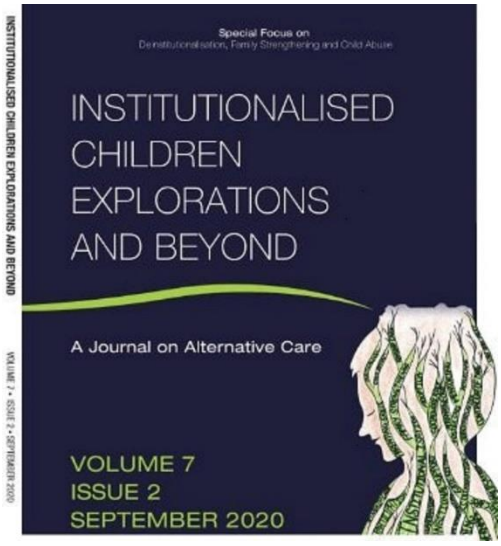
PATRICK TOMLINSON ASSOCIATES
DEVELOPING PEOPLE AND ORGANIZATIONS



MENTAL HEALTH NEEDS OF CHILDREN IN CARE
INTERVIEW WITH MR. PATRICK TOMLINSON[2] (2020)

BY LEENA PRASAD[1]

The interview for ICB's present issue has been conducted with Patrick Tomlinson who is an expert in the field of alternative care for children, with knowledge and experience both in academia and child care practice, with a particular interest and subject expertise in mental health and psychosocial development. This interview primarily focuses on the mental health needs of children in care. This objective has been divided into three sections, exploring institutional care, family and community-based care, and the context in South Asia, respectively.

A. INSTITUTIONAL CARE

1. Children in institutional care have suffered significant trauma in separation, as well as with issues embedded in dysfunctional families, before entering care. What are some of the impacts of institutional care on the mental health of children? How do they influence their growth and developmental outcomes?

First, I think the term institution is in danger of being misunderstood. Does it simply mean a children's home as opposed to a family? Is there a certain size at which a home becomes institutional? Or is the definition more about the experience of those living in a home? There are many excellent examples, throughout history where residential care homes for children and young people, equip those people very well for adult life. In some cases, the quality of experience may even exceed the quality of ordinary family life. Perry and Szalavitz (2006) have made the point in the book, 'The Boy who was Raised as a Dog', that the size of a typical family group, which has daily contact with each other has massively declined in the USA and other

countries, during the last 100 or more years. They also say that what traumatized children need most is a healthy community to buffer their pain. Ludy-Dobson and Perry (2010) showed that a central factor in a child's development and recovery from trauma is the number of positive relational interactions taking place for the child every day. The interactions might include caregivers, other family, peers, schoolteachers etc. A high level of positive interactions may be more possible to achieve in a small therapeutic group home than a foster family. However, we also know that there is a history of poorly run residential homes where positive interactions are not the norm. We know that in ineffective homes, children and young people with significant problems can be a bad influence on each other.

I think one of the most important things is understanding what a child needs and where those needs can be best met. As Whittaker and over 30 colleagues (2016) from around the world have made clear in their Consensus Statement, there are many types of children's homes. The needs of children also vary widely. So, rather than focusing on the questions, is 'institutional' care or therapeutic care, good or not? Or is foster care good or not? We should focus on the needs of each child, and how they will be best met. For some children, supporting their family and kinship carers may be the best option. For others, it may be foster care, and for some, it will be a residential care home. As James Anglin (2004) and many others have argued, residential care should not be considered as a 'last resort', rather a unique option in a range of positive options. In each case, the most important concern is matching the child's needs to the service provided and resources available. Probably a lot of the historic and present difficulties in institutional care and foster care are not so much due to the merits of either, but to do with a lack of clear planning and assessment.

A problem I have seen for over three decades and in different countries is the placement of children in situations that are not resourced to support their needs. Placing traumatized children in especially large institutions or in foster care, where the resources are inadequate for a challenging task is a recipe for failure. I have met many foster parents, who have been given incredibly challenging children but: with scant information about the child; only basic training, and little day-to-day support. Whenever it is not possible to meet children's needs, institutionalized practice is more likely to develop as a way of controlling and managing the situation. Here is a light example from England. A barber told me that going back in time, he used to go to an institution for 'juvenile delinquents' and do 50 haircuts in an afternoon. The young people must have been lined up and all given the same cut! Any practice, that removes children from what is 'normal' in their culture and which is based mainly on the needs of the home and not the child, could be considered institutional. It is becoming removed from the general norms of 'ordinary' society that tends to be a pattern of institutionalization. In general, it is healthy for any home, whether family or residential care, to be able to engage positively with society and the local community.

