

# 'Do you seek to be a specialist therapeutic residential care provider for children and young people who have complex needs?' Some thoughts on the necessary criteria for practice in specialist residential services

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## **Introduction**

This paper explores aspects of the provision of specialist therapeutic residential child care for children between the ages of 6 and 18 years who have experienced significant loss and neglect in their lives. The views expressed are purely those of the author and do not refer to any particular service. These views are meant to provoke some thought around how we define specialist therapeutic residential services.

The children and young people who access such services are looked after and have been taken into care to live separately from their families as this is deemed to be in their best interests. The reality in the UK is that each week, at least one child will die as the result of an adult's cruelty (NSPCC, 2009). In my view, specialist therapeutic residential services are needed to respond to the reality which some children have experienced and survived in our society. The challenge is to ensure that such services in which children who are cared away from their family homes, truly provide stability and the opportunity to heal, develop and grow. Many residential child care practitioners are attracted to work for such organisations due to the emphasis their values and organisational structures which tend to be based on traditional therapeutic community principles (Main, 1946). They may also be attracted because of a personal commitment to help provide high quality services to meet the needs of children.

By sharing my thoughts on the strategic aims of any organisation which wants to deliver services for children who may have complex needs due to severe trauma, it is hoped that those who are providing specialist therapeutic residential services will reflect on their own vision for these children.

## Characteristics of children requiring specialist therapeutic services.

In 2004, a report was published by the Scottish Executive on the mental health of young people in residential care in Scotland (Meltzer et al., 2004). Among the report's findings were the following:

- 45% were assessed as having a mental disorder;
- 38% had clinically significant conduct disorders;
- 16% were assessed as having emotional disorders such as anxiety and depression;
- 10% were rated as hyperactive.

Some of these mental health indicators are symptoms relating to chronic trauma and dissociative disorders (Terr, 1991; Putnam, 1993). For many centuries, various theorists and clinicians have postulated about the psychological and emotional distress observed in children, and some began to attribute some of the causes to early childhood experiences of neglect and trauma. In 2001, the Department of Health started to record the principal need of the child that led to social service intervention.

### Factors resulting in intervention by social services

The experiences of young people taken into care during 2001 include:

- Abuse and neglect (62%)
- Family dysfunction (10%)
- Disability (4%)
- Parental illness or disability (6%)
- Family in acute stress (7%)
- Socially unacceptable behaviour (4%)
- Low income (1 % )
- Absent parenting (6%)

(Department of Health, 2001)

Chronic traumatisation relates to the recurrent exposure to major stressors over time, such as child abuse. Evidence now strongly supports the view that chronic traumatisation increases the risk of trauma-related disorders (Perry, 2003; 2005). Young people entering care in Scotland may already have experienced trauma and difficulties over and above those experienced by most of their peers. Even the experience of entering the care system can involve major and sometimes traumatic upheaval in the child's life (McCann et al., 1996). A factor such as the moving to and from residential homes is damaging and it is

believed that certain children with complex needs related to trauma are more likely to experience placement breakdowns. Farmer and Pollock (1998) found that sexually abused children and young people who become looked after had more moves in their first six months in care than other children and they showed new behaviour problems. What was concerning in this study is that fewer than one in five entered care because of the abuse, 'so this aspect of their history was easily overlooked' (Farmer and Pollock, 1998:63).

Recent reports in Scotland (SWIA 2006) suggest that little progress has been made on understanding and providing appropriate care and help for children who have been traumatised through sexual abuse. It appears that professionals lack knowledge and skill in working with sexually abused children and with children and young people who acted in a sexually harmful way to others. There is acknowledgement that there is a shortage of specialist resources for young people who have been sexually abused or show sexually harmful behaviour. It is my belief that local authorities expect specialist therapeutic residential services to be able not only to meet the needs of children who have complex trauma-based needs but also to help create an environment where they can heal.

### **Building the therapeutic organisation**

The key elements in the therapeutic community approach focus on creating environments where children can heal: this includes participation, personal agency, communication and social learning. Interestingly, all of these elements are mentioned in policy documents aiming to have a direct impact in improving the provision of care for children who are looked after away from home (SWIA, 2006; Scottish Government, 2009). These are also key elements in some therapeutic approaches such as the Sanctuary model (Bloom, 1997) which provides a framework to assist in the development of healing environments for children.

