Working with Children with Complex Presentations: A New Zealand Approach

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This paper describes ongoing research and practice undertaken by *Department of Child, Youth, and Family* specialists and social workers working with two children described as having high and complex needs. The paper first describes characteristics (familial, historical, behavioural, cognitive) of each child and the previous diagnostic understandings formed about them. It then describes the theoretical models used and the programmes developed to address each child's individual complex needs. The interventions were conceptualised as multi-disciplinary and multi-systemic. An Action Research approach was used. This allowed constant adjustment of the intervention to account for developing understandings gained with regard to the theoretical constructs, as well as the ability to respond appropriately to the daily practical experience of the children and those involved with them.

The "High and Complex Needs Programme" was developed within the Department of Child, Youth, and Family (CYF), in a move towards greater intersectoral collaboration. It is aimed at children identified as having needs for care and treatment so severe that they require a specially tailored, individually developed intervention. Wells and Smith (2000) estimated that approximately 120-200 children within New Zealand currently meet this criterion. They found that one third of the Department's clients had a moderate to severe mental illness (assessed by an appropriate clinician), and service provision to these clients was problematic.

CYF Tauranga was given High and Complex Needs funding to develop a "wrap-around" programme for two identified special needs children. The site was very representative as it contains both the best and worst social indices in the country. No body of research or practice exists in New Zealand with respect to the design, management, implementation, and delivery of treatments for multiple needs children. Interventions for the two boys we have named Jack and David, had to be designed and delivered in the absence of practice wisdom, programme guidelines and protocols, or a body of trained staff. The interventions had to be designed, implemented and evaluated as a stand alone project.

Child Characteristics

Jack

Aged 11, Jack is one of four children born to a mother with a diagnosis of severe paranoid schizophrenia. His grandmother also has this diagnosis. Both women remain in sheltered care. His father, in whose sole care he mostly lived up to the age of 5, has been described as "unusual, socially isolate, with strange ideas about life and about Jack". Jack has a complex ethnicity of mixed Eastern European/New Zealand European/Central American heritage. He came into the care of CYF service when he was abandoned by his father at age 5. At that time Jack stated that he thought he was a car (an Austin Princess). He has supervised contact with his mother.

Jack has a complex psychiatric and medical history, first identified as having (possible/potential) mental illness at age 5. Suggested diagnoses (made by both psychiatrists and psychologists over the next 7 years) included Asperger's Disorder; Pervasive Developmental Disorder; Autism; Atypical Depressive Disorder; Schizotypal Personality Disorder; Attachment Disorder; and Post-traumatic Stress Disorder. There has been considerable conflict among professionals about probable diagnosis, treatment, and medication. More recently he has been found to have some neurological problems.

Long term observation of Jack since he came into CYF care, suggests he shows strong indicators for a history of disturbed (disorganised) attachment and experience of significant abuse and trauma from an early age. He is highly reactive to verbal cues (raised voices, critical comments or teasing), has little sense of social relationships, poor management of internal emotional states, and a limited sense of himself. Jack also displays certain personality characteristics (paranoia, oppositionality, aggression) that are consistent with a history of both trauma and pervasive neglect.

More recently Jack's behaviour and psychological state has deteriorated. He has shown marked mood swings, unusual imaginings, hypersensitivity, deterioration in co-ordination, and difficulty interacting appropriately with others. Managing Jack within the school system became increasingly difficult (it had always been problematic); he was described as "show-off, disruptive, unpredictable, explosive, oppositional, aggressive, intimidating, disrespectful, and entirely self-focused".

David

Aged 9, David spent his early life in his mother's care. His parents, young at the time of his birth, were believed to be drug and alcohol users. David is of predominantly New Zealand European ethnicity. As a very young child David had an extensive notification history with CYF, for suspected serious physical abuse, verbal and emotional abuse, aggressive and sexualised behaviour towards other children, and other disturbed behaviours (e.g., urinating on dolls at day-care). Independent sources provided evidence of severe physical, verbal and emotional abuse by his mother who appeared subject to erratic mood swings, depression, suicidality, anger, and continued substance abuse. David came into permanent care at age 4.