So, to go back to your question. Let us assume that a residential home is well run, and functions based on a clear ethos of meeting children's needs. In fact, substantial research into what makes the difference between effective and ineffective homes has found that having a clear

model and good leadership is most important (Clough et al., 2006). If we have this, these are some of the key potential benefits for children:

- The opportunity for children to form positive relationships and attachments with adults. A care home can provide many different opportunities for relationships.
- Every aspect of daily life can be used as a therapeutic opportunity. And in a lively group home, there are many opportunities for relational interaction (Ward, 2002).
- The opportunity for positive peer relationships. This is a critical factor in healthy child development. Inevitably, traumatized children may find this exceedingly difficult. Therefore, any home must be able to support and safely manage relationships between children. (Shonkoff and Phillips, 2000, p.92, p.165).
- A well-run home will support and improve relationships, wherever possible, between a child and his birth family. This can be easier for a care home to do, compared with a foster family. The care home can be more neutral. As one child in residential care said, "I don't need a family; I already have a family!" (Anglin, 2004, p.184).
- Every aspect of the care home and the organization that runs it can be internalized by children as a healthy functional model. Like a family, within an extended family, within a community.

2. What are some of the factors in institutional care that lead to these outcomes? In your view, are these consistently observed across care institutions globally? What are some of the developmental markers for the trauma that you consider important in placement?

Having a clear therapeutic model that is appropriate for the task and good quality leadership is vitally important. Well run therapeutic care services or any kind of children's home, will tend to have the following characteristics:

- They will be clear about what they do and for which children. They will have a way of assessing the suitability of children for placement. There will be ongoing assessment throughout placement: to identify children's needs; to inform an individual plan for each child, and to measure progress towards desired outcomes.
- There will be an emphasis on the safety of children, staff and everyone involved.
- Children's rights will be fully recognized. Children will also learn responsibility.
- Families of children will be included. Whatever is possible and appropriate will be done to improve relationships between the child and family. Not only is this good practice, but the reality is also that most children will be in contact with their families after they leave care (Tilbury and Osmond, 2006).
- The home will achieve a healthy balance of meeting the needs of individual children within the group context. Each child must have positive experiences of individual attention.
- The home will be a place, which offers a richness of experiences and encourages learning in everyone. Education will be valued highly.

- Staff will be well-supported, supervised and trained. Everyone who works in the home and wider organization will understand trauma, its impact on development, and what is needed for recovery. Staff development will be an important part of the culture.
- There will be a strong culture that is congruent with the task of care. The values of the home will be clear and demonstrated consistently by everyone involved.
- There will be a feeling of warmth in the home, which is apparent to anyone who visits the home. This will be reflected in the physical environment and the interactions between people.
- There will be good transition planning for when a child leaves the home.
- As James Anglin (2002) has put it, the home will always be seeking to achieve a consistent and congruent approach in the best interests of the child.

It has been argued that trauma, which occurs in a social context must be healed in a social context (Farragher and Yanosy, 2005, p.100). Or as Karen Treisman (2016) puts it, relational trauma requires relational repair. Where trauma has been complex, from early childhood, it is not just one relationship or one incident that has been the problem for the child. It can be argued that the problem has been the whole of the child's environmental context. In this sense, it may be that a service, which provides the whole context of a supportive network is most important for these children. Certainly, children who have experienced such environmental failure cannot be helped by individual therapy alone. They need to experience a primary home experience and everything that goes with it.

Throughout the last 70 years or more, there have been many examples of good practice in providing therapeutic care for children living in out of home care, across the world. The problem has been in achieving good practice consistently. Progress has been slow and checkered, going backwards at times, as well as forward. To some extent, therapeutic childcare for traumatized children is always going to be difficult. It is one of the most challenging tasks. Richard Balbernie (1971), who was the Principal at the Cotswold Community, a therapeutic community in the UK where I began my work, referred to this in the title of his paper, as "The Impossible Task".

