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DEVELOPING PEOPLE AND ORGANIZATIONS

THERAPEUTIC MODEL DEVELOPMENT: CREATIVITY, OWNERSHIP, AND AUTHORITY
PATRICK TOMLINSON (JANUARY 2022)

Abstract: This extensive paper discusses the history of therapeutic model development and the immense value of having a strong and clearly articulated model. The paper focuses on residential care, though many of the principles are relevant to other services involving children and families. In the last two decades, there has been vast research on residential care around the world. The aim has been to discover the key principles of what works and helps children, young people, and their families achieve positive outcomes. This is summarized, alongside the author's 35+ years of working with and developing therapeutic models. Specific reference is made to four different models in three different countries. As well as discussing key elements of therapeutic models, the process of model development is considered in detail. The paper will argue that creativity is an essential part of the development process, which is a process of change for individuals and organizations. Model development is not just about having an articulated model but how one is created. When this is done well there are major potential improvements within organizational culture. There will be an improved sense of ownership and authority, which are both fundamental to the primary task - children's development.

INTRODUCTION

Therapeutic Models have been around a long time, at least for a century. Since 1985, I have been involved with organizations that either had a unique model or decided to develop one. Three that I describe here, the Cotswold Community, SACCS, and the Lighthouse Foundation, developed highly effective models that became recognized nationally and internationally.

In recent years, the research base of therapeutic models has grown significantly. There have been several meta-studies analysing decades of research. This has led to an international consensus on the key elements of a therapeutic model (Whittaker et al., 2016, James, 2017, Oranga Tamiriki, 2020). In 2014, an international working group (Whittaker, Del Valle, & Holmes, 2014, p. 24). issued a consensus statement defining therapeutic residential care as involving,

> … the planful use of a purposefully constructed, multidimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community based formal and informal helping resources.

Evidence indicates that having a clearly articulated model is vitally important. James (2017, p.10) goes as far as to say, that without one nothing else will likely matter. Identifying the need for a clearly articulated model is not new, as Fahlberg (1990, p.51) said,

> The most important task of treatment must be clearly and succinctly stated. Specific problems and dynamics vary from child to child, but a philosophy of treatment must clearly identify the category of problems that are most essential for the program to confront if successful treatment is to occur.

Research is also beginning to examine the way an articulated model is created. For instance, is it ‘homegrown’ or ‘imported’? The model creation process is integral to the strength of the model. As is the resulting sense of ownership and authority to the implementation and fidelity of the model. Therapeutic models for residential care consist of three key areas, leadership, culture, and practice. They must be worked on in that order. Leadership shapes culture, and together leadership and culture provide the containing structure that practice sits within.

Research has evidenced the importance of leadership and having a clear model as the most crucial factors in achieving positive outcomes for children. Clough et al. (2006, p.42) found through their research into what works in residential care, that a strong staff culture tends to lead to a strong children culture, which leads to good outcomes.

Strong Staff Culture → Strong Young Person Culture → Positive Outcomes

A strong culture exists when staff respond to situations because of their alignment to organisational values (Barton et al., 2012, p.210). Therefore, it is important that a therapeutic model considers the entire system and not just the direct work with service users. The model helps create a consistent level of care (Tomlinson, 2019). Byrne (2013, p.146) highlights the importance of this,

> When practitioners identify themselves as providing therapeutic care it is important that they are clear about the approach that informs their practice. The reason is that where several practitioners are working with the same client, the active interventions will be different depending on the theory influencing each individual practitioner. Mixed approaches could lead to inconsistency in service provision and unhelpful or confusing outcomes for the client.

1

THE COTSWOLD COMMUNITY: A THERAPEUTIC COMMUNITY WHOLE-SYSTEM APPROACH

I had the great fortune of beginning my work in a therapeutic residential community in 1985. This was the Cotswold Community in England. It was set up by the Government in 1967 as an experiment to see if it could become an alternative model to the failing Approved School/Borstal systems. The Community had forty boys who had suffered trauma, abuse, and neglect. The boys lived in four houses on a farm setting. It was like a small village with staff also living on site. The model was well designed from the beginning. A key aspect was the integration of the organizational and clinical approaches. It was a whole-system approach. Everything was planned in relation to the primary task, i.e., the task that the organisation must perform to survive (Miller and Rice, 1967, p.25) and (Clough et al., 2006, p.34).

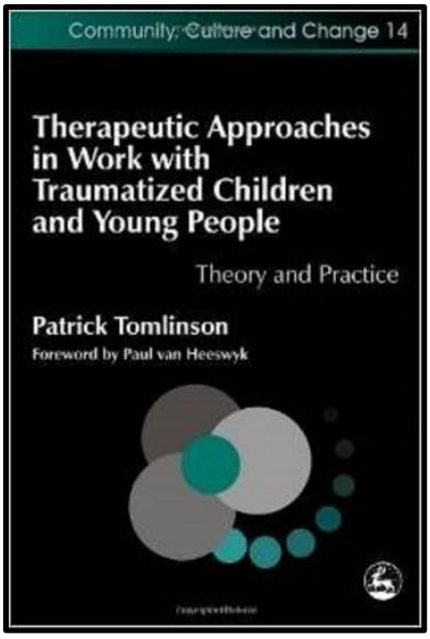
Kezelman and Stavropoulos (2012, p.16) claim that a whole-system approach is the most appropriate for services treating trauma. James (2017, p.5) also confirms the value of this approach,

> Residential care program models can be described as milieu-wide approaches, specifically developed for the residential care context. They tend to be comprehensive in scope and potentially affect every aspect of practice within a residential care setting.

A whole-system approach is also an integrated model. It is one that James Anglin (2002, 2004) has referred to as seeking a consistent and congruent approach in the best interests of the child. Anglin explained, how in such an organization, which he also argued tended to be the most effective organization, all decisions would be considered on the impact they would have on the children's interests. In other words, how do the different options we have in any decision impact the primary task? In my experience in the Community, this would include decisions on individual children, group management, daily routines, organization processes, finances, housekeeping, staff selection and training – down to the detail of food provision, shopping, budgets, cooking, etc. The provision of food and mealtimes was one area of major change in the Community.

Food and Mealtimes

The centralized provision of food from a large kitchen was devolved to each home. Menzies Lyth (1985) who was the organizational consultant at the time, explains in detail how the change was worked on in terms of the benefit for the primary task, i.e., the children's development. The abolition of the central kitchen, the redeployment of staff from the kitchen, the responsibility for food and meal provision in each home, naturally encountered resistance. However, the long-term benefits for the children, staff, and culture were great. The change led to improvements in skills, such as budgeting, planning, and shopping. It also impacted the development of qualities such as responsibility and creativity, as well as the obvious change which was learning about food and cooking. When I arrived a few years after the change, I was certainly faced with the challenge of cooking meals for up to fifteen people. It was a good role model for the young people to take with them into the outside world - to be involved in the whole process around food. One young person I looked after who is now in his forties and enjoys cooking, can remember what I used to cook on a Friday night, many years ago – chops, chips, and peas! His experience would have been much different if the meals were just delivered to the home in steel containers as they had been.



"The Community's therapeutic approach was largely based upon Barbara Dockar-Drysdale's application of Donald Winnicott's psychoanalytic theory of child development and treatment (Dockar-Drysdale, 1990, 1993). Winnicott's ideas are particularly relevant to work with children who have been traumatized during infancy. Approaches derived from the work of psychoanalysts Melanie Klein and Wilfred Bion among others were also incorporated. The organizational and management structure was based on an open systems model developed through close work with consultants from the Tavistock Institute of Human Relations. This consultancy spanned 30 years, beginning with A.K. Rice, who was followed by Isabel Menzies Lyth and then Eric Miller. Careful attention was paid to ensure that the structure adopted, and all aspects of the Community were supportive of the treatment task." (Tomlinson, 2004, pp.22-23)

An Explicit Model

Menzies Lyth (1979, p.230) explains why it is important to have an explicit model,

> Very frequently it seems, the explicit or implicit model for operating units is some version of the family, which may be inappropriate. It denies the reality that this is a work situation which needs management with clarification of roles, responsibilities, and relationships. Further, the so-called family model often denies the reality of the family. A well-functioning ordinary family is likely to have a complicated and effective management system even though it would not be described in those terms and is often not noticed because it is implicit and stable over lengthy periods. In institutions the same effect can only be achieved by making explicit the managerial functions and relationships.

