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Non-Directive Play Therapy with Children and Young People in Residential Care: A Qualitative Study of Play Therapists' Experiences.

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Abstract

There are approximately 7630 looked after children in residential care (dcsf, 2007). The prevalence of mental health issues for looked after children in residential care has been identified as high (McCann et al, 1996). Recognising their increased need and particular circumstances it has been suggested that looked after children and their carers should have access to specialist mental health support and intervention (DoH, 2002). Non-directive play therapy (NDPT) is one therapeutic option that has been employed in some residential settings, despite the constraints of these settings perhaps being at odds with the way in which play therapy is classically practiced. The experience of conducting NDPT in such settings was explored by questioning seven play therapists using a semi-structured interview about their work with children in residential care. The resulting interviews were transcribed and analysed. The themes that emerged highlight the complexity of the population of looked after children in residential care, and the challenges of establishing the necessary support for interventions to occur effectively. The suggestion that conducting therapy with this client group presents particular challenges has implications for practice.

Acknowledgements

I would like to express my thanks and gratitude to the therapists from around the country who volunteered to participate in this research and were willing to share their experiences with me. I enjoyed hearing their thoughts and found their accounts and opinions fascinating. My thanks are also extended to both my official supervisor for his comments, patience and endurance and my unofficial supervisor- my sister, for her tips and guidance. Both offered support and direction and helped ensure that what I wanted to convey would be heard by readers. Additional thanks go to those who helped with proof reading. Finally, thanks goes to the York course for inspiring me to investigate non-directive play therapy and work with children in residential care more deeply, and connected me to a great group of people.

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Reflexive Preface

This study aimed to explore and investigate play therapists' experience of working with children in residential care. The research topic arose from personal interest, having previously worked both as a residential worker and as a play therapist with children in residential care. It was clear from play therapy literature, studied during my play therapy training, that many considerations held as important for appropriate referrals, are difficult to achieve in the residential setting; such as consistency of support and stability of placement. However, the literature also indicated that play therapists work in a variety of settings with looked after children in residential care; through Children and Adolescent Mental Health Services (CAMHS), schools, privately and as permanent employees of residential care homes. Therefore, I became interested in the experiences of therapists working in these contexts and how they viewed their work, what issues they found and how they practically addressed them if they did arise. I hoped that through this research I would gain a wider understanding of the issues that are experienced in settings other than my own and whether there were common areas of difficulty, or perceived advantage, for play therapists working with children in residential care. I hoped that investigation of this area could provoke thinking and consideration around play therapy with looked after children in residential care and provide suggestions for effective working.

Chapter 1

Literature Review

Literature Review

A thorough search of the relevant literature was attempted (see Appendix 1 for details of the approach used)

Introduction

In investigating the literature around the use of non-directive play therapy (NDPT) in the residential setting it became clear that there was not a great deal written directly on this topic. It was therefore important to explore research concerning both the concept of residential provision and how therapy, of various types, has or has not been incorporated into this client group's care. Residential provision for children in England takes many forms including, local authority homes, hospital units, special schools, residential schools, children's homes, secure accommodation, and therapeutic communities. Within these settings the number, age and backgrounds of the children and young people can vary considerably (Utting, 1991). For the purposes of this research, residential provision referred to will only include care for 'looked after' children (the Children Act, 1989) in England without physical impairments and who have not entered the Criminal Justice System to the extent that they are accommodated securely or in youth offending units.

Brief History of Residential Care in England (1944 – 2009)

Over time the aims and objectives of residential establishments and the care provided has changed dramatically; these changes paralleling the way in which the client group has been viewed, labelled and treated. In 1944, the Curtis Committee investigated the provision for children who did not have a normal home life. They found significant variation in the care offered with some provisions considered Dickensian (House of Commons, 1998). Their recommendations were incorporated into The Children Act, 1948 (Smith, 2009). The Act emphasised foster care as the preferred form of substitute care for young people. Despite this preferential view of foster care, the number of children in residential care in the 1950s and 1960s remained high, over six times that of today (52122 in 1958-9, Balbernie, 1966:35).

In the 1980s and 90s a number of scandals and subsequent investigations (e.g. the 'Pindown' inquiry, Levy & Kahan, 1991 and the Waterhouse report, 2000) may have increased suspicion of residential provisions and contributed to the very definite shift against residential care. In the decade between two research investigations carried out by Berridge (Berridge, 1985 and Berridge & Brodie, 1998), sixteen of the twenty original homes studied had closed, and the number of children in England living in children's homes on any one day had more than halved, reducing from around 16000 to 7700 (Berridge & Brodie, 1998:12).

Poor outcome statistics together with multiple scandals and comparatively high costs to other forms of care (Utting, 1997; DfES, 2006; House of Commons,

2009) have contributed to group care being seen by some as negative both theoretically and financially (Smith, 2009). In England today around 7630 children are cared for in residential settings (dcsf, 2007, data as of 31 March 2007, excluding secure accommodation and medical provisions). However, many children who enter the care system do so for only a brief period (McAuley & Young, 2006) therefore many more children experience residential care in any one year than is seen on an individual day.

Residential care has been viewed by many English local authorities as a last resort (Smith, 2009), a view less prevalent in mainland Europe (Petrie et al, 2006). Despite being viewed unfavourably, it is acknowledged that for some young people residential care is a necessary, and at times the preferred, option (Rodway, 1981; Thoburn, 2007; DfES, 2007; House of Commons, 2009).

The Mental Health Needs of Looked After Children

A high prevalence of mental health problems has been identified in the looked after population and particularly for children in residential care. McCann et al found 96% of the respondents in residential care could be identified as having a psychiatric disorder compared to 57% of those in foster care and 15% in the comparison group (1996:29). McAuley & Young (2006) refer to a number of studies which highlight the disparity between the prevalence of mental health problems in looked after children compared to the general population. The mental health problems for these young people are not restricted to their current circumstances; care leavers are disproportionately represented in adult mental

health services, they are more likely to be involved in substance abuse, suffer from depression and commit suicide (Rushton & Minnis 2002, cited in Kendrick, 2008).

Research suggests that mental health provision for looked after children in residential care is deficient (Hunt & MacLeod, 1999, cited in Aldgate & Statham, 2001; Berridge & Brodie, 1998). Blower et al (2004) found that even where young people's mental health needs have been identified there is frequently a gap in the delivery of effective interventions. Others have found that despite a high level of mental health referral, few children receive treatment (Jackson et al, 2000 cited in DoH, 2002).

Recommendations and additions to policy have emphasised the need for the mental health needs of young people in residential care to be addressed effectively (DoH, 2002; House of Commons, 2009) and highlight the importance and necessity of collaborative practice (DfES, 2003). Over the past decade additional funding has been allocated for targeted CAMHS provision for disadvantaged groups (Charman, 2004). The CAMHS Innovation Grant, 1998 (referred to in Kurtz & James, 2002) has led to a number of projects which recognise the importance of consultancy as well as direct work with looked after children. Some projects have attempted to address the specific needs of the looked after population by organising direct access services and offering training and support for residential staff (e.g. van Beinum et al, 2002; Arcelus et al, 1999). These projects purport to be responsive and flexible, providing ease of access and a range of services. Arcelus et al (1999) argue that services for this group need to

take into account features such as high mobility and lack of advocacy, otherwise more stable populations will always take precedence. However CAMHS projects specifically targeting looked after children in residential care are not universal. A recent review of CAMHS has again confirmed that access to mental health provision by looked after children is often unnecessarily delayed and hindered (dcsf, 2008). Therefore how such projects become integrated into the wider CAMHS network and reach children and young people in the wide range of residential provisions across the country remains to be seen.

Why Individual Therapy May Not Be Accessed For Looked After Children In Residential Care.

There may be reluctance in seeking out therapy for children in residential care because of the legacy of unethical practices and apparent therapeutic justification which were used by perpetrators of abuse in residential care exposed by the inquiries of the 1980s and 1990s. The 'Pindown' regime in Staffordshire children's homes (Levy & Kahan, 1991) was a direct example of where therapeutic ideas were warped into abusive practice. In the abuse investigated in Leicestershire children's homes therapy was again associated:

> 'Based on a curious mélange of the work of Dockar-Drysdale, Bettelheim and a Canadian film called *Warrendale*, Beck and his associates developed a form of 'regression therapy' with difficult and disturbed adolescents which came to provide a cover for their systematic humiliation and abuse,

both physical and sexual, of the young people and junior staff involved (Kirkwood, 1993).' (Daniels & Jenkins, 2000:51).

This suggests that any therapeutic work carried out with children in residential care needs to be carried out by trained professionals who are accredited and adhere to the guidelines agreed by the appropriate governing bodies (e.g. BAPT, BAADTHa BAAT, UKCP and the HPC).

Some have suggested that another reason why services may not be accessed by children in residential care may be because these children do not 'have advocates or stable figures to seek support of this kind for them' (Polnay et al, 1996 cited in Arcelus et al, 1999:242). The lack of a consistent, full-time, primary care figure is a natural consequence of group care and temporary placements associated with residential care.

Historically some CAMH services have had to limit their work to children in permanent placements to better manage their caseload resulting in looked after children being unable to access services because of their mobility (Barrows, 1996). Government initiatives around specialist services for vulnerable groups and reducing waiting times have made improvements in this area (dcsf, 2008). However, targets have not been universally reached and children in care may still lose contact with services while they are waiting to be seen, due to the transient nature of the population (dcsf, 2008).

