This document is updated for each review and report. It is sent to them at the start of their work, or following publication where significant aspects have been misconstrued, misunderstood, misinterpreted about Residential Child Care

This version is a response to the Children's Commissioner publication 'Family and its protective effect. Part One of the Independent Family Review.

It is thought necessary as the publication considers residential child care options as 'institutional'. Page 42 – 43 'A significant minority of children live in institutions…'

Is family based care better than Residential Child Care?

Re:thinking Residential Child Care

Reconsidering family and group care

A train journey sitting opposite 4 unknown teenagers encouraged me to follow a thought I'd had for along while. This is what they said

I've got a sister, two step-sisters and a half brother

I've got a brother, and two step-sisters

This got me thinking about varieties of families. There are birth, created and constructed families. These are all present in the everyday. They are not unusual. What makes any of the varieties become unusual is when they are omitted from thinking, or given a special status, or where one form is given greater validity than the others.

What makes a family? It is what happens in the everyday. Clearly from the above, or from the ties that unbind in separation, it is not blood. The ties that bind, that make a family, is the experience of parenting and being parented, the experience of living together as a group. This group might be as small as two, but often with extended others, supporters, relations, that we might take as an extended family. When we start to look for what is common and we make for a wider and deeper definition of 'family' than the shorthand for which it is used.

The use of the term 'family' is often used to distinguish the socio-political perspective of the speaker e.g. the party of the family. It is applied to reduce the focus, to highlight and

enhance some ‘families’ over others, that what happens in one sort of ‘family’ is better than, or outperforms, others. It is not inclusive statement, but exclusive. A statement of values, but clearly not necessarily of fact, or reality.

Since the start of the use of standards in the public care of children residential child care has consistently had the outcomes similar to the following: 16% Outstanding, 64% Good (80% Good or Outstanding), 18% Requiring Improvement to be Good (98% meeting standards) 2% Inadequate.

These figures show a sector demonstrating its ability to respond and sustain the identified quality of care. The Quality Standards for children’s homes were written with a view to a parenting perspective being codified into regulation, this could then be inspected. It was an unspoken concern that quality child care would be hard to find, there has been further raising of the bar partly as a result of continuing this belief and partly as more homes have been able to meet the required standards.

It is interesting to note the lack of comparators for quality of care. It is fostering agencies that are inspected not foster care. We also know nothing about the quality of care or parenting of an equivalence in families outside of the care system. We have Stability Index for children in care but not all others.

It should be noted that those children living in residential care are the most vulnerable with heightened needs, intensity, frequency. Frequently they have not had their needs attended appropriately and often have been placed in family-based care serially and sequentially.

There are several strongly evidenced responses to critics of residential care

- The evidence is that it provides a quality of care and parenting
- That many children experience serial and sequential placements is evidence of a system that makes and breaks relationships knowing that relationships and attachments are vital to recovery
- Access to residential provision is hierarchical, the previous environments must have failed the young person for them to cross the threshold
- Using residential care as a last resort is to undermine the efficacy of what is offered, interventions that do not meet need frequently add to the complexity
- Figures show children arrive and leave in mid-teens, too late and too short a time
- Children’s homes act to mitigate the failures of the care system
- We attribute failure to children’s homes when the outcomes are a correlation of previous interventions.
- Outcomes are recorded by last placement but not necessarily attributable to it
- Assessing outcomes when placed in a secure emotional base the development made in residential settings can be at least as good as fostering and often as good as all other settings including families
- Positive children’s homes are found in positive children’s systems.

How might this thinking be important in changing our thinking of placements for children living away from home?

Parenting and family work from a care setting - what does this mean for practice?

The narrative of successive governments is commonly that families, undefined, are at the heart of a healthy society. Early intervention is required to prevent problems escalating and prevent poor outcomes. There is recognition that there need to be services that families can draw on for relationship support, to build and sustain relationship quality and to support families through relationship distress and breakdown.

The attention to develop capacity and expertise for high need families is frequently argued as 'preventative support to develop and sustain relationships'. When universal and specialist services have not proven effective there is often an argument deployed for a need for other services 'for those in greatest need' 'as an alternative to intensive, interventions'. Moral, social and financial perspectives intermingle. The result for the child is of a still further step to having their needs appropriately met.

There is a reluctance to confirm the severity of need. The definition of need and thus intervention derives from the needs of majority of children rather than the small group with high level needs. Being so family-focused is to lose being child-focused.

