Multidisciplinary approach to the treatment of child abuse and neglect

Fred Gravestock

Child abuse and neglect is a complex problem that requires a sophisticated treatment response. Utilising comprehensive research literature, the Abused Child Trust has developed a model for intervening with families in which maltreatment is a major concern. The intervention program operates on a multidisciplinary model, and incorporates counselling, specialised educational support, and health care. The service at Contact House is presented in detail, to serve as a stimulus for discussion as to the appropriate level of service required by at-risk families.

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The establishment of therapy and intervention services for maltreated children and their families is vital as the consequences of abuse and neglect are negative and often lifelong. Indeed, without access to effective intervention, victims of child abuse and neglect evidence failure on a range of developmentally salient issues and are at risk for the emergence of psychopathology (Cicchetti & Toth, 1995). In the development and maintenance of an effective intervention strategy, an agency must keep abreast of the accumulation of knowledge available in the recent literature. This must not be restricted to the effects of the factors associated with child maltreatment, but incorporate up-to-date information on intervention programs, treatment protocols and program evaluation.

The maintenance of an effective and family oriented intervention service is at the heart of the mission of the Abused Child Trust, which is:

- to provide specialised services for abused children and their families through individualised therapy programs; and
- to enable the children to grow through and learn from their experiences of abuse, so that they will not enter the cycle of child abuse as adults.

Utilising current literature and the wealth of available practice, the Trust has developed a therapeutic program aimed at meeting many of the needs of individual families. A multidisciplinary team (comprising psychologist, social worker, occupational therapist, early childhood teacher, teacher's aide, paediatrician and clinical nurse) manages the therapeutic interventions available for each family. This approach enables the majority of the assessed needs of the family to be addressed.

Child abuse and neglect has attracted a great deal of attention from both researchers and practitioners. An overview of what is known about child abuse and neglect will therefore establish the context for the development of this service.

INCIDENCE OF CHILD ABUSE AND NEGLECT

A widely accepted definition of child abuse and neglect is any action or lack of action that endangers or impairs a child's physical, cognitive, or emotional health and development. It is seldom the result of a single incident, it occurs in all socio-economic groups and it is most often perpetrated by someone known to the child (Broadbent & Bentley, 1997). Abuse and neglect are generally categorised under four headings, namely: physical, emotional, neglect and sexual. The most recently available statistics on the incidence of child abuse and neglect, presented in Table 1, reinforce that it is a serious community problem.

While there has been a recent inquiry into paedophilia in Queensland (Children's Commission, 1997), it must be remembered that in most child maltreatment cases, the person is known and trusted by the victim. Specifically, the person believed to be responsible for the abuse or neglect was the natural parent in 71% of cases and the stepparent in 10% of cases (Broadbent & Bentley, 1997). Other results from this research suggest that the factors associated with abuse and neglect are complex and no single factor

Table 1 Substantiated child abuse and neglect in Australia 1995-96 for children aged 0-16 (Broadbent & Bentley, 1997)

	Australia	*Queensland*
Total notifications	91,734	15,362
Substantiated Abuse	**Number**	**Number**
Physical abuse	8,467	1,620
Emotional abuse	9,265	896
Neglect	7,299	1,845
Sexual abuse	4,802	301
Total substantiated	**29,833**	**4,662**

(eg, type of family structure) can fully explain the problem.

COST OF CHILD ABUSE AND NEGLECT

There have been no Australian studies that specifically determine the costs associated with child maltreatment, but if those studies conducted in the USA are any indication, the financial and human costs are indeed great (Dubowitz, 1990). It has been conservatively estimated though, that the overall cost of child abuse and neglect in South Australia in 1995/6 was $354m (Charles, 1998). This is more than that state earned in the same period from wine exports ($318m) or the export of wool and sheepskins ($239m).

FACTORS ASSOCIATED WITH INCREASED RISK OF CHILD ABUSE AND NEGLECT

The risk factors associated with child abuse and neglect have been determined by comprehensive research conducted over many years. While it is not the purpose of this paper to present this literature in detail, the reader is referred to a number of reviews (Iwaniec, 1996; Edari & McManus, 1998; Coohey & Braun, 1997; Magura & Laudet, 1996; Cicchetti & Toth, 1995). A number of factors associated with increasing at-risk behaviour have been outlined below. These however are not intended to reduce the problem to naive or simplistic principles, but to identify factors that must be considered and understood before any intervention can proceed.