The outcomes for children in our care are largely dependent on the organisation's ability to:

- acknowledge factors influencing the child's experience;
- provide excellent quality of care;
- access both formal psychotherapeutic support and informal social milieu therapeutic experience, for example, implementing recognised approaches such as the Sanctuary model.

For any organisation, time needs to be taken to explore what structures are required truly to meet the complex needs of children who are accessing specialist therapeutic residential services. The need to implement a clear and considered strategy to not only improve outcomes but also be able to evidence these within a clear theoretical framework is important. The organisation needs not only this, however. It also needs the capacity to

understand that the very structures within staff groups can break down if not acknowledged and understood.

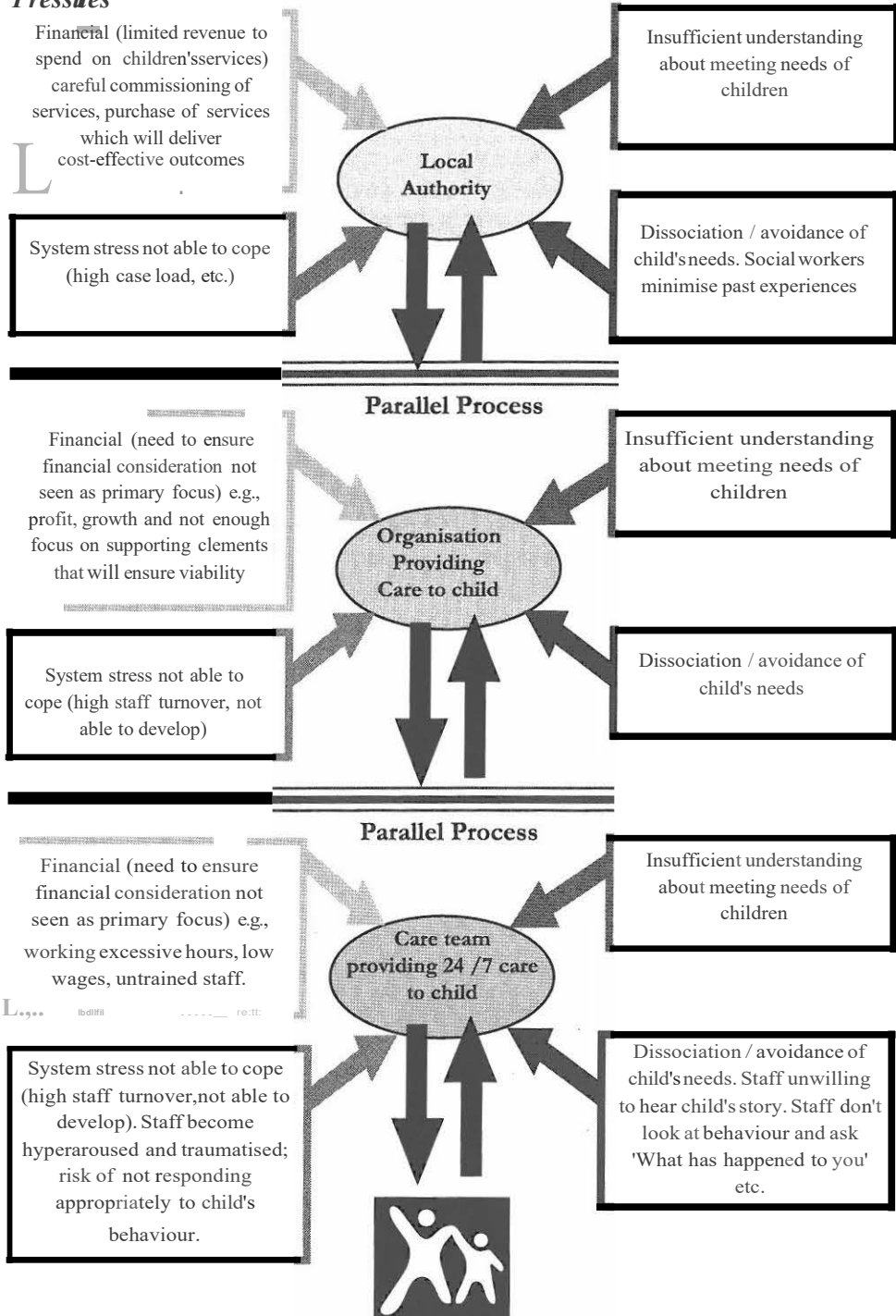
This can be due to tensions which may be created by parallel processes and traumatic re-enactments which can occur in any organisational system (Bion, 1977). Specialist therapeutic residential services need to not only understand children but also need to recognise how trauma can present itself at different levels of the organisations. I argue that the natural propensity to make changes at the macro and micro levels in organisations can be 'circumvented' and opportunities lost due to:

The fear of the unknown and the potential danger to the status quo....[This] entails leaving conformist standards and becoming a 'deviant' in the eyes of society [or group] (Jones, 1982, p.134)

There is a need to do that which is at times is not instinctual and to allow systems, groups and ourselves to be open to reflection and challenge. It is crucial to be able to communicate about issues which have in the past been left unspoken. This is the only way that dysfunctional cultures which can naturally occur in organisations can be changed (Foulkes and Anthony, 1965). This is what is meant by the common saying 'Hurt people, hurt people'; as 'loss of words' is a key hallmark to the start of damaging communication. This can be represented in diagrammatic form :( shown overleaf).

**Pressures and factors which can occur at various levels within society and group functions that can impact on the child's care within a residential setting:**

**Pressures**



My experience of implementing such approaches in organisations is that it takes a significant emotional shift to encourage open communication among the staff team which means truly saying what is normally left 'unspoken.'

Another benefit is that this approach challenges what can be called 'the fallacy of delusional equilibrium' (Docker-Drysdale, 1991, p. 148). This implies that by keeping things calm and smooth on the surface, any chaos below this need not be recognised or addressed. Breakdown of this false equilibrium at any time often means that suppressed feelings are projected onto any available scapegoat. If such processes go unchallenged and services have not been developed to meet such complex needs, abusive practices can begin to occur within the residential care environment, which can be disguised as an attempt to manage children's behaviour (Levy and Kahan, 1991).

Specialist therapeutic residential services need to have a range of structures in place to address the needs of their children and the staff groups who work with them. A clear theoretical framework should be in place and implemented through adequate training. This will provide a foundation for the development of the culture and vision of the organisation. Good management is important. I would, however, propose that it is possible to have management without therapy, but not therapy without management. Management in this context includes safety, boundaries and all aspects of the organisational structure. Without these structures, feelings of mistrust, insecurity and anxiety are likely to be the dominant dynamics within the environment. This, of course, can be a parallel in terms of the children's experiences. The whole environment must be organised and managed in such a way that the therapeutic model can be implemented and that everyone has a clear understanding of tasks, roles and responsibilities.

Currently the dominant focus within service development in Scotland's 'therapeutic' provision has been on the 'bricks and mortar' of the homes. Therapeutic is seen in terms of size, for example, the small group care house. However, I suggest that much more needs to be done to ensure the basis for the belief that this is therapeutic in its own right is researched and evidence based. My belief is that for some children this may in fact create a more intense experience, which may not necessarily be positive. Issues such as attachment can on the one hand be extremely healing; on the other, if we do not have the necessary knowledge to facilitate healing, it may increase the likelihood of placement breakdown. I advocate therefore that those organisations providing specialist therapeutic residential services in Scotland ensure that they have the structures in place which are required to provide for the needs of most hurt and injured children in our society and help them heal.