It is interesting to think that the UK Government had the foresight to set up such an innovative service in 1967. It was possibly the first children's therapeutic residential whole-system model. Therefore, aspects of the Cotswold Community's work were ahead of their time. From when I started there in 1985, I learnt about trauma-related concepts, such as,

1. The impact of trauma on child development - now referred to as developmental trauma (Van der Kolk, 2005).
2. Syndromes of deprivation - Dockar-Drysdale (1970) described the different impacts of trauma on child development based upon the extent of the trauma and the age of the child. She outlined the treatment approach according to the stage at which the child's development was disrupted. This was a clear model and has much in common with Perry's (2014) Neurosequential Model of Therapeutics.
3. Brain plasticity (Merzenich, 2013) - given the right conditions the brain is plastic and can recover; prolonged extreme stress and fear can cause the brain to become flooded with cortisol and adrenaline, which have a freezing effect. Dockar-Drysdale wrote about what she termed the 'frozen child' in 1958, which I think was a remarkable insight. Her preference for the term frozen rather than 'affectionless', which was commonly used at the time, clearly implies her belief in brain plasticity,

> … 'affectionless' sounds final, but a thaw can follow a frost. (p.17)

Concepts such as these, are often referred to as if they are new knowledge revealed by neuroscientific research. Many details are new, but the basic concepts are not. However, it is excellent that the concepts are becoming more widely known.

It is also important to acknowledge that pioneering therapeutic models were developed long before 1967. For example, pioneers such as Bruno Bettleheim at Orthogenic School Chicago, Barbara Dockar-Drysdale at Mulberry Bush England, John Brown at Browndale Canada, A.S. Neill at Summerhill School England, August Aichorn in Austria, George Lyward at Finchden Manor England, among others. They wrote about their methods, and they had a profound influence. We certainly read about them in our training in the Cotswold Community. These

pioneers were often influenced by psychodynamic principles. For example, the psychoanalyst and paediatrician Donald Winnicott had a major influence in England from the 1940s, as did John Bowlby. Sigmund Freud was influential on the work of August Aichorn and Bruno Bettleheim.

I spent fifteen years at the Cotswold Community, and it laid a foundation for everything I have done since. As well as the integration of management and therapy, other key factors stand out. The Community had a living-learning culture. It was a 'culture of enquiry' (Whitwell 1998, Bloom, 2005. P.65). We were continuously trying to learn from our experience and to make improvements. No matter what one's position, everyone was encouraged to contribute to development. As part of this, we created an in-house training programme. We also had regular training days led by external professionals. Our internal programme became university accredited.

Through the work of Dockar-Drysdale (1970, 1970a) a Needs Assessment was implemented – to identify the needs of each child, to form an individual plan, and to measure progress towards desired outcomes. The assessment and other processes focused on outcomes as well as needs. We used various tools for measuring a child's ability to communicate, his emotional stage of development, etc. Though we did not use the terms at the time, this was outcomes and evidence-based work. All policies and practices were reviewed regularly to help ensure they were aligned with the model. These three elements, training, assessment, and policy alignment are crucial aspects of any model and its implementation. The Cotswold model was well-established by the time I arrived. Miller (1989) claimed that when the experiment started in 1967,

> 80% of the boys leaving the approved school reoffended, within three years; ten years later, the proportion had dropped to 20%.

While I was there the model was always adapting according to circumstances and learning from our experiences. A model is never finished, it is always evolving. As Whitwell (1998) states, "A culture of continuous self-examination is necessary and is supported by external consultants". In 2004, a book that I authored on the Community's work was published - 'Therapeutic Approaches in Work with Traumatized Children and Young People'.

2

THE SACCS RECOVERY PROGRAMME

After the Cotswold Community, I worked at SACCS in England. With their pioneering founder, Mary Walsh, we led the development of the SACCS Recovery Programme for traumatized

children. A core element in this model was the integration of the three strands of the approach – therapeutic parenting, therapy, and life story work. Tomlinson (2008, p.361) states,

> These three strands of therapeutic work are strongly connected, so that everyone involved works together as a team in supporting the child's recovery. Issues such as confidentiality are held by the whole team, rather than 'split off' into professional factions. Together the child's therapeutic parenting team, therapist and life-story worker are called the recovery team.

Importantly, the three professional disciplines became to be equal parts of the therapeutic approach, rather than a hierarchy. It is common in residential care that the social care workers who spend the most time with young people are often treated with a lack of professional regard. To enhance the care worker's role, which we called therapeutic parenting, SACCS created the UK's first foundation and bachelor's degrees in therapeutic care. This was done in partnership with Wrexham Glyndŵr University and is still running today alongside a bachelor's degree.

> This innovative course is designed for those working or volunteering with children dealing with the impact of trauma. A specialist programme, it provides a vital insight into childhood trauma and post-traumatic growth and ensures those working with the most vulnerable children in society are trained to the highest standard. (Wrexham Glyndŵr)

An Outcomes-Based Approach

Another key aspect of the SACCS model was the outcomes-based approach. This means that what matters most are the outcomes young people achieve that are likely to benefit their lives. All positive outcomes are connected to the fundamental human needs of safety, happiness, and development (Willis, 2001 p.153). A focus on outcomes can help a service shift its attention from what it delivers to the difference it makes. At SACCS we defined 24 outcomes (see Appendix 1) that were necessary for a child to make a good recovery. Pugh and Philpot (2006) explain what recovery means,

> Recovery for the children at SACCS is summarised by the child having internalised their attachments and consolidated their emotional development to a point where these can be successfully transferred to other environments and relationships and that they have the potential to achieve to full ability in all aspects of their life.

Having defined the outcomes, we identified the necessary developmental 'tasks' to be completed to achieve each outcome and then wrote guidance on 'how to' support and enable the child in this process (see Appendix 1). Once desired outcomes are clear, there must be a way of assessing where a child is in moving towards them. In other words, what is their stage of development and how is it progressing? We split the 24 outcomes under six developmental domains,

- Learning
- Physical Development
- Emotional Development
- Attachment
- Identity
- Social and Communicative Development.

The assessment used a spider diagram to plot where the child was on each domain (see Appendix 2). While the concept of a spider or radar diagram is not unique it was the first application of it in the field and has since been used by similar organizations. With an assessment of the child's development and needs, we created an individual recovery plan to focus on how to best meet those needs. This plan covered all aspects of their daily life and relationships. Ward (2004) highlights the importance of a good assessment process,

> You can have assessment without treatment, but you certainly can't have treatment without assessment.

Another key point Ward made about assessment, is that what matters most... is that the whole team is engaged both in the process of assessment and in the process of treatment. This is a crucial feature of a therapeutic model. Everyone who works with a young person is involved. And those who are not directly involved understand their role and contribution. This follows on from what Dockar-Drysdale (1993, p.93) said,

> … all needs assessments must, in my view, be made by a group, *never* by an individual collecting information or depending on interview procedure.