Many therapy modalities advocate a degree of stability and containment before any individual therapy should commence (Boston & Szur, 1983; Cattanach, 1992). Some therapists may feel that, simply due to the living arrangements, multiple carers, and likely transitions associated with children in care (Utting, 1997, Smith, 2009) direct therapy would not be advisable. Some literature suggests however, that an individual therapeutic relationship would be in the child's best interests and could possibly help them, even when they are not in a stable family environment (Copley & Forryan, 1997). However, there have been a number of objections to the use of the more traditional psychotherapeutic approaches with looked after children, firstly due to their reliance on verbal exchanges and secondly in that they may expect children to acknowledge some of their defences, when doing so could be harmful (Zimmerman, 2004). Defences that may be in place could be sustaining the child's ability to function and without them they could be even more vulnerable, particularly as being in care can be viewed as continuing traumatic life circumstances (DfES, 2006).

The Therapeutic Milieu as an Alternative to Individual Therapy

Therapeutic communities function in a way designed to overcome some of the problems identified above. They recognise the specific psychological and therapeutic needs of children living away from home with a history of abuse and how this may impact on their ability to engage with individual psychotherapy.

'verbal interpretation often cannot be used with our very ill clients. It will then be what we do rather than what we say that can be of use to them' (Dockar-Drysdale, 1990:159-160).

Therapeutic Communities emphasise the importance of the therapeutic milieu and see this as the catalyst for change for severely damaged children (e.g. Trieschman et al, 1969). Therapeutic Communities also have consultancy from trained child psychotherapists (Tomlinson, 2004; Dockar-Drysdale, 1993). However, the role of therapy can be inconsistent in organisations purporting to be therapeutic communities. In some a consultant would only meet with staff, in others the consultant may also be involved in individual work with young people (Cant, 2005). In the current economic climate, with residential care costing significantly more than foster care (Utting, 1997), local authorities may prefer to know they are funding direct professional time with their child rather than difficult to quantify consultancy.

Tomlinson (2004) describes the Cotswold Community where consultation from a psychotherapist is provided weekly but individual sessions occur between children and residential staff. Tomlinson's description bears striking resemblance to therapy yet it is carried out without training, personal analysis or the oversight of a governing body. Dockar-Drysdale (1993) even expands on Axline's (1947) eight principles of NDPT believing that they are relevant to the playing she is describing care workers should have weekly with their allocated child:

> ‘What I have been putting forward is the suggestion that child care workers, although not psychotherapists, can nevertheless do valuable therapeutic work of a special kind. I am suggesting that some of this already existing play could be channelled into non-directive play therapy.’ Dockar-Drysdale (1993:155).

In reading this apparently spontaneous use of play therapy without training it should be remembered that the British Association of Play Therapists (BAPT), was set up in 1992 and the codes of practice and conduct as well as guidance on supervision were only agreed in 2002 (www.bapt.info.com). In fact it could be that the importance and effectiveness of these sessions referred to by Dockar-Drysdale led to increased numbers of people seeking training and wanting to become play therapists.

It could be argued that with increased standardisation through government guidance and legislation (DfES, 2003; DoH 2002a); aspects of care that were at one time unique to therapeutic communities, are now expected in the basic childcare provided by all residential homes. McMahon (2009) explicitly recognises that well contained and managed care supporting the child throughout the day is not exclusive to therapeutic communities and can occur in other provisions too, such as local authority homes.

Integrating Individual Therapy With Residential Care

Some therapists have advocated combining individual therapy with milieu therapy and argue for more flexible working practices to be incorporated into child psychotherapy (Günter, 2005; Cant, 2002):

> 'In my view, individual therapy is not something that contrasts with milieu therapy, but something that offers space which can be intensively exploited in the framework of a holding and protecting therapeutic milieu where work can be done on transference and inner conflicts on the one hand, and personal care, encouragement and support can be provided on the other.' Günter (2005:172).

Others also advocate for practice to adapt to facilitate work with looked after children, these suggestions are not restricted to psychoanalytic psychotherapy. For example McMahon (2009), referring to play therapy, supports the assertion that confidentiality has to be held by the team when working with children in residential care.

Play Therapy With Children in Residential Care

In researching individual play therapy with children in residential care it was clear that there is little current research. It is hard to find any reference to children in residential care in some of the key play therapy texts (e.g. Landreth, 2002). Although some earlier play therapy texts include many references to play therapy

in this context (West, 1996; McMahon, 1992) the reduction in residential population and changes in employment regulations that have occurred in the past decade and a half may make some of their comments outdated.

Current government guidance recognises that therapeutic work with looked after children is critical (DoH, 2002). However, 'relatively few intensive child therapy outcome studies for maltreated children exist in the psychological literature' (Ryan, 2004:76). The residential population is a relatively small percentage of the overall population of maltreated children and therefore there is understandably even less research directly relating to this client group.

The few studies that do reflect on play therapy with children in residential care often refer to a specific residential setting which may have qualities that are uncharacteristic of the majority of residential homes in England (e.g. Doyle & Stoop, 1999; Crenshaw & Foreacre, 2001).

Play therapy has recently been more clearly defined as a time-limited intervention (Ryan, 1999). However, some play therapy practitioners have suggested that when a child has experienced significant trauma or has serious attachment issues a more open-ended and long term intervention is more appropriate (West, 1996). It has also been suggested that in complex cases other interventions such as educative work or family therapy, may be necessary to incorporate into a child's care package, in addition to NDPT (West, 1996; Ryan, 1999). Others, such as Crenshaw & Foreacre (2001), believe that when working with this group of young people certain adaptations in approach or practice may be necessary.

Some of the challenges to therapy with this client group and some of the adaptations used in response to these are described below. Many of the issues are not exclusive to NDPT.

Establishing a Therapeutic Relationship

Kasinski saw a child's inability to tolerate being cared for in a family being likely to indicate that they would not be 'amenable to most of the commonly available forms of supportive or reparative work' (2003:43). Tomlinson (2004) described the trauma in a child's early years and subsequent failures to provide containing care as causing the child to find developing trust in a relationship very threatening. This suggests that establishing a therapeutic relationship may take longer when a child has attachment issues or is 'looked after'. In addition, when the child does experience the possibility of a connection they may react with basic fight or flight responses to avoid the threat they perceive (Crenshaw & Foreacre, 2001). This could result in sporadic attendance or the need for longer interventions, both of which may be unmanageable and unacceptable by the purchasing organisation when waiting lists and budgets become part of the equation.

Others have argued that when a child is getting used to new carers, a new school and a new area they may not be willing or able to make use of a therapist, viewing them as yet another stranger (Hunter, 2001). This suggests that the child would need to feel a level of stability in their day to day lives before a therapeutic relationship is introduced.

The importance of therapy being experienced as non-threatening suggests that using a medium such as art, drama, music or play may be more appropriate than an analytical approach (Mann & McDermott, 1983). As it has been seen that neglect and abuse can lead to developmental delay, (Crittenden, 1985) a non-verbal approach may also be advantageous so that cognitive or verbal competence does not limit the child's ability to engage in the therapy.

Working With a Team Rather Than Main Carer

Many researchers have highlighted the importance, when working with severely disturbed young people, of the therapist's role with the wider system (e.g. Wiener et al, 1999; Crenshaw & Foreacre, 2001; Sprince, 2000). Both psychoanalytic and humanistic therapists have advocated the importance of the therapeutic alliance between the therapist and other professionals involved in the child's care (Hunter, 2001; Cant, 2002, 2005; McMahon, 1992; Ryan, 2007). Recent government reports have also echoed such an approach, for example 'Promoting the Health of Looked After Children', (DoH, 2002) emphasises the need for CAMH services working with looked after children to recognise that as important as seeing the individual children is the training and consultation offered to the carers. 'It is particularly important…when working with children in statutory settings, that all those involved in caring for them work together to provide an enabling milieu which supports therapeutic progress.' (Wilson & Ryan, 2005:232). Such a statement bears some resemblance to what was original proposed by the

therapeutic communities but perhaps also allows for integration with the child's wider world to include social workers, family members and education.

However staff turnover within residential care has been identified as high (Berridge & Brodie, 1998) this, in addition to high staff / child ratios (House of Commons, 1998) could mean the therapist is faced with sharing aspects of a child's therapeutic hour with a repeatedly changing group of twenty or so residential staff and other professionals. This could obviously feel incredibly exposing and suggests creative thinking needs to be given as to what should be shared in order to benefit the child and who this should be shared with to maintain an acceptable level of confidentiality.

Limit Testing

'Children admitted to a residential treatment center typically manifest a degree of behavioural and / or emotional disturbance considerably more severe than children who can be treated in community-based settings.' (Crenshaw & Foreacre, 2001:139). The level of violence, sexualised behaviour and the risk of allegations could make one to one work with children in residential care incredibly anxiety provoking (Crenshaw & Foreacre, 2001) and possibly unmanageable for some therapists or young people. Repeated destructive behaviour will present difficulties for music therapists, art therapists, play therapists and other disciplines, particularly if the room has multi-purposes or the same materials are required for other clients.

The necessity of clear, firm limits reassuring the child of their safety has been highlighted as critical with maltreated children (Ryan, 2007). The associated attachment difficulties for this group are likely to lead to more testing behaviours (Howe, 2005); their internal working model of relationships may lead them to anticipate rejection and initiate maladaptive attachment behaviour in the one to one situation.