I have outlined some brief thoughts below to illustrate some areas which I believe will have an impact on all levels in the organisation, with points of action which might be considered:

- (1) **Staff training:** Staff need to be trained in all aspects of child development, the effects of childhood trauma, and the rationale for any therapeutic models which are put into place. *Proposed action: Review of your organisation's current training programme, with a greater focus on developing peer mentoring in situ, to show and model to staff how the work should be undertaken, building upon the experience and commitment of skilled workers.*
- (2) **Support and supervision structures:** It seems common-sense and logical, but there should be an aim for any organisation to have only professionals with substantial experience in direct supervision of child care workers undertaking the supervision task. The teaching of the skills required should be provided in situ during work with children. Direction and facilitation of interaction of inexperienced practitioners with children is invaluable. In my view, skills cannot be learned purely from books or through didactic methods. This is akin to believing that the analysis of cement could tell us how to construct a building. *Proposed action: Review of job descriptions and criteria for specific roles.*
- (3) **Understanding tensions:** The best interests of the child can easily be forgotten as the worker strives to satisfy superiors, co-workers and organisation. This is a process which should be open to identification and challenge through the application of therapeutic community principles. Such processes will provide containers and boundaries for all. *Proposed action: Explore how tensions are going to be managed and responded to within your organisation (e.g. Financial or growth targets) so as to ensure they do not affect care. This could include a clear statement from organisation as to its 'vision' endorsed by all in the organisation distributed to staff and children.*
- (4) **Therapy services:** A clear commitment should focus on the fact that many of the children entering our care may require the opportunity to access therapeutic services. This requires the organisation to have appropriate structures and knowledge in relation to assessment and psychotherapeutic interventions, along with contraindications of various therapeutic approaches for children. Naturally, this process will need to be a multi-disciplinary approach between Health (CAMHS), social work and residential childcare providers. *Proposed action: Re-emphasise how the child's emotional needs are going to be met in the care planning process and before placement and ensure that therapeutic means to meet the needs are identified. Services should be able to answer the question 'Can we meet the emotional needs of this child?'*
- (5) **Education for children:** The permanent exclusion rate among children in care is well documented (Her Majesty's Inspector of Education/ Social Work Services Inspectorate, 2001). Work with traumatised children in educational settings requires having a consistent approach to that which is applied in the residential

setting. Some traditional approaches to teaching and learning are not successful if behaviour relates to complex trauma / dissociation. Trauma / dissociation can give rise to hyperarousal which is difficult to deal with in a traditional classroom setting. The overall mental, physical and emotional wellbeing of the child are the essential pre-conditions for successful learning, and this is acknowledged in policy documents relating to education (Her Majesty's Inspector of Education 2006).  
*Proposed action: Develop education on site or educational supports. Provide advocacy about the needs of traumatised children.*

## Conclusion

The UN Convention on the Rights of the Child states: 'Governments should do all they can to promote physical and psychological recovery and the 'social reintegration' of children who have been neglected, exploited, tortured or been subject to any form of cruel, inhuman or degrading treatment' (UNICEF, 2009). To do so requires that Governments need to ensure that children have access to appropriate services. Specialist therapeutic residential services offer one resource to help meet these needs. As I sit and write this conclusion, I would like to emphasis the words of Donald Winnicott (1964):

Now what happens if the home fails the child before he has a framework of his own nature? The popular idea is that, finding himself 'free' he proceeds to enjoy himself. This is far from the truth. Finding the framework of life is broken, he no longer feels free. He becomes anxious and begins to look for a framework elsewhere. (Winnicott, 1964, p. 228)

All specialist therapeutic residential services need to demonstrate an ability to meet the psychological and emotional needs of the client group they have been set up to work with. They should also open themselves up to assessment against this by the appropriate regulatory care inspection frameworks. At the moment, standards for therapeutic communities for children are currently being finalised by the Royal College of Psychiatry 'Community of Communities' initiative. This may be a good starting point.

We should also pay attention to how the overall system can reflect dysfunction, and be prepared to deal with this. I propose that one way of breaking re-enactment patterns and parallel processes is to focus in on the particular needs of the children coming to stay with the organisation and to develop appropriate structures to meet these. These structures then direct the organisation along with the vision. In the end, this leads to shared governance. If we are able to focus solely on what are the underlying needs of the children in all of our residential child care services in Scotland, I believe we will be able to design key performance indicators which are measurable. This will help us to provide the evidence that we not only provide a good standard of care but also help children heal.



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So I will end as I started with a question: 'Do you seek to be a specialist therapeutic residential care provider for children and young people who have complex needs?'

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