SPECIALIST EDUCATION SERVICES

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

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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 children's abilities and potential*
- ✓ *we believe in unconditional positive regard*
- ✓ *we believe our children deserve fun and happiness in childhood*
- ✓ *we believe in a 'can do' philosophy*
- ✓ *we believe in success and learning from mistakes*
- ✓ *we believe intelligence is multifaceted*
- ✓ *we believe learning is a lifelong process*

- ✓ *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 are future orientated*

We constantly strive to integrate health, social work and educational perspectives and incorporate best practice from the different approaches in a holistic, nurturing, learning environment.

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

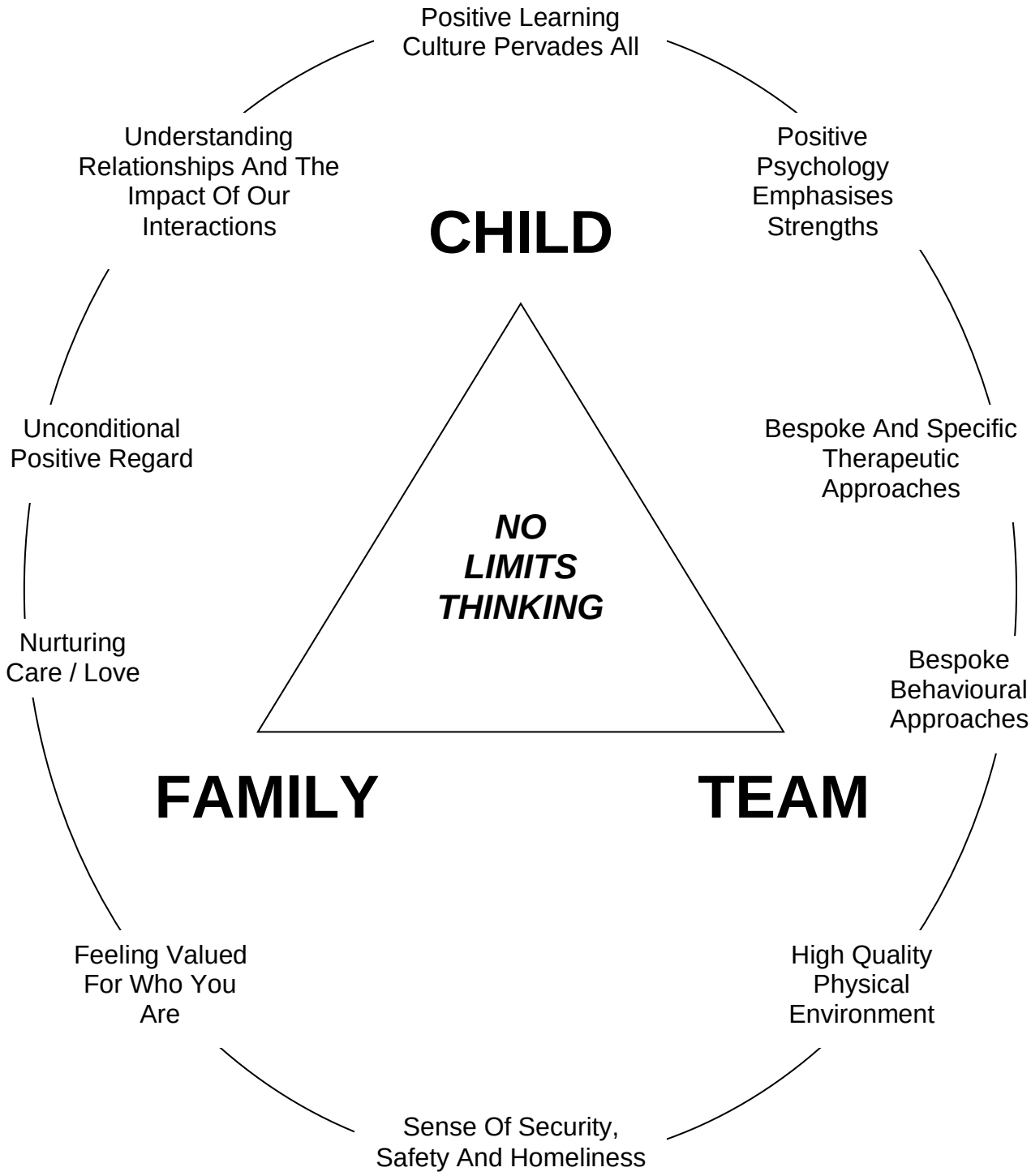
structures. **All aspects of a child's life at SES are potentially capable of having therapeutic impact.**

