PATRICK TOMLINSON ASSOCIATES (2025) FRAMEWORK (WORKPLACE CURRICULUM) FOR THE DEVELOPMENT OF A THERAPEUTIC MODEL

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A RESEARCH-INFORMED AND EVIDENCE-BASED MODEL

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CREATE YOUR ORGANIZATION'S UNIQUE THERAPEUTIC MODEL FOR TRAUMATIZED CHILDREN AND YOUNG PEOPLE

INTRODUCTION

The development of a model is a complex task. This document aims to provide a structure for working together on this task so that the work can be managed step by step. The process can be adapted according to need. The document is divided into three parts,

1. Leadership and Management
2. Organizational Culture
3. Practice

The three parts can be considered as the whole system. This is a whole-system approach to a therapeutic model. There is research evidence to suggest that this approach is most effective in delivering positive outcomes for service users. Kezelman and Stavropoulos (2012, p.16) in their research on trauma services link the organizational context and the recovery process,

> Both administrative and clinical experience suggests that attributes of the system `as a whole' have a very significant impact on the implementation and potentially the effectiveness of any services offered.

The development project is broken down into 22 key areas of work. Under each of them, there is a summary of why it is relevant to the model. In some organizations, some of the areas of work may not be so relevant and there may be others that need adding. The language may also need adapting. There are bullet points at the end of each section highlighting the specific tasks that need to be completed in creating the model for that section. Again, not each task is always relevant and others can be added.

If the three parts of a model are not effectively integrated the effectiveness of the work is likely to be undermined and not congruent with the 'best interests of the child' (Anglin, 2002). The steps/sections of each part are a way of organizing the project. All the '22 Steps' cover vital areas of a therapeutic model. Key elements of practice supported by research and experience over many decades are all included. (see, Tomlinson, 2019).

The clear organization of the 22 Steps, also provides a focus for different aspects of the model and who might be involved in the development of the different areas. There is an overlap between the parts so there is no clear rule as to who might be involved in working on the different parts. This is a matter to be decided by the Leadership of the organization in consultation with others.

There is an introduction to each of the 22 sections to explain why that area is relevant to the development of a model. The aim is to provide a general orientation for the work that will take place. It is not meant to be prescriptive, but just to provide a framework from which a model can be developed.

Whilst the document follows a chronological process, some things may need to be skipped and come back to once other parts have been completed. Many areas that will come under the model will already be in place. Once the model is defined, current organizational structures, processes, practices, and policies will need to be reviewed and where necessary (and possible) adapted to the model.

Clough et al. (2006, p.64) in their major research on studies into what works in residential care outline what must be included in an effective model,

> We repeat the core areas for consideration:
> - ensuring goals are in harmony
> - establishing the structure of the home
> - establishing clear and coherent leadership
> - establishing well-articulated objectives, consistent throughout the organization
> - staff feel that they have significant responsibility for life within the home.
>
> ... The fundamental requirement for an effective service is that different types of goals are as congruent as possible. However, this abstract state needs to be underpinned by sound professional knowledge, appropriate processes, and the good practice that the research studies have identified.

WHY HAVE A THERAPEUTIC MODEL?

For several decades it has been recognized that it is important in trauma-based services to have a well-articulated therapeutic model. Along with leadership, this has been identified as a key factor in well-run organizations (see, Tomlinson, 2019).

Having a model and strong leadership are associated with positive outcomes for children and young people. Conversely, not having a clear model, ethos, or philosophy is often a factor in poor outcomes, bad practices, and negative outcomes. One of the key benefits of having a model is that it should improve safety and reduce risk. It is a positive protective factor (see, Wardhaugh and Wilding, 1993, Tomlinson, 2019).

Recent research from neurobiology, trauma, and the conditions necessary for recovery have affirmed the value of the consistency brought about by a clear therapeutic approach. This is so clear now that in many parts of the world, it is becoming a requirement that organizations in this field have a therapeutic model. In some cases, children will no longer be placed with organizations that do not have one.

Having a model is important but not a guarantee of positive outcomes. It must be delivered in the context of good leadership and become embedded in the culture. All aspects of the organization must be congruent (Anglin, 2002, 2004) and aligned with it. This includes leadership, management, organization policies, and procedures, as well as any kind of therapy that is used in working with children. This is referred to as a 'whole system' model and has been evidenced to be most effective (Kezelman and Stavropoulos, 2012, p.16).

KEY BENEFITS OF HAVING A MODEL

1. A clear model framework increases safety and reduces risk.

2. An articulated model clarifies the task and reduces confusion. This leads to a higher level of congruence, with improved outcomes for all stakeholders. A model creates a shared language and processes, which helps integrate different professional disciplines.