In the last few years, there seems to be a potentially positive consensus developing on the key principles of good quality therapeutic care, as I have described above. The bigger question is whether Governments and societies will be willing and able to address the needs of these children. As Shonkoff and Phillips (2000, p.10) state,

> Interventions that work are rarely simple, inexpensive, or easy to implement.

The threat is that political intervention tends to be driven more by short-term economics, rather than by a long-term view. As shown by the ACEs study (AAP, 2014), untreated trauma can cause a lifetime of serious physical and mental health problems. What if the cheap option now is very costly in the long term? Hannon et al. (2010) in the UK also found that while effective interventions may be costlier in the short-term by the age of adulthood the costs are already repaid. Some of the markers from trauma, to be considered before placement are,

- Does the child form healthy relationships with adults and peers?
- Are there any positive attachments in the child's life?
- How does the child function in a group?
- How disruptive is the child?
- Is the child able to play?
- Does the child show any sense of self-preservation?
- Does the child show any sense of concern towards others?
- Does the child seem to enjoy anything healthily?
- Is the child able to learn at home and school?
- How does the child manage stress?
- Can he/she regulate his/her feelings?
- Does he/she panic in an out-of-control way?
- Does the child seem to freeze, shut off, dissociate?
- What do we know of the child's history?

These are just brief examples, which can be explored more fully in an assessment. Taking age into consideration, the more negative the answer to these questions, the more severe the trauma is likely to be and the greater the resources needed to enable recovery.

3. In your view, what are the mental health needs of children in out-of-home care? Does it depend on determinants such as age, gender, history of trauma, and family situation?

The second part of this question could be a good way of assessing what children's needs are. If we were to assess their needs under those areas, we might achieve a good understanding of the child. In particular, it is essential to understand how trauma and adversity have impacted the child's development. Complex childhood trauma is also sometimes referred to as developmental trauma (Van der Kolk, 2005). Rather than the child's chronological age, it is vital to understand his/her developmental age in key areas of functioning (Perry, 2014, Dockar-Drysdale, 1990, p.29).

We should also consider the child's needs concerning culture, ethnicity and religion. Once we have a full understanding of the child, we then need to ensure that the placement also understands these needs and can meet them. We need to listen carefully to the child and involve him/her in the whole process as appropriate to his/her level of functioning.

4. Extensive research on the impacts of institutional care highlights the importance of secure attachment and an enduring bond between a child and his/her primary caregiver.
   a) In situations where restoration to the family may not be possible, are there possible systemic changes that can be made in alternative care to provide for these basic attachment needs of the children?
   b) What is the scope, if any, of improved institutional care for persistent mental health and developmental benefits for children?

Attachment can indeed be the most important need for the child, especially if the examples of healthy attachments in the child's life have been limited. Attachment can only develop, where safety and trust become established. Therefore, safety is paramount. Anything that can be done systemically to improve a sense of safety and security is vitally important. For example, carers will feel safer when they are supported appropriately. Children will not be able to feel safe with carers who do not feel safe themselves. I have often found in residential and foster care that those closest to the children, can feel unsupported and sometimes isolated. Unfortunately, this means that rather than being open to the needs of the child, they become defensive. Therefore, we must do whatever is possible to improve the feeling of safety for those who are working with and looking after the children. Good quality support and training are essential.

If we go back in time, there has even been a culture where social care workers have been advised and trained to not get emotionally involved in their work. Donald Winnicott (1947, p.63), the English Psychiatrist and Paediatrician, was right when he said,

> It might be asked why …get emotionally involved? The answer is that these children….do not get anywhere unless someone does, in fact, get emotionally involved with them. To get under someone's skin, is the first thing these children do when they begin to get hope.

Winnicott's view on the importance of relationship and emotional involvement has been reaffirmed by neuroscience research. However, the nature of involvement with traumatized children can be extremely difficult. Therefore, there must be good quality support for those who are involved with such difficult work. Another systemic change that would be helpful is to do whatever is possible to ensure that the people selected for this work have the necessary personal qualities and characteristics. As well as the ability to relate well with children, resilience is vitally important. This does not just mean being able to survive extreme difficulties. It means having a balance of being sensitive to children and their needs, while not being easily overwhelmed.