5 THE SES WAY

We believe SES is unique, with it's 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


Positive Learning Culture Pervades All
Positive Psychology Emphasises Strengths
Bespoke And Specific Therapeutic Approaches
Bespoke Behavioural Approaches
High Quality Physical Environment
Sense Of Security, Safety And Homeliness
Feeling Valued For Who You Are
Nurturing Care / Love
Unconditional Positive Regard
Understanding Relationships And The Impact Of Our Interactions
CHILD
NO LIMITS THINKING
FAMILY
TEAM

6 WHAT INFLUENCES OUR THERAPEUTIC APPROACH?

The therapeutic approach of SES has strong connections with Planned Environment Therapy, the Secure Base Model and Behavioural Neuroscience. The following summarises the historical background and key ideas that stem from these.

6.1 PLANNED ENVIRONMENT THERAPY

6.1.1 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).

6.1.2 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 meet 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 individuals self esteem. It is characterised by the validation of ones 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 then 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.

6.1.3 The Therapeutic Care and Education Perspective

A parallel process was at work in examining ways of working with troubled children and young people. The 19th 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.

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

6.2 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.

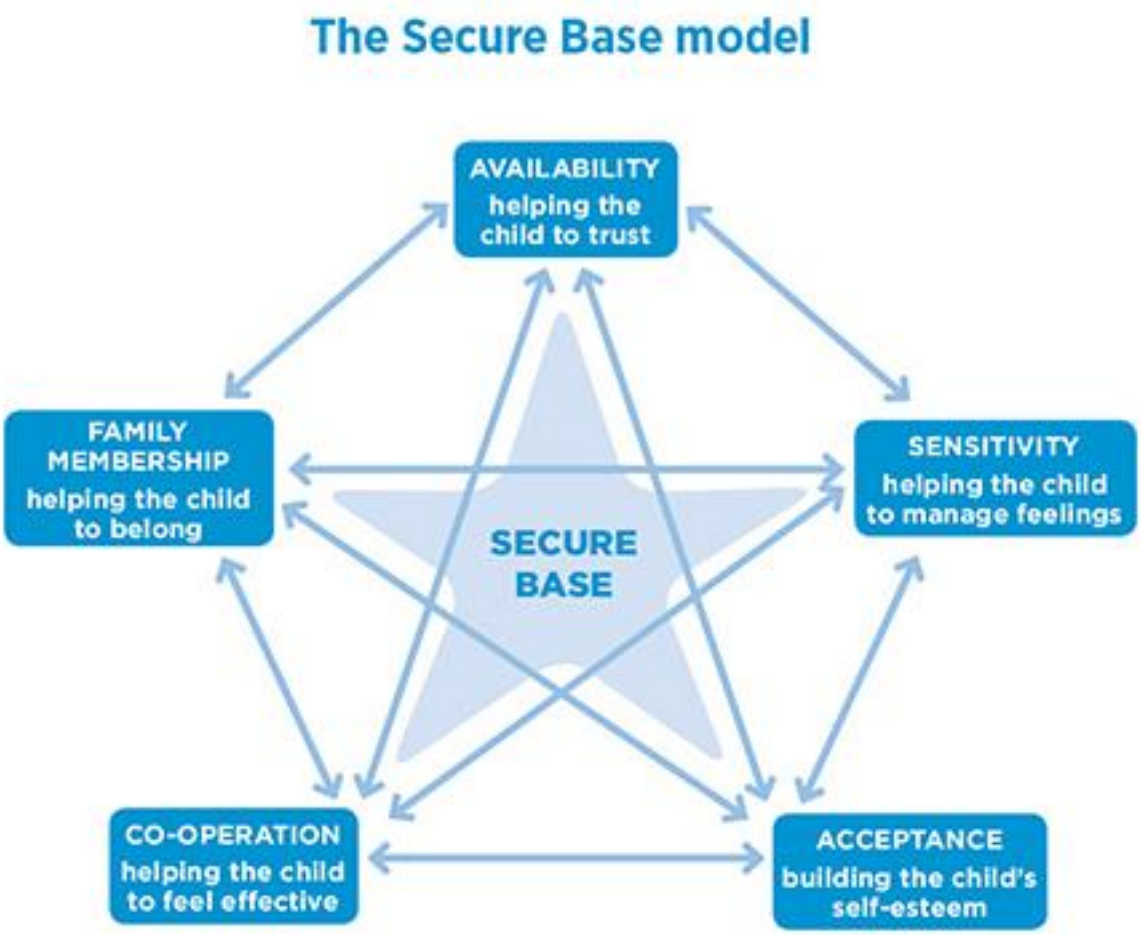
It can be helpful to think about caregiver/child interactions as having the potential to shape the thinking and feeling and ultimately the behaviour of the child.
This process begins with the child's needs and behaviour and then focuses on what is going on in the mind of the caregiver. How a caregiver 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



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.

