

# **SPECIALIST EDUCATION SERVICES**

## **“The SES Way” An Exploration of our Therapeutic Model Policy and Practice**

Date created or revised: 0219

Date of next review: 0220

*SES Avocet Ltd (4926028) and SES Turnstone Ltd (7972485)  
are subsidiary companies of Specialist Education Services Holdings Ltd (7970185)*

## CONTENTS

1	INTRODUCTION	3
2	VISION STATEMENT	3
3	AIMS AND OBJECTIVES OF SES	4

### **PART ONE: POLICY AND HISTORICAL CONTEXT**

4	SES: BASIS OF THERAPEUTIC APPROACHES	5
5	THE SES WAY	6
6	WHAT INFLUENCES OUR THERAPEUTIC APPROACH?	8
	6.1 Milieu Therapy	8
	6.2 The Medical/Psychiatric Perspective	8
	6.3 The Therapeutic Care And Education Perspective	9
	6.4 Planned Environment Therapy	10
	6.5 The Secure Base Model	12
	6.6 Behavioural Neuroscience	13

### **PART TWO: PUTTING POLICY INTO PRACTICE**

7	KEY COMPONENTS OF OUR THERAPEUTIC APPROACH	14
	7.1 Portfolio Of Achievements And Needs (Pan) Process	14
	7.2 Pan Planning Structures	16
8	PLANNED ENVIRONMENT THERAPY IN ACTION	16
9	SECURE BASE MODEL IN ACTION	20

10	CONSULTANTS WORKING WITH THE SES TEAM IN SUPPORTING HOLISTIC THERAPEUTIC APPROACH	23
11	TRAINING STAFF	24
11.1	Our Shared Biological Inheritance	25
	<i>11.1.1 Our emotional needs include:</i>	25
	<i>11.1.2 Our tools and resources include:</i>	26
	<i>11.1.3 Achieving Mental And Physical Health</i>	26
11.2	Learning As Therapy	26
11.3	Behavioural Interventions As Therapy	27
11.4	Family Links As Therapy	27
12	WHAT ARE THE RESULTS OF THERAPEUTIC INTERVENTIONS	27
12.1	Respite	27
12.2	Relationships	27
12.3	Re-Signification	28

## 1 INTRODUCTION

This document is presented in two parts, the first outlining the beliefs and values of SES, and the underpinning theoretical background to our therapeutic approach. The second describes how this translates into everyday practice.

Bespoke, personalised, specialised education, health and care are hallmarks of SES establishments' operation, based on a positive psychology perspective that underpins our values and approach, known as the SES Way.

We are often asked, "What therapeutic model do you work to?" Very often those that ask already have their own preconceptions about what is or is not "therapeutic". As there is a great deal of confusion (and debate) about Therapy and Therapeutic with a capital T, we have tried to encapsulate our philosophy in the SES Way.

Historically, many professionals and organisations talk in terms of 'treatment' or 'healing'. Often this means viewing the child as having 'deficits' which are then worked on as part of a treatment programme. This concept, for us, is mistakenly a 'doing to' rather than a 'doing with' approach.

Our perspective, backed up by the emerging research and understanding of neuroscience and brain plasticity, is that planned, personalised learning (i.e. learning viewed in it's broadest sense) and putting the child at the centre, working from strengths and ambitions is the 'therapy'.

We embrace the opportunity as professionals to learn from our young people through what they bring personally and what they bring in respect of challenge.

**At SES we purposefully create a personalised response, starting from the young person's Development and Learning planning structures alongside our holistic planned environment therapeutic response, recognising that every interaction is learning and has the potential to be therapeutic for them.**

## 2 VISION STATEMENT

Our vision statement expresses our values:

- ✓ we believe in a 'no limits' approach to helping children
- ✓ we believe in success not failure
- ✓ we believe learning is a lifelong process
- ✓ we believe in being inclusive not exclusive
- ✓ we believe intelligence is multifaceted
- ✓ we believe creativity and imagination are the keys to developing passions and talents, and preparing for life in a rapidly changing world
- ✓ we believe assessment of progress is based on improvements on 'previous best'

- ✓ we believe in a 'can do' philosophy
- ✓ we believe in children's abilities and potential
- ✓ we are future orientated

### **3 AIMS AND OBJECTIVES OF SES**

The purpose of SES is to provide a holistic therapeutic facility that offers a safe, nurturing, caring, positive and protective homely environment that promotes personal growth, development and learning.

- To create and maintain appropriate caring boundaries for each young person that helps them make the transition from dependence to autonomy
- To develop a Portfolio of Achievements and Needs (PAN) which looks to preferred futures, enhances self esteem, develops strengths to maximise their personal potential, produces opportunities to succeed and moves the young person to an appropriate level of self-determination.
- To provide the platform for future permanence for each young person. This may be in the form of a return to their own home and family, permanent alternative placement in foster care, adoption, long term residential care elsewhere or independent living.
- To achieve the highest possible standard of educational achievement measured by:
  - ✓ A movement from disaffection to engagement in the learning process
  - ✓ Improvements in behaviour conducive to learning
  - ✓ A growing enthusiasm for learning
  - ✓ Specific and generalised achievements
  - ✓ Tangible accredited outcomes
  - ✓ Emerging gifts, talents and passions
  - ✓ National accreditation
- To make the curriculum fit the student not the student fit the curriculum.

# PART ONE: POLICY AND HISTORICAL CONTEXT

## 4 SES: BASIS OF THERAPEUTIC APPROACHES

*“Without theory practice is but routine form of habit. Theory alone can bring form and develop the spirit of invention.”*

(Louis Pasteur (1859), address in taking up his professorship at Lille.)

Over the years and years of residential work with children described variously as: ‘maladjusted’, EBD, BESD, SEMH, disturbed and disturbing, troubled children, problem children, delinquent, unhappy children, emotionally damaged, etc., an ongoing debate has been held about how to describe the theoretical underpinnings of successful care and education and which methodologies work best.

From early pioneers like Mary Carpenter in the mid 1800s who emphasised the therapeutic power of caring environments for vulnerable children and Dr Bernardo who established the first residential child care facilities for underprivileged and orphaned children in the last quarter of the nineteenth century, to the psychotherapeutic interventions sparked by the work of Freud, followed by the move away from a medical model to an educational psychology based, learning theories influence (sometimes referred to as behaviour therapy), to a more contemporary interest in ways in which the individual and environmental factors interact in the form of a bio-psychosocial framework of understanding, where the biological, psychological and social aspects of the individual and/or context are each equally important, workers with these children have defined and explained their approaches under a broad umbrella of ‘therapeutic’ and some have offered specific therapy.

An examination of the dictionary definitions of the key words results in the following:

**Therapy** - any treatment aimed at curing a physical or mental disorder  
- a treatment which helps someone feel better, grow stronger, etc.