3. It is highly beneficial for organizations to understand trauma and how to respond to it. This is becoming trauma-informed.
4. Greater consistency and quality of professional and organizational development. Improved performance, funding, and cost-efficiency.
5. The development work is a helpful way of reviewing the organization's culture and practice.
6. The work involved will be a positive experience of team building - creating a shared vision, values, and commitment. The involvement of the organization in the creation process will lead to a high level of engagement and ownership.
7. A high-quality model will further consolidate the organization's position – in terms of being a high-caliber service provider, attracting referrals, funding, and good-quality staff.
8. Holding a conference, and publishing papers/a book all help to establish the organization as a leading authority in the field.
9. In some countries having an articulated therapeutic model is becoming a regulatory requirement, influencing the placement of children. Therefore, not having a model could jeopardize an organization's future.

The first of the above benefits, improving safety and reducing risk is critical. It has been known in the field of trauma work since the 19th century that nothing can be done until a level of safety is established. Kezelman and Stavropoulos (2012, p.71) state,

> The three phases of treatment (which date to the work of Janet in the late nineteenth century, and which current research findings endorse) are broadly described as follows:
> **(1)** Safety and stabilisation
> **(2)** Processing
> **(3)** Integration

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. A consensus statement from 32 experts from 12 nations, based on extensive research about the key principles of Therapeutic Residential Care confirmed that safety is the number one principle out of the 5 they identified (Whittaker et al., 2016, p.96),

> **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.

As discussed earlier, Wardhaugh and Wilding (1993) have powerfully highlighted the risks involved in not having a clear model.

PHASE 1 - CREATING A 'HOME-GROWN' MODEL

This document outlines the areas of a framework or workplace curriculum (Billett, 2005) for developing a therapeutic model. The framework is designed as an active, learning and

development process. The areas covered by the framework are based on the evidence and research as to what is important to children in residential care and other care settings, and what helps them to achieve positive outcomes in their lives.

A framework such as this provides a way of assisting an organization to create and articulate its model. In recent years this has been referred to as creating a home-grown model. The only other way to have a model is to import and license one from somewhere else. James (2017, p,7) highlights some of the benefits of creating a home-grown model rather than importing one,

> It is believed that instead 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. These may be informed by existing models, may meet the agency's needs for providing a general framework for their services and are, at minimum, sufficiently cogent to meet requirements for licensing and accreditation.

Referring to research on residential care James (p.7-8) continues,

> In the already mentioned Special Issue on residential care in the Journal of Emotional and Behavioral Disorders, Lee and McMillen (2017) 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.

And (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.

The aim of creating a therapeutic model is to significantly improve outcomes for the service users, the organization, and all stakeholders. This is achieved through the change process, which is model development.

It usually takes one year to work through the framework and produce a model written in a document. The model is then ready for the implementation process. As variables are involved, such as how long the organization has been established, the size of the organization, whether there is a working model (if not fully articulated), the resources available, and other contextual matters, the model process could take longer or less than a year. A **Pre-Model Assessment** will help to clarify these issues and readiness for model development.

The key reason why a year is usually needed is not because of how long it takes to gather information or write anything but because of the need for time to process such a significant change. Inclusivity is also vitally important at all levels of the organization. Without time to

properly review, reflect, and consider the meaning of change there is not likely to be strong ownership and commitment to the model produced. The aim is for as many people as possible to digest the meaning of the model, and its implications for their role, and identify with it. Ideally, to see some of their influence and contribution to it (see, Tomlinson, 2021a, 2021b, 2022).

PHASE 2 - MODEL IMPLEMENTATION

After creating a model document and approving this stage as complete the next stage is implementation. The implementation phase can also be expected to take up to a year. A key part of this phase is to test the model in practice and tweak parts of it wherever necessary.

With the 22 sections completed a training programme can now be created based on the model. Organizational policies, practices, and procedures will also need to be reviewed to ensure that they are aligned with the model. Finally, an outcomes measurement process will need to be in place or developed to ascertain whether the aims of the model are being achieved. The fidelity of the model is in its implementation. As Duppong Hurley et al. (2017) state,

> 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.

Oranga Tamiriki (2020, p.9) concur,

> Where treatment was delivered as intended, children and young people in TRC exhibited lower rates of internalising and externalising behaviours while in care.

PHASE 3 – MODEL ESTABLISHMENT AND ONGOING DEVELOPMENT

This phase is about fully establishing the model in the culture and practice of the organization. Where everyone whatever their role, understands the model, is committed to it, and the way they work is aligned with the model. To some extent, this is always a work in progress and things never remain static. For example, things may become stagnant and go backward.

The context of the work and external factors is always changing so the model must adapt and evolve. Additionally, we should not view any model as the finished article but as a process of continuous learning and development. Research and experience may lead us to question parts of the model and to discover new insights.

Therefore, it is essential to put in place a way of managing the ongoing process of change. For example, there needs to be a way of agreeing whether proposed changes and additions to the model are aligned or not. Changes might include new training events, new procedures and processes, new approaches to an aspect of the model, and changes to policies. If these

processes are not managed consistently there is a high risk that there will soon be contradictory and incongruent practices sliding into the unmanaged space.

Continuous development and creative thinking should be encouraged but there must be a way of managing it. A simple solution is to establish a **Model Committee** made up of technical and operational representatives whose task is to review and recommend proposed changes. This could be done on a 3 or 6-month basis. All stakeholders can be encouraged to submit proposals for review. Any significant changes in the organization, including changes to the model, could then be submitted to senior management for approval and signing off.

