Nottinghamshire County Council Fostering Futures Therapeutic Parenting Scheme

I am a Social Work Practice Consultant, an accredited DDP Practitioner and Intermediate Theraplay Practitioner. My work has been increasingly informed by neurodevelopmental psychology and the understanding of therapeutic interventions around complex trauma in childhood. I feel extremely lucky to have entered my career at a time when knowledge about attachment theory, traumatic stress in childhood is ever expanding and when opportunities for study, co-working, training and intervention are continuously unfolding.

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August 2017

"I can't do this anymore…it's too hard, I feel overwhelmed, I think we will have to let him go"

Our service hears this more often than one would like, as I'm sure do other fostering agencies. Every Social Worker's nightmare! What are we going to do now?

The cry is usually followed by a series of discussions between foster carers, supervising social workers and children's social workers and can quickly escalate into involving team managers and the search for an alternative placement.

Underneath the dialogue, the feelings are often: a sense of failure, disappointment, anxiety, anger, dread, fear, shame and frustration. These can be experienced by any person during the crisis. The foster carer may find the shame intolerable and be desperate for the source of the shame (the child) to be removed. The child's social worker may feel panic and anxiety and then put pressure on anyone who will listen to 'fix' the child so they do not have to move. The supervising social worker may feel angry with the child's social worker for placing such a challenging child with these foster carers (and why didn't someone say this behaviour might happen?).

These feelings can reflect the parallel dramas of everyday life in the foster home. Someone in the drama needs to press “pause” and stand back for an objective perspective on what is happening.

In Fostering Futures, that role often falls to the therapeutic worker and supervising social worker who will work alongside the foster carer to try and find a way through.

Like many fostering teams, we place some of the most damaged children in the country with therapeutic/reparative foster parents. However, we believe our way of working with foster carers and viewing them as co-therapists has so much to offer children that it should be more widely used.

What makes for a therapeutic foster placement and what is different about Fostering Futures?

We strive to **empower** carers to be at the core of the child's healing.

The vast majority of our **interventions** take place in the foster home and sessions, wherever possible, are filmed. Prior to any direct work involving the child and carer, time is spent with the foster carer/s exploring what is happening and how this impacts on relationships within the family.

At this stage, the foster carer may be exhausted and depleted of empathy.

This is a common situation for those carers looking after children who have been traumatised by their early experiences of neglect and/or abuse. Trying to care for a child who has no expectation that he/she will be cared for safely and therefore resists close, intimate relationships can result in the carer feeling deskilled. Over time it can be hard to persist with safe parenting when a child is constantly rejecting that care. Baylin and Hughes refer to this type of situation as Blocked Care. When this happens the drive to fix the child becomes almost desperate and is reinforced by other professionals wanting to find a quick solution. The momentum can take on a life of its own and can culminate in unwise decision-making. In effect, such decisions fail to address the problems which are then taken by the child into the next placement.

Our work focuses on the **relationship** between child and foster carer as it unfolds and evolves, co-creating new meanings for the child and carer. A light

is shone on how past complex traumas are being played out in the relationships within the foster home. Dan Hughes' **PACE (Playfulness, Acceptance, Curiosity, Empathy)** model of attachment-building is fundamental to the interpretation of the dynamics. This model enables the carer to develop their "toolkit" at managing challenging situations.

For example, washing a child's hair, when done with sensitivity takes into account the temperature of the water, the pressure of how the scalp is manipulated, taking care not to get shampoo in the child's eyes. All this is done with an element of playfulness which works towards facilitating healthy attachments, to build a child's strong sense of self, positive self-esteem and the capacity to form ongoing relationships. Often when children have suffered significant abuse the hair washing experience is an altogether different matter. How can the child trust /believe the carer won't hurt her? How can the child trust anyone but themselves? Trauma triggers of abusive experiences which may have occurred in the bathroom could be being re-lived. The child's behaviour suddenly seems irrational and contrary to the carer's intention to provide a loving intimate experience for the child. The "there and then" has become the "here and now".