**Therapeutic** - of or for healing  
- causing someone to feel happier and more relaxed or to be more healthy

Our philosophy of a personalised approach coupled with the view of ‘care and education without limits’ expressed in our vision statement intrinsically rejects the ‘one size fits all’ mentality and instead adopts an eclectic therapeutic approach that puts the individual child at the centre. Our definition of therapeutic therefore becomes a generic descriptor representing this eclectic approach, which purposefully seeks to utilise the best approach for the individual (bespoke interventions) whilst underpinning this with some clear environmental and social

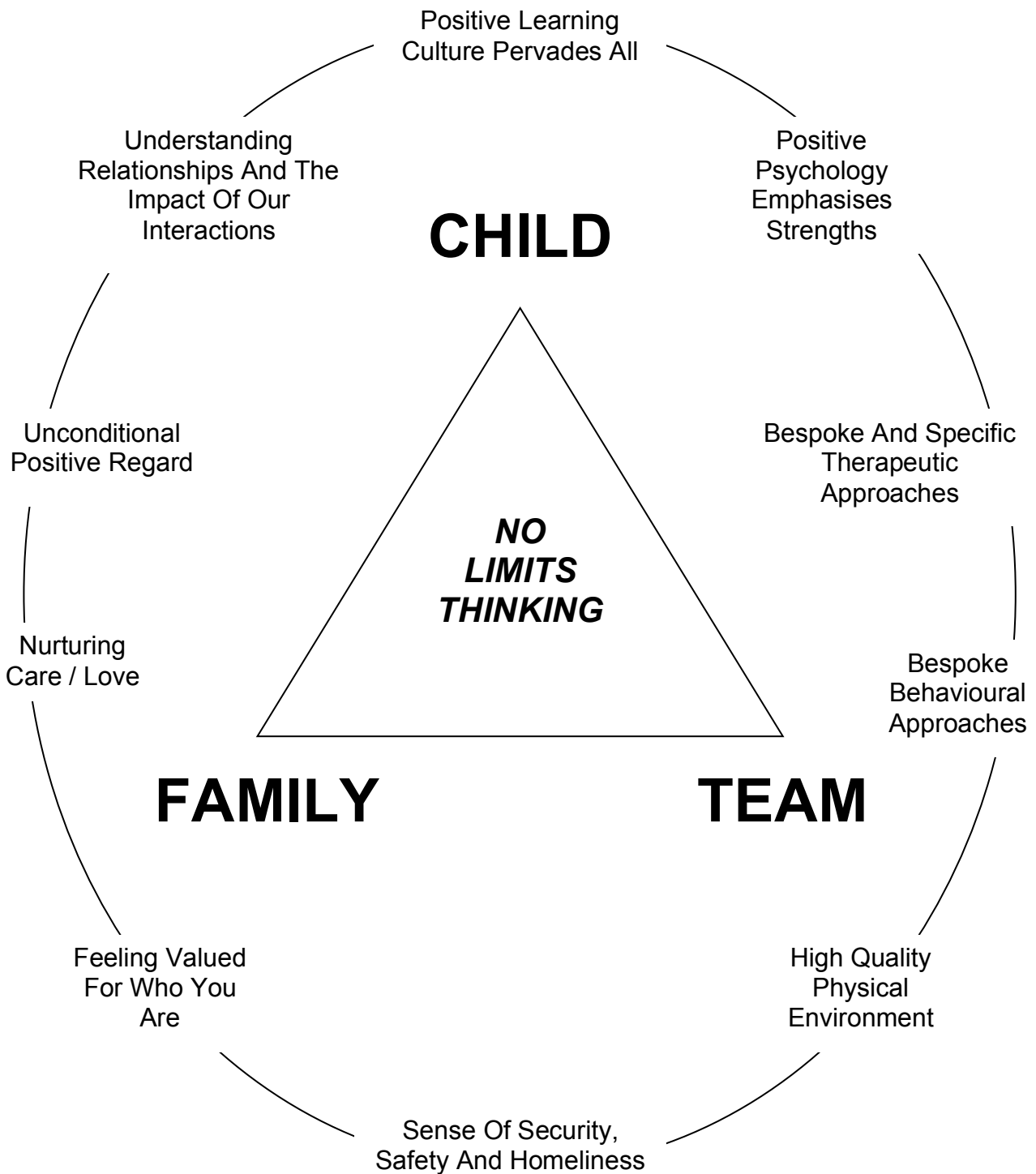
structures. **All aspects of a child's life at SES are potentially capable of having therapeutic impact.**

## **5 THE SES WAY**

We believe SES is unique, with its core no limits vision and philosophy that leads to positivity and aspiration for all young people. Both Avocet House and Turnstone House are total learning environments, where adults and young people learn about themselves and each other from their daily interactions and relationships. All young people coming to SES are seen firstly as individuals, therefore their needs are unique and as such a carefully planned, individually constructed approach leads to long term therapeutic outcomes from the initial point of entry. These outcomes are planned and tracked through our PAN process, specifically the Development and Learning structures.

This personalised response can be summarised as 'The SES Way', best represented in diagrammatic form overleaf:

# THE SES WAY





## 6 WHAT INFLUENCES OUR THERAPEUTIC APPROACH?

The therapeutic approach of SES has strong connections with Planned Environment Therapy, and more recently, the Secure Base Model. The following summarises the background and key ideas that stem from both.

### 6.1 MILIEU THERAPY

Milieu Therapy has its historical roots in work in Europe, Scandinavia and the USA. Planned Environment Therapy fundamentally stemmed from Milieu Therapy, which essentially came from a medical/psychiatric hospital background. A brief understanding of this medical perspective is useful.

Milieu therapy has been in practice in various forms since the 1800's. However, significant research into understanding the milieu as a therapeutic approach to adult inpatient mental health nursing began in the 1950's. Many individuals have contributed to the research surrounding milieu therapy. Of particular interest are the contributions of Jones (1953, 1968), and Gunderson (1978).

### 6.2 THE MEDICAL/PSYCHIATRIC PERSPECTIVE

The underlying principles are that the client is an active, not passive, participant in their own life. This implies and allows the client to own their behaviour and environment, and as a result need to be involved in the management of both. The milieu sees the individual as independent and it is the individual that must deal with conflict, distortions and inappropriate behaviour in the here and now, whilst taking into consideration the impact on any other individual's milieu. It is essential that peers be involved for the learning that comes from interaction as well as the therapeutic healing effect of peer pressure.

Jones (1953) developed a concept of the therapeutic community. He aimed to design a culture that would promote positive healthy personalities. Jones wished to have his clients improve their behaviour. He is also one of the first to acknowledge that the acute inpatient or hospital environment affects behaviours, progress and symptoms of clients.

Key principles of Jones' milieu therapy include the promotion of fundamental respect for individuals; the promotion of socialisation which provides opportunities for clients to be involved in the management and daily running of the unit; encouragement of clients to act in a way that is at a level equal to their own ability and subsequently enhance their self esteem and to encourage staff and client communication for maximum therapeutic benefit (Jones, 1953).

Gunderson (1978) introduces five key therapeutic processes, containment, structure, validation, involvement and support.

- Containment is a maintenance function. It promotes physical well being whilst the individual is allowed to regain and maintain self control. This in turn presents a safe environment for the client. It is expected that the successful implementation of containment will lead and foster feelings of internal security.