THE ROLE OF THE EXTERNAL CONSULTANT/CO-CREATOR (also see, Tomlinson, 2022)

Patrick Tomlinson has been involved in developing therapeutic models for over 25 years. Since its inception in 2008, Patrick Tomlinson Associates has provided a Therapeutic Model Development service. The core value of creativity has been central to the work and that is why organizations are assisted to create their unique model which they have complete ownership of. This is done through a process of collaboration and co-creation.

Fourteen therapeutic models have been created in several countries and three are in progress (England, Ireland, Northern Ireland, Portugal, and Australia). Some of the models have achieved national and international recognition. For example, Thoburn and Ainsworth (2015, p.45) state in the book, *Therapeutic Residential Care for Children: Developing Evidence-Based International Practice*,

> 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 models have been for a wide variety of organizations, covering residential care, children and family services, education, foster care, and community services. The models have all been articulated in a model document. The size of the model documents has varied from 5,000 to 70,000 words. They are tailored according to need and the smaller documents can be built upon in the future.

The models that have been co-created have been in organizations that vary in size and complexity. For example, start-up organizations to well-established organizations with hundreds and in one case thousands of staff. And organizations that provide one service, such as residential care, and others that provide several services. In general, having an external consultant can act as a form of emotional containment, which enables the staff within the organisation to think more clearly and identify their solutions. The consultant/co-creator provides several areas of support,

1. Vast experience which enables understanding of the model development process and potential challenges involved.
2. The consultant aims to ensure that the way of working together models the model. For example, if reflective practice is an important part of the model, it must also be an important part of the model development work.

3. Model Development is a significant process of organizational change. The external consultant provides a form of containment that enables, understanding, differences and resistance to be worked through, and internalization of the model's meaning.
4. As there is a process of change for the organization this means that the people involved also need to develop. The mentoring provided by the consultant supports this.
5. Research-informed material is provided from an extensive library to underpin the validity of the model.
6. The writing process is supported by review and feedback, editing, and adding material as needed.

Wilson (2003, p.232) states that the benefit of the role of an external consultant,

> … is his or her particular specialism and external perspective. The consultant has a unique relationship to the organisation, being invoked from outside, rather than employed from within.

The organizational consultant Eric Miller (1989, p. xviii) emphasized the value of the external consultant when working on a major change project,

> 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.

Whitwell (1998) describes the value of the more removed perspective as helping those inside the organization be more able to see the wood through the trees, or as Miller (p. xvii) explains,

> I have to stand back far enough far enough to discover alternative ways of looking at a situation, ways that may be less accessible to those who are caught up in it.

Wilson (p.221) elaborates further on this point,

> The essential value of consultation is that it exists 'outside', or rather, 'on the edge' of an organisation. As Silveira (1991) puts it, the consultant in a residential institution is 'the nonresident crossing the boundary every time he visits, looking in and looking out'. The strength of his or her contribution resides in being slightly at odds with the organisation: a part of and yet apart from the living goings-on of the organisation. This is the very element that the organisation needs because of temporary or prolonged moments of blindness that occur, inherent in its involvement with its own working. The directors, trustees and management may lose sight of their mission or strategy and become over-embroiled in their practice. The consultant offers, from a special place of difference, something relatively uncompromised or cloyed by institutional pressures – a bird's eye view, without as it were, having too much institutional wool being pulled over it.

This is a key reason why the model development process can be significantly aided by having an external consultant/co-creator. Once the model development task is complete and by the end of the model implementation phase, Miller (xviii) explains,

> My task is then to become redundant. The intervention will be successful if clients have transformed the dependence on me into fuller exercise of their own authority and competence.

In the beginning, the consultant will work with the organization to agree upon how they will work together. This is influenced by the size of the organization, the resources available, the organization's stage of development, and how much of a model may already be in place. A pre-model assessment can help to establish the reality of these factors.

MODEL PARTS AND SECTIONS

This is a guide to key areas of a therapeutic model and how they may be integrated into the three parts. The language can be changed, sections can be moved or merged, and new ones can be added according to the needs of the specific service.

PART 1 - LEADERSHIP AND MANAGEMENT

1.1 THE PRIMARY TASK (MISSION) AND CORE VALUES
1.2 THE ORGANIZATION'S VISION AND CULTURE
1.3 LEADERSHIP
1.4 THE LANGUAGE OF THE ORGANIZATION
1.5 BOUNDARY MANAGEMENT
1.6 TRAUMA RE-ENACTMENT AND ITS IMPACT ON THE ORGANIZATION
1.7 INDEPENDENT CONSULTANCY AND MONITORING
1.8 DEMANDS OF THE WORK AND STAFF SUPPORT
1.9 MANAGING CHANGE

PART 2 - ORGANIZATIONAL CULTURE

2.10 THE IMPORTANCE OF BOUNDARIES
2.11 THE RELATIONSHIP BETWEEN THE ORGANIZATION AND THERAPEUTIC TASK
2.12 THE NATURE OF AUTHORITY
2.13 THE ORGANIZATION AND COMMUNITY
2.14 CREATING A SENSE OF COMMUNITY
2.15 ORGANIZATION AS 'FAMILY'
2.16 GROUP PROCESSES