As discussed earlier, most child abuse and neglect occurs at the hands of a parent or stepparent. Factors that have been found, both through intervention work and worldwide research, to be associated with *parents* maltreating their children include:

- parental histsory of abuse and neglect
- poor parental models
- inconsistent child management strategies
- lack of knowledge of child development
- unrealistic expectations of children
- stress management deficits
- poor coping skills
- unwanted pregnancy
- limited family and social support
- intellectual disability
- emotional disturbance
- anger management deficits
- criminal history

Child abuse and neglect occurs most frequently within the context of the family environment. *Family* factors often found to be associated with child abuse and neglect include:

- marital dysfunction
- repeated parental separation
- disorganised and chaotic families
- domestic violence
- social deprivation
- ethnic background
- poor parent-child attachment
- poor supervision of children
- high degree of mobility
- poor financial resources
- limited community support

While the child cannot be held responsible for the abuse or neglect experienced, there are a number of *child* factors that increase the potential risk of maltreatment, including:

- non rhythmic life pattern
- distractability
- behaviour problems
- position and role in the family
- high levels of activity
- irritability
- child with disability

LONG-TERM CONSEQUENCES OF ABUSE AND NEGLECT

The long-term impact of child abuse and neglect cannot be easily predicted. Many factors must be taken into account including degree and duration of abuse, perpetrator, family structure and support, types of interventions, and resiliency factors of those involved (Cicchetti & Toth, 1995; Edari & McManus, 1998). Current research tends to conceptualise child maltreatment in a developmental framework.

Research has indicated that child maltreatment can have the following consequences on subsequent growth and development:

- impaired physical development (Oates et al., 1995)
- impaired cognitive development (Oates et al., 1995)
- lower social maturity (Oates, 1986)
- poor language development and diminished verbal skills (Oates, 1986)
- psychiatric disorders – depression, suicide and self destructive behaviour (Read,1998)
- sexual difficulties (Finkelhor, 1984; McClelland et al., 1995)
- conduct disorder and delinquency (Kaufman, 1991; Widom, 1992)
- inability to form meaningful relationships (Burdekin, 1993)
- diminished life coping skills (Farber & Egeland, 1987)

- lower self esteem (Blanchard, Molloy & Brown, 1992)
- abuse of own children (Finkelhor, 1984, 1986)
- chronic illness (Blanchard et al., 1992)
- substance abuse (Morrison Dore, Doris & Wright, 1995)
- negative attributions pervading memories, particularly of own parents (Gara, Rosenberg & Herzog, 1996).

These events have a significant impact upon an individual's ability to function within society, specifically with employment, educational attainment, relationship development, and parenting.

DEVELOPMENT OF AN INTERVENTION STRATEGY

As there are three different levels at which an intervention service may operate (primary, secondary and tertiary), an agency must select where its efforts are to be targeted, and what type of program it is able to offer. As well as determining the level at which the intervention is to occur, three major models for the treatment of child maltreatment have been developed over time. The first of these was the psychiatric model, followed by the sociological, and then the psychosocial models. The latter integrates the strong elements of the first two models, and is the current preferred modality for the Abused Child Trust and most other intervention services working with child abuse and neglect (Peterson & Brown, 1994; Tomison, 1996).

INTERVENTION PROGRAMS OF THE ABUSED CHILD TRUST

As the Abused Child Trust is a community-based service that is not fully funded by government, it relies heavily upon financial support from the business sector and the general public. Consequently its very public fund raising activities and media profile are carried out in the name of the Trust. However, its services to clients are conducted from Contact House, a neutrally named agency without associated stigma.

