‘Profiles’

Diana M.L. Birch

About the Author

Diana Birch- born in London -her Italian mother was 'liberated' in world war II by her English father. Bilingual roots have ensured an international flavour to her work with periods in Italy, Russia, Jamaica, USA and other states. Trained at the Royal Free & St George's, interest in youth arose on starting advice clinics for schools.Absence of training in UK in Adolescent health motivated a 'personal' programme progressing via paediatrics to sexuality, psychotherapy. Dissatisfied with statutory services she founded Youth Support and works solely for the charity. Aspects are court work child protection, family assessment. Wide experience of family disorder alcohol,substance abuse and research in teen pregnancy for which she was awarded Doctorate at London University, holds Fellowships of the Royal College of Physicians, the Royal College of Paediatrics and Child Health and the Society for Adolescent Medicine (USA). Author of several books "Are you my sister, Mummy?"school age pregnancy; "The child that rocks the cradle" long term results; "Bonds and boundaries"- child protection in the family; "Inner Worlds" on emotional issues. Interests include drama and animal therapies. Youth Support has branched into a mini farm, pet shop and Cyber-cafe. Animals play a major part in her life she is never without a Great Dane having bred dogs for many years, also plays at music and Judo. She has an actress daughter and a musician son.

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"... It would be a truism to say that the family is an essential part of our civilization. The way we arrange our families practically shows what our culture is like , just as a picture of the face portrays the individual" DW Winnicott

'Profiles'

to Lisa

… and the many young women like her who have struggled to make themselves a family ...

Contents

Preface

It cannot be disputed that the best way for a child to be brought up is with two caring parents and ideally that these should be their natural parents. Many children are not so fortunate but may have one natural parents who does care for them and wants to parent them. Sometimes these parents lack the skills or the strengths needed to bring up their children alone - but often with the right help and support , they are able to be loving and competent mothers and fathers.

It is the greatest disservice to a child to fail to support their family so that they may remain in a home with their natural parents. It is also a tragedy if we fail to protect a child from an abusive household. To be able to judge this situation and to provide for a child's needs in the best possible way - we need accurate information and skilled judgement - this is what we aim to achieve in our assessments and in the care and support we provide at YSH and at 'The Bridge'.

This evaluation of our services and the results that we have achieved over the years will highlight how we have been able to uphold these principles in our work.

Introduction

'Profiles' describes the work of our assessment unit from it's opening in 1990 to the present day.

It aims to answer the frequently asked questions regarding the nature of our work and whom we admit.

- Which young people are sent to us?
- What sort of families do we work with?
- Which individuals do well?
- Which families have a better prognosis?

The nature of our work is very varied and our referrals may come from social services, from health authorities (particularly mental health) , or from the legal system. A number of our day cases attending for therapy may self refer or be sent by their parents or schools. The greatest majority of our cases however are referred as part of ongoing care proceedings and many therefore make first contact via the legal system.

Cases fall into a number of categories with regard to the nature of the referrals. At one end of the scale we may have families or individuals where a considerable amount of social service intervention has already taken place, where there is a general agreement between family and professionals regarding what has happened, what has gone wrong and what needs to be done and the referral is primarily for rehabilitation and therapy to address commonly acknowledged concerns.

These are the 'easiest' cases to deal with and the prognosis is good. The only proviso here is that sometimes the parents can have been quite cleverly deceptive and give the impression of being open, straightforward and wanting to work when really they feel that they can bide their time and show us how good they really are without having to work at it. Some do feel that a three month placement is just that - three months to sit back and just 'do their time'. We have to be ready to challenge such a stance.

At the opposite end of the scale we have highly uncooperative parents or young people who do not want to be here, have come under sufferance and feel 'blackmailed' into entering the unit - 'I had to come or they

would have taken my child' - these are difficult to work with and attempt to disrupt the care of other people. They often manipulate the situation to force us to ask them to leave - making it look like a failure of the unit rather than a failure on their part to engage.

Their attitude is that it is our fault for being there (otherwise they would not have had to come) they cannot see that if we had not been the chosen unit they would probably have gone elsewhere or have lost their child. It is an uphill struggle to get these type of parents to acknowledge their own responsibility in their plight. We need to somehow instil at very least a minimal degree of acceptance that - 'I am here because I have problems parenting my children' or 'I have come to get help with my personal problems so that I won't neglect my children again' or ' I needed to come here to help protect my children from being hurt by my boyfriends again' . … Just a little bit of 'maybe it's partly my doing' rather than all 'it's my social worker's fault … why doesn't she just leave us alone' or 'it's your fault with all your stupid rules and groups - I don't need them!'

These are the resident cases. Even with a variety of approaches and attitudes to the unit prior to admission it is still difficult to accurately estimate the likely prognosis at the beginning of placement. The programme is intensive and personally tailored to each individual and aimed to confront and deal with many of the individual's forms of resistance and denial. Hence even cases with an apparently poor prognosis can turn out better than expected and can do well. It is very important to deal with people on an individual basis - look at specific difficulties and specific attitudes and ways of coping rather than to make too many generalisations.

Everyone needs a period of settling in and adjustment. They may then go through a period of denial and resistance, perhaps expressing anger and resentment at having to be in the unit or reacting against the fact that their therapy is beginning to bring out feelings and thoughts that they wished to remain hidden. This maybe be followed by a period of engagement in the programme and positive work.

As residents begin to engage in the therapy process, they will go through a 'honeymoon' stage when they feel very positive about their groups and sessions - 'I've never had anyone listen to me like this before' …. 'I never realised how I could change my life ..' etc. etc. It is important to support patients through this phase and on through the following which is

sometimes a rather cruel awakening to the fact that it takes time to make real changes and the harsh realities of life are still there.

It is also important to avoid ‘false cures’ - getting rid of or helping people to deal with a ‘symptom’ such as not eating properly, relying on abusive relationships, self harming, rather than looking at the underlying cause - which is often rooted in early life and emotional development. A ‘false cure’ will only remove one symptom to allow it to be replaced by another.

Parents who are attempting to deliberately mislead and pretend to engage in the treatment process will be able to maintain a false front for some time. These are the couples who can often keep up a deception on an ‘outpatient’ basis or when referred say for a specialist assessment at a hospital outpatients or paediatric or psychiatric clinic for example. However in the intensive atmosphere of a residential unit they often have difficulty maintaining their deception. This is a twenty four hour assessment in a ‘pressure cooker’ type of environment. Cracks soon begin to show and we may have to wait our time for this to happen.

It is for these reasons that assessment and rehabilitation take time.

Our initial referrals usually come for three months although we do cut this time short if it is clear that the parents have no intention of working or if features of severe concern arise leading us to believe that further work will be damaging to the children.

Hurrying the process along to reduce time in the unit or misguidedly try to save funding that way - leads to a partial remission of problems which inevitably recur when the family moves back out into the community.

Alternatively an assessment may be incomplete leading to the concealment of dangerous features or to the misjudging of a parent who is not given sufficient opportunity to show his or her good points. In both cases this is a great disservice to the children of the family who risk either being returned to an abusive household or of being removed by default from a perfectly adequate home environment.

It goes without saying that it is imperative that we get the balance right - not be over cautious and remove children from possibly abusive households to help the professionals to deal with the probable level of

risk - or to be over optimistic and push a family to care for a child that they for whatever reason, cannot cope with.

- To quote from ‘Bonds and Boundaries’ (p9) ...

> *“Removal from the family is sadly not a panacea - we see young people whose self esteem is in their boots - crying out to know why their families did not want them, why they failed their parents so badly - and often recreating their own family disturbance and imagined parental traumas in an attempt to understand and identify with their absent parents.*
>
> *Mark was placed in care at the age of four, lived in children's homes and then a 'good' foster family. He did well at school and college, gained professional qualifications and then 'blew it all', lost his job, on the verge of divorce and with seething rage directed at his four year old daughter. He remembers nothing of his early life but his fantasy is that his behaviour was so bad that his parents had to send him away. He needs to somehow prove that his parents were good and he was bad by recreating the scene in this generation.”*

When we consider rehabilitation , or trial rehabilitation as opposed to assessment work - it is even more important to give adequate time. Families will have been traumatised by separations and children will certainly have been emotionally damaged by being separated from their parents. To place children back with parents as a trial rehabilitation and then to give insufficient time for this process to be undertaken in a safe and complete manner will merely serve to further confuse and traumatise the children. If rehabilitation is worth doing - then it is worth doing well and in the correct time-scale. Rehabilitation work should not be undertaken in less than three months and will more usually require a six month placement.

Therapy and psychological assessment are only a part of our work - practical issues are of particular importance in assessment. We assess and teach life skills , cooking, cleaning, laundry, budgeting and all aspects of running a home. We also place high priority on parenting skills and hold

sessions and individual work on emotional and physical aspects of parenting.

Often our parents have little knowledge or experience of how to raise a child and they do need to be taught how to do this - we like to work alongside them to teach and show them what to do - not to preach, criticise or look down on them. They are often very vulnerable and have low self esteem - hence need to have their confidence boosted with positive reinforcement rather than being made to feel failures and bad parents because they do not have the necessary skills.

Parents may lack skills due to having had little good parenting themselves or may never have see mothers caring for their children in their own extended families - many have come from the care system and thus lack the experience of family life. Others may have mild to moderate learning disabilities and thus have to be taught carefully what they need to know.

Our day attenders are mainly cases referred by the legal profession or by guardians ad litem on the basis of a 'pre-assessment' opinion. We look at whether there are any indications that this family would benefit from a residential placement or whether it is worthwhile doing some work with an individual. These 'pre-assessments' may involve just one meeting or may extend to several days spent at the unit undergoing a fairly comprehensive evaluation.

Some of our cases - residential or day cases - involve very high risk families. Children may have been severely injured and may be at risk from their parents - or the parents may have a mental illness psychosis or severe learning disability such that the safety of the children is compromised with these particular parents. In that case our staff take on a very strict and close supervision of the children - what we call 'specialling' - when the staff are constantly present on a twenty four hour basis.

Any would state that it is ill advised to place high risk cases in a residential unit - but the argument is that often the facts are not known, parents are suspected of serious abuse - but this does have to be proved in some way and the residential unit provides the only 'safe' way to do this.

We are very aware of the risks to the children - and they are not all on a physical level - imagine how a child must feel being placed with a parent who injured him or her?

Babies may not understand or be aware - but older children are often aware of who hurt them whilst being unable to speak up and say. It can be torture for them to have to be cared for by that same parent who may have harmed them in a life threatening manner.

This is precisely why such matters must be sorted out in a residential unit where assessment can go hand in hand with protection.

Four year old Lee was placed in the unit with his mother. He came straight from hospital where he had been on life support for some months following a fractured skull and cerebral haemorrhage. He was still partly paralysed down one side and struggled to make speech sounds.

Mother was suspected of causing his injury and had been his only carer at the time of the incident. However she maintained that she had been terribly wronged and played every type of manipulation to make staff feel sorry for her and see what a good, caring mother she really was.

Eventually it became clear that her behaviour towards her child when she thought staff were watching was quite different from her behaviour towards him when she believed herself to be unobserved. After a series of concerns it was thought best to separate the child and let him sleep in the nursery at night.

She maintained that the boy would pine without her but when staff broke the news to Lee that he would not be sleeping in the same room as Mum, he punched the air and whooped 'Yes!' … A very telling gesture!

We professionals might never have known the true facts of the case and who hurt Lee. But, apart from some post traumatic amnesia, Lee knew who had hurt him and he had to endure the fear of being with her every night thinking that she may harm him again.

However sorry we may feel for a parent and their tale of woe, we must always keep foremost in our minds the children who have suffered and who may not be able to speak out.

The work of the unit can be divided into -

- Diagnosis / basic assessment

  Identifying the problems - making an initial evaluation of the situation and deciding whether further work is desirable or possible.

- Prescriptive treatment -

  Formulating a treatment programme or designing a care plan for the children and putting forward recommendations as to further treatment, assessment or rehabilitation or perhaps an alternative action (such as separation of parents and children).

- Full assessment / Rehabilitation

  In other words carrying out the proposed treatment programme and further assessing progress and ability to change and learn.

- Final analysis of results of programme.

- Follow up support and evaluation.

Individuals or families will spend varying lengths of time at each stage depending on their particular circumstances and on the needs of the referring agency. Some may only complete part of the process and others continue right through to after care.

For example the basic assessment and diagnostic phase may reveal such deep disturbance and concerns that it may be recommended that no further work be done with the family. On the other hand a referral may come to us where that first stage has been more or less completed beforehand - in which case treatment can begin almost immediately.

Assessment and rehabilitation cannot be completely separated and t is inevitable that, particularly in families where the parent is willing to co-operate, the assessment process will begin to be part of the rehabilitation.. Parents who engage in the treatment programme on an assessment level will give of themselves and thus begin the rehabilitation process. Assessment is a team effort, a co-operation between parent and staff and is not just ‘observation’.

* * * * *

General Information on Referrals to the Assessment Unit

Case profiles - all admissions to YSH 1990 - 1998

Resident cases

The index case is nearly always female although 24% were admitted with a male partner.

Data based on female admissions:

Age on admission -

Age on Admission		
average	range	
22.2	13	56

The average age on admission was 22.2 years with variations from 13 years to 56 years in the case of the index family member.

The unit's full name - 'Youth Support House' - implies a very young clientele , but this is nowadays somewhat of a misnomer for although the unit was initially set up for the support and treatment of young people and particularly young abused women and pregnant school girls we have gradually taken a higher proportion of older women and families. The advent of the Children Act which was implemented in 1991, changed the focus for work in that subsequently local authorities were obliged to make fuller use of assessment facilities for families in preparation of care plans and in conducting care proceedings.

We had also noted for some time during the eighties and early nineties, that referring agencies such as social service departments were reluctant to place single girls needing therapy and support since this was regarded as an expensive option in comparison with say foster care and many girls in care were left in children's homes rather than being transferred to

specialist units. This policy resulted in young women not receiving the help they needed when they were undergoing the turmoil of adolescence and processing their experiences of abusive childhoods or dealing with early teenage pregnancies. Eventually these women would be referred to us when the situation became desperate and they by that time had perhaps had two or three children, had children removed from their care and had undergone a series of painful and difficult experiences perhaps also having had abusive relationships with more than one partner.

We therefore found that cases which we could have worked with more easily at a early age and where much preventive work could have been done, were being referred at a later stage with often insurmountable difficulties.

Opportunities had been lost for personal work and therapy - for prevention of further unwanted pregnancies - for possible prevention of abusive relationships and abusive patterns of behaviour. Moreover the children who had often experienced neglect, abuse or removal from their parents might well have been spared this experience by early referral for help. The statistics and facts surrounding the outcomes for young women who have children at an early age are detailed in the two books 'Are you my sister, Mummy?' and 'The child that rocks the cradle' and the latter covers important information on the poorer prognosis for mothers who have been in the care system. It is a tragedy that in our modern society so much of the decision making process regarding the care of young people and of children depends on money. However even on this level an accurate assessment of the investment must surely reveal how worthwhile it is to invest in the future of a young child and it's mother.

Good quality assessment, therapy and aftercare will never be cheap in respect of short term budgets - but in the long term it pays enormous dividends. When we can support a family to stay together or a mother of whatever age and her child to become rehabilitated together, we are removing a family from the self perpetuating trap of the care system. It has been shown that mothers in care are more likely to have their own children placed in care. We are also allowing the mother or father to feel competent as parents - thus helping to remove the need to have more children in the hope that they will eventually be able to parent and keep one child. We are also endeavouring to break the cycle of abuse and by helping parents out of the 'victim' position which engenders patters of abusive relationships and domestic violence as well as abusive parenting.

On the other hand of course it must be said that good quality assessment of the abusive family will often reveal concerns that have been covered up in the normal course of events. Children may therefore be afforded protection which could otherwise have been denied to them. It is generally hoped that a child may be able to be raised by his or her natural parents and much long term pain and distress is caused when children are separated from their parent of origin - however we need to also accept that there are times when parents can be deliberately abusive and cruel and children may not be safe in their parents care.