Like Jack, David had a complex and conflicted history of diagnoses, treatments and medication. Suggested diagnoses and labels included: "normal"; Attention Deficit Hyperactivity Disorder; intracranial pressure resulting in behavioural disorder; Psychosocial Dwarfism (Failure to Thrive); Attachment Disorder; Pervasive Developmental Disorder such as Autism or Asperger's; Developmental Aphasia; Conduct Disorder; prenatal maternal use of drugs/alcohol; impacts of early neglect/abuse; Language Disorder; Enuresis; Encopresis; Anxiety; "catastrophic reaction to change"; Abnormal learned Social Behaviour; and mild Mental Retardation.

David's placement in care proved very difficult because of his presentation. He experienced numerous placements and changes in caregiver, and was only managed in the education setting with a full-time teacher aide. David had a range of seriously disturbed behaviours including extreme hypervigilance; dissociation; anxiety; disorganised attachment; regressed behaviours; highly destructive play; violent and aggressive behaviours; violence to animals (including strangling two kittens); lack of remorse; cruelty to children at school; smearing faeces; masturbatory behaviours; self-harming behaviours; poor physical co-ordination; poor ability to concentrate or sustain attention; very poor ability to relate to others; poor ability to follow rules and appreciate consequences; and poor language skills. David was placed in a special school.

Theoretical Issues

The development of a treatment programme started with theoretical understandings which best explained the children's current presentation, and also had the potential to provide therapeutic direction over time. Two significant theoretical streams were identified: Theory of Mind (a developmental perspective), and Developmental Psychopathology (a multi-disciplinary research perspective), with its attendant recent work in the area of Multiple Complex Developmental Disorder. They provided significant rationale for clinical explanation of the children's presentation, which could then be used effectively for the training and support of the adult system surrounding the children. These perspectives were particularly helpful in clarifying which aspects of affective state, behaviour, and cognitive skill, should be focused on, in what order, and in what mix.

Cicchetti and Toth (1995), Fonagy, Steele, Higgitt, and Target, (1994), and Rutter and Sroufe (2000), among others working within a developmental psychopathology framework, have described a range of symptoms and common causative factors associated with maltreatment, neglect and poor attachment. Cicchetti and Toth (1995) note the critical impact child abuse and neglect has on stage-salient issues of development such as development of attachment, developing sense of self, peer relationships, and adaptation to school. Further review of this developing body of literature provides descriptions of children very similar to those in this programme, their presentation marked by rapid regressions, disordered thinking, ego-syntonic affective withdrawal, internal disorganisation, episodic psychotic symptoms, social inhibition, poor relatedness, and lack of empathy and social understanding (Ad-Dab'Bagh, 2001; Calvert & Lightfoot, 2001; Cohen 1983, 1987; Kernberg, 1982; Petri & Vela 1990; Pine, 1993).

Theory of Mind considers how children engage with the social milieu in which they exist in a develop-mentally appropriate way. It considers how they develop an understanding of self and other, including insight into the mental phenomena (perceptions, desires, beliefs, and intentions) of others and themselves (Carpenter, 2001; Frye & Moore, 1991). The Theory of Mind construct is now thought to represent a central mechanism possibly underlying many other domains of development (Baron-Cohen, 1995). Among the developmental tasks of the child particularly thought to be related to Theory of Mind, are: perception of self; understanding of self as separate from others; understanding of social relationships; understanding of social skills in relationships; understanding of social rules; knowledge, understanding, and management of feelings (ability to contain strong feelings and regulate emotional arousal); and language development, especially symbolic language and the ability to label and symbolise objects created by oneself or others (Frye & Moore, 1991, Premack & Woodruf, 1978).

Theory of Mind was conceptualised as being particularly useful to our work because it stems from the tenet "all individual development originates in interpersonal activity" (Vygotsky, 1978). It provides a template for understanding key areas in which early deprivation and abuse may have had a direct impact on normative development. Theory of Mind literature provides examples of interventions based on play, language, and social skills, all of which concentrate on repairing early developmental deficits (Brunner, 1990; Steerneman, Jackson, Pelzer, & Muris, 1996). Other research has suggested children with more pervasive and severe developmental deficits may show poor generalisation of behavioural and cognitive skills when more orthodox forms of behaviour management are applied (Furman, Giberson, White, Gravin, & Wehner, 1989; Schneider, 1989).