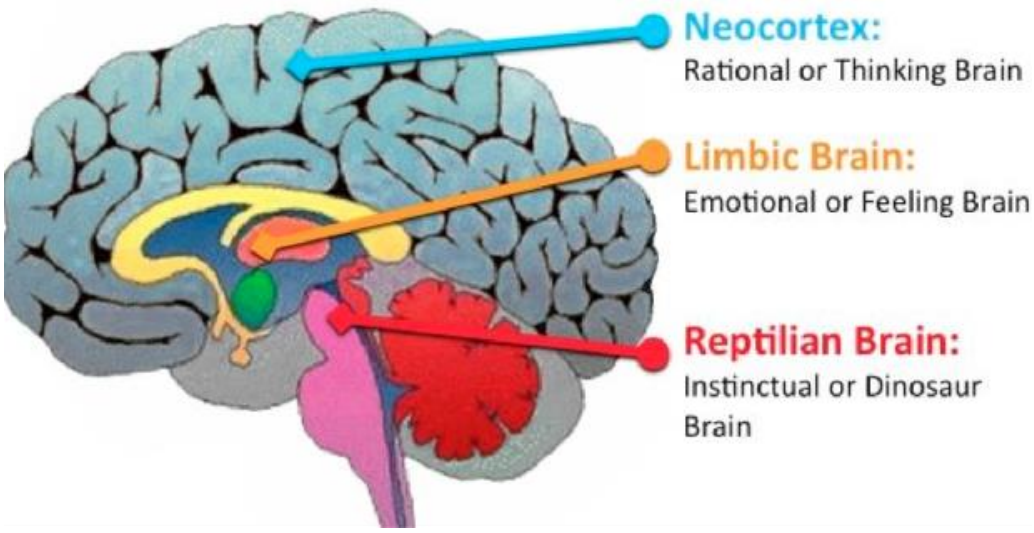
Beek and Schofield's research (2004) suggests that, over time, positive caregiving across the five dimensions provides a secure base from which the child can explore, learn and develop in a positive direction.

6.3 NEUROSCIENCE

In the past decade there has been significant advance in neuroscience and our understanding of brain and body systems, and their connection to human behaviour. This has influenced and reinforced our SES thinking about how important "parenting" is. Several key researchers and pioneers have impacted on our practice, in particular, the work of Margot Sunderland, (Director of Education and Training, Centre for Child Mental Health, London), Bernard Allen (Education Consultant), Dr Bruce Perry (American Psychiatrist, clinician and researcher) and Professor Bessel van der Kolk (Trauma Research Author). The area of Neuroscience is, and will continue to be, a growing influence on our practice.