- Structure is the process of organising time and activity. Clients need to be provided with the extra security offered by structure. It is not uncommon for clients to suffer from sleep related disturbances such as sleep/rest cycles becoming irregular. When these types of needs are met the clinician can focus on interventions for dealing with problems such as maladaptive behaviours. Clinicians need to be aware of the necessity of both quiet and busy times. Structure needs to be created through activities, groups and socialisation. Successful implementation of structure allows the individual to learn and maintain self control. The client will therefore engage in daily activities such as active participation in ward activities.
- Support is the enhancement of the individual's self esteem. It is characterised by the validation of one's ability to accomplish tasks associated with academic and athletic ability, social acceptance and physical appearance. With improved self esteem the client can move beyond simple survival toward a richer fulfilling life. Channels of support include psycho educational and group therapy opportunities. For example the ward program may offer activities such as problem solving and story telling with relaxation training. A successful outcome should include and be demonstrated by increased willingness to face unfamiliar tasks, decreased anxiety surrounding body image perceptions and personal appearance in addition to the ability to focus on accomplishing tasks.
- Involvement is the process in which a client attends actively to their social environment and interacts with it. Clinicians need to emphasise social involvement and assist in decision making processes if required. Interventions may include leadership programs, communication, assertiveness and personal communication skills. Whilst integration is difficult to evaluate within the short time frame of the acute setting a sign that integration is successful would include active participation without prompting to attend groups and activities.
- Validation supports the differentiation of self, which can be defined as the ability to distinguish between thoughts and feelings within an emotional relationship system. It is a way of understanding thoughts and emotions and how to connect them with self enhancing rather than self destructive behaviours. Staff should focus on what has happened to the client rather than what may be wrong with them. They should give the individual the opportunity to tell and explore their story. Story telling is a positive therapeutic tool in these situations. Positive outcomes for the client include an understanding of the emotive self and coping systems to help them neutralise any emotions and assist them to work through the situation.

Even with this medical model there are immediate similarities with our work at SES.

### 6.3 THE THERAPEUTIC CARE AND EDUCATION PERSPECTIVE

A parallel process was at work in examining ways of working with troubled children and young people. The 19<sup>th</sup> century orphanages and houses of refuge as well as subsequent training schools and reformatories utilised a limited number of programme components: work, education and rehabilitation.

From the turn of the century (and particularly after WW1) treatment of young people in most residential centres has been guided by psychoanalytic, behavioural or learning theory with two psychoanalytic approaches (intensive individual treatment and milieu therapy) dominating the field in the formative years, shaping and evolving the standard model.

Probably the first consistent exponent of Environment Therapy (Milieu Therapy by another name) was August Aichhorn whose practice in Vienna and his book of 1935 "Wayward Youth" exerted a strong influence on the subsequent treatment practices. Another key figure in the early years of thinking about Environment Therapy was Dr Marjorie Franklin who became involved with the Hawkspur Camp, founded as the first practical experiment in planned environmental therapy, an experiment in therapeutic community living. This brought her in touch with David Wills appointed as "Camp Chief", whose own ideas, forged from a very different experience, were so complementary to her own. The development and evolution of Environment Therapy and Therapeutic Communities is inexorably interwoven with a whole range of pioneers in thinking and working (Bruno Bettelheim, Homer Lane, Otto Shaw, A. S. Neil, Arthur Barron, Frederick Lennhoff, Barbara Docker-Drysdale, Richard Balbernie, to name but a few). Each made their own significant contribution to theory and practice.

#### 6.4 PLANNED ENVIRONMENT THERAPY

In 1963 a Planned Environment Therapy discussion group was formed under Dr Franklin's leadership and in 1966 the Planned Environment Therapy Trust was formed and still exists today promoting effective treatment for children and adults with emotional and psychological disorders. It also maintains a unique archive of materials relevant to the field of therapeutic care.

In 1973 David Wills wrote an article in Vol 2 of "Studies in Environment Therapy". Its title was, "Planned Environment Therapy – What is it?"

**At SES we have created a holistic therapeutic milieu available through the total care given to the young people by all the staff in the team, bringing the work of Dr Marjorie Franklin and David Wills with Planned Environment Therapy, into the 21st century.**

- In Environment Therapy the most important part of the environment is the worker. The type of person should be someone who:
  - a) has feeling as well as intellect
  - b) is a person with integrity
  - c) shows empathy and care
  - d) shows respect for others
  - e) as a role model enlarges and enriches others who associate with them
  - f) has firm (but not rigid) moral principles
  - g) is courteous and gentle in dealings with others
  - h) is a social person

- The relationships are between person and person first and client and worker second
- The environment releases the child to be –themselves - their real self – thus revealing issues
- The child is responded to in a warm and welcoming way at all times even when negative transference is taking place (i.e. the child transfers to the adult feelings they have or have had for one or other of their parents, or for other people in their life – this can be both positive and negative)
- Positive transference can be particularly effective in building relationships and helping the child progress
- It is the environment therapy that is planned not just the environment
- The worker is not left alone to identify or plan responses to the child's needs but is surrounded by others who support identification, interpretation and planning
- Workers should be supported to deal with the impact of the behaviours on themselves to lessen the chance of their judgement being clouded or their attitude warped
- Where a young person seeks maternal or paternal care or support (e.g. play, stories at bedtime, curled up beside an adult watching TV, etc.) it is given unconditionally whatever their age. Wills uses the following quote to illustrate the thinking:

*“At the heart of the problem is the lack of love. Love therefore must be at the heart of the cure. Whatever else we do we must make each child feel that they are loved. We, who have no blood relationship to the child, must provide what its parents failed to provide. To put it another way, the maladjusted child has never learned how to form relationships – what the psychologists call affective relationships – with other people. That is what they have to learn while they are with us, and they can only learn from experience.”*

- The aim is to create a kind of microcosm of ordinary society with its social and economic obligations, its social and economic pressures and its responsibilities to support oneself and the community
- The method is to foster those parts of the personality that are whole, to strengthen the psyche to cope with/manage its own conflicts
- There is a belief that all living things have a tendency towards wholeness, to self-correct, an inbuilt therapeutic drive – and PET removes the impediments to the natural tendency to self-heal and by strengthening the “whole” elements it facilitates a natural therapeutic tendency
- The community demands of its members mature and rational behaviour and brings about a natural pressure to that end
- PET accepts no “us and them” within the community – e.g. everyone is addressed by their first name irrespective of any hierarchy
- There is some form of democratic machinery for the expression of opinion in general and the management of the day to day affairs of the community – shared responsibility
- A third component of PET along with the psychological and social is the educational influence, and the combining of all three into an holistic whole. It is concerned with learning rather than teaching; it is concerned with all those things that a person needs to fulfill themselves – different in each individual case

- It is concerned with the fullest possible creative expression – arts, crafts, skills, techniques
- It is about making sure that there is opportunity to discover talent and then practice it

## 6.5 THE SECURE BASE MODEL

The Secure Base model, created by Beek and Schofield, provides a positive framework for therapeutic caregiving which helps infants, children and young people to move towards greater security and builds resilience. The model focuses on the interactions that occur between caregivers and children on a day to day, minute by minute basis within the caregiving environment. But it also considers how those relationships can enable the child to develop competence in the outside world of school, peer group and community.