Literature in the area of child psychology/psychiatry, child development, and abnormal psychology remains conflicted about the most appropriate way to describe that group of children who display severely compromised functioning across a range of affective, cognitive, and behavioural domains. Such children may be variously diagnosed with Pervasive Developmental Disorder, Childhood Schizophrenia, Childhood Borderline Syndrome, Multiple Complex Developmental Disorder or Childhood Psychosis (Towbin, Dykens, Pearson, & Cohen, 1993). They commonly present with a history of known and severe negative impacts, often beginning prior to their birth and continuing until the intervention of social service agencies.

Recent literature suggests that the emerging diagnostic category of Multiple Complex Developmental Disorder develops out of the context of severe neglect, abuse and poor attachment (Ad-Dab'Bagh, 2001; Towbin, et al, 1993). Research has demonstrated the presence of neuropsychological indicators as well as persisting adverse environmental patterns (Perry, 1995). These neurological traits are often described as "soft" features, and are primarily associated with frontal lobe functioning, particularly poor executive functioning, involving increased impulsivity, cognitive inflexibility, poor self monitoring and perseveration (Cohen, Shaywitz, Young, & Shaywitz, 1983; Judd & Rugg, 1993), and deficits in auditory processing (Lincoln, Bloom, Katz, & Bokesenbaym, 1998). Notably, such features have also been described in previous work on childhood schizophrenia (Werry, 1994).

Programme Design

Method and Context

Our clinical research approach was based on Action Research methods (Greenwood & Levin, 1998; Hart & Bond, 1995, Reason & Bradbury, 2001). This methodology aims to take action, and also create knowledge or extend theory about that action. It has the advantage of providing a process for thinking about research in an area where little research had been undertaken; it allows research to inform and develop practice.

The programme itself required co-ordination of a number of sectors particularly Child, Youth, and Family Service; Education; and Health. The package included an inter-agency wraparound, in co-ordination with other service sectors, including school and home-based behaviour management, individual therapy, and social skills development. It provided an integrated support network centred on the primary caregivers, with organised regular respite care, a specialist treatment and support team, regular therapy, and ongoing consultation with doctors and psychiatrists. Child, Youth, and Family Specialist Services (a unit of psychologists, therapists and specialist social workers providing services to social workers) were contracted, when no other service providers were able to be engaged, to provide the treatment component of the intervention including: assessment; behaviour management; social skills training; staff training and support; therapy (for one of the boys); and evaluation.

Treatment

The aim of the treatment component of the programme was to alter existing pathology, repair developmental gaps, promote resilience, and teach new skills. Important delivery strategies were: individual therapy, behaviour management, teaching social skills, a focus on repair of identified deficits using Theory of Mind as the primary model, and creating an active sense of relational space and personal agency.

The general approach for treatment was to focus on the symptoms providing the most clinical disturbance, individual distress, or social difficulty, at the time. The initial goal was to encourage the boys to make small, incremental, positive gains, and feel they had achieved personal successes. Rewards assisted in encouraging and fostering a positive learning environment. This strategy was adopted across all three of their major contexts: school, home, and individual therapy.

Targeted behaviours. The basis for the programme was Theory of Mind concepts. The underlying proposition was that these children had not mastered key developmental tasks for their age, particularly basic skills such as: perception of self; understanding of others as separate beings with their "own self"; understanding of relationships, and basic social skills for being in a relationship; understanding of social rules; knowledge and understanding of feelings; and a basic ability to contain strong feelings, and regulate emotional arousal. These are facets of personality learnt in a close, intimate, relationship with a significant caregiver, i.e., through satisfactory attachment.

Targeted behaviours for the boys were similar: [1] recognition of own internal states (feelings, thoughts, beliefs) and their relationship to external behaviour and physical body states (perception of self); [2] recognition of the impact their behaviour had on others (perception of others); [3] physical aggression towards others; [4] verbal abusiveness, inappropriate verbal remarks, verbal intrusiveness; [5] sexualised language, sexualised or inappropriate behaviour, and for one of the boys, [6] inappropriate eating habits.