There is no doubting that the response for children with high level needs is intensive , strongly targeted, wrap around, unconditional, empathetic care delivering physical, emotional, and psychological development. So, what is it that is needed?

Parent-child relationship, attachment theory and neuroscience – a child's relational needs (Bruce Perry)

- Secure attachment
- Physical affection and physical contact
- Interactive play and opportunities for independent play and exploration
- Encouragement and praise
- Shared adventure
- Appropriate limits and boundaries
- Parenting rehearsals
- Principles rather than techniques
- Praise and boundary setting
- Solution- focused – opportunity rather than problems

Hypothesis - the need to rehabilitate family work within RCC - in order to meet the full range needs of young people we will need to remember, reclaim, review, renew, - and a renaissance of RCC

We have the potential to reconsider the idea of family and parenting as possible for residential settings and to look at the full range of provision for all children living away from home in all circumstances and for all needs.

A cultural review of Children's Services

We need to look at ourselves as professional and politicians, as practitioners and policy makers.

"The purpose of undertaking the cultural review is for the practitioner to alert themselves to areas where their own assumptions, prejudices or simply lack of knowledge might have a bearing on their response to a family and, ultimately, on the approach taken to working with them. Similarly, issues that a worker may be carrying in their head, such as agency norms and awareness, will also have an impact; as will the families' likely assumptions about the worker and the agency." (Dalziel and Sawyer (2008) Putting analysis into assessment)

English responses to evaluating residential child care have rarely been positive. When there is positive evidence or comment it is notable that quickly there is other evidence provided to revert back to the underlying negativity. In such circumstances there is a need for a cultural review.

A Cultural Review requires questions such as:

- What do I know about children and families with this particular background or life experience?
- Where does my knowledge come from?
- What prejudices may I hold (positive or negative)?
- What norms and practices do I take with me?
- What do I know/expect about children of this age, their lives and needs?
- What do I know of children with high level needs?
- What experience have of this group?
- How might they and their carers perceive me? As someone who cannot recognise their needs?
- Is my perspective and action experienced as not being about them?
- What impact might this assessment have on the child and carers lives?
- How much weight do I give to knowing it can have a great effect if I cannot get the matching of needs to services/placements right?

If we know that in Scotland it is seen differently. In appreciating Adam Ingram launching their 2009 National Residential Child Care Initiative observing '*the cost of failing to invest in high quality care is one we can't afford for our young people or society as a whole'* and the desire to make residential child care the 'first *and best placement of choice for those children whose needs it serves'* we might see the use of RCC is a social construct.

Elements towards constructing a view of residential child care

- It offers environments that are both generalist and universalist as well as specialist
- We have used RCC in more diverse ways than we use it now
- It has changed over time from offering an upbringing to now being an intervention – the diversity of needs and preferences can be such that it is necessary that we do both.
- It is differently used in other European countries – as an upbringing and intervention
- Many young people consistently report it to be their placement of choice
- That by taking a view of personalisation and individual care planning we have diminished the understanding and skills for groupwork and group living, there is a component of peer relationships as an active factor we have diminished
- In the way we use RCC now we have constructed it only as 'high cost.' We have constructed a graded, sequential, hierarchical view of care that may not be in the best interests of young people There are 2 connected matters here –
  i) the 'do more for less' exhortation has a focus on cost alone whereas 'do different' might lead us to interesting reconsiderations. Maybe we need not to look at services but at targeted solutions?
  ii) through calculating costs accurately and holistically we may use all placements effectively and efficiently thus improving the lives of young people by matching their needs to the care. Through emphasising procurement in our current commissioning perspective administration and financial demands have come to be major factors in the shaping of placement provision. We have been able to do the easy work of a focus on cost but we have struggled with establishing cost-effectiveness, and by doing so set placement types as alternatives, or competitors, whereas all the evidence tells us they will be better used as meeting assessed needs of young people. We need to ensure the continuum of provision for all children living away from home is available as a choice presented horizontally and through assessment rather than hierarchically and experientially.
  iii) We need to appreciate the complexity of assessing and meeting needs, and resist inappropriate normalisation, in fact a reducing of the range and depth of need in order to make a placement but which leads us to serial breakdowns.
- through developing a focus on the needs of the young person and placement type we have not always been able to see the young person in context of their family system. Being so child-focused is to lose being family-focused. Whilst we have been concentrating on the doing of ourselves, we often have not also been so focussed on the doing of others important to them. The original family remain important, even if only as a memory or experience, but frequently still involved. If the idea of a family, if the actuality, can evolve so too can a young person. Whilst we are doing our work maybe others are doing family work, maybe that connects up. Whatever, for the young person we need their family to support the progress

they have made whilst in our care rather than returning to an unmodified family circumstance. We know a lot about the effects of family structures and systems.