PHILOSOPHY UNDERLYING THE WORK AT CONTACT HOUSE

The professional services delivered at Contact House are underpinned by a specific philosophy. The elements crucial to the practice include (though presented in no particular order of priority):

- protection of the child is the primary focus of all therapy
- the client (child, parent and foster parent) is valued
- all therapy has a strong family orientation in its approach
- therapy is best delivered by a multidisciplinary team
- therapists act as change agents
- child developmental needs (cognitive, emotional, social and physical) are emphasised
- effective work is best conducted in partnership with other agencies
- realistic goals are established in collaboration with the family
- families have a clear understanding of the intervention process
- therapy is based on the specific and individual needs of the family
- Contact House has a non-judgemental and culturally sensitive environment.

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INTERVENTION PROGRAMS

Based on ten years of informed practice, Contact House conducts a tertiary intervention service comprising three particular programs as described in detail below.

Therapy Program

Before embarking on a description of the therapy program at Contact House, it is instructive to consider an overview of the literature pertaining to work with parents. A common intervention strategy in abuse and neglect prevention is that of parent management training. This has been one of the better investigated treatments in child and adolescent therapy (Kazdin, 1997). The results from decades of research of parent management training with the general population and specific clinical groups, demonstrated that:

- it has led to marked improvements in child behaviour on parent report, teacher report, direct observation of behaviour in the home and at school, and in institutional records (ie, police contact, arrests);
- magnitude of change has placed conduct problem behaviour to within nonclinic levels of functioning at home and at school;
- treatment gains have been maintained over 1 to 3 years following treatment;
- improvements not directly focused on in treatment, improvements in behaviour of siblings at home, improvements in maternal psychopathology (particularly depression) have been repeatedly documented (Kazdin, 1997).

While the results for parent management training for the population in general have been positive, few studies have focused specifically on the needs of families involved in child abuse and neglect. Two reviews conducted in the USA of evaluations of ongoing prevention services for child abuse and neglect, indicated that improved parental skill level and behaviour were an important aspect of minimising the risk for further abusive behaviour, reports to protective agencies, and visits to hospital (James, 1994b; Wekerle & Wolfe, 1993).

Regarding child and adolescent therapy, diverse treatments exist for a wide range of clinically significant problems and disorders. Many of these treatments have been carefully tested and constitute a literature that now encompasses several hundred controlled outcome studies (Durlack, et al. 1995). Meta-analyses have attested to the efficacy of many of the treatments and have been consistent in concluding that therapy is effective and more effective than the mere passage of time (Weisz et al., 1995). However the conditions under which therapy research is conducted tend to be special and relatively narrow. Indeed, the vast majority of treatments utilised with children have not been investigated (Kazdin, 1988; Kazdin & Weisz, 1998). Thus as a general principle, there would be widespread agreement that applying treatments with some empirical evidence on their behalf is to be preferred, even if all of the criteria are not met for a fairly well-established or very well-established treatment (Kazdin & Weisz, 1998).

In addition to attention to maltreating parents and to parent-child interaction, child therapy is a necessary component of an intervention approach to abused and neglected children (Toth & Cicchetti, 1993). Despite knowledge of the consequences of abuse and neglect, a theoretically derived approach to therapy has been slow to emerge. While there have been many proposed approaches, the field is far from a consensus regarding the most effective treatment (Cicchetti & Toth, 1995). Techniques utilised range from non-directive play therapy to behaviour modification, with the range indicative of the heterogeneity of the functioning displayed by maltreated children. A range of treatment options needs to be available in order to facilitate the most beneficial outcome for different children.

In child oriented work, a number of issues are critical in any therapeutic intervention, particularly those developmental factors adversely affected by abuse and neglect. As suggested earlier, research has demonstrated that maltreated children show delays in language, cognitive and motor skills, with some concern about the personal-social area (Appelbaum, 1977). There is some debate about whether developmental delays with this group of children precedes maltreatment or results from it (Wright, 1994). Therefore the role of developmental therapy is not only valuable to promote skill attainment necessary for all life skills and transition into normalised educational settings, but may be a protective or resiliency factor from future abuse. An especially important issue is treatment focussing on the attachment relationship between the primary care giver and the child (Cicchetti & Toth, 1995). Additionally, as the school is an important agent in the child's growth and development, its involvement in the assessment and therapeutic process is recommended (Cicchetti, Toth & Hennessy, 1993).

It is important therefore that any intervention dealing with families affected by child abuse and neglect, be mindful of the outcomes of the research literature.