PART 3 - PRACTICE

3.17 OUTCOMES
3.18 THE IMPORTANCE OF THEORY
3.19 THE THERAPEUTIC APPROACH

<u>This section is extensive and it will vary according to the needs of the service. It may include the following (this is not a complete list, there may be others to add, and some may not be relevant)</u>

- How relationships will be developed between staff and children, and between children
- How children's need for nurture will be met
- How appropriate boundaries will be established and how challenges to boundaries will be addressed
- How crisis and critical incidents will be worked with
- How children's learning and education will be encouraged and supported
- How daily routines will be approached
- How children's cultural and religious needs will be met
- How issues related to traumatic events in the children's past will be worked with
- How Individual Care Plans will be developed
- How issues related to children's sexuality and gender will be worked with
- How play will be supported and embedded in the home culture
- How children's interests and skills will be developed (including links with the local community)
- How children's relationships with their families will be supported and developed
- How plans will be made for children's transition when they leave, how they will be supported during the transition and afterward

- Clarify in detail how the whole organization will be related to the therapeutic task
- Clarify a clear referral procedure to assess children and their suitability for the service
- Clarify the system for case management the people involved (internally and externally), who holds responsibility for what, and how decisions are made.

3.20 CHILD SAFETY
3.21 THE 'HOME' MEETING
3.22 PROMOTING RESPONSIBLE CHILDREN (EMPOWERMENT PROCESSES)

For each Section, from 1.1 - 3.22, there is an explanation at the beginning, which outlines what the section is about and why it is included. At the end of each section are TASKS to complete. These are key tasks that must be completed and implemented so that the organization has a working model. There are examples below from each part, to show what this looks like.

PART 1 - LEADERSHIP AND MANAGEMENT

1.1 THE PRIMARY TASK (MISSION) AND CORE VALUES

Given the challenging nature of the work, organizations that work with traumatized children must be clear about their primary task. The primary task is the task the organization must perform over and above everything else – the reason for its existence. For example, - is the primary task may be, to safely contain children or to enable them to recover from their experiences? Clarity on this makes a significant difference to all matters of the organization's activity. The precise definition of the 'primary task' is essential and constant vigilance is needed to stay 'on task', faced with the ever-present challenges involved in the work.

As well as having a clearly defined task, the approach to the task or methods and tools used also need clarifying.

The therapeutic approach in all its details, the resources used, and how they are applied and organized, should give the best possible fit with the primary task. Both the 'clinical' approaches used in working with children and the way the whole organization works are relevant to the task. The organizational culture needs to support and facilitate the work with the children in a complementary way. A theoretical understanding of what is being 'treated' - and with what 'aim' - is necessary, so that theory can be applied to practice.

Processes and therapeutic approaches, however sophisticated will be of limited value unless they are embedded within a culture that reflects their core aims and values.

TASKS: THE FOLLOWING NEED TO BE DEFINED

- The organization's primary task (mission).
- The organization's core values, which will underpin the primary task.
- The type of children who are suitable for this task and how they will be selected.
- The methods that will be used in the work.
- The resources that are needed, how many carers, managers, directors, consultants, buildings, vehicles, etc.
- How the resources are organized to support the primary task.

1.4 THE LANGUAGE OF THE ORGANIZATION

The children's trauma will have an impact on everyone in the organization, both directly and indirectly and everyone will have an emotional response to this. In the same way, everyone's response will have an impact on the children, directly or indirectly. The organization provides a therapeutic milieu, which is about recovery from trauma. Therefore, the organization needs to have a shared language and understanding related to trauma. The language of the organization needs to be embedded within a trauma-informed culture.

The organization needs to have a clear understanding of child development, trauma, and recovery. There are theoretical variations on these themes. Therefore, a consensus on the core theoretical foundations, organizational beliefs, and therapeutic approaches needs to be agreed upon. Once the underpinning theory has been mapped out, it needs to be converted into a straightforward language that is understandable to everyone. This can then be incorporated into training, daily interactions, supervision, and other processes.

TASKS

- Clarify the language that will be used in the organization to describe the work that is taking place and to communicate within the organization.
- Set up processes that may be necessary to develop this, for example, workshops and training sessions for everyone who works in the organization.

PART 2 - ORGANIZATIONAL CULTURE

2.10 THE IMPORTANCE OF BOUNDARIES

To support the therapeutic task the whole organization will need to be clear about its boundaries. The larger and more complex the organization the more challenging this is. The whole boundary system of the organization will be experienced and internalized by everyone in the organization, including the children. The clearer the boundaries are

between different roles and departments, the less confused everyone will be and more able to maintain clear and appropriate boundaries in working with children. A clear structure of authority where it is understood exactly who is responsible for what is especially important.

