THERAPEUTIC COMMUNITIES

There has been a recent rise in interest from policymakers and commissioners in the important role therapeutic communities play in supporting some of the most traumatised children and young people

HIGHWAYSTARZ/ADOBE STOCK

Countless reports and the experience of providers and local authorities alike tell us that there is rising demand and complexity across children's social care. Residential care, fostering and specialist education have all become increasingly segmented with specialist services and models emerging. This presents significant challenges for those who commission and purchase services and for those who operate them, either as a core activity or especially as a component part of a wider portfolio. There is a real lack of understanding and consensus, on both sides, about what systems and structures to expect in order to deliver quality, value and outcomes.

The term "therapeutic" has been increasingly adopted over the last decade but what does this term mean, and how does it translate into the realities of daily practice? Are staff working in residential children's homes and other social care settings trained to understand and operate a "therapeutic" model?

With this in mind it is perhaps unsurprising that The Consortium of Therapeutic Communities (TCTC) and the quality improvement network Community of Communities at the Royal College of Psychiatrists have seen steady growth in membership and engagement. Children's social care and education services, mostly small and medium sized, represent the fastest growing and most active networks for both these agencies. Services come almost always seeking a model for practice because just getting by without one doesn't work. »

Policy context

The term "therapeutic" – at least in the way commissioning specifications set out – focuses on the direct work of a therapist in weekly sessions with a child. While this important technical component has its place, it is only one limited element. In order for residential care, fostering, education or supported housing to be "therapeutic" something more is needed.

Many children and young people arriving in residential children's homes, therapeutic schools and foster care, were referred because of a complete breakdown in their capacity to sustain good relationships with family, carers, teachers and local health services. This breakdown is predicated upon the enormous and overwhelming pressures placed on them by what Bessel Van Der Kolk calls "developmental trauma" (2014). Those working in the sector come face to face with the damage caused by abuse in childhood. Such children can rarely sit and talk with an adult for more than a few minutes let alone engage in an hour of psychotherapy.

Therapeutic communities, while they come in many different shapes and sizes, provide a whole service approach to the treatment and care of young people, an approach that co-ops both staff and the young people in recognising and bringing their internal resources together around a clear model to face the task in hand.

The task is to create a space in the home which is safe enough to act as a corrective environment against the trauma and volatility of children's pasts. We are not just thinking about one-to-one relationship, but harnessing the power of all the relationships that make up the organisation to create a network strong enough that children won't fall through it. This creates an environment in which the staff, who must support the children and each other, can also thrive. In this way, the level of care and support, missing in the children's early environment, is both replaced and sustained for long enough to allow children to begin development anew. The model works with, but isn't limited to, any simplistic diagnostic approach that treats a "disorder" instead of a child. This kind of setting was once described by Terry Bruce, a psychiatrist who advised a number of therapeutic communities, as being "founded on the premise that severely conduct disordered children are reacting comprehensibly to emotionally intolerable conditions in their upbringing and that their behaviour can be ameliorated in an environment that is geared to enabling them to develop reflective functioning: a state of mind in which the child is able to reflect on his or her behaviour and that of others as opposed to reacting explosively when faced with emotionally stressful situations" (cited in Nicholson, 2010, p200).

To create a setting where children and adult staff are co-operating to support the therapeutic model sounds idealistic, except that this is exactly what therapeutic communities are achieving.

The success of therapeutic communities is partly based on the fact that children are involved as co-constructors of the services. Seen as whole people with well capacities, and not just as "damaged", they have important views and contributions to make to the daily work of therapeutic living. This is very different to encouraging "participation" as a regulatory necessity. For children who were harmed by adults and feel immensely distrusting of them, this new relational contract with adults is crucial and empowers them to use their innate power and control in reflective ways to support themselves and others, rather than in reactive and harmful ways compelled by painful memories.