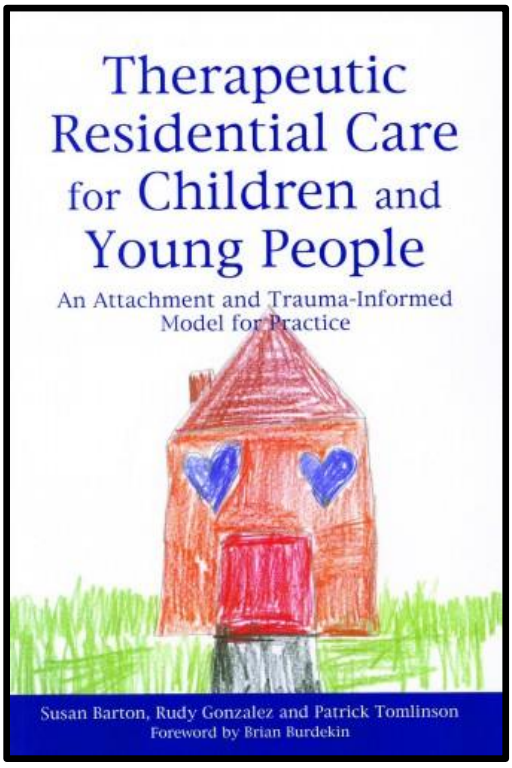
A few years ago in Ireland, a Guardian ad Litem asked me if I had heard of the SACCS Model and explained that she had placed two children there. She said that it was the gold standard in residential care. When she visited the children's homes, everything she experienced reflected exactly what the SACCS model was about. In other words, the model had exceptional fidelity. This is a crucial point in model development work. It is one task to create a model, it is another to implement it effectively. A great model on paper does not amount to much unless it implemented effectively. As a way of celebrating the creation of the model, SACCS held a conference in 2007, on trauma and recovery in London, with guest speakers, Bruce Perry and Bessel van der Kolk. Their work on trauma had been fundamental to us in understanding trauma and recovery.

3

THE LIGHTHOUSE FOUNDATION'S THERAPEUTIC FAMILY MODEL OF CARE™

After six years of working at SACCS, I began working independently. Shortly after, the Lighthouse Foundation in Melbourne, Australia led by another pioneer, Susan Barton, asked me if I could help them articulate and develop their model. Lighthouse was well-established and had a strong model. They were influenced by the book on the Cotswold Community, and it fitted well with their ethos. The work we did together resulted in the publication of, Therapeutic Residential Child Care: An Attachment and Trauma Informed Model (2012). Steckley (2013) summarizes,

> From the introduction through the final appendices, I was struck by the constant and integrated presence of thinking, feeling and reflection as integral to meeting the needs of young people, whether at an individual or organizational level ...This book offers vision and motivation to those with requisite courage to work towards a more humane system of care for children and young people……Elements of neurobiological and social ecological theories of development, the Sanctuary Model, organizational psychology, systems theory and even anthropology are also well integrated and usefully applied at relevant points throughout the book.



At the time, Lighthouse worked with homeless young people or those in danger of becoming homeless. An interesting aspect of the Lighthouse model was that two carers would live in a home with young people 24/7. Very different to a team working a 'shift' pattern.

The work with Lighthouse showed me how the core principles of a therapeutic model are transferable to different services and cultures. It also helped me understand the importance of cultural sensitivity. In a book on developing evidence-based international practice, Thorburn and Ainsworth (2015, p.45) stated,

"In Australia, the most clearly articulated model of Therapeutic Residential Care is that offered by the Lighthouse Foundation (Ainsworth 2012; Barton, Gonzales and Tomlinson 2012) that owes much to the Cotswold Community in the UK."

The point about evidence-based practice is vitally important. Good models are underpinned by evidence-based research. Most importantly they produce evidence-based outcomes for their service users.

4

SOCIAL RETURN ON INVESTMENT (SROI)

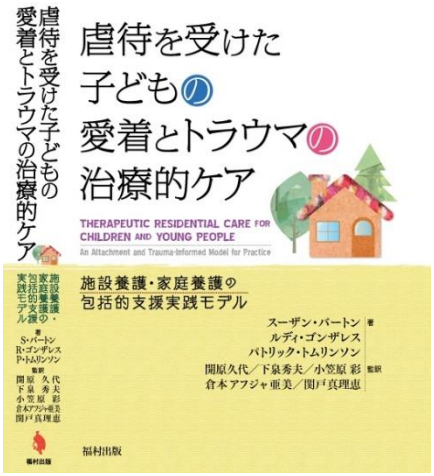
The Lighthouse model leads to a holistic transformation of young people's lives. The changes are sustainable and the investment into the programme generates significant social returns. Investing in high-quality residential care, and any other kind of effective children's and family service can also have major long-term economic benefits. The Lighthouse Foundation states,

> Independent (third party) Evaluations are also initiated by the Lighthouse Institute. An independent 'Social Return on Investment' report by Social Ventures Australia (2012) estimated that the work Lighthouse Foundation returns to the wider community delivers approximately $12 in social value for every $1 invested, making the Lighthouse Model of Care one of the most cost-effective therapeutic programs in Australia. Of over 130 charities evaluated on this same scale by Social Ventures Australia, Lighthouse Foundation retained the highest return-on-investment ratio (as of 2019).
>
> In 2018, Ernst and Young conducted an independent evaluation of the long-term effectiveness of the Lighthouse program in ending homelessness permanently for the young people who have graduated from the residential programs. It found that over 75% of Lighthouse graduates never again experienced a night of homelessness. This was a back-up of the Social Ventures Australia report from 2011 that showed over 80% of past residents ended their homeless state permanently.

The Lighthouse model, which over one thousand young people have passed through, highlights the critical importance of a social return on investment. Similar findings were made by Hannon et al.'s (2010) UK research. They found that investing in high-quality residential care is hugely cost-effective in the long term. A similar view was reached by The New Economics Foundation (Lawlor, 2008) who published another UK research paper – *A False Economy: How failing to invest in the Care System for Children will Cost us All.* The economic analysis found that extremely positive long-term results could be achieved by investing in high-quality residential care (see Appendix 5).

> The NEF also found that the cost-cutting approach had an adverse effect. Where costs are driven down, smaller high-quality services cannot compete with large companies. What gets cut out are often key ingredients, which are perceived as luxuries, such as specialized therapy and staff training. As a result, the benefits for children, staff, and economics, suffer. The cost of not meeting the needs of children who have suffered such childhood adversities are staggering on so many levels. The Adverse Childhood Experiences study highlighted the serious long-term issues involved (Centers for Disease Control and Prevention, 2014).

After the work with Lighthouse, I decided to focus my work more specifically on working with organizations to co-create therapeutic models. A government-initiated project in Japan asked me to assist them in looking at developing therapeutic approaches for residential and foster care. Dr. Hisayo Kaihara, the psychiatrist, who led the project had been interested in the models of SACCS and Lighthouse. One of the outcomes of this work was the translation of the Lighthouse book into Japanese. Another outcome has been the establishment of smaller therapeutic residential care homes in Japan.



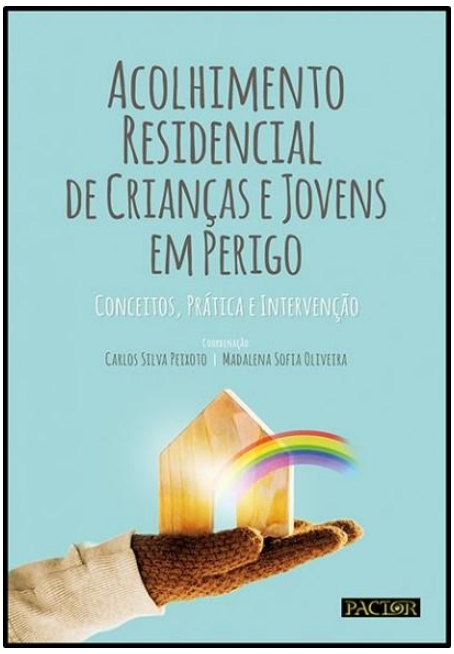
5

CREATIVITY AND CO-CREATION OF MODELS

I believe that co-creation is the most helpful process for model development. Creativity is vital in human nature and especially important in our field of work. Creativity, play, imagination, and hope all go together. They are vital in the recovery process and believing in the possibility of a better future. Creative forces are necessary to overcome the huge obstacles faced by traumatized young people, their families, and those who work with them. Van der Kolk (2014, p.17) states,

> Imagination is absolutely critical to the quality of our lives…. Imagination gives us the opportunity to envision new possibilities - it is an essential launchpad for making our hopes come true. It fires our creativity, relieves our boredom, alleviates our pain, enhances our pleasure, and enriches our most intimate relationships. When people are compulsively and constantly pulled back into the past, to the last time they felt intense involvement and deep emotions, they suffer from a failure of imagination, a loss of the mental flexibility. Without imagination there is no hope, no chance to envision a better future, no place to go, no goal to reach.