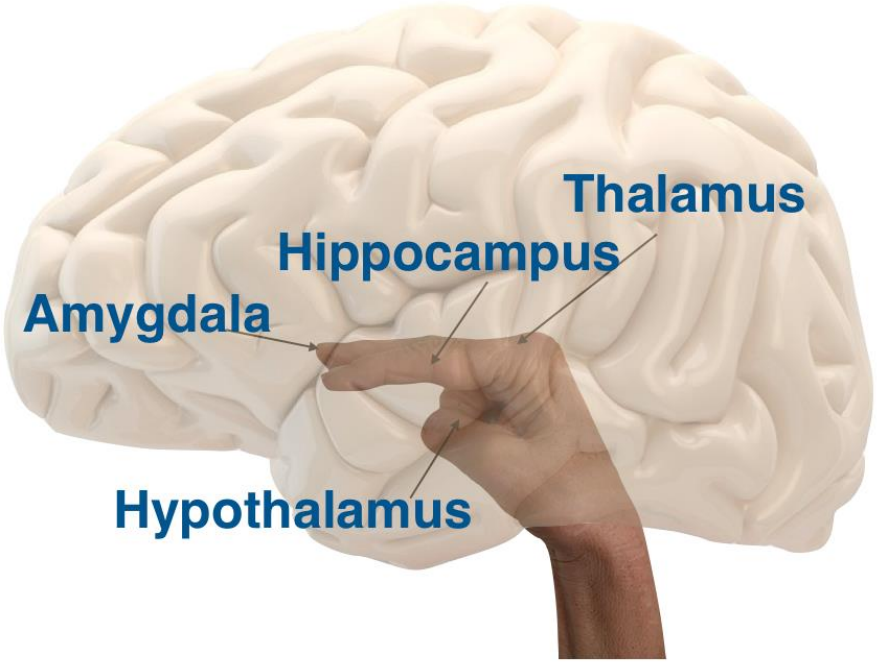
6.3.1 Brain Theory and Structure

Brain theory is constantly evolving as a result of significant scientific advances by neuroscientists. Traditionally, the brain has been described as being in three parts, known as 'Triune Brain Theory'.



- **Reptilian** (largely unchanged by evolution – controls bodily functions, e.g. heart, lungs, stomach. Poly vagal System links to good physical health and immune system)
- **Mammalian** (also known as the limbic system - triggers strong emotions to be managed by rational brain)
- **Rational** (also known as neocortex, the higher brain – frontal lobes/neocortex)

The Limbic System is found in the middle of the brain and can be visualized by making a fist with two fingers sticking out, as below:



Recent research indicates that the cerebral cortex and the limbic system are highly integrated and not as two separate structures as previously thought. The literature of Bernard Allen describes how humans have two different types of information processing systems, 'conscious minds' and 'BodyBrains'; the BodyBrain is located all around the body (e.g. in the gut), not just in the brain. It is our subconscious processing system, that is quick and efficient, perhaps controlling up to 98% of our functioning. When conscious minds are trying to control and calm down their BodyBrains, scans have shown that the front part of the cerebral cortex is working extremely hard.

We have two emotional systems that work in opposition to wind up or calm down BodyBrains. When BodyBrains become too excited the influence of the mind fades and we can't think so clearly. The same biological changes may be experienced in different ways according to other internal changes and how we interpret what is happening. Serotonin is a neurotransmitter which is associated with positive mood. The same levels of physiological arousal in various systems throughout the body and brain may be experienced as excitement, if there is also serotonin active in the system. Without the contribution of serotonin they could be experienced as frustration or anger, When BodyBrains calm down too much, the influence of the mind also fades. We may experience this as mind wandering or dozing off. Very low levels of physiological arousal can be interpreted as pleasantly relaxed and calm in the presence of serotonin, or as depressed and bored without it (for further detail see Bernard Allen – Mental Fitness 2019).

6.3.2 Brain Development

Brain development, or learning, is actually the process of creating, strengthening, and discarding connections among the neurons; these connections are called synapses. Synapses organize the brain by forming pathways that connect the parts of the brain governing everything we do—from breathing and sleeping to thinking and feeling. This is the essence of postnatal brain development, because at birth, very few synapses have been formed. The synapses present at birth are primarily those that govern our bodily functions such as heart rate, breathing, eating, and sleeping.

The development of synapses occurs at an astounding rate during a child's early years in response to that child's experiences. At its peak, the cerebral cortex of a healthy toddler may create 2 million synapses per second. By the time children are 2 years old, their brains have approximately 100 trillion synapses, many more than they will ever need. Based on the child's experiences, some synapses are strengthened and remain intact, but many are gradually discarded. This process of synapse elimination—or pruning—is a normal part of development. By the time children reach adolescence, about half of their synapses have been discarded, leaving the number they will have for most of the rest of their lives

By 3 years of age, a baby's brain has reached almost 90 percent of its adult size. The growth in each region of the brain largely depends on receiving stimulation, which spurs activity in that region. This stimulation provides the foundation for learning.

At around 7 years of age, the pruning slows down; more and more brain cells are myelinated (a whitish material that is made of protein and fats surrounding brain cells). This allows better communication between brain cells and strengthens pathways.

The brain is neuro plastic. There is huge hope and optimism for professionals to help a child or young person develop new pathways through therapeutic interventions and relationships.

6.3.3 Emotional Systems in the Brain

Research by Panksepp has shown there are several ingrained emotional systems deep in the lower brain - Rage, Fear, Separation Distress, Seeking, Care, Play and Lust.

Fear, Rage and Grief systems are instinctual and primitive.

- Rage, Fear and Separation Distress are set up from birth and support survival. Infants get overwhelmed by the triggering of these systems because there is so little higher rational brain functioning at this stage to help them think, reason and calm themselves down.
- If a child is not given enough help with the intense lower brain feelings and primitive impulses, their brain may not develop the pathways to enable him to manage stressful situations.