Support For Therapists

Children in residential care are typically highly complex cases, a high proportion of whom have suffered multiple abuse and neglect. By being in residential care children are also likely to be exposed to additional stressors such as loss of primary care figure, disruption in their education and social life and exposure to other children's abusive histories and consequential behaviours (DfES, 2006; Barter, 2003).

Due to the child's early experience, the content of the therapy is likely to have a significant impact on the therapist. 'The therapist loses her innocence; simple physical contact loses its simplicity, and memories of children's stories of abuse contaminate sexual relationships.' (Cattanach, 1992:147). Sprince (2002) refers to being terrified at times when working as a psychotherapist with the most challenging adolescent boys in a special boarding school. Through her training, personal analysis and clinical supervision Sprince describes how she was able to better understand the intense feelings she experienced as unconscious

transmissions from the child and use this to support the wider organisation and care staff.

Crenshaw & Foreacre (2001) believed it was an advantage of residential work that there is a network of support available to both children and staff. They recognise that without colleague support and supervision the work could become overwhelming. However, if the therapist is independent and only employed for their clinical hours with individual children, support from the shared experiences and understanding of others is unlikely to be available and they will have to rely on their clinical supervision. Some homes may not be able to afford additional consultancy time for the care staff and therefore this sharing of the experience and feelings would be limited for the care staff too.

Location of Therapy

Offering therapy within the residential setting eases the problem of transport difficulties and helps integrated working (Kot & Tyndall-Lind, 2005). However working with children on-site produces additional threats to the therapy hour's safety through disturbance from other residents, particularly if staff are not wholly supportive and understanding of the intervention.

Stability of Placement

'Play Therapy with abused children can only be effective if the child is reasonably safe.' (Cattanach, 1992:50). This suggests that therapists need to be aware of the

risk of further abuse from the original perpetrators and assured of the child's safety in the home. Safety is also compromised by the mobility of looked after children (Barrows, 1996). Care Matters (DfES, 2006) identified that children in care are moved between placements far too frequently and this can negatively affect many areas of their lives. Multiple moves not only impact on the practicality of therapy but could jeopardise future engagement (McAuley, 2005). Therefore the timing of a therapeutic intervention is critical to avoid poorly timed disruptions which could have lasting implications.

Evidence Base

Considering the above areas some suggestions as to the application of therapy within the residential context may be hinted at, however there is little empirical evidence comparing different approaches' efficacy with this client group (Hunter, 2001).

One reason for the lack of consistent messages about the success of therapeutic interventions may be the diversity of residential provision for looked after children. The diversity as well as significant change within the same establishments due to legislation over the past 20 years makes it difficult for best practice and successful interventions to be identified; long-term follow-up can be seen to be out of date quite quickly.

'Innovations take many forms, but few are properly evaluated and many are abandoned even before they have been rewarded with criticism or review.'

(Berridge & Brodie, 1998:54). Cameron (2006) discusses the importance of evidence-based practice but recognises that research methods or measurements typically used may not be appropriate to investigate therapeutic treatments.

What constitutes a good outcome for this client group has also been debated; some have suggested that with a severely deprived client group our idea of what a successful intervention outcome looks like, may need to be significantly altered (Wiener et al, 1999).

Summary

As has been seen through this chapter, the needs of looked after children pose particular problems to mental health services (McAuley & Young, 2006). They need to accommodate this population that can move over a substantial geographical distance and have a succession of different primary carers. A population whose presenting behaviours mean that waiting lists and long referral processes could result in additional placement breakdowns. A population where the prevalence of mental health problems is high (Meltzer et al, 2003) the care task is stressful (Smith, 2009) and the level of training of the residential staff has continued to be problematic (House of Commons, 2009). Therefore 'Approaches need to address both the needs of the young people and their carers.' (McAuley & Young, 2006:98) and be willing to engage in work where placement stability is unlikely to meet the criteria that is usually required (Callaghan et al, 2004).

The literature in relation to the successful application of NDPT with children in residential care was identified as scarce and typically focuses on an individual residential establishment, which may have qualities that are uncharacteristic of other residential homes. It is hoped that through this research a greater understanding of play therapists' experiences working with children in residential care and what they believe helped or hindered effective working, in a variety of settings, will be explored. The following chapter describes the methodology employed to achieve these aims.

Chapter 2

Methodology

Methodology

Introduction and Research Aims

As described in the previous chapter, the literature concerning play therapy with children in residential care is sparse and typically focuses on single cases or isolated provisions. Therefore many areas were identified that could benefit from further exploration in relation to the practice of play therapy with children in residential care.

The primary focus of this study was to explore the views and opinions of play therapists working with children in residential care from a variety of different settings and work contexts to better understand how they viewed the role of play therapy for this client group and the extent to which the residential context did or did not impact on their work. This chapter examines the methodology applied in conducting this research.

The aim was to elicit opinions and to gain insight into aspects of individuals' practice, so a qualitative rather than quantitative approach was identified as most appropriate (McLeod, 2001; Flick, 2007, Silverman, 2000). Qualitative research cannot lead to statistically generalisable results however it can 'identify the factors that contribute to successful or unsuccessful delivery of a programme' (Ritchie & Lewis 2003:29). The specialist nature of the sample group (play therapists) and the complexity of the systems involved also suggest a qualitative approach is most appropriate (Ritchie & Lewis, 2003).

As the aim of the research was to understand the phenomena from the perspective of those involved; namely the play therapists, a phenomenological approach was identified as appropriate. In phenomenological research, 'the aim of the researcher is to describe as accurately as possible the phenomenon, refraining from any pre-given framework, but remaining true to the facts.' (Groenewald, 2004:5). The phenomenological approach believes that it is impossible to reach a certain and unequivocal understanding of social phenomena; that people can only be certain about how things appear to themselves. Any cause and effect arguments should remain speculative. However, these methods do play a key role in identifying important influences and generating hypotheses about social phenomena (Ritchie & Lewis, 2003).

Interviewing is a widely used qualitative data-collection technique (Holstein & Gubrium, 2002) due to its flexibility and the personal responses it can elicit (McLeod, 2001). A semi-structured interview was chosen, as it is an appropriate data collection method for phenomenological research (Creswell, 2007).

Individual interviews are more accessible than focus groups and therefore ideal for a busy population that is geographically dispersed (Ritchie & Lewis, 2003); the interviewer could travel to them at a time that was convenient for the two participants concerned (interviewer and interviewee).

Selection of Participants

A purposive sample was sought to include participants who had experience of working with a variety of residential care provisions. It was hoped that a variety of employment statuses would also be obtained, i.e. independent, employed permanently by the home or employed by the health authority. This enabled key comparisons and patterns to be identified through the analysis (Mason, 2002).

A sample size of between 6 and 8 therapists was sought as an appropriate number for qualitative research of this nature; allowing a level of depth without producing an overly cumbersome data set (Pope et al, 2000). To increase the likelihood of participants having a shared understanding and knowledge of NDPT, around which the interview schedule was devised, only qualified play therapists who were members of BAPT were sought. Participants also had to have experience of working with one or more child who lived in residential care when they worked with them. This was necessary to obtain views based on actual experiences and cases, rather than uninformed opinion of the issues involved; this is necessary for phenomenological research (Kruger, 1988 cited in Groenewald, 2004).

The focus was on children in residential care who did not have clear additional needs, therefore specialist settings such as special schools for children with disabilities, hospices or detention centres were not included.

There are 253 full members of the BAPT (personal correspondence from BAPT Administrative Assistant, 20 April, 2009) to which an e-mail (Appendix 2) was

distributed. Participants were self-selecting by replying to this initial contact. Volunteers from Scotland were asked to be reserves due to geographic distance and the fact that care proceedings are different there; these volunteers were not required as an adequate sample number was reached with participants from England and Wales. To a certain extent the sample was one of convenience as for some respondents, availability and geographical distance meant arranging an interview was not possible.

Limitations of Participant Recruitment

Participants were self-selecting and had in common that they were willing to share their experience. It could be suggested that those who did not put themselves forward may have declined to participate because of limited experience or a negative experience, skewing the study participants in favour of those who had overcome challenges. However, examples were given by the participants of a variety of problems and included interventions that had broken down suggesting that it was not simply successful and straightforward work that these therapists had experienced or were willing to share.

Semi-Structured Interview Schedule

The semi-structured interview schedule used, can be found in Appendix 3.

A drawback of interviewing as a research technique is that personal assumptions and beliefs can be embedded in the questions posed (Potter, 2002 cited in

Silverman, 2007). Phenomenological research believes that researchers cannot be detached from their personal presuppositions (Hammersley, 2000 cited in Groenewald, 2004). It is through consciously bracketing out personal assumptions and beliefs that the researcher can effectively investigate the phenomenon. It is true that the choice of topic for this research reflected the researcher's personal experience; crucially the challenges perceived when working with children in residential care. Although researchers such as McCracken (1988) see this as the researcher not having "critical distance" others believe that efforts can be made to manage this when undertaking research of this nature. Residential provision is diverse (Berridge & Brodie 1998; Milligan & Stevens, 2006) and the researcher's experience is limited to one setting. The researcher was therefore open to the possibility that the challenges could vary depending on the therapist, residential provision and employment status, that the issues may not be unique to this client group and that there could be undiscovered advantages for the child or the therapist when NDPT is applied in the residential setting.