It can be helpful to think about caregiver/child interactions as having the potential to shape the thinking and feeling and ultimately the behaviour of the child.

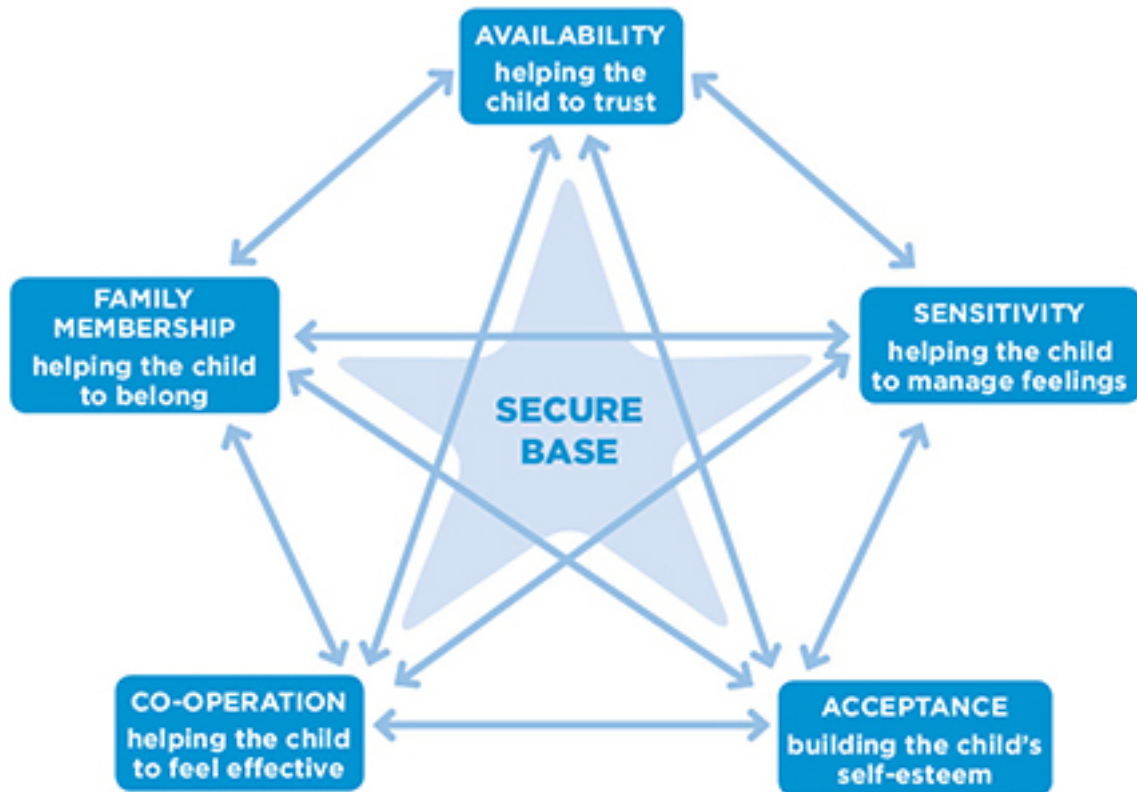
This process begins with the child's needs and behaviour and then focuses on what is going on in the mind of the caregiver. How a caregiver thinks and feels about a child's needs and behaviour will determine his or her caregiving behaviours. The caregiver may draw on their own ideas about what children need or what makes a good parent from their own experiences or from what they have learned from training. The caregiving behaviours that result convey certain messages to the child. The child's thinking and feeling about themselves and other people will be affected by these messages and there will be a consequent impact on his or her development.

This caregiving cycle encompasses the many interactions of family life or life in a residential care setting. These range from the moment to moment exchanges over breakfast to managing major emotional or behavioural crises. Each interaction conveys a number of messages to the child and has an incremental effect on the child's beliefs about him or herself, beliefs about other people and the relationship between self and others. These internal working models will influence the child's functioning and development.

The Secure Base Model groups these caregiver/child interactions into five dimensions of caregiving. The first four dimensions are drawn from attachment theory, a critical area of knowledge and training that all SES staff will explore throughout their induction and subsequent professional development. Beek and Schofield add an additional dimension, family membership, that is relevant for all children but can be particularly challenging for children who are separated from their families of origin. The five dimensions are:

Availability	Helping the child to trust
Sensitivity	Helping the child to manage feelings and behaviour
Acceptance	Building the child's self esteem
Co-operation	Helping the child to feel effective - and be co-operative
Family membership	Helping the child to belong

## The Secure Base model



It is important to bear in mind that the dimensions are not entirely distinct from each other. Rather, in the real world of caregiving, they overlap and combine with each other. For example, a caregiver who is playing with a child in a focused, child-led way may be doing so with sensitivity and acceptance as well as demonstrating availability and promoting co-operation.

Beek and Schofield's research (2004) suggests that, over time, positive caregiving across the five dimensions provides a secure base from which the child can explore, learn and develop in a positive direction.

### 6.6 BEHAVIOURAL NEUROSCIENCE

Although still in its infancy, neuroscience and our understanding of the brain has already influenced our thinking about how important "parenting" is. There is a growing wealth of evidence about the brain science of human relationships that points to how critical parent-child relationships are. In particular the work of Margot Sunderland, (Director of Education and Training, Centre for Child Mental Health, London) has impacted on our practice.

The area of Neuroscience is, and will be, a growing influence on our practice.

## PART TWO: PUTTING POLICY INTO PRACTICE

### 7 KEY COMPONENTS OF OUR THERAPEUTIC APPROACH

SES has a broad view of what constitutes "therapy". The therapeutic milieu is grounded in the overall eclectic approach to promoting positive change in the children and young people in its care. No single therapeutic orientation is adopted, with our "no limits thinking" we are open to any approach that promotes positive emotional well being. Key aspects of this are:

- A sense of security, safety and homeliness
- An environment that values students as persons; it nurtures self respect and self esteem
- Supportive interpersonal relationships with staff who respect students as people
- Emphasis on self control and cooperation rather than externally imposed control
- Development of social, personal and academic skills; to become self directing
- Opportunities to exercise responsibility
- Positive role models and positive models of relationships
- Humanity and flexibility in the running of the community
- A belief in learning without limits and support to achieve success in learning