The Care, Seeking and Play systems enable cells and pathways in the body to be activated by positive natural chemicals and hormones through good parent – child relationships. These include:

- Oxytocin (released at birth to support bonding)
- Opioids (hormones that give us a sense of well being; produced when a child is lovingly touched or held by a parent of caring person)
- However, if the parent responds with criticism or shouting, these positive chemicals are blocked; child may suffer from stress that can cause permanent changes in the brain.

The Care, Play and Seeking systems are prosocial, protective and affiliative. Lots of joyous and playful times with children can activate positive arousal chemicals in the brain as well as the brain's Play system; this will increase the zest for life. Therefore, we need to provide lots of imaginative, explorative activities to activate the Seeking system. This will increase the appetite for life, curiosity, and the drive and motivation to make her creative ideas reality.

Calm or Alarm – '*They are like muscles… the more we activate the pro-social or primitive alarm systems, the more they become personality traits.'*

6.3.4 Stress Regulation System

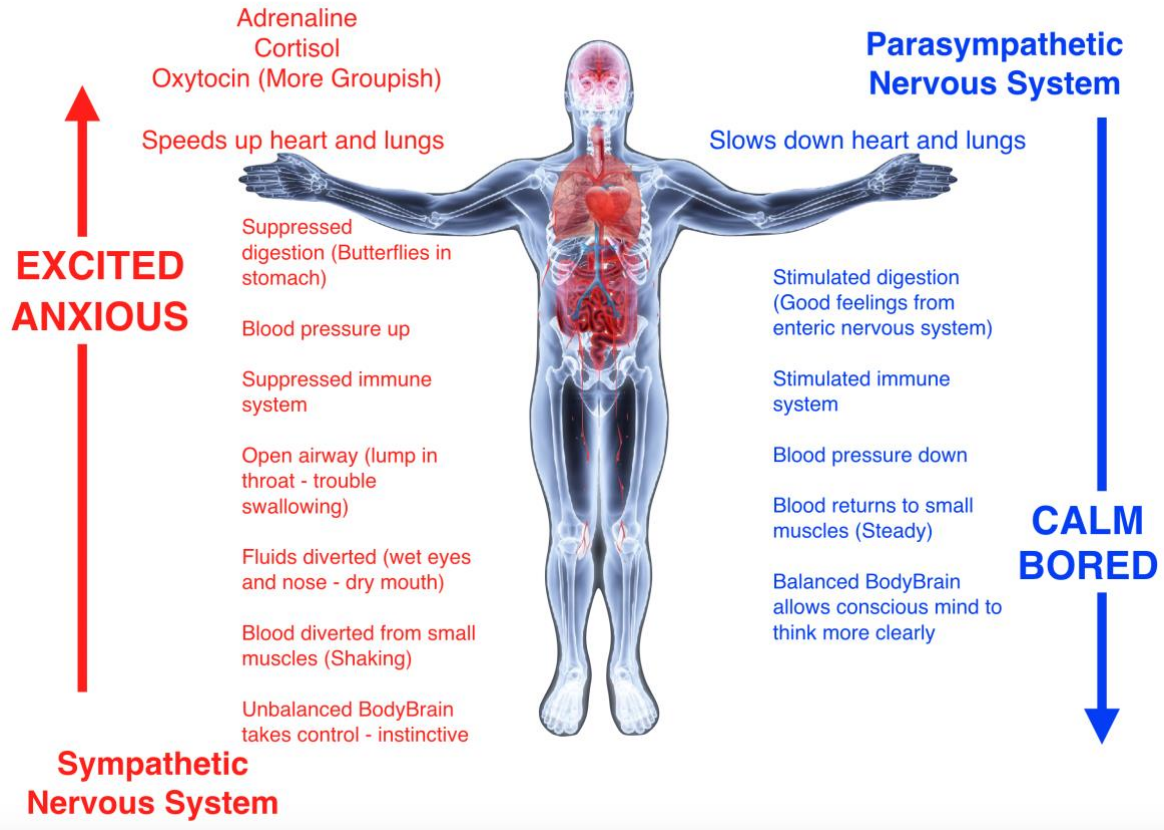
Our stress-regulation system is vital to our survival and is activated by our primitive survival circuits: rage, fear and separation distress. The stress regulation system involves:

- brain
- aspects of autonomic nervous system
- aspects of endocrine (hormone) system

The autonomic nervous system comprises of the parasympathetic and sympathetic nervous systems.