In an attempt to create critical distance, the researcher used both the literature review and play therapy texts (Landreth, 2002, Wilson & Ryan, 2005, West, 1996, Cattanach, 2003, McMahon, 1992) to construct the interview schedule. From this literature, a list was devised of topics relating to play therapy; these included referral procedures, limits, themes, confidentiality, report writing, play equipment, working with parents etc. From these topics questions were prepared (McCracken, 1988). In this way questions related to topics relevant to all play therapy referrals not just topics identified in previous research as potentially

different when working with children in residential care. It was hoped that this would increase the neutrality of the interview schedule.

Although biases are impossible to rule out, repeated drafts were made and the constructive feedback from peers, the pilot interviews and supervision were used to ensure questions were open and neutral. Additionally, two questions found in Barbour (2008) were adapted and incorporated into the interview schedule to facilitate the expression of ideas that the participants felt were critical.

Semi-structured interviews and their guides or schedules can vary in length and structure (Denscombe, 2007; Kvale, 2009). As a less experienced interviewer, structure was beneficial. The questions were clustered into five sections that seemed to make chronological and logical sense in that they followed the process of therapy from referral to the sessions themselves and finally focus on more general opinions about work with children in residential care. It was hoped that this structure would help both the participants and the interviewer navigate the interview and ensure that all the topics of interest were covered.

Ethical considerations

Any research study raises ethical considerations (Ritchie & Lewis, 2003). The key ethical considerations for this research were informed consent, anonymity and confidentiality of the information shared.

As can be seen from the initial contact, permission form and the interview schedule itself (Appendices 2-4) informed consent was gained through participants being aware from the start of the nature of the research, how their data would be used, that their participation was voluntary and that their permission would be needed for the interviews to be audio-recorded. Although examples were invited, it was made explicit that names would be changed and participants could also choose to use aliases for people and places.

As specified above, BAPT has just 253 full members and the number of children accessing psychological and psychiatric support while in residential care has also been identified as low (Berridge & Brodie, 1998). For this reason, it was decided that transcripts would not be attached to this study as at times, the content may risk identification of the therapist, residential establishment or the children involved.

Participants were able to request a copy of the recording for their information and / or a copy of the transcription for verification if they wished. The offer of an electronic copy of the finished dissertation was also offered as a matter of courtesy.

The Pilot Interviews

Formal piloting was carried out on two occasions. Researchers have suggested that interviewing is a skill that can improve with practice (Fontana & Frey, 1994), therefore the pilot interviews provided some additional experience for a relatively

inexperienced interviewer. The first pilot interview was with a therapist who had significant experience but with whom the researcher had a professional relationship with so was deemed unsuitable for inclusion. The second pilot interview was held with a volunteer who had responded to the initial e-mail but who had only seen one child more than three years ago. This pilot interview included audio-recording however the data was not used in analysis as it was made clear to the participant that the interview was for piloting purposes. Through pilot interviewing two participants with contrasting experience, important information was gained indicating that the interview was viable with therapists with varying levels of experience.

The pilot interviews allowed pre-testing of the interview and provided important knowledge needed for informed consent; for example an informed estimation of the time the interview would take (van Teijlingen & Hundley, 2001). As suggested by van Teijlingen & Hundley (2001) the pilot study was used to seek feedback about ambiguities and difficult questions in an attempt to improve the interview schedule itself and to ensure instructions were clear (McLeod, 2003). Feedback from the pilot studies led to further revisions including rewording the questions relating to limits and referral criteria.

The pilot interviews and the actual interviews took place in a location chosen by the participant and therefore convenient to them. In all cases this was either the participant's home or workplace.

Analysis

In phenomenological research the researcher must not rely on personal beliefs about the phenomena under investigation (Denscombe, 2007). Although there was a personal interest for the researcher in whether there were unique challenges when play therapists work with children in residential care and how practice may be adapted, through the analysis assumptions were put to the side and open coding was used identifying, unique, interesting and informative data whether contradictory or not to prior experience and research.

All the interviews were successfully recorded on a digital audio recorder, and the recordings were transcribed by the researcher as soon as it was possible to do so. Identifying features were changed at the point of transcription so the written record was anonymised.

There was no independent verifier of the accuracy of the transcriptions, however participants had the choice to request a copy to verify themselves; only one participant chose to do so. Some researchers have suggested that transcribing the data yourself can be beneficial to the research process (Kvale, 1996) allowing repeated immersion in the data, aiding analysis. Although due to travelling and time demands transcription was not always possible immediately, notes on a summary sheet (Appendix 5) were made immediately following each interview. This allowed central thoughts or feelings connected to the interview to be noted immediately. Notes made included methodological issues, factual information,

general content and salient points. These notes helped ensure these impressions were not lost when it came to more structured analysis of the transcribed data.

Each interview transcript was labelled with key information such as length, date and an alias for the participant. The transcripts were given line numbers to aid reference. Through the initial notes and the transcribing process familiarity with the tone and content of each interview was achieved. This knowledge was used to choose an interview that stood out. An interview was chosen that provided a mixture of experiences and opinions and contrasted with the researcher's own experience. The interview was transferred to a table. This transcript was read and re-read and notes, in the form of open coding, were made in the column to the right of the interview. The data from each transcript was analysed holistically, not question by question; it was hoped that this would aid the emergence of independent themes, not categories based on previous topic areas or assumptions (Holliday, 2007). Different coloured highlighter pens were used to identify significant words or phrases that might be used as exemplars later. An interview that contrasted with the first interview was analysed next and again notes made and interesting aspects highlighted. This process was repeated with each transcript alternating between contrasting interviews. This alternation was used to avoid falling into set themes prematurely.

The steps in the process of analysis were based on the phenomenological analysis guidance provided by Willig (2008). The notes, or open coding, from each interview were then clustered into groups. A descriptive label was given to each major cluster conveying the nature of the theme and encompassing any sub-

themes within it. The themes and sub-themes were transferred to a summary table for each participant (an example is provided in Appendix 6). Each participant's summary table included references to specific extracts from the transcripts; therefore the integrity of the participants' actual words remained throughout the process of analysis.

The seven participants' themes were then grouped to develop 'Master Themes'. This process involved the abandonment of some themes and the integration of others (Willig, 2008). Through this process seven master themes emerged. The master theme tables can be found in Appendix 7. The transcripts were then re-read to establish whether the master themes were restricted to particular schedule questions. Although some themes were predominantly linked to a question in the interview schedule; for example Theme 7, was strongly related to Question 19, contributing information and opinion could be found for all the themes at other points during the interview both before and after the related questions. All seven master themes are present in all the interviews.

Each master theme had several sub-themes. During the writing up process sub-themes were integrated or relabelled to aid coherence and better encapsulate the content of the themes.

The following chapter refers to some general findings before exploring the seven master themes in more detail. The themes are discussed both in relation to the content of the participants' interviews and existing literature.

Chapter 3

Findings and Discussion

Findings and Discussion

Through this chapter an overview of the findings is provided. The seven master themes that emerged from the analysis are discussed in relation to the participants' comments, past research and knowledge relating to children in residential care.

Introduction to the dataset

The interviews lasted between 26 minutes and 78 minutes. This variation in length could be due to the relatively structured aspects of the semi-structured interview schedule, as Ritchie & Lewis write; 'Because there is limited probing, the in-depth material is likely to come disproportionately from more confident or articulate people.' (2003:111-112). However the shorter interviews did not seem to correspond with less confident participants and are more likely to be a consequence of a smaller range of children or locations worked with, and personal variation in conversation style. For example the shortest interview was gathered from Gaby, Gaby has only worked with one residential home and had very clear systems established. The longest interview was gained from Ava who had more years' experience and had worked in a variety of locations as an independent therapist and as a CAMHS employee. Gaby was very clear and concise in her answers whereas others such as Ava and Cassie were more likely to provide a number of examples illustrating their points.

The table below highlights the participants' employment status when working with children in residential care and the type of residential establishments they have worked with.

Name	**Employment type**	**Homes worked with**
Ava	Independent play therapist and later CAMHS employee	Multiple homes run by both the voluntary sector and local authority.
Bella	Independent play therapist	Multiple residential settings including a children's home and special schools.
Cassie	Employed permanently by the residential organisation	Multiple homes run by one organisation.
Della	CAMHS employee	Multiple local authority homes.
Fern	CAMHS employee, allocated worker for looked after children	Multiple local authority homes.
Gaby	Private Firm	1 private adolescent unit
Hattie	CAMHS employee in the past	Not specified

Participants were from all three of the BAPT approved training providers in England; four had attended York, two had studied at Roehampton and one qualified from Liverpool Hope University.

The participants were geographically dispersed across England and Wales, although this does not mean that they are representative of the population of play therapists as a whole, it did have the benefit of the sample being diverse and having worked with a variety of local authorities. All participants were female and white.

Although exact numbers of children were not obtained, it can be estimated from information given within the interviews that the participants had a combined experience of over a dozen residential homes and more than twenty individual children. Again the gender of the children worked with was not requested however those who did identify the gender of the children identified a greater number of boys; this is in accord with data for children in residential care (dcsf, 2007). Also corresponding with the same national statistics was the assertion by four of the participants that they were frequently dealing with older children and adolescents.

Although the findings from qualitative research are not statistically generalisable (McCracken, 1988); responses can be considered to be informative about how these therapists experienced working with children in residential care. Where there is a consensus or differing opinion, hypotheses can be made about possible reasons for this. Although conclusions may be difficult, speculative hypotheses can be made and may be supported by existing literature and research.

