson with authority. The chairperson must be able to elicit and condense each team member's contribution and locate it within the forcefield diagram. He or she must

also be able to orchestrate the creative powers of the team during the hypothesis formation stage of the conference. When the team have listed tentative recommendations and plans, the chairperson must be able to assess each team member's commitment to them. He or she must be prepared to delay closure, if one or more team members have lingering doubts about some aspect of the hypothesis and recommendations. The chairperson must facilitate the team member's exploration of these doubts so that eventually a consensual team opinion

may be reached. However, he or she must also be able to recognise when a consensual team position is unobtainable, and advise that the dissenting team member's view be recorded as such in the final report.

Throughout the conference, when differences of opinion occur between team members, the chairperson must be able to determine the extent to which the disagreement is based upon differences in professional assessment or differences in personal countertransference reactions. Ideally the chairperson should have a low level of direct contact with the family so that he or she is to some degree protected from countertransference issues. Thus the chairperson is in a position to help other staff to deal with these issues, particularly the keyworkers who have been intensively involved with the family. (We have described these countertransference problems fully in Carr,1989).

FEEDBACK TO THE FAMILY AND THE CASE CONFERENCE

The keyworkers and the chairperson meet with the family a few days before the NAI case conference and present to them in a detailed way the hypothesis, the evidence on which it is based, the recommendations and the action plan. The keyworkers allow the parents an appropriate amount of time and space to emotionally process the results of the assessment. For example, if the recommendation is that the child remain in care, feedback may be given in a day long session, so as to provide the parents time to understand and react to the loss of their child.

One keyworker then writes up a report to be presented to the case conference. This report contains:

1. a list of members of the assessment team;
2. a list of the assessment procedures, the dates on which they were conducted and the staff members responsible;
3. a statement of the circumstances leading to the referral;
4. a clear narrative statement of the information obtained under the headings specified in the forcefield diagram;
5. the completed forcefield diagram;
6. the hypothesis in narrative and diagrammatic form (if clarity warrants this)
7. the recommendations and the proposed action plan;

8. the family's reaction to the feedback.

Fuller specialist reports such as those from the psychiatrist, psychologist, and psychotherapist may be appended to the team's composite report along with those of other involved professionals, e.g. the radiologist or paediatrician.

This report is presented at the case conference by one or more team members. Conference members are invited to explore the accuracy of the facts at which the hypothesis is based, the plausibility of the hypothesis and the viability of the recommendations. In all cases we have assessed in this manner, the conference has accepted the core of our report and recommendations.

CLOSING COMMENTS

The assessment programme described in this paper is expensive. An average of 159 man hours of professional time are required per case. When the cost of this professional time investment and administrative overheads are combined, the total cost per family assessment is about £4,000. However, a reading of the inquiry reports suggests that at least in some cases where recommendations about childcare; are bought more cheaply and based on a cursory rather than an intensive assessment, the consequences can be very expensive (Beal et al., 1985; DHSS,1983)

We do not believe that a comprehensive assessment as complex as that described here is necessary in every case of non-accidental injury. However, we do believe that this type of assessment service can be invaluable to case conferences where there is difficulty making decisions about long term planning for specific cases. In our district, which has a population of 47,600 children under the age of 16, about 18 cases of physical child abuse (as distinct from other forms of abuse) are identified annually. Only four families (or 25 per cent of all registered physically abused cases) are referred to us per year for this type of extensive assessment.

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