We argue that given how residential care, specialist education and specialist foster care is used in the current climate, the young people – and local authorities – have a right to expect theoretically informed and robust intervention and support by default. All residential children's services need to be "therapeutic" because the underpinning work must be to address trauma, insecure attachment, and multiple adverse childhood experiences. The thoughtful management and containment of risk emerges from this understanding, and shouldn't be seen as the sole task.

Therapeutic service standards

There are sets of therapeutic service standards already developed in the UK. Developed initially for children's therapeutic communities (TCs) in 2009 and themselves arising out of established work in adult mental health, there is now an evolved set of standards specifically for therapeutic child care (TCC). These came from the ground up – primarily from organisations that were actually delivering TCC but struggling to express and meet the standards for TCs due to their lack of use of group processes and relational dynamics. Therapeutic communities standards didn't quite "fit" the operating systems of TCC and so bespoke standards were a natural evolution.

Interest and application of both sets of standards has risen year on year as more services either want an external validation framework to help them with governance and engaging with commissioners, or services seeking to develop practice in a therapeutic direction, perhaps for specific parts of a larger portfolio, and seeking collegiate networks for support.

The Consortium of Therapeutic Communities holds and reviews the underpinning core values. These are shared with Community of Communities (CofC) at the Royal College of Psychiatrists and are the foundation upon which the standards are written. Services working with the standards engage either developmentally or as full members of the CofC network.

This is a quality improvement cycle of self-assessment and gathering of an evidence

THE 10 TC CORE VALUES

- **Attachment**
  Healthy attachment is a developmental requirement for all human beings, and should be seen as a basic human right.
- **Containment**
  A safe and supportive environment is required for an individual to develop, to grow, or to change.
- **Respect**
  People need to feel respected and valued by others to be healthy. Everybody is unique and nobody should be defined or described by their problems alone.
- **Communication**
  All behaviour has meaning and represents communication which deserves understanding.
- **Interdependence**
  Personal wellbeing arises from one's ability to develop relationships which recognise mutual need.
- **Relationships**
  Understanding how you relate to others and how others relate to you leads to better intimate, family, social and working relationships.
- **Participation**
  Ability to influence one's environment and relationships is necessary for personal wellbeing. Being involved in decision-making is required for shared participation, responsibility, and ownership.
- **Process**
  There is not always a right answer and it is often useful for individuals, groups and organisations to reflect rather than act immediately.
- **Balance**
  Positive and negative experiences are necessary for healthy development of individuals, groups and the community.
- **Responsibility**
  Each individual has responsibility to the group, and the group in turn has collective responsibility to all individuals in it.

Source: The Consortium of Therapeutic Communities

ADCS VIEW WE NEED TO RETHINK OUR APPROACH TO THERAPEUTIC CARE

Charlotte Ramsden, ADCS president 2021/22

What is care for and what should it look like? The answer, of course, is different for each child or young person, built around and responsive to their individual needs. However, there are a few basic principles that I think we can all agree on.

Care should protect children from harm and improve their experiences and outcomes. More than that, care should be caring and loving, and it should foster the development of positive and meaningful relationships between children and the carers and professionals in their lives as well as the families from which they come.

Children and young people are coming to our attention with more complex and multiple needs, as shown in ADCS's Safeguarding Pressures Phase 7 report. Directors of children's services are especially concerned about growing difficulties in accessing the right help and support for a small but extremely vulnerable cohort of children and young people with the most complex and overlapping health and social care needs, who find themselves on the edge of the criminal justice or care systems and/or on the brink of hospitalisation.

A particular issue for us is access to CAMHS (child and adolescent mental health services) for children and young people who require inpatient services. Due to the extremely limited availability of Tier 4 CAMHS beds there can be long delays before children receive the mental health support and therapeutic intervention they need. When a bed is found it is likely to be many miles away from friends, family and their community.