Following safety, ongoing stability is crucially important. It is not helpful for children who have become settled to be suddenly moved. In the same way, it is not helpful if staff are coming and going so much that the child is unable to form reliable relationships. Therefore, helping service providers achieve stability is important, as long as this does not mean avoiding healthy change. It is easy for stable to also mean stuck. For example, where children might stay in a placement too long when they are ready to move on. The challenge is to get the balance right. In some countries, such as the UK, policies have been continuously changed by Governments, in a way that has contributed to an unstable environment for service providers and users.

If the term 'institutional care' in the question, simply means a residential home, then the potential for development in treating mental health and development problems is great. High quality therapeutic residential care can treat the most extreme cases of complex childhood trauma. I have seen this as have many others. I think this can only happen in homes where a

child can receive a good level of individual attention within the group. Maybe groups of around 5-10 children are the maximum size for children with complex trauma. It can also be helpful if a group, is connected to other groups, so there is a sense of a wider community. Some children may need to be in a smaller group. I think we should be careful to not be too prescriptive about the size of groups. The main indicator of what works are the outcomes being achieved by the children.

B. FAMILY AND COMMUNITY-BASED CARE

5. It is universally accepted that the best setting for children to grow is within their families. Yet, with incidences of poverty, abuse, neglect and exploitation prevalent within families, how can this dilemma be best resolved, keeping the best interest of the children at the core?

Ironically, the family is also often referred to as an institution. For example, when people talk about the great institution of the family. The concept of a family, as with residential care, can mean many different things. The meaning of family can be so diverse that it is not helpful to just say, family. Families are so different, that what one person thinks of as family would be inconceivable to another. And as Perry and Szalavitz (2016) have pointed out in the relatively short space of a few hundred years in human history, what 'family' means has changed out of recognition. The human norm, historically, has been to parent a child in the context of a family group, of anything from 20 to 100 or more people living closely with each other. This is where the saying 'it takes a village to raise a child' comes from. Keeping in mind that it is not clear precisely what family means, I agree that whatever it means, it can be argued that a family is the best place for a child to be. Therefore, doing whatever can be done to support the parenting potential of families is an important focus. I do not know a great deal about it, but I believe that the 'Wraparound' service in the USA has pioneered some excellent work in this area.

Whoever is making decisions on this issue must be clear about the safety and other needs of children. They must also understand what can be done to make improvements in the family situation, wherever possible. Where a child is to be removed, alternatives such as kinship care should be considered. Where this is not suitable, identifying a good quality residential service or foster care can be a positive option. The main point is to be clear that if the child stays with the family, he/she will be safe and able to develop, and the same if he/she is removed. I am not sure that these matters can be resolved as such, as they are so complex. Those making the decisions are always going to be weighing up many factors and making an informed judgement. The aim should be to make those judgements as well-informed as we can. And, to ensure a process of continual monitoring and evaluation, so that we can learn from the decisions that are made. These decisions always happen within a cultural context, and that context is always evolving. What might seem right today may be seen quite differently in 10 years.

6. The carer team in alternative care, comprising of caregivers, foster parents, kinships carers etc. depending on the form of care, may have mental health concerns of their own.

These aspects may emerge in the screening stages. The demands of the job, coupled with individual mental health concerns, may discourage them from committing to the demands of the role. In this process;

a) **How can the carers be vetted (as in foster care placement, adoption, caregivers in residential care etc.) to make sure they are a good fit for the child?**
b) **How can the carers be supported, trained, and strengthened? Are there such training initiatives that you may be aware of?**

First, the organization needs to truly value the importance of these issues, such as the selection, support, training, and development of carers. There is a great benefit of working with those in management positions about employee support and development. How a carer feels valued is hugely important and the attitude of the most senior people provides a powerful example. The whole culture of the organization is transmitted in hundreds of different ways to the carers, as it is to the children. Therefore, we could have excellent training in a culture that is not properly aligned, and it would not be of much use. It might even alienate the carers, as what they experience in the training might be in contradiction to their experiences in the organization.

So, going back to what I said earlier, clarity of ethos and good leadership is vital. This should build a strong culture where the values of the organization are clear. We could have an excellent staff selection process, but if the first experience of the employee in the organization is one of not being noticed, listened to, treated with respect, etc. it would achieve little. Leadership, culture, and values are a matter of application and attitude. Assessment and screening can be introduced. Some effective methods can be brought, such as adult attachment interview and psychometric tests. However, an organization can achieve a lot by developing processes that ask the right sort of questions and look at the relevant issues. In my view, while a good level of intelligence is important in a care worker, personal characteristics are more important than academic qualifications.