Seven master themes emerged which encompassed a number of sub-themes. Each of the seven master themes will be discussed in more detail below.

Theme 1: <u>The Child And Their Presenting Problems</u>

This category included comments about the children, their history and their family. All the participants made reference to externalising behaviours these

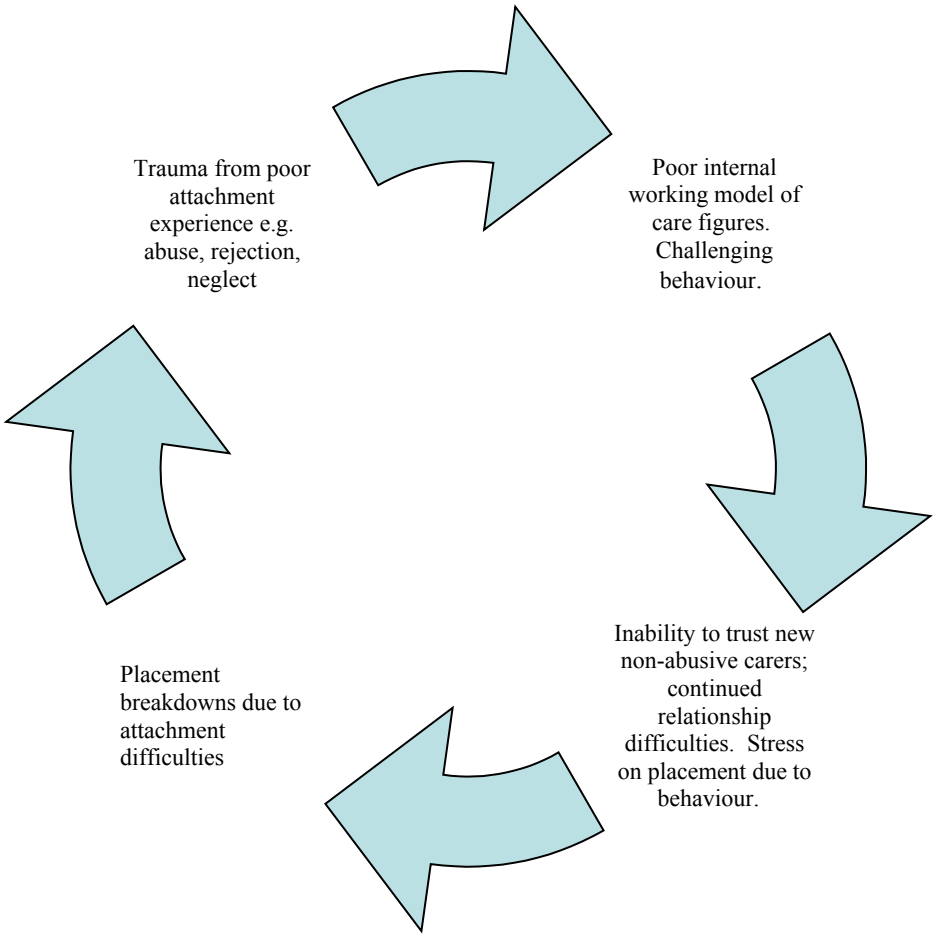
included; temper outbursts, sexualised behaviour and school difficulties. Challenging behaviour within the client group was to be expected from existing literature (Sinclair & Gibbs, 1998; Meltzer et al, 2003). Although socially unacceptable behaviour only accounts for the category of need for 2% of looked after children (dcsf, 2007) it is recognised that abuse and neglect can lead to difficult and challenging behaviour (Howe, 2005), and this is the category of need of 62% of looked after children (dcsf, 2007). Early abusive experiences were common for the children referred to by participants. Five participants spoke about 'abuse' in the children's past, another referred to neglect and one referred to abuse in a less explicit way mentioning 'damaged backgrounds' and 'damaging foster experiences'. With or without a history of specific abuse, separation from birth family can be seen as an inevitable trauma for this client group (Hunter, 2001).

Early experience and its impact on attachment

Attachment or relationship issues for these children and young people were referred to by all of the participants, either explicitly or through highlighting that the child had a background of neglect resulting in basic mistrust.

Five of the seven participants spoke of multiple past placements and failed fostering arrangements. Past research has identified that abusive experiences seriously impact on a child's ability to form secure attachments (Aideuis, 2007) and can lead to challenging behaviour which can impact on the child's ability to engage appropriately in interpersonal relationships (Howe, 2005). This would

explain continuing difficulties in foster care and placement breakdowns following a child's placement in care.



Many of the children described by the participants seemed locked into the above sequence of events prior to their entry into residential care. It was suggested by two of the participants (Cassie and Fern) that residential care could break this cycle and a level of consistency and permanency could be established. Fern suggested that for some children, the lack of an intense attachment relationship in residential care was experienced as a relief:

'*you know he was a child who thrived in a children's home… because he couldn't manage relationships*'. Fern 269-271.

Similarly others have recognised the difficulty for certain looked after children to manage a family setting; they have suggested that residential care may be the placement of choice for certain young people, particularly adolescents (Utting, 1997).

Links to other looked after or traumatised children

It was clear from examples given by participants, that referring to children in residential care as a discrete group had practical difficulties. At least three of those interviewed (Gaby, Bella and Ava) had worked with children who had not been in residential care when they started therapy. Additionally, experiences of therapy bridging between residential care and fostering were also mentioned (Gaby and Della). Trying to delineate the participants' work exclusively to children in residential care was a naïve expectation due to the mobile nature of the population of looked after children (DoH, 1998).

Participants seemed to suggest that the critical common feature identifying the children they were discussing was not their living arrangements. Five of the seven participants made links between children and young people seen in residential care and other traumatised children they had worked with; typically other looked after children in foster care. It was the view of the majority of the participants that the

experience of trauma and early abuse identified these children and their presentation in the playroom, not their current living arrangements.

'*Lot of the theme was… extreme aggression and self harm aggression … I don't think that is typical to residential schools, I think that's typical of those who've had that life experience*.' Bella, 497-499

'*you can't really sort out the results of the trauma that brought them into residential care and the effects of being in residential care because it's all part of the same um lack of adequate care, isn't it?'* Cassie, 676-679

Research has identified children entering residential care as complex, and not a homogenous group (DoH, 1998). As the numbers in residential care continue to decline there is likely to be less differentiation between the population of children in residential care and the more challenging children in foster care, both groups are understood to have more complex needs than previously (Utting, 1997). Therefore it is understandable that some of the participants made clear links between the children they saw from residential care and other looked after children.

The commonality with other traumatised children was used by participants to explain why there were no unique themes for this group, although typical themes were referred to. Common themes included aggression (referred to by Bella, Della, Fern and Cassie), and limit testing. Hattie described limit testing as 'chunkier' and all the other participants said that limits were challenged more by children in residential care:

'*I think the limit setting stands out um they'll, they'll go that one step more'* Della, 297-298

Increased limit testing was related by some participants to the children's issues around trust and safety, which again can be linked to poor or disrupted early attachments and / or abuse (Erikson, 1950; Bowlby, 1988; Howe, 2005). What was surprising to the researcher was that for some participants, despite limit testing being raised as an issue, they felt their responses were the same as with other children and that although tested, the limits were not repeatedly broken and sessions did not have to end prematurely (Ava, Hattie, and Gaby). This suggests that for these play therapists the rules and boundaries of play therapy itself seemed to provide the structure and support necessary for limit testing not to be a major issue for the therapist, simply a theme for the child and a consequence of their experiences.

Aggression and violence could well be anticipated; Berridge & Brodie (1998) found that the predominant reason for children to be looked after in residential care was control problems. In a national investigation Meltzer et al (2003) found 60% of children in residential care were identified as having conduct disorders. The examples provided by participants suggest that violence and aggression were central to the behaviour of many of the children. Hattie spoke of having had a chair thrown at her, Fern spoke of aggression being common and gave an example of one boy seeming repeatedly to try and hurt her:

'I had to acknowledge that you would really want to hit me. And he was "yes, yes I do" you know, "I really want to bray ya", "I feel like throwing this chair at you", "I feel like" and you know, the good thing about him was he, he began to verbalise what he would really do'. Fern, 652-656

However, despite the significant potential for violence of the children discussed, none of the therapists appeared worried or overly cautious around this. The home Gaby has worked with sends two members of staff with a young person when they come to attend therapy, due to the potential risk they posed, but Gaby was clear that this was the home's decision and not at her request and she saw the child alone.

The necessity of physical intervention was mentioned by Cassie, Della and Fern. This was linked by some of the participants to the restraints that the child may experience within residential care. Having to hold or stop a child physically in the playroom was highlighted by Della as something not prepared for through training but necessary for safety at times. The examples were spoken of in a way that communicated a sense that the situations had been manageable and that this was not a regular occurrence:

'the therapist has various ways of um defusing situations and acknowledging the feelings er, so actually this happens very very rarely um, but just occasionally you might need to er get the help of the carer to actually physically restrain the child if they were doing something dangerous to themselves or to you'. Cassie, 739-744

Length of Intervention

All participants spoke of the likelihood that therapy would be long term with these children. '*they tend to go longer; I tend to see them longer'*. Della, 248-249. Hattie expressed a personal preference for long term interventions and although Ava said that her workplace restricted her to a year, the cases where the child was from residential care did tend to be a year and in her private work she had seen a child for substantially longer. Gaby had a set system of 20 sessions but with the understanding with the home that if a span of two years was needed this would be funded too.