The needs of these young people are severe. They can often present a huge risk to themselves, and sometimes others too. When placements are needed, they are often needed urgently and at very short notice, but a placement in a secure children's home (SCH) is often the only option and there are issues here too. It can take days or even weeks to find a placement in a SCH, regardless of the severity of the situation. While staff in SCHs can keep children safe they aren't mental health professionals and can't provide the treatment these young people need. Research commissioned by the Department for Education exploring local authority use of secure placements found that while providers may claim to provide therapeutic services, when this "offer" is interrogated, it can mean different things across a vast spectrum. There is no clear definition or set of standards for a placement which provides "therapeutic" care and there is, therefore, a gap in provision.

A wholly new approach and therapeutic offering is required to respond to the acute needs of these children and that these low-incidence-but-high-cost placements are best coordinated and commissioned in partnership whether the child's primary presenting need is justice, welfare or mental health related. A range of appropriate step-down arrangements including therapeutic support provided in the community are also required to ensure we can support young people to successfully reintegrate into the community when they are ready.

Meeting the needs of this very vulnerable cohort of young people must be a key focus for the Care Review, and for the SEND Review.

portfolio, which is then assessed by a visiting peer review team, led by the Royal College, but made up of other therapeutic service practitioners, experts by experience and specialists from within the network. This experiential and inclusive process involves the young people and staff, leading to a report and recommendations for further development. The process itself is relational in its delivery. Its innovation is to establish a cycle of genuine organisational reflection and self-regulation. Staff think together about the quality of their work; children develop agency, both giving voice to the ways the community or home can be improved. Naturally, young people and staff become more committed to the therapeutic task when invited to shape it.

Service design – therapeutic care or community?

The nature of the task lends itself to thoughts about the size and location of services – rural or urban, self-contained or more integrated into a wider community or other agencies? It also allows thoughts about the volume and shape of staff resources – how many, from what disciplines, trained with what competencies?

We can also then think about how many young people will live together and can that be used helpfully or will it be unhelpful to the task? There has been a trend over the last 20-30 years for smaller children's homes, partially rooted in the language of the Children Act 1989 with its focus on family-style settings. It was also a systems response to the abuse scandals of the preceding period which were more dominated by institutional care.

Currently, the most common registration for a children's home is 3-4 bedrooms, but there is still high demand and use of solo and two-placement services, often with very high staff ratios, typically more geographically isolated, developed as a response to high risk levels. There is little if any evidence base to support the notion that smaller is better, or that isolating young people to manage risks has any longer term beneficial outcome, but as an immediate containment of risk it is easy to see how this trend has emerged.

Trauma is what underpins the presenting risks and needs – trauma is created in dysfunctional and abusive relationships and so it is through a corrective relational experience, guided by clear evidence-based interventions with sound theoretical footings that positive change can be achieved. Risks do need to be contained - and safety is the underpinning foundation for therapeutic work - but physical containment is only a first step: the real work – psychological containment – is what comes afterwards.

This does have obvious considerations about how many young people and what combination of needs and risks might be cared for in a location. In services with lower complexity of needs, greater diversity can be sensibly worked with together – the core activities around trauma, self-esteem, building resilience, improving emotional literacy which you would see in any service, provide enough cohesion for the group and then the more individual and tailored interventions through therapy, or keyworking, or family work can be layered on top.

However, more complex needs may require more structured approaches, some risks are better managed on smaller scale (e.g. fire raising or suicidal ideation) whilst other needs, such as harmful sexual behaviour, aggressive and reactive conduct, anxiety and attachment issues, have a good evidence base that draws well on group work.

Therapeutic Child Care would adopt a systemic approach to service design, assessment, intervention and governance in a multitude of designs where a domestic or more family style of delivery is appropriate and »

helpful to the task. It is readily applied to residential care, fostering and education and is helpful in stepdown, supported housing and other transitional services. A common model is a cluster of small homes linked to a small school. These models can also allow for homes where education is delivered in the mainstream provision. The systemic approach becomes all the more important in these contexts where multiple agencies are involved. The key considerations are the task and system – these need to be oriented and matched so that children, their vulnerabilities and needs remain at the heart of the service and alive in the minds of those operating them. This understanding, enshrined and articulated in the service standard, is vital to new service design, service development, commissioning, quality assurance and improvement, and also helps in engaging with regulators and other multi-agency systems.

TCs develop practice down a further pathway where there is conscious use of the group: group work, group dynamics and a total therapeutic milieu – a living/learning system – in which relationships are central to the approach being used to create change. They are "practice communities" where children's mistakes are not disasters, but can be responded to with understanding, in order that the accrued psychological and social insight and self-awareness will later protect them in the wider community. The immersive process of a journey through a therapeutic community is itself part of the therapy. Built on core values (see box), the TC approach has a long and rich history in the UK and internationally and while falling out of favour with the policy directions of the 1990s, it is now seeing a resurgence – especially in the local authority quest for practice efficacy and value for money.

Implications for the workforce

The application of the core values has also allowed the development of a set of Therapeutic Community Practitioner Competencies (Nicholson, 2014) to help identify the personal knowledge and skills that staff will need to work relationally in a dynamic system. These are useful for job specifications and to help with values-based interviewing and activities – relational work places more emphasis on "who you are" than "what you know" as knowledge can be trained. They are also used at appraisal in some settings, as well as for workforce development planning on a larger scale, measuring the organisational competence and where strategic and focused training and support might be required. Organisations can cross-reference the knowledge of internal and external training to help plan and evidence staff skills linked directly to the therapeutic task at hand, which will vary from service to service.

On a more day-to-day operational sense, the use of structured systems for practice impacts

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A therapeutic community is an immersive approach

on the style and tone of communication between staff, between adults and children, and between different disciplines.

Staff using themselves, consciously, in relationship with others, requires focused management, leadership and direct maintenance. The style of line management supervision needs to be reflective at an individual level, but is often in TCs supplemented by group supervisions or "sensitivity groups" to sensitise staff to the psychological and psychodynamic factors at play in their work, facilitated by therapists. These are important spaces for staff to think together about their own group and individual functioning and dynamics, how this relates to the task at a given point, and how this sometimes parallels the dynamics of the young people's group providing data to think with.

Any residential practitioner can identify the defensive mechanisms that can get played out when anxieties are high in a service – the scapegoating of a young person, or staff member, the splits that can emerge between departments - care and education is a common fault line. Left unattended, these unconscious dynamics, which are a natural response to the inherent challenges in trauma work, will work against the task and against the outcomes the service is trying to achieve. Boundaries, their creation, revision, application in the day to day, how they are negotiated with young people, how they are updated and maintained, are the very essence of therapeutic work. Children are excluded from services not because of their behaviour or mental health difficulties, but because the staff who make up the organisation at all levels are not sufficiently in touch with their own tendency to fragment and weaken the "holding" of the "facilitating environment", as Winnicott describes it (1986). The adults lead on this kind of holding, especially so in TCC, but in the therapeutic community the responsibility and accountability is shared with the young people. Surprising as it may be for young people with such chaotic lives, treated in this way by staff, as also competent, considerate and capable, the young people rise to the challenge.

We know that when people are clear about what they are doing, are trained with the knowledge to do work at increasingly sophisticated levels, understand how their work relates to others, have a voice in the decisions of the service, are involved in the day to day decision making and have a sense of the positive impact of their work – they are more satisfied, engaged, and have a stronger sense of purpose and ultimately are more committed.

Values-based, relational approaches create the conditions for these positive aspects to flourish. Of course, the most important element is the young people's experience on the receiving end of care and support – clear tasks and appropriate systems lead to better matching, more responsive interventions, clearer targets and progress maintenance and ultimately more stability and better outcomes.

Relationships that are meaningful and authentic, have open communication, and are based on respect and listening. They allow the safe testing of boundaries, use of reflection and feedback for learning, empower people to exercise agency and build self-capacity and pro-social functioning across time. Evidence-based therapeutic childcare and therapeutic community practice are deliberately designed to harness the power of relationships. ■

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FURTHER READING

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