Perception of self as different from other, feelings, personal space and intrusiveness on that space, are abstract, and somewhat difficult concepts to work with in children who have developed little symbolic language to refer to these constructs. To assist in working with these targeted behaviours, one of the Specialist Services team who has some artistic skill, drew a range of graphic aids. These included faces showing common feelings, a drawing of two children in bubbles to depict the concept of personal boundaries, and a series of volcano drawings to illustrate escalation of emotions. A standardised set of responses was developed to address the targeted behaviours when they occurred. Caregivers and school staff were also asked to use the graphic aids in a standardised way. The behaviour management programme entailed the provision of rewards for the absence of targeted behaviours after a given period of time (gradually increased).

Therapy. It was decided to provide long term, focused therapy that would occur in a predictable way (i.e., twice a week, at the same place, with the same person). It proved difficult to recruit therapists to work in this style, given the prevailing focus on short term work and also the lack of skilled child therapists. Therapists were required to participate in the quarterly case meetings and to maintain very regular contact with the project manager and social worker.

Therapy was integrated within the overall intervention and the therapists were required to follow (as closely as possible) the full programme as developed. Individual therapy was intended to focus on the development of an understanding of self and others, understanding social roles and rules, recognising and managing internal states (feelings). It was intended that the relationship between each child and his therapist would be a primary vehicle for change. This type of approach closely fitted the theoretical understandings within Theory of Mind and concepts from developmental psychopathology.

Both children and their therapists worked extensively with books, stories, pictures and interactive play. David was encouraged to use a sand tray and to gain a sense of himself through repetitive play routines. Jack and his therapist cooked together and grew a garden to help him gain a sense of time, of taking turns, and internal self management. Each child worked with photographs to develop understanding of family structures, the change in individuals over time etc. Jack found sound very difficult to tolerate, leading to work with music in his therapy. Therapy has evolved over the past two years. Extensive use is now made of the actual environment in which therapy takes place. Both Jack and David have developed social relationships with other people in each setting, show increased social awareness of normal social interactions, and an ability (at times) to moderate arousal states.

Social skills. It was originally intended that both boys would be provided with separate social skills group training. However it became clear that neither child was ready for this component of the programme, at the beginning. They were too dysregulated overall, and social interaction generated further anxiety and agitation. We realised the boys were not able to understand or appreciate the concepts of personal and relationship skills, social appropriateness, and social rules. They first needed to gain more awareness of their own affective states, their own behaviour and how it was governed by those states, and begin to develop skills to regulate and contain strong emotion, i.e., manage their internal states. An intermediary stage was provided for each boy, where they mixed socially with other children in the community, in a controlled setting such as Athletics Club or swimming class.

Care-giving context. Social workers identified basic principles of care for the boys, consistent with a "primary care" model, providing: [1] a long-term placement to address their needs for permanency, security, and attachment; [2] in a setting that would be able to maintain and modify the boys' behaviour by providing firm and consistent boundaries; [3] with a commitment to unconditional care (e.g., none of the three foster homes David had lived in previously had been able to sustain him for longer than 12 months); [4] in a sole placement.

Permanent respite caregivers were also appointed and included in the behaviour management training. Respite caregivers came into the home, and the primary foster parents moved elsewhere for that period. This had the excellent advantage that the child remained in his own home. It ensured consistency for the child, and timeout for the primary caregivers. The boys understood that their primary foster parents maintained contact with their own children and grandchildren at such times.

Educational context. Both the boys had teacher aide assistance funded by what was then the Specialist Education Service (SES). David was already placed in a satellite class of the "special school" system, based in a primary school, where he had been for 12 months. Jack's school placement needed to be changed; he was placed in a regular classroom, after some careful preparation of both the teacher and the other children. Focus at school was on social skills with both adults and children, rule based behaviour, arousal management (especially anxiety), and being orientated to learning (maintaining concentration, reducing annoying behaviours in classroom).

Training and development. The caregivers, respite caregivers, teacher, and teacher aides, were all provided with training, in behavioural management. This included a full description of the strategies, their intent, opportunity to discuss and question the principles, and role plays by the Specialist Services team to demonstrate technique. Secondly and most importantly, the caregivers and schools were all allocated a caregiver liaison and support person from the Specialist Services team. This person visited regularly to discuss progress, answer any questions, help to develop understanding, assist with any difficulties including cultural difficulties, and monitor progress with respect to applying behaviour management.

It became clear that caregivers and school staff would do far better in coping with the boys and their behaviour, be more tolerant, more successful in handling them and applying behavioural principles, and report more clinically useful data, if they were able to understand the children better. A more comprehensive training on the boys' clinical presentation, as well as relevant psychological ideas was then presented. This included a basic introduction to child trauma, reactivation by traumatic cues, and hypervigilance. This became especially important with respect to one of the boys, who displayed a significant propensity to be triggered into traumatic symptomatology, particularly by cues reminiscent of verbal violence.

Review and evaluation. The initial treatment plan lasted nine months. Baseline assessment was via direct interview, observations, and assessment by the authors, as well as an extensive search of departmental records. Both boys were administered WISC-III (Wechsler, 1992, Australian Adaptation) evaluations by clinicians external to Specialist Services at the beginning of the programme, and at the end of the nine-month period. Each boy's caregivers and teacher also completed a Child Behaviour Checklist (CBCL; Achenbach, 1991), at the beginning of treatment, and every three months thereafter.

Regular clinical reviews were completed every three months by way of observations at home and school, and psychometric evaluation using the CBCL. These reviews were used to inform the team about treatment progress, and provide a basis for ongoing adjustment of the treatment strategies, particularly which symptoms might be considered "extinguished", and which symptoms were currently providing the most significant disruption to functioning, and therefore needing to be focussed on for the following 3 month period. Assessment interviews were also conducted with the boys mid-point in the nine-month period, to assess general progress of treatment.

Results

Fit with Theoretical Model: Issues of Working with Disrupted and Abnormal Attachment

As the programme developed, it became more observable that arousal states were linked to anxiety generated by past trauma. The very early and pervasive experience of abuse and neglect in the boys' history, was an extremely significant issue, which impacted on all aspects of treatment. The challenge was to provide negative consequences for behaviour, without increasing hypervigilance and arousal associated with traumas of the past. It was equally hard to use some forms of positive reinforcement with children who had such a poor sense of self and little self esteem, and (in the case of one boy), highly developed paranoia. The need for low affect emotional styles in the caregivers was critical; we found that a highly reactive style tended to maintain behaviour in the child. High levels of reactivity also tended to re-cue an already traumatised child, as it replicated in part their previous environment.

Care Situation. A number of significant issues arose from the caregiver situation, including cultural and gender issues, degree of knowledge and understanding about child development, child behaviour, child management, impacts of trauma and neglect, and understanding of arousal states, and affective styles. The need for low affect environments, characterised by minimal emotional reactivity by those persons close to the boys, showed up clearly in the early stages of the programme. This is predicted by literature, but was difficult to ensure during selection and even more difficult to 'create' in situ.

Both boys showed a preference for male caregivers and this then altered the premise of the care-giving couple. Not only did it have a significant impact on the couples themselves but raised complex issues about gender and the ways in which these children understood and related to "mothers". In time these issues became more evident in the therapeutic context (both therapists were female) and could then be worked with. The caregivers frequently debated the behavioural plan, and how it should be applied in the home context. On occasions they would try to change elements of the plan, or even cease to administer it without consultation .

Reviews highlighted the need for more extensive training, monitoring, and support for the caregivers, the difficulty of the 'real life' context, and the high level of input needed from time to time (not just in the early stages of the programme). Because of the issues revealed in caregiving high needs children, a further research project, using the skills of an I/O psychology student, was established to investigate the use of Job Analysis, and ensure appropriate selection and training of foster parents and caregivers in similar circumstances (Sanft, 2002).

Impact of Contact with Family. Issues within the boys' family systems continue, and impacted noticeably on the programme. On many occasions family contact (meeting the legal requirements of both the Guardianship Act and the CYF Act), created significant disturbance for either the child, the caregivers, or both, disrupting the programme. We had provided some family members with training on behavioural management, but this had variable success. Both boys continued to maintain contact with family by supervised access; both appeared to experience sibling contacts as the most positive of these contacts.

Impacts of medication. Both boys had been on medication for a number of years. In David's case, for more than 5 years, and from a concerningly young age. Both boys continue to have their medication varied frequently, as the Child Psychiatrist (CAMHS) and other health professionals trial different dosages, or combinations of drug. Both boys had their medication changed at least twice after the commencement of the Special Needs Project, in an 8 month period. It was thought some aspects of the boys behaviour and general functioning may have been more associated with detrimental side-effects of medication, than with individual deficits. Certainly on occasion, change or variation of medication had a significant impact on ability to establish, apply and consolidate the treatment. Changes in medication were useful in that they enabled all involved to see the quite dramatic changes in behaviour , affect, and cognition that did occur from time to time.

Therapy. Initially neither child had a sufficient sense of 'self' or 'other' to engage in relationship with their therapist. The therapists both worked to develop for each child a sense of this through conversations (narrative work), play (especially shared games, card games, snakes and ladders, other activities) and photographs which helped to establish a sense of object consistency over time. When one therapist had extended leave overseas she prepared the child using a world map, sending postcards from each marked destination point to hold his sense of her. This work provided a rich source of further therapeutic work on her return. One therapist used shared social activities such as going to cafes, walking her dog, putting up Christmas decorations to provide an embedded sense of 'being in relationship' in everyday situations. Each therapeutic task was then used within office based sessions for reflection, further narrative elaboration and development – in effect the development of internal working models for the future.

School. It was essential to actively engage the schools in the plan. Significant programmes such as these in the school context raises major issues such as need to contain in the classroom and limit the negative impact on other children's ability to concentrate and learn, support for the teacher, safety of the other children, and protection of our clients from bullying or verbal cruelty which arose constantly. Wider issues within education such as imminent restructuring and resourcing, also impacted on the programme.

Measurement of Change

There has been some difficulty in assessing overall effectiveness. Treatment integrity was compromised by the wide variety of variables that could not be controlled. In a laboratory setting or an institution, where variables are much easier to control, the expected level of compliance with the treatment plan would be in the range of 80%. We estimate the treatment plan in this research achieved something like a 50% level of compliance. Moreover, we found the expectations of some involved in the programme, particularly caregivers, teachers, and others who had little experience/knowledge or understanding of the traumatised child, were at times too high or unrealistic. In a programm of this nature, tiny positive steps are common, and this needs to be appreciated. Change will be slow and gradual, and this also needs to be understood.

In clinical terms, angry and aggressive behaviour was noticeably reduced, and this was pleasing. Comments by the boys made it clear they had gained more understanding about themselves, their behaviour, and the impact of their behaviour on others. However, as knowledge and insight increased, so did awareness of their difference and difficulties. For both boys, this caused distress, and an increase in anxious, depressed symptoms. Each child was evaluated every six months, by clinician review, and caregiver and school completed CBCLs. There were also clinical review meetings every 3 months which discussed progress, and guided behavioural management strategies.

Psychometric Results. On the CBCL both boys showed similar trends in their results. Both boys showed a noticeable decrease in Delinquent Behaviour at home, and a noticeable decrease in Aggressive Behaviour at school. Overall, both boys showed a noticeable decrease in scores on the Externalising scale for reports from both home and school, but an increase on the Internalising scale for both contexts.

In clinical terms, it appeared that angry and aggressive behaviour towards adults, other children, pets and objects, reduced as the boys gained more understanding about themselves, their behaviour, and the impact of their behaviour on others. However it seemed that as the boys' social awareness and personal insight increased, so did their awareness of how much they differed from other children. Because of this trend, total clinical scores for both boys in both contexts, did not appreciably change.

On the WISC-3, both boys showed improvements in functioning on the Verbal, Performance, and Full IQ scales. Jack, the older of the boys, showed a greater increase in overall scores. David who displayed more developmental delay for his age at the beginning of the programme, showed more on-task behaviour, more social engagement, and greater "readiness" for learning during testing, which we hope will foreshadow greater developmental gains in the future.

Concept of a Behavioural Management Programme in a Multi-setting Community Context

At one point or another, nearly everyone required to work within, or support, the behaviour modification component, questioned/criticised/rejected it, refused to comply with it, or otherwise reflected negatively on it. Encouraging people to comply with the plan in a structured consistent way, could have almost been a full-time role on its own. It is clear in retrospect, that the procedures needed to be "sold" more energetically and more extensively than they were. It is likely that more specific and individualised presentations to each sector of the boy's overall environment might have been better than a large network meeting. Throughout all areas of the treatment, it has both been necessary, and required some skill, to provide an easily understood picture of the very complex and confused clinical presentation of Jack and David to persons with no clinical background. With many people, we needed to provide this information over and over. A large amount of networking and team management has been required.

There were negative impacts on the programme, difficult to control for in a community setting. There does not appear to have been a fortnight when some part of the programme has not been disrupted through external factors beyond the control of ourselves or the social worker, e.g., [1] medication reviews, (had a huge ongoing impact on our ability to stabilise both boys, and consistently apply the programme), [2] need to place in emergency respite care outside the home, due to caregiver emergencies, [3] contacts with family members have been predominantly destabilising for both boys, and provoked significant reactions in presentation, [4] one child's propensity to easy bruising led to suspicions he might be experiencing physical abuse from his caregivers, [5] difficulties with peer relationships at school impacted on functioning.

Discussion

Jack and David are children whose early life experiences, pre-natal difficulties and possible genetic factors predispose them to extreme difficulties in adjustment within society. Their complex presentations and the difficulty of management lead to severe conflicts among professionals which further impacted on long term planning for them. The ability to access the High and Complex Needs funding and the availability of a group of skilled staff, enabled the primary clinicians to develop a 'wrap around' treatment programme based on robust theoretical models.

A significant factor evident in evaluating both the children and programme was the clear indication that prior to its initiation, nearly all of those involved in the diagnosis, treatment and care of the children had overlooked the likely impacts of an early childhood history of abuse, neglect, disturbed attachment and the experience of domestic violence on development and functioning. The multidisciplinary concept afforded by developmental psychopathology, with its integration of relevant principles from Theory of Mind models, allowed the programme to evolve and incorporate new data about each boy as they came to hand. This approach also allowed a better fit between intersectoral partners, between caregivers and staff, and between the programme and the families.

One of the advantages of the Special Needs Programme was the decision to treat current behaviours rather than diagnoses. A decision was made early in the conceptualisation of treatment planning to address the behavioural and emotional difficulties that had both caused the boys to be identified as "high needs" and were significantly impacting on their ability to function in the everyday world. In hindsight, this has been an extremely good decision. The programme has clearly demonstrated the value, for children such as Jack and David, of such an integrated approach. Both boys have made clear and measurable gains in key psychological areas such as self/other understanding, understanding of and application of social rules, the ability to recognise and manage internal states. Both boys have been maintained in a stable care giving situation since the beginning of the programme. Jack has been in mainstream school fulltime for a year and it is proposed to begin David in a regular classroom as soon as funding for teacher aide support is available. Both boys have maintained appropriate relationships with their family of origin.

The programme could not have been developed and become a success without the team having constant regard to knowledge developed within scientific psychology in its many forms. As an evolving programme new aspects of psychological knowledge and research could be considered and incorporated where appropriate. Diagnosis remains an area of significant controversy in child and adolescent mental health and this has a direct impact on the management of cases such as Jack and David. Controversy also makes it more difficult to develop working partnerships between professionals and other service providers.

When evaluating efforts such as these, it is of course problematic to speculate what the consequences would have been of not providing an intensive intervention. Recent research indicates that in fact children with mental health or behavioural problems have little likelihood of achieving either placement stability or improved psychological adjustment, in traditional foster care situations. Alternative care and treatment options need to be provided for these children (Barber, 2001). This initiative is an attempt to use a multidisciplinary approach grounded in current psychological research understandings, within a practice base. We believe the programme has already demonstrated the value of such an approach for both of the children, their caregivers, and for the development of clinical data in the field.

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