The tendency for long-term interventions contrasts with the view that NDPT is a time-limited intervention (Ryan, 1999). However, in relation to complex cases Wilson & Ryan (2005) suggest that individuals may require therapy sessions to continue over a year although they advocate for interim reviews. A similar system to that described by Wilson & Ryan was referred to by Gaby and Ava in relation to their work. However, the majority of those interviewed seemed to indicate that a longer intervention for this client group was assumed from the start without the explicit reviews, although regular feedback meetings were described by all.

The participants noted that these children had experienced years of instability, abuse and neglect, resulting in complex needs. With such histories, therapy is likely to be long term in both play therapy (West, 1996; Crenshaw & Foreacre, 2001; McMahon, 2009) and other forms of therapy (Howe, 2005; McAuley &

Young, 2006; Lanyado, 2003). Therefore it is not surprising that typically examples provided by participants were of interventions lasting a year or more.

Theme 2: <u>Helpful Aspects of Non-Directive Play Therapy When Working With Children in Residential Care</u>

This category related to the positive aspects that the participants felt play therapy provided for the children in residential care. It includes their hopes for what play therapy might provide, replicate or create.

Links with early attachment building behaviours

Benefits suggested by those interviewed included compensatory aspects (mentioned by four of the seven participants), both in attachment terms and the child being able to behave as an infant.

'really you're trying to um replicate what a mother might be doing with a tiny baby ... non-directive play therapy is absolutely brilliant at that isn't it?' Cassie, 873 – 880

'some of them will use play therapy to go back to um, you know, to infancy' Ava, 1153-1154

Play therapy, psychotherapy and attachment writers have acknowledged the relevance of the therapeutic relationship to attachment; 'Psychotherapy can be viewed as a time-limited corrective attachment relationship' (Crittenden,

2000:68). Attachment researchers have advocated for interventions for children who have suffered abuse to recognise the attachment histories of the young people and direct interventions accordingly (Howe, 2005).

Hunter (2001) identifies play, attunement and maternal reverie as having a crucial role in psychotherapy with children in care. Play and attunement are central aspects in play therapy (McMahon, 2009) and therefore it could be suggested that NDPT may be a highly suitable modality of therapy for this client group. Materials suggested for the play therapy room (Landreth, 2002; Wilson & Ryan, 2005) include baby equipment, facilitating the re-creation of mother-infant interactions perhaps more so than other therapies. It could also be argued that play therapy's three core conditions of empathy, unconditional positive regard and congruence effectively create attunement, a characteristic identified as key to the development of a secure attachment (Riley, 1993).

Child-centeredness and the contrast to the children and young people's other experiences

The therapy hour being a 'safe space' and its contrast to the children's usual experiences has been identified as a positive experience for the child both in psychotherapy (Hunter, 2001) and play therapy (McMahon, 2009). The advantage of the contrast of the playroom to the children's everyday life was something highlighted by five of the seven participants.

'you're not trying to parent the child and you're not using behavioural techniques, you are giving them that space to kind of explore their own inner emotional world and I think that's a really unique space,' Ava, 1191–1194.

Fern, Della, Gaby and Hattie made similar comparisons that in play therapy they weren't assessing, educating or managing behaviour; the playroom was a safe space for the child to be themselves. This highlights the person-centred nature of play therapy and how this aspect of the modality may have a particular role for this client group.

Learning about the child and sharing this with carers

All the participants acknowledged the key role of the child's external world. Changes the play therapist could support in the wider system were identified as making a difference for the child:

'I think it's important that we help the person looking after them, understand the child in order that they can meet their needs on a day to day basis.' Gaby, 535-537

Feedback meetings and participating in looked after child reviews whether through reports or in person were mentioned by all participants. Past literature has also highlighted the importance of relating with the wider network around a child (Crenshaw & Foreacre, 2001; Wilson & Ryan, 2001). Crenshaw & Foreacre (2001) also recognise that information provided by the residential staff is

beneficial to the therapist. Receiving helpful information from the carers was acknowledged explicitly by Cassie, Della and Fern.

In looking at effective CAMHS provision for looked after children McAuley & Young write, 'Approaches need to address both the needs of the young people and their carers' (2006:98). Play therapy holds carer consultation as central to the intervention (McGuire & McGuire, 2000) and suggests effective relationships and communication with carers 'can contribute to successful play therapy outcomes' (Cates et al, 2006:87). The avoidance of an 'expert' approach and valuing of the carers' views, experiences and opinions would also suggest that the play therapy modality is one that could be beneficial in the residential context working with residential carers as co-professionals.

Other researchers have identified that work with carers is as valuable, if not more valuable, as direct work with certain young people in care (van Beinum et al, 2002; Hay et al, 1995). Although practical feasibility can limit integration with the wider network (Arcelus et al, 1999); the participants in this study, even when unable to attend local authority reviews, still held their feedback meetings with the child's direct carers as central to the work. This suggests that play therapy fits with the government aims of ensuring carers as well as the young people are offered support when children have mental health issues (DfES, 2007; DoH, 2004).

Theme 3: Advantages and Disadvantages of Therapists' Different Employment Statuses.

A number of aspects of the therapists' work were dependent on the context of their employment including funding, facility issues and the availability of a team.

All the therapists spoke in favour of designated rooms away from the child's home and each had to manage a degree of tolerance for shared usage even, to some extent, in the CAMHS services.

Funding

There were advantages and disadvantages to many of the contexts; for example although Gaby as a private worker, described very clear systems of referral, feedback and process to the therapy sessions, the funding arrangements limited her involvement at external meetings. In contrast, although Cassie, as a permanent employee of the residential organisation, was very able to link with residential workers, transitional work was not an option as the funding was arranged through the residential fee. Funding was raised as an issue by five of the seven participants. Funding often linked to the risk of sudden moves and instability for both the child and the therapy itself.

The therapists in CAMHS settings were those least likely to feel the threat of funding prematurely ending an intervention. This may have been because they typically worked with children from the locality and a child could move from

residential care to another care setting in the same area without necessitating that the CAMHS provision ended.

The stability of therapy for the child was very much linked to the funding path for both the therapy and the child's placement. For example, children within Cassie's organisation automatically received therapy once they had settled into the organisation and continued to have therapy until shortly before they left. In contrast for Bella, an independent play therapist, funding for sessions was in addition to funding for the child's special school placement and she reported that sometimes the distant social services would not find the additional money. Reluctance in relation to additional costs can be understood when it is considered that residential care is very costly (Utting, 1997). Local authorities may feel that the fee they have already paid should incorporate any intervention necessary for the young person or should be provided by local CAMHS provisions. This could suggest that there is a risk that unless a residential provision can have direct access to the local CAMH service or funds therapy from within the child's fee, the provision of individual therapy could be delayed or uncertain.

Managing systemic issues

Two participants employed by CAMHS referred to a model of working where a 'case worker' would be assigned to each referral. Their role would be to manage the systemic aspects of the task, leaving the therapist to focus on their work with the child. Without an allocated person the therapist may well end up managing

systemic issues themselves, which some have suggested can be time-consuming and complex (Hunter, 2001).

Fern spoke of systemic aspects having the ability to 'scupper' therapy before it begins and highlighted the variety of people that needed to work together to ensure a child could access an intervention. It was suggested by Bella that communication with the local authority could be additionally problematic when working independently,

'It's very, very hard as a play therapist to have a voice within that whole system… unless you're regularly part of the school … system'. Bella, 340-341

Although it was suggested by Bella that being within the system would alleviate some of this frustration, Cassie, who was employed within the residential provision, spoke clearly about it being difficult to be heard at times and gave examples where what she, as a therapist, thought was best was over-ridden by organisational decisions. It appeared that whatever the type of employment, there would be issues when working with the wider system around a child, some of which are discussed in the next master theme.

The Benefits of a Team

The benefits of being part of a team were expressed by six of the seven participants. The benefits of a team included not only managing the systemic aspects of the work but also providing a resource for referring children on and for

obtaining professional support and opinion. Other benefits referred to by participants included ensuring the child was getting the appropriate intervention (Cassie), achieving greater understanding in the care team (Bella), knowing other aspects such as life story work and general day to day care for the child, are being taken care of (Cassie, Gaby) and protecting the therapist from becoming overwhelmed (Ava).

Others have highlighted that there are particular stressors and difficulties for the therapist and the wider network when working with looked after children which may be alleviated by joint working (Barrows, 1996; Rocco-Briggs, 2008). Government Guidance (DoH, 2002; DoH, 2004) currently advocates for psychology and psychiatry to be part of a multidisciplinary team when managing the cases of looked after children. As McAuley & Young write, 'Where they were able to access timely multi-disciplinary assessments, they found that this reduced stress for everyone, provided valuable insights and led to more considered decisions concerning placements.' (2006:98). This would seem to be supported by the majority of participants in this study highlighting the importance of sharing knowledge and having a multi-disciplinary team to call on.

Working with the child's carers

The positive aspects of integrating with the child's carers are discussed in the previous theme. However, the employment status of the therapist had a significant impact on the ease and frequency with which participants could liaise with carers. Cassie, as part of the organisation had multiple ways, through well-

established systems, of integrating and influencing the direct carers and saw this as a great advantage. Other participants, both independent and from CAMH services, were responsible for attempting to arrange and ensure meetings occurred and some indicated that they faced difficulties ensuring consistency and commitment to these (e.g. Ava, Bella and Della).