How do you see Looked After Children? 1948 in 2021?

The current fashion is for Innovation and evidence. Residential child care has always been innovative and as a result there is a great deal of evidence and experience informed knowledge already existing that maybe can be placed into the new evidence frameworks. There is much we can value at a distance

Bruce Perry has explained that he sees his work as standing on the shoulders of giants such as Bowlby – Child Care and Growth of Love, and Winnicott – Child, family and outside world

Bowlby	**Winnicott**
Circumstance, character, disposition of parents	Internal disposition of infant
Quality of care central to infant experience of self and world is objective – immediate cause and explanation of later character, disposition and behaviour of child	Infant experience is objective and subjective – environment is proximate
Emphasis on extra-psychic as formative of internal	Emphasis on intra-psychic
Effects of absence and loss	Affects – the *experience* of loss
Emphasise preventative over remedial – concentrate on home life	Imaginative recreation was possible
'Better a bad home than a substitute home'	Non-family settings - Hostel – Residential Care as Therapy
Delinquency as pathology to be removed	Delinquency as sign of hope to be understood
Child to demonstrate concern	Society to demonstrate concern

It is important to place these perspectives in historical context of their time. It shows a continuity of the dilemmas faced today

The Curtis Report instigated by concern for what were called 'boarded out children' concluded '*measures should be taken to ensure that these children are brought up under conditions best calculated to compensate them for the lack of parental care.'* It proposed family based 'homely' care. It had an optimism that most children would respond.

Bowlby favoured family-based care even extending to 'cottage homes' but was '*reluctant to fully endorse the sort of therapeutic benefits to be derived from systematic, specialised hostel-type provision.'* Bowlby had the aim of reducing if not totally removing

the potential for young people to become ‘taken into care’ by removing the causes and thus need for cure of deprivation.

The experiences of Winnicott led him to the view that deprivation was never going to go away completely, he endorsed all provision. He was not confident in the resilience of the ordinary family in all circumstances to provide the required structures for deprived young people. A small well-supported residential home, ‘primary home provision’, could provide a suitable ‘facilitating environment’ for young people

Home is where we start from….’*This ain’t a unit it’s a home’*

Young people’s views

A Children’s Rights Director report carried the same message of many that have preceded and followed it. Many young people like children’s homes, they felt cared for and looked after. Some children feel that the children’s home that they live in is exactly where they want to be. It is fair to say that some children do not like living in residential care. But it can be seen as a positive choice:

When

- Providing stability and a stimulating environment
- Widening cultural and educational horizons
- Creating a framework for emotionally secure relationships with adults - may benefit from having a number of carers
- Providing a setting for intensive therapeutic work
- When a young person feels threatened by prospect of living in a family or does not want to be part of substitute family as still very much part of their own family
- When the emotional load of caring for a very disturbed or chaotic young person is best distributed amongst a number of carers

What can we take from this understanding?

Place is an active creation. We inhabit places and create them through the interaction of our self in relation to others. Being social beings we create place as a social activity. We have the idea of ‘family’. It is acting as-a-family that creates family. Family does not exist in and of itself as the exclusive use of the term implies.

If function determines form, what are we thinking of it is the place of family for LAC?

The experience of place being a facilitating and nurturing environment is provided for younger people by parents in the act of being parents

Group care and individual care.

Individuation or personalisation?

Group care and individual care have never been distinct. Family care must include individual care. What is needed is to match the care setting to the needs of the young person, whether that be foster care or group care. The starting point in any setting is the immediate close relationship with a carer. In residential child care, this is provided by the keyworker. The keyworker may have a co-worker, and certainly will have more than one young person for whom they are "key". So there begins the formation of a sibling group. This group in itself is part of a larger group – often no bigger than a large family of, say, six young people.

With this understanding of young people and their needs, we can see how residential child care can structure their development, moving from a close circle to another bigger circle and then into wider social living. Residential child care provides a successful space for young people to explore successfully these different spaces, each with different expectations. This success can be transferred to other arenas.