Relevant training can be diverse. For example, from learning about child development to developing observational skills. Reflective practice is hugely important. It can be developed by creating a culture where people are continuously trying to reflect on their experience and learn from it. Asking questions and being curious is an important part of this. I think we should create something, such as a therapeutic model, out of the situation we have. A process of evolution, rather than by importing something from outside of the local culture. Get people together and think about the issue of training, for example. Of course, this needs to be led by experienced people but informed by the needs and possibilities of the context. Training is often thought about in terms of group events. However, learning on the job, guided by a supervisor or mentor can be the most powerful form of learning. An interesting thing for me in doing this interview is that the quality of the questions is as important as the answers. Maybe, the key to our learning in this field is not so much about having the 'right' answers but continuing to ask the right kind of questions.

7. **In alternative care, children are often subject to multiple transitions in placements. The deinstitutionalisation and reintegration process entails that they are uprooted from previously familiar settings back, albeit, to the family and community.**
    a) **What are the psychological impacts of such transitions on children?**
    b) **How can a sense of stability and predictability, fundamentals to emotional well-being, be ushered in these situations?**
    c) **How can the ongoing mental health needs of the children be addressed once the child has been transitioned to a family setting?**

How transitions are managed is a central part of the child's treatment and recovery process. Childhood trauma is often connected to abrupt and frightening change rather than a transition that can be made sense of by the child. In a healthy childhood, transitions are planned for and anticipated. Simply, a child is helped daily, to manage transitions. For example, from the beginning of a feeding experience, as a baby, to the end of it. As a young child, from being at home to being at school. Transitions do not usually happen suddenly, without warning and when they do, the unusual nature of this is understood. Oppositely, a traumatized child may have experienced, sudden and incomprehensible transitions. These may range from a loving parent, suddenly becoming a hurtful parent, to a sudden change of home or disappearance of a carer. Therefore, we should think of transitions both in the big and small contexts. The transitions in and out of care are big. But the small transitions that take place every day are equally important. Such as, between night-time and sleeping, between morning and waking, between home and school. The way these transitions are worked with and anticipated, with each child's needs in mind will provide a positive model for handling the bigger transitions. In general, a good transition is planned. A process that allows the child and adults to explore the issues and feelings involved. A transition for a child is also usually a transition for an adult, so working together on it may provide unique solutions that are helpful. For instance, a parent may be anxious about a child's first day at school, as well as the child being anxious. Between them, they find a way of managing it that is helpful to both. A bit like Winnicott's (1953) idea of a transitional object, a solution to the gap is found by both being open to it.

In a general sense, the more stable and predictable the environment the more it is possible to think about transitions. For there to be a transition, there must be a transition from something that is understood and reliable to something different. It is helpful to identify the transition long enough in advance for it to be understood before it happens. Planning and talking about transitions are important. Traumatized children who are likely to feel unsafe and out of control, benefit from knowing whatever is happening in the important areas of their life. This can range from what is for dinner, to who is putting me to bed tonight, waking me in the morning, to the bigger questions, such as, when will I be leaving this home? Also, traumatized children are likely to feel as if things are out of control and they have no choice, so involving them and listening to them is important. If the child feels he/she has a degree of control and choice, it is likely to be helpful.

In simple terms, poorly planned transitions are likely to be unhelpful and even traumatic for children, whose suffering and trauma is so much related to abrupt and harmful transitions in

their lives. Well-planned transitions can be therapeutic and provide a healthy model for managing change. For this to be the case, transitions must be recognized and thought about in every detail of day-to-day life, and not something that just happens at the end of the placement. As the beginning and end of placement is such a significant transition, how children and adults join and leave the home, will provide a constant message of how these transitions are managed. What kind of rituals are there around these events? Also, of vital importance is what happens after a transition, such as leaving. What ongoing support and connection can be expected? Do young people who leave come back and visit? Are they remembered or forgotten? A transition out of home, for any young person, can be a daunting prospect. Children leaving care do not tend to fare well across the world. A carefully planned transition with ongoing support can make a huge difference to their prospects. A transition should be based on an assessment of the child's readiness, and the suitability of where he/she is going to meet his/her ongoing needs. The support to be provided once the move has happened should be understood, agreed in advance and clear to everyone involved.