Family composition -

Family Composition			
Parents -	single parent 76 %		with partner 24 %
Children	on referral 1.08	born during stay 16 %	at discharge 1.25

In 76% of cases single parent families were referred for assessment. Around a quarter of women (24%) were admitted with a partner and although a number of women particularly the younger women were admitted without children or without being pregnant, on average residents had just one child (1.08).

If one takes into account births occurring within the unit during their admission stay, the average number of children per woman on discharge was 1.25 children, and 16% of female admissions gave birth during their stay.

Length of treatment -

For residents the average length of stay was 5.4 months within the residential unit.

The younger girls tended to have longer stays since many were in care before coming to the unit and they were too young to then go on to independent accommodation.

At the time of writing this evaluation we did not have a functioning half way unit with semi-independence facilities but this has now recently opened and is beginning to bridge the gap in services for vulnerable families and parents and young people who successfully complete an initial stage of residential treatment and are not yet ready for complete independence. This is particularly important for our families where a high level of support is needed in the first instance and they do have to be weaned gradually into an independent position.

A quarter (24%) of patients went on to outreach care in the community which lasted on average three months for those who were extended this facility. In this case residents move from a position of having intensive support and twenty four hour surveillance in the residential unit to at first going home to their own flat for periods of time in the day with staff accompanying them to assist in preparation of the home. This progresses to weekends away perhaps and then to living in their own home whilst attending the unit on two or three days per week and having staff visit them in their home on two or three days per week. Gradually the number of days attendance is reduced on a sliding scale over a three to six month period - depending on the needs of the family.

Past History and Presenting Problems

An evaluation of problems and experiences relevant to our referrals reveals a considerably pessimistic past history for the average woman with family being admitted to our unit. As time has gone on the level of complexity and degree of pathology has tended to increase and many of our referrals have been turned away by other units or may have had unsatisfactory admissions elsewhere. It is important to bear this fact in mind when looking at our results.

In total 84% of our cases have been admitted to other units before being referred to us. Many patients have in fact been through several units before coming to us and the younger girls coming from care situations have often been to 6 or more children's homes or placement units.

Abuse - The great majority of our referrals have been abused - 82% of women being referred to the unit have been abused themselves and of these 79% have been physically abused and 64% sexually abused. Of the

sexually abused 30% involved incest, 8% with their siblings and 21% paternal and 1% maternal incest.

Jackie had been abused sexually by her father and had also slept with three of her brothers. The family had very disturbed structure with no appropriate boundaries and the siblings thought it quite normal to be sexually active amongst themselves. Jackie became pregnant by her youngest brother when she was fourteen and he was fifteen.

She was a very damaged young woman who was quite unable to protect herself or her child from further abuse. She was aggressive and disruptive and had no idea of personal boundaries either involving sexuality - where she was frankly seductive to any male - placing the unit gardener and handyman at such risk that they had to be chaperoned; or involving personal property - just helping herself to other people's possessions.

* * * * *

Frances had spent her childhood being passed from pillar to post staying with various family members and also having periods in children's homes and foster care. Her mother suffered from a mental illness and had been unable to care for her but in the brief periods she spent at home would have a sexual relationship with Frances.

The sexual abuse had been deeply disturbing in itself but this was compounded by the fact that mother would at intervals discover where Frances was placed and make abusive telephone calls to her explicitly going over what she had done to her over the phone.

This level of sexual abuse which had begun at a very early age is profoundly disturbing to the developing child and to their psyche. Frances showed signs of a developing severe personality disorder. She could be very amiable in the unit at times but also made women uncomfortable y needing to be inappropriately close and staff had to take very great care of boundary issues as she attempted to cuddle and 'wanted hugs' very frequently.

She was a very needy girl who was in competition with her baby most of the time and used the child to gain attention. She could also be cruel to her child and at times appeared to demonstrate a sadistic quality to their relationship.

It seemed highly likely that Frances might sexually abuse her own child in an attempt to understand what her mother had done to her and to somehow 'get her own back' and even the score. Frances did not have the capacity to safely parent her child.

Reasons for referral - Reasons for referral were usually multiple but 21% of women were pregnant at the time of referral, 97% had parenting difficulties, 40% had a mental health problem and 9% had significant learning difficulties and in these cases this was the main reason for referral.

A couple who both had significant learning disabilities managed to care for themselves in the community. They had their own house and shared household tasks most of the time - each had skills which complemented the other's deficiencies and thus they managed to get by. Most of the time they were a very affectionate loving couple who cared for each other and gave each other frequent treats and presents - they were rather like two children clinging together and keeping the outside world at bay.

When their twin children were born, their coping skills were over-stretched. Residential assessment was organised in order to look at how the couple's dynamics changed with the altering roles - jealousy and there being no emotional space being a possibility in so close a dependant relationship. Also it was important to judge to what extent the couple were able to learn appropriate parenting skills and to retain and put into practice such knowledge.

This couple who's coping skills and life skills were such that they were just able to function on a husband / wife basis where they were also relating with each other on a child / child basis and parent / child role with each other - were tipped off balance by having to then function on a parent / child basis with another individual - their 'actual' child.

Presenting problems - Looking more closely at the multiple problems which were a factor around the time of admission and before, a high proportion - 35% - had been involved in drug abuse at some time prior to admission and 28% in alcohol abuse. Around a third (35%) had been involved in self harming issues such as cutting, and these were often severe cases with scars of old cuts stretching up both arms.

Eating disorders were mainly part of a wider spectrum of self harming - most of our alcoholic patients were also bulimic at some time and any of the 'cutters' would also restrict their food intake at times in the manner of anorexics. All the eating disorder patients had been sexually abused. Many used the behaviour as an attention seeking device and 'swapped symptoms' from time to time so that there was no clear cut diagnosis.

Prostitution - Continuing the theme of abusive life styles, 14% of the women had been involved in prostitution and all of these women had also been sexually abused in their childhoods. Most were not actively involved in this activity during the time of admission - some having stopped as their life style changed when their children were born (around a third) , some reducing their activities following social services involvement with their children (approximately another third) and of the remainder most, although still involved at referral, had stopped while in the unit .

> *Marian was, as she put it - at the threshold of a new life - when she came to us with her fourth child. Her previous children had been removed a few years before when she was drinking, on the 'game' and involved in violent relationships.*
>
> *She had been scared into wanting to change by a number of events - a close friend had been murdered by her pimp, another had been beaten up by a customer and she had been very upset by the loss of her older children.*
>
> *Eventually she felt that she had reached a turning point when her father died. At that time she 'gave up drinking' and had conceived her latest child. She was thus determined that this was an auspicious sign and that she was going to be a model parent to this new baby and change her life.*

A small proportion - about 3% - attempted to continue their activities whilst resident at the unit. This was actively discouraged and was obviously detrimental to the progress of the assessment. We did experience problems with 'customers' telephoning the residents pay-phone, with women attempting to involve younger more vulnerable girls and with the possibility of children witnessing sexual activities when they were taken out on seemingly innocent shopping trips etc. which we later found out to be sexual encounters. Fortunately our close monitoring system did expose most of this activity and appropriate steps were taken.

Maureen was adamant that she had given up her life as a prostitute. Her previous activities had caused great concern to her social worker who was aware that she had left her children alone when plying her trade and had sometimes brought customers home took to leaving the unit to 'visit a friend' at the same time of day two or three times per week. The day after there seemed to be extra money available. One of the younger girls, a waif like creature with learning disabilities, was befriended by Maureen who promised to take her out with her.

We were suspicious of these outings and dissuaded the younger girl from going out - we also surveyed a nearby know 'pick up' area for prostitutes at the time when Maureen left the unit and saw her solicit customers.

Homelessness - On admission 12% of our residents were homeless. This was a small proportion but it did cause difficulties when we came to the end of the placement and the scheduled rehabilitation could not continue at the foreseen pace due to lack of accommodation for the family to go on to. The family might therefore be left in limbo whilst waiting for a council or housing association flat to be allocated.

Crime and Violence - With regard to a history involving incidents of crime and violence, 41% of female residents had been involved in criminal activities and 69% had a violent boyfriends. Almost two thirds (61%) of women had been involved in violent acts themselves, this figure relates to violence involving peers or adults and is excluding possible involvement in child abuse.

Child Bearing History -

On average the women admitted to the residential unit had their first child at the age of l8 and by the time of referral to the unit had just over two children (2.2 children) each.

Most of them had children removed from them in the past and on average had 1.7 children removed from each mother.

With regard to children, 89% of admissions have been involved in child protection processes, 65% had a child removed prior to admission and 47% had a new child just before admission. 70% of women admitted to the unit have been in care themselves, a very significant figure which will be further discussed.

General Outcome -

Overall 60% of residents found their experiences positive in terms of themselves ie therapy and personal growth, acquisition of life skills and coping abilities - and in 51% of cases the experience was also seen as positive for their children. However, 23% found the experience negative for themselves and in 33% of cases this was a negative experience for the children. (This is explained more fully below).

In 43% of cases mother and family were rehabilitated together at the end of the residential placement, and 26% were rehabilitated but separately. In other words, the residential experience of assessment produced an outcome which was positive for mother or child and was therefore regarded as a rehabilitation even though they did not live together. For example, a child might have been adopted successfully with the approval of the mother or a child may have gone to live with extended family under an arrangement which was to the benefit of both mother and child.

> *Tina was a schoolgirl who had been in care most of her life. She became pregnant by an older man on an exploratory adventure when she absconded from her children's home. She tried to act 'grown up' and care for her premature son but really she still*

needed to be a child and was unable to cope with the rigors of motherhood.

With careful counselling and support she was helped to see that for her placing her baby with a caring adoptive family was an act of love and not an act of abandonment. She did not want her child to go through years in foster care and children's homes as she had, never feeling that he belonged anywhere.

* * * * *

Another 'success' was that of Carol who had moderately severe learning difficulties complicated by epilepsy. She had problems looking after herself and often went without proper nourishment. She loved her baby very much and did not want to be separated from her however it was clear that she could not cope and treated the baby rather like a toy doll - playing with her when she wanted to and 'putting her away' when se was preoccupied with other things. She did not understand the need for constancy and routine in a child's life and that a baby needed twenty four hour care.

A successful solution was found when Carol's sister agreed to take the baby. Carol was relieved of the 'drudgery' of child care whilst full able to visit and 'play' whenever she wanted.

Morbidity and Mortality -

The level of seriousness of our cases and the degree of disturbance in our families means that they are subject to a significant level of morbidity and mortality. Our patients are often from deprived backgrounds and live disordered and often abusive lifestyles. They indulge in harmful behaviours and place themselves in high risk situations.

Four percent of residents died as a consequence of circumstances which were pertinent at the time of admission although none died during admission. Deaths were caused by drug overdose, suicide, alcoholism and overwhelming infection caused by concomitant drug abuse and pelvic inflammatory disease. There were often several factors operative in each case - for example self harm, alcohol and drug abuse associated with

a borderline personality disorder involving bulimic behaviour or - in another case ….

Angela had been sexually abused by her father, she was left with a low self esteem and fell into a series of relationships with abusive and violent men. Self harming behaviours including alcohol abuse and the occasional drug use added to her difficulties and she had been known to cut her arms and to neglect herself including depriving herself of appropriate nourishment.

When she had her first child she decided to put some order in her life and stopped using drugs and excess alcohol. However her partner continued to be violent towards her and his behaviour escalated as she gave more attention to her child. The result was that the child became neglected as she tried to keep a balance between them and defuse the situation.

When she became pregnant for the second time, her partner beat her so badly that she nearly lost the child. She left him and took her son to a refuge where she stayed until just after the birth of her baby daughter. However soon after she returned to her own accommodation he was able to find out where she lived and moved back in with her. He at first feigned remorse and said things would be different but soon began to abuse her again.

One morning she awoke to find the baby bleeding from the mouth and subsequent investigation showed that she had been slapped across the face and had a fractured arm. Both children were removed from her care and she vowed to split permanently from their father and do everything she could to get them back.

After months of supervised contact time with the children, during which period she attended AA (Alcoholics Anonymous) and stayed away from her ex boyfriend, she was admitted to the unit for a course of therapy and a phased rehabilitation with her children. The night before admission her 'ex' caught her in the street and beat her up again. She responded well to therapy but the local authority took the view that if she was unable to protect herself from the boyfriend's attacks, she would not be able to protect her children either and they were removed from her.

Was she unable to protect herself? Certainly this was true, but in her case it was not due to lack of motivation or due to sabotaging her programme and covertly 'inviting him back' - the mechanism often seen with women in abusive partnerships. In Angela's case he was a resourceful and devious man who tried every tactic to find out where she was and punish her - hence we had a situation of a 'victim' being further persecuted by the system while the 'perpetrator' remained relatively unscathed.

Angela was in despair when she lost her children. She started drinking again and slipped into a deep depression culminating in suicide.

It was always sad to hear that a patient had died, but even more so when she was young.

Kelly was a teenage mother. She loved her baby and wanted to be a good mother to him. She had experienced a very rejecting and abusive childhood and was determined to be a better mother to her child than her own had been. None of her family cared for her, she was abused physically and sexually. Her father was also a drug addict. Despite time in children's homes she found herself frequently living 'on the street' where she learned to inhale solvents, first sniffing glue and then the more dangerous lighter fuels, to dull the emotional pain of her existence.

Her baby son was the only good thing in her life. When he was born she decided to 'clean up her act' and stop using solvents and drinking to excess. The baby was 'jittery' in the first weeks of life and slow to feed- he suffered from withdrawal symptoms from mother's drug use.

Kelly tried to kick her habit and when she was free of 'substances' she was a cheerful and pleasant person, very well liked in the unit and able to make jokes at her own and other's expenses. She was a loveable rogue that we all held high hopes for. However she had several 'slips' back into solvent abuse and would then become aggressive, unpredictable and a danger to all around her including her son - whom she could have harmed without intending to do so.

Our unit policy excludes the use or possession of drugs or alcohol o the premises and our substance abuse treatment programme is based on abstention. Kelly was given several warnings and her supplies were confiscated. However she continued to smuggle cans of lighter fluid into the house and would frequently have a can up her sleeve.

After a particularly severe 'binge' a room search revealed that she had concealed 23 large cans of lighter fluid in her room over a period of twenty four hours and had used most of them. This was a life threatening level of usage. Everything possible had been done to stop her acquiring supplies, but she found ways round every restriction.

At this point a resident would normally be expelled from the unit for non compliance with the treatment programme, but Kelly was so obviously besotted with her baby that we decided to give her another chance - she was therefore suspended from the unit for five days during which time she could think things over and return without lighter fluid if she wanted to seriously engage in the treatment programme. The social services also agreed that the baby could stay in the unit to wait for her return rather than remove the child immediately as had been their initial plan.

Kelly was picked up by her social worker and returned to her previous placement in foster care - within three days she was dead. Kelly's heart stopped under the influence of excessive amounts of lighter fuel. Her baby was taken for adoption.

A garden of remembrance has been set up at Youth Support House called 'Kelly's Garden' where anyone wishing to mourn the loss of a loved one can sit in peace or plant a flower. We received a donation from John McCarthy - the journalist who was held hostage in Beirut for several years - in order to set up the garden. John's experience of torture and abuse at the hands of his captives helped him to understand how children feel when trapped within families where they cannot speak out and may be subjected to years of abuse.

Children - mortality -

If we consider only index children - only 1% of children died, again not actually in the unit. One child died at birth in hospital of congenital malformation and was simultaneously assaulted by the distressed mentally unbalanced mother although this was thought not to have contributed to the death (see below for death rate of non index children).

Re-admissions and late results

Ten percent of cases were readmitted at some stage, usually because of either a re-emergence of a problem such as alcoholism or birth of another child requiring support, or being allowed a second chance to see if they could come to terms with their problems or parenting difficulties.

> *Rosemary first came to the unit with her family - husband and children - she was an alcoholic and had run into a number of problems - marital, parenting and personal emotional difficulties. She worked hard during her stay and gave up drinking, was a model mother and worked hard on her family relationships. However placement was short and the family was returned to the community at a stage when Rosemary was vulnerable and needing to consolidate her position.*
>
> *She slipped back into drinking - but fortunately had gained enough from the unit to be able to come and ask for help. She was voluntarily admitted and gave up drink 'permanently' - seven years have passed since the family first came to us and they are still doing well.*

Sometimes families or individuals need a little more time - often they are almost rushed through a treatment process with the court proceedings going on around them and intense surveillance of their progress from a number of professionals - this can hinder self discovery and therapy. Sometimes we need to wait for the turmoil of care proceedings and initial assessment to pass before we can settle down to real personal growth.

In addition 10% of the cases where there have been a negative outcome on discharge later showed a positive outcome on long term follow up. This percentage showed they had acquired parenting skills and coping skills during their stay although not able to immediately profit from their

experience and apply their newly found skills to their lives; with the passage of time they have managed to sort their lives out and parent their children adequately.

Similarly, 6% of cases where there seems to be a positive outcome at the end of the rehabilitation process showed a negative outcome later in terms of a complex set of circumstances usually related to patients with multiple difficulties involving alcoholism or borderline personality disorder where they were not able to sustain their position in the outside world.

Violent relationships -

At time of referral 59% of women had violent partners. Partnerships, however, were generally unstable with 68% having changed partners before admission. A further 36% changed partners at the time of admission.

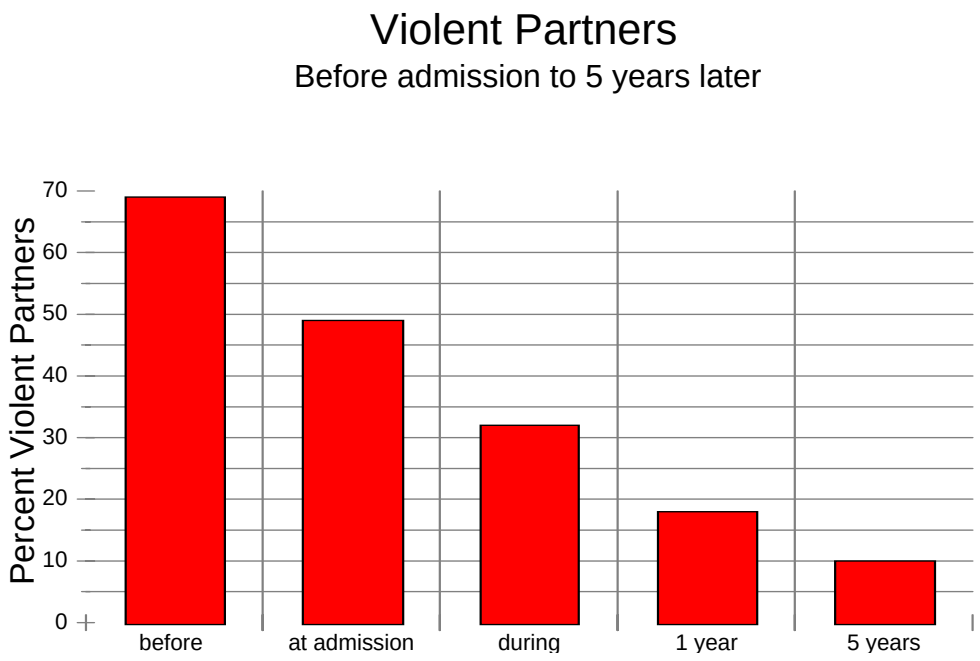
Nearly two thirds (62%) of the women had a violent partner at some time, either before or during admission or in the year following admission and the average number of violent partners was 1.67 per woman.

Interestingly, the percentages at various stages were 69% had a violent partner before admission, 49% at admission, 32% during admission and only 18% one year later, with a reduction of 10% on longer follow up between 1-5 years.

This is to some extent indicative of a positive feature in terms of showing a progression of perhaps learning to avoid an abusive partnership. However, it is also perhaps a selective figure in that some women will attempt to conceal the presence of a violent partner for fear of having their children removed from them. Secondly the statistics are difficult to check at later follow up due to the fact that the worse case scenarios are the ones more likely to fail follow up, and we lose touch with them.

Hence profiles will tend to get better as time goes on because of the selection of cases. Nevertheless, if one looks at the figures up to the end of the first year after discharge it does seem that there is a real decrease in the number of abusive partnerships.

Violent Partners		
		percentage
Stage	before	69
	at admission	49
	during	32
	1 year	18
	5 years	10



Violent relationships constitute a dilemma in assessment. A woman may be a very adequate mother in all other aspects of her parenting - but her relationships may cause concern. She may have had only one violent partner, or this may be part of a pattern of violent relationships. The male may present a danger to her alone and only to the children by virtue of their being 'caught in the crossfire' or traumatised by witnessing violence or neglected by their mother being preoccupied with the violent arguments.

> *Little Annie was burned when she toddled up to a hot iron whilst her parents were fighting and later her older sister fell out of bed and broke her arm. Both parents doted on their children but the domestic violence caused them to be at risk of harm.*

Witnessing violence can be equally traumatic although often not recognised as such by a mother who may be in denial as to the severity of the problem. This is sometimes seen in an extreme state -

Julie was fond of her boyfriend although she did eventually acknowledge that his violence was unacceptable and tried to leave him.

One night he called at her home, broke down the door and beat her - eventually trying to saw her head off with a large carving knife. Fortunately she managed to fight him off and call for help.

Her children witnessed the brutal attack but Julie had very little insight into the effect of this and thought that since he had never lifted a finger against them - they must care for him and would easily get over it.

Alternatively the violence may extend itself to the children directly when a cruel and violent man might beat or harm the children as well as their mother.

Helena suffered repeated brutal beatings and acts of torture at the hands of her sadistic boyfriend - she was too afraid to leave him and when he forced her to neglect her baby to give him attention, she did so despite her natural misgivings. Despite threats to her life, she plucked up courage to go to the police when he eventually started to physically abuse the child but not until the baby had three broken limbs.

* * * * *

Another woman was even slower to take action. She endured life threatening attacks from three men - one of whom was charged with attempted murder. Her children were at risk from her partners but the youngest was nearly killed before she was able to seek help. He was tortured and abused and his testicles were nearly avulsed with wire.

This case was difficult due to the pattern of abusive men - it is more difficult to break such a pattern when the nature of the relationships decreases the woman's confidence and self worth so that with each new abuse she is less able to work free and becomes more dependant on the abusive dynamic.

It should not be underestimated however that these women are often under enormous threat and have had very real threats and attempts on their lives. Some of their partners are sadistic and psychopathic. They are in fear of their lives and need support and protection in order to break free.

To give an idea of the extent of the threat -

One man attacked his partner and her child - injuring the child severely - she had a fractured skull and cerebral haemorrhages rendering her unconscious.

The attacker then escaped police intervention but found out in which hospital the child was being cared for. He broke into the intensive care ward and was surprised by the ward staff whilst he attempted to suffocate his stepdaughter with a pillow.

Just as we have said that it is difficult for a woman to break free from a pattern of abusive relationships - so it is also difficult to assess whether or not she is able to do so and whether she will return to an abusive man or drift back into such a relationship with a new man. Sadly, in many cases this is indeed what happens and a woman will allow herself to be abused repeatedly. This is more often the case when she has also been abused herself as a child and the pattern of abuse has been laid down at an early age - such a woman does not know better - is in a 'victim' position and believes that all relationships are based on violence and that it is 'normal' to act that way - she may even see the 'attention' which she receives when beaten as a kind of caring and when she is not harmed may perversely feel that she is being neglected.

Much of the time she may also be in denial of the abuse -

'He is really a caring man……'

'He does not mean to hurt me…'
'He is under a lot of stress and has to get it out somehow'
'I should not have pushed him, he could not take it'
'I'm sure if he was given the chance, he would settle down and be OK. People should just leave us alone'
'He says he's sorry and won't hurt me again'.

All these excuses have been heard over and over again. The victim taking the blame herself, making excuses and living in the false hope that he will change and make amends.

This is very similar to the reaction of the partner of an alcoholic or drug addict where the relationship is similar - a dependant relationship where the partner takes responsibility for the actions of the other and does not let them 'grow up' assume responsibility and accept the consequences of their actions. In such a situation the partner is actually 'enabling' the other to continue in their harmful behaviour by making excuses, covering up and protecting them from the true consequences of their actions.

Tessa came from a happy family background and had not been abused or hurt by her family. She did well at school and had never been in trouble - she was thus atypical of the sort of girl who would become dependant on an abusive relationship.

On her seventeenth birthday she went to a fairground near her home and met Andy - a slightly older boy who worked on the amusements. His life had been a contrast to her own safe existence - he had been eventually abandoned by his abusive parents and lived rough before joining the fair. He had practically no schooling and could not read or write. He was often involved in fights and had been on probation for causing injury to another young man.

Tessa found him exciting and called him her 'wild child'. She ran away from home to be with him, much to the worry and distress of her family but she knew he needed her and needed to be cared for - she treated him like a naughty child and constantly made excuses for his bad behaviour. She believed herself to be deeply in love with him and he with her.

Within a short space of time they married and Tessa became pregnant. As is common in such relationships - when the man is in the role of the naughty needy child, there is often not enough space

in the relationship for a baby. Andy reacted by becoming irritable and then violent - at first with peripheral matters - smashing things up and getting into fights - then shouting and verbal abuse of Tessa - she denied the violence in this period saying ' He never really hurt me .. I don't think he would ever mean to harm me ..' However he did hit her …

The neighbours complained and social services intervened to protect the as yet unborn child. A child protection case conference was held based on Andy's past history of violence and it was agreed that the family would be assessed. In due course Tessa and new-born baby entered a unit and Andy was allowed to visit. This arrangement soon came to an end when Andy had a fight with another resident father and Tessa then came under pressure from him to leave the unit. She took to seeing him covertly when supposedly on shopping trips and on one occasion he tried to snatch the baby from her. He also held the baby upside down in the middle of a busy road to make her say she would go back to him.

Tessa took this as a sign of love and concern - she was in total denial of the danger to the child and did not perceive his as an attack on the baby. When she was discharged from the unit soon after this incident, she was placed in her own flat on the understanding that Andy did not have access to the child. and went to live with Andy. However he moved in with them and it was several weeks before they were discovered at which point Tessa maintained that she had done this to prove to social services that Andy was a good father and in fact she had 'proved this' because the baby had not been harmed in this time.

There followed months with the child in foster care and difficult court proceedings continuing. Tessa's family disowned her because they felt she had sabotaged her chances of having her child back and had in effect given up their grandchild for a man like Andy. Tessa supported him throughout the proceedings stubbornly refusing to see sense. She began therapy but showed no insight into the situation at all. Matters seemed hopeless until following a particularly nasty outburst from Andy, Tessa decided to sever all links with him. She felt he had gone too far and she wanted to make a new start - and concentrate her efforts on getting her child back. She attended a pre-assessment interview and presented quite a different persona - she did genuinely seem resolved.

Tessa failed to win her court case to be reunited with her child but had high hopes that she would be able to keep the second baby that she was by now expecting. She was going to stay away from Andy - who was now in prison for a series of offences and she changed her address so that he would leave her alone. All seemed well .. until he sent her a message that he had decided to 'reform' and .. she went back to him .. with the result that she lost her second child also.

It is easy to become cynical and say that a woman who has been in a series of abusive relationships will never be able to break free and change her 'blueprint' for life. Certainly Tessa was a disappointment since she did seem resolved - she was very young and thus could have made changes - also she did not have an established pattern of abusive relationships, this was the first - and she did not have a past history of abuse. She had a lot of positive features in her story but the attraction of her 'wild child' was too great and she went back to him. She only attended for a short pre-assessment and thus in depth work had not been done with her - she did not have the opportunity to engage in therapy which may have made an impact on her self concepts.

Diane on the other hand presented with a very negative history and a number of features which made her prognosis poor. Despite this she did well and managed to break free of the abusive cycle of relationships.

Diane had a difficult childhood and had been abused by her older brother. Her first boyfriend cheated on her and had an affair with her best friend - at the same time he was aggressive and irritable with her. Eventually he left her and she took up with another man who was physically violent. By the time she was admitted to the residential unit she had experienced severe violence at the hands of several men and her children had been removed from her following assaults on two of the children and due to fears for their safety in future relationships.

In Diane's case she made a resolve to break free from these relationships, she remained steadfast during the trial for cruelty and child abuse of her last partner and decided to engage in therapy to change her outlook on life. She gradually began to see that she could be a good mother and a capable individual without

the ‘support’ of a man and that if she chose a man in her life she deserved better than her previous choices.

Therapy helped her to gain personal strength, self worth and self confidence. She gradually lost her fears and was able to become more assertive. She also acquired skills to help her to ‘judge’ other people in her life as to whether they were good for her or harmful to her and her children. She gained in parenting skills and in confidence as a mother and trusted her ability to protect her children from harm.

Diane gradually had her children returned to her and has remained free of harmful relationships, her family are doing well in the community following a period of outreach help.

Thus , given the right support and therapeutic help , it is possible to rehabilitate families even when there has been a long history of abusive relationships.

Day case referrals - 'Outpatients'

Many residents went through a phase of attending on a daily basis usually as part of their follow up and outreach services. The information regarding them is discussed elsewhere. Here I will confine myself to discussing patients who attended on a day basis only. These are divided into those who attended for purely therapy and others who were referred for assessment, part of which might include therapy.

Patients Receiving Therapy Only -

With regard to patients referred for therapy alone, 36 patients have attended on a regular basis. Of these -

15% were children under the age of 12;
30% were teenagers between ages 13 years and l9 years ; and
55% were adults over the age of 20 years .

Children -

Three quarters of the young children were boys who were referred for behavioural difficulties, anger management and difficulty coping with the environment and aggression. 75% of the children had also been subjected to violence or witnessed violence within the household and also showed sadness and depressive features. All responded well to the therapy and attention they received by attending the centre.

Carl's parents had divorced - it was an acrimonious matter and arrangements for contact between the children and their father were difficult. There had been domestic violence and mother and children were afraid of the consequences of father's anger. He had attempted to break down the door of their home and had made various threats about what he would do if he was denied access to his children.

Carl's younger brother was too afraid to see father and refused to leave the house at the appropriate time when access had been arranged. Mother did not want to see him but was also afraid of the consequences if the children did not meet Dad. Carl would reluctantly go out with father to keep the peace.

Carl presented for therapy as a sad little boy with an enormous degree of pent up anger. He was very bright but had been doing badly at school, getting into fights and being destructive of property. At home his younger brother had become the brunt of his anger and he cried as he related how he loved his brother and did not understand why he kept punching him and had wrecked his bedroom. He behaved reasonably well with mother to whom he felt very protective.

It transpired in therapy that Carl was feeling that he had to protect the family from harm and from the fear of his father. He felt adults were impotent to protect children and that his mother was weak and vulnerable - it fell to him to appease Dad by seeing him and at the same time he felt like a sacrificial lamb offered up in appeasement - this left him feeling vulnerable and unprotected himself. Thus his anger and frustration at not being protected - plus a fear that he would become a violent man like his father.

Carl was helped to see that adults could protect him and make decisions for him. Mother took control at home and an application was made in court to stop contact with father. Gradually he gained confidence again, became happy and content and came top of his class a school earning the deserved praise of his teachers.

Adolescents -

Teenagers were mainly girls, 29% of whom had suffered physical abuse and 71% sexual abuse. 43% were victims of paternal incest. The girls showed symptoms of behavioural difficulties in 43%, depression 57%. One third showed signs of developing personality disorder and 14% were violent or aggressive. One third used drugs and 14% were pregnant. Just under half self harmed and a similar figure had been in care.

Their presenting problems usually related to unhappiness and inability to cope in school, reporting bullying or difficulty with peer relationship and sexual boundaries.

Only one teenage male was referred for therapy who had been both physically and sexually abused, living on the streets self harming and into drugs and alcohol. He responded well to the attention he received as a result of attending therapy but did not make long term gains since his attendance at the unit was prematurely curtailed due to other circumstances.

The girls generally responded well to therapeutic input and although in the case of one girl with a history of sexual abuse and a severe personality disorder we subsequently lost contact with her, in other cases subsequent contact within the space of a year or more showed that they had maintained the gains that they had achieved in therapy.

Rebecca presented at fourteen with a number of emotional difficulties and a sense of adolescent confusion regarding her identity and what she wanted her role to be in life. She related poorly to peers at school and drifted from one 'group' to another attempting to gain friends but always keeping herself slightly aloof. She dressed differently from her fellow pupils and her clothes made a real statement of 'separateness'. Her slightly superior stance hid a fear of rejection and vulnerability but also provoked a hostile reaction from other girls so that she ended up causing the very situation she feared - she was marginalised and bullied and soon started to avoid school altogether.

In therapy it soon became apparent that Rebecca's main difficulty lay in her relationship with her father who was divorced from her mother and who had a very young girlfriend - not much older than herself. She was angry with him and felt rejected and confused.

Rebecca 'used' almost every aspect of her lifestyle to attack her father - she showed him how hurt and betrayed she felt in every way she could. Even her 'need' for therapy was somehow used against him since he was himself a psychologist and therapist and by coming to us for treatment she was showing him how impotent he was to help her.

Adults -

With regard to the adult cases attending for therapy only, 57% had been physically abused and 50% sexually abused. 43% had suffered from incest which was paternal.

Just under a third (29%) had a parenting problem and 7% were pregnant. Almost all (93%) were depressed, 14% suffered a behavioural problem and 57% a personality disorder which in 43% would be linked to mental illness. 21% were abusing alcohol and 7% were also using drugs. Half (50%) of the cases self harmed and 21% had been in care themselves.

Half of the women had a violent partner and just over half had had children removed for child protection issues or inability to cope.

Two of these patients died, one subsequent to therapy after we lost contact with her and this was suicide precipitated by depression arising from the loss of her children. The other case died early in therapy - an adult male who died of alcohol overdose coupled with antabuse which had not been prescribed by us. (We disapprove of using drugs such as antabuse in alcoholism).

Apart from these two deaths adult patients attending therapy had a positive outcome of their treatment programme. The oldest patient referred for therapy was in her 80s and was able to successfully complete a piece of work regarding sexual abuse she had suffered as a child.

> *Agnes was referred by a concerned friend who noted that the usually active eighty year old had stopped going out and would have frequent bouts of crying for no good reason.*
>
> *Her story was that she had recently been accosted by an elderly male neighbour who had forced a kiss on her whilst she was out on a shopping trip. Later he had called at her home and tried to push his way in the door. She had not seen him for several years but had problems with him some twenty years earlier when her husband was still alive. At the time she had told her husband who had warned him off. Now he had moved back into the area and she felt vulnerable and unprotected.*

Her reaction was unusually strong for what appeared to be a relatively minor incident which could have been dealt with perhaps by asking a friend to speak to the man. In therapy sessions it transpired that the real problem had been much earlier in Agnes' life when she had been sexually abused at the age of eight.

At the time she had been walking back from school through the same village where she now lived and she was molested by a man who lay in wait for her in a group of trees. The recent incident had awakened memories of this occasion which she had never spoken of before.

A short course of therapy helped Agnes come to terms with her childhood experiences and she regained the confidence to be able to deal with her life and with the threat of her neighbour. She arranged a meeting with the man and a mutual friend during which she was able to put him in his place and tell him to leave her alone.

Day Cases - Family Assessment -

As we have noted - the prognosis for day cases was worse than that for resident cases. Data on the children of day cases are discussed below.

Parental features and past history -

These features were comparable to the profile for resident referrals. Three quarters of mothers had been in care themselves as children, a very slightly higher figure than for residents.

The same proportion had been physically abused as children and 64% had been sexually abused. In half of these cases the sexual abuse was as a result of paternal incest.

Past History - Day Cases
Residential data in (%) for comparison

Mother in care themselves	-	74%	(70%)
Abuse - Physically abused	-	74%	(79%)
Sexually abused	-	64%	(64%)
Incest	-	32%	(30%) - all paternal.

With regard to behavioural problems such as drug and alcohol abuse one third demonstrated some kind of behavioural problem but figures were lower than for resident cases thus raising the suspicion of under reporting or covering up problems which would have become more obvious in a residential setting.

The same proviso applies to possible under reporting of history of criminal activities and violence.

Past History - Day Cases		
	Day cases	(Residential)
Drug abuse	20%	(35%)
Alcohol abuse	24%	(28%)
Self harm	24%	(35%)
Prostitution	8%	(14%)
Crime and violence -		
Woman aggressive and violent -	50%	(61%)
History of criminal activities	16%	(41%)

Fewer families were homeless at time of referral than for residents - this is understandable since they would be inclined to be referred for residential care if homeless. Fewer had a new baby since again this would tend to influence the decision to admit with a new child to avoid separation of mother and newborn during the assessment process.

The poorer prognosis is evident in the higher figures for involvement in child protection (98%) and for having a child removed from the family prior to referral (90%). Whilst certainly indicating the poorer prognosis, it does also highlight the fact that in many of our day cases referral was late in the day and there was a sense of 'fait accompli' and a certain degree of hopelessness which was reflected in the fact that nearly half of the mothers (46%) described themselves as depressed and low at the time of referral.

Features at time of referral - Day Cases		
	Day Cases	(Residential)
Homelessness	8%	(12%)
Involved in child protection	98%	(89%)
Child removed (before admission)	90%	(65%)
New child just before admission.	32%	(47%)

Violent Relationships - A very high proportion of day cases (84%) had violent partners. This was a higher figure than resident cases (69%) but the figures here were affected by the fact that we excluded some of the more violent partners from residential attendance at the unit. The pattern of violent relationships was set at an early stage by the fact that 64% of

women had violent parents and were accustomed to scenes of domestic violence in their childhoods.

Violent Relationships		
	Day cases	(Residents)
Violent Partner	84%	(69%)
Violent parent	64%	
Average number of violent partners -	1.6	(1.7)

Reason for Referral

At referral , the day cases had a rather different profile from the resident cases. Very few were pregnant - only 2% in contrast to the 21% of residents, many more had learning disabilities - 24% as opposed to 9% of residents. Nearly all - 98% - were referred due to parenting difficulties and for assessment of parenting skills. Approximately a third of the parents had a history of a mental health problem and, although not presenting for this reason, 62% of the parents were found to have a moderately severe personality disorder.

Reasons for referral		
	Day cases	(Residents)
Pregnant	2%	(21%)
Parenting difficulties	98%	(97%)
Mental Health problem	30%	(40%)
Learning disability	24%	(9%)

Family composition for day cases - 49% were seen with their children and those who did not have their children with them had children in foster care or children's homes and were not given permission to bring them to the assessment. Sometimes the parent was seen alone initially and only if the interview was positive would the children be allowed to participate in future sessions.

38% of day case referrals were seen with a partner - which is a higher figure than for residents (24%) This is an indication of the number of couples who would be willing to undertake a joint family assessment - but the numbers who potentially could be admitted are skewed by the fact that a local authority might wish to assess the mother alone in the first instance or may wish to save money by not referring more than one adult for residential treatment - Also may of the men have serious problems such as violence, or may have a history of sexual abuse or sexual violence in which case they would be difficult to contain within the unit and might prove a danger to their children or spouse or to other residents.

Recommendations - The conclusions of the day case assessment recommended therapy in 74% of cases; further assessment on a residential basis in 57% of cases and rehabilitation of the family and children in 34%.

The recommendations were accepted in only just under half of the cases (48%). This failure to follow the recommendations related mainly to the fact that the cases were referred at a late stage in proceedings when decisions regarding the families future had mainly been made and there was a reluctance to delay the final outcome whilst awaiting the result of further assessment or treatment. Also due to the generally poorer prognosis of many of these cases, there was reluctance on the part of local authorities to offer residential care or further assessment.

In 9% of cases we recommended no further treatment or assessment and in these cases the prognosis was very poor and it was felt that any further intervention would be harmful to the children.

> *Hugh was a twenty five year old man who was partnered by an older woman Patricia, aged thirty four. Patricia had begun her childbearing at an early age and had older children aged 15 and 17 who were with foster parents. Her elder daughter, at the age of 8 , had been sexually abused by Patricia's first husband and Pat had rejected the girl and pushed her out of the home when she found out about this, siding with the man despite the fact that this was not the first time that he had been involved in sexual offences.*
>
> *Hugh had a chequered history - disruptive and difficult a school, barely literate, involved in minor crime and assault, a previous*

girlfriend had complained of rape and physical assault. He had met Patricia five years earlier in a pub and they now had three children aged four, two and a baby. The birth of the baby had precipitated social work involvement and the children had been removed to foster care following concerns about them being underfed, dirty and covered in bruises.

The referral for a 'pre-assessment' consultation followed the parents requesting a residential assessment to prove that they were good parents and wanted their children back. A residential placement was not sought by the local authority in the first instance due to concerns over the poor prognosis and fears that the children would suffer further harm physical and emotional. The children had by this stage been in foster care for four months and contact with parents had not gone well.

Six sessions were arranged with periods when parents were seen separately, together and with various permutations of children to look at the different levels of relating in the family. The family sessions were videotaped to allow later analysis of the tapes and professional discussion by team members. This is our usual practice and parents are informed beforehand that we may do this.

Patricia was a very passive woman , looking to Hugh for a lead all the time. She was reasonably cooperative in her sessions but had no insight into her children's needs emotional or physical and had to be reminded constantly about checking on the baby, watching the children's safety as they played around her and even had to be prompted to talk to them.

Hugh on the other hand tried hard to be the father in control of the situation. He watched the staff carefully for leads as to what he was expected to do and made much of playing with the children. He maintained that he had been grossly wronged and misjudged and was in fact a caring father and husband.

We were concerned about the quality of the relationship between parents and children. The two and four year olds were withdrawn and had to be coaxed to play, they were wary of their parents and there seemed to be no warmth in the relationship. Gradually as the children began to respond to staff and become more outgoing and confident, clashes occurred between father and children as he began to lose control. He began to be short tempered and irritable

although attempting to conceal his anger with 'sweet words' - this made the children even more insecure and they failed to respond to his overtures causing him to become even more angry. Eventually he began to handle them roughly and he struck the eldest when he thought staff were not looking.

The marital relationship also showed cracks - one morning as the session was beginning Patricia seemed upset in the waiting room and Hugh was seen to whisper a threat to her and pinch her arm - she looked as if she had been crying. They were then taken into a couples session and whilst waiting for the therapist to enter the room - were observed for a few seconds on video link whilst the machine was being turned on - he threatened her and then hit her hard across the face.

When staff re-entered the room Patricia was choking back tears but denied that there had been any problem and Hugh had immediately composed himself. Later on being challenged he denied the incident. Most revealing was Patricia's reaction - she became very angry and accused staff of making things up and very self righteously denied there had been any problems stating that Hugh was a model father and husband and that we were trying to make up lies about him - a parallel of her reaction to her older daughter when complaining about the abuse perpetrated by her first husband.

In this case there were several features of concern not least of which was the parents lack of honesty with staff, attempts at concealing aggression and very poor parenting skills. Perhaps the greatest concern was the complete lack of insight and the way in which Pat continually placed the needs of the man in her life above the needs of her children - this was a recurrent pattern for her to reject a child in favour of a partner and to deny abuse to side with the perpetrator of that abuse. Hugh was a self centred young man who would always be 'in competition' with his children.

It was felt that this family could not be worked with to effect changes in the parents attitude. Their positions were too entrenched and they were unwilling to work - not accepting that any changes were necessary. The children were at risk of harm at the hands of their parents.

Case Profiles - Male Residents

Approximately a quarter (24%) of residents were admitted with their male partners - data on 26 males has been analysed. These males are not necessarily representative of all male partners of residents since obviously the other 76% of residents had partners who had broken up with them or were unwilling to be involved in the assessment or were considered unsuitable. Hence the more disturbed or violent partners were not included in this analysis.

The female residents whose partners were included were also a slightly different population group from the residents as a whole - They were slightly older - Average age of females admitted with male partners 27 years (range 16 to 56 years) - (average age all resident females 22 years - range 13 to 56 years). Average age of males admitted as part of family assessment - 29 years (range 17 to 57 years).

The average length of residential stay was much the same for two parent families as for one parent families but a higher proportion tended to go on to outreach care - an double figure of 48% as opposed to 24% for all families.

Average length of stay for families with male member -
5.2 months (5.4 for all residents)

Outreach follow up
available to 48% - (24% of all residents)
average length 2 months (3 for all residents)

Child protection -
The proportion of children abused was the same in families with father admitted as resident as for all families - 85% of cases involved the child being abused (84% index cases residents).

In 55% both parents contributed to the abuse. In 64% the male was involved and in 9% male only was responsible.

In 91% female was involved and in 36% female alone was responsible - 63% of resident males made partial admission of responsibility and 9% of males made 'full' admission of responsibility. This is discussed further in chapter on assessment of serious injury.

Outcome -

The outcome for families with father admitted was slightly better than for singe parent families. The experience was perceived as positive for 64% of males as opposed to 60% of single parents and 52% of families were rehabilitated as opposed to 43% of single families.

Outcome	Male	All
positive for self	64%	(60%)
positive for child	56%	(51%)
Rehabilitated together	52%	(43%)

It is naturally more desirable for a child to be brought up with natural mother and a father figure and the parents benefit from mutual support if they are able to give this to each other. This is not always the case unfortunately and there are instances where the presence of the father is detrimental to the assessment process.

> *Marlon entered the unit more as a ploy to keep an eye on his girlfriend than to engage in the assessment. She was afraid of him and under his control.*
>
> *When he absented himself from the unit , she would attend groups and work well. However when he was present she adopted a stance of non co-operation and would not speak in groups or disclose information to staff.*
>
> *Marlon's presence was entirely disruptive, he was taunting of staff in a 'passive aggressive' manner and attempted to cause confusion in the unit to detract attention from is own deficiencies.*

Fewer males - in fact only half the number - (20%) had been in care themselves than their female partners (40%) and this was a lower figure for females who had a partner than for female residents in general (70%).

The care experience is detrimental to the formation of stable relationships; women who have been in care tend to have more frequent and shorter relationships and have children by a number of different fathers (see 'The child that rocks the cradle') . Hence it is likely that women who are admitted with their partners will be less likely to have been in care.

Similarly fewer males (54%) have been abused as children than their female counterparts(79%) and only a third as many (19% as opposed to 64% of women) admit to sexual abuse . This figure may be lower than expected due to males being reluctant to disclose sexual abuses which they might consider degrading and unmanly.

Past History - Cases including Male

All residential data in (%) for comparison

Male partner in care themselves	-	20%		
Female of family in care themselves		40%	(70%)	
Male abused - Physically abused	-	54%	(79%)	
Sexually abused	-	19%	(64%)	
Incest	-	4%	(30%)	- all paternal.

Liam was so brutalised in beatings by his father and older brothers that he took out his anger and frustration in his relationships. It took six months of therapy for him to calm down and find a different way of relating - he managed a successful rehabilitation.

* * * * *

Ted had been regularly beaten by his mother to the extent that he feared most women and was unable to control his aggressive girlfriend or protect their children from her abusive attacks. He eventually acquired the strength to leave her and to disclose what she had done to the appropriate authorities.

* * * * *

Bryan was used as a 'hot water bottle' by male and female members of his family - being even sexually abused by his mother. This deeply traumatic experience left him very damaged, and severely disturbed his personality. He abused his own children ut accused them of responsibility for the abuse, regarding all around him including family and children as abusers.

His disturbance grew with the passage of time and he became obsessed with power wanting to be strong to defeat the abusers he saw around him. He thus began to train hard at weightlifting and other exercises and also took steroids to increase his bulk. This combination of mental emotional and drug induced stress produced a very dangerous psychosis. His placement was terminated and the family eventually rehabilitated without him.

In cases where the father is involved - there is also a lower rate of drug abuse, although alcohol abuse is higher. There is no difference in incidence of violence but a higher proportion of families have been involved in child protection and have had children removed from the family prior to admission.

Past History - Male Cases		
	Males cases	(All residential)
Drug abuse	27%	(35%)
Alcohol abuse	35%	(28%)
Violence -	62%	(61%)
Involved in child protection	100%	(89%)
Child removed (before admission)	85%	(65%)
Average number of children removed	1.8	(1.7)

All the fathers were regarded as having parenting difficulties and 50% had a personality problem. 42% had a mild or moderate learning disability.

Reasons for referral		
	Male cases	(All residents)
Parenting difficulties	100%	(97%)
Mental Health problem	15%	(40%)
Learning disability	42%	(9%)
Personality disorder	50%	

Information Regarding the Children

Resident's Children

Figures have been analysed for a total of 87 index children, in other words children who were admitted with their resident mothers and whose circumstances constituted the prime basis for the referral , where there was no clear cut 'index' case - the youngest child has been taken as the index child. Data also includes information on 82 previous children of these same mothers - some of whom were also admitted to the unit at the same time or at a later date, making a total of 170 children in all in the residential unit.

Children		Number
Residential	Index	87
	Previous	83
	total	170
Day cases		113
All children		283

On average resident mothers had one other child (other than the index case) and 19% of those with other children were rehabilitated with these previous children during the course of the assessment / rehabilitation programme.

The scenario was worse for previous children than for index children even though the index child had 'precipitated ' the referral.

With regard to abuse in general, 84% of index cases and 98% of previous cases have suffered abuse. In total 91% of residential cases have suffered child abuse.

A total of 96% of previous children had suffered emotional abuse and 67% of the index children (81% of children as a whole) - nearly all (98%) of previous children had been neglected as opposed to 69% of index children (82% overall) and 82% of previous children and 48% of index children suffered from failure to thrive (65% overall).

Children Percent affected			
Nature of abuse	Index	Previous	Total
emotional	67	96	81
neglect	69	98	83
failure to thrive	48	82	65

One index child and five previous children had died (3% overall).

In the neonatal period 4% of previous children and no index children suffered from sudden infant death syndrome (cot death) making 2% overall.

A proportion of new-borns were affected by their mothers alcohol and drug intake during pregnancy with the result that 8% of children suffered from foetal alcohol syndrome, and 6% of previous children and 8% index children suffered from drug withdrawal or drug reaction (7% overall).

Children Percent affected			
Neonatal Problem	Index	Previous	Total
Died	1	5	3
SIDS (cot death)	0	4	2
Foetal Alcohol	7	8	8
Drug withdrawal	8	6	7

When one analyses types of abuse, 62% of previous children and 20% of index children had suffered significant bruising (45% overall) 7% of children suffered fractures. Eleven percent (11%) of previous children and 2% of index children had suffered burns (7% overall).

Five percent (5%) of previous and 8% of index children had suffered a head injury (6% overall) and this was one feature where the index children had the worse statistics. The only other time when this happened was in regard to suffocation with 2% of previous children and 5% of index children having suffered suffocation (4% overall).

This probably relates to the seriousness of the two conditions, head injuries and suffocation, in that such cases are more likely to be referred for full investigation and assessment. Suffocation was mainly a feature of a Munchausen type of pathology on the part of the mother (and of one father).

Children Percent affected			
Nature of abuse	Index	Previous	Total
bruising	28	62	45
burn	2	11	7
fracture	7	7	7
head injury	8	5	6
suffocation	5	2	4
munchausen	5	7	6

Just under a fifth (19%) of previous children and 10% of index children had suffered from child sexual abuse (14% overall).

Children of Day Cases -

When one looks at children who are attending as day cases, 93% of the day cases suffered abuse and looking at all the children (283 altogether) 92% had suffered abuse. This is residential children and day children all together.

In general, therefore, the situation for previous children was worse and the situation for day cases was worse. This is to an extent inevitable since many day cases attend for a pre-assessment opinion and if the circumstances are too adverse and the prognosis poor then the cases do not go on to full residential assessment.

Children		Number	Abused	percent
Residential	Index	87	73	84
	Previous	83	81	98
	total	170	154	91
Day cases		113	105	93
All children		283	259	92

Only a total of 44% of abused children of day cases were rehabilitated within the family this constituting 27% who were rehabilitated to their natural parents and a further 17% who went to live with their extended families. This contrasts with a figure of 61% of abused children of residents who lived with their families - constituting 32% with natural parents and 29% with the extended family. (NB the previously quoted figure of 43% of children rehabilitated with their resident parents refers to percentage of all abused and non abused children).

Rehabilitation Rates Abused Children	Percent		
	Rehabilitated with parent	Rehabilitated with extended family	total percent
Day Cases	27	17	44
Residential	32	29	61
All children	29	23	52

When one considers the extent and severity of the abuse - the more severely abused children were less likely to be rehabilitated with their parents. The table below has used a score of number of features of abuse - ie bruises, burns, fractures, sexual abuse, emotional abuse, neglect, failure to thrive and scored one point for each feature present. Children who scored more highly were more significantly abused and less likely to be rehabilitated with their parents.

Rehabilitation Rates Day Cases	Percent By Severity	of abuse	
	Rehabilitated with parent	Rehabilitated with extended family	total percent
Not abused *	33	0	29
Score 1 and 2	59	8	67
Score 3 and 4	24	19	43
Score 5+	19	15	34
*non abused children had abused siblings			

What were the features of abuse in children of ‘day cases’?

Basic general features of abuse such as emotional abuse, neglect and failure to thrive were all more common in day cases.

Children		
	Percent affected	
Nature of abuse	Resident	Day Case
emotional	81	91
neglect	83	85
failure to thrive	65	71

Neonatal problems such as foetal alcohol syndrome and drug withdrawal were less prevalent in day case referrals - possibly due to the fact that children with significant neonatal risk would be more likely to be referred for admission rather than being sent for a pre admission assessment.

Children		
	Percent affected	
Neonatal Problem	Resident	Day Case
Died	3	0
SIDS (cot death)	2	0
Foetal Alcohol	8	4
Drug withdrawal	7	0

Nearly all aspects of abuse were more prevalent in day cases - only the serious forms of abuse - such as head injury were more likely to be admitted for residential treatment. 21% of day attenders children had been sexually abused - a third more than the figure (14%) for residents. This reflected the poor prognosis in sexual abuse cases where residential referral was probably not thought to be worthwhile by the referring agency.

Children		
	Percent affected	
Nature of abuse	Resident	Day case
bruising	45	58
burn	7	4
fracture	7	12
head injury	6	5
suffocation	4	0
munchausen	6	4

In one third of cases of abused children who were day attenders - both parents were responsible for the abuse. The mother was responsible in 67% and totally responsible in 34% - this is the same figure as for males who were involved in 67% and exclusively responsible in 34%. These same proportions are seen also with respect to resident children who have been abused.

Only 13% of abusive parents made a full or partially full admission of their responsibility in their child's abuse - and a third made a partial admission. Later in the course of assessment a further 8% disclosed details amounting to a reasonably full admission and 22% were partially admitting their role. Females were more likely to make an admission than males - in fact only 5% of fathers or stepfathers made a 'full' admission as opposed to 15% of mothers.

The Evaluation of Parents or a Family Where a Child has Sustained Serious Injury

The Evaluation consists of two main areas -

- A - The injury, it's circumstances and an evaluation of past events.

- B - Assessment of the parents / family looking at present functioning and future prognosis.

A - The injury, it's circumstances and an evaluation of past events.

In other words , what happened and who is responsible?

Sometimes this part of the assessment is incomplete and it may be almost impossible to ascertain the true nature of events and each individual's roles within those events.

Where two parents (or more than one adult) is potentially culpable each may attempt to throw suspicion on the other or both may remain quiet not divulging relevant information hence making it impossible to determine who was in fact responsible for a child's injuries - information may also be falsified or covered up.

It should be pointed out at this stage that the task confronting an assessment unit is very different from that confronting say the paediatrician or social worker attached to a hospital or acute unit. There the emphasis is on the examination of the child and evaluation of the injury. Much can be learned from the acute examination - perhaps nature and age of injury, is it characteristic of non accidental injury? The immediate history is also very important and the demeanour of parents and child can be very revealing.

Often, by the time that a case is sent for assessment, the trail of evidence has grown cold and the waters have been muddied by numerous other investigations and questioning - many of our cases have been through another unit before coming to us and families will have been interviewed

by social workers, medical staff, police, solicitors, psychiatrists … etc .. etc .. etc. We are also dependant on the description of injuries obtained from another professional - or more than one professional - and sometimes these descriptions or opinions may differ from one another. Part of the assessment process will involve evaluating other evidence and reports as well as the story told by the parents and family members who have been referred to the unit and the views of social workers and guardians who are currently involved.

Hence , although it is of great advantage to the assessment to have an accurate description of past events - we often have to accept that our information may be incomplete or incorrect.

B - Assessment of the parents / family looking at future prognosis.

The prime question to be asked here is - could this parent be responsible for injuring a child? - Leading to - Could a harmful situation arise again? Will this child / children be safe with this parent?

Much of this part of the assessment hinges on the emotional / psychological make up of the parent and the way that individual responds in therapy sessions and in psychometric testing. What are his or her own parenting experiences? How were they treated as children?

> *Ann suffered an abusive childhood where mother would slap and hit the children whenever she was annoyed or upset and father was often drunk and violent. Ann's own children were covered in bruises, underfed and emotionally stressed. The younger children were developmentally delayed, withdrawn and pale. The older boy was angrily acting out, truanted from school and ran away from home.*
>
> *In therapy Ann was needy and self centred. She was unable to perceive that her children were suffering and jealously maintained that they had no right to be treated better than she had been as a child. She was jealous of any attention given to the children and responded by venting her anger and frustration on them. Her placement ended after she severely beat her son. All the children were placed in foster care and eventual placed with permanent alternative carers.*

Ann was an example of someone with an abusive background and an experience of poor parenting who was unable to respond to therapy, however Brenda responded positively.

> *Brenda was abused sexually and physically, used as a skivvy within her family of origin and when she started a family of her own had no perception of what 'good parenting' should be. Her children were neglected and underfed, poorly dressed and dirty. They frequently developed minor illness and skin infections such as impetigo and scabies. Frequent 'accidents' occurred and placement in the unit was provoked by the youngest child sustaining a hairline fracture of his skull for the second time in the space of six months.*
>
> *Despite an uphill struggle, Brenda did respond to help and was able to slowly learn more appropriate parenting skills. A bonus in her favour was the fact that her personality was very different from that of Ann. Brenda was loving of her children and they did form a cohesive family - although at the time of referral, Brenda was more in the role of another child rather than that of mother.*

In Ann's case the prognosis was poor and the likelihood of her injuring her children again was high. Brenda's children however had been harmed more out of ignorance than out of malice and with some continued support, the prognosis was good - as she learned more appropriate parenting skills the chances of her children coming to harm was considerably diminished.

What is the personality 'type' or makeup of the parent.

As we have seen, although an individual's parenting experience and childhood history is of very great importance it is not necessarily the case that those with abusive childhoods will become abusive parents and indeed there is a chance that they will have the capacity to learn good parenting and to respond to therapy.

Much depends on the personality of the individual, which though moulded by childhood and life events, is multifactorial, somewhat intangible and has it's origins in the very early development of the

psyche. {Further explanation and information on personality and personality types may be found in 'Inner Worlds' - part one}.

Catherine and Dorothy had similar personality types - both were very needy, self centred and had no consideration for others. Neither was able to show any real feelings for their children, nor empathy for the child's feelings of hurt or pain and no remorse for their behaviour. In both cases their children suffered fractures and severe injury and there were indications that they were themselves responsible for these injuries - however they both denied this. They demonstrated features of a severe personality disorder - a psychopathic personality in fact - however both came from quite different backgrounds.

Catherine was the youngest and least able of four siblings but she was the favourite of her mother and father doted on her also. Her older brothers did everything for her and she was given as much as the family could afford in terms of material things, clothes etc. She was however a very selfish girl who wanted attention all the time and when the family went through a difficult patch with a family illness - she acted up to regain their attention , eventually acquiring a boyfriend and becoming pregnant. Her daughter was admitted to hospital with fractured limbs and skull at the age of six weeks.

During admission to the unit Catherine was completely unable to empathise with the pain the child may have suffered and her reaction was generally one of annoyance that the child had somehow caused her suffering - in other words she blamed the baby for getting hurt and thus getting her admitted to the unit. Catherine posed a danger to any child in her care.

Dorothy presented to the unit with a very different background but with a similar level of risk to her child.

Dorothy's baby was deemed to be at risk of injury at her hands also - in fact one of her key workers at hand-over expressed the opinion that he 'would not leave her in care of his pet hamster'.

She had experienced a very abusive childhood being physically chastised from an early age and sexually abused by a number of

family members. Dorothy was excluded from the unit and her baby placed in foster care after several incidents when she tried to 'use' the baby to get attention from staff culminating in an incident when she held the baby over a concrete floor and threatened to dash the child's head against the floor if she was not given what she wanted - her revenge she said, was that she would place blame on the staff who would be sacked for hurting the baby. Hence no remorse, using the child as one would use an inanimate object.

Seeing how a parent handles a child is very important - but 'technique' can be taught - rough inept handling is not so worrying as rough, unfeeling handling - in other words treating the baby as an inanimate object. The parents perception of the child is more telling than the physical handling. Tied up with this is the way that the parent perceives, treats and relates to other people - often the uncaring, cold and detached or selfish manner of the parent with perhaps a personality disorder can be seen not only in the manner in which the child is handled , but also in the way the individual relates to staff and to others in the unit.

This is something which is important to assess - particularly in a residential unit where staff and residents are in close proximity over twenty four hours of the day and where residents live in a close community - it soon becomes apparent who is needy, helpful, caring, jealous, attention seeking or disruptive and who needs to be upper dog and bully the others. These relationships are all 'mirrors' of the relationship between couples and between parent and child and give clues to family functioning. In the same way - although it may sound facetious to say so - watching how individuals treat the unit pets can be very revealing - a cruel personality or someone who mistreats the animals will usually react the same way with children.

One girl wanted very much to be seen to be helpful and to show how well she could care for the animals in the unit's 'mini farm'. She would come down to feed or play with an animal but would actually use the creature for her own pleasure. For example - the pig was fast asleep and I asked her to leave it alone because I was trying to fix the gate of the pig pen. She went inside and prodded it until it squealed - 'there you see she was awake all the time and wanted me' .. A rabbit might then get the treatment - she would do something to make the animal uncomfortable - hold it upside down

or tweak it's whiskers when I was 'apparently' not looking and then profess to be calming it down and looking after it when others had 'neglected' it.

The pattern of behaviour was repeated with her baby who was used by her to gain attention. She would make the baby cry so that she could then make a fuss of quieting her - would wake the baby up when she was asleep so that she could 'play' with her ... Subtle cruelty was used with both baby and pets.

* * * * *

One of our most disturbed males was thought to have poisoned a dog. He was caught out hurting one of his children - being quite cruel and sadistic. Soon after the staff member who reported this had her dog die suddenly and mysteriously - the Vet said it was poisoned.

* * * * *

Keith had a very sneering attitude towards staff in the unit and was taunting and threatening towards women. He would sarcastically make enquiries as to the health of the unit pets and then watch from a distance as staff found the animals had been let out of their cages or had been injured.

When his (adverse) report was filed he took his revenge by beheading a pet rabbit and leaving the body where the children would find it.

When it comes to the assessment of a family where a child has sustained a severe injury - it is likely that we will be dealing with parents with relatively severe emotional or mental disorder. Here the way that individual relates to others is very important to gauge.

'Splitting' is a common phenomenon of the disturbed personality - where various aspects of a persons inner self, emotions or behaviour will be

'split' off from each other as if they belonged to different people rather than were part of the same individual. At it's extreme this means that the individual may perceive staff as being all helpful, on their side and adored one moment and then as the opposite - obstructive, opposing and hated, the next moment. Many complaints against staff or against the unit can arise out of this mechanism - the staff member has fallen off the pedestal and will then be punished for the perceived 'betrayal'.

Another aspect of the 'split' is that when the individual wreaks his or her revenge on the 'hated' part - she does not associate this with 'wounding' the 'adored' part of the person. Hence the origin of the lack of remorse.

> *Enid presented a confusing picture to staff. She would act very angrily or badly one moment and then behave as if the incident had never happened. In sessions she might glower at me with what seemed intense hate and then smile broadly when meeting me in the corridor. One day she smashed the pay phone in the hall because she could not get through to the required number and then matter-of-factly asked staff for change to use the phone in the street.*

Hurting someone and then asking them a favour as if not expecting them to 'be hurt' was her forte. Her 'split' involved the way she perceived others, the way she perceived the world around her and the way she perceived her internal world - her self. We are not really discussing multiple personalities here - but rather that the various components of the personality can be split from each other.

> *In Enid's case - what she did when she was 'bad' was unrelated to what she did when she was 'good' - and 'good Enid' had no responsibility or remorse for what 'bad Enid' might have been up to.*
>
> *This mechanism was seen in it's extreme when she discussed her child who had received fatal injuries and dreadful neglect. Whilst it became clear that she was herself responsible for his death, she also spent considerable periods in therapy time working on her loss and bereavement as a mother. Note that the emphasis was on her feelings of loss and hurt - not the child's hurt and pain.*

We should of course remember that not all parents with a personality disorder will injury their children - we do need to assess the type of personality problem and the degree to which that is expressed in each individual. The three factors - personality, individual circumstances and environmental or life events interact. The personality of the child and the mother child interaction is also of prime importance.

Some children will be provocative, 'wind their parents up' and practically incite a parent to hit them whereas another child will be placid , keep their heads down and may be able to defuse a potentially violent or abusive situation. A child may be perceived as 'different' by the parent and thus the brunt of abuse - for example the conception may have been unwanted, the birth difficult, the child may remind the mother of an unhappy relationship or a hated partner, or the child may be too like another previously abused sibling. A father might suspect the child is not his. Parents may attribute all manner of misplaced emotions and perceptions on a child. All these factors can be explored in assessment.

* * * * *

Take two cases which presented in very similar manner but had two very different outcomes.

Two little girls approximately six months of age at referral had sustained cerebral haemorrhages, had been desperately ill on life support in hospital and were left with paraplegia - i.e. were paralysed down one side. They both also had retinal haemorrhages and were thought to be partially blind as a result. Both had middle class parents who were holding down good jobs and were well thought of in their communities. Both sets of parents denied any knowledge of injury to their child and also vouched for each other. Neither of the social workers was satisfied with the explanation (or lack of explanation) for the child's condition and police had decided not to proceed with any criminal investigation due to lack of evidence.

Here the similarities ended.

> *Baby Amy's parents were a loving well bonded couple - they shared all parenting tasks and expressed concern for each other's*

feelings. They 'looked after' each other in the unit each acknowledging how hard it was for the other to be placed under suspicion and to have to endure the rigors of an assessment unit. Moreover they cared a great deal for their child - being attentive to her every need and empathetic with her distress.

Mother and father took turns to sit by her even while she slept in case she should need something, they learned and practised her physiotherapy routine and were eager to buy her special toys, anything that might help her, particularly bright objects to stimulate her vision …

When it was found out that Amy was indeed blind - they cried for her. *They did everything in their power to reduce her suffering and jumped through every available hoop to be able to keep their baby - whilst at the same time maintaining their innocence.*

They co-operated with staff, but not in an ingratiating way and demonstrated a degree of genuineness in their interaction with others. They in no way fitted the expected profile for abusive parents.

Amy did not have a skull fracture and it transpired that her injuries were not a case of child abuse - but down to a combination of medical circumstances which led to a brain haemorrhage and subsequent retinal haemorrhages were caused by the trauma of resuscitation when she collapsed.

A very sad case of a little girl who has remained severely handicapped, paralysed and blind and whose parents had their sufferings added to by being placed under suspicion of harming their child and by having to endure placement in a residential unit. Not perhaps anybody's fault - but nevertheless an unfortunate chain of events.

The assessment process was successful in this case in showing how the family functioned. The mix of individual, group and couples sessions revealed how the parents related together and sessions coupled with observation of parenting showed how they responded to and perceived their child. Without such intervention they could have remained under suspicion indefinitely as they attended one interview after another gradually increasing in their frustration and resentment at being

disbelieved and unsupported in their task of parenting a severely disabled child.

Baby Bonnie has a different story.

Her parents whilst superficially seeming to say the right things and appear concerned had scarcely visited her in the intensive care unit in the hospital. - After all, why would she need them there if she was unconscious and unable to respond? They did have taxing jobs.

She had an unexplained skull fracture and bruises which they attributed to the activities of the ambulance staff. Neither parent seemed to appreciate the severity of her injuries, their life threatening qualities and the possibility that she could remain disabled, blind or paralysed. This was more than a matter of protective denial as often happens with parents of a handicapped child - it was more a matter of not wishing to acknowledge that she had any special needs, that anything untoward may have happened and a desire to divert attention away from Bonnie's needs on to the parent's needs.

The whole emphasis of the 'hurt' felt by the family was not for Bonnie - but harm, inconvenience and distress caused to the parents - particularly father who lamented the effect such a scandal (being suspected of child abuse) could have on his job, felt very sorry for himself in the unit and when he cried - he cried for himself - not for his child.

His wife in turn was also concentrating on her husband's distress and oblivious to her daughter - hardly ever picking her up spontaneously, failing to give her eye contact and hardly speaking to her as a mother normally would.

They related to staff in an ingratiating manner - on the basis of they're being professional people and superior to most other residents - hence expecting to be 'on a par' with the staff and thus obviously above suspicion. This was fine if staff agreed with them and went along with their ideas - but when any hint of challenge was in the air they immediately became quite uncooperative, complaining and aggressive.

With each other - their relationship was collusive in nature, attempting to put on a united front but with no apparent warmth between them. There was no spontaneity in their interactions in couples sessions and they gave the impression of just saying what they thought the therapist would want them to say.

With their daughter, the situation actually deteriorated as the assessment progressed and as they realised that rather than just being able to 'sail through' and being given the seal of approval as the good parents we must see them to be, we were expressing concern at what we saw. There then surfaced anger and blame of Bonnie for being hurt - and father's interventions in physiotherapy involved 'making her use' her paralysed hand because she was only 'putting it on' and with firm handling he thought she would stop being lazy.

The assessment process here revealed that Bonnie had suffered a serious and life threatening non accidental injury at the hands of her father who was a very self centred, 'psychopathic' individual with no capacity for empathy or remorse. There were also deep problems with the mother whose relationship with her daughter was damaged and who at best failed to protect Bonnie from harm and at worst had colluded with her husband. Bonnie's father posed a danger to Bonnie and to other children in his care.

Denial and blaming the child for the injury are common features which arise in the therapy component of the assessment. It seems as if it becomes a matter of - 'How dare you be hurt and show me up as a bad parent?' This is different from - although often seen together with - the deliberate deceit or concealment of an injury, and also a separate mechanism from the protective denial, fear and 'memory loss' of the parent unable to take in the hugeness of the situation.

Parents who lie and attempt to deliberately deceive - making up false explanations for their child's injuries and maintaining their innocence can usually be caught out in the assessment unit where detailed notes are taken by each member of staff and staff compare notes and work closely as a team. Often stories can slightly vary from time to time or different versions are told to different members of staff. Such matters are merely noted in the first instance and not immediately challenged so as to build up a dossier of information - conflicting information can then be

challenged at the appropriate time - usually in an individual session with a senior member of staff.

This 'challenge' when handled skilfully can give invaluable information, the reaction of the individual will give clues to their internal emotional state and their personality. There are three main outcomes - firstly they may attempt to diminish concerns, to say they did not really mean what they said on such and such an occasion and play the whole challenge down.

Secondly the reaction may be to feel 'cornered' and thus become aggressive and defensive - the staff have lied, the unit is crap anyway, their solicitor will sort us out - how dare we suggest …. In the case of such a reaction it is important not to identify individual staff members in a 'who said this to whom' or 'who reported this' manner - such individuals will attempt to persecute identified members of staff and can become quite vindictive - some nasty reprisals have occurred - cars damaged, tyres let down, physical assault, children threatened, staff followed home and homes damaged.

In addition to the 'revenge' component of these actions one must keep in mind that these tactics also serve as a diversion - taking one's mind off the key issue - the injured child - and diverting on to dealing with complaints, which can be very time and energy consuming; watching out for personal safety; giving attention to the safety of other residents who may be also under threat; and perhaps dealing with inter professional or staff disagreements provoked by these tactics.

The 'team' approach cannot be stressed enough. If this breaks down or is seen to be weak, a manipulative resident can attempt to drive wedges between staff and between other professionals resulting in the disastrous situation when an abusive parent plays 'poor little me' assuming a victim position to divert attention from the injured child and to canvass support from the 'good staff' against the 'bad staff' who are cast in the role of wicked persecutors daring to suggest that this poor little mother could possibly be capable of injuring their beloved child. A high index of suspicion must be maintained in dealing with child protection cases - the most angelic parent and apparently devoted mother or father *can* be responsible for injuring their child and it is the greatest disservice that we can give to a child to ignore this. We also need to be aware that a parent who is trying to set staff against one another will try every trick in the book and stoop to every level involving disability, race, social class,

anything to make him seem ‘discriminated against’ … he is older than the other residents … it is because he is not clever enough … he has a skin-head hairstyle …. his therapist does not like him. With these factors in mind, a very big emphasis is placed on team work and team cohesion in the weekly staff meetings and training sessions within the unit.

> *David was a narcissistic young man who was admitted to the unit with his partner and two children following an injury to the eldest daughter.*
>
> *His youngest child, a six week old baby, required medical treatment for a congenital problem but David would not take him for his appointments - always managing to divert attention onto himself by fabricating some illness which needed urgent attention. The older daughter at the age of one was withdrawn, had failure to thrive and frequent bruising. She would cry at meal times and frequently vomit her feeds. David was suspected of force feeding her to try to make her gain weight thus shortening their time in the unit. However he appeared to be concerned and attentive - always wanting to supervise meal times - to his daughter’s distress.*
>
> *David was observed by a member of the nursing staff to force food down the child’s throat and then jam the spoon so hard into her mouth that her gum started to bleed.*
>
> *His response was to accuse the nurse of having fed the child and injured her. As an ‘outraged’ and ‘concerned parent’ he began a campaign against the woman telling all the other residents to beware of how she handled their children. He coerced another parent to complain to the health authority and have the unit investigated and so alarmed a very vulnerable resident that she attacked a member of staff and smashed a window. He cleverly stayed in the background orchestrating the drama.*

The third type of outcome that may arise in a ‘confrontation’ session is the most desirable - this is a breaking through the deceit and or denial and the parent faces up to the discrepancies and differing stories and tells the ‘truth’. This may come as a progression through the other stages above - first denial and minimising, then anger and then acceptance and disclosure. There may be a tremendous sense of relief surrounding the disclosure, not needing to keep up a pretence and lie any more - and a

great out-pouring of emotion - this needs to be handled carefully by a competent therapist. There are of course times when the 'truth' elicited this time is no more so than the preceding 'truth' but this is usually pretty self evident and the demeanour of the parent is very revealing.

Disclosure and Admission of Responsibility

We have discussed the parent who may be deliberately lying and deceiving in order to cover up the truth regarding injury to a child. Let us now turn our attention to the parent who may not be entirely consciously deceitful or withholding of information, but who may not be able to process the facts or 'remember' what happened.

In each individual there will be a fine balance between the conscious and the subconscious way that the dilemma is dealt with - in other words an interplay between the degree of deliberate cover up, fear and denial and failure of acceptance and blocking of memory. There will almost always be a mixture of factors at play.

A parent who has injured a child while under stress, depression or emotional turmoil may (unlike the parents with severe personality disorders described above) feel tremendously remorseful and wish to make amends. They may also wish to tell the truth and face up to their responsibilities. A number of factors come into play however even at this stage which preclude the disclosure of the complete story.

The most powerful is perhaps a protective 'amnesia' for all the facts. A denial that 'I could really be the monster who did that to my baby' - hence a parent may begin by acknowledging that they think they are responsible and wish to take the blame - while still blocking off some of the details from memory recall. Gradually with supportive handling and therapy they may be able to disclose a higher proportion of the facts - although often the final details might never be entirely brought to light.

Some professionals working in the child protection field appear to hold the view that anything short of complete confession is by definition deceit and that parents who have not fully admitted their part in the abuse of their child cannot be worked with. The fact that a disclosure or admission is not complete is perhaps not as important as one might at first believe -

the main concern is that there be acknowledgement of having caused harm, acceptance of responsibility and a feeling of remorse.

In the case of families referred to the unit for assessment following the abuse of a child - only 7% of parents had made what appeared to be a 'full' admission before entering the unit and 31% had made a partial admission. During the treatment / assessment process 7% made further disclosure resulting in what one could regard as a full admission and 25% made a partial admission later.

The process of disclosure, recall and confrontation of denial is thus aided by the assessment and therapy programme - but similarly it can be hindered by some aspects of the child protection process. For example a parent can be deeply afraid that if they disclose what happened, they may lose their child, or that if they change their story they will be thought badly of and not be trusted - hence they may stick with a steadfast lie rather than change their story to the truth.

If we for the present disregard whether a disclosure is full or partial - the effect of admission on prognosis can be gauged by looking at the proportion of cases where the child was rehabilitated to the parents.

Looking at the children who were our 'index cases' (ie current admissions) In families where the mother alone was responsible for the child's abuse - if there was any acknowledgement of this then 52% were rehabilitated together - whereas rehabilitation occurred in only 17% where there was no admission. Where the male alone was responsible figures are deceptive since the children were generally rehabilitated to the mother and the father left the family - hence admission or the lack of it made no difference to the statistics. However the picture is very clear when one considers the families where both the mother and father were responsible for the abuse of their children. In these cases any degree of admission resulted in a 54% rehabilitation rate whereas there were no successful rehabilitations in the cases of those where there was no admission of responsibility.

The situation for 'previous' children of these families was similar. When mother had been responsible, only 5% of children where there was no admission were living together as opposed to 24% of children whose mothers had made an admission.

Admission of responsibility			
Resident Cases	**Percent**	**Rehabilitated**	
	Any admission	No admission	
Index children			
Mother resp	52	17	
Father resp	100	100 *	*rehab to mother
Both parents	54	0	
Previous children			
Mother resp	24	5	
Father resp	60	43	
Both parents	29	0	

Two mothers who made more or less complete disclosures in therapy during their assessment did very well with their children. Both had been under considerable strain and felt quite unsupported prior to injuring their children and both responded well to the support and encouragement of the unit.

Pamela was a career woman who had a reasonably happy marriage and a nice house. When she became pregnant although they had planned the pregnancy - she was a little daunted to hear she was expecting twins but to an outside observer appeared to sail through her pregnancy, to give birth to two healthy babies and to take them home to a happy family life.

Within weeks both children had fractured limbs and bruises. Pamela was depressed and withdrawn and could hardly bring herself to speak of what had happened. Her husband was confused and could not understand how this could be - he at first fell under suspicion but Pamela realised she was somehow to blame although she 'could not remember' why this might be.

In therapy Pamela was able to realise how unsupported she had been with her two babies -she had not a clue how to look after them and everyone expected her to cope - which she did not. Her husband worked long hours and did not even realise that she needed help. Her mother never called on her even though she lived nearby and never offered to help. Pamela was isolated at home with two demanding children - she had nobody to talk to or to

support her and at night she would wake frequently for feeds. She was exhausted and added to this her pregnancy had left her anaemic and physically weak.

In this weakened state she could not cope and whilst stressed to her limit -she roughly handled her babies, thus harming them. The details of this rough handling gradually emerged over a number of months therapy and at the same time, Pamela was able to understand and explore how her relationship with her own mother had provoked her breakdown.

Mother had been a highly critical and undermining individual who was cold and distant and lacked real 'mothering' skills. Pamela thus grew up without a good model for a warm maternal relationship and found it hard to create a warm loving environment for her own children. Moreover mothers harsh criticism rang in Pamela's ears as she realised she was 'failing' as a mother- thus diminishing her self confidence, lowering her self worth and throwing her into a downward spiral of self deprecation.

As she recovered, she was able to accept professional help, use staff for support and guidance and as a source of self confidence and was able to become more assertive towards her mother. She was able to 'take control' of her life and of her parenting and became a competent and loving mother. Couples work helped address the balance in the marital relationship and the couple were able to share child care in a positive manner. The twins have remained successfully rehabilitated with their parents.

In Pamela's case complete 'admission' at an early stage would have been unbearable. Her initial 'forgetfulness' was a very necessary protective measure. Her self worth was so low and the emotional assault of her mother's wanting her to fail - to show she could not be a better mother then herself - was so potent that to have admitted to herself that she had abused her children would have been tantamount to emotional suicide.

It was only after her ego had been strengthened by therapy and her trust had been gained by her realising that she could rely on the support of staff, that she could begin to slowly accept what had happened and acknowledge her responsibility. As she realised she was understood and

not judged she began to ‘remember’ and process her actions. Then as she recovered further she was actually able to not only express her own remorse, but also to very healthily express anger for the lack of support she had experienced in the twins early weeks and anger at her mother’s attitude.

Sally is an example of another woman who lacked support.

> *Sally had a critical uncaring mother who had died some years previously, but who had throughout her childhood instilled in her a sense of failure and incompetence. She also had a mother in law with a scathing tongue who found every opportunity of putting her down.*
>
> *When her first child was born Sally knew she was going to fail as a mother - and fail she did. Her daughter was difficult to feed, vomited, would not gain weight - and every time she vomited Sally felt a failure. At the clinic she was told the child was under weight and this provoked further sense of failure - she feared going back if the child did not gain - so she tried to force her to eat - which only made things worse. Sally was actually feeding the wrong strength milk but had never been told how to make up feeds. She also did not realise at the time that the baby was suffering from a medical condition which made her difficult to feed. She just tried to continue - becoming more and more frustrated with the child until she snapped and injured the baby.*
>
> *Following this incident the child was removed and Sally was unable to deal with her inner emotions and feelings regarding her actions - she felt betrayed and persecuted and the investigative procedure surrounding the child’s injury served to heighten this process leaving her bitter and feeling intensely misunderstood and unsupported.*
>
> *It was only with the advent of a second child that Sally and her husband were admitted to the unit. The second child was also difficult to feed, was diagnosed as having a medical condition requiring treatment and an operation. Sally was closely monitored and helped. She was able to build a trust in staff who supported her - as did her husband. Very great gains were made both in*

individual therapy and couples work where their relationship was strengthened and flourished.

Sally gradually acquired mothering skills and gained in self confidence - she was able to remember a good deal of how she had felt with her first born and what had taken place in the home leading to the injury. Eventually she told us as much as she will probably ever be capable of disclosing.

Sally and Pamela initially could not entirely face the truth because they could not take in or cope with the concept of whom they had become - child abusing monsters - unworthy and failed parents - their egos could not survive facing up to the enormity of what they had done.

Andrew avoided disclosure for a different reason. He was afraid of the consequences - afraid he might be punished, go to prison; he was afraid of what people would think; afraid the neighbours would beat him up; afraid of social services depriving him of his child and afraid of his partner's anger if she found out what he had done.

Andrew's dilemma was that once he had begun with a lie , it was difficult to stop. Each time he tried to cover up he dug himself deeper into trouble and with each day that passed, it was that much more difficult to change his story and confess.

Eventually he found himself 'cornered' and there was no option but to confess - which he did but perhaps not completely. For him this had been a big step for he was used to being bullied and controlled as a child by a domineering mother and sisters and had projected his fear of them and their reprisals onto the persona of his social worker and his partner. Hence he was up against very powerful and punitive imagery when he 'confessed' and it is thus likely that he may have 'watered down' some of the details. The strength of his fear was such that he once remarked when some pet chickens had been cornered and torn to shreds by a local fox - that 'I know how they feel'.

The important factors for us to weigh up in a professional evaluation of child protection are not just - has this parent confessed or not and is the

admission full? More importantly - Why have they not disclosed? What is hindering disclosure? What could assist them to face up to the nature of events?

Also of practical importance in future management. Are they showing sufficient concern and remorse? Can they empathise with their child? Can they be considered safe carers of their child in the future?

If the answers to these questions are positive - then it is counter productive to expend a great deal of energy on pursuing what may be an incomplete admission in the hopes that more information will be forthcoming - it is best to look to the future and help the family to move on and heal their wounds.

And wounds do have to be healed - just as a death has to be acknowledged and mourned - so a traumatic event, an injury to a child, an abusive episode has to be acknowledged and mourned so that the family can move on. A position must therefore be reached when the explanation or story given needs to be acknowledged and accepted if it is to be processed in this way.

> *Jack was a rather down to earth simple man. He was strong and rather ungainly. When his baby son broke his leg there seemed to be no good explanation as to how this could have happened but he had a nagging feeling that perhaps he could have been somehow responsible. He had handled him roughly when tired and unwell and thought he may have been unaware of his own strength.*
>
> *He felt guilty and wanted to say something - but at the same time felt an absolute repulsion that anyone could harm a child and an overwhelming self loathing to think that he could somehow have been involved. He therefore at first kept his suspicions to himself waiting for the 'professionals' to determine what had happened. Much to his relief he thought he understood that the medical evidence excluded the actions which he thought might have injured the child - so he said nothing, not wanting to introduce a red herring into the investigation.*
>
> *During the residential assessment a therapy session elicited his disclosure and it was explained to him that he had misunderstood the medical evidence. His outpouring of emotion included relief*

that his inner fears were taken seriously and believed and he was also greatly relieved by being able to 'confess', unburden himself and face up to his situation. He felt enormous remorse and pain at realising he had caused his son's injury - but with acceptance and acknowledgement of the facts he was able to 'mourn' for his son's pain and his own involvement in that hurt.

The Very Young Parent

How we manage young mothers -

Although at Youth Support we deal with a very varied client group - we also have particular expertise in dealing with young mothers. This group has been the subject of research which has been widely regarded as the leading authority on schoolgirl pregnancy. The initial study formed the basis of an MD (Doctorate in medicine) thesis and has also been published as the book "Are you my sister, Mummy?". It was this early work that prompted the formation of 'Youth Support' charity in 1986.

Further work has also been done covering more than 15 years of follow up of pregnant schoolgirls and young parents which formed the basis of the book "The Child that Rocks the Cradle" . This revealed the long term prognosis and problems facing young parents and also highlighted their strengths and weaknesses. There were many success stories and also families where tragic lives had caused a great deal of pain in three generations - teenage girl, her mother and her baby.

One of the most striking findings of the research was the very poor prognosis for families of girls who had been in care, the repetitive nature of their problems and lifestyles and the very clear message that we need to keep children out of the care system and with their natural parents whenever possible. Supporting deprived parents to care for their own children is a very clear and effective investment in the future.

In view of this long history of support of and research conducted with young parents, we are particularly aware of the difficulties facing young girls and are better able to cater to their specific requirements.

Many of our clients / patients are very needy young women with deprived histories who are unable to 'prioritise' a baby's or child's needs above their own. This is a specific difficulty which we encounter with deprived young mothers who very much need a period of 'mothering' themselves - this factor is confronted in our programme

(and in fact is also dealt with in one of my publications 'Bond and Boundaries'p10 and p75).

“ .... A teenage mother may well prove, with help, to be an excellent parent, able to meet her child's needs in a way that cannot be faulted. On the other hand she may be too much a child herself, needing love, care and attention which her child cannot supply.

The same situation could apply to a mother who is for other reasons unable to meet her child's needs - by virtue of mental or physical illness or deprived circumstances. It is important that such mothers and fathers be given the chance to explore their own potential - to be supported and encouraged and to be allowed to share in the decision whether to parent their own children or give them over to the care of another.

I know how grateful fourteen year old Kim was when I asked her if she would like me to find a foster mother for her child. She had wanted so much to please us all by being a good mother - but the depression and loss of herself showed through. At the court hearing they called her an unfit parent and brought up all her past delinquency - several months work on self worth destroyed in a day. But her little son will know, when he reaches his adolescence that he was a valued child, that his mother tried her best, and then gave him up in love.

I am constantly being told by my paediatric colleagues that good bonding between parent and child is essential for future mental health and that this can only occur in the first year of life - many authors have disputed this time limitation and even Bowlby has revised his views. However - even if this were so - surely the chance of establishing a rapport with your own mother - at whatever age is preferable to whatever bond may be established with a stranger? ...”

* * * * *

“ ... If a young person has gone through years of deprivation and abuse, they have never had their own needs met - they are like an empty vessel, deprived of love and affection.

They thus enter adult life , unable to 'give' what they have never received. This 'emptiness' affects their day to day relationships,

friendships, work experiences and profoundly influences their sexual relationships and parenting. ....

.... Contact with others tends to be based on what the 'needy child' can get from the other - there is intense competition for attention - since there is not and never was enough mother to go round. Hence it can be easy to see the jealousy, the insensitivity to the needs of others and the 'inability to place others (including their own children's) needs above their own without sometimes appreciating the pain and shallowness of such relationships. ...”

Their is also a need for support and ‘containment’ which we also stress in our programme - we have had a number of successes with highly disruptive and ‘absconding’ young people on the basis of ‘firm but caring’ containment.

(Also see Bonds and Boundaries p11)

“ ... our first task is to accept the needs of the patient's inner child, to allow them to be child like and to parent them - often for the first time in their lives. Here 'dependence' is healthy and a required stage in the treatment process - however, like all good parents, we need to set boundaries and be consistent in our caring during this childlike dependency stage.

As the patient grows in trust and confidence, we also, as good parents, relinquish some control and responsibility so that our 'children' can grow up. Having had some of their own needs met, they can now look to their own children's needs - but gradually at first. We take them through Bowlby's 'exploring from a safe base' , we ARE that safe base. They go through an adolescence with us 'holding' and 'containing' their anxieties and gradually emerge as competent adults. ... .”

In fact the philosophy of our unit (Bonds and Boundaries p31) specifically deals with allowing the young mother to gradually grow up and accept responsibility for her own child while being nurtured within the unit.
It can take a long time to build trust with such young deprived girls and we often find that the first weeks are pretty appalling but then girls can

engage in treatment and improve unexpectedly and surprisingly well. There is often a testing out of staff, a need to rebel against the 'children's home' ethos and we make it very clear that we are not a children's home and the young parent will not be treated like a child - they will be respected and treated like adults - whilst we expect them to respect us and other residents. At the same time they are given tender loving care, support and are allowed to experience their 'inner child' in groups, in play and in being cared for.

Often young parents have been through a period when their behaviour has not been contained - they may have been allowed to run riot in homes or have been pushy and demanding in foster homes. The lack of containment can be scary and provoke further disruptive behaviour - scared young people tend to become aggressive, threatening or violent young people. Their behaviour often seeks to find boundaries in their boundary-less world and they look for containment and control. Control signifies caring. Hence after initial rebellion an outrageously disruptive habitual absconder may settle down and begin to work with us, eventually becoming a 'good parent'

The presence of the child can be a powerful motivator and it is a mistake to begin assessment with a young parent without their child. This is sometimes suggested by agencies who are afraid of disrupting the child by placement with their mother whose prognosis may be considered less than ideal. It is counterproductive because without their child the young parent will not concentrate on their programme - feels 'what is the point?' and may sabotage their placement in frustration at being deprived of their baby.

Young parents have their own room and generally sleep with their baby 'roomed in ' with them unless 'special surveillance' is instituted. The baby would also be expected to spend time in the baby unit with staff. We have a highly structured programme with staff supervising and if necessary taking over some of the child care tasks until the mother is able to cope and do this herself. It is very important as I have stressed earlier - to work alongside and not preach down to these young parents.

At the same time as parenting and bonding and the parent child relationship are being enhanced, we have a therapy programme which helps the mother to cope with her own personal difficulties. In our therapy we place a lot of emphasis on self esteem which is often very low in girls we work with - we have done research on this issue and consider

it very important in girls experiencing an early pregnancy - and also in young fathers. (Inner Worlds p127).

> *“ ... Pregnancy can be used by some deprived girls as a source of self worth and as a false solution to their problems. That being so, an alternative solution must be offered.*
>
> *These girls need an alternative source of self worth. They must be given a different way of valuing themselves in order to ensure that, when they become pregnant, this is because they desire parenthood with all its responsibilities, hardships and joys and not merely as the only perceived escape from a catalogue of problems.*
>
> *The same argument applies to the young men who become young fathers, some of whom subconsciously 'need to be fathers', and to the young men ..... who resort to inverted value systems. ...”*
>
> * * * * *
>
> *" ... Seen from the young girl's viewpoint, pregnancy may not be so undesirable. Certainly it brings heartache and hardship, the extent of which should not be underestimated, but for under-privileged girls with little education and non existent job prospects, motherhood is a fulfilment. With the birth of her baby a 'failed' school drop out, an unemployable misfit, becomes an acceptable member of society with a valued role - that of a mother. She is successful and out of her loveless world she has created her own baby who will love her."*
>
> (Birch 1989 "Progress in Obstetrics and Gynaecology - vol. 7").

This unique approach to the problems of young deprived mothers gives an optimum chance of success in caring for her child.

Young fathers - are also catered for - they are able to join in our full programme and are often admitted together with their partners at request of social services departments. Naturally fathers have to be over sixteen to be admitted as a ‘family group’ to comply with legal requirements

regarding underage sex. If not resident boyfriends and ‘baby fathers’ can attend sessions and visit. The level of interaction with mother and baby or children is tailored to the particular case and can be on whatever level thought appropriate by referring agency.

Prognostic Signs

What are the positive prognostic signs which will give us an indication as to whether a family will have a positive outcome?

This is a hard question to answer due to the individual nature of all our referrals and the way that some people seem to do well against all odds whereas others with a relatively good prognosis may sabotage their placements.

So far as actual figures are concerned - certain aspects of the history - ie what has happened to the child give us some indication - Abused children and those with the worst forms of abuse tend to be less likely to be rehabilitated and certainly the more severe the abuse the less likely is rehabilitation - we have seen this in the chapter on day cases where the number of 'counts' of abuse gave a negative prognostic sign.

With the resident children the same is true and serious aspects such as fractures and head injury and sexual abuse point to a poor prognosis. With more general signs of abuse such as neglect, emotional abuse or failure to thrive these features are so prevalent that the numbers approximate to the mean for the whole group - they form part of a spectrum of abuse and are often seen in combination with other injuries.

Residents

Rehabilitated Together

Child Factors

		Percentage	
	% of total	% Rehabilitated	
All cases		42	
Abused		32	
Neglect	70	32	
Fracture	7	60	*
Head Injury	8	57	*
CSA	10	25	

*small numbers

When it comes to looking at 'adult factors' - there are some expected results - for example parents with a personality disorder are less likely to be rehabilitated with their children. 28% of women with personality disorders managed to care for their own children as opposed to 42% of the whole sample. This figure dropped to only 9% for those with severe personality disorders of the psychopathic type.

Prostitution was a negative finding as was self harming, use of drugs or alcohol and involvement in criminal activities or violence. The involvement of a violent partner was not such a negative indicator which is somewhat surprising.

Residents

Rehabilitated Together

Adult Factors

	% of total	Percentage % Rehabilitated
All cases	100	42
Violent Partner	59	45
abused	80	41
Learning Disability	9	38
alcohol	29	36
drugs	37	34
in care	67	33
crime	39	32
History of violence	60	31
self harm	36	30
Personality Disorder	57	28
prostitution	15	23
Severe PD:Psychopathic	26	9

A history of mother having been abused had a very slight negative effect but since such a high proportion of the sample were affected by this factor it lost some of it's relevance. However having been in care was a definite negative indicator.