'the ideal is to have structures in place and the play therapy to be part of the, play therapist … to be part of the team. In the school often like the way I did it, which was peripatetic is the hardest and not ideal'. Bella, 638-641

In contrast, the benefit of independence from the residential provider was also highlighted. Bella saw her role in reviews to support the child and not simply meet the adults' need for information and Fern highlighted the importance of being separate to the child's home:

'And I think it's actually important that the child feels that they have an advocate, somebody who knows them, who hasn't got a vested interest um and who can represent their views and wishes'. Fern, 812-814

What was clear was that no context was ideal and each presented areas of frustration and difficulty to be overcome when attempting to work with children from residential care. The central obstacles that appeared to challenge the participants, no matter what their work context, are described in more detail in the following theme.

Theme 4: <u>Challenges to Effective Play Therapy When Working With Residential Settings</u>

All the participants described areas of difficulty when conducting play therapy with children from residential care. The issues appear to fit under the four following headings.

Understanding of therapy and the carer's role

Difficulties related to residential staff not understanding the role of therapy and their role in supporting the child were raised by the majority of the participants. Understanding was seen as key to starting therapy '*make sure ... that they have a good understanding of therapy'* Cassie, 1065.

While there was not a consistent view that the therapist should be part of the residential organisation's staff, the majority of those interviewed highlighted the importance of communication with the residential staff team to aid their understanding, Cassie and Gaby had the least issue with understanding, the majority of their work was with a single residential organisation. Cassie noted that because therapy is integrated into the care package at her place of work, the majority of staff recognise the importance of therapy.

Gaby spoke about being asked about the possibility of training to inform the adolescent unit about the role of therapy. Bella stated that she wished she could have been more involved in training to improve understanding. To improve understanding participants referred to meeting with carers and providing written

information. Participants spoke of the importance of 'groundwork' (Fern), and 'preparation' (Bella and Della) prior to working with the child. Suggestions included written information (Ava), a contract (Gaby) and being prepared to repeat the information many times. As Hattie put it; *'You've got to be known and understood and accessible*.' (163-164).

Play therapy literature highlights the importance of helping parents to understand play therapy's role for the child and their role in supporting the intervention (Landreth, 2002). Although participants spoke of meeting key-workers or managers to discuss play therapy, the issue of multiple carers led to other staff members being involved in supporting the child when they had little understanding of their role or the concept of therapy. This problem was raised explicitly by five of the participants.

The findings agree with past research highlighting that residential care is diverse (Sinclair & Gibbs, 1998) and therefore how therapy is understood and integrated into a service will vary depending on the house's ethos and the staff's views. This was clearly evident through the interviews where certain houses were spoken of favourably and where work with others was described as harder and more problematic (e.g. Ava, Della, Fern who had all worked with a number of homes).

The importance of working relationships and communication

Examples of interventions going well or smoothly often involved the therapist having a relationship with a residential care home, this might not necessarily mean

the house employing the therapist directly. A number of the CAMHS therapists spoke about having seen a number of children from a home and the staff knowing the therapist and the roles involved:

'I'm lucky because I've got a good relationship with the home and ... over the time we've, they've got an understanding.' Della, 356-358

However relationship frustrations were also common, perhaps highlighting the negative aspects of group care such as high staff turnover and low training levels leading to the continued deprivation some have suggested is associated with being looked after (Emanuel, 2002; Heron & Chakrabarti, 2003). Four participants mentioned information or sessions being lost or forgotten (Ava, Gaby, Bella, Fern).

'even if you speak to the manager and get to know the manager who 'oh yes I'll make sure everybody knows' and you get to know the deputy manager and 'oh yes, I'll make sure everybody knows' it can still be the odd week when something gets lost' Ava, 455-459

Relationships with social workers were also variable, some participants insisted that referrals were made by the local authority social worker and would hold joint meetings with them and members of the residential provision. Others (typically therapists from the private sector) had a more distant relationship with the local authority, sometimes due to the physical distance of out of county placements. Considering it is the local authority that handles the funding agreements and often

holds full parental responsibility for the children, the lack of a relationship between the local authority and the therapist is something that could potentially cause major difficulties.

The necessity of resilience

Significant preparation and resilience were suggested as key to conducting therapy with children in residential care. Typically the participants referred to a struggle to establish the support and understanding necessary for a successful intervention. Bella, as a peripatetic worker spoke of negotiating and begging when trying to establish things the way she thought they should be. Repetition and being prepared to be let down were other clear messages from the interviews, 'e*xpect that there will be blips and you will have to explain yourself again…'* Ava 1399-1400

Effort and the impact of working with the child's network is something that other studies have highlighted as central to work with this client group (Hay et al, 1995; Wakelyn, 2008). It should however be noted that other non-residential contexts can place similar demands on therapists when attempting to integrate school and home and when working with parents who may be struggling themselves and feel criticised or inadequate due to the recommendation of therapy (Landreth, 2002).

Consistency issues

Participants valued consistency highly, recognising that consistency and continuity were beneficial to these children who have had difficult early years. The consistency of the therapy hour is intended to communicate safety and reliability to the child (West, 1996). The participants expressed frustration and sadness that consistency was not evident at times:

'something that's meant to happen for them doesn't happen and the continuity and the consistency that's meant to be there is not there'. Ava, 467-469

Links were made with attachment. Some participants wanted the carers to perform the function of an attachment figure, providing a reliable and consistent base for the child. However, perhaps such an expectation is inappropriate with the current role of residential care, typically that of a transitional placement.

'you're really trying to help them to change their attachment patterns but sometimes I think, um well perhaps they're wise not to attach to this person because they could disappear.' Cassie 967-970

Team care or multiple carers was a major contributing factor in the struggle for consistency. However, the therapists interviewed seemed prepared for that, talking of limiting the number of people who would accompany the child but not expecting it to always be the same person (Ava, Cassie, Della, Fern, and Gaby). What seemed to create frustration were forgotten sessions, miscommunication and

a lack of understanding in those who did accompany young people as this impacted on the experience of therapy for the child. These issues were referred to by all the participants except Cassie who was employed permanently by a large organisation where therapy was part of the care package for all the young people. However even in Cassie's context, consistency of main carer did vary and she identified a consistent key carer as contributing to a more successful intervention,

'some children are lucky and they get a key carer who stays around a long time and then you can really do really good work, that um you might have the carer in the room or, or you might just be working with the carer ... those children always do better really...' Cassie 893-900

The topic of the role of the carer accompanying the child was spoken about passionately. The more extreme cases of carers not fulfilling their role by refusing to wait in the building, allowing children to wander off, sending them to appointments alone or failing to remember sessions perhaps points to aspects of residential care highlighted by research; that the work is demanding and stressful (Sprince, 2002) and many residential workers are poorly trained and staff turnover is high (Utting, 1997).

Despite the limitations all those interviewed expressed persistence and valued their role for the young people, recognising that the work with the staff was part of their role as therapist.

Theme 5: <u>The Struggle to Realise Stability and How This Impacts On the Appropriateness of Play Therapy.</u>

This theme relates to whether a child should receive play therapy when not in a permanent placement.

Work through transitions

At least three of the seven participants commented on cases that they had seen through a transition both to and from residential care. In these cases the therapist remained a point of stability while external circumstances changed. Additionally, experiences of therapy bridging between residential care and fostering were also mentioned (Gaby and Della). Previous research has highlighted the important role therapy can play for children through transitions (Lanyado, 2003). However, Gaby referred to a sudden move resulting in the premature termination of therapy due to the child moving a great distance away. Gaby spoke about her belief that if the young person had stayed within close geographical range she may have been able to continue to see the young person.

Residential Care can be stabilising for some young people

Two participants gave examples of children's behaviour settling in residential placements, suggesting that the residential experience may be felt as comparatively stable for these young people and therefore conducive to them accessing individual therapy.

Comments such as *'stable-ish'* (Ava, 925) and *'I think that's a really dated viewpoint'* (Gaby, 445) suggest that the definition of what constitutes a safe or stable placement needs to be flexible so that therapeutic interventions reach children even when the length of their placement is unknown.

Participants highlighted the 'needs' of this client group and used this as justification that something needed to be offered or children could remain without beneficial therapeutic input waiting for the 'right' conditions.

'I think that means sometimes a child's in a placement, in a unsettled placement for ... years with no therapy and that happens... I don't think there should be just rules like that.' Della, 478-480

Working with limited stability

It was suggested that delaying therapeutic input due to the transitory nature of residential placements might be unfairly discriminating against looked after children, as complete stability was something impossible to achieve. It was also recognised that change is an inevitable aspect of all children's lives.

Recently psychotherapy literature has also advocated for the possibility of working with children and their systems while children are in transitional placements (Wakelyn, 2008; Cant, 2005). Government guidance has also highlighted the need for designated services for these young people (DfES, 2004; DoH, 2004).

However, comments indicating that working with a child in a possible transitory placement was viable, were to some extent contradicted by discussions about the limitations of the therapy due to inevitable moves and changes in key-carers.

'I think it's, in a perfect world a child would be settled and your therapeutic interventions would be a lot more effective' Fern, 807-809.

Five of the seven participants recognised that the temporary nature of residential care did impact on the therapy, most obviously through sudden moves and subsequent premature endings. Stability is very difficult to guarantee for these young people; moving to foster care is often a key aim of placing a child in residential care.