Creativity is a life force. A level of inner security is necessary for it to happen. It is impossible to be creative in a hypervigilant survival state. A degree of threat might be a stimulus if it is within the context of an overarching sense of security. Like play, creativity brings the authentic real self alive. Creativity is a playful state, in which people learn, experiment, and grow. These life-affirming processes bring about commitment and interest in work that transcends 'employment'. There is a powerful sense of purpose. This is associated with achievement over time (Duckworth, 2016, Dweck, 2006). The process of creating a model also leads to a feeling of ownership – 'this is ours'. The commitment to the created model improves long-term sustainability. Sometimes people say, there is no need to re-invent the wheel. However, creativity is part of human nature and people do need to be inventive and to add something new. We are more likely to embrace something if we are part of creating it.



I have been involved, so far, in the co-creation of twelve therapeutic models, in England, Australia, Ireland, and Portugal. Several of the models are complete and implemented, and some are still in progress. An interesting recent model development project has been with *Lar de Nossa Senhora do Livramento*, a therapeutic residential service in Porto, Portugal. In this service, forty-five girls live in groups of up to nine in one large home. Each group has its own living space, so it is like a small home within the large home. Unlike some children's homes situated in relatively isolated locations, Livramento is close to the centre of Porto. It is well-integrated into the local community, with all the services and facilities that help give a sense of 'normality' (Anglin, 2002).

This model development project gained unprecedented funding from Europe Social Innovation 2020. The work is included in the first major publication on therapeutic residential care for children and young people in Portugal (Peixoto and Oliveira, 2021). I also contributed two chapters to this book, Transition Panning: Leaving a Residential Care Home, and Assessment of Needs (Tomlinson, 2021).

The creative process of adaptation leads to learning for all involved. Everyone who can be involved should be - leaders, managers, staff, service users and their families, and other stakeholders. Everyone has much to offer from their unique perspective. McMillan (2019, p.4) highlights the importance of involving service users and other stakeholders in the co-production and co-designing of services. This is a more advanced level of the design process than simply engaging, consulting, and informing, and significantly more so than just educating and coercing (Slay and Stephens, 2013).

As said, becoming a learning organization is central to establishing a culture that is always developing, adapting, and progressing. Understanding the importance of local culture is a key part of this. The organizations I have worked with cover a broad range of services – residential care, foster care, disability services, community services, family services, among others. To indicate the organizational differences I have worked with, the number of employees has ranged from 50 to 5,000. This means that the development work and processes must be tailored to each situation. Each has its complexities, strengths, and vulnerabilities. Another significant difference is each organization's stage of development. For example, creating a model with a new organization and a well-established one are quite different processes.

I have never been involved in the process of importing a licensed model. The one I have read the most on is the Sanctuary Model. Without a doubt the quality of thinking behind their work is excellent. So, it is not that I am critical of the model or any others (see MacDonald and Millen,

2012), just that my own experience and theoretical preference is to maximise the creative process and customization. However, in some circumstances, it may be helpful to access an existing model.

6

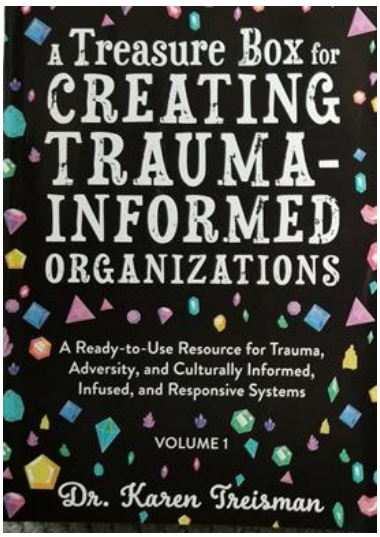
A PROCESS OF CHANGE AND MODEL FIDELITY

Therapeutic model development is a process of change, and this cannot be underestimated. The creativity and ownership involved are due to the engagement in a meaningful change process. This happens at the level of the individual and organization. Effective model development can never be a paper exercise. What matters is that the model on paper is reflected in its implementation. Not only must all aspects of the organization's work reflect the model, but positive outcomes must be achieved. As said, the fidelity of the model is crucial. Oranga Tamiriki (2020, p.12) explain what this means in therapeutic residential care (TRC),

> Treatment fidelity refers to the extent to which treatment and care is implemented as intended. This includes adherence to, and implementation of, the key aspects and components of treatment design, and the delivery of treatment through skilled and appropriately trained professionals. Previous research has found that treatment delivered within a TRC context is more effective, and client satisfaction higher, where there is high treatment fidelity (Duppong Hurley et al., 2017). Where treatment was delivered as intended, children and young people in TRC exhibited lower rates of internalising and externalising behaviours while in care.

Creating a model requires a process of review and reflection. It asks questions like,

- Why do we do things in the way we do?
- Might there be better ways?
- What is the evidence behind the way we do things?
- How strong, clear, and effective is our way of doing things?



These questions are examined purposefully on all aspects of the organization's work. Treisman (2021, Vol. 2, p.62) in her epic work on Trauma-Informed Organizations refers to this as 'modelling the model'. She emphasizes, that the senior leadership team, especially have the responsibility for 'setting the tone' and 'modelling the model'. It is here where the culture of the organization begins to evolve. The way a model is created must reflect its essence and core values.

The change process involves the entire organization system. Changes must be worked through and need time. There must be a balance between producing a model on paper and allowing the necessary time for the work to be processed by individuals and the whole organization. This leads to a

development in the maturity of the organization and the people within it. With this, alongside the model, there is a greater chance of long-term sustainability. Without it, the change is likely to be only a short-term manipulation. Miller and Rice (1967, p.269) stated,

> Long-term solutions to the problem of maintaining adaptiveness to change cannot … depend on manipulative techniques. On the contrary, they must depend on helping the individual to develop greater maturity in controlling the boundary between his own inner world and the realities of the external environment.

This might be considered as becoming more effective in managing oneself in relation to the work. To enable this kind of change to take place the work needs to progress at the right pace. This is influenced by,

- the resources available for the work,
- other significant changes and events that might be taking place
- the organization's history and present culture
- the capacity of the project leaders, etc.

At the end of the creation process, people must be able to identify with the model. Implementation will only work well if the model is internalized. During the implementation stage, there are three key areas of further development,

1. An in-house training programme based on the model.
2. The alignment of all the organization's policies and procedures with the model.
3. An assessment process, based on the needs and progress of young people, to implement individual therapeutic plans, and to measure outcomes.

After this, there must be ways of continuously evaluating the model and making adaptations. As said, the organization must establish a living, learning culture. I refer to the three stages of model development, **1.** Creation, **2.** Implementation, and **3.** Establishment. While circumstances and time are variable, stage one typically takes one year, stage two another year, and establishment in the third year though it is always ongoing.

7

THE EXTERNAL CO-CREATOR ROLE

One way of creating a model is through an internal project without an external person. This approach worked well at SACCS. However, it requires a big commitment of internal resources, strong leadership, and a high level of experience within the team.

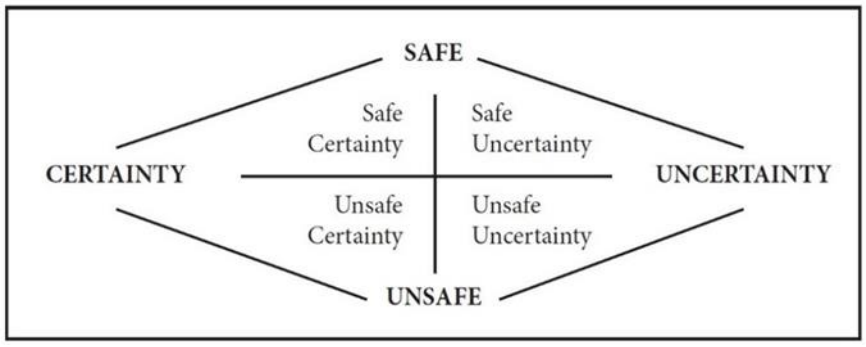
Collaborating with an external person can bring great benefits. A co-creator will need to be experienced in leadership, organizational culture, and therapeutic work. The external role can include consultation and mentorship. When all aspects of the organization's work are reviewed,

an external lens can help see the 'wood through the trees' (Whitwell, 1998a). Or as Miller (1993, p.xvii) states,

> And indeed a degree of detachment goes with the job. I have to stand back far enough to discover alternative ways of looking at a situation, ways that may be less accessible to those caught up in it.