It is important therefore that any intervention dealing with families affected by child abuse and neglect, be mindful of the outcomes of the research literature. The Abused Child Trust's therapeutic intervention aims to resolve issues which maintain destructive thinking, feeling and behaviour; encourage effective family interaction; and develop the ability of individuals to take responsibility for their behaviour.

The therapeutic interventions utilised at Contact House focus broadly on parents, family and the child. Specific parent-oriented interventions include:

- parent training in child behaviour management;
- general parenting matters;
- attachment and bonding with child issues;
- individual counselling for parent to assist in resolution of own issues;
- anger and stress management;
- marital counselling.

Interventions for the child include individual counselling, play therapy, intellectual, emotional and developmental assessment and intervention. Family therapy is used to address issues that reside in the group. The intervention assists in the promotion of a lifestyle conducive to mental health of each family member.

The therapeutic interventions are conducted either at Contact House or in the family home by a team composed of a psychologist, social worker and occupational therapist. These positions are funded by the Department of Families, Youth & Community Care, Queensland Health, and Commonwealth Special Education.

Early Childhood Program

When children who have been abused and neglected reach kindergarten/ preschool age, many long-term effects of maltreatment can already be clearly observed. These include low self esteem, speech problems and language delays, short attention span, impaired social and emotional functioning, and delayed cognitive skills (Oates et al., 1995).

The Early Childhood Program (ECP) therefore provides an educational environment addressing the developmental needs of children who have experienced maltreatment. Its primary focus is to assist these children to overcome their delays and develop to their full potential. Research has found that adequate school performance was an important developmental milestone, and that poor school performance can have serious long-term effects on children (Kendall-Tackett & Eckenrode, 1996). Abused and neglected children often enter school with significant developmental delays and are less likely to experience social and academic success (Kendall-Tackett & Eckenrode, 1996).

Staffed by an Early Childhood Teacher and Teacher's Aide – funded by Education Queensland – the objectives of the ECP include:

- providing the educational component of an interdisciplinary approach to treating child abuse and neglect within families;

- assessing the child's current level of functioning and implement an individualised education plan;
- providing a safe, non-threatening, predictable, consistent and nurturing environment that facilitates the acquiring of knowledge, development of skills and the forming and reshaping of attitudes;
- addressing the developmental delays of the child through the provision of structured activities and free play within a structured environment;
- ensuring that the transition of each child into regular childcare or schooling environments is smooth and as quick as is developmentally appropriate.

The process utilised to manage the educationally based intervention of developmental delays is the Individual Education Plan (IEP). These are determined for each child following observations and thorough assessments by the Early Childhood Teacher in consultation with the Occupational Therapist and Educational Psychologist. Once the IEP is developed, weekly plans for each child are prepared, implemented and reviewed. The IEP focuses upon six areas of vulnerability identified by educational researchers (Kline, 1977; Daro, 1988; Oates et al., 1995):

- socialisation and play
- behaviour
- language
- motor skills and co-ordination
- self care
- pre-academic skills

Health Program

The health program recognises that abused and neglected children have special health needs. Research has shown that entering alternative care is an important indicator of the medical and psychological problems experienced by maltreated children. While these children are perceived to be at greater risk than those left at home, their needs would be typical of those families assessed as requiring the support of an intervention service.

Specifically, the research (Takayama, Wolfe & Coulter, 1998; Chernoff et al., 1994; Hochstadt et al., 1987) indicates the following in relation to children in care:

- a significant number have an abnormality in at least one body system;
- 25% failed the vision screen;
- 15% failed the hearing screen;
- were significantly lighter in weight than the general population;
- were significantly shorter than the general population;
- required significant amounts of medical sub-speciality care;
- had a higher incidence of developmental delays;
- had major deficits in adaptive behaviour;
- had a large number of behavioural problems;
- 75% had a family history of mental illness or drug abuse or alcohol abuse;
- 12% required routine general medical follow-up only.