The organizational culture and structure need to be compatible with the therapeutic task. Miller (1993, p.4) described how effective management of the 'holding environment', (taken from Winnicott's (1990) idea of what a mother provides for her infant) of an organization can promote psychological security for its staff. Talking about organizations whose task is to provide care, he states, that there is,

> … the need for a match between the holding environment that staff have to provide for their clients or patients and the holding environment that organizations and management provide for them.

For example, a management structure that allows little autonomy and responsibility in the staff is not likely to encourage the growth of autonomy and responsibility in the children. Boundaries are established around and within a home that give individuals an appropriate amount of space within which to negotiate and make choices.

Organizations that work with traumatized children can expect considerable difficulty in maintaining effective boundary management. There are several reasons for this. The work involves significant levels of anxiety that will impact those working directly with children and the whole organization.

Maintaining clear boundaries is especially difficult when people are anxious and where boundaries are being continuously tested. Thinking becomes difficult and management can become reactive and too rigid or on the other hand too permissive due to fear of negative reactions. In many ways, the dynamics of abuse, denial, and secrecy, can infiltrate the whole organization. There is always the danger that organizations can become closed systems much like those in which family abuse occurs.

When we are working with children traumatized by abuse, and particularly sexual abuse, being clear about things is often responded to as if it is abusive. This can lead to collusion as a way of avoiding the anxiety involved. The concept of 'tough love' can also be challenging for the organization to manage. On the one hand, providing care for some of society's most ill-treated and vulnerable children, but on the other also needing to be very firm and resilient in the work with children. Many people come into the work wanting to provide love and care for the children and find themselves being reacted to as if they are being hurtful and abusive.

For the worker to be supported in thinking about and understanding the difficult feelings we have described, there must be specifically designed forums for this purpose. The forums, which can include supervision, team meetings, consultancy, and training, will need to be clear in terms of boundaries and tasks. They will need to be reliable and consistent. In working with children who present such challenges to our: emotions; thinking; and ability to hold boundaries; and where staff must deal with high levels of uncertainty, it is helpful that

the key structures for staff support are reliable and predictable. This helps create a sense of security.

In the cultural context, it is mainly about ensuring the culture reflects clear and respectful boundaries. What are the cultural norms about behaviour? Is the culture respectful and informed on the subject of appropriate boundaries? It is a bit formal and informal. So, on the one hand, it is important within the culture for people to have a clear sense of each other's roles, responsibilities, authority, etc., and also how to behave with young people so that anyone regardless of role always behaves sensitively and appropriately. But also, the informal bit - how do people talk to each other, interact, etc.?

Issues of gender, sexuality, ethnicity, disability, race, etc. come into it. What is allowed implicitly as well as explicitly in the culture – what is appropriate? Are there expectations for every employee and also board members, etc. matters such as dress, and language? The whole organization must be trauma-informed so that the cultural understanding and implementation of boundaries are aligned with the primary task.

TASKS

- Set up a process for clarifying the boundaries between systems within the organization, who should be involved, etc.
- Clarify the boundaries between systems within the organization, for example, between the home and senior management team, and between the finance department and the home.
- Clarify who is responsible for managing each boundary. For example, who is managing the home boundary, and who is managing the senior management team boundary? Once this is clear, it also becomes clear who should be talking to whom about an issue between the home and senior management.
- Draw and agree on an Organization Chart.
- Define a pattern of meetings to review/reflect on work done and plan forward.

2.12 THE NATURE OF AUTHORITY

To manage the systems and their boundaries effectively, the organization beginning with its leader needs to know what its authority is and then exercise it appropriately in line with the therapeutic task. With authority comes the requirement to take responsibility and to be held accountable. If authority is fudged, no one knows who is responsible for what, and holding anyone accountable for anything is impossible.

It is immediately clear how this issue is directly relevant to the development of children, whose relationship with authority is often immature, negative, and distorted by their experiences. The way the leader exercises her authority provides a role model for the whole organization and is central to the therapeutic task. Menzies Lyth (1985, p.242) argued,

> It seems a fault in many children's institutions that they do not handle authority effectively. There may be too much permissiveness, people being allowed or encouraged to follow their own bent without sufficient accountability, guidance or discipline. If this does not work (and it frequently does not, leading to excessive acting out by both staff and children) it may be replaced in time by an excessively rigid and

punitive regime. Both are detrimental to child development. The 'superego' of the institution needs to be authoritative and responsible, though not authoritarian; firm and kindly, but not sloppily permissive.

TASKS

- Clarify the key principles related to the appropriate nature of authority within the organization.

PART 3 - PRACTICE

3.17 OUTCOMES

Once the primary task is defined and the category of children identified, it is then very important to define the outcomes that will be aimed for. Work with traumatized children is complex and it is, therefore, possible that the approaches adopted might not work. Progress might also be variable. For example, some children take one step forward and then two back. Others might seem to be stuck for a long period and then suddenly seem to move forward. Therefore, it is important to keep an open mind on any evaluation. Regular assessment can be an essential tool in thinking together as a team about a child, considering how they are getting on, what seems to be working or not, etc.

Despite the unpredictable nature of progress in the short term, if a program is effective, it should be possible to identify generally positive outcomes for groups of children in the long term. By defining clear and achievable outcomes at the beginning, expectations can also be set realistically. Clarity of outcomes will also help to ensure that the best methods and resources are used to achieve the outcomes.

TASKS

- Define the outcomes that will be aimed for in the work with children.
- Define how progress towards the outcomes will be assessed, what assessment tools will be used, who will use them, and how often.
- Define a process, such as an individual care plan that will ensure children's needs are consistently met based on the assessment.
- Clarify how children's progress will be documented and reported internally and externally.

3.18 THE IMPORTANCE OF THEORY

A 'trauma-informed approach is best suited to organizations that provide therapeutic care for traumatized children. This approach is evidence-informed and influences all aspects of the work,

- the work with individual children
- the work in groups
- the way we organize the home environment and daily routine
- the way we run our organization and work together
- and our relationship with the wider community

Bloom (2005, p.67) defined a trauma-informed organization as one,

> ……that heals from its own past history of chronic stress and trauma and rejects the notion of inevitable crisis is an organization that is able to contain the emotional turmoil so characteristic of working with traumatized individuals without becoming "trauma-organized" itself.

Tomlinson (2004, p.17) argues,

> There is no simple solution to recovery from trauma. It cannot be prescribed but needs an environment where it is safe to think about the trauma, experience feelings about it, and make reliable provision to heal it. This type of environment has been referred to as a 'holding environment'.

Children need a secure environment, where they know what to expect and what is expected of them (Perry and Szalavitz, 2006). In the same way, a theory can provide a consistent way of doing things which enables a team of people from different backgrounds and experiences, to work together. In this sense, the theory can provide a form of containment, which helps professionals to think about their work, especially when things become overwhelming and difficult to make sense of. Bloom (2005, p.56) pointed out the potential risks where there is not a clear and consistent theoretical approach,

> The staff often work at cross-purposes without even recognising that their conflicts are due to conflicts in basic theoretical models and instead attribute the problems to the resistance of the children or personality conflicts among the staff.

Emphasising the need for a trauma-informed approach she continues (ibid) to advise that,

> An approach to childcare that takes into account the impact of overwhelming stress on child development is particularly important since it has been established that a large proportion of a residential treatment population have a history of exposure to violence, abuse and neglect.

A trauma-informed approach will include different theoretical perspectives. Kezelman and Stavropoulos (2012, p.76) argue the benefit of this,

> 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.

Theories from the following fields are particularly useful, others may be added.

- ✓ Child Development
- ✓ Attachment
- ✓ Neuroscience
- ✓ Trauma
- ✓ Loss and Grief
- ✓ Psychodynamic
- ✓ Systems

3.20 CHILD SAFETY

From a child safety perspective, all members of the community must be aware of and support the values of the organization. An organization that is fractured, and where negative behaviours and serious relationship conflict exist, could potentially place the children at risk.

An organization that promotes awareness through trauma-informed processes across all departments becomes less vulnerable to trauma re-enactment. The organization needs to be consistent and emotionally intelligent, and the children need to experience the adults' role modelling this too.

Traumatized children often have major anxieties about their 'omnipotence' and their destructiveness. It is common for these children to project their past experiences onto others, particularly parental figures. These projections can be positive and negative, seeing the carer as good or bad. It can often be difficult to differentiate between reality and fantasy for the child, which can be very hard when investigating allegations of abuse.

The organization needs to have clear policies on child protection and complaints procedures to support this work.

TASKS

- Define clear policies and procedures within the organization to support high standards of work, which protect children.
- Ensure that policies regarding children's safety are thorough, such as the child protection and complaints policies.
- Clarify how all staff members will be trained and supported concerning the therapeutic task.

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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.

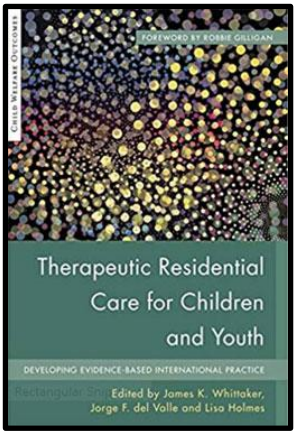
His experience spans from 1985 in the field of trauma and attachment-informed services. He began as a residential care worker in a therapeutic community for young people and has experience as a team leader, senior manager, Director, CEO, consultant, and mentor. He is the author/co-author/editor of numerous papers and books. He is a qualified clinician, strategic leader, and manager. Working in several countries, Patrick 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
- Non-Executive Director

Web Sites: Patrick Tomlinson Associates: www.patricktomlinson.com
CAST (Character Assessment & Selection Tool) www.castassessment.com

Contact – ptomassociates@gmail.com

ENDORSEMENTS



"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."

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Therapeutic Residential Child Care for Children and Young People: An Attachment and Trauma-Informed Model for Practice (Susan Barton, Rudy Gonzalez and Patrick Tomlinson, 2012) *London, Jessica Kingsley.*

"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 organisational 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." Excerpt of a book review, by **Laura Steckley, Course Director, MSc Advanced Residential Child Care, Glasgow School of Social Work, Scotland**

I have had the absolute pleasure of working with Patrick. He is someone who truly models the model. He is kind, caring, interested, reflective, and passionate. Patrick has a unique way of bringing out the best in people and truly trying to see the potential and unique skills of those he works with; including being strengths-based.