Fear and anxiety is what seems to drive the child's behaviour and sometimes it is hard for carers to find a way through. We believe breakthroughs can happen most effectively when the foster carers are using themselves as the main resource in the healing process. What this demands of **therapeutic workers** is to provide for foster carers a "secure base" in which they can say "he's horrible, I cannot do this anymore" We will not make instant judgements but will explore deeper meanings as to how the carers are key players in the child's daily dramas. This is no easy task given that we are intruding on their emotional privacy as well as the exposure most foster carers feel being a "public parent" for all to see.

Our work may progress to **direct intervention** with the child and foster carer. The Social Work Team members are therapeutically trained to work alongside foster carers. The aim is for all therapeutic workers to have undergone at least level one training in Dyadic Developmental Psychotherapy, **Theraplay, Life Story work and the importance of psycho-educational tools/strategies,**

sensory integration awareness and an understanding of how this relates to trauma.

The communication between carer and therapeutic worker is key in the development of trust and honesty. It enables foster carers to express their own vulnerabilities, their own attachment issues and to use their self-awareness in order to effectively support the child. For example, Carer Mandy was able to say how hearing put down (*derogatory/offensive?)*comments about women from her eleven year old foster son triggered her into distressing feelings about her own abusive background. The therapeutic worker facilitated this exploration, which led to the carer separating out her own experiences from those of the child, becoming more self-aware and more confident. Using her 'toolkit' then became much more effective. This is the concept of **Mindsight** as coined and described by Daniel Siegel. In other words this exploration enabled Mandy to understand the internal world of her foster son better and through support find a way of responding that was free from her own agenda.

As carer Julie states;

"Developing my skills using this style of parenting has given me a new-found confidence in working with children who have been so affected by their life experiences. It's a bit like having a toolkit of responses to choose from when a child is feeling distressed. One has to adapt, be mindful of trying to "repair" any breaks in the attachment you are trying to facilitate."

Therapeutic Parenting in action

Carer Julie says….

"Last Friday Billy announced that he had something to tell me from when he lived at Main St. with his mum. This puts him at no older than 5 or 6.

He said he'd been walking around the Town all day with mum and hadn't eaten. They called in at various pubs. Later that afternoon he recalls mum going into the bakery to buy a hot sausage roll which is one of Billy's favourite food. His mum ate the sausage roll while Billy watched. He said he didn't say anything as he thought it was 'another of mum's tricks'. Afterwards he asked if

she would buy him one as he was hungry. He said mum laughed and walked off ahead of him.

Billy asked me how it made me feel listening as my face didn't look as if I thought it was funny. I told him this was because I didn't think it was funny. I found it quite cruel and I felt sad and angry hearing this. He happily accepted a cuddle from me and said he knew 'that wouldn't happen in this family ever'.

The next morning I made Billy some different pancakes for breakfast. I don't usually like them but these smelt lovely. I commented on this to him and asked if perhaps I could have a little taste. I've never before asked him anything like this. He completely 'shut down' which he hasn't for a long time. He gave no eye contact, expression or made a sound for about 20mins. During that time I did lots of waiting and 'wondering' talking out loud to myself about what on earth had suddenly changed. Billy eventually said he 'thought the memory he'd shared had come flooding back into [his] meerkat brain and [he] thought I might eat all the pancakes'. He cried a few tears and was happy for me to cuddle him. He also added that his 'elephant brain had calmed the meerkats in the end'. I thanked him and said how much it helps me to take care of him when he explains things to me that make him feel “wobbly” inside.

After he'd eaten and got dressed we went out in the car. Billy was more than happy and didn't ask where we were going. I drove until I found a bakery, went in and came out with 3 large warm sausage rolls and gave them to Billy.

I told him these were for him to eat to himself. I said they smelt wonderful and felt sure they would taste good but they were only for him. I told him I felt very sorry that he should have to have such a sad memory that he had shared with me but he'd worked it out brilliantly and had managed himself and his feelings by using his knowledge of how his brain works. I said I hoped this new memory would be firmly placed in his elephant brain. I told him he could eat the sausage rolls as and when he liked but he ate all 3 slowly and steadily and saved none to 'hoard' which is unusual. He seems very happy and didn't question anything.”