The parasympathetic nervous system acts like a brake, slowing us down to rest, digest and connect, or in extreme situations to shut the body down in the freeze response. The sympathetic nervous system acts like an accelerator, preparing us for action, such as fight or flight

In early childhood, research on the biology of stress shows how major adversity can weaken developing brain architecture and permanently set the body's stress response system on high alert. The child's brain is like a trigger-happy alarm system, wired to fire at any sensory stimulus that is reminiscent of an earlier threatening situation: a voice tone, a sudden movement, a smell that triggers unconscious memories. The survival response is triggered that propels the child into fight, flight or freeze.



When the child feels threatened, they have limited access to thinking because their lower brain regions (brain stem and limbic system) are dominant and they are surviving the best way they can. Learning is therefore blocked until regulation happens and for this, the child is dependent on the presence of a self regulated/regulating adult.

The lower brain alarm system is the amygdala, which senses threat and communicates with the hypothalamus. The hypothalamus releases stress hormones (e.g. adrenalin), preparing body for flight or fight. The stress hormones block positive arousal chemicals to ensure full attention is on threat. If you have been helped in childhood with intense feelings of anger, frustration and distress, the higher human brain intervenes and can quieten down the amygdala, releasing anti-anxiety chemicals. If you experienced a difficult childhood and were not supported to manage feelings, the higher brain may not have developed the necessary wiring. The child can stay stressed for hours, days, weeks or even longer

To support children with activated stress systems, we can utilise the science of comforting. Comforting activates the Vagus nerve, this belongs to the 'slow down and relax' parasympathetic branch of the ANS. If we do not comfort and sooth a distressed child the body can become hard wired for hyperarousal, making life stressful and exhausting. This can lead to a range of health problems, e.g. breathing disorders, heart disease, fatigue, headaches etc. The Vagus Nerve is found in the brain stem, and it rapidly

restores key body systems. Establishing good vagal tone is essential for emotional balance, clear thinking, better attention and a more efficient immune system.

We need to stimulate the anti-stress chemical systems in the brain through:

- Touch and massage
- Sucking (babies!)
- Warmth
- Movement and rocking
- Low sounds

When children and young people suffer from relational trauma, it can result in:

- Underdeveloped brain systems badly affecting capacity for attention, learning, concentration, creativity, empathy, kindness.
- Smaller brains: less sophisticated neuronal networks
- Alarm systems in the brain have a field day
- Immune system is compromised

6.3.5 <u>The Importance of Relationships</u>

There is a growing wealth of evidence about the brain science of human relationships that points to how critical parent-child relationships are. This impacts on our practice.

The parent/carer-child connection is the most powerful mental health intervention known to mankind" **(***Bessel Van Der Kolk)*

Positive human interaction creates the conditions of safety needed for activation of the social engagement system. Science shows that providing stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behaviour, and health. Early experiences influence the developing brain.

In the environment of the home, school, classroom and relationships, new learning experiences can help develop new neural pathways throughout childhood and adolescence. The capacity of the developing brain is not fixed or static, which means that new experiences that are offered to children can have far-reaching and positive effects, no matter how challenging the children's start in life.

"The more healthy relationships a child has, the more likely he will be to recover from trauma and thrive. Relationships are the agents of change and the most powerful therapy is human love" (Bruce Perry)

Anyone who has seen parents playing with infants will have seen how they enjoy each other's company, e.g. adults cooing and babies chuckling in

return. The baby is playing a major part in this “dance”. Dr. Edward Tronick Still Face Experiment highlights what happens if the parent doesn’t respond:

https://youtu.be/apzXGEbZht0

Imagine a child growing up in a family where parents are not engaging with them through neglect, drug/alcohol dependency and/or are abusive, physically, sexually. This is what will have happened to the majority of children and young people coming to live at SES. Attachment theory teaches us that there are two important outcomes:

- How adults are viewed, and
- What the children think of themselves

Adults will be perceived as unavailable, frightening, rejecting, neglecting abusive. The children will have built a view of themselves as worthless, bad, unlovable etc.

6.3.6 Impact of Childhood Trauma

As already highlighted, what happens in early childhood can matter for a lifetime. To successfully support our children’s future, we must recognise problems and address them as soon as possible.

The Adverse Childhood Experiences study revealed irrefutable evidence showing that childhood experiences are the most powerful determinants of who we become as adults. And that traumatic childhood experiences, when unaddressed, have a significant graded relationship to the development of the most troublesome health, mental health and social problems of today The study found that:

- 4 ACEs - Life span reduction of 10 years
- 6 ACEs - Life span reduction of 20 years

Consideration of ACEs is therefore crucial to thinking about how to improve the lives of children and young people, to support better transitions into adulthood, and achieve good outcomes for all adults.