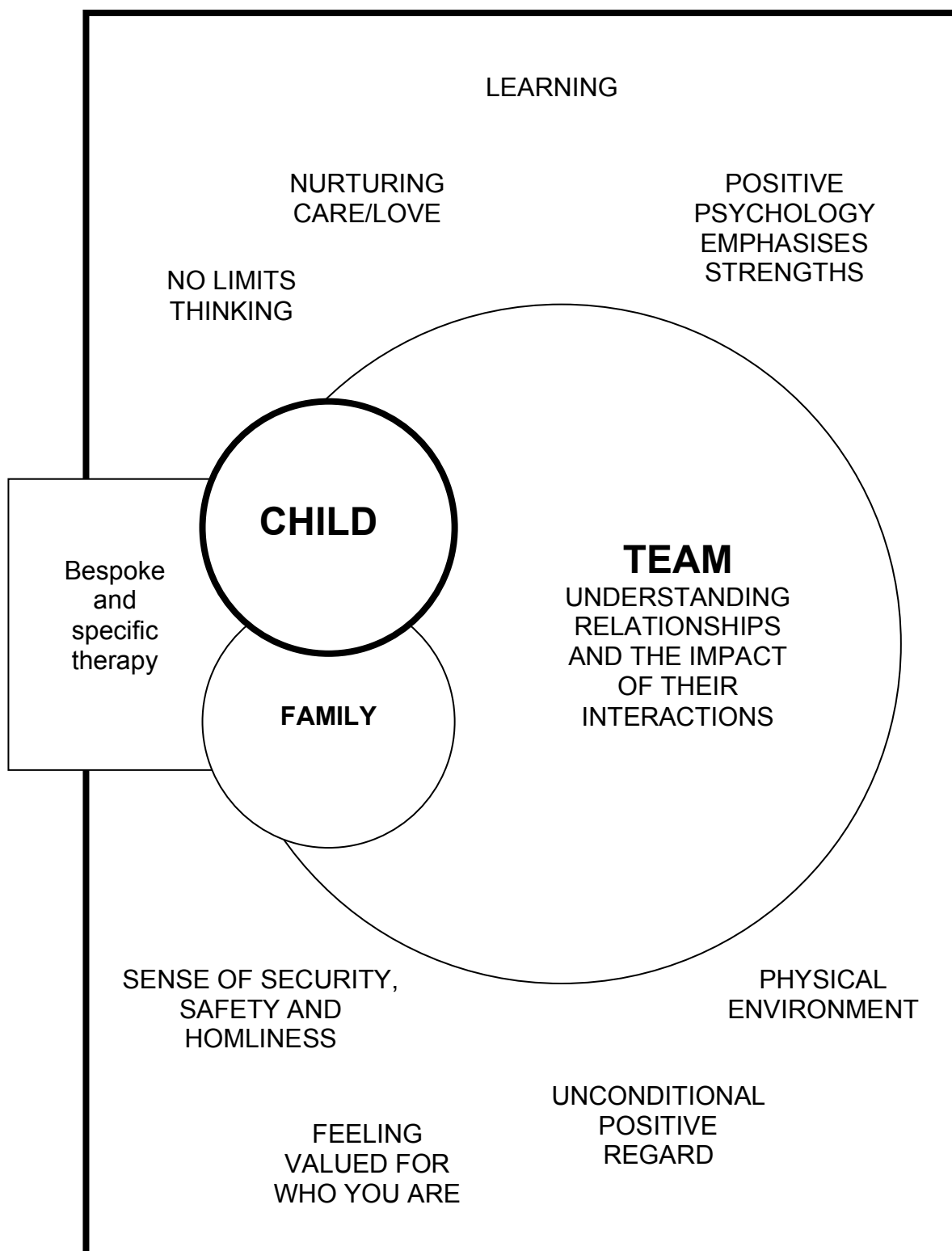
The diagram on the following page represents this therapeutic milieu; in essence this is the SES Way highlighted in a different format.

#### 7.1 PORTFOLIO OF ACHIEVEMENTS AND NEEDS (PAN) PROCESS

At the centre of our work is a 'no limits' highly personalised recovery package developed from the child's Portfolio of Achievements and Needs (PAN). Our students need an holistic framework of care, support and guidance, for them to start to re-engage in the learning process. SES provides such a framework of high quality care and therapeutic intervention embedded in a highly personalised learning experience. **We accept no barriers to innovation, creativity and response in order to reawaken a passion for learning in each student.**

Portfolio of Achievement and Need (PAN) refers to the process of overall planning that supports an individuals learning and development at SES. Therapeutic, care, health and education planning is embedded within this process.

Bespoke, school day 'curriculum learning' is catered for in detail within the Learning Centre planning structures. However, at SES we also believe that all parts of the waking day and all experiences are potential learning opportunities.



The PAN process and planning structures are what we use to draw together social, health and academic learning development. It commences as part of the admissions process, identifying long-term aspirations for young people in partnership with the placing authority, and where appropriate, their family. Key documents such as the lead consultant report and Principal's Statement of Intent letter inform the subsequent PAN planning structures



Learning targets are not deficit based by concentrating solely on perceived 'needs'. We actively seek to start with a child's strengths, passions and talents and expand from there.

## 7.2 PAN PLANNING STRUCTURES

There are three PAN planning structures that identify how staff can plan the overall personalised response for a young person at SES. These are the Development and Learning Overview, Development and Learning Plan and Development and Learning Focus. The Development and Learning Overview is a once only document created at the outset of a young person's placement with SES, using information gathered through the referral and admission process. As such it provides a detailed baseline that all future progress can be judged against. The DLO outlines the young person's care history, provides a brief pen picture and summarises their achievements and needs in each of six dimensions.

- Education training and employment
- Social emotional and mental health
- Physical health and medical conditions
- Family relationships and identity
- Practical life skills for independent living
- Living arrangements and support beyond SES

The key adults agree on the desired long-term outcomes in each area for the placement through discussion with the lead consultant, executive team (Principal, Registered Manager and Head of Education), and placing authority with the help of the initial paperwork.

The Development and Learning Plan and Focus are drawn from the overview, carefully mapping the personalised journey and response required for each young person.

## 8 PLANNED ENVIRONMENT THERAPY IN ACTION

Will's descriptors (1973), as detailed in section 5.4 above, are incorporated into the ethos, atmosphere and practice at both Avocet House and Turnstone House. The blue text below describes how each of Will's key points translates into our practice:

- In Environment Therapy the most important part of the environment is the worker.
- We put great care and detail in our recruitment process, with emphasis on appointing the right people who are excited by our philosophy and innovative practice. Once appointed the adult is regarded with the same 'no limits' opportunities as the young people in our care. This is reflected in the quality of the induction and training the new SES member receives, also certified by our Investors in People Gold status.

- The relationships are between person and person first and client and worker second  
We look for child-centred people and stress the importance of a non-institutional approach, promoting quality positive relationships which are so critical for the ethos and culture of SES.
- The environment releases the child to be themselves - their real self – thus revealing the true issues
- Time and time again we have feedback from family members and social workers that their child is 'totally different' after coming to us. There are many examples of children in SES care achieving the highest of awards, signifying progress and achievement as young people.
- The child is responded to in a warm and welcoming way at all times even when negative transference is taking place (i.e. the child transfers to the adult feelings he has or had for one or other of his parents, or for other people in his life – this can be both positive and negative)
- At SES, this is the unconditional positive regard we expect from all adults; it is the unconditional affection of a good parent that means that whatever else we do we must make the child feel loved despite unwanted outward behaviours.
- Positive transference can be particularly effective in building relationships and helping the child progress  
Case Coordinators, Personal Tutors, Link Tutors and Learning Mentors aim to give a range of dedicated relationship options in addition to generic team members
- It is the environment therapy that is planned not just the environment
- Everything we do at SES is part of a planned environment and planned “therapy” – a seamless domestic, nurturing, caring, learning environment which masks a highly professional approach to planning and integration of learning
- The worker is not left alone to identify or plan responses to the child’s needs but is surrounded by others who support identification, interpretation and planning
- Team of supporting adults in a range of roles including SES consultants, produce a comprehensive personalised development and learning structure to meet the young person’s individual talents and needs. Adults are provided with personal support (PSM) and professional development (PDM) at a sector leading level.
- Workers should be supported to deal with the impact of the behaviours on themselves to lessen the chance of their judgement being clouded or their attitude warped
- Structured support systems in place assisting reflective and restorative practice at SES, enabling staff to tolerate and contain high levels of disturbance and emotional dis-regulation (PSM, PDM, helpline, consultants)