While this exposure to an external view can be helpful it also produces change-related anxiety. Therefore, the effective work of the external role is important in helping to establish a safe and collaborative relationship. As Miller (p.xviii) says,

> Change, even when intellectually people see it as necessary and desirable, always arouses anxiety. It is part of my task as a consultant to contain some of that anxiety so that members of the client system are not crippled by it.



As I have already mentioned the importance of safety (security), it is helpful to expand upon this. I find this diagram and concept by Mason (1993, 2017) to be helpful. Creativity requires the capacity to embrace uncertainty. We do not know exactly what the result of our exploration and creative process will be. We must have an open mind. We need to be willing to give up old ideas and integrate new ones. This is the state of safe uncertainty. It is also an important part of any therapeutic work. Richard Rollinson (2003, p.218), who was Director of the Mulberry Bush Therapeutic School, which has now been running for over seventy years, captures this very well. Referring to a talk given by the founder Dockar-Drysdale, he says,

> She spoke to them about the dangers of becoming complacent or certain. She declared that the work must always proceed in a way that can tolerate doubt or not knowing. Only in this way can we hope to ensure that we are carrying on thinking. It is in absolutist or crisis cultures that there is no doubt; there is only absolute certainty. A culture with structures, boundaries and spaces will support thought. Thought will contain uncertainty and, thus, thoughtful responses can be made to the children, not only when adults are supporting healthy functioning but even when they are managing breakdown. The emotional 'mess' can be tolerated, and dealing with it can remain at the core of our work. It need not be driven out. Of course, the sufferings of uncertainty are real, but nothing like the eventual suffering born of absolute certainty.

An important function of the co-creator role is to help contain anxiety so that the organization and people involved can think more freely and effectively. Even when this goes well there will

also be difficulties in the process. The external role can help keep the work on track, allowing for adaptations, and containing the day-to-day work and its crises. The model work can also function as a container. Bringing people together on a model project can help strengthen relationships, teams, and organizational culture.

Research-Informed Base

One of the key principles found by international research on model development is the importance of having a research-informed base. This needs to draw from many theoretical disciplines, as Kezelman and Stavropoulos (2012, p.xxviii) stated,

> Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted. People can and do recover and their children can do well. For this to occur, mental health and human service delivery need to reflect the current research insights.

and (p.76)

> While effective treatment of complex trauma needs to address several key dimensions (i.e., irrespective of the particular approach used) the current literature also advises of the need for knowledge of more than one modality.

In large organizations, there may be a research and development type of department. In smaller organizations, this is not likely. So, the external co-creator can help provide an organization with material from research that helps underpin best practice. The knowledge from research can also challenge poor practice. Whitwell (1998a) has highlighted how residential care services,

> … are especially prone to redefining bad practice as good practice, hence many of the abuse scandals that have come to light in the last few years. Consultants can play an important part in helping to prevent this because they are less likely to get drawn into a collusive system.

As the change process is going to be significant it can be helpful for organizational leaders to have individual consultancy and mentoring. This space can help them work on their understanding and ideas about the model, and to process concerns and feelings related to change. By the time a model is created, each person involved will have been on their journey of development. This will have great benefits with the implementation phase. It is one of the exciting aspects of an engaging creative process that everyone learns and grows through it. James (2017, p.11) emphasizes the importance of this,

> Explicit inclusion of direct care staff in the training and implementation activities of a program model or specific evidence-based intervention is believed to enhance commitment and buy-in and positively affect retention. In the absence of a stable

> workforce, the implementation of evidence-based treatments is likely to be unsuccessful.

8

CULTURAL CONTEXT AND HOME-GROWN MODELS

Understanding the cultural context is vitally important. The way we create therapeutic environments must be culturally sensitive. Models must be grounded in cultural values, language, and belief systems. Therefore, it is most helpful that a model evolves from within the culture it sits in. As James (2017, p.7) explains,

> It is believed that instead (*of imported models*) agencies use "home-grown" milieu-based models, which have developed over time and thus have validity within the context of an agency's history and environmental context.

James (pp.7-8) refers to the work of Lee and McMillen (2017) in the Special Issue on residential care, in the Journal of Emotional and Behavioral Disorders, in which they,

> … recommended the development, specification and careful evaluation of "home-grown" programs as a viable alternative for residential care agencies that cannot or do not want to shift to one of the existing evidence-based program models but want to develop an overall evidence-based approach to their program.

James (p.9) argues that definite scientific conclusions on the effectiveness of imported evidence-based models cannot be drawn, and claims (p.12),

> Lee and McMillen's recent article opened the possibility of different avenues toward evidence-based practice that may be more fitting for the residential care context than the transportation of 'packaged models' into agencies. These avenues should be explored.

9

OWNERSHIP AND AUTHORITY

This is a key outcome of creating a home-grown model. The model created by the organization is owned by it. The ownership is literal and metaphorical. The intellectual property of the model is owned as an asset. There are no ongoing licensing fees to pay. However, ownership is a much broader concept. The work involved in the creative process results in a deep sense of, 'this is ours we made this'. This sense of ownership is also central to the therapeutic task. People feel connected and take ownership of their work. It contributes to a culture where ownership and responsibility are in the centre. This is also vital for the development of children and young people.

Having ownership has great benefits. It helps improve a sense of security which is especially important in a field of work, which has so much uncertainty and vulnerability. Ownership is so important that one organization I worked with made it one of its core values. Creating a model and owning it will have an impact on authority. The organization is more likely to have belief and confidence in what it does. The learning in developing the model contributes to this. The organizations that I have referred to such as Cotswold Community, SACCS, and Lighthouse became authorities in their field. It has an enormous impact on the culture when an organization becomes known for its good practice, its work is published, and it becomes considered a centre of excellence.

Experiencing appropriate authority is a central need for children who are taken into care. They have usually suffered because of primary carers being unable to use authority healthily. The children may associate authority with abuse or neglect, or both. However, as we know, managing authority in such complex services is always a challenge. Authority can become controlling and coercive, even abusive, and at the other end, too permissive and unsafe. Therefore, an appropriate authoritative culture is essential to the primary task. The co-creator keeping an observant eye on what is going on internally can help to continuously examine the nature of authority.

10

A BRIEF SUMMARY OF KEY FINDINGS FROM INTERNATIONAL RESEARCH

Decades of research have culminated more recently in meta-studies of the research. There has been a convergence and collaboration between experts in many countries. For example, Whittaker et al. (2016) published a consensus statement from thirty-two academics from twelve different nations. The research supports the concepts and ways of working described in this article. Oranga Tamiriki who also conducted a meta-study argue (2020, p.4),

> Therapeutic residential care should be tailored to the communities and cultures of the children they serve and allow meaningful connections with families. There are many models of care that fall under TRC with varying degrees of evidence base. However, the emerging consensus is that TRC should be tailored to the communities, cultures and social relationships of the children and families that they serve.

Having a Model is Vitally Important

Residential Care is an important part of the care continuum. Family involvement is vital as is cultural sensitivity. James (2017, p.10) claims,

> A sound program model is the necessary foundation or umbrella for effective residential care practice, and without it nothing else will likely matter.

Home-Grown Models

Developing home-grown models emerges favourably from the research. Benefits of Developing

your Model include creativity, ownership, integration, learning from experience, and cultural sensitivity.

An Overarching Framework

The research finds that an overarching framework based upon universal principles is most likely to be effective. Whittaker et al. (2016) identified **5 Key Principles,**

1. Do no harm – Safety First

"We are acutely mindful that the first principle undergirding therapeutic residential care must be primum non nocere'': to first, do no harm. Thus, our strong consensus is that "Safety First'' be the guiding principle in the design and implementation of all TRC programs." (p.96)

2. Partnership with families

"Our vision of therapeutic residential care is integrally linked with the spirit of partnership between the families we seek to serve and our total staff complement—whether as social pedagogues, child or youth care workers, family teachers, or mental health professionals. Thus, a hallmark of TRC programs—in whatever particular cultural expression they assume—is to strive constantly to forge and maintain strong and vital family linkages." (p.96)

3. Anchored in communities, culture, and web of social relationships

"Our view of therapeutic residential care is one in which services are fully anchored in the communities, cultures, and web of social relationships that define and inform the children and families we serve. We view TRC programs not as isolated and self-contained islands, but in every sense as contextually grounded." (p.97)

4. Learning through living in the context of deeply personal, human relationships

"We view therapeutic residential care as something more than simply a platform for collecting evidence-based interventions or promising techniques or strategies. TRC is at its core informed by a culture that stresses learning through living and where the heart of teaching occurs in a series of deeply personal, human relationships." (p.97)

5. Use evidence-based models with effective strategies for practice. Clear in procedures, structures, and protocols.

"We view an ultimate epistemological goal for therapeutic residential care as the identification of a group of evidence-based models or strategies for practice that are effective in achieving desired outcomes for youth and families, replicable from one site to another, and scalable, i.e., sufficiently clear in procedures, structures, and protocols to provide for full access to service in a given locality, region, or jurisdiction." (p.98)

Similarly, Oranga Tamiriki (2020, p.35) states,

"In their recent review, Bath and Smith (2015) identified core therapeutic imperatives for working with traumatised children in therapeutic residential care services and implications for practice:

- Safety
- Healthy connections

- Adaptive coping”

Oranga Tamiriki (p.14) also highlight that the living environment is a vital component of effective and safe TRC,

> The environment in which children and young people in TRC live and spend most of their time is a key contributor to the effectiveness and outcomes of care. To maximise gains from direct individual or group therapy, the living environment outside of these sessions should be warm, nurturing, and provide opportunities for social learning and modelling.

11

OTHER IMPORTANT ELEMENTS FROM RESEARCH

Tailored to Children’s Needs; Positive peer culture; The importance of training.
Lawlor (2008, p.38) outlines what is meant by child-centred care and includes, participation, belonging, stability, enjoying and achieving, safety, and communication (see Appendix 4).

Working with Theories of Change Rather than a Particular Model
Referring to the Aspen Institute, Lawlor (2008, p.7) says that a theory of change,

> Defines all building blocks required to bring about a given long-term goal. This set of connected building blocks – interchangeably referred to as outcomes, results, accomplishments, or preconditions – is depicted on a map known as a pathway of change/change framework, which is a graphic representation of the change process.

A therapeutic model is a theory of change and creating a model is a change process. Therefore, as well as the writing of the model, attention must be paid to the change process, for the whole organization and the key project leaders. Strong leadership is essential. The organization, teams, and individuals must develop and evolve as part of the process. Oranga Tamiriki (p.33) state,

> What is said to underlie models or programmes of TRC, what makes them therapeutic, is the willingness to work purposefully and strategically with “theories of change” for the positive development of children in care who have significant difficulties (Jakobsen, 2014).
>
> Building in this principle of working with theories of change, as opposed to a particular model, will allow for greater flexibility in the delivery of TRC, and greater capacity to cater for the uniqueness of each child for whom TRC is intended.

Treatment Fidelity
The effective implementation of a model is critical to its success. An excellent model on paper

but not implemented well, will not achieve positive outcomes. Implementation is stage 2 of the model process – 1. Creation 2. Implementation 3. Establishment.

Manualization Benefits

The concept of a manual can be unhelpful if it leads to a prescriptive, non-thinking approach. But it is necessary to clarify the details of the model, the underlying ethos, and how various tasks are carried out. A manual is also important for the dissemination of the model, training, and evaluation. James (2017, p.10) explains why manualization is important,

> An important next step should be the manualization of your model. Many agencies already use manuals to guide part of their practice, but manualization is often resisted by the practice community for fear that it will undermine client-centered care and that it would stifle the 'creative' part of relational work with clients. Some have critically described it as a 'paint by numbers' approach (e.g., Silverman, 1996). Yet the process of actually manualizing a program model can lead to greater clarity about the flow and the elements of an already implicit program model and can point to important conceptual gaps. Developing a manual is important in the dissemination of the model, i.e., the training of staff, and it is a necessary step for evaluative work (e.g., Addis and Cardemil, 2005).

Outcomes and Evaluation

Outcomes for children and young people must be regularly assessed and reviewed. The model should be continuously evaluated with new research and evidence considered. Without evaluation, there is no evidence-based practice. James (2017, p.12) highlights the crucial links between evaluation, evidence-based practice, and building an evaluation and research infrastructure,

> Evidence-based practice inherently involves systematic evaluation throughout the practice process. It is the final step in the evidence-based practice process (Thyer, 2004) and is supposed to lead to refinement in practice with the goal of improving outcomes over time. One could argue that without evaluation there is no evidence-based practice. Some agencies may have sufficient resources to build their own research and evaluation unit; others may have to partner with local universities or external evaluation/research teams (also see Thompson et al., 2017). Such partnerships can be highly fruitful and are an explicit way of closing the research to practice gap.

Readiness for Model Development

As I have discussed model development is a significant process of change that requires a long-term commitment of resources. Therefore, before beginning such a project, it is important to evaluate the organization's level of readiness - to identify strengths as well as potential challenges and obstacles (see Appendix 3). James (p.12) concludes,

> If an agency does not meet criteria for readiness, it might be better to delay implementation efforts.

CONCLUSION

Therapeutic models for children and young people who have suffered childhood adversities and who have been taken into care have existed for a century or more. The way of referring to them has changed over the years. The term model has been used for fifty years or so. Certain theories, such as attachment, psychodynamic, systems, neuroscience, and trauma, among others have been influential. My first experience of a therapeutic model was in 1985 at the Cotswold Community. That model was one of the first that fully recognized the importance of what is now called a whole-system model - the integration of leadership, culture, and therapeutic practice with children and young people.

My experience has always been in creating models, with organizations in various parts of the world. I have read about models that are imported and licensed, such as the Sanctuary model. What I have read about Sanctuary, as an example, makes sense to me. As I am not experienced in importing models, it would be unfair to be critical of the process. It is more that I am in favour of the creation process for the reasons I have described.

There has been vast research on what works in residential care in the last twenty years. In recent years, there has been a move towards an international consensus among experts in the field. The messages from the research are strong and I have attempted to summarize them. An organization that provides residential care to children and young people must have a clearly articulated model that is embedded in all aspects of its work. The benefits are supported by research on the long-term individual, societal, and economic consequences. The benefits can go on for generations, as can the costs if the children do not receive the services they need.

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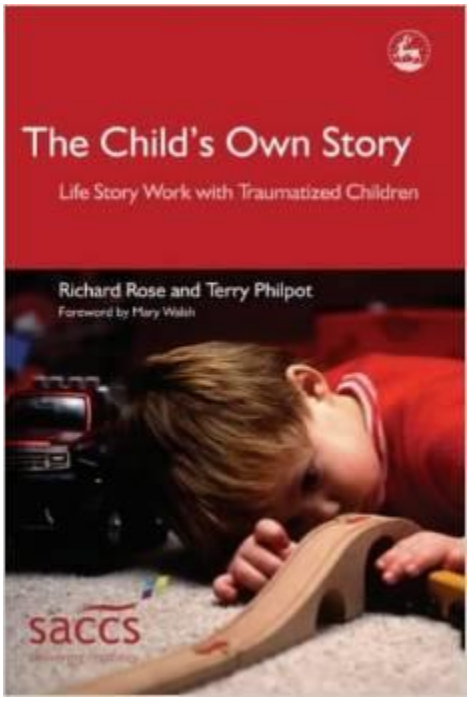

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APPENDIX 1 – 24 OUTCOMES FOR RECOVERY

In 2002, SACCS began to define outcomes in work with traumatized children. We began by asking, how would we know if a child's treatment had been successful, what would a 'recovered Jack' look like? — 'recovery for the children at SACCS is summarised by the child having internalised their attachments and consolidated their emotional development to a point where these can be successfully transferred to other environments and relationships and that they have the potential to achieve to full ability in all aspects of their life' (Pughe & Philpot, 2006). The focus of work is on enabling children to achieve positive outcomes.
We arrived at 24 Outcomes for recovery (Walsh, 2002): When the child:

- has a sense of self — who they are and where they've been.
- has an understanding of their past history and experiences.
- is able to show appropriate reactions.
- has developed internal controls.
- is able to make use of opportunities.
- is able to make appropriate choices.
- is able to make appropriate adult and peer relationships.
- is able to make academic progress.
- is able to take responsibility.
- has developed conscience.
- is no longer hurting themselves or others.
- is developing insights.
- has completed important developmental tasks.
- has developed cause and effect thinking.
- understands sequences.
- has developed motor skills.
- has developed abstract thinking.
- has improved physical health.
- has normal sleeping habits.
- has normal personal hygiene.
- has normal eating behaviours.
- has normal body language.
- has normal self-image.
- is able to make positive contributions.

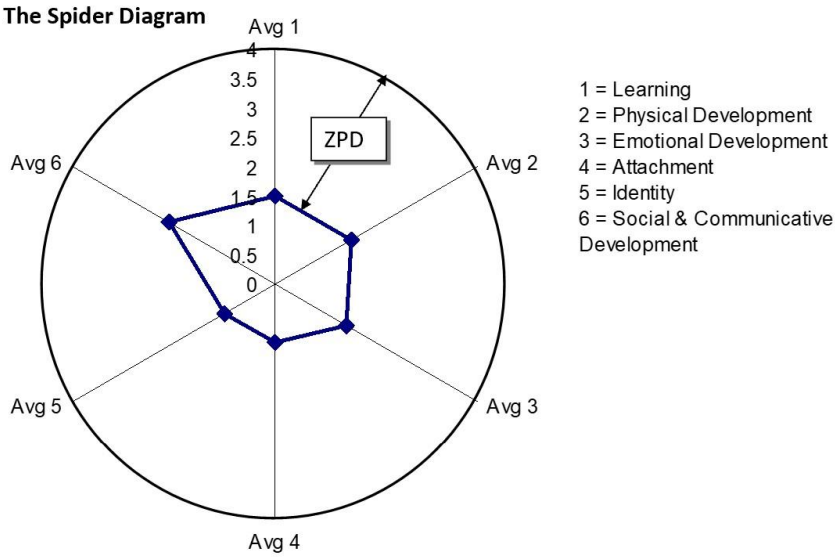
Where we use the word normal, we do not mean an overly prescriptive view. We mean that the child is broadly able to function in a manner that is not detrimental to their overall well-being. We defined the meaning of each outcome (Walsh & Tomlinson, 2006) in, for instance, the following.

When the child has a sense of self - i.e., who they are and where they have been: this means that the child has a sense of their own identity, and culture regardless of creed, race, nationality, or religion, especially if there are also issues of disability and/or gender. They

understand about their family of origin, have worked through what they love, hate, are angry about, are frightened of and are not in denial. They know who they are in relationship to important people in their past and significant people in their present. They have integrated their past experiences into their present reality. Their personality is clear and intact. The child is living mostly in the present. Their past is no longer controlling their lives.

When the child is able to make positive contributions: this means that the child is able to respect themselves and their opinions as a creative force. They are able to ask for what they want and intervene appropriately in a positive way in other interactions. They are able to view the world as a healthy, safe, and exciting place that they have a part in creating and influencing.

APPENDIX 2 - THE SPIDER DIAGRAM

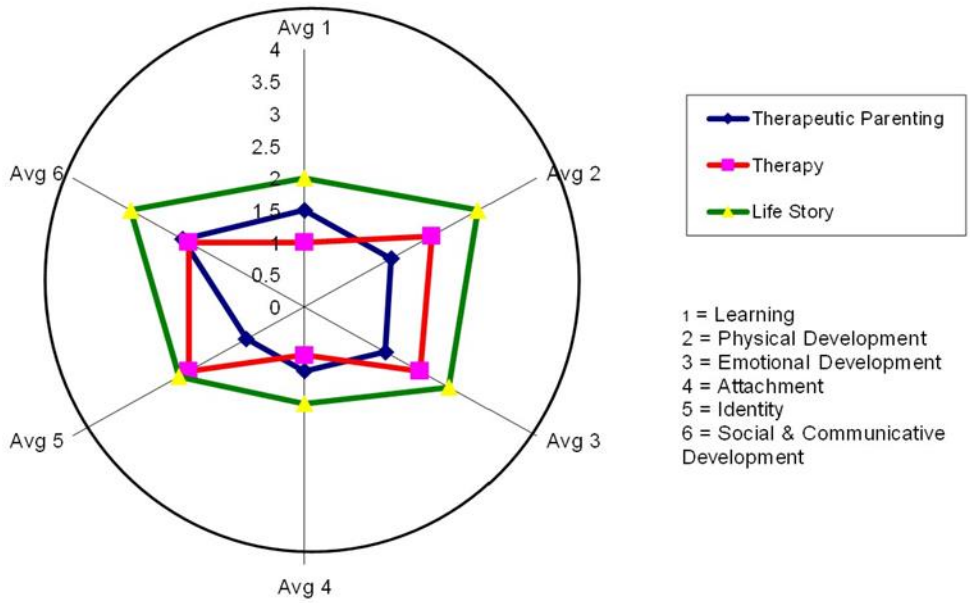


ZPD - The greater the gap between the circumference and the inner shape the greater the therapeutic support the child will need. Vygotsky (1978) - 'Zone of Proximal Development'. 'Scaffolding' is the support required to improve the child's functioning.

"To help get a picture snapshot of the child and her development we use a spider diagram (see below), sometimes also called a radar diagram. The six developmental outcome areas are represented by the six axes. The child's score is plotted along each axis and the points are joined together to create a shape within the circle. This is done by taking the average score (between 1 and 4) from the series of questions under each area. For example, the average score of the four questions under learning might be 1.5 and this will be plotted on axis 1. The points on the six axes are joined together, creating a shape representing the child's current stage of development. When we were developing our model and looked at different ways of visually representing the child's progress, the spider diagram was by far the most popular. I think this is partly because it symbolically captures the sense of the healthy child and the small or damaged child within. This could be seen as the small 'ego-core' of the child as it grows over time, towards a 'well-rounded child'. The outer circumference represents where a child with 'normal' or healthy development could be. The shape of the assessed child shows where the gaps are and how far there is to go. The greater the gap between the circumference and the inner shape, the greater the therapeutic support the child will need. This gap is similar to Vygotsky's (1978) concept of the 'Zone of Proximal Development', or how the child is able to function on her own compared to how she could function with the input of others (Mooney, 2000). The support necessary to enable the child to move from where she is now to where she could be, Vygotsky termed 'scaffolding'. In our context, this is where the therapeutic work takes place. The time we need to help a child reach her potential with us is normally 3.5 years or more. The scores from the three parts of the recovery team are plotted on the same diagram, and this creates an instant and striking view of how the child is perceived and functions in the three different areas."