Comprising a clinical nurse and a visiting consultant paediatrician, the health program aims to provide a health screening assessment on each child and family, to co-ordinate and liaise with medical, audiology and dental services, and to assist families to better manage children with developmental delays

Table 2 Referral criteria utilised by Contact House

Inclusion	Exclusion
Child aged 0 to 8 years	Sexual abuse as primary reason for referral
Child at risk of abuse and neglect	Parent/s with untreated psychiatric condition
	Parent/s with untreated substance abuse

Referrals to Contact House

The majority of families are referred to Contact House by the Department of Families, Youth & Community Care; however, a number do refer themselves. The referral criteria utilised by Contact House are set out in Table 2.

Through an understanding of the literature and extensive experience, the Trust acknowledges that not all families can be engaged in the programs offered by the agency. The literature provides a consistently clear picture on factors associated with untreatability (Jones, 1987), and these include:

- parental history of severe childhood abuse;
- a persistent denial of abusive behaviour;
- severe personality disorder (sociopathy, borderline, or grossly inadequate personality);
- mental disability when associated with personality disorder;
- parents addicted to drugs or alcohol;
- lack of empathic feeling for the child;
- long history of abuse and neglect prior to discovery;
- abuse that was premeditated;
- Munchausen by proxy, nonaccidental poisoning and severe failure to thrive are highly resistant.

A review of characteristics associated with progress in therapy highlight the following client factors as critical to positive therapy outcomes (Berg, 1994):

- be of above average intelligence;
- have at least one meaningful relationship with another person;
- not be in emotional crisis;
- have an ability to express feelings and interact with therapist;
- be motivated to work at therapy;
- have a specific complaint.

Due to the nature of the therapy provided by the Trust, it may be impossible to hold to these criteria in the selection of clients. However, the acknowledgment of these contributory factors leads to a more informed therapeutic practice that may contain modified treatment goals and an appropriate case plan.

CLIENT PROFILE

At any one time between forty and fifty families are involved with the programs at Contact House, with their general characteristics outlined in Table 3.

CLIENT MANAGEMENT PROCESS UTILISED AT CONTACT HOUSE

To facilitate effective therapeutic interventions for families attending Contact House, a detailed referral and assessment process has been developed. This process ensures that the needs of the families can be determined in a manner that encourages their participation. While a multidisciplinary team is involved in case planning and review, each client has a Case Manager. In this role, the appointed professional coordinates all of the activities affecting the nominated client.

The major steps in the case management process are:

- referral received and details recorded
- case conference
- assessment phase
- formal case presentation
- ongoing management review
- discharge

For purposes of family assessment and therapeutic efficacy, a number of structured and semi-structured protocols are administered at different stages of the therapeutic intervention. Data is usually collected from each family, on a pre-treatment and post-treatment basis. Administration of protocols at a six months follow-up would be valuable, but not possible due to the costs involved

Each family is formally presented for discussion at a multidisciplinary case conference. A standardised format for presentation of material facilitates the discussion. The main areas covered in each case presentation include:

1. Orientation
   a) reason for presentation
   b) referral details and referrer perceptions
   c) overview of family and issues
2. Problems
   a) current details
   b) past history
3. Background
   a) family developmental history
   b) developmental history of children
4. Present state / functioning
5. Observation made during assessment
6. Summary
7. Issues / formulation
8. Prognosis
9. Management plan

Families are discharged when they attain therapeutic goals, express a desire to cease any further therapy, or fail to attend despite repeated attempts to hold appointments.

PROGRAM EVALUATION

In the current environment, characterised by accountability and economic rationalism, providers of social and human services are increasingly concerned with program effectiveness and validity (Dickey & Cohen, 1991; James, 1994b; Owen, 1993; QCOSS, 1997). Indeed, as agencies are so reliant upon government funding, corporate sponsorship and general donations, longevity of service is now inextricably linked to demonstrated service efficacy. One significant consequence of this is that the Abused Child Trust, like other human service organisations, must devote resources in the deployment of an evaluation methodology, maintained in conjunction with the services provided.

However, for the Trust, the addition of an evaluation methodology is not a simple or straightforward matter. This is due in part to the highly complex nature of the evaluation process, and in part to the multiple and disparate groups that have an interest and investment in such an organisation (Cronbach et al., 1980; McFarland et al., 1997).

For an evaluation to be effective the process must commence with a clear statement of the purpose of this activity, and have the support of those directly affected by the process. From a philosophical perspective, evaluative activities, if they are to be meaningful, must be complementary to and supportive of program development and provision (Owen, 1993; Tomison, 1996).