- Where a young person seeks maternal or paternal care or support (e.g. play, stories at bedtime, curled up beside an adult watching TV, etc.) it is given unconditionally whatever their age
- At SES, not only is it given unconditionally it is planned for (individual programmes, PAN meetings)
- Wills uses the following quote to illustrate the thinking:

*“Make children feel that they are loved, but make them understand also that the love of parents is very different from that of friends. Convince them that parental affection will always be there waiting for them, whatever their faults, because the tender affection of parents withstands every test. But make them recognize that the affection of friends is the result of esteem, confidence and choice. Children must learn that friendship is based on merit and that it is won or lost according as they are strong or weak, devoted to others or egotistically centred on self.”*

In PET the worker provides the former, the community the latter.

We don't attempt to replace parents but we do create significant adults for children, who build affective relationships. Community aspect involves developing peer relationships, both internally and external links, as well individuals being counseled through friendship and peer relationship issues. We are a community within a community.

- The aim is to create a kind of microcosm of ordinary society with its social and economic obligations, its social and economic pressures and its responsibilities to support oneself and the community  
The 'voice of the child' is central to our community growth and development, as is the responsibility to other community (internal and external) members, (e.g. PAN process, house meetings, charity work, involvement with the wider society in clubs and activities, travels abroad, etc.)
- The method is to foster those parts of the personality that are whole, to strengthen the psyche to cope with/manage its own conflicts
- At the core of the SES vision and philosophy is to start with strengths as part of the PAN process. We have a personalised approach to learning and make the curriculum (broadest definition) fit the child not the child fit the curriculum
- There is a belief that all living things have a tendency towards wholeness, to self-correct, an inbuilt therapeutic drive – and PET removes the impediments to the natural tendency to self-heal and by strengthening the “whole” elements it facilitates a natural therapeutic tendency
- The SES vision and philosophy is for the young person to have a fresh start, for the team to start with the young person's strengths, believe in them, validate their worth, provide unconditional positive regard, and adopt a person centered approach.
- The community demands of its members mature and rational behaviour and brings about a natural pressure to that end
- We develop individual programmes, PAN targets, community activity and peer cooperation

- PET brooks no “us and them” within the community – e.g. everyone addressed by their first name irrespective of any hierarchy
- All (adults and young people) at SES are known by first names and ideas are listened to with no prejudice, irrespective of source or role.
- There is some form of democratic machinery for the expression of opinion in general and the management of the day to day affairs of the community – shared responsibility
- We develop a comprehensive system in which young people are involved in various of decision making processes, such as in committees, house meetings, Learning Centre curriculum involvement and key worker meetings, or staff interviews.
- A third component of PET along with the psychological and social is the educational influence  
SES vision and philosophy, we excel at this within the total learning environment. ‘No Limits’ thinking pervades.
- It is concerned with learning rather than teaching; it is concerned with all those things that a person needs to fulfill themselves – different in each individual case  
SES vision and philosophy, personalisation for every young person through their development and learning structures. To SES every experience can be part of formal learning even though it may not initially appear so to the young person
- It is concerned with the fullest possible creative expression – arts, crafts, skills, techniques  
SES vision and philosophy, breadth and depth of personal curriculum and twenty four hour opportunities, all underpinned by no limits thinking.
- Making sure that there is opportunity to discover talent and then practice it
- This encapsulates the SES vision and ethos of no limits, discovering and unlocking gifts and talents in all young people.

In summary, the key critical components of the Avocet House and Turnstone House environment are:

- Unconditional positive regard and strong positive adult relationships.
- Nurturing, particularly for a specific and intensive period after admission (although not exclusively so), is crucial in helping the child or young person feel safe and cared for.
- The experience of living in a supportive and caring community, i.e. a group living experience more akin to familial living, domesticity as compared to institutionalization, is also fundamental to the therapeutic process.
- A welcoming of open honest expression of fears, anxieties and worries/difficulties and an understanding that acting out behaviours are a way of testing trust, registering anxieties and exploring caring boundaries.
- A commitment to helping the child develop self discipline and responsibility for his own actions through ‘reality confrontation’ (i.e. examining the tension

between their own perception of their behaviour and how that behaviour is seen by or impacts on others)

- Food, its production, nutritional value and eating
- Last but far from least, the physicality and scale of the buildings, site and location, heating lighting, colour, texture, furnishings, decoration, etc.

## **9 SECURE BASE MODEL IN ACTION**

The Secure Base Model provides a framework for adults at Avocet House and Turnstone House, and others who support the young people, to think in more detail about the different but connected caregiving approaches that can help a child to move towards greater security. It is a positive, strengths based approach that focuses on the interaction between the caregiver and the child, but also considers how that relationship can enable the child to develop competence in the outside world and manage often complex relationships with birth family members.

To fully embrace and utilise the Secure Base Model, it is essential for all SES adults to have a clear understanding of how attachment theory relates to SES young people. Alongside this, all adults should develop an understanding of the importance of developing empathy within the whole community. Recognising the fundamental importance of relationships through the caregiving cycle is critical, and reinforces the core value of Planned Environment Therapy in that the worker is the most important part of the environment.

To enable young people the opportunity to flourish, key adults should regularly consider if they are effectively providing all five dimensions of the Secure Base for young people. Resources to support this process are available on:

<http://www.uea.ac.uk/providingasecurebase>

The following summaries and strengths/difficulties for each dimension provide a useful tool to discuss and consider if SES are planning effectively for young people:

### **Availability**

This dimension focuses on the caregiver's ability to convey a strong sense of being physically and emotionally available to meet the child's needs, both when they are together and when they are apart. When the caregiver can do this, the child begins to trust that his needs will be met warmly, consistently and reliably. Anxiety is reduced and the child gains the confidence to explore the world, safe in the knowledge that care and protection is there if needed.

Strengths in this dimension might be indicated by:

- Plenty of physical time available to focus on the child.
- Emotional space and availability (i.e. not preoccupied with own difficult feelings and unmet needs or emotionally detached and cut off).
- The capacity to reflect on the child's needs to build trust in them as caregiver(s) and to think about ways in which they might support the child to do so.

- Alert to child's needs and signals (e.g. able to identify and describe a time when the child was worried or upset, how the child showed this/did not show it, what signs they might look for in the child to signal distress etc).

Difficulties in this dimension might be indicated by:

- Lack of time/energy.
- The caregiver's own unmet needs (perhaps from the past) are coming to the fore.
- The caregiver seems overwhelmed by the child's demands.
- The caregiver feels marginalised by child.
- The caregiver distances themselves from the child.
- Caregiver doesn't believe a child should need that much attention.