8. How does deinstitutionalization account for preparing the family and community to accept and integrate a child who has been separated? Parenting skills training and community support initiatives are some examples of positive practice. In your experience, have you come across such psychosocial tools and support systems available to them and if yes, what are they?

The main thing I have seen is that if the family feels supported and connected, they will be able to function more effectively. One of the challenges may be that the family feels isolated and disconnected from a support system. I would look at how the family can strengthen its capacities and support network. Depending on the strength of this, would the family also benefit from an ongoing professional support/mentor? Someone whom they trust and have built a relationship with. Training may be helpful, but mostly within the context of a supportive relationship. The worst thing is for the family to become isolated. Children leaving a care home have expressed the view that if things do not work out when they leave, they should have the option to return (Hanon et al., 2010, p.101). Whether this is possible or not, the child must be able to keep in touch with a social worker or carer from the residential home, to discuss how things are going, and to receive some ongoing help when needed. Much as we would hope for when any young person makes such an important transition.

C. SOUTH ASIA CONTEXT

9. What are some of the cultural considerations that inform care and support in the SAARC region?

I have little experience with the SAARC region. What I would say is that the local culture is most important to consider. One of the challenges with some of the international research is how to make sense of the findings in the local context. Here is an example, from Tuhin Islam Khalil (2013) in Bangladesh. He explained in an interview that children living in a large residential home where he worked were often running away and 'dropping out'. Contact with the

children's mothers was not encouraged as many of them were sex workers. Tuhinul recognized that the children needed their 'mums'. He changed the organization's policy so that,

> Mum can come and visit any time they want. They do not even need an appointment to come. So, it is like magic, within a month the dropout rate has nearly gone.

This was an excellent example of thinking about the underlying issues in the local context and meeting the need. Within SAARC there will be many cultural differences, which will influence what is needed. Rather than focus on literally how big or small a home should be, I think we should focus on principles related to children's needs. Such as, all children should receive some daily individual attention within a healthy caring relationship. If principles like this mean that one kind of setting is more appropriate than another, and we have evidence that that is the case, we should make decisions on that basis. Whittaker et al. (2016) 'consensus statement' based on international research, lists 5 key evidence-supported areas of good practice. As said earlier, the most important thing for traumatized children and any child is positive outcomes. I think policymakers need to understand what the key outcomes are and what kind of practices are likely to achieve those outcomes. Hold organizations accountable for their practices but do not make assumptions that good practice with positive outcomes cannot be found in a variety of settings, including institutions.

During the last couple of years, I have seen some excellent work with young people, in a setting, for up to 40 children, in groups of 5-10 children. Some of the most positive aspects of the practice would not be possible in a smaller group setting. The larger group provides a potentially rich sense of community. There are great possibilities for forming relationships and connections. Sadly, governments may make sweeping changes, which will make this kind of environment a thing of the past, regardless of the outcomes being achieved, or the lack of any proven better alternatives. Historically, some countries altogether abolished residential care, only to find that it was needed and had to be recreated. Others have reduced the size of homes, to 5 or fewer children, often only 1 or 2. There are occasions when this may be necessary, but in general, it may achieve little. There is much to learn from research and experience, and many socio-economic matters to consider. In my view, the people in the local situation must be central to the process of consideration and change.

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1. This interview was conducted over email in March 2020, by Ms. Leena Prasad, Asst. Director (Advocacy, Research, Training - A.R.T.); Udayan Care.

2. Patrick's experience spans from 1985 mainly in the field of trauma and attachment informed services. He began as a residential care worker in a UK therapeutic community and held roles as team leader; senior manager; Director; CEO; consultant and mentor. He is the author of numerous papers and books. He is a qualified clinician, strategic leader, and manager. Patrick Tomlinson Associates (PTA) was founded in 2008 to support the development of people and organizations and provides,

- ✓ Therapeutic Model Development
- ✓ Developmental Mentoring, Consultancy and Clinical Supervision
- ✓ Personal and Professional Development Assessment for Staff Selection and Development

These services have been provided in Australia, Japan, UK, Ireland, Romania, and Portugal, among others. Therapeutic models that Patrick has worked on have gained widespread recognition.

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