Though widely acknowledged as a vital component of an agency's operation, few conduct evaluation either extensively or thoroughly (Wekerle & Wolfe, 1993; Owen, 1993; James, 1994a; Yeh, White & Ozcan, 1997). This was highlighted by the results of a study completed by the National Child Protection Clearing House. Reviewing child abuse treatment and prevention programs in Australia, only 16% of the agencies reported having an extensive evaluation program, with 27% reporting no evaluative activity, and 57% reporting a partial evaluation process (Tomison, 1996). This was also reflected in the experience of child protection agencies in the USA. Two reviews of evaluations of ongoing

Table 3 Profile of family types modified from that developed by Family Connexions (Ray & Lees, 1997)

Family environment	Survival
Child safety	Usually low
General well-being	Low
Substance abuse	Common
Domestic violence	Common
Child abuse	Common
Neglect of child	Usual
Employment	Nil
Financial status	Poverty
Alternative care for children	Usual
Social circumstance	Isolated
Emotional support for children	Very limited
Parenting ability	Inadequate
Parents abused as children	Usual
Family cohesion	Weak
Previous parental models	Negative
Anticipated response to intervention	Poor
Referral state	Chaos

prevention services for child abuse and neglect indicated that, while some positive outcomes have been obtained, adequate evaluation studies were still too few in proportion to the number of existing programs (Wekerle & Wolfe, 1993; James, 1994). This paucity of research is not restricted solely to tertiary intervention programs.

It has been suggested that government and non-government agencies have not developed sophisticated evaluation frameworks for several important reasons (McIntosh, 1991; Ainsworth, 1998):

- evaluation requires resources (time, effort and money) that could be allocated to direct client service;
- there is a current lack of practice-based models on which to build;
- the complexity of family functioning over time make change difficult to measure.

CONCLUSION

The Abused Child Trust operates a specialised therapeutic intervention program at Contact House. The program's strengths are that the interventions have a sound theoretical basis and operate in the context of a multidisciplinary framework. The impact of child abuse and neglect on the functioning of an individual and a family are far reaching, with the negative effects on growth and development best ameliorated with a broad based early intervention program. □

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11th Biennial Interntional Foster Care Organisation (IFCO) Conference

Fostering the Future

19-23 July 1999 – University of Melbourne

CALL FOR ABSTRACTS

(Closing date 1 March 1999)

Jointly sponsored by the Children's Welfare Association of Victoria, Victorian Association of Young People in Care, Foster Care Association of Victoria and the Department of Human Services.

This conference will be an exciting exploration of the challenges facing us in caring for the world's children into the 21st century and search for answers to those challenges. It seems that wherever we look in the world, the issues facing families and children get tougher, the resources to help them tighter and the demands on the community to care for these children and their families is higher. As part of this bigger picture, this conference is an opportunity for governments, services, carers and young people to address and improve these difficulties.

The conference will draw 800-1000 national and international delegates including young people, carers, agency and policy/program workers. Five dynamic keynote speakers have been scheduled into the program, selected for their expertise and leadership in their fields:

Mick Dodson, Director of the Indigenous Law Centre at the University of NSW, will address the issues of the over-representation of indigenous children in care around the world and the significant issues this raises in the field of foster care.

Teresa Lum, from the Federation of British Columbia Youth In Care Network in Canada, will examine the factors that promote success and best practice approaches in care, including connectedness with family and networks and stability in care.

Jill Wain, Acting Manager of Children's Services, Westcare in Melbourne, who as both a carer and later a worker has focussed on building positive partnerships between all stakeholders.

Angela Maria Pangan, President and Executive Director of NORFIL Foundation in the Philippines, will address the issues facing foster care in developing nations, where local cultural, structural, socio-economic and organisational factors present a particular set of challenges.

Dr Frank Kunstal, a recognised psychologist, author and trainer in the USA who works extensively with seriously emotionally troubled children, will be considering the challenges of caring for children and young people with specific high support needs within a foster care placement.

FOR FURTHER INFORMATION REGARDING THE SUBMISSION OF ABSTRACTS, PLEASE CONTACT:

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