The Team

Fostering futures in Nottinghamshire began in 2000, with the intention of placing 'hard to place' children with foster carers who had professional experience and training in working with children. The model for the Service was termed 'Professional Fostering' as carers were self-employed and received a fee. Carers were required to be at home, available to the children and were not permitted to have other employment.

At that time, there were ten approved carers, managed by a Team Manager.

Over the last decade, the rationale for the scheme has changed. With the reduction in residential homes, the drive to return young people to foster care remains one of providing families for children with complex needs.

Our approved carers are still self –employed and receive a fee based on this being their sole employment. There is an expectation they attend on-going training provided by the Social Work team.

We now have 50 foster homes, caring for 90 children.

Our team has increased since 2008 and our therapeutic model has developed as the team has benefited from the growing expertise and practice knowledge of its members. We now have 10 team members, three of whom work therapeutically with carers and children. Training includes: DDP accreditation, Theraplay levels 1 and 2, Life Story Work and developing new meanings through narrative formation. An understanding of Sensory Integration techniques is an area of training as a Team we would like to develop further expertise.

Working alongside carers as 'co-therapists' has to a large extent been validated over the years. There have been fewer disruptions of children having to move placement and an excellent retention rate of foster carers.

We have been influenced by the work of Dan Hughes and trauma-related family interventions. His style of parenting with PACE provides carers with a framework in which to parent the dysregulated child, as does Blaustein and Kinniburgh's ARC model (Affect, Regulation and Competency**).**

As our knowledge of therapeutic parenting has increased, training carers has developed over the years to reflect this. Therapeutic support to carers is considered key in the importance of the child's healing.

Carers are expected to attend six-weekly Team Development meetings with staff to build a cohesive theory-based model in which carers can enhance their therapeutic responses to some of the challenges they face.

Smaller topic-based workshops are also available to carers for their on-going development. For example, the Secure Base model of parenting, Building Resilience in Children, Adult Attachment and the impact this has on the carer when helping the traumatised child. Using the PACE model of parenting, Neurobiological insights into Brain –Based Parenting to mention just a few.

More recently, we have begun to provide one-off consultations twice a month, responding as and when carers need additional support which seems to be accessed by carers who at times just need more direction and someone to listen to them.

Summary

Working with families using this model has reinforced our belief that carers are at the heart of healing for the children. For this to be really successful, all the professionals around the child need to place value on the status of carers. Whilst acknowledging the power differentials and the importance of safeguarding, workers need to treat carers as equal partners in creating the therapeutic experience.

The obstacles to this include: expectations that children can heal quickly from past traumas, a blame culture when matters become too challenging, a lack of trust in the process and the potential for knee-jerk reactions.

For this work to happen safely, the carer and the child need to be well supported. Foster carers need specialist initial and on-going training and support to address their own needs and those of the children.

Social Workers need specialist knowledge and training to understand the implications of placing children with complex needs in families. Even with so much understanding available, the placing and matching of children with

carers can often be something of a lottery. Scarce resources can lead to pragmatic decisions rather than those in the interests of the children.

Research tells us that child mental health difficulties are rapidly on the increase. Those early years when the architecture of the brain is at its most critical in terms of healthy growth and development and heavily reliant on the security of “safe” primary carers. Those early broken attachments and abusive handling can greatly impact on the child.

Given the complexity of this subject matter it is not surprising that there are many views/treatments methods for traumatic stress in childhood. Those children who enter the care system will have their own experience that is unique to them, the context, culture and community within which each has lived. It is important to consider the damage already experienced by the child is not further compounded by decision-making that at times can be done in haste, not thought through and without full knowledge of what the child needs. We should aim to offer the child a truly healing experience. I believe our therapeutic model offers hope to those children who have lost so much already.

Betty O’Sullivan

References

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