I always leave my conversations and interactions with Patrick feeling listened to, stretched in the best possible way, and enriched. Patrick is always learning and seeking knowledge, and this is not only impressive but also wonderful as he is able to integrate so many ideas and concepts from a range of disciplines to create interesting and important links and ways forward.

As well as always striving for better and best practice, Patrick is a keen collaborator and therefore really feels like a team player. What I am often struck by is how containing and calm and thoughtful Patrick is, which is a rare and crucial quality for leaders, especially in the world of trauma. This feeling and sentiment has been echoed to me by many people whom Patrick has worked with. Patrick has a combination of high-quality leadership skills, years of experience within a range of contexts including residential services, and expertise within the area of trauma and attachment- making for a formidable combination; yet does this with humility and humanness.

He is integrity, alongside vision. Patrick is certainly someone I have really enjoyed working with and would go to for advice; as well as someone I would recommend highly and would love to work with again. **Dr. Karen Treisman - Clinical Psychologist, Trainer, & Author of Working with Relational & Developmental Trauma in Children & Adolescents**

From 2021-2025, Patrick has supported Uniting's Therapeutic Model of Care project from creation to implementation. Uniting is a large umbrella organization in Australia, combining 22 organizations, and 7000 staff and volunteers, and impacting the lives of thousands of service users every year.

As the lead development consultant and member of our external advisory group, Patrick provided contemporary and trauma-informed advice supporting the model design, development, and implementation. He also provided clinical supervision to me, as the project lead. Additionally, he facilitated monthly reflective practice for the project team and brought considerable knowledge, practice wisdom, and resources to each part of the process.

Given his significant experience working with organisations globally, his advice was always attuned to operational realities. Patrick is approachable and dependable, and I look forward to future opportunities to work together again. **Tymur Hussein -** Consultant, Developer, & Project Leader, Melbourne, Australia

I have had the pleasure of working with Patrick over the past two years in my role as the project lead for the MASP therapeutic model of care. Patrick was contacted during the decision-making phase of the project, and he later agreed to support MASP with the model development process.

Patrick's vast knowledge of organisational theory and practice, model development, and the writing process was invaluable. He provided weekly online consultations and made himself available for questions and contact in between. We followed his twenty-two-step curriculum throughout the development period and were given access to a curated library of resources, books, PowerPoints, and papers that provided inspiration and direction.

Model development of this kind takes many months. It is a combination of technical work, creative thinking, and persistence. Edwin Friedman (1999, p.127), captures something of the style that Patrick adopted when consulting to MASP:

"Instead of anxiously providing data or offering advice and new techniques, a consultant can provide the kind of inquisitive, non-anxious climate that helps clients view the effects of their own thinking, those clients, whether parents or presidents, can often begin to develop more objectivity and self-regulation with regard to that relationship system."

Independent consultation is, in our view, essential to good model writing. Patrick provided generous support, invited new questions, and contributed new knowledge. The work with him felt like a protected space and a place where learning and creativity could flourish.

On a more personal note, all the consultancy work with Patrick was conducted online and conversations mainly involved just the two of us, with me acting as a conduit and facilitator for the wider development group. Looking back on it all, I am astonished at how much was achieved using this approach. Not only was the model developed and written during the "Covid years", I think it is fair to say that the development process comprehensively transformed the organisation. Whilst we continue to work through the implementation and evaluation phases of the model, we have come a very long way in just a few months.

I have also gained personally from talking with Patrick about all sorts of things that might loosely be called "the context of model development". I was tasked with leading a significant project which, for many reasons, I felt ill-equipped to deliver. Patrick was an unwavering and generous guide. He taught me everything about organisational change process, how to plan, gain traction, and how to see the work through to its end.

Although he often works with experienced and accomplished organisations and practitioners to put the polish on their ideas, I can highly recommend Patrick to those who are just starting out in this kind of work. Having said all that, I hope that we will continue to collaborate for many years to come. **Helena Moore** - Director of Practice, Mallee Accommodation and Support Program, Mildura, Victoria, Australia

His deep knowledge of the development of therapeutic models and his vast field experience made us believe that, in Portugal, and our Residential Home it would be possible to start this process of changing the paradigm of generalist residential care.
After an unprecedented approval of an application to Portugal Social Innovation, Patrick was selected by us as the main mentor in the co-construction of a therapeutic intervention model of the Residential Service (for 40 girls) for which I am responsible. Since then it has been a very intense and exciting experience.

The technical and scientific support he provides is incredible. Patrick guarantees support through a vast bibliography not only published by himself but also by other leading authors, through individual and team supervision on a very regular basis. It allows our professional development and our critical sense. The way of working is in permanent collaboration and co-construction.

