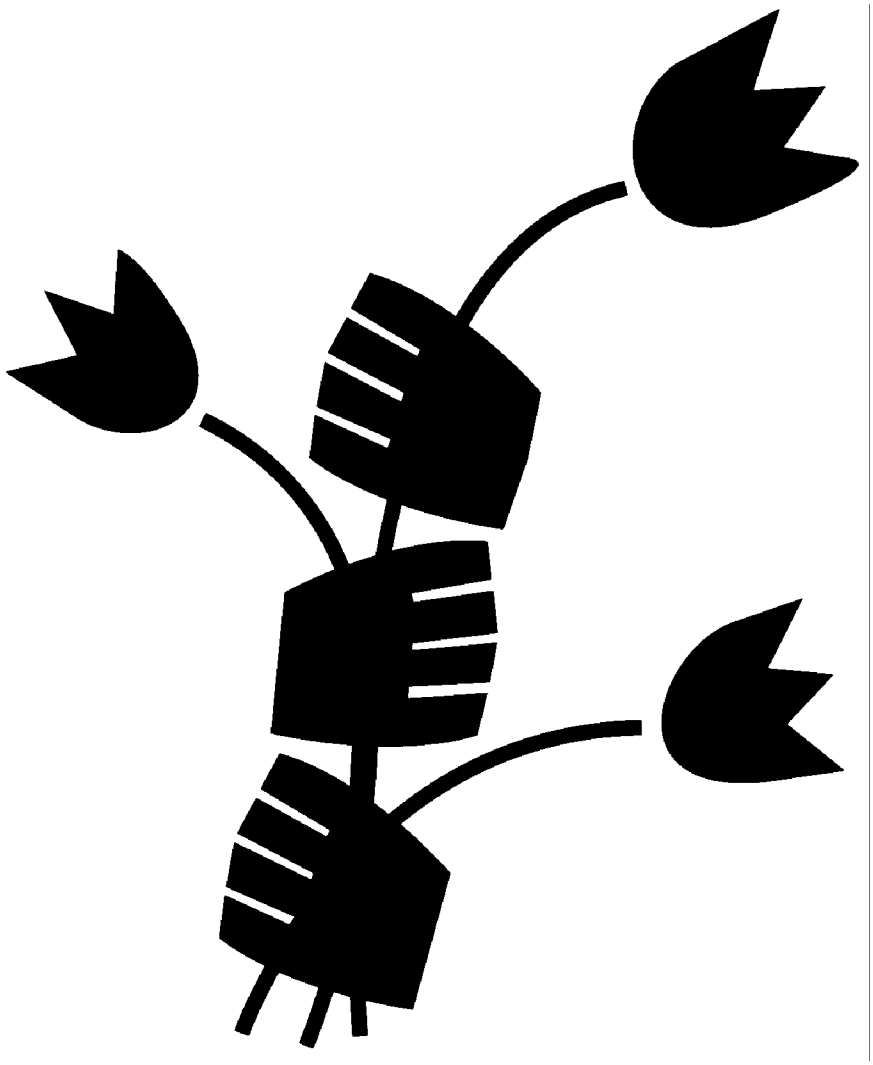
Health Canada Santé Canada

Improving Child and Family Welfare:

A Summary and Reconsideration of 11 Recent National Welfare Grant Demonstration Projects



Canada

Improving Child and Family Welfare:

A Summary and Reconsideration of 11 Recent National Welfare Grant Demonstration Projects

Andy Wachtel

Research Services
United Way of the Lower Mainland

for National Welfare Grants
Health and Welfare Canada

Reprinted 1994

Additional copies are available from:

National Clearinghouse on Family Violence
Family Violence Prevention Division
Health Canada
Ottawa, Ontario
K1A 1B5
Tel: (613) 957-2938

or call the toll free number,
1-800-267-1291

*TDD toll-free number
(*Telecommunication device
for the Deaf), 1-800-561-5643
or (613)952-6396

Également disponible en français sous le titre
L'amélioration de l'aide sociale à l'enfance et à la famille

Cat. H72-21/96-1994E
ISBN 0-662-21363-7

Abstract

National Welfare Grants (NWG) is part of Health and Welfare Canada. Its mandate is to emphasize the values of social investment, social participation and strengthening the social welfare network in its project funding. This paper reexamines a set of 11 recent NWG-funded demonstration projects from this vantage point. Five deal with child sexual abuse, either in terms of how to organize our response to it more effectively or what treatment approaches are useful. Three consider child welfare issues that are related to indirect or secondary abuse: children who grow up with violence even if they are not the targets; and children whom we try to protect by taking into alternative care. The final trio of projects tests family support models. These are approaches that try to develop stronger parental social networks or pro-family neighbourhood structures to attack the underlying problems that cause or permit abuse.

These projects differ markedly. Viewed together, however, they suggest a number of common themes and perspectives.

An overriding theme is that our children are at risk in many contexts. The price they pay as abuse victims or for living in developmentally compromising circumstances places a heavy burden on them, and an equally serious drain on our whole society.

One implication is a need for increased social investment in family and community. That is, newly popular ecological perspectives again situate "cases" within the larger contexts of family, community and society. Comprehensive assistance means programs that empower individuals, connect them within a larger milieu, and thereby break the causal chain that leads to revictimization or creates a risk of intergenerational abuse.

A second implication is that broader social participation is necessary. One approach taken in various projects is to mobilize individuals through mutual help and client empowerment strategies. Another focus is to facilitate the spread of our best strategies by testing demonstration and development projects in rural, regional and minority contexts.

These two sets of implications in turn point to the third the need to strengthen the social welfare network so that it can enlarge its perspective, act flexibly and absorb new ideas quickly. That means commitment to ongoing and innovative training (a focus in several projects) and more attention to effective dissemination of knowledge. Beyond that is the need to test mechanisms that turn the rhetoric of interdisciplinary coordination into actual integrated response. Several of these demonstration projects have created new bridging roles to work within the formal service system or to foster formal-informal system linkages.

The fact that these diverse but contemporaneous studies can be seen as sharing many perspectives in common is largely because the role of demonstration projects is to test the "new wisdom," and these ideas are in the wind now. The discussion section considers some implications of this. For example, demonstration projects rarely appear radical, yet many become part of the new wave of accepted knowledge even before they have completed their work. The world does not stand still while we do our research. In turn, this means that the demonstration projects' positive findings tend to be undervalued (or taken somewhat for granted); often, what is more critical

are the humbling lessons these projects have had to learn about the difficulties of translating cogent rationales into working programs. The hard task is to use this knowledge from the demonstration projects to improve other programs that are in the process of leap-frogging them. This report suggests that a real commitment will be needed to timely and broad discussion of project results, better ways to involve others active in the same field, and an unusual level of intellectual honesty, even if it leaves programs open to easy criticism.

A number of these projects were jointly funded under the Child Sexual Abuse (1986-1991) and/or Family Violence (1988-1992) Initiatives, and/or with the Mental Health Division of Health and Welfare Canada.

TABLE OF CONTENTS

Introduction

National Welfare Grants (NWG) of Health and Welfare Canada has been a prime federal funding program for research and demonstration projects aimed at the enhancement of social service provision. In a process of self-review and renewal that marked its 25th anniversary in 1987, NWG mapped out a new direction.

> To remain at the forefront of social research and development, NWG has re-oriented its work, explicitly using social development as a central process for enhancing the social well-being of Canadians. For NWG, social development is defined as the ongoing process of achieving social well-being involving the positive process of change that emphasizes prevention.[1]

This represented a shift to a proactive approach: selecting priority issues through a consultative process and targeting funding to build the body of knowledge about each.

NWG's new approach embodies three broad principles:

> Social investment — public commitment to the value of individual social and economic well-being and a healthy social environment.
>
> Social participation — opportunity for ... Canadians to participate in the identification of social needs and the determination of interventions.
>
> Strengthening the social welfare network strengthened capacity ... through increased quality and availability of information which informs decision making...[2]

In seeking to model these principles in its program, NWG is drawing on its legacy of recently funded projects. This paper summarizes and reconsiders the lessons of three sets of projects, some dealing with the response to child abuse, some focusing more generally on child welfare issues, and others testing family support program approaches. These projects produced valuable reports, each of which received attention in its own right. This summary does not replace those reports but aims to draw attention to them as a body of work with broad implications for policy makers in the social service arena.

These projects are from various parts of Canada. A summary (and companion video) covering some comparable projects in Quebec has already appeared.[3] A number of cross-references to those projects will be found below, especially in the section on family support approaches.

(For information on how to order further information on specific projects, see "Contacts" on the inside back cover of this report.)

Three Themes

Specifically, this re-analysis draws out three broad and closely related themes in NWG's newly articulated program: prevention, social linkage and empowerment.[4]

Most social service, projects can be situated along the prevention continuum. The focus might be mainly "primary" prevention; that is, aiming at the underlying causes of social problems. Or "secondary" prevention, making sure that nascent problems don't become serious and entrenched. Or "tertiary" prevention, providing treatment to halt further deterioration and to try to eliminate the long-term consequences of existing problems.

Social linkages as a focus acknowledges that persons are not isolates but actors within a broader network of individuals, organizations and communities. Social welfare services vary in the extent to which they concentrate on individuals individuals within a social network or the community.

Empowerment is a process of giving people the tools to exercise more control over their conditions of life. Traditionally, not all social service programs have thought of their activities in these terms. More and more, however, empowerment is an explicit undertaking. It is based on a better appreciation of folk wisdom:

> Give people a fish and you feed them for a day, teach people to fish and they can feed themselves.

That is, this perspective acknowledges that the resources of the social service system are often limited while the needs are inherently great. Fortunately, the resources of the populations served can be increased because their potential is great. The NWG projects discussed here demonstrate a range of approaches with broad applicability.

A Caveat: Demonstration Projects as Social Experiments

If these concepts of prevention, social linkage and empowerment are simple, their actualization in practice is anything but. The theoretical rationale for a new program may be elegant, meant to address a set of needs, create the conditions for certain changes or resolve particular problems. By contrast, social reality is generally complex and messy. Thus, demonstration project proposals, with their dear goals, methods and anticipated outcomes, tend to have to be modified in practice as the project confronts various unscripted situations. Indeed, sometimes the most important "findings" arise out of these unexpected circumstances.

Summaries of projects necessarily gloss over a lot of the intricacies. This report, which tries to summarize a dozen or so projects, risks serious over-simplification. Readers who want to consider the fuller implications will want to order at least the detailed summary of each project of interest, possibly the full text of some, and, where necessary, follow up with direct contact with the researchers and project staff.

I. Child Abuse Projects

NWG has funded a number of projects dealing with child abuse or child sexual abuse. The ones discussed below all tend toward the tertiary prevention (or treatment) end of the continuum in that they deal with aspects of the ongoing response to people who have been victimized. Along the other two dimensions, empowerment and social linkage, they range from system-enhancing approaches (such as helping child-serving professionals identify problems better and marshal a more effective and supportive response), to new approaches to individual remediation and therapy, to the current system/community development approaches that give victims and survivors a stronger voice.

Educating Professionals for Child Sexual Abuse Treatment[5]

It has been a truism in child abuse circles that an effective response requires a skilled multidisciplinary team approach. At the same time, training-related projects aimed at strengthening the service response tend to receive little recognition outside the circle of service professionals directly involved. However, training initiatives are important, not only for their own sake, but also as an indication of the increasing breadth and sophistication den-landed of workers in the response system today.