As Narey observed in his report regarding children's homes there are some young people for whom family life or a family setting is not right at a particular time. Group care can allow a young person to be supported to see behind and beyond the dynamics of their family and the earlier experiences that drive them to compulsively repeat traumatic situations and experiences. To do so requires a setting that can withstand – through understanding – the actions of a young person. Good leadership, well-motivated and trained staff who are well supported and supervised, and a clear vision, ethos and philosophy of care, all add up to good outputs from residential childcare, irrespective of the setting or size.

Caring or Parenting?

'There is no such thing as a baby, only a baby and someone' – Winnicott.

Taking the role and task being of parenting for all young people living away from home we have to make the Maslow pyramid into everyday life. The **8 Pillars of Parenting** is a good common core (Cameron and Maginn) to assist us in this work regardless of the setting

- Primary care and protection - Sensitivity to a child's basic needs shows the child that we care and that they are important. Education is paramount because in our complex world knowledge and skills are essential to survival.
- Secure attachments, making close relationships **-** Secure attachments act as a buffer against risk and operate as a protective mechanism.
- Positive self-perception - To allow the child to develop a positive self image. Positive and negative statements have a powerful impact on self-perception and esteem.

- Emotional compliance - This ability underpins the successful development of relationships outside of the family and can moderate susceptibility to the propensity for later mental health problems.
- Self management skills - Self-image is the insulation, which prevents inappropriate behaviour when enticing or compelling outside factors try to intrude.
- Resilience - Resilient individuals are able to understand what has happened to them in life (insight) develop understanding of others (empathy) and experience a quality of life that is often denied to others who have suffered negative life experiences (achievement).
- A sense of belonging - Research and theory on relationships have highlighted the need to belong.
- Personal and social responsibilities - Essentially personal and social responsibility mean's being able to coordinate one's own perspective with the help of others and developing personal views of fairness and reciprocity.

In 'The Residential Solution', Ann Davis categorises residential settings on the basis of their attitude to family life. She distinguishes between three models of residential care.

- Substitute Family Care. Under this model, residential settings seek to create a family like atmosphere, and family group. We might have been doing this all along, but we recognise it less now?
- Family Alternative Care. Taking an extended family perspective and incorporating the positive aspects of communal life. Many boarding schools see themselves in this way as residential communities, quite separate from and superseding children's family life during term time.
- Family Supplement Care. This model contains three main concepts: the need to rehabilitate families; the need to rehabilitate individuals to family life; and the need to share care with families. This maybe the model of most congruence with the view of family support. Such community-based short-term residential care allows for care to be shared as opposed to substituting entirely. For instance, a child may spend all week at a children's' home, while another is admitted to care at weekends. The arrangement made is dependent on the family situation. This was the conclusion of the Barclay Report, and more recently of the CSJ Family hubs extending the work of Family Centres. Instead of being seen as isolated from communities, residential establishments are be seen as part of the neighbourhood in which they are located, as focal points of community-oriented social work. The emphasis is on flexibility. For example, there may be a range of accommodation and support services; day attendance, part-time residence, or full time care; open visiting hours; flexible staff roles; and a willingness to respond appropriately to the specific needs of each individual family. There is also an emphasis on purposeful intervention with the family. For example, there may be clear plans for time limited family work, for rehabilitation, or for the maintenance of family responsibility and close links between the family and the child. It may provide help with factors such as income, housing, or employment, which effect the family's capacity to care for the child.

The effect of such family thinking on the RCC sector more generally

A good admission is paced slowly, allowing time for preliminary family work. Some admissions will always occur quickly, in a crisis. These should be rare. There should be allow time for proper planning affording understanding and planning not just for the child, placement and care planning, but also family work.

The initial contact will resume its importance. It always sets the tone for future relationships and family work. It is where the home gets to experience the family dynamics. It is where the family work starts. There are 'practical, psychological, symbolic and power dimensions' (Milham) of family life that a young person takes with them to placement – and when they leave too. An initial contract can be negotiated with the family at this point. This may clarify the importance to be attached to the family's continuing role and involvement with the child.

We are able to recognize the two homes of the child have different roles and meaning. There is a disappointing separation in supporting contact. It should be undertaken by the keyworker , maybe along with the social worker, but never by a separate service. With all involved in parenting co-operating several things are seen

- an active and practical interest in the family and in the children's home
- the involvement of the wider family who might not otherwise be seen, or who need particular encouragement to visit and maintain links with the child;
- to explain to the family the role of the children's home and clarify mutual expectations;
- to familiarize themselves with the family home and members, as part of the work surrounding the child
- to form child-centred relationships with the family and for the family with staff .