‘The trauma keeps them rigidly fixated on the past, making them fight the last battle over and over again’ (Van der Kolk 1996)

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 personal, emotional, social 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

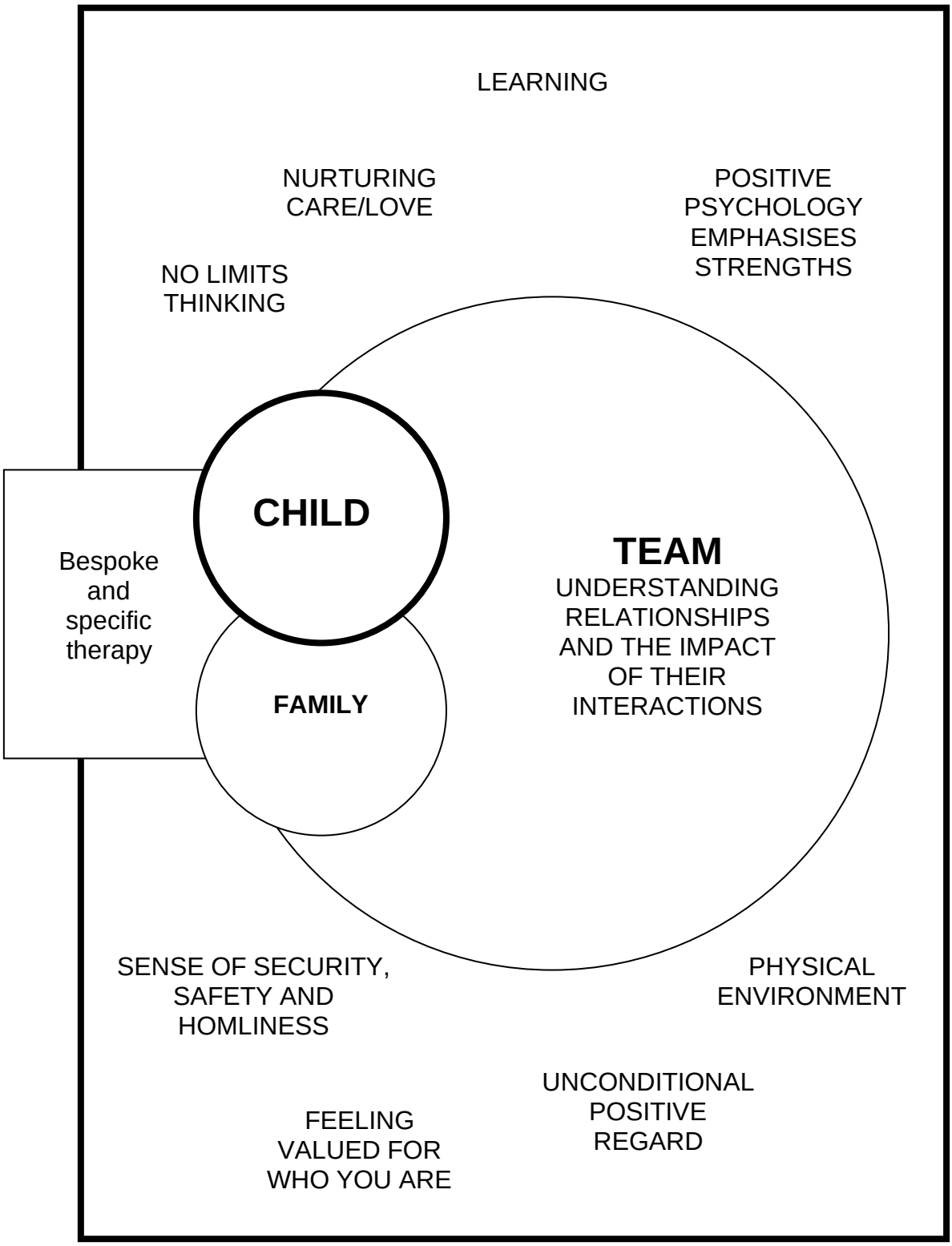
The diagram on the following page represents this therapeutic milieu; in essence this is the SES Way highlighted in a different format.

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 (see section 7.2) 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 (DEVELOPMENT AND LEARNING)

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. As part of the evaluation the young person's views on their progress are evidenced, along with other incidental outcomes outside of the targeted foci.