The survey project, ***Educating Professionals for Child Sexual Abuse Treatment***, raised these issues directly. In a sense, the results of a set of questionnaires on the broad range of training needs for those doing child sexual abuse therapy were several steps removed from service provision. As such, the project report might appear to be of interest only to a small audience of professional educators. However, the findings are arguably of much broader concern because of what they reveal about our long-term capacity to mount an adequate response to this problem. In terms of NWG program principles, we continue to place children (our real social capital) at risk through lack of appropriate investment in training.

The researchers, from the University of Guelph, Department of Family Studies, argued that, while child sexual abuse caseloads have mushroomed and public awareness has increased enormously, professional education has not been keeping pace. In this study, the set out: (a) to outline the knowledge and skills necessary for treating child sexual abuse; (b) to identify the level at which these skills should most appropriately be taught; (c) to document the extent to which they were covered. in current professional education programs; and (d) conversely, to uncover what the barriers were to integrating this training into professional curricula in both formative and continuing education. Their premise was that child sexual abuse has such wide-ranging impacts that all treatment professionals, whether they acknowledge it or not, work with clients affected by this problem.

The researchers surveyed 341 agencies and treatment facilities, 736 practising therapists and 61 professional schools in social work, psychology and family therapy. To provide greater depth, they also conducted surveys or telephone interviews with 76 experts in child sexual abuse training and treatment.

The findings were broadly consistent across all sectors: major deficiencies were reported in services for male victims, survivors and offenders, and in group treatment (compared with individual or family therapy). Agency directors stated that they would have liked to be able to recruit better trained staff. For their part, directors of professional schools responded that they would have liked to be able to provide more training;

however, only a fifth had any concrete plans to do so. And practitioners concurred that they would have liked more training during their professional education, more opportunity for continuing education and ongoing support through clinical supervision. It is telling that agency directors are systematically more optimistic than clinicians as to how much support, supervision or opportunity for in-service training is available.

The researchers defined required areas of core knowledge (child development, human sexuality and power issues) and skills (such as adult and child counselling, and group and family therapy). Similarly, they identified topic-specific knowledge (e.g., child sexual abuse indicators, dynamics, legal and ethical issues) and related skills (e.g., assessment, referral and dealing with disclosure). Ideally, the specific knowledge and skills would be included in required courses, not optional ones.

> In 1990, twenty percent of professional programs still did not offer any instruction at all in child sexual abuse. Instruction which is offered tends to focus more on the dynamics of...abuse rather than on its treatment, to be optional rather than required, and to be taught at a fairly introductory level.[6]

There was consensus that professional education should include some supervised clinical experience in working directly with child sexual abuse. Similarly, newly graduated professionals should have had some opportunity during their schooling to begin confronting their own personal issues and reactions to child sexual abuse issues.

The researchers made a series of recommendations to the agencies and schools surveyed and extended some to the professional associations and accrediting bodies (e.g., to establish some child sexual abuse training as a prerequisite for accreditation), the relevant provincial and territorial ministries (to support training initiatives and child sexual abuse treatment programs, and to help develop guidelines for competency), and Health and Welfare Canada (to support professional training through projects developing training protocols, research and coordinated training efforts).

Both "carrot" and "stick" recommendations were suggested as being necessary to overcome institutional barriers to better formative training.

> The greatest single barrier to increasing coverage of child sexual abuse is that the program content is at capacity. Other barriers of note are lack of faculty expertise, lack of financial resources, and child sexual abuse not being a faculty priority.[7]

Multiple Personality: A Training Model[8]

Child abuse is not a new problem. What has changed is the nature and sophistication of our recognition of it. Child abuse received fresh currency as a social problem three decades ago when new groups, notably radiologists and emergency room physicians, discovered they could identify a "battered child syndrome."[9] This "rediscovery" of child abuse led to further consideration of other forms of child maltreatment. Hitherto "mysterious" physical manifestations such as failure to thrive in infants and extreme developmental arrest in children were recognized as consequences of abuse and neglect.[10] Along that same line, cases of child sexual abuse within the family began to be uncovered in some numbers. This came as quite a shock to the general public, who had been largely unaware of the problem and, in quite a different fashion, to child welfare workers. For the latter group, the shock was one of horrified recognition, a new understanding of issues in their caseloads. Incest, for instance, had been viewed in the psychological literature as a very rare aberration. But now it became evident that the family was no sanctuary, from this or from a number of other even more common forms of abuse and insult.[11] Nor was the broader community of friends, neighbours, caregivers and relatives a place of

safety; it represented a measure of risk to the child as well.

Even as service providers began to face up to the relative commonality of many dangers that children faced, they were confronted with further issues, some quite unexpected. Many previously seemingly unrelated phenomena were being linked to a history of childhood abuse. For example, our rationally oriented culture does not regard dissociative states (such as falling into trances or having "out-of-body experiences") as normal. The very existence of multiple personality and other forms of extreme dissociation has been hard to accept. However, evidence has been mounting that multiple personality is a mental health problem with relatively high prevalence, perhaps comparable in numbers to well-known disorders such as schizophrenia. It is in this context that the Education/Dissociation project was developed.

This project, sponsored by the Ontario Institute for Studies in Education and The Children's Aid Society of Metropolitan Toronto, provided training (through workshops, a training manual, public forums, and large annual conferences) to a cross-section of service providers who work with child abuse victims and adult survivors in the region in and around Toronto. It also produced various public awareness resources (including a booklet, video[12] and many interviews in the media).

The materials were developed on the basis of information from a survey of 185 persons in treatment for multiple personality disorders locally. The vast majority reported involvement with the mental health system, a slight majority had received treatment for substance abuse, and lesser or greater numbers were showing up in every crisis service caseload. The research showed that, to date, misdiagnosis and consequent improper treatment have been likely in these cases. These mistakes have been costly, not only to the victims themselves but also to the broad response system to which they return again and again in crisis. Thus, social investment in better training of professionals might pay double dividends.

One thousand copies of a video "Multiple Personality: Putting Many Faces on Child Abuse" were produced. Using a number of candid interviews with persons with dissociative disorders, the video introduced the broad themes of the project. These were:

- Dissociation is a "post-traumatic stress condition," a sort of "self-hypnosis" survival mechanism used by some abused children to defend themselves in a situation where abuse cannot be avoided and the child is under pressure to maintain secrecy;

- Extreme dissociation is ultimately a dysfunctional coping mechanism and can make living an ordinary life impossible;

  The divided consciousness and the secrecy, both of which were necessary for protection in childhood, have become generalized, and individuals suffering from multiple personality are rarely aware of the extent of their dissociative symptomatology or of the extent of their abuse history.[13]

- Misdiagnosis has been common.

  Research has documented that individuals in treatment for multiple personality have been involved in the psychiatric system for an average of seven years before they receive an accurate diagnosis...[14]

But, the project argued, multiple personality disorder can be treated successfully by psychotherapy in an outpatient setting.

> Treatment success is dependent on the recovery, the reliving, and the reworking of memories of early traumatic events in the individual's life and the learning of

new, non-dissociative coping skills.[15]

The project developed several levels of training. Level one was training for recognition and referral. This involved a one-day workshop aimed at the very wide range of workers who might be expected to come into professional contact with persons with dissociative disorders. The video was designed to be used as a discussion tool in this workshop. In all, some 2500 professionals received this basic training during the demonstration project.

Level two was training in treatment; 170 professionals completed this program. It consisted of a 30-hour clinical course on assessment and treatment (offered variously in weekly three-hour blocks, weekly one-day sessions or a week-long intensive workshop). The course assumed competence in psychotherapy and offered a review of theories of personality and the therapeutic approaches that are consistent with each. Some experience in doing therapy with persons in a trance state was deemed desirable. Follow-up case consultation or supervision formed an essential additional component of the training.

One result of this training activity was the formation of a network in a half dozen centres in southern Ontario for treatment practitioners. The groups served to provide ongoing support and peer consultation about therapy with persons suffering from dissociative disorders. Information on new research findings and treatment approaches could be shared quickly.

Education/Dissociation has gone on to provide further workshops and training materials to professionals in other areas of Ontario, in Nova Scotia and Saskatchewan. While this was an important start in improving our response, the researchers worried that treatment resources remain inadequate for the size of the task identified:

We are living in a recessionary time when short-term interventions are popular, and we demand quick cures. For individuals with multiple personality, quick cures are not cures at all... Group therapy or support groups may offer a helpful adjunct...but they can in no way substitute for ...rigorous individual psychotherapy... Short-term therapy only scratches the surface...[16]

The Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims.[17]

The previous project, on multiple personality, identified an emergent issue and offered training to professionals in how to recognize and treat it. Some issues are already a little further along, and invite exploration of the relative efficacy of alternative treatment approaches. The Marymound project was a good example of this type.

One of the long-standing issues in service delivery is that there is seldom the opportunity to conduct comparative evaluation of treatment approaches. Such evaluation is always touted as an important goal but tends not to be undertaken, either because of the expense or the difficulty in running such a project. In these senses, the project at the Marymound Family Resource Centre, a treatment facility situated in the core area of Winnipeg, was ambitious.

The project staff sought to demonstrate a service approach to two under-served groupings adolescent male victims of child sexual abuse and adolescent perpetrators. Each posed distinctive treatment problems.

> Boys are raised...to believe that being a victim is inherently feminine, being abused by a man implicates their own sexuality, and being molested by a woman is an initiation ritual to be strived for rather than shunned... All this discourages ...boys from disclosing their own victimization and from admitting their feelings of hurt, anxiety or fear which, in turn, encourages hostility that can lead to future sexual offending behaviour.[18]

That is, treatment of male victims is tertiary prevention in terms of their own trauma but is seen as more immediate prevention in addressing the risk of them offending in turn.

> In the past, young perpetrators were a neglected population in the clinical and research literature due to the perpetuation of some myths... Mistakenly, there were beliefs that incidence figures for this population were low and that crimes committed by adolescents were less serious than those committed by adults.[19]

Treatment for adolescent offenders was seen as important in avoiding the entrenchment of sexually abusive career patterns.

The project emphasized the social linkage of adolescent and his family. For victims, the researchers argued: "Reactions of the family can greatly affect the victim and consequently, the prognosis for treatment." A similar case could be made for involvement of the family in the treatment of juvenile offenders. Moreover, the researchers noted: "Up to 1988, it proved difficult to find empirical findings ... regarding family intervention with this client population."[20] Marymound staff felt there was a real opportunity to make a contribution to knowledge in the field.

Accordingly, the demonstration project recruited 39 teenage offenders (responsible for an admitted 750 incidents of sexual assault involving 69 known victims) and 29 adolescent victims of sexual abuse by males. It tested the utility of a sequential treatment model, and the same basic model with family therapy added. The augmented model was an 18-month process divided into three phases: assessment (four months); adjustment (eight months); and adaption (six months). The assessment phase consisted of intake meetings, individual sessions with the client and family meetings. The adjustment phase included group therapy sessions for the youths, siblings and parents, and a continuation of the individual therapy with the clients. The adaption phase continued the individual therapy and added family therapy sessions. The comparison model that staff tested was the same length and general structure but was without a family participation component.

As is often the case in demonstration projects, various problems were encountered and changes had to be made to the model. For instance, the project staff found that offenders' families tended to be dysfunctional, single-parent units characterized by intergenerational physical or sexual abuse and concurrent spousal abuse. The victims' families were comparably dysfunctional. Although this was not unexpected, it did begin to indicate that these families would prove difficult to involve as a real resource in therapy.

Secondly, it turned out that almost one quarter of the victims had themselves started abusing others; in terms of maintaining the integrity of the program model being tested, these boys should have received offender-specific treatment prior to working on their victimization issues. However, in another sense, this "glitch" was informative; it provided a strong warning that any treatment program (perhaps especially for male victims of sexual abuse) has to keep the possibility of abuse-reactive behaviour, including victimization of others, very much in the forefront.[21]

A fair proportion of the clients did not complete the treatment (39% of the offenders, 28% of the victims). As well, some families withdrew from the family therapy component and these cases were reclassified as "no family therapy" model in the evaluation. Overall, these problems tended to undermine the careful matching of clients in each treatment approach.

The participants were assessed on a wide range of dimensions (depression, locus of control, self-concept, distorted beliefs, loneliness, social desirability, family functioning, family problems and risk of re-offending) using a battery of standardized psychological tests, self-report questionnaires, therapist observations, and for recidivism, police department records covering an 18-month period post-treatment. Two matched offender cases and two matched victim cases were selected for detailed description based on ongoing case notes.

In several ways, the project findings failed to confirm the workers' hypotheses. The sequential treatment approach showed mixed results. For the abusers, depression, distorted beliefs and risk of re-offending declined, and self-concept improved. In the enhanced model, with family therapy added, depression, family problems and assessed risk of re-offending declined, and family functioning improved. In other ways, however, the addition of family therapy did not prove effective; in fact, the youths in that model did more poorly in terms of cognitive distortions.

The rate of re-offending within 18 months of the treatment was established at 8.3%, roughly comparable to rates in evaluations of other intervention programs with adolescent sex offenders.

For the victims, the sequential therapy model did not appear to meet their needs. Little change was measured in many of the psycho-social variables (and cognitive distortions were increasing). Only two of the original 12 families receiving the enhanced model completed the therapy so no comparison was possible. The researchers speculated that the treatment model was too rigid to meet the highly individual needs of these victims. Again, however, it must be stressed that this "negative finding" that a year-and-a-half period of intervention was not sufficient to remediate the trauma of teenaged abuse victims provided a very important cautionary note for those still hoping for a "quick fix."

The failure of this study to demonstrate the effectiveness of a family therapy component induced some critical rethinking within Marymound. The researchers came to recognize that the literature supported the desirability of family involvement and change but did not yet sufficiently identify the program elements necessary for its achievement. The dysfunctional families many of these boys come from simply were not able (or willing) to engage in the treatment process.[22] In a sense, this understanding is consonant with much of the family support approach discussed below. It is essential not to underestimate the amount of work (both in scope and duration) that may be necessary to bring about significant and lasting change in such cases. Real empowerment of the families may be necessary before they can act as a positive support to these youth.

While the Marymound project proved difficult, it did provide a basis in experience that permitted the researchers to recommend the following:

- that special offense-specific treatment for adolescent sex offenders is warranted;

- that this requires adequate resources for risk assessment, screening, treatment and aftercare within community-based and high-security residential settings;

- that treatment programs need to have an enforceable mandate, full access to police reports, other documentation, system-ratified treatment expectations, identification of a case manager, an escort to ensure emotional support and good attendance, regular accountability reviews and control/safety plans distributed to the helping network; and

- that ongoing community education on the issue is essential to uncover abuse as early as possible and direct abuse victims into treatment before they act out aggressively and abuse others in turn.

The focus on a coordinated system response stated in these recommendations anticipates the goals of several projects discussed later in this review. Their central premise is that a victim's life chances can be significantly improved only if there is first genuine reform within the response system itself.

That is, it is not only that an effective response is key to a positive outcome for the victimized child but also that an insensitive and inadequate response represents secondary abuse. The project reviewed next takes that argument as its point of departure.

The London Family Court Clinic Child Witness Project[23]

> Clinical research clearly provides evidence of system-induced trauma of child sexual abuse victims in their involvement with the criminal justice system.[24]

The London Family Court Clinic has a relatively long and thoroughly distinguished history of innovation in child abuse response. Despite its vigorous attack on this problem, however, staff had become aware that disclosure and its aftermath themselves created huge additional stresses on the sexually abused child. Most troubling were stresses internal to the response, generated by a "complex, adult-oriented, and at times unpredictable and incomprehensible judicial system."[25] To protect the victims from this further abuse, the clinic proposed a child witness support project in 1987. Legislative changes then being implemented, notably provisions in Bill C-15 that were designed to facilitate the testimony of young children in child sexual abuse cases, made it all the more important to find ways of assisting child witnesses through the court. This project aimed to do that and at the same time monitor changes in court practice. At one level, this research design was a straightforward comparative test of two service models, as in the preceding project. In practice, however, it was a more ambitious and wide-ranging effort, involving many elements of the response system police, crown attorneys, court services, mental health workers in coordinated change.

Children were randomly assigned either to the service already in place (i.e., children were given a courtroom tour and verbal explanation of court procedures by the Victim Witness Assistance Program staff approximately a week before trial) or to an enhanced service (which added an average of five court preparation sessions).

These sessions were designed to educate the witnesses about courtroom procedures and etiquette, and to reduce their stre and fears of court through stress-reduction techniques. Use of a model courtroom and dolls, drawings, relaxation tapes and role playing were some of the methods employed... In addition, this model offered two forms of consultation with crown attorneys, one prior to and one after the child's court appearance. The first consultation was in the form of a verbal consultation report which addressed the child's cognitive and emotional status... The second was a written victim impact statement which was provided, upon request, at the disposition hearing... Supportive follow-up sessions occurred for this intervention model and the goal was to help the child witnesses to integrate and to interpret what had transpired in court.[26]

Preliminary review showed that 25 to 30 children a year were receiving the existing brief court orientation service; these represented at least 75% of those who eventually testified. There was indication that some children were traumatized by the prospect of having to testify and that Crown counsel were too busy to do extensive preparation with them. Police, another professional group involved in the cases, felt they had neither the time nor the training to provide the support these children needed. Based on these figures and probable increased awareness because of legal initiatives, the project staff estimated that 100 children would need their services over the period of the grant. As they noted afterwards: "We underestimated."[27] In the end, over 220 children participated. One hundred and forty-four children met initial selection criteria for the research; 120 completed enough of the process to be included in the evaluation. By chance, the enhanced model group (N=71) were more in need of intervention (than the regular service model group) because their abuse was more likely to be intrafamilial, repeated, and to have progressed to intercourse. In

that sense, the demonstration model was given a severe test.

In developing the intervention, the researchers had identified nine areas of stress associated with testifying in court: (1) delays; (2) public exposure; (3) facing the accused; (4) understanding complex procedures; (5) change in Crown attorneys; (6) cross examination, (7) exclusion of witnesses; (8) apprehension and placement outside the home, and (9) lack of witness preparation.

With regard to the last point, the argument was that child witnesses were vulnerable because,of their limited social awareness, lack of life experience and naive understanding of the criminal justice system. Note that the project focused on this element, tried to address some others, but did not seek systematically to relieve all of the stresses.

The children were given psychological tests and questionnaires before and after court appearance to measure the impact of the abuse and of the system-induced stress. In that regard, a first finding was that most traditional measures do not capture the distress of the child witness very well. Fear of facing the accused was the foremost fear expressed and was more severe for girls and for older children. Family pressure, lack of support and issues around guilt were important issues in intrafamilial cases. Some mothers were nonsupportive. Some, who had a history of victimization themselves, were so retraumatized by what had happened to their children that they required hospitalization.

Delays in the court system were demonstrated to be very debilitating, especially for young children. Keeping the children in legal limbo delayed or arrested the healing process. However, it appeared that extensive preparation was a helpful way of engaging the children during that time. Overall, Bill C-15 notwithstanding, the research reaffirmed that the court was not yet a very friendly place for child witnesses; alternative procedures were not widely used.

The special preparation improved the children's knowledge of court. The stress reduction component made them feel (subjectively) less afraid and, by several measures less diffusely fearful about court and clearer about their fears (e.g., afraid of being revictimized). Crown counsel felt these children performed better as witnesses and the outcomes were better than for less well-prepared children.

The project worker also acted as a case manager and advocate on behalf of the child in relation to other parts of the system. In this way, the project also served to sensitize system workers. For example, police had not been laying charges in many cases (faced with a 10% conviction rate). However, the project rate was much higher, and the extra preparation group had a 60% conviction rate which the project staff hoped would influence the police over time. Crown counsel reported becoming more willing to use a screen in court (to block the sight of the accused from the child while testifying). Crown counsel also were more prone to see the children earlier in the process (often at the request of the worker) and to call explanatory expert testimony.

That said, it was also evident that the project, though well monitored throughout, could not demonstrate the precise impact of all of its many elements. To begin with, it was never a rigorous experiment in practice. The exact mix of services provided varied to some extent depending on the children's needs.[28] More telling, but also in a positive sense, was that the control group of children who did not receive the enhanced court preparation services also benefited from changes in attitudes on the part of police and Crown counsel. Thus, the differences between the test and the control groups were eroded over time and the real contribution of the witness preparation became more difficult to demonstrate. Finally, while a good deal of documentation on the effects of the implementation of Bill C-15 was accomplished, the researchers recognized that a separate comparison site in the study would have disentangled these more precisely.

Nevertheless, the researchers were on solid ground in making recommendations for further follow-up, including:

- longitudinal study of the impact on children of having to testify;
- further study of factors predictive of abuse;
- research into judicial attitudes, sentencing patterns and adoption of C-15 reforms;
- further refinement of methods for preparing witnesses; and
- research into the benefits of providing expert testimony on case outcome and attitude shift within the system.

The central recommendation was about the enhanced service model itself. The staff believed that all children require the education component of the witness preparation program; many also require a stress reduction component. Intrafamilial abuse is an extra stress or and requires additional intervention and support. There was some indication that similar core services would be useful for child witnesses in physical abuse cases.

Recommendations were also made about courtroom practice. These tended to reaffirm earlier analysis and included:

- Cases involving child witnesses should be expedited;
- Allowing direct cross-examination by the accused is abusive, the law should require appointed counsel; and
- Expert testimony should be used more to interpret the case to the court.

As in various other regards, the Child Witness project served as a model in terms of dissemination. Findings were discussed widely, especially through presentations at meetings and media interviews.

The Manitoba Rural Child Sexual Abuse Project[29]

> The purpose of the ...project was to design, implement and evaluate a coordinated program for the investigation and early treatment of child sexual abuse in a rural locale in Manitoba.[30]

This apparently simple statement of goals actually represented the extreme in ambition among these NWG-funded child abuse demonstration projects. The project aimed at a major change in the way in which the response system worked in child sexual abuse cases. The rationale was; that rural areas were "vulnerable to problems of resource shortage" and so required "more conscious coordination of services" for children and families in order to compensate. In fact, however, this rationale would fit virtually any but the best organized and resourced centres in the country.

This vision of service called for the integration of investigation, criminal justice and treatment processes. To that end, a third goal was to promote mutual understanding across sectors and the building of a shared ideology.

To try to establish the benefits of response system coordination, the project was set up by the research team from the University of Manitoba as a comparison between two reasonably matched rural regions. South central Manitoba (1986 population, 52 000) was the test site; south eastern Manitoba, the control site. Both were mixed ethnic agricultural areas, each served by a child and family services agency, community mental health team and a family violence centre. Family sizes were large; three or children on average. The frequency and type of child sexual abuse reported was also similar in both regions. The average victim was female, eight years old, and had been abused for eight months. The perpetrator was most often the father, next came siblings and step-relations. The average age of offenders was the early thirties. Families in which a child disclosed abuse were characterized by restricted social

support networks: four friends and two professionals on average.

In outline, the coordinated service model involved seven new elements:

1 . the establishment of a treatment coordinator position;
2. garnering commitment from managerial levels of multi-service agencies;
3. holding initial meetings with all parties to solidify commitment publicly;
4. scheduling regular and ongoing meetings with all agency personnel;
5. the creation of parent support worker (PSW) positions;
6. coordination of the legal-investigatory phase; and
7. development and implementation of a coordinated, systematic intervention plan involving all the therapists and the designation of a case manager.

The key new position was that of the treatment coordinator, a local "traffic cop" for child sexual abuse cases.

> To establish the treatment coordinator position, project personnel met with upper level management of the various government departments dealing with child sexual abuse... The coordinator was expected to create an integrated model of service delivery by bringing together different social service agencies and assisting them to develop a shared sense of direction and purpose... Specific areas of intervention were in the creation of a multi-agency team, integration of legal-investigatory and treatment modalities, and reduction of fragmented service delivery by promoting collaboration amongst service providers.[31]

The argument for coordination was stated forcefully.

> Families can be involved with up to 26 different professionals in the course of disclosure, investigation and treatment. The coordinator position was developed to reduce the confusion, anxiety, fragmentation and feelings of isolation that can arise for everyone out of such complexity.[32]

Each case was assigned a parent support worker and an overall case manager, accountable to the treatment coordinator. The aim was to create a standardized systemic intervention. Joint police-child welfare interviews were conducted by specialized staff. The information they both needed was broadly similar, traditionally, however, their respective investigative processes differed.

> All legal action should be undertaken with a view toward a treatment plan for the whole family. one way this may be achieved is by the establishment of conjoint training sessions for child welfare workers, police and Crown attorneys that will result in a core group of specialists in the field of child sexual abuse.[33]

In this model, treatment of family members received its mandate through child protection action, dear boundaries were established in a "treatment contract" if the family was resistant. That is, the child protection agency was the control agent and the therapist was freed somewhat from being in a confrontational position.

The other new position, that of PSW, was a "neutral counsellor," not directly responsible to the police or child welfare authorities. The PSW offered crisis services (1 to 2 hours per week) to non-offending parents for six to eight weeks following disclosure.

> By educating the mother about how to respond to her child's questions or needs, sensitizing her to the child's emotional

> reactions ...and helping her devise a thoughtful safety plan in the family, the mother was assisted to be a better resource to her victimized child. Often workers had to concentrate on helping the mother understand her own past victimization and how this may have blocked her availability as a positive, supportive resource for her child.[34]

Aside from these key roles, the project also developed a number of new service components based on a "family systems" approach to the issue.

> The field is characterized by extended investigative activities, delayed treatment services ...and disjointed treatment approaches that tend to focus narrowly on victims or perpetrators while ignoring that there is an entire family system in trouble.[35]

New services included juvenile male sex offender treatment services: individual, group and family. It was not easy to tell how viable these were. of the relatively small number of cases that arose during the demonstration period, four juvenile offenders received group treatment, two also received individual treatment. All of these were court mandated. The therapy plan led to an "apology session." The Marymound project experience should make us cautious in assuming that this enhanced local response will have proved sufficient.

A young girl's group was run by a male-female team consisting of a community mental health worker and a, child welfare worker. The group offered the girls peer support and a safe place to practise self-protective assertiveness skills.

> Although victims may not "act out," this is not necessarily an indicator that they are functioning well. Work with adult sexual abuse survivors indicates that life for many is a process of silence, a silent suffering.[36]

This stance was important, in that it contradicted a common mental health service criterion (i.e., only to respond if distress was overt).

In addition to these new offender and victim services, a 10-week (non-offending) mother's support group was organized.

The project started in February 1989 and coordinated approach was begun in April. During the next 10 months, 22 cases received coordinated treatment services. The short time period meant most were still quite preliminary when the study period ended.

To try to assess whether the level of coordination was increasing under the enhanced model, service contacts were monitored over a one-year period. The two areas started at similar levels; however, the number of contacts in the test areas doubled (but with considerable variation). This difference was mostly accounted for by more active contact with colleagues working on behalf of, rather than directly with, their clients. It was evident that investigative workers had more contact with other workers on their child and family services team; that is, more treatment resources were accessed within the agency and "allowed family service workers to bridge with investigative workers as the cases progressed through the investigative phase."[37]

Follow-up showed that the test area was better served overall: 71% of cases in the test area received some treatment versus 29% in the comparison area.

The project included paper and pencil outcome tests for non-offending mothers at first intervention, at the end of crisis services, and at roughly 10 months after disclosure. These showed that depression resolved in the test group but not in the controls. Post traumatic stress disorder symptoms (intrusive thoughts and issue avoidance) moderated over time for both groups of mothers (apparently more quickly but no more completely for the test group).

In these regards and others, the project built up good evidence for the utility of greater coordination and better integrated service delivery and for the general efficacy of its specific service model. This was reported in a summary report, in many ways a model of an informative précis of project rationale and structure. However, perhaps more than usual, this summary document was either bland or uncritically optimistic in the discussion of many difficult issues. Important nuances contained in the larger report, dealing with practical difficulties in implementing a truly coordinated response, were lost.

> While commitment to the goals of the project were generally acknowledged by all the participating agencies, sustained effort proved much more difficult to achieve. In the end, closer working relationships amongst the statutory agencies required more resources than those involved either wished to provide or were capable of pursuing.[38]

In the end, the researchers hazarded a positive but careful overall assessment:

> The coordinated approach is more beneficial but is not possible to maintain without some increased cost in professional service resources... We as researchers remain cautious about the test community's capacity to maintain such an intensive approach to investigation and treatment without the infusion of some (albeit modest) additional treatment resources.[39]

II. Child Welfare/ Family Violence Project

A number of NWG demonstration projects can be seen as intermediate in focus, broader in this sense than the child abuse projects discussed previously and more narrowly framed than the family support projects summarized in Section III. Two of these child welfare projects deal, at least in part, with the impact on children of violence in their families. Compared, for example, with the Marymound sequential treatment project (which also tests a treatment model), these child welfare projects broaden the focus by including both direct and "indirect" abuse.

The third child welfare project described here is about the impact on children of being removed from their families and placed in alternative care. The project goal is to empower youth-in-care by fostering the development of self-help groups. This can be compared to the London Family Court child witness project summarized earlier in that both recognize the potential for secondary abuse in our response to victimized children. The child welfare project is broader in focus only in the sense that it adopts a longer time perspective. A court case, even if it drags on, is over and done with eventually, witness support does not include long-term follow-up. For children taken into care, however, the system's direct impact is ongoing, often involving a succession of residential resources.

Youth in Transition: A Group Counselling Project for Teenagers Experiencing Family Violence[40]

The concept of child abuse has undergone a process of progressive elaboration that has taken it well beyond the recognition of physical abuse and neglect and mobilization to deal with child sexual abuse, as outlined earlier in this review. Part of this elaboration was the growing appreciation that other circumstances present broadly similar issues.[41] Thus, for example, children of alcoholics or of parents periodically hospitalized for psychosis generally faced serious developmental compromises in their upbringing. Equally important, many of the same social and emotional supports helped to mitigate these adverse effects.[42]

Bryony House, a women's transition house in Halifax founded in 1978, came to recognize (as did many other shelters) that the children in the families seeking refuge in the house are also in crisis and require support. They have been taken to an unfamiliar environment and must manage despite the fact that their family history has tended to leave them with poor self-esteem, an inability to deal with anger, poor personal coping skills and little confidence in the ability of their mother. Being a witness to violence directed against their mother represented another type of insult against the child. Also, the crisis around leaving the home and entering a transition house was an important time to intervene if the new-found safety was not to be experienced by the child as another instance of abuse.

In light of this argument, the Nova Scotia government began funding a child care worker in the facility in 1985 and a second counsellor was secured with private funding. Based on an assessment of the child's needs and developmental level, these workers provided structured, safe emotional outlets for the children using art, drama, puppetry and so on. These focused on prevention. The children were helped to recognize and express their feelings without resorting to violence (the dysfunctional strategy that they have witnessed in their own home). The counsellors also ran a parenting workshop for the mothers to help them

understand their children's needs: topics covered developmental stages, discipline, health issues, effects of violence on children and community resources available to one-parent families. The staff helped parents to re-establish health care routines for their children (e.g., catch up on missed appointments with doctors, dentists), and become more secure about their children's safety and care, so they were better able to attend their own appointments for care or counselling.

Bryony House wanted to build further on this experience. It sought research assistance from the Institute for the Study of Women at Mount Saint Vincent University. After considering the needs carefully, the two organizations framed a proposal for a demonstration program that would permit focused attention specifically on the needs of older children and teens, the age groups that had not been well served by the transition house programs.

The sheltered transition phase was typically very short (a maximum of 6 weeks, an average of 3) and then the child often had to adapt to a new single parent family situation, typically in a new location and a new school. Support during these continuing transitions was nearly unavailable as counselling for teens was in short supply in Halifax. The proposal was to provide a six-month series of group counselling sessions at a non-stigmatizing location. A community centre was chosen as the project site.

The demonstration project (currently in its last year) aims at decreasing aggressive behaviour in the short-term, building self-esteem, decreasing feelings of isolation and connecting the children to other specialized counselling if indicated. Longer term, the aim is to prevent cyclical abuse (or re-victimization). The program includes same-sex groups for older children, preteens, early teens and older teens. The co-counsellors, a male art therapist and a female clinician (both trained social workers) model functional adult behaviour (where conflict is negotiated without recourse to violence). Meetings are an hour and a half weekly, either after school or in the evening. If necessary, transportation is provided. The project also makes tutoring available.

The first set of groups (six groups totalling 30 adolescents) were held February to November 1990. The second set of groups had 33 participants. Demand has been high, and a waiting list was established.

Evaluation of the group process is being based on "group history" notes made by the co-therapists. Outcome measures are based on standard tests of the members' self-esteem, perceived social competency and a personality inventory pre- and post-counselling. The latter is also completed by the youths' parents and teachers. Scholastic achievement is being monitored. Preliminary results suggest significant improvement on self-esteem and locus of control measures. The final evaluation will be available in 1993.

The co-counsellors have tried to maintain close contact with the youths' mothers. However, many mothers would have preferred parallel support groups for themselves (with child care to facilitate attendance). A few were able to join an existing mothers' support group at the centre.

The Transition House is a classic tertiary prevention mechanism. The Youth in Transition project, while similar, broadens the understanding of the needs of the other family members during the transition crisis and tries to provide short- to medium-term counselling to carry sustain them. In its more holistic analysis and interest in aftercare, it hints at (and is consistent with) some of the family support interventions discussed below.

The next demonstration project stems from a similar problem analysis but seeks to test a set of outreach services in a rural setting.

A Holistic Response to Victims of Family Violence in a Rural Environment[43]

The Naomi (Transition House) Society in Antigonish, Nova Scotia was founded in 1983. Staff felt that growing awareness of family violence and a more effective intervention system have not yet touched rural women in any fundamental way. The response to date, short-term transition housing, has not addressed the problem effectively, only 17% of Naomi Society's clients chose to use transition housing.

Isolation — lack of public transport, women having no independent means, no telephone (or no privacy because of party lines) and no close neighbours) — is one of the risk factors that requires special attention in a rural area. Naomi Society staff recognized that many women in the county had never travel very far from home. Partly as a result, inter-county suspicion and parochialism were barriers; some women in Antigonish would not use services in neighbouring Pictou county even if distance were not an issue.

Another risk that the staff identified was the idea that family problems are private; this value remains very strong in the rural community.

Because of these difficulties in assisting rural women who were experiencing violence, the possibility of addressing the needs of their children was even more remote. Child protection services and mental health services (hospital-based referral mainly) were crisis oriented; they did not provide guidance in preventing family violence. The school psychologist focused on learning difficulties and not trauma-related impacts.

In view of this analysis of the problem, Naomi Society, in concert with the Antigonish and Area Inter-agency Committee on Domestic Violence, proposed a three-pronged program. to serve their rural catchment area (population 19 000). These related services were a rural outreach program covering 10 communities, a school-based violence prevention program for elementary school-aged children and a mother-centred program to address the needs; of children witnessing violence. Because creating a support base for abused women (so that they, among other things, can be better resources to their children) is logically a first need, the rural outreach program is somewhat further ahead of the others.

> The Naomi Society's Mobile Resource Unit (MRU) is a unique approach to delivering existing services and programs to rural communities. This program is coordinated by the Rural Outreach Worker. She enables social, legal, health and educational agency/institutional representatives to meet, in workshop settings, with community residents in their own rural communities. Service professionals provide information and resources regarding the role and function of their particular agency in order to raise awareness...[44]

The rural outreach worker held consultations (hosted by local home and school associations, churches, or women's auxiliaries) in the 10 target communities to ascertain interest, in all, there were 115 participants. The communities were enthusiastic about the proposed rural information workshops. Invitations were extended through church bulletins and school notices, local newspapers and cablevision stations, and through word of mouth. The first series (a daytime and an evening presentation in each community) was held in spring 1992. A second series of workshops (all scheduled in the evening) was planned for November 1992 but had to be rescheduled for spring because local co-sponsors wanted more time to organize and publicize the meetings. Bad weather hinders travel in the winter, only spring and fall series are feasible.

This is a primary prevention program (giving women the knowledge of services and encouraging the strengthening of community linkages) with secondary and tertiary prevention aspects. The outreach service provides a non-stigmatizing forum (attracting women to

educational workshops on parenting skills, welfare rights, legal rights, nutrition, budgeting for new mothers, job re-entry skills) but one that can also address more sensitive issues such as the effects of battering, improving self-esteem and prevention of violence against women and children.

In the project's first year, two women's support groups (involving 13 participants) were established. They were co-facilitated by survivors and/or volunteers who work with victims of family violence. The facilitators received training in group dynamics, communication skills and feminist counselling principles. Training was also open to other group members who want to take leadership roles within the groups. The support groups are open ended; evaluations are solicited at 10-week intervals to monitor member satisfaction and help keep the groups on track. These two groups stopped in the fall. There is interest in beginning them again in the spring and some women in a third community are considering forming a group if numbers permit.

The groups have chosen to meet in members' homes or in a "neutral" location such as a church meeting room. Group rules specify anonymity (for the volunteer facilitators as well as other participants) and confidentiality; meeting times and locations are not publicized. To help maintain privacy, all referrals are through the Naomi Society office. The original idea was that meetings should be "incognito" if possible (i.e., women may not want it known they are attending a group but might rather say they are visiting).

The school-based component is a primary prevention program, emphasizing alternative methods of family conflict resolution. Staff are developing a video, aimed at Grades 4 to 6, using the NFB film, Feeling Yes, Feeling No, as a model. They have enlisted the technical assistance of a local video company and the skills of some experienced actors and teacher advisors. Local children were cast in the youth roles and a national broadcaster volunteered to do the narration.

Three in-school workshops helped generate the conflict scenarios. Scenes portraying various levels of family violence and situations of peer conflict were selected. The video promotes assertiveness and problem-resolution skills. it has a double (non-stigmatizing) message, recognizable for children in violent families but also one that places that experience within a general context of conflict solving that all children face. The video and a study guide will be available in early 1993.

A straightforward tertiary prevention program, the mother-centred component is designed both to assist mothers to help their traumatized children and to provide direct help to the children. One component is a help and referral line, staffed during office hours by Naomi Society's receptionist or a project assistant. It has received a wide range of inquiries, including some from single parent fathers looking for support services. The other component of the Child, Adolescent and Mothers' Support Service is space adjoining the society's offices. This facility includes a play therapy room, another counselling office or group meeting room and a kitchenette. The child/adolescent counsellor offers individual or group therapy, information and counselling to mothers about their children's needs, and can also follow up with home visits, act as liaison between mother and community professionals, and is available to do public education.

Like this rural outreach program, the next project also aims at serving a previously ill-served and somewhat isolated population segment and emphasizes self-help group formation (as a mechanism of empowerment and social linkage) and information resource development. The parallels are somewhat masked by the differences in the target groups and the sponsoring organizations involved.

National Youth in Care Network: Local Development Project[45]

The National Youth in Care Network grew out of an invitation in 1985 to seven young people to address the International Child and Youth Care Workers Conference in Vancouver on the issue of youth empowerment. Thinking through their presentations made the youth involved even more aware of their experiences of disempowerment. They felt that:

> The child welfare system is breeding dependency ...and many young people are graduating into the ranks of the homeless, the jobless, the friendless, the drug-addicted, or any combination of these.[46]
>
> Historically, [youth in care] have never been asked for our opinions and input in the care that the state has taken the responsibility to provide. However, this situation is rapidly changing. As the challenges for us and care givers become greater ...caregivers and service providers everywhere are turning to us, the consumers, for our insight.[47]

They decided to form an organization that would provide a voice for youth in/from care, aged 14 to 24, and also act as a support group. The result was the creation of the Network in 1986. By way of fostering the development of local groups, the Network proposed the writing of a resource manual and an associated training program.

> One of the major roadblocks to local development appears to be a basic lack of know-how and skills young peole aren't quite sure how to start and maintain local groups, and adult supporters aren't exactly sure how to support the youth in their efforts.[48]

The manual contains information on how to start a group, find a place to meet, get administrative support and supplies, hire youth staff, arrange transportation and other bread-and-butter issues. It discusses the role of adult supporters and where they might be recruited. Membership recruitment is another key topic, much of the information reflects the experience of existing groups.

Planning and running meetings and events is the central topic. The manual describes various approaches and strategies. One section is a workbook originally developed for use by youth-in-care delegates to conventions to help them cohere quickly as a group. It includes all sorts of suggestions for group activities: name games and ice breakers, games that focus on interpersonal relations and communication skills, on risk taking and stress reduction, and personal awareness.

The draft manual (and introductory training workshop format) was pilot tested in new or developing groups in Port Moody, British Columbia, Saskatoon and St. John's (and, in its earliest drafts, in North Bay, Ontario). Comment was also received from other local groups that were sent the draft material for review. The suggestions were mainly to make some sections even more practical. For example, ways were needed to alert adult supporters about effective communication (e.g., in style, word choice) with the youth membership. As well, additional fund-raising ideas were wanted. The Network's national development officer is planning a national workshop to train youth in the use of the completed manual. This workshop will also improve inter-regional linkages. The finished manual will be available in early, 1993 and will be widely advertised in the child welfare field.

III. Family Support Projects in Child Welfare Contexts

Many of the demonstration projects above have anticipated the set of family support projects presented next. Tertiary prevention programs, because they "pick up the pieces," constantly point back to primary prevention, that is, to the need to stop tragedies before they occur by concentrating on the conditions that underlie problems of abuse. Treatment is inherently incomplete unless these conditions are addressed. To take one example, the Marymound project tried to include families in their treatment programs for adolescent offenders and victims only to find that often these parents were not in a state to participate.

Attempts at more fundamental change generally have taken an ecological approach recognizing the individual within a family, a broader personal social network, a community. These social ties represent both key supports for the individual and some ongoing risks. This perspective points to strategies that aim to build supportive personal social networks or to develop positive community structures or both. These approaches explicitly set out to involve people and empower them. More than most of the treatment-oriented projects above, fan-lily support projects involve "working with" people rather than "working on" cases.

Family support approaches are receiving wide recognition and increasing support these days. Although many of the prototype programs come from the United States, Canada has developed both its own substantive analyses and funding mechanisms.[49]

The three demonstration projects reviewed here all focused on promoting the capacity of disadvantaged parents to construct more supportive personal social networks. They shared other common features, stemming from a parallel analysis. Research has shown that parents depend on social supports for information and advice, concrete assistance and validation.[50] Without these resources to counterbalance the stresses of childrearing, poverty, marginality, etc., the risk that parents will be abusive toward their children increases.

Some parents lack the social skills to build positive social networks. A history of abuse may leave them without trust in others or faith in themselves. They are at times passive and withdrawn, or aggressive, insensitive and demanding.

Some parents lack the resources necessary for sustaining relationships. They are handicapped by lack of mobility, information about potential sources of assistance, or cash. And they can be burdened by inadequate or unsafe living conditions, and heavy child-rearing demands. These demonstration projects looked at three ways that child welfare organizations could be involved in addressing these problems.

"The Friendship Group": A Social Support Training Project[51]

The Social Support Training Project was not a full-fledged family support program; rather, it was a component part of one, a formal skill-training curriculum taught in a weekly group meeting (The Friendship Group) over 16 sessions. It was meant for people (e.g., single parent mothers) who lacked basic social skills and therefore experienced isolation. Many of these parents had a history of destructive friendships and relationships or at least an unfavourable balance between

supportive and negative social contacts. Their lack of personal supports arguably increased the risk of child maltreatment.

The curriculum had been tested first in Seattle, Washington, it was implemented on a demonstration basis in Vancouver. The parents were clients in agencies that provided therapeutic daycare and parenting education. All were identified by child protection workers as having serious parenting problems. Most had low incomes. All but two were females Many had mental health problems; a majority had substance abuse problems. Significantly, most were also abuse survivors.

> Few have had any treatment to help them deal with the emotional consequences of their own abuse histories. As a result, trust and boundary issues frequently interfere with their relationships with others. Many remain enmeshed in abusive family-of-origin networks. Even the word "friend" may be a troublesome concept to these parents. "Friends" all too often are the very people who have stolen their money, turned them in to the child protection officials or taken advantage of them in some way.[52]

The researcher developed the curriculum based on a striking observation made at an earlier parent support group:

> Bringing parents together in a weekly group meeting seemed to have little effect on relationship development. While parents had the opportunity to get to know other parents, they rarely made friendships that they considered significant. Rather, most parents continued to prefer to interact primarily with staff members ... [because they] made much more rewarding network members. They offered the praise, attention and concrete help that was rarely forthcoming from other parents. *It was as if the majority of parents did not know how to be a rewarding friend.*[53]

The course was built around a sort of board game metaphor, with a "relationship roadmap" that ran from the relatively populous *Aquaintanceville* through progressively more intimate *Buddyborough*, Friendly *City and Personal Friendsville to Partnersburg* (population 1). Using this game imagery, the manual for group leaders covered the nature and stages of relationships, communication skills and access to community resources for network development. Attention was given to helping participants determine whether a relationship seemed safe (or was exploitative or threatening). The approach was low-key, collaborative rather than competitive and, as much as possible, humorous, to make learning a rewarding experience.

The demonstration project tested the effectiveness of the project with 25 parents. Their personal social networks became somewhat less dense, less kin-based, included more neighbours and fellow participants in organizational activities. However, the researchers noted a shift, not so much in the number of friends that these mothers had, as in how existing ones were viewed and valued.

> They value their social contacts more and place less reliance on family networks. Thy are empowered in their relationships with friends. For some people, the group offers beginning information on how to act, think and feel in new ways with friends.[54]

This short, formal intervention was seen only as a beginning. Members were encouraged to develop plans for further work during the last month of the group. Participants were recognized in a formal "graduation" ceremony. Beyond that, follow-up was offered on an individual basis to support ongoing personal social network change.

Parent Mutual Aid Organizations[55]

Whereas the previous project tested a curriculum, the Parent Mutual Aid Organization (PMAO) project sought to set up the sort of ongoing mutual aid groups among high-risk parents that this curriculum could enable. This demonstration project was carried out by researchers from the Centre for Social Welfare Studies, Wilfred Laurier University in cooperation with the Children's Aid Societies in three southwestern Ontario cities.

The research asked two main questions:

1. Is it possible to create mutual aid organizations that bring informal helping resources within the reach of high risk families? and
2. Are partnerships between child welfare agencies and mutual aid organizations feasible and do these partnerships represent a preferred way of reaching families in need?

The "conventional wisdom" held that parents fear child welfare agencies because admission of family problems can raise questions about apprehending their children. However, the sponsoring agencies saw great potential benefits in adding parallel informal helping mechanisms to the formal services they provided. Because families generally faced multiple stresses, and because it was hard (and somewhat artificial) to determine which of these should be dealt with first, it was not possible in practice to address all the family's needs with available formal services. Informal self-help and mutual aid approaches offered a range of additional opportunities and allowed participants to work at reducing many areas of stress simultaneously.

The researchers found support for this perspective in the literature:

> Mutual aid groups that work seem to have several characteristics: members share a common experience, membership is voluntary, equality among members is stressed, members meet regularly, and leadership is provided by members themselves.[56]

The literature indicated as well that family support programs were successful to the extent that they established ongoing and multifaceted direct contact.[57] So the PMAO project aimed to provide various opportunities per week for participants to meet, a variety of services (parent relief, information, personal development courses, emotional support), facilitation in making friendships that extended outside the group setting, and opportunities for members to take on volunteer or leadership roles and participate more widely in the community. By engaging in positive social interaction and finding that they could reciprocate in assisting others as well as asking for assistance, parents could build a greater sense of self-worth.

Each of the groups was staffed by a skilled but non-professional facilitator. In Brantford, some programming was scheduled for each day of the work week and some weekends. All parents in child welfare cases were invited to join. Most of the participants were young mothers, generally with pre-school-aged children.

Each PMAO activity included a "check-in" component, which gave members a chance to talk about issues of personal importance and work out tensions in the group. In the early period, recreational activities predominated. For instance, an aerobics class proved to be a socially acceptable activity which also allowed the group to address broader issues of health, nutrition, body image and self-esteem. A nursery program with a period for supervised parent-child interaction provided respite, a chance for socializing and parent skill training. Weekly drop-in "pot luck" meals were actually carefully planned events, allowing participants to contribute, attend a supportive family-oriented event (which attracted some fathers as well), and also provided real assistance in varying the diet and serving something special, especially in the period between welfare cheques. In fact, project staff

found that the parents tended to plan a whole calendar of special events doing the budgeting, fund raising and organization of celebrations for birthdays, holidays, graduations, even a dinner in honour of a parent winning a child support enforcement case. The Children's Aid Society of Brantford was able to offer space for most of the local PMAO activities in its Family Resource Centre, which had a daycare, various meeting rooms and a hall).

The PMAOs planned various services that were new to the sponsoring agencies. For example, one group raised funds to hold a one-week summer camp for families; the Children's Aid Society had traditionally run only children's camps.

These experiences allowed the project staff to generalize about group organization and process:

1. The organization can be hard to start and may take three to five years to get established.[58]
2. The emphasis has to be on member empowerment even at the expense of getting tasks accomplished.
3. Good group habits (caring, responsible behaviour, member ownership of group well-being) have to be fostered from the beginning; many parents will have little background in group participation.
4. Organizations grow through definable stages and have to be properly resourced from the beginning if they are to succeed.
5. Collective decision making, suitable in a small group, must change and become more formal as it grows.
6. Powerful and dysfunctional members have an impact; the group facilitator and nascent group leaders must be aware of process issues.
7. Support resources (space, child care, transportation) are critical.
8. The linkage with and support within the host agency are crucial variables. Working with clients may require a new approach for agency staff, they may require training and encouragement to change.

Overall, the demonstration projects received positive evaluations. PMAO members were compared on various measures (e.g., self-esteem, parental attitudes, perceived life stress, use of welfare services) with a non-random but probably lower-risk comparison group of child welfare clients. Generally, the parents in the mutual aid groups showed consistent overall change, the comparison group showed no such pattern of change. This was the single most telling finding for the sponsoring agencies. The comparison group was receiving all of the usual formal services; clearly, these alone were not enough to promote change.

Between 20% and 60% of all child welfare clients referred to the PMAO attended program activities more than 20 times. The projects attracted and kept the participation of a significant number of high-risk parents.

The issues of whether group participants required less attention from child protection workers and whether their children had a lower risk of coming into care were important in demonstrating the cost-effectiveness of this approach. The PMAO parents required out-of home placements for their children only one third to one half as often as the controls. These placements were largely the short- to medium-duration.[59] The researchers were able to estimate a large cost saving, enough to substantially support the cost of this enhanced service.

The Neighbourhood Parent Support Project[60]

This final demonstration project took the already ambitious goal of fostering positive change in parents' personal social networks and added a second explicit emphasis, that of building a community with pro-family norms and values. Thus, while the actual demonstration was small in scale, its conceptual scope was huge.

The Neighbourhood Parent Support Project (NPSP) was based on research carried out in the 1970s by James Garbarino, a noted U.S. specialist in child welfare. Those studies[61] showed that residents in neighbourhoods that were characterized by high levels of child maltreatment tended to have personal social networks that were non-supportive of parenting and pro-child values.

> The research ...demonstrated that, in two equally impoverished areas, there were different levels of child maltreatment incidence ...attributed to different stress and support levels experienced by the parents in the respective neighbourhoods... These findings led [the authors] to conclude that formal services would need to change from a one-to-one rehabilitation model to a community consultation one in which the clients, in addition to being children and families, would be social networks and neighbourhoods.[62]

One clear implication was that formal service programs alone would never have a sufficient impact on families in these neighbourhoods; informal helping structures must also be mobilized. In Winnipeg, some moves had been made to improve formal service delivery to families at the neighbourhood level. Notably, in the late 1960s and 1970s, child and family resource centres emerged as the front-line preventive service delivery approach in one of six regional family and child welfare service agencies in Winnipeg. But, even in this region, the change was not enough to represent a real paradigm shift to an ecological model; the agency's interventions were still formal and at the personal level connecting parents with homemaker services, respite care, Big Brothers, etc. Since people continued to prefer to use informal supports before formal ones, these agency services tended to be called on in last resort situations, if at all.

The service gap became all the more evident as fiscal constraints grew more stringent in the 1980s.

> Recent service cutbacks have resulted in a decrease in "supportive" type services and an increase in authoritarian protective type services ...[which] create a high level of suspicion and mistrust ...[and contribute] to service avoidance ...[and perhaps] to the high rate of inner-city mobility which has been observed amongst these families. Thus a vicious cycle of authoritarianism, fear, mistrust, service avoidance, and service provision only at times of crisis emerges.[63]

Based on this analysis of the deeper needs of families within a community context, the goal of the NPSP was to demonstrate:

1. a method of intervening in informal personal and neighbourhood networks to strengthen their support for parenting[64];
2. a way to mesh these informed supports with existing formal services; and
3. an approach to measuring the relationship between stress, social supports for parenting and risk for child maltreatment that would both guide and indicate the success of these service approaches.

The researchers, from the Faculty of Social Work at the University of Manitoba, selected two small high-risk neighbourhoods in central Winnipeg for the demonstration. They used an elaborate method, involving consultations and ethnographic study, to characterize and compare the two areas. While there were differences (especially in ethnic composition), they found that parents in both areas were experiencing high stress related to a common set of factors worries about parenting, depression, extreme thinking and weak parenting support networks. The NPSP hoped to test its approach in both neighbourhoods. However, the need for a multilingual, multi-cultural approach in one of these made a demonstration project too complex to set up there and so that area was used as a comparison instead.

The major innovation of the NPSP was the introduction of a new kind of service provider, the Parent Support Worker (PSW). This role bridged the two traditionally distinct roles of caseworker/parent counsellor (dealing with personal network enhancement) and community organizer (facilitating change in local social organization).

The PSW's activity with mothers included helping them map their personal social networks. This identified formal and informal supports for parenting, stresses and gaps in their support systems, and negative connections (e.g., relatives, friends or neighbours who promoted or participated in risk-inducing or disruptive activities such as quarrelling, drinking and drug-taking). The PSW then acted as a consultant to the mothers to help them change these personal connections in ways that would activate support and reduce stress.

> She "connected" with people at ...family centres, parent-child centres, daycare centres, apartment building play centres and parent time-out programs. She also floated freely about in the neighbourhood, stopping in at coffee shops, restaurants, laundromats, churches and apartment buildings. As well, she connected with formal service providers such as Child and Family Service offices ... social assistance offices, public health nurse, youth outreach workers and community ministry workers.[65]

The PSW had direct contact with about 100 parents over a two-year period and worked intensively with a cohort of 26 women and their personal social network contacts. The PSW also worked with a number of natural helpers and connectors in the neighbourhood who were used as referral resources for project parents.

In some situations, cognitive exploration of the network map ...might be sufficient to assist the parent in developing a more supportive network. In other cases, it might require that the worker and parent convene meetings with service providers, other neighbourhood members and family to dear up stress-laden communication channels and to develop more supportive approaches... Other situations might require that the worker personally assist the parent by connecting the parent with another person and reinforcing the tie... In all these activities, the worker might coach the parent in social skill development, how to communicate in a given situation ...making better use of available resources, and advocating for herself.[66]

The study illustrated that this work was very intensive and required a rare combination of skills. Introduction of such a role also took careful planning and sensitivity because it is new to community members, many of whom were resistant to the notion of another social service professional being "parachuted in." As well, the PSW had to overcome resistance within the formal service sector, some workers feared that community networking would connect parents informally rather than to formal services and so make cases even more difficult to manage.

The researchers sampled stress, parent support levels and relative child maltreatment risk in the project neighbourhood and the control one at the beginning and end of the intervention. Similarly, the stress/support and risk levels for 17 parents in the project were tracked over the period of the project. As well, the personal social networks of 9 of the parents (5 high risk, 4 low risk) were mapped in sufficient detail over this period to enable an assessment of the results of the intervention. In the project report, the presentation of these findings made for heavy reading; the implications were often hazy. Fortunately, at least the general direction of these findings was clear:

> In other words, when support is high in proportion to stress, risk can be expected to go down ...[67]

Overall, project results were encouraging. At the micro level, participating parents' enlarged and

diversified over time; the number of neighbour-friends grew and ties to family members decreased. The level of emotional support, information exchange and advice increased, especially among the high-risk parents. More broadly, the personal social networks of the project parents began to cluster and give more sense of community in a milieu where parents were in the minority.[68]

The number of parents directly involved in the project was too small to clearly affect the measure of overall neighbourhood vulnerability to risk. However, the researchers note many indications that were consistent with the project having a positive effect. The comparison neighbourhood had less personal and family violence and better child care norms than the project neighbourhood; despite this relative advantage, the level of risk for child maltreatment was not any better than in the project neighbourhood. The researchers argued that this suggested that other parental supports were improving in the project area and compensating for the stressors.

At an organizational level, the PSW can be demonstrated to have become a significant community resource. The project recruited a mother to compile a neighbourhood information and resource brochure; 1000 copies were distributed. Because of the high mobility in the area, this brochure was especially welcome as an introduction to local services. A social work student was used to facilitate formation of a mothers' babysitting cooperative. The PSW took over the facilitation of a respite program, the Parents Thursday Morning Out group. She also helped convene a "neighbourhood assembly," attended by 28 parents and agency representatives. It was a forum for presenting parent needs and concerns.

Based on the project results, the researchers felt confident in recommending that a PSW position be created in every inner-city neighbourhood. They remained convinced that child welfare services (including homemakers, parent aides, respite care, parent education and parent support groups), public health, recreation, education, and employment services all should be delivered from a neighbourhood Family Resource Centre. Finally, the researchers recommended that child protection services be organized on a larger scale but be delivered locally, perhaps also out of Family Resource Centres.

IV. Discussion and Summary

NWG's new mandate is to emphasize the values of social investment, social participation and strengthen the social welfare network through its project funding. This paper reexamined a set of 11 recent NWG-funded demonstration projects (eight of them completed, three in their final stages) from that vantage point.

Looked at as a set of projects that were all testing current ideas about child welfare and related issues at about the same time, it is perhaps not surprising that certain themes arose repeatedly.

One observation is that our growing knowledge base raises complexities and interconnections that workers weren't likely to think of in the past. Professionals and workers in a wide variety of fields have to be much better trained and also open to making continual investment in further learning and skill development.

Two of the child abuse projects provided good illustrations of this point. The Multiple Personality Training Model showed how an apparently "exotic" phenomenon has become understood as a relatively common response to child sexual abuse, frequent enough so that a whole range of professionals in social services, health and justice have to take it into account in their clientele. Similarly, the Marymound Model demonstrated some of the complexity in dealing with adolescent abuse victims who were themselves starting to offend; new skills and approaches were demanded. The child welfare projects added another dimension children who grew up with violence (even if they were not the targets) were also victimized by that experience and suffered consequences similar to other abused children. This not only suggested the need for new services for these children, but also broader training for service deliverers.

It is trite to observe that people want better services, a stronger and more skilful response. Demonstration projects, because they tend to be relatively well resourced and see themselves as exploratory, sometime succeed in getting beneath these statements of pious intent. For example, the survey on Educating Professionals for Child Sexual Abuse Treatment confirmed a general desire for better levels of training but also exposed major obstacles to achieving this. Key actors were shown to have systematically divergent views about the place that should be given to specialized training; in particular, workers faced a situation where their knowledge and skills in child sexual abuse treatment were seen as broadly inadequate but this area was neither about to be given greater priority during professional training nor supported sufficiently through continuing education. This set of findings gives advocates some levers to try to move beyond rhetoric to change.

Another maxim that often deserves genuine attention is the medical intervention motto: "do no harm." Several demonstration projects took on the issue of secondary abuse. The London Family Court Clinic Child Witness Project was developed in a context where many people across Canada questioned whether our legal response to child sexual abuse represented a further victimization of the child. Its findings were important across the whole range of organizations involved in child sexual abuse cases in refocusing and defusing that argument. The Youth in Transition project noted how transition houses, although of great value as an intervention in wife-battering situations, had to be recognized as part of an ongoing crisis from the point of view of the children. The National Youth in Care Network project was explicitly about remediating the effects, often long term and systemic, of our efforts to protect children by placing them in alternative care.

A third shibboleth is coordination. Calls for interagency, interdisciplinary coordination have been prominent in the literature on child abuse and, more broadly, within child welfare. However, several of these demonstration projects could legitimately claim that trying to achieve better coordination in practice was their truly novel aspect. The Manitoba Rural Child Sexual Abuse project centred on this point. It produced some very nuanced findings about difficulties in achieving coordination, information which is critical to policy makers and program planners considering system reform. Its own innovation was the creation of several coordinating and case management roles to try to achieve better levels of service for clients. In a somewhat similar fashion, the Neighbourhood Parent Support project developed a new worker role to try to bridge the divide between formal service systems and informal supports. The skills needed to perform these coordinating roles are hard to find (and are rarely taught). If we are to go further in these directions, there are training, disciplinary boundary and other issues of "control" and "turf" that require serious attention.

A fourth catchphrase is involvement of family and community. In different ways, many of the demonstration projects focused on tills. The family support projects all sought to provide mechanisms (training, coaching, fostering mutual aid) that would empower and link vulnerable people. The Parent Mutual Aid Organizations and the Neighbourhood Parent Support Project also aimed to build a more supportive community for embattled parents. But this process was hardly straightforward. For many clients in family support projects, the goal was to move away from reliance on destructive kin relationships and build supportive, more egalitarian relationships with friends and neighbours. That point underlined the fact that neither fancily nor community are resources that can be taken for granted; often they must be developed. Thus, the Marymound project was unable to fully test the enhanced family involvement component in its adolescent treatment model because the families were not at a point where they could participate. Similarly, the Rural Outreach project in Antigonish had to deal with the fact that rural communities did not simply lack certain resources but that the nature of life in a small community (e.g., relative isolation, lack of privacy, strong social values about family integrity) presented obstacles to developing family violence prevention and treatment services.

These observations find an easy translation into the language of NWG's new mandate. For instance, the points just discussed imply a need for increased social investment in family and community. Newly popular ecological perspectives again situate "cases" within the larger contexts of family, community and society. In these terms, comprehensive assistance means programs that empower individuals, connect them within a larger milieu and thereby break the causal chain that leads to revictimization or creates a risk of intergenerational abuse.

A second implication is that broader social participation is necessary. One approach taken in various projects is to mobilize individuals through mutual help and client empowerment strategies. Another focus is to facilitate the spread of our best strategies by testing demonstration and development projects with rural, regional and minority bases.

These two sets of implications in turn place an emphasis on the third, the need to strengthen the social welfare network so that it can enlarge its perspective, act flexibly and absorb new ideas quickly. This means commitment to ongoing and innovative training (as noted above, a focus in several projects) and more attention to effective dissemination of knowledge. Beyond that is the need to test mechanisms that turn mere expressions of the desirability of interdisciplinary coordination into actual integrated response. Again, a number of demonstration projects experimented with new bridging roles to work within the formal service system or to foster formal-informal system linkages.

One thing that tends to unify this assemblage of surveys, studies, training curricula, comparisons of treatment approaches and various social experiments, is precisely that all are demonstration projects. Demonstration projects are selected because they test the "new wisdom," and certain ideas are in the wind. For the same reason, demonstration projects rarely appear radical; in fact, many become part of the new wave of accepted knowledge even before they have completed their work. Programs for children who have witnessed family violence have become relatively accepted. Similarly, child witness support programs did not wait for publication of the findings of the London Family Court Clinic study, however well received this report has been.

More generally, an argument can be made that demonstration projects' positive findings tend to be undervalued for several reasons. One is a result of the developmental nature of so many of these projects. They have obstacles, they tend to change as the staff learn more about the issues, and they tend to document all this faithfully. In short, they appear less impressive than they might. Of course, from a program planner's perspective, this level of intellectual honesty is important and truly impressive, because it takes risks, leaving programs open to easy criticism.

Most of these demonstration projects were small scale. Even the conceptually most ambitious projects in this grouping (e.g., the Manitoba Rural Child Sexual Abuse project and the Neighbourhood Parent Support project) involved relatively few clients.

The NWG demonstration projects are generally not the only initiatives that are testing currently "hot" ideas. Often, the knowledge base is growing along several fronts. For example, in terms of the topics in this set of demonstration projects, treatment for adolescent sex offenders, child witness preparation and family support approaches have all been mushrooming in North America.

Finally, however, positive findings hardly guarantee that any particular demonstration project will be swamped by a tide of similar programs. For example, notwithstanding the cogency of the Manitoba Rural Child Abuse project, there is still much more proscription of coordinated case models than actual implementation of them.

All this places a heavy burden on NWGs if optimal benefit is to be derived from the hard-won experience of the demonstration projects it funds. There needs to be strong commitment to timely and broad discussion of project results. NWG has seen that responsibility in terms of fostering dissemination of the project reports, publication of accessible summaries and presentations at workshops and research conferences. This paper marks another sort of initiative, discussing a set of topically related projects together. Also considered are mechanisms such as sponsored symposia to bring together staff and researchers from related demonstration projects and others active in the same field. In fact, because of the pace at which development takes place in certain instances, the program may help sponsor workshops early in the demonstration period to consider interim results and implementation issues.

In summary, there is certainly scope for these NWG demonstration projects to live up to their mandate. Not all were uniformly "successful" or equally "important." At the same time, each has legitimate lessons to teach. And, aside from the needs they raise for consolidation of new knowledge, the demonstration projects tend to identify some of the next set of hot topics (for the field as a whole, not specifically for NWG as one funding Program). In this instance, the Marymound research on treatment programs for adolescent sex offenders leads directly to the need to consider evolving programs for sexually reactive and sexually intrusive children. The Rural Manitoba case management model begs the question of what other case coordinating mechanisms are workable, especially in the

absence of resources to support full-time coordinators. Multiple personality and other dissociative disorders are central to the emergent issue of ritual abuse. Child witness preparation and support projects touch directly on the research topic of victim statement validation and the service issue of support programs for adult survivors of abuse who are now parents. The family support projects, with their emphasis on strengthening personal social networks and developing neighbourhood support, need to be situated within a continuum in which increasing prominence is being given to formal, holistic but short-term (crisis) services — so-called "family preservation" programs. To round out this list, the rural family violence and child abuse prevention projects indicate the need to explore approaches in isolated communities, notably initiatives in reworking native child welfare and promoting community healing on reserves and in remote and northern communities.

Notes

1. National Welfare Grants. (1991) "A Social Development Framework for National Welfare Grants." Internal discussion paper, p. 1.

2. Ibid., diagram 1.

3. Carignan, P. (1992) *Parents and Children, Winners: Five Promotion and Prevention Projects*. Quebec: Centre de recherche sur les services communitaires, Laval University.