A positive engagement with RCC should help counterbalance the powerlessness which the family may feel as a result of their child's admission. Staff need to understand what 'working with and alongside the family' means. Assessment of the child also means an assessment of the family. But the worker must also respond to the family's feelings. A good assessment is not a cold, clinical compilation. It is a developing reciprocal relationship, which allows the family to share feelings (anxiety, guilt, stigma, compulsion and ambivalence) associated with the facts. Emotional support to the family may thus be an integral part of the assessment process.

This last section is not new. I've taken it from 'Family work in Residential Child Care' – I am trying to role model the review of what we know – by John Kelshall and Billy McCollough for what is now Together Trust. I recommend it as a reference and primer for your work.

Millham et al summarizing why RCC staff should facilitate close links with families

- research shows the child often functions better with the parent in contact
- contact home is an indicator the child will return home

- if we have new ways of using RCC as short breaks the child will not have the confusion of new family circumstances to get used to
- for longer term placements the RCCWs are may well be lifelong supportive relationships
- RCC can perform a family and friendship links into adult life – there are many Old Residents/Communities that support each other

If we are able to support a renegotiation of RCC then we stand a chance of meeting needs better. This means conceiving of RCC being offered in differing ways. This will require an increase in what we see as valid for RCC alongside an increased differentiation and specialization.

We have opportunity to reconsider the role of the bounded organization in children's lives.

- That boundaries can be useful for an assessed group of young people allowing interventions to have the correct focus – reflection is only possible within a space that has defined role and task
- For others the boundaries can be more liquid depending upon their strengths and stage of development and resilience. This may need a greater differentiation of settings than we have now and some of the learning we have experience of in our not so long ago past

Relational working

Relational work is underpinned by interaction, negotiation, flexibility and mutual trust builds the 'community of interest' and requires

- an appreciation that personal, professional and social values influence the nature and process of the working relationship
- the importance of building relationships over time, trust has to be established or anticipated - there has to be a history and a future.
- mutual trust is greater than individual self-interest

A strategy for the achievement of the above

- Shifting from product to learning;
- Developing explicit skills, attitudes, and abilities as well as knowledge;
- Developing appropriate assessment procedures;
- Rewarding transformative practice;
- Encouraging discussion of practice of both commissioner and provider;
- Providing transformative learning for all commissioners and providers
- Fostering new collegiality;
- Linking quality improvement to learning;
- Auditing improvement.

Residential Child Care has always been a contested area. It has to struggle for its own space in which to work and think.

In this past period we have been increasingly swift in implementing initiatives but insufficiently reflective and not prepared for implications or unintended consequences We have not been overtly developing child care theory and practice. We have taken forwards services using imported foundations without considering consequences.

There is the need to recover important conceptual thinking. This paper closes with some examples, more will appear on the NCERCC website.

What works in Residential Child Care – a research review (NCERCC).

Needs and types

There is no one thing we can now call Residential Child Care in the singular only Residential Child Care in the plural. Diversity in terms of settings and approaches

1. Children with relatively simple or straightforward needs
These children need either short-term or relatively 'ordinary' substitute care.
Why are they a child in care?
Their families may be stable and supportive but there has been a crisis or difficulty and they need short term, days or weeks, of support.
What do they need?
Good quality daily care and support.
How will they behave?
There can be a reasonable expectation that the child will return home and resume their usual lifestyle.
Where will they be placed?
Usually fostering, but there are many children who have preference for residential child care or are unsuited for fostering and so can go to a short break or short stay mainstream children's home.
What is a short break children's home?
Short breaks are often part of a wider package of care, which can involve health and education services and other agencies and are for children with learning disabilities and allow carers and families to 'take a break'. The children will have permanent and substantial physical and /or learning disabilities but will not be very challenging in their behaviour or require expert nursing care.
Short stay mainstream children's homes
Short stay mainstream children's homes provide time-limited care for children. These homes may serve different purposes; a child may need looking after because of unplanned or unforeseen events; or they may be waiting for a long-term place to become open; or it may be for assessment.