Young people participate fully in the PAN process, with an individual PAN meeting deliberately structured to place the child in the driving seat and the adults in supporting roles. There is a clear focus on looking to the future and agreeing targets to support that personal journey. Much of this is about improving the 'here and now'. Targets within action plans are framed in specific and measurable terms. They may be planned in conjunction with the young person's Development and Learning Plan or Focus, or could be aspirational to promote no-limits thinking.

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, and that importance of relationships and their impact on developing neuroscience.

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 BEHAVIOURAL NEUROSCIENCE IN ACTION

Our constantly evolving understanding of behavioural neuroscience enables SES to consider how the personalised needs of our young people can be effectively planned for. As research and science progresses, SES will continue to embrace the opportunities this will bring.

Of paramount importance is the recognition that a young person’s learning opportunities and therapeutic interventions support and help develop new neural pathways within the brain and promote positive stress regulation.

Every interaction, intervention and relationship with our young people potentially supports the Care, Play and Seeking emotional systems, enabling cells and pathways in the body to be activated by positive natural chemicals and hormones. When opiods and oxytocin are in dominance in the brain, the world feels like a warm, inviting place; they bring a sense of calm and contentment. We therefore expect all adults to provide nurture and build relationships with young people (Care), to share enjoyment, laughter, fun, joy and relaxation (Play) and to be energized, engaged, curious, motivated and show interest (Seeking).

How our body manages stress can be supported by providing physiological, relational and cognitive regulation. Examples of these include:

- Physiological
    - our tone of voice, posture, touch, eye contact
    - promotion of oxytocin
    - pattern/rhythm/repetition
    - soothing and calming
    - activities that allow stomping, scrunching, shouting
    - singing, clapping, whittling
    - mindfulness
    - stroking, hugging, rocking
    - food
    - supported risky play

- Relational
    - scavenger hunts
    - messy, wet activities
    - exploring senses
    - growing, eating and making
    - activities that generate oxytocin, serotonin, dopamine, endorphins
    - play and fun

- Cognitive
    - writing lists
    - counting
    - talking therapy
    - ordering, sorting
    - puppets, imaginative play
    - art

Providing opportunities for children to learn outdoors is essential as this promotes the release of serotonin. Simply taking along walk every day is a good habit for young people and staff to develop. Research in the field of Biophilia shows that learning outdoors reduces stress, improves attention and clarity of thinking.

We can and must promote and improve a young person's Mental Fitness (Bernard Allen), enabling greater awareness and control of their own thoughts, feelings and behaviour. At its simplest level this could be allowing young people to be involved in decisions about themselves or participating in restorative approaches. This begins to build their internal locus of control, reducing the sense of helplessness that looked after children can feel. Planning for the future as part of their PAN process engages neural circuits that are associated with motivation and positive moods. We need to teach young people to recognise how to control their own feelings by calming their own biological systems, developing greater self control and changing their habitual patterns of behaviour.

Our understanding of attachment theory and the impact of childhood trauma provides a clear framework for how we can provide for our children to allow them to learn to have a positive view of themselves and us, the adults who care for them. Examples include:

- Help them feel safe - for example, through structure.
- Be consistent, predictable and repetitive - stick by them
- Have unconditional positive regard, disliking the behaviour whilst loving the child
- Teach new ways of behaving, thinking about themselves
- Recognise what level they're operating at, at any one time – parent these children based on emotional age
- Nurture the children
- Try to understand the behaviours before considering consequences
- Model and teach appropriate social behaviour
- Listen to and talk with the children
- Have realistic expectations of the children

- Be patient with their progress and with yourself
- Be steady, attentive, respectful, honest and caring
- Take care of yourself

“Exposing the child, over and over again, to developmentally appropriate experiences is the key. We need to provide environments which are relationally enriched, safe, predictable, and nurturing.” (Bruce Perry)

11 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.

12 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 have supported staff in developing professional expertise that complements the SES Way, with trained practitioners in both Trauma Informed Schools and Thrive Approach. These both enable adults to become trauma informed, promoting the wellbeing and mental health of children and 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 our 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.

12.1 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.

12.1.1 Our emotional needs include:

- 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.

12.1.2 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.

12.1.3 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.

12.2 LEARNING AS THERAPEUTIC ACTIVITY

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.

12.3 BEHAVIOURAL INTERVENTIONS AS THERAPEUTIC ACTIVITY

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.

12.4 FAMILY LINKS AS THERAPEUTIC ACTIVITY

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.