4. For a further perspective, see Whitmore, E. and Kerans, P. (1988) "Participation, empowerment and welfare." *Canadian Review of Social Policy*, 22, pp. 51-60.

5. Avis, J.M. *et al*. (1992) "Meeting the Challenge: Educating Professionals for Child Sexual Abuse Treatment." Summary report. University of Guelph, Department of Family Studies.

6. Ibid., p. 19.

7. Ibid., p. 19.

8. Rivera, M. (1991) *Education/Dissociation: An Impact Assessment*. Report to NWG; 27 December 1991.

9. See: Kempe, C.H. et al. (1962) "The Battered Child Syndrome." *Journal of the American Medical Association*, 181: 17-24; and Pfohl, S.J. (1977) "The 'Discovery' of Child Abuse." *Social Problems*, 24 (2): 310-323.

10. See: Koel, B.S. (1969) "Failure to Thrive and Fatal Injury as a Continuum." Reprinted in J.V. Cook and R.T. Bowles, eds., *Child Abuse: Commission and Omission*. Toronto: Butterworths, 1980: 73-76.

11. For a general review of this history, see: Wachtel, A. (1989) *Child Abuse: Discussion Paper*. Ottawa: National Clearinghouse on Family Violence, Health and Welfare Canada. Note, too, that this rediscovery had an important other stand aside from the movement against child abuse. This was via the movement against violence against women, where the issue was raised powerfully by adult survivors. For some of this history, see the citations in Rivera, M. (1992) *Multiple Personality: A Training Model*. Toronto: Education/Dissociation.

12. Education/Dissociation (1991) *Multiple Personality: Putting Many Faces on Child Abuse*. (video)

13. Supra, note 11, p. 3.

14. Ibid., p. 3.

15. Ibid., p. 18.

16. Ibid., p. 17.

17. Campbell, Linda et al. (1992) *The Marymound Model: A sequential approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims*. Winnipeg: Marymound/Popular Printers.

18. Ibid., p. 12.

19. Ibid., p. 15.

20. Ibid., p. 21.

21. For a review of some of this literature, see Wachtel, A. (1992) *Sexually Intrusive Children: A Review of the Literature.*

Vancouver: Greater Vancouver Mental Health Service Society.

22. The researchers also speculate that there are inherent contradictions in the adolescent offender situation that make family involvement problematic. That is, the need for the family to set clear boundaries and monitor the adolescent's activities is inevitably in conflict with the adolescent's developmental need to separate and differentiate himself from his parents.

23. Sas, Louise *et al. Reducing the System-Induced Trauma for Child Sexual Abuse Victims Through Court Preparation, Assessment, and Follow-up*. London, Ont.: Child Witness Project, London Family Court Clinic.

24. Ibid. *Executive Summary*. London, Ont.: Child Witness Project, London Family Court Clinic, p. 1.

25. Ibid., p. 5.

26. Ibid., p. 1. This overview suggests a more uniform approach than was actually implemented. The package was applied in a personalized fashion as needed; children averaged four one-hour sessions before the preliminary hearing and two before trial five on average overall. Most were taught etiquette, roles in the courtroom, giving evidence, etc. Fewerused the judges gown, etc. Breathing strategies, cognitive restructuring and strength or coping enhancing strategies were used fairly often, 70% developed a list of positive reasons for going to court. Victim impact statements were prepared in 32% of the cases.

27. Ibid., p. 6.

28. See 26 supra.

29. Levine, K. and Scott, K., eds. (1991) Manitoba Rural Child Sexual Abuse Project: A Brief Overview.

30. Ibid., p. 1.

31. Ibid., p. 6.

32. Ibid., p. 6.

33. Ibid., p. 8.

34. Ibid., p. 10.

35. Adkins, E. et al. (1991) *Child Sexual Abuse in Rural Community Settings: The Implementation and Evaluation of a Coordinated Service Model*. Final Report. Winnipeg: Child and Family Research Group, Faculty of Social Work, University of Manitoba, p. 186.

36. Supra, note 29, p.11.

37. Ibid., p. 5.

38. Supra, note 35. p.73.

39. Ibid., pp. 187-188.

40. Poff, D.C. and Trull, W. (1988) "Group Counseling Project: Teenagers at Bryony House." Funding proposal to National Welfare Grants, Aug. 1988. Information on the first year of the project has been published in: Marsh, S. "Youth in Transition Answers a Need." *ISW Bulletin* (Institute for the Study of Women, Mount St. Vincent University), Fall 1990, pp. 8-9; and Marsh, S. "Trying to Understand Family Violence: A Room of Their Own." *ISW Bulletin*, Spring/Summer 1991, p. 1 et passim.

41. For a provocative and probably somewhat overstated analysis, see Finkelhor, D. (1983) "Common Features of Family Abuse" in D. Finkelhor et al., eds., *The Dark Side of*

families. Sage Publications, pp. 17-28. Available as a reprint from the National Clearinghouse on Family Violence, Health and Welfare Canada.

42. Moore, T. et al. (1990) "Research on Children from Violent Families." *Canada's Mental Health*, 38, 2/3. Available as a reprint from the National Clearinghouse on Family Violence, Health and Welfare Canada.

43. Naomi Society. (1989) "A Holistic Response to Victims of Family Violence in a Rural Environment." Demonstration Grant Proposal, Noami Society for Battered Women, August 1989. An interim report on the project has been published: Falconer, L. "Rural Outreach Program Summary." Naomi Society for Victims of Family Violence, October 1992.

44. Naomi Society. (1992) *Annual Report, 1991*. Naomi Society for Victims of Family Violence, March 1992.

45. National Youth in Care Network (1989) "Local Development Project: Strengthening the Backbone of the National Youth in Care Network." Proposal to NWG, August 1989.

46. National Youth in Care Network (1991) Local Development Manual. Draft: June 1991, p. 3.

47. Ibid., p. 2.

48. Supra, note 47, p.4.

49. For an overview of U.S. approaches, see: Zigler, E. and Black, K.B. (1989) "America's Family Support Movement: Strengths and Limitations." *American Journal of Orthopsychiatry* 59 (1), January 1989; pp. 6-19; and companion articles in this special issue of the journal. For an influential Canadian review, see: Ministry of Community and Social Services, Ontario (1990) *Better Beginnings, Better Futures: An Integrated Model of Primary Prevention of Emotional and Behavioural Problems*. Toronto: Queen's Printer, and, with regard to a funding mechanism the Child Development Initiative, targeted at community-based support programs for infants and young children: Health and Welfare, Canada. (1992) *Brighter Futures: Children Matter*. Ottawa: Supply and Services Canada.

50. Notably, these projects acknowledge the influence of the American social ecologist, James Garbarino, as in his book: Children and Families in the Social Environment. New York: Aldine, 1982.

51. Lovell, M.L. (1991) *The Friendship Group: Learning the Skills to Create Social Support. A Manual for Group Leaders*. Vancouver: The Social Support Training Project, U.B.C. School of Social Work.

52. Ibid., p. 4.

53. Ibid., p. 5; emphasis added.

54. Ibid., p. 5.

55. Cameron, Gary *et al*. (1992) "Parent Mutual Aid Organizations in Child Welfare Demonstration Project: Summary and Highlights." July 1992.

56. Ibid., p. 2.

57. For a concise review of the factors that promote project success, see supra, note 3.

58. For a parallel project with a long history, see the description of La Maison des Parents, supra, note 3.

59. For an interesting partial contrast, a program that sought to avoid long term placement by making brief respite placements at the request of the mother very easy to arrange, see the description of Familles Gardiennes de la Basse-Ville in Quebec, supra, note 3.

60. Lugtig, D. and Fuchs, D. *Building on the Strengths of Local Neighborhood: Social Network Ties for the Prevention of Child Maltreatment*. Final report of the Neighborhood Parenting Support Project. Winnipeg: Child and Family Service Research Group, Faculty of Social Work, University of Manitoba.

61. Garbarino, 1976; Garbarino and Crouter, 1978; Garbarino and Sherman, 1980.

62. Supra, note 60, p. 1.

63. Ibid., p. 182.

64. For a similar personal social network approach, but using non-professional workers, see the description of the Connexion project in Quebec, supra, note 3.

65. Supra, note 60, p. 6.

66. Ibid., p. 7.

67. Ibid., p. 162.

68. For a broadly parallel analysis of the situation of "vulnerable" families and how parents can move from isolation to mutual aid and community action, see the description of La Perentele, a project in Laval, Quebec, supra, note 3. More information on this project is now available; see: Gusse, I. *et al*. (1992) *La Parentele: Summary Report of the Pilot Project*. DSC Cité de la Santé de Laval, September 1992. Telephone (514) 686-2000.

Contacts

1. Educating Professionals for Child Sexual Abuse Treatment Survey: Dr. Judith Myers Avis (Principal Investigator), Department of Family Studies, University of Guelph, Guelph, Ontario N1G 2W1.
   Telephone: (519) 824-4120.

2. Multiple Personality Training Model Project: Dr. Margo Rivera, Director, c/o Maijory Old, 133 Silverstone Drive, Rexdale, Ontario M9V 3G8. Telephone: (416) 749-1850.

3. The Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims: John Lussier (Project Director), Marymound Inc. Family Resource Centre, 349 College Avenue, Winnipeg, Manitoba R2W 1M2. Telephone: (204) 944-7400; Fax: (204) 589-6061.

4. London Family Court Clinic Child Witness Project: Dr. Louise Sas (Principal Investigator), London Family Court Clinic, 254 Pall Mall Street, Suite 200, London, Ontario N6A 5P6. Telephone: (519) 679-7250; Fax: (519) 675-7772.

5. Coordinated Child Sexual Service Model in a Rural Community Setting: Dr. Barry Trute (Co-principal Investigator), Child and Family Services Research Group, Faculty of Social Work, University of Manitoba, Winnipeg, Manitoba R3T 2N2.

6. Youth in Transition Project: Dr. Deborah C. Poff, Institute for the Study of Women, Mount St. Vincent University, Halifax, Nova Scotia B3M 2J6. Telephone: (902) 443-4450; Fax: (902) 443-1352.

7. Rural Outreach Program: Ms. Dorothy Gilson, Executive Director, Naomi Society for Victims of Family Violence, #201-220 Main Street, Antigonish, Nova Scotia B2G 2C2. Telephone (902) 863-3807; Fax (902) 863-1162.

8. National Youth in Care Network Local Development Project: Ms. Tracy Black-Poore, National Youth in Care Network, 607-251 Bank St. Ottawa, Ontario K2P 1X3. Telephone: (613) 230-8945.

9. The Social Support Training Project: Dr. Madeline Lovell (Principal Investigator), Sociology Department, Seattle University, Seattle, Washington 98105, U.S.A. Telephone: (206) 296-5387.

10. Parent Mutual Aid Organization Project: Dr. Gary Cameron (Principal Investigator), Centre for Social Welfare Studies, Faculty of Social Work, Wilfrid Laurier University, 75 University Avenue West, Waterloo, Ontario N21 3C5. Telephone: (519) 884-1970.

11. The Neighbourhood Parenting Support Project: Don Lugtig (Project Coordinator) or Don Fuchs (Principal Investigator), Child and Family Service Research Group, Faculty of Social Work, University of Manitoba, Winnipeg, Manitoba R3T 2N2. Telephone: (204) 474-9869.