2. Children or families with deep rooted, complex or chronic needs with a long history of disability, difficulty or disruption, including abuse or

neglect
These children require more than simply a substitute family care.
Why are they a child in care?
There may be longer times when these children need stabilising, from weeks and months to years. They may have been a child in care before.
What do they need?
They need individualised care in a safe and containing environment, provided by grown-ups who are consistently thoughtful about each child's care. There will be clear boundaries and limits with some negotiated flexibility.
How will they behave?
Their behaviour may be unsafe, self-harming or unpredictable and need to be managed in order to stabilise their lives.
Where will they be placed?
Long term mainstream children's homes
These homes provide care for a child for a substantial period of time, possibly until the child reaches adulthood. Most homes provide children with a key worker who will work with a child to ensure that their needs are being met in line with their Care Plan. This will include how a child's emotional, educational, social and health needs will be met. There will also be consideration given to the contact a child will have with their family and friends. These homes tend to provide care for groups of children and a key task for workers within the home is balancing the needs of each individual child with the needs of the group.
Children's homes for children with disabilities
Some children with disabilities have complex needs resulting from disability rather than a lack of parenting capacity. They require specialised long-term care that can provide care, education and health needs often in one place.
Residential Special Schools
Residential Special Schools provide an enriched educational experience but also address children's disability, and/or social, emotional psychological and behavioural needs. Residential Special Schools can be children's homes too if young people live there more than just term time. There will specialist staffing and provision.

3. Children with extensive, complex and enduring needs compounded by very difficult behaviour who require more specialised and intensive resources
These children with 'high cost: low incidence needs' require particular care and specialist settings. The children have serious psychological needs and behavioural problems that can overshadow other goals.
Why are they a child in care?
Their needs may have been obvious from an early age and be the result of physical or sexual abuse. They may be involved with Youth Justice or mental health teams.
What do they need?
Intensive support and treatment with care, education and health all on one

site and directed to creating a change in the child's and families circumstances.

How will they behave?

They will find it hard to sit still, often easily be verbally and physically aggressive, unpredictable, irrational, or unable to reason and show little concern for others. They can be out of touch with their emotions and show little or no sense of guilt or apology.

Where will they be placed?

These children need a place with a therapeutic community, an adolescent mental health unit, a small 'intensive care' residential setting, secure unit or occasionally a place that is just for them on their own but still residential child care.

What is a Therapeutic Community?

Within a clear set of boundaries concerning time, place and roles there will be very close relationships between children and grown-ups with frequent sharing of information and open resolution of problems, tensions and conflicts. Daily life will be purposeful tasks – therapeutic, domestic, organisational, educational – and there will be a shared commitment to the goal of learning from the experience of living and/ or working together

What is an adolescent psychiatric unit?

The focus here is on health and they are often close to or part of hospitals. The staff are mostly nurses and doctors, but there are social workers and teachers too. Young people will have needs such as a psychiatric illness, eating disorder, suffering from post-traumatic stress, or complex conditions that may include learning difficulties and behavioural problems. Some have experienced abuse or have difficult family and social circumstances.

What is a secure children's home?

Secure Children's Homes are specialist residential resources offering a high quality of care, education, assessment and therapeutic work. These are the only children's homes allowed to lock doors to prevent children leaving. Such restriction of liberty is a serious matter and entry is only by having a legal order from a Court made to protect the child or the community.

What is a one-bedded children's home?

Some homes are specifically registered and designed to have just one child living in them. For some children, living with a group of other children is not the best way in which to meet their needs. They need to have the opportunity to have the specialist support that residential child care can provide, but without the complexities that group living might bring. Their placement will follow an assessment and be meeting a specific treatment or care need. A key difference between foster care and a one bedded home is that a team of staff are employed to work with the child in the children's home. The staff members do not live on site and go home at the end of their shift

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Berridge and Brodie Children's Homes Revisited (1997)

An enhanced, integrated model of residential child care: short-term breaks for young people with severe learning disabilities and additional health needs

Relationship with family

- Short break as a form of family support and shared care
- A service for parents and children
- A break for children also seen as part of the package
- Liaison with parents to ensure consistency
- Different role of voluntary sector: more *individual* support for families

Inter-professional working

- Good multiagency planning and involvement: positive links with social workers
- Great consistency of professional approach
- All children go to school: all SEN statements: favourable teacher: pupil ratio

Nature of Residential practice

- Clear sense of purpose for settings
- Structured programme, expert-led
- High level of interaction: leisure used purposefully
- 'Normalizing' activity
- Acquire instrumental skills
- Staff demonstrate specialist skills, positive attitude towards children
- Reports written positively and show signs of progress
- Focus on developmental issues rather than behaviour only