I must highlight not only Patrick's high competence but also his characteristics of attention, support, and facilitation of personal and professional reflection processes. In this way and with total freedom and autonomy Patrick has been able to create an opportunity for change, not only at our Home but in each of the people with whom he works more closely, facilitating our professional maturity. Despite not living in Portugal, he has always ensured a physical presence throughout this process and high proximity in meeting our needs and

answering our doubts. I strongly recommend Patrick to all Residential Care Homes and professionals in this field. **Ivone Soares de Almeida - Technical Director, Porto**

It's been fantastic to work alongside Patrick Tomlinson over the past few years, especially to create a therapeutic approach that is young person-focused and genuinely trauma-informed. His theoretical understanding and knowledge of the sector are second to none as is his ability to help organisations embed this in practice. Certainly, Concrete Rose Collective CIC looks forward to continuing the journey together to meaningfully impact the lives of those we support. **Mike Farrington** - Founder and Operational Lead, Concrete Rose Collective CIC, UK

I had the good fortune to benefit from Patrick being a senior manager in a therapeutic residential care setting, early on in my career. During this time, I developed my practice and understanding through his high-quality coaching and mentoring which ultimately supported me into management. Patrick has a deep understanding of therapeutic model development, organisation dynamics, and leadership. I continue to draw on his teachings in my senior management position to this day and he is a go-to mentor, skillful at facilitating self-reflection. **Emma Griffiths - CEO at Gloucestershire Counselling Service, UK**

I have had the pleasure to work collaboratively with Patrick Tomlinson Associates for over 3 years. The key to the success of the work has been the way we have established a strong working relationship across international boundaries. Patrick has brought a variety of essential skills to the projects that we have worked on. He has demonstrated great knowledge and expertise, reliability, and high-quality work, and has always delivered on time. His service has been very productive and cost-effective, due to his ability to systematically work through any potential challenges that would take a less evolved individual many additional months. We are now in a position where we are ready to achieve our strategic aim of transferring our practice model to organisations across Australia and then internationally, thanks to the enormous contribution of Patrick Tomlinson.
Rudy Gonzalez - Executive Director (Former), Lighthouse Foundation, Australia

I worked with Patrick when he became Interim CEO at **Three Steps.** We worked hard on establishing our model. Everyone was included, all staff, the young people, and adults in our care. Mission and values were created, and the entire organization responded and endorsed them. This became a unique driving force to continue improving quality. A full structure review took place ensuring clarity on roles and responsibilities, and oversight measures. This provided containment to the organisation. Through this cultural change, everyone began wanting to be a part of creating therapeutic environments, for all to flourish. The head office which was previously all one white colour was transformed with child-friendly spaces, fingerprint trees, children's art, and sensory integration items. The children's homes became more colourful, welcoming, and homely. During the two years that I worked with Patrick; I can only describe what took place as a process of transformational change. **Eilis Carroll - CEO/Director of Care Services (former), Three Steps Residential Assessment and Intervention, Ireland**

I have been leading a 3-year research project funded by the Japanese Ministry of Health, Labour and Welfare. We are researching worldwide, effective approaches in working with traumatized children in residential and foster care. I have consulted with Patrick Tomlinson for over 2 years by email and he visited Japan in 2012 and 2013 to work on the project. His advice and assistance have been so great, helpful, reliable, prompt, kind and warm, and fit to Japanese society. He is the very right person to quickly understand the situation and the problems of 'looked after' children in Japan, visiting several children's homes, talking with carers of children's homes, foster parents, senior executives, and professionals. **Dr. Hisayo Kaihara - MD (Child Psychiatrist), Tokyo, Japan**

I have known Patrick for 25 years. I have worked with him in several organisations in the UK and Ireland. These organizations deliver therapeutic services to young people who have attachment and/or learning difficulties. Patrick has always sought to develop models of care that provide a secure base to contain, orientate, and inspire the individuals and teams who carry out such important and difficult work. He understands how leadership and management structures need both to reflect the model of care and to facilitate its implementation.

He has a proven track record of delivering positive organisational change that results in enduring and successful outcomes for clients and staff. He has an impressive aptitude for identifying core issues and developing practical plans of action. **Paul Van Heeswijk - Consultant Child and Adolescent Psychotherapist**

Patrick has been very helpful in assisting with the therapeutic model development for the service I lead. It has been a tough but very fulfilling journey. Being mentored by Patrick has definitely been of most importance for the achievement of positive results. **Rui Lopes - Director de Casa de Acolhimento Residencial, Lisbon Area, Portugal**

I have known Patrick since 1985 when he joined the staff team of the Cotswold Community, a pioneering therapeutic community for seriously emotionally damaged boys, as a Residential Social Worker. He developed into a team leader and manager and then a member of the senior management team, responsible for the whole Community. He developed the staff training into a 3-year accredited programme and psychological testing for staff selection. Patrick has had several papers and books published on all aspects of therapeutic care. He has acted as a consultant and trainer to several organisations in several countries. He has acquired a combination of skills, unusual in their breadth and depth, based on his lived experience as a therapeutic carer, manager, leader, trainer, and consultant. **John Whitwell** - Former, Principal of The Cotswold Community, and Managing Director of ISP, UK