Other features of positive prognosis were - age of mother - the older mothers tended to do slightly better - average age of positive cases was 25 years and of negative outcomes was 21. Probably due to this age difference positive cases tended to have slightly more children - but this was not a significant figure. Positive prognosis was also more likely with women who had delayed the birth of their first child - average age of first baby for positive cases was 19.6 years and of negative cases was 16.6 years.

Families with positive outcomes tended to stay longer in residential treatment - those rehabilitated with their children stayed for 8 months and those who were not rehabilitated stayed for half the time - 4 months - hence longer placements do have worthwhile results.

As I have said earlier - those admitted with partners fare better - 38% of those undergoing successful rehabilitation and only 18% of those where rehabilitation failed. More of the successful cases also went on to after care and 56% of positive cases had outreach as opposed to 6% of negative cases.

Positive features in parents included acceptance of their situation and of their responsibility with acknowledgement of the relevant facts; honesty in dealing with the truth and in rapport with staff; appropriate concern for the child and for any injury that may have been sustained; appropriate expression of feelings including anger. One of the most telling features is in expression of remorse and regret centred on the child rather than regret for what has happened to themselves.

Prognostic Signs

Positive	Negative
Acceptance	Denial
Honesty	Deception
Acceptance of responsibility	Blaming others
Appropriate concern for child	'Using' the child
	Diverting feelings onto self
	Victim 'poor me'
Appropriate expression of anger	Suppression of feelings
Remorse for the child	Lack of remorse
	'Remorse' for self
Good object relations	Splitting

- Appendix One -
Basic Data and Statistics

Age on Admission		
average	range	
22.2	13	56

Family Composition			
Parents -	single parent		with partner
	76 %		24 %
Children	on referral	born during stay	at discharge
	1.08	16 %	1.25

Average Length of Stay -

- Residential Treatment 5.4 months
- Outreach care 3 months
- Semi-independence unit (The Bridge) Opened May 1998

84% had been through another unit previously.

Outcome -

positive for self 60%
negative for self 23%

positive for child 51%
negative for child 33%

Rehabilitated together 43%
Rehabilitated separately 26%

Re-admissions 10%
Late positives 10%
Late negatives 6%

Child Bearing -

Age at first delivery - 18 years
Average number of children 2.3
Average number of children removed (accommodated) 1.7

Past History (Female referrals)

Abuse - Physically abused - 79%
Sexually abused - 64%
Incest 30%
Sibling incest 8% Paternal 21% Maternal 1%

Drug abuse 35%
Alcohol abuse 28%
Self harm 35%

Prostitution 14%

Crime and violence -
Woman aggressive and violent - 61%
History of criminal activities 41%

Reason for Admission

Pregnant 21%
Parenting difficulties 97%
Mental Health problem 40%
Learning disability 9%

Violent Relationships -

Violent Partners		
		percentage
Stage	before	69
	at admission	49
	during	32
	1 year	18
	5 years	10

Average number of violent partners - 1.67

Presenting problems -

Homelessness	12%
Involved in child protection	89%
Child removed (before admission)	65%
New child just before admission.	47%
Mother in care themselves	70%

Day Cases - Basic Data

Past History - Day Cases
Residential data in (%) for comparison

Mother in care themselves - 74% (70%)

Abuse - Physically abused - 74% (79%)
Sexually abused - 64% (64%)
Incest - 32% (30%) - all paternal.

Past History - Day Cases

	Day cases	(Residential)
Drug abuse	20%	(35%)
Alcohol abuse	24%	(28%)
Self harm	24%	(35%)
Prostitution	8%	(14%)
Crime and violence -		
Woman aggressive and violent -	50%	(61%)
History of criminal activities	16%	(41%)

Features at time of referral - Day Cases

	Day Cases	(Residential)
Homelessness	8%	(12%)
Involved in child protection	98%	(89%)
Child removed (before admission)	90%	(65%)
New child just before admission.	32%	(47%)

Violent Relationships		
	Day cases	(Residents)
Violent Partner	84%	(69%)
Violent parent	64%	
Average number of violent partners -	1.6	(1.7)

Reasons for referral		
	Day cases	(Residents)
Pregnant	2%	(21%)
Parenting difficulties	98%	(97%)
Mental Health problem	30%	(40%)
Learning disability	24%	(9%)

Case Profiles - Male Residents

24% of residents were admitted with their male partners - data on 26 males has been analysed.

Average age of females admitted with male partners 27 years (range 16 to 56 years) - (average age all resident females 22 years - range 13 to 56 years). Average age of males admitted as part of family assessment - 29 years (range 17 to 57 years)

Average length of stay for families with male member -
5.2 months (5.4 for all residents)

Outreach follow up
available to 48% -
average length 2 months (3 for all residents)

Child protection -
85% of cases involved the child being abused
In 55% both parents contributed to the abuse
In 64% the male was involved and in 9% male only was responsible
In 91% female was involved and in 36% female alone responsible
63% of males made partial admission of responsibility
9% of males made 'full' admission of responsibility.

Outcome -

	Male	All
positive for self	64%	(60%)
positive for child	56%	(51%)
Rehabilitated together	52%	(43%)

Past History - Cases including Male
All residential data in (%) for comparison

Male partner in care themselves -		20%		
Female of family in care themselves		40%	(70%)	
Male abused -	Physically abused -	54%	(79%)	
	Sexually abused -	19%	(64%)	
	Incest -	4%	(30%)	- all paternal.

Past History - Male Cases		
	Males cases	(All residential)
Drug abuse	27%	(35%)
Alcohol abuse	35%	(28%)
Violence -	62%	(61%)
Involved in child protection	100%	(89%)
Child removed (before admission)	85%	(65%)
Average number of children removed	1.8	(1.7)

Reasons for referral		
	Male cases	(All residents)
Parenting difficulties	100%	(97%)
Mental Health problem	15%	(40%)
Learning disability	42%	(9%)
Personality disorder	50%	

Data Regarding Children

Children		Number	Abused	percent
Residential	Index	87	73	84
	Previous	83	81	98
	total	170	154	91
Day cases		113	105	93
All children		283	259	92

Average mother had one other child (in addition to index case)
19% of previous children rehabilitated with mother

Children	Percent affected		
Nature of abuse	Index	Previous	Total
emotional	67	96	81
neglect	69	98	83
failure to thrive	48	82	65
sexual abuse	10	19	14

Children	Percent affected		
Neonatal Problem	Index	Previous	Total
Died	1	5	3
SIDS (cot death)	0	4	2
Foetal Alcohol	7	8	8
Drug withdrawal	8	6	7

Children			
	Percent affected		
Nature of abuse	Index	Previous	Total
bruising	28	62	45
burn	2	11	7
fracture	7	7	7
head injury	8	5	6
suffocation	5	2	4
munchausen	5	7	6

Children of day cases -

Children		
	Percent affected	
Nature of abuse	Resident	Day Case
emotional	81	91
neglect	83	85
failure to thrive	65	71

Children		
	Percent affected	
Neonatal Problem	Resident	Day Case
Died	3	0
SIDS (cot death)	2	0
Foetal Alcohol	8	4
Drug withdrawal	7	0

Children		
	Percent affected	
Nature of abuse	Resident	Day case
bruising	45	58
burn	7	4
fracture	7	12
head injury	6	5
suffocation	4	0
munchausen	6	4

Responsibilty for abuse - day cases

33% both parents were responsible for the abuse.
67% Mother involved.
34% Mother alone.

67% father (male) involved
34% father alone.

13% ‘full’ admission
5% males 15% females ‘full’ admission

Rehabilitation Rates -

*=rehab to mother		Rehabilitation Rates Resident Cases	
Responsibility		Any admission	No admission
mother	index	52	17
father (male)		100 *	100 *
both parents		54	0
mother	previous	24	5
father		60	43
both parents		29	0

Rehabilitation Rates Abused Children	Percent		
	Rehabilitated with parent	Rehabilitated with extended family	total percent
Day Cases	27	17	44
Residential	32	29	61
All children	29	23	52

Rehabilitation Rates Day Cases	Percent By Severity	of abuse	
	Rehabilitated with parent	Rehabilitated with extended family	total percent
Not abused *	33	0	29
Score 1 and 2	59	8	67
Score 3 and 4	24	19	43
Score 5+	19	15	34
*non abused children had abused siblings			

Data - Prognostic Signs

Residents

Rehabilitated Together

Child Factors

	Percentage	
	% of total	% Rehabilitated
All cases		42
Abused		32
Neglect	70	32
Fracture	7	60 *
Head Injury	8	57 *
Sexual Abuse	10	25

*small numbers

Residents

Rehabilitated Together

Adult Factors

	Percentage	
	% of total	% Rehabilitated
All cases	100	42
Violent Partner	59	45
abused	80	41
Learning Disability	9	38
alcohol	29	36
drugs	37	34
in care	67	33
crime	39	32
History of violence	60	31
self harm	36	30
Personality Disorder	57	28
prostitution	15	23
Severe PD:Psychopathic	26	9

Length of stay -
Families rehabilitated with their children stayed for 8 months
not rehabilitated stayed for half the time - 4 months -
hence longer placements do have worthwhile results.

age of mother -
average age of positive cases was 25 years
of negative outcomes was 21.
average age of first baby for positive cases was 19.6 years
and of negative cases was 16.6 years.

- Appendix Two -
Typical Draft Residential Programme

The programme takes the following form - Residents are given a draft timetable on admission and this is then modified to cater for particular needs as they arise.

The programme includes the following although exact timings may alter from week to week - The timetable is tailored to the individual and to the issues which come to the fore as placement progresses.

- Mondays -
    - Early morning group - daily readings and setting goals for the day.
    - 'Tape group' - looking at a variety of emotional issues - presented in a gentle 'low anxiety' manner, based on watching a video or listening to a tape and discussing the content - includes assertiveness techniques and social situations, parenting and emotional needs of children, substance and alcohol abuse.
    - Time in baby unit under staff supervision - this also happens between sessions.
    - Swimming or another activity with child - as a family exercise in order to foster enjoyment of shared experiences with children and how to play together.
- Tuesdays -
    - Early morning group - daily readings and setting goals for the day.
    - Drama Group - role play and psychodrama. Learning how to cope with stress, going over painful or difficult situations and learning new ways of coping, dealing with confrontations, assertiveness without aggression.
    - Anger management Group. Looking at issues around domestic violence and how to handle our own anger.

- Wednesdays -
    - Early morning group - daily readings and setting goals for the day.
    - Relaxation group - learning relaxation and stress reduction techniques.
    - Step group - building tolerance of frustration, using the twelve step programme of many self help groups as a daily living programme. Ability to ask for help.
    - Cooking for lunch club - life skills, cooking, budgeting.
    - Lunch club - social skills and looking at different aspects of community and family life - meeting others and 'giving'. Old people come in and talk to residents and their children - aspects also of 'adopt a gran'.
    - ‘Story telling’ group with a focus on ‘survivor / victim’ issues.
    - Aromatherapy - opportunity to be spoilt, massage and perfumed oils. Increases self worth and body image.
- Thursdays -
    - Early morning group - daily readings and setting goals for the day.
    - Work out - to aid fitness and body image (optional)
    - Time in baby unit/ nursery - learning parenting skills and seeing child’s abilities and needs. This features in the ‘gaps’ in the programme throughout the week.
    - Health Education session.
    - Self worth group. Active group - role play - very 'light' playful group. Increases self worth and trust levels.
    - Individual session with one of therapists also other individual sessions arranged as appropriate throughout week.

- Fridays -
    - Early morning group - daily readings and setting goals for the day.
    - Social Skills group
    - Art therapy group
    - Play therapy with children/ babies as appropriate (may be scheduled at other times of week)

At weekends it is generally expected that Parents will care for their children with the help of staff - They are supervised but encouraged to take children to the park, local shops etc.

Drug Testing -

We perform on site regular and spot testing of urine samples. This takes only a few minutes and provides accurate estimate of useage of - Cannabis - amphetamines - benzodiazepines - cocaine - heroin and opiates - plus salivary alcohol testing.

Special surveillance -

We provide 24 hour special cover to provide added monitoring of high risk cases.

Psychometric Testing and Psychological Evaluation -

All our residents have a ‘work book’ which they complete with their therapists - this includes a ‘life story’ which they write, a family tree and self evaluation via questionnaires regarding self esteem and relationships. We also include life script work, object relations and personality inventories.

Selected residents have IQ tests memory tests and other psychometric tests as appropriate.

Parent / child interaction is also gauged using a parenting stress index which has parent centred and child centred components.

All children are assessed for growth , developmental achievement and progress and behavioural patterns.

Youth Support Publications

The following publications are available from "Youth Support".

Books

"Are you my sister, Mummy?" Study of school age pregnancy. 2nd edit. 1992

"The Child that Rocks the Cradle" Fifteen year follow up of schoolgirl mothers and their families. 1996

"Bonds and Boundaries" - Child protection and the family.

"Retracing the Echoes" Children of the Russian revolution - Emotional aspects of growing up.

"**Inner Worlds"** 2nd Edition - first published as 'Inner Worlds and Outer Challenges' Development of the personality and assaults of emotional environment.

"Putting Down Strays" - life in Italy from late 19th century to the second world war. Laura Busini- Birch.

"Mother or Child?" Tape slide presentation

"A Thought for Today" Daily Readings used in the groups at Youth Support. Published 1996

"Youth , Our Resource for the Future" Proceedings of the Youth Support Conference on Adolescent Health and Welfare Tenth Anniversary October 1996.

"Profiles" Referrals to our assessment unit 1990-1998 - Published November 1998

Journal - Journal of Adolescent Health and Welfare - Back copies.

Reports, Articles and Reprints

1.1 "Schoolgirl Pregnancy". overview and medical aspects.

1.2 "Teenage sexuality and the Media"

1.3 "Schoolgirl pregnancy - a culture of poverty"

1.4 "That old Black Magic? - Sexual belief systems.

1.5 "Schoolage Pregnancy, the International scene"

1.6 "Sex Education - Does Mother Know Best?"

1.7 "Teenage Pregnancy - A problem for the nineties?"

1.8 "Self Esteem in early pregnancy"

2.1 "The search for the True self in adolescence - the dilemma of childhood handicap"

2.2 Sports Medicine - "The Training stresses for children and Young People" "Diet and Preparing for the Marathon"

2.3 "Healing abuse - Working with family that is not there".

2.4 "HIV infection - AIDS and the Young" conf report.

2.5 "Providing staff support in child abuse procedures".

2.6 "Emotional Abuse - The hidden scars"

2.7 "Working with families - how not to perpetuate the abuse"

2.8 "Reflections-Emotional development, origin of personality"

2.9 "The invisible woman - the hysterical personality"

2.10 "Fear is the key - the depressed adolescent"

2.12 "One Track Minds - obsessive part of our personalities"

2.11 "Divided loyalties - the schizoid teenager".

'Profiles'

'Profiles' provides a detailed description of the individuals and families who have been referred to our assessment and rehabilitation service since the opening of our unit in 1990. We look at types of referrals, the way we work with cases, and draw on results and outcome to formulate information regarding prognostic signs.

It cannot be disputed that the best way for a child to be brought up is with two caring parents and ideally that these should be their natural parents. Many children are not so fortunate but may have one natural parent who does care for them and wants to parent them. Sometimes these parents lack the skills or the strengths needed to bring up their children alone - but often with the right help and support , they are able to be loving and competent mothers and fathers.

It is the greatest disservice to a child to fail to support their family so that they may remain in a home with their natural parents. - It is also a tragedy if we fail to protect a child from an abusive household. To be able to judge this situation and to provide for a child's needs in the best possible way - we need accurate information and skilled judgement - this is what we aim to achieve in our assessments and in the care and support we provide at YSH and at 'The Bridge'.

This evaluation of our services and the results that we have achieved over the years will highlight how we have been able to uphold these principles in our work.

Youth Support Publications
ISBN : 1 870717 10 4