Past research has found significantly larger treatment effects for play therapy carried out in residential settings compared to other settings (Bratton et al, 2005). However caution is given about drawing firm conclusions from this due to the low number of studies involved. The studies may relate to a provision similar to that described by Crenshaw and Foreacre, (2001) or Doyle & Stoop (1999), which may contract with the purchasing organisation a set length of residency for the child. Play therapy being carried out in such residential provisions may well be different to play therapy carried out with children in residential care and perhaps highlights a more holistic approach to the child; consultation and integration with the care staff and not simply seeing the child for weekly sessions. This highlights

another difficulty of research related to residential care due to the variability of provision (Sinclair & Gibbs, 1998).

Theme 6: Confidentiality Considerations

Literature had suggested that confidentially would be a major concern for therapists working with children in residential care (Hunter, 2001; Cant, 2005), due to the team care approach and the inability to link up with one or two clear parental figures. However, it was clear from these participants that confidentiality was typically no more an issue with this client group than any other child worked with:

'I always sort of keep to the same rules really…That I don't divulge details of the child's session, I feedback on the basis of the the themes.' Ava, 821-825

The thematic feedback and clear involvement of the children and young people in being aware of what will and will not be shared seemed to provide parameters around confidentiality that the therapists were confident and clear on.

There was a consensus that it was the therapist's role to share information with key people to help carers understand the child's needs and look after them better. At times information shared related to more general information about the effects of abuse and attachment but also could involve the child's themes from the playroom, or with the child's permission, more specific details of the therapy sessions.

'*I think you know there's this big hang-up about confidentiality and therapy. Sometimes information needs to be shared with the child's carer in order for them to be able to look after the child or young person.'* Gaby, 507-510

There was also a very clear message through the interviews of the child-centred aspects of the non-directive approach; that the children were involved in knowing and agreeing what would be shared (Hattie, Gaby, Fern, Bella and Cassie).

'I invite the child to um help me contribute in my notes preparation.' Hattie, 324-325

Cassie was the only participant to speak about a large team approach to confidentiality. The team approach may be a consequence of the type of residential provision she worked for; a large organisation overseeing a number of homes with therapy integrated into all the children and young people's care plans. It appeared that the other participants typically linked with a limited number of key people from the residential home such as the key-worker and manager.

The privacy of the therapy hour was also noted as key to the children's experience (Ava, Bella and Fern) and not always expected by children as it contrasts with their past experience and perhaps the lack of privacy in a group home.

One explanation for why confidentiality did not feature as prominently in this research compared to the literature in general may be that these participants are

speaking exclusively about play therapy and not psychotherapy as others have (e.g. Cant, 2005). Play therapy currently advocates strongly for the importance of involving carers and not being in the position of expert (McGuire & McGuire, 2000; Wilson & Ryan, 2001). It also proposes thematic feedback rather than detail being shared (Wilson & Ryan, 2005), which may also lead to less conflict for the therapist when sharing in multidisciplinary meetings.

Theme 7: Alternatives To and Interventions Evolving From Non-Directive Play Therapy

When discussing complementary or alternative therapeutic interventions, participants provided actual examples to illustrate their ideas, both successful and those that had not gone as planned. This suggests that participants were not simply theorising but providing evidence and examples of interventions, identified to meet the individual needs of children.

Filial Therapy

Filial Therapy was referred to by four participants.

'I really like that idea of filial play I would like to develop that for key carers to have that um just that special play time with their children 'cause I just think that building attachments that's what you need isn't it?' Cassie, 881-884

However Cassie also raised the issue that without a single carer, attachment work with children in care could be problematic. Only Ava had actually used filial therapy with residential staff. Ava spoke more about the staff continuing to consult with her rather than successful filial therapy sessions, she also noted that their skill level had not been high. From the participants' comments it appears that although filial therapy is considered to have potential for children in residential care theoretically, the practical use of this approach may not be supported within residential care:

'...if there isn't anyone to do the filial with that's reliable then that's not going to work either.' Ava, 1292 - 1294

Filial therapy literature also predominantly refers to interventions between children and parental figures (Vanfleet, 2005). Where filial therapy training has occurred with non-parents, change is recorded in the carers rather than the children (Landreth, 2002). Although increased skill such as improved empathic responses may be beneficial for residential care staff, the appropriateness of filial therapy for this client group while care staff are transient and contact work hours limited is debateable.

Meta-analyses carried out by both LeBlanc & Ritchie (1999) and Bratton et al (2005) showed that play therapy approaches which involved parents in treatment produced the greatest effects. Interestingly, participants gave a clear message that birth parents were rarely involved in the play therapy (e.g. Ava, Fern) due to the particular histories of the young people (Cassie, Fern) and the fact that many

children are moved a great distance from their place of birth (Gaby). Residential care staff, although in the role of carer, are not consistent figures due to working hours and staff turnover, therefore the potential for them to fulfil the role of parents in a similar way to that reported by past research is questionable.

The role of consultancy

Few examples were given where consultancy rather than individual therapy was recommended, although Hattie and Fern spoke of consultancy possibly being used as a first step, leading to individual play therapy when the child is ready. However, there may be methodological issues limiting the occurrence of reference to consultancy as opposed to individual therapy. The decision to provide consultancy may have occurred at the assessment stage of referrals, a process that many participants were not involved in. Gaby spoke of consultancy and individual therapy being offered in conjunction and the majority of participants viewed consultancy as a valuable and critical provision for staff while individual children and young people engaged in individual play therapy.

'I think it's really useful for residential placements to have somebody to consult with. Um, so I wouldn't want it to be either or. And at the moment ... that's how it works ... because we've got the primary mental health worker who does consultation'. Ava, 1334-1341

Much of the consultancy seemed to be provided by the therapists themselves through their feedback meetings with carers. Held (2005) identified that one of the factors affecting placement stability for looked after children was 'increased multi-agency and multi-disciplinary support to placements' (p3). As discussed earlier, many of the therapists advocated for multidisciplinary meetings and valued the contribution of others such as psychiatrists, the case holder or peers. Perhaps due to the nature of the interview itself more information about the input of other professionals was not elicited.

Directive Pieces of Work

Three participants suggested that what is learned through NDPT with a child in residential care may lead to the therapist carrying out directive pieces of work. Sex education, relationship needs and anger management were areas where participants felt additional work may be useful. Interestingly, the participants did not see these directive approaches as an alternative to NDPT but created in response to what was discovered through NDPT sessions. This perhaps highlights the usefulness of play therapy in assessing the needs of this client group, highlighting areas for future interventions.

'*My experience has been this child centred play therapy is a great starting point and it's great at working through unresolved trauma and abuse however, I also believe that the child needs an educational component to the work.*' Gaby, 400-404

The need for more than one approach again highlights the complexity of the cases and adds weight to the suggestion in government guidance that multi-disciplinary teams should be available to provide integrated working for this vulnerable group (DoH, 2002; DoH, 2004).

It is interesting that the directive pieces of work were described as being carried out by the play therapists themselves, perhaps supporting the literature that suggests residential staff often lack the training that would provide the appropriate knowledge and confidence to address these issues (Utting, 1991; House of Commons, 1998).

Alternatives for some young people

Ava spoke of play therapy possibly being 'too much' for some young people in residential care and Cassie similarly raised that adolescents could feel exposed and not want to engage in therapy, this has also been suggested in the literature particularly in respect of psychotherapy (Wakelyn, 2008). Cassie spoke of wanting to broaden the range of therapies on offer to include Cognitive Behavioural Therapy or short-term pieces of work to meet the needs of the adolescents more effectively. Ava spoke of the importance of being realistic and referring children on to psychiatrists or other professionals where necessary, again highlighting the need for various approaches within one service, something that has been highlighted in government guidance (DoH, 2002).

The following chapter draws some conclusions from the above findings and identifies implications for practice and makes recommendations for future research.

Chapter 4

Implications and Conclusions

Conclusions and Implications for Practice

As a qualitative small-scale study, attempts to make generalisations from findings should be treated with caution. However, as described in the previous chapter common areas of difficulty and need were identified by participants from a variety of residential care settings and many of the areas of difficulty were supported by past research. General conclusions and suggestions of how these may relate to therapists' practice with this client group and training considerations are described below under the seven master theme headings.

The Child and Their Presenting Problems

- Challenging behaviour

The potential for violence and aggression in residential care is well recognised (Balloch et al, 1998; DfES, 2007). Typical themes in the play of the children referred to in this study included aggression and limit testing. Although play therapy training seems to have provided these participants with the ability to cope when faced with challenging behaviour, the risks involved should not be ignored. Therapists about to work with this client group need to be prepared for challenging behaviour. The potential for difficult behaviour suggests that the proximity of a carer has an additional importance. However, the consistent presence of an appropriate adult for the child was identified by participants as something difficult to achieve when working with children from residential care. The findings suggest that therapists who are about to work with this client group need to be prepared for the possibility of both witnessing violence and potentially

being on the receiving end of aggression and limit testing, more so than is typical with other young people.

- Lack of attachment figure

Reference was made to residential care interrupting a cycle of repeated placement breakdowns for some children and so potentially improving the stability of the carers around the child. However, a number of the participants questioned how much of a reparative secure attachment could develop within residential care with no clear primary attachment figure. Two participants queried the extent to which play therapy can fulfil its role to provide both an environment where children can change their emotional and behