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## THE CONCEPTION OF SAM 0-12

– Shaping a programme for oppositional behaviour in Brussels –

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### Mind the gap

*Introduction* – One of the major challenges we face today as a CKG (*Centre for Child Care and Family Support*) in the metropolitan context of Brussels is the question of family support in cases of antisocial and oppositional behaviour in children. This comes as no surprise, as children in big cities are raised within very diverse and sometimes loosely structured social networks, often with a lack of stable role models (Gorman-Smith, 2003). Parents too experience more difficulties building a social network they can rely on when problems occur. We considered it our task to meet this situation and find appropriate answers to it. When we decided to take action upon this problem, however, we soon realised that a straightforward solution was not readily at hand. There were many hurdles to be taken, not in the least because of the contextual specificity of the Brussels setting. At least, that is what we believed back then...

Another problem, however, proved to be far more crucial in not finding an intervention scheme for oppositional behaviour that was applicable in our setting right away. We will make this problem – that eventually turned out to be an opportunity – the actual focus of this paper, as this was the real hurdle we had to take in implementing effective action on oppositional behaviour. Uncovering it might help others to make their actions more effective. Before we can do this, we will sketch the actual starting position when we decided to deal with oppositional behaviour. On the one hand, we wanted to take action upon a specific problem (oppositional behaviour),

for which several programs were readily available. On the other hand, according to our practitioners, these programs, taken separately, were insufficiently flexible and not realistic in our setting as they would produce a more *offer-driven* care. They felt they needed a *demand-driven* approach instead – one that could cope with the great diversity of demands and age groups they were confronted with. They felt, therefore, that limiting themselves to a single programme offer was not an option, even if the programme – as most do – had multiple targets or domains of action (parents, children, school...). Not a single program met their *demand-driven* standards.

*Filling the Gap* – It is in this context that the “specificity of Brussels”-argument got a very different meaning – appearing as a problem at first, and an opportunity afterwards. As the dominant feeling was that the mainly outcome-focused programmes had little to do with *their* daily preoccupations – real-life human relations and hard-fought processes of change – practitioners tended to use “contextual specificity” to explain this “gap”, but at the same time to justify it. As such, “contextual specificity” became an argument against the straightforward

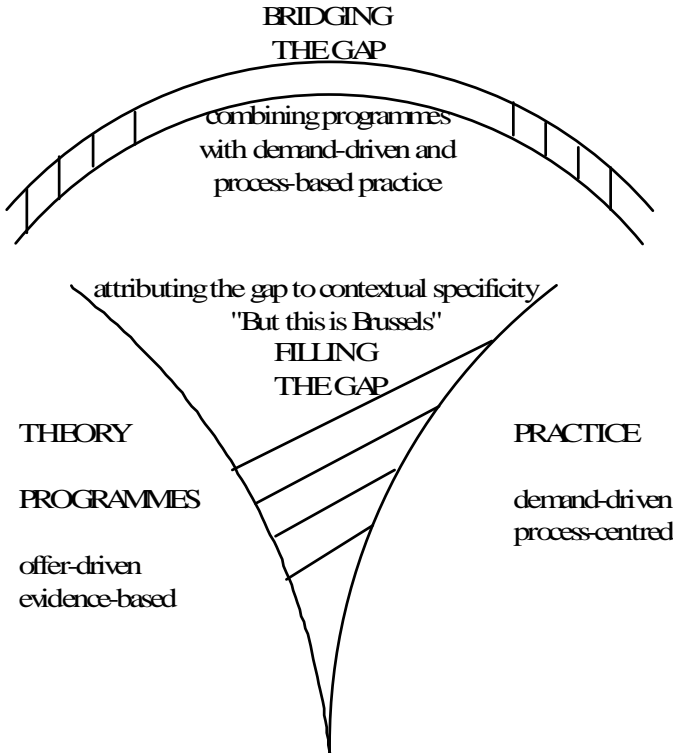


Figure 1 - People attributed the gap between theory/programmes and practice to the contextual specificity. That's how they filled the gap, but in the same time, this "justified" this gap. This article is about "bridging" the gap instead.

implementation of an evidence-based intervention. One could indeed compare it with a gap. Practitioners experienced a gap between what they saw as product-based, offer-driven programmes and process-centred, demand-driven practice. People don't like this gap and that's why we try to fill it up with “contextual specificity”. Obviously, “Brussels” is only one possible way to fill the gap. But it's our feeling that it's widely felt – and filled – in the domain of social action.

*Bridging the Gap* – Seeing now that the “Brussels context” was filling a gap, we had to acknowledge this gap and the grain of truth in this position. We wanted to “bridge” the gap instead. That’s why we felt we had to look for interventions that take into account this daily experience of “real-life human relations and hard-fought processes of change” and this demand-driven approach, while not giving up the evidence-based perspective.

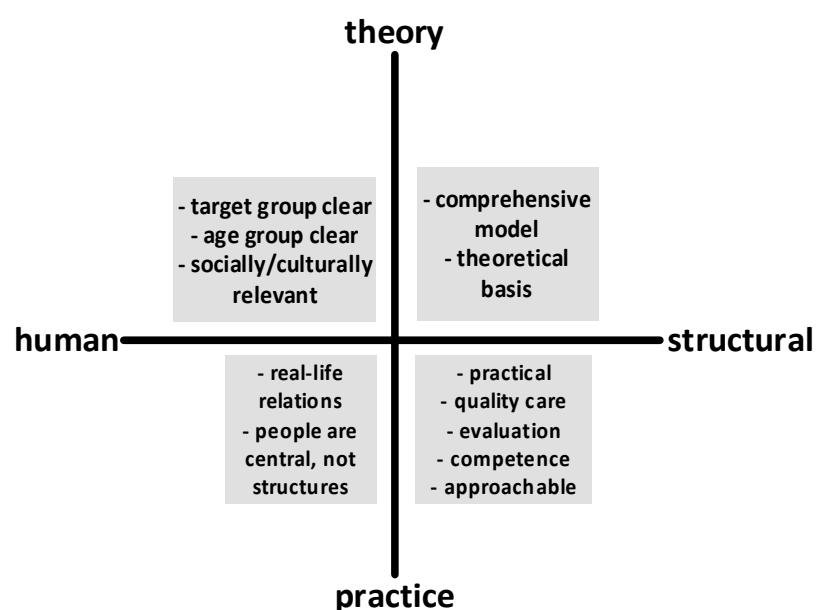
Looking back today, bridging this gap was more crucial to us than technical changes or contextual awareness in implementing effective action upon oppositional behaviour. It is the dynamics of this difficult integration of evidence-based practice and the daily needs of our practitioners that we will concentrate on in the first part of this paper. In the second part, we will present our action programme for the treatment of oppositional behaviour that resulted from this process: SAM 0-12 (*Sleutelen Aan Moeilijk gedrag, voor kinderen tussen 0 en 12 jaar en hun ouders*).

## What matters in taking action

We started by asking ourselves what really matters when taking action in this field. To address the concerns of our practitioners, we complemented the study of scientific meta-analyses on the subject (e.g. Moran *et al.*, 2004; Bradley & Mandell, 2005) with their experience in the field. But let us begin where we started from at that time: the evidence-based component of taking action. We distinguish twelve strongly evidence-based components for effective action in this domain. To do this, we based ourselves mainly on the landmark study by Moran *et al.* – “*What Works in Parenting Support? A Review of the International Evidence*” – and selected the proven components which apply to this domain.

[1] First of all, we need a *comprehensive model* – models that prove to acknowledge the different dimensions of a problem by integrating them are generally speaking more effective. Thus, programmes that work with parents and children have the highest overall effect sizes (Bradley & Scott, 2005). This does not mean that child-only or parent-only interventions are *always* less good: the same authors suggest a specificity

of treatment effect, e.g., only those conditions with child-training components had a positive impact on peer relations. [2] Secondly, a strong *theoretical basis* is highly correlated with effectiveness. Common sense heuristics, tradition or past experiences are bad guides. In the case of oppositional behaviour, programs are usually based on long-standing theoretical traditions: learning theory, social information theory, system theory and/or Patterson’s coercive model [3, 4, 5] The *target group* and the *age group* must be clear and the program as a whole must be *socially and culturally relevant*. One-size-fits-all programmes tend to do best... for those who need it the least (Moran *et al.*, 2004). A good ‘match’ with client characteristics on these three dimensions adds dramatically to program success. Miller & Prinz (2003) suggest that mismatch was a strong predictor of drop-out. [6, 7, 8] Integrated *quality care, evaluation and competence management* improve effectiveness tremendously, this is “maybe as important as all the other factors together” (Moran *et al.*, 2004). Quality care must be visible and explicit, evaluation and feedback by clients must be standardised and the staff competence must be guaranteed by supervision and continued training. [9] Effective interventions are *approachable* and conceptualised in terms of user convenience. Is the place within easy reach, is there a child care solution, at what time are sessions scheduled, etc. [10] Learning *practical skills* increases effectiveness as they give people the tools to change. Thus, parents are taught procedures to alter their children’s behaviours and to change the patterns of communication away from a coercive to a more prosocial orientation (Bradley & Scott, 2005). [11, 12] Interventions must be based on *real-life relations* and *people – not structures – must be the action focus*. This seems common sense, but it is



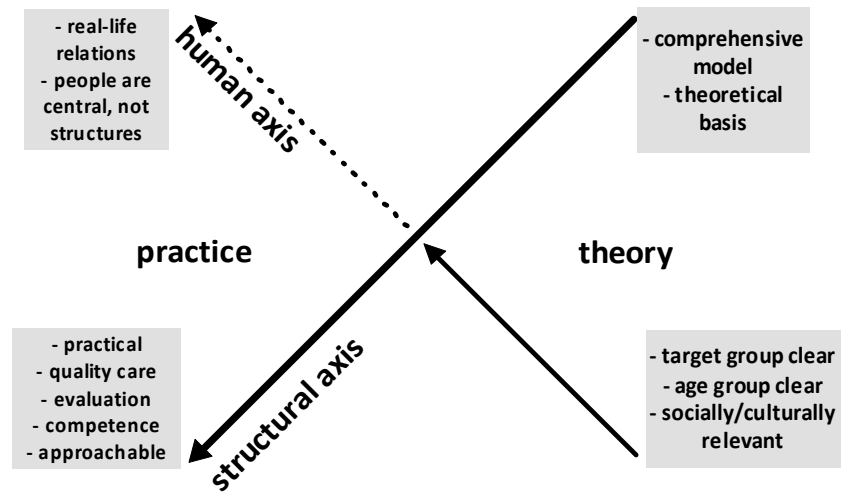
Figuur 2 - Evidence-based components for effective action in the domain

not. It is a huge investment of time and energy not to think of our actions in terms of our familiar structures. For example, always meeting clients in a context of assistance is part of our familiar structures. In some contexts, it might be an alternative to meet clients in the role of facilitator of real-life relations, e.g. in the context of a parents' group. For conceptual clarity, we divided these twelve components for effective action in four groups, based on two dimensions: practical/ theoretical and structural/ human.

We could find a reasonable number of programmes confronting oppositional behaviour that met these evidence-based standards. But, as we noticed, this evidence-based perspective was not enough for our practitioners. They still experienced a gap between what was a good according to this evidence-based model and what they thought to be a good action. More particularly, they missed two things. First of all, an explicit *demand-driven perspective*, i.e. where structures and programme procedures would not hamper their efforts to respond to a great variety of demands. Secondly, they missed a *process-centred perspective*, in which it was clear that a human real-life process is both the most difficult and the most rewarding aspect of supporting people. From a user perspective, evidence-based practice is inclined to focus on the measurable aspects of care. This is both its (theoretical) strength and its (practical) weakness.

The gap between the two sets of knowledge was bridged by using the practical knowledge – what our practitioners contributed – as a framework, a superstructure, for the evidence-based groundwork (*arrows in figure 2*). Thus, the evidence-based content is 'embedded' in a relationship-based framework, combining the evidence-based action perspective with the practitioners' perspective. We soon dubbed this model our *Blueprint for Action* as it became a quality management tool in its own right. Indeed, indirectly it helped us a lot in defining future actions in many domains like the Educational Shop (*Opvoedingswinkel*), social child care (*Sociale Kinderopvang*), etc. Today it is a guideline we use whenever new domains of action have to be implemented.

Basically, the framework consists in the articulation between the two axes we introduced in *figure 1*. It shows how the structural axis is relatively easy to implement (*full thick line*) and tends to be self-generating. Put bluntly:



Figuur 3 - *Blueprint for Action*

once structures are in place, it is hard to get rid of them. The human axis, on the contrary, is much more fragile, certainly when it is confronted with heavy structures (*dotted line after 'bumping into' the structural axis*). In this case, structures function as a structure wall (*structuurmuur*).

Furthermore, the human axis is not self-generating at all: every time again it has to be “realised” in unique human interactions. This articulation of the axes takes into account the two major preoccupations of our practitioners. The *demand-driven perspective* is translated into the warning that structures (procedures, offer-centred approach) are the means to reach the goal on the human axis, not a goal in their own right: in that case they become a structure wall. The *process-centred perspective* is translated into the insight that the human axis is the “axis of investment” as it is not self-generating. “Hiding” in self-generating structures (Verhaeghe, 2002) is the sign of disinvestment.

Combining the knowledge sets of both theoretical meta-analyses and daily practice, our *Blueprint for Action* thus emphasizes the importance of activating interventions based on human relations rather than interventionalist actions based on structures. This scheme was the basis for our selection of treatment programmes for disruptive behaviour.

## Case-study: the birth of SAM 0-12

*Introduction* – In the selection process, three basic conditions were to be met. In line with our vision, SAM 0-12 had to be **evidence-based, demand-driven and process-centred**. Let's start with defining the aim of the project. SAM 0-12 (*Sleutelen aan Moeilijk gedrag*) centralises all demands of our target population – families with children between ages 0 and 12 – concerning oppositional behaviour. In function of the specificity of the situation – both the problem and the possibilities for change – an individualised pathway is proposed.

*Demand-driven* – In line with our aim of covering the whole spectrum of demands concerning oppositional behaviour (*demand-driven approach*), SAM 0-12 had to be able to respond to everything from general questions on disruptive behaviour to more serious behavioural disorders. This is why we decided to select a range of evidence-based programmes, that together would cover the range of demands. We selected these programmes: *Peuter in Zicht, Opvoeden en Zo, Kinderen... de baas!?, Drukke kinderen, Samen met Joep Loep Sporen na Speuren, Ouders Speuren naar Sporen, Hoe kleiner, hoe fijner, Minder boos en opstandig, Zelfcontrole, Stop 4-7*. With this range of programmes, we cover the age-group as well as our target population (0-12) and the range of demands with regard to oppositional behaviour. SAM 0-12 can now offer a parent or child training, ambulatory support, information supply, reorientation, or a combination of any of these.

Ambulatory support is the solution proposed to families that prefer a one-to-one approach or people who lack the mobility to come to the Centre. It can also be a tailored solution for people who can't be helped in Dutch. It consists of a weekly home visit in which the "here and now" situation is taken as a starting point. It has the additional advantage that practitioners actually "witness" the situation. Information supply is organised for groups in evening sessions, but can also be provided independently, via the extensive information centre. The evening sessions have the additional advantage that people can meet and discuss with peers, creating a sense of empowerment and self-help. The programs are used when parents want to have some

clear tools to alter their children's behaviours and to change the patterns of communication in the home away from a coercive to a more prosocial orientation. Finally, when no adapted answer to their needs is possible, we do reorientation towards other programmes (e.g. in Centres for Mental Health) or psychiatric help. With this whole range of possibilities our program can meet a broad inflow, both helping people and guiding them.

*Evidence-based* – SAM 0-12 embodies our twelve evidence-based guidelines to assure effective action. Our target group as a CKG consists of families with children between 0-12 years old. The range of programmes enables us to cover this group. Let's look at this in more detail. [1] We need a *comprehensive model*. SAM 0-12 tries to integrate action upon different aspects of oppositional behaviour. The program gives us the freedom to work on multiple aspects (parents and children) or a single aspect. This is in line with Bradley and Scott's double advice. On the one hand that overall effect size is at its best when a coordinated action is undertaken, on the other hand that working on one dimension might sometimes be more appropriate: "Furthermore, the specificity of treatment effects suggests it may be worthwhile matching children's problems with treatment modalities, rather than applying a one-size fits all approach." (Bradley & Scott, 2005, 393). [2] A strong *theoretical basis* is highly correlated with effectiveness. All programmes in SAM 0-12 are strongly rooted in theory, but combining them has the advantage of theoretical plurality. Not one theoretical concept is able to explain everything. That is why SAM 0-12 combines insights from learning theory, social information theory and system theory. [3, 4, 5] The *target group* and the *age group* must be clear and the program as a whole must be *socially and culturally relevant*. We have integrated programmes for toddlers, pre-school children and primary school children. *Peuter in Zicht*, e.g., is specifically targeted at toddlers. Socio-cultural relevance is also taken into account. We have pathways for people who (culturally) prefer a community-based approach where they can meet with peers or people who prefer to be coached individually. [6, 7, 8] Integrated *quality care, evaluation and competence management* improve effectiveness dramatically. SAM 0-12 integrates permanent evaluation in the ambulatory setting and the groups have a standardised

evaluation moment. There is also a pre and post measurement of the child's behaviour. Finally, experiences of the practitioners and participants are shared and points of interest are used to improve future sessions. [9] Effective interventions are *approachable* and conceptualised in terms of user convenience. To guarantee this, some educational material of the programmes is offered in other languages (Turkish, Arabic) and we guarantee that SAM 0-12 is completely free. Approachable also means that we reach out: when people can't come to us, we go to them. [10] Learning *practical skills* increases effectiveness. Programmes were selected on this basis as we believe in the empowering nature of skills that are applicable in the natural setting. [11, 12] Interventions must be based on *real-life relations* and *people – not structures – must be the action focus*. SAM 0-12 stimulates empowerment. People are invited to share their experiences, to learn from each other and to forge ties. Practitioners try to be facilitators in this process. SAM 0-12 tries to make structures secondary to people by having a wide range of possibilities, not a one-size-fits-all solution to take or leave.

*Process-based* – By integrating multiple modalities of action, every client can shape his own trajectory, his own process, without being limited by a programme-dependent pathway. For some clients, just a little help, or being able to meet peers is enough. For some others the process is longer. Anyway, a flexible approach guarantees that the needs of every client are met, not only the ones of those who fit in the box.

## Conclusion

In our *Centre for Child Care and Family Support (CKG)* in Brussels, we worked to create a comprehensive programme addressing oppositional behaviour. With this programme, we wanted to join the strength of evidence-based standards with the demand-driven and process-centred philosophy of our Centre. The SAM 0-12 project was put into action in October 2007, after the long process of preparation we described in this paper. The results remain largely to be seen. We might be confronted with unexpected events during the implementation of SAM 0-12, and it is sure that this programme will grow while being applied. We will address the implementation and results of this project in future communications.

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