### **Sensitivity**

Sensitivity refers to the caregiver's capacity to 'stand in the shoes' of the child, to think flexibly about what the child may be thinking and feeling and to reflect this back to the child. The sensitive caregiver also thinks about their own feelings and shares them appropriately with the child. The child thus learns to think about and value his or her own ideas and feelings and the thoughts and feelings of others and is helped to reflect on, organise and manage their own feelings and behaviour.

Strengths in this dimension might be indicated by:

- The caregiver can think and talk about the child's feelings, recognise that the child has strong feelings at times, and that they are understandable, 'in the circumstances'.
- The caregiver has the capacity to 'stand in the shoes' of the child, to think flexibly about what the child may be thinking and feeling and to reflect this back to the child.
- The caregiver can think and talk about their own feelings and share them appropriately with the child and other people.

Difficulties in this dimension might be indicated by:

- The caregiver lacks interest and curiosity in what is in the child's mind.
- The caregiver appears overwhelmed by own strong feelings - or finds it hard to think and talk about own feelings. (N.B. There is a 'normal variation' in this; it is extremes that are of concern. Key is the capacity to acknowledge and understand the child's needs).
- The caregiver finds it hard to think and talk about the child's past – finds it too painful or feels that the child needs 'a fresh start'.
- The caregiver has difficulty in thinking flexibly about a range of possible reasons for the child behaving in a certain way.
- The caregiver is frequently negative or angry towards child without 'pause for thought' about why child is behaving in this way or how best to respond. .

### **Acceptance**

This dimension describes the ways in which the caregiver is able to convey that the child is unconditionally accepted and valued for who he is, for his difficulties as well as his strengths. This forms the foundation of positive self-esteem, so that the child can experience himself as worthy of receiving love, help and support and also as

robust and able to deal with set-backs and adversity. This area of caregiving builds on the dimensions of *availability* and *sensitivity*. Children need to learn to trust and to manage their feelings and behaviour in order to believe the praise of caregivers and to take up opportunities that are on offer.

Strengths in this dimension might be indicated by:

- The caregiver shows joy, pride and pleasure in the child.
- The caregiver can praise the child easily and readily.
- The caregiver can help the child to accept failures, setbacks etc in a kind, supportive way.
- The caregiver can actively support the child in pursuing (child led) experiences, interests and activities.

Difficulties in this dimension might be indicated by:

- A tendency to focus on negative aspects of the child, little pleasure or pride evident.
- Finding it hard to accept/enjoy the child's individuality and ways in which the child is different to other family members.
- The child seen as 'a burden.'
- The caregiver offers little

### **Co-operation**

Within this dimension, the caregiver thinks about the child as an autonomous individual whose wishes, feelings and goals are valid and meaningful and who needs to feel effective. The carer therefore looks for ways of promoting autonomy, but also working together and achieving co-operation with the child wherever possible. This helps the child to feel more effective and competent, to feel confident in turning to others for help, if necessary, and to be able to compromise and co-operate.

Strengths in this dimension might be indicated by:

- The caregiver thinks about the child as an autonomous individual whose wishes, feelings and goals are valid and meaningful and who needs to feel effective (for example, 'he gets settled with his toys and it's understandable that he hates it when we have to go out').
- The caregiver can look for ways of working together to achieve enjoyable co-operation with the child wherever possible (for example, 'we make a game of clearing the toys up and he enjoys that so he doesn't mind going out so much').
- The caregiver promotes choice and effectiveness wherever possible.
- The caregiver can set safe and clear boundaries and limits – and also negotiate within them.

Difficulties in this dimension might be indicated by:

- The caregiver emphasises the need for control, for example - differences of opinion with the child are a battle that they must win.
- The caregiver finds it difficult to accept /enjoy child's need for autonomy and to allow choice/promote competence and effectiveness.
- The caregiver finds it difficult to allow child to take moderate risks.

### **Family membership**

Family membership is a vital strand of healthy emotional and psychosocial development. A child who has no close family relationships will carry feelings of psychological and social dislocation. In contrast, the certainty of unconditional family membership can provide anchorage and the reassurance of practical and emotional support throughout life, acting as a psychosocial secure base for exploration, identity and personal development.

When children are separated from their birth families, the family membership dimension refers to the capacity of the caregiver to include the child, socially and personally as a full family or residential group member, at a level that is appropriate to the longer term plan for the child. At the same time, the caregiver must help the child to establish an appropriate sense of connectedness and belonging to his birth family. In this way, the child can develop a comfortable sense of belonging to more than one family and a more coherent identity.

Strengths in this dimension might be indicated by:

- The caregiver is able to give verbal and non-verbal messages of the child's inclusion in the family.

For children who are members of more than one family:

- The caregiver is able to talk openly and appropriately with the child about both the strengths and the difficulties of their other families.
- The caregiver is able to support the child to get 'the best' from both families.

Difficulties in this dimension might be indicated by:

- The caregiver tends to treat the child differently to other children in the family (this may be very subtle, for example, providing a different sort of biscuit for a lunch box).

For children who are members of more than one family:

- The caregiver is anxious that they might 'lose' the child to the other family or that the other family's values might conflict with and displace their own in the child's mind.
- The caregiver talks/thinks negatively about other family.
- The caregiver creates (unreasonable) barriers to contact between the child and the other family.

## **10 CONSULTANTS WORKING WITH THE SES TEAM IN SUPPORTING HOLISTIC THERAPEUTIC APPROACH**

SES consultants work at a number of levels, including child specific, team development and strategic. Their influence is carefully integrated into all aspects of the work with children from admissions, casework planning, bespoke individual interventions, training, and systemic family therapy to extending our "no limits" thinking and energising our innovation.

Individual therapeutic work with young people is based on a belief that there is a dynamic process operating in which the young person explores at their own pace



those issues, past and current, conscious and unconscious, that are affecting their lives in the present. The young people's inner resources are then enabled by the therapeutic process to bring about positive growth and change.

SES will identify through appropriate assessment procedures whatever additional specialist therapeutic input is required. This will be provided either from within the staff team and/or will be procured from outside the staff team on an individual basis and for an intensity and duration prescribed by such assessment. To support the assessment and response process SES employs Educational Psychology, Child and Adolescent Therapy and Psychiatric support on a consultancy basis. Systemic family therapy is an integral part of our service.

A range of other bespoke therapies may be used in support of the child according to assessed need and as addressed in individual children's plans (e.g. Art Therapy, Play Therapy, Individual Psychotherapy, specialist counseling) and are likely to be considered only after the child or young person has settled fully. The type and amount of help given will be decided by the professionals concerned and be based upon the young person's unique set of problems and their ability to articulate them.

All planned therapeutic interventions need to have a focus on developing trusting relationships within the context of our SES environments. At SES we understand that a regular and reliable relationship with the adults they see on a daily basis within our establishments is a far bigger priority than meeting a therapist once a fortnight in a remote clinic environment. Developing psychological formulations with a network of childcare professionals in the child's system offers a much more appropriate understanding of the young person and appropriate intervention; alongside the provision of regular supervision and support for the staff who struggle day to day to understand and manage the behaviour.