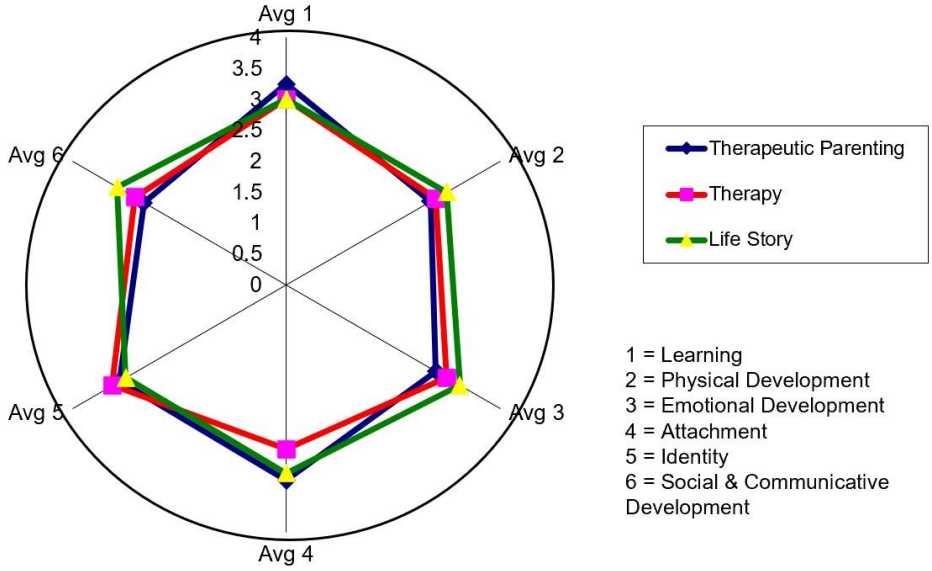
"Vygotsky's (1978) concept of the 'zone of proximal development', where children are encouraged to undertake tasks, which they might not be able to achieve on their own but can achieve with the assistance of another. This enables children to improve their developmental competencies, including the social and relational (Macdonald and Millen, 2012)."

1st Assessment - the child is assessed independently by 3 different professionals who work with the child



As we can see, everyone sees a child who is extremely set-back in his development and who has huge needs. However, there are differences in the 3 pictures. We often see this with such a child – a child that Winnicott (1962) may have called 'Unintegrated', or Solomon and George (1999), a child with 'Disorganized Attachment'. He will be different things to different people at different times, compliant one minute and chaotic the next.

5th Assessment after 2 ½ years



This data suggests that the child is making good progress. The zone of proximal development is smaller; he needs less input to function to his true potential. However, recovery is not a cure but a lifelong journey. As Dockar-Drysdale (1969, p.50) has said, "I really want to jettison the concept of 'cure' at once and replace this by 'evolvement'."

APPENDIX 3 - READINESS FOR MODEL DEVELOPMENT: GUIDING QUESTIONS

James (2017, pp.10-11) suggests these guiding questions,

- "When did your program model develop?
- What are the theories that are guiding your agency's approach?
- What is your theory of change?
- What implications does your overall model have for staff, for children and their families?
- How explicit is your program model in the day-to-day work of your agency?
- Do all staff (residential care staff included) understand the model?
- Who is responsible for the integrity of the model?
- How does the model change between the levels of care?
- Has the model changed over time?
- Are you satisfied with the elements and the outcomes of your program model?

There are also readiness scales, created to help agencies in the initial decision-making and planning phase. Questions to be addressed during this phase include: "Questions to be addressed during this phase include:

- What is the primary reason your agency wants to adopt a specific evidence-based model/treatment?
- What are your agency's short- and long-term goals? Who is your client population?
- Which evidence-based model/treatment is being considered and how does it fit you're your agency's client population and its stated goals?
- How stable is your agency? Where is your agency developmentally (e.g., Is it a new or established agency? Has it recently gone through significant changes or even turmoil?
- Who is the initiator of this effort? Is there leadership support and buy-in? Is there buy-in from all/most staff?
- How would you describe your agency's working climate?
- How committed is the agency to implementing the EBP?
- Does your agency have the resources (personnel, contextual, financial) to implement the EBP?"

APPENDIX 4 – WHAT DO WE MEAN BY 'CHILD-CENTRED' CARE* (Lawlor, 2008, p.38)

Participation
• Children are involved in all aspects of their own lives.
• They are consulted and included in care plans and reviews.
• They share the tasks of everyday living.
• They take responsibility for decisions about their lives.
• There is collective involvement in running services.

Belonging
• Attachments are developed.
• Children experience real caring and trusting relationships.
• They also achieve emotional and personal growth.

Stability
• There is long-term commitment to the child or young person.
• There is continuity and stability in placements, education, and relationships.

Enjoy and achieve
• Children are encouraged and supported to achieve at their own pace.
• They have an environment that fosters learning, development, and creativity.
• They can access 'a comprehensive range of services that meet their health, education, social, psychological, and emotional needs.
• They feel cared for and valued.
• Personal achievements are recognised.

Safety
• Children can learn to take risks in a safe way.
• Risk assessment is balanced with other aspects of the child's or young person's well-being.

Communication
• There is an open environment for exchange of ideas.
• The voice of the young person is listened to and valued.
• Children are engaged in way that is stimulating and fun.

**This summary is based on Voice's Blueprint Project (2004), the work of the Alliance for Child-Centred Care and discussions with stakeholders as part of this research. P.38*

APPENDIX 5 – SOCIAL RETURN ON INVESTMENT (Lawlor, 2008, p.3)

"Our economic analysis has found:
• For every additional pound invested in higher-quality residential care, between £4 and £6 worth of additional social value is generated.
• In one of the case studies we were able to aggregate this across the population of young people in residential care, which suggested that the total value of these services is equivalent to almost £700 million over 20 years. Put another way, what is saved on other social costs by investment in this kind of residential care would be enough to pay for the country's entire annual care bill for children in care.
• Although a small-scale study, this approach highlights the false economy inherent in bargaining down unit costs, at the expense of quality. We found that providers could almost double what they were charging each week and it would still represent a positive return. By this we mean that when the benefits are aggregated across all government spending and into the future, the knock-on social and economic savings are greater than the cost.

The cost-cutting environment in which these projects operate is taking its toll, however. One of the providers that we examined, Shaftesbury Young People, has itself recently lost out on contracts to larger providers because it could not compete on price. Policy has recently acknowledged the importance of promoting children's well-being, and child-centred approaches are being promoted as a way to maximise this. It is these very methods, however, that are being sacrificed in the competitive tendering process. Providers are being forced to view essential psychotherapeutic and advocacy services as 'nice to have', and staff are being pressurised to slim down their offering to compete on price."

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Patrick Tomlinson Brief Bio

The primary goal of Patrick's work is the development of people and organizations. Throughout his career, he has identified development to be the driving force related to positive outcomes - for everyone, service users, professionals, and organizations.

His experience spans from 1985 in the field of trauma and attachment informed services. He began as a residential care worker and has since been a team leader, senior manager, Director, CEO, consultant, and mentor. He is the author/co-author/editor of numerous papers and books. He is a qualified clinician, strategic leader, and manager.

Working in many countries, he has helped develop therapeutic models that have gained national and international recognition. In 2008 he created Patrick Tomlinson Associates to provide services focused on development for people and organizations. The following services are provided,

- Therapeutic Model Development
- Developmental Mentoring, Consultancy, & Clinical Supervision
- Character Assessment & Selection Tool (CAST): for Personal & Professional Development, & Staff Selection

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PATRICK TOMLINSON ASSOCIATES (PTA)
THERAPEUTIC MODEL DEVELOPMENT INFORMATION

PTA Model Development Website: https://www.patricktomlinson.com/therapeutic-model-development/

PTA 22 Steps Model Development Process- A Framework (Curriculum) For the Development of a Therapeutic Model: A Research-Informed & Evidence-Based Model
This is for organizations who wish to create their model with the assistance of Patrick Tomlinson. It is a process of co-creation, consultancy, and mentoring. The document describes exactly what is involved and the structure of the work. (Please contact for more info: ptomassociates@gmail.com)

Create your Organization's Unique Therapeutic Model for Traumatized Children & Young People: An Online Training & Consultancy Framework with Patrick Tomlinson
This is for organizations who wish to learn about key principles in model development but wish to do the work themselves. It is not a model creation project though much will be learnt that may support an organization's model development process.
https://www.patricktomlinson.com/pdf/pta-therapeutic-model-development-training-and-consultancy-framework.pdf

Patrick Tomlinson Developmental Mentoring
For professionals who are interested in working on their development and may also be interested in learning about therapeutic model development.
https://www.patricktomlinson.com/mentoring-consultancy-and-clinical-supervision/

Patrick Tomlinson Additional Articles on Model Development
What a Therapeutic Model is and Why it is Important to Have One (2019)
https://www.patricktomlinson.com/what-a-therapeutic-model-is-and-why-it-is-important-to-have-one-patrick-tomlinson-2019/17

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