## **11 TRAINING STAFF**

SES has an extensive staff support and development program to assist the staff teams. This begins with the interview process where the scene is set through discussion tasks and questions, with many issues being explored between candidates and the interview panel. Successful candidates have an intensive six month induction training period, in which many core issues such as the SES therapeutic model, attachment and trauma are explored.

Beyond induction, staff have a bespoke professional development plan, as well as regular planned training through team meetings. Core principles on child development, young person's personalised needs and attachment based theory will be revisited, alongside the completion of the Level 3 Diploma for Residential Child Care.

Monthly consultations with independent psychiatrists and/or psychologists enable staff to organically grow their understanding of therapeutic practice in the context of the SES young people.

SES further support staff through an annual conference, aimed at developing professional knowledge and connecting with the underpinning no limits vision. Core reading materials and resources are identified, with past contributors including Dr. Margot Sunderland, Bernard Allen and Sir Ken Robinson.

To help staff fully explore how they can support young people in a therapeutic way, some essential ways of working are discussed through training, incorporating:

- Authentic relationships – be genuine with young people by showing vulnerability, take appropriate risks
- Acknowledge emotional gifts – make sure they are noticed and named to increase the possibility of it happening again
- Listen carefully – acknowledge the message being given
- Keep trying – don't give up, and provide a message of consistency and trust
- Expect others to achieve – believe that change can happen, have a no limits approach
- Recognise your own mistakes – reflect on them and apologise, we are all human
- Don't be reliant on vested power – personal authority is more effective
- Make personal boundaries clear and known
- Provide a safe base – ensure young people know your care is unconditional
- Be playful – engaging in play unites us and helps build relationships
- Use physical contact – demonstrate appropriate positive physical boundaries
- Be stuck – you cannot always have the answer, acknowledge this
- Allow people space
- Make a connection – this takes time and is essential in forming relationships
- Be aware of your body language - what do you want your body to say
- Explain what you see – feed this back in a reflective way
- Don't try to make people do things
- We all do the best we can – based on our knowledge and own experiences
- Be flexible – work dynamically
- Be curious – you are not the all-knowing expert
- Don't confuse attachment issues with ASD
- Be aware of your own prejudices – our responses are based on our beliefs and experiences

The key concepts below further help staff understand the how the SES Way contributes to day to day practice.

## 11.1 OUR SHARED BIOLOGICAL INHERITANCE

We are all born with essential physical and emotional needs and the innate resources to help us fulfill them. These needs have evolved over millions of years and are incorporated into our biology, whatever our cultural background.

When our emotional needs are not being met, or when our resources are being used incorrectly, we suffer considerable distress. And so do those around us.

### 11.1.1 Our emotional needs include:

The SES Way: An Exploration of our Therapeutic Model: Policy and Practice: 0219

- the need for security (stable home life and a safe territory to live in);
- the need for intimacy and friendship;
- the need to give and receive attention;
- the need for a sense of autonomy and control;
- the need to feel connected to others and be part of a wider community;
- the need to feel competent which comes from successful learning and effectively applying skills (the antidote to 'low self-esteem');
- the need for privacy (to reflect on and consolidate our experiences)
- the need to be 'stretched' in what we do, from which comes our sense that life is meaningful.

#### 11.1.2 Our tools and resources include:

- The ability to learn and add new knowledge to innate knowledge, memory and the ability to forget;
- curiosity, imagination and the ability to problem solve;
- the ability to focus attention;
- the ability to understand through metaphor (pattern-matching);
- self-awareness (an observing self);
- resilience;
- the ability to empathise and connect with others;
- a dreaming brain that de-arouses the autonomic nervous system every night thereby keeping us sane.

#### 11.1.3 Achieving Mental And Physical Health

Those whose needs are well met in the world do not have mental health problems and are better integrated with other people. Those whose needs are not fulfilled, for whatever reason, or whose innate resources are damaged or being used incorrectly, may suffer considerable distress or develop, as a means of coping, antisocial behaviours which can prove a burden to others or to society at large.

Therapeutic interventions are about restoring or repairing the 'tools' and 'resources' and addressing emotional needs.

### 11.2 LEARNING AS THERAPY

This relies on re-exciting children with the idea of learning based on their strengths, interests and passions as a starting point. Learning is seen as an all-encompassing aspect of a child's life over a 24hr period not just in a narrow 'classroom' sense, where learning becomes something one does for oneself rather than something someone else does to you.

Learning is a highly personalised process involving 1:1 support from a Learning Mentor and key worker (Personal Tutor). Between them they have an overview of

the totality of the learning process for the child and their Portfolio of Achievements and Needs.

An understanding of and particular response to more generalised learning difficulties, specific learning difficulties, etc. including pre-admission and baseline learning needs assessment are features of SES.

### 11.3 BEHAVIOURAL INTERVENTIONS AS THERAPY

Individual programmes are developed and used as appropriate to the individual and context. Elements of cognitive behaviour therapy are used to intervene in habitual patterns of thinking, where problematic behaviour is addressed by developing different strategies to deal with the emotions or thoughts that lead to it.

### 11.4 FAMILY LINKS AS THERAPY

Our relationship with family members and significant adults is a critical feature of our therapeutic response to a child as two of the greatest fears of a child are loss of parental love and/or of parental desertion. This of course can also translate to other key family members or significant adults in the child's life thus far. This may or may not be connected with specific therapeutic interventions around the family.

## 12 WHAT ARE THE RESULTS OF THERAPEUTIC INTERVENTIONS

This section refers to Paul Cooper's, PhD Thesis, 1990.

*"Respite, relationships and re-signification : a study of the effects of residential schooling on children with emotional and behavioural difficulties, with particular reference to the pupils' perspective"*

Despite its age this thesis reached the heart of what good therapeutic work does, and was grounded in talking to children and young people. It still applies.

### 12.1 RESPITE

This enables many children to 'break the cycle' of their involvement in what for many of them has been distressing circumstances, usually over time. Respite in itself is a necessary starting point for their positive development, since in many ways it gives them relief from circumstances that may have been painful for both themselves and others around them.

### 12.2 RELATIONSHIPS

High quality adult-child relationships contribute to the development of a more positive self image by giving the child a sense of being valued and cared for and about by significant others who they have learned to trust. Relationships are the single most important mechanism at work, since it is through relationships that children are often first exposed to an image of themselves that challenges their own low opinions of themselves as bad and worthless individuals. It is the reflection of

themselves that they see in others responses to them that enables children to develop a positive self-image. This in turn gives them the confidence to take on new challenges (educational, social, emotional etc.) in the knowledge that they will be accepted and valued by others even if they fail.

### 12.3 RE-SIGNIFICATION

The development of new and positive identities which undermine the child's original negative view of self, by revealing evidence of desirable, positive qualities. This is achieved through the opportunities to take on new challenges, learn new skills, develop a deeper knowledge of themselves and move towards a more willing acceptance of themselves. To succeed this process depends upon the supportive structure of good quality child adult relationships, a safe and secure environment, the provision of carefully controlled challenging situations and experiences, in which effort and success are rewarded and community involvement is encouraged and acknowledged. Positive signification involves highlighting the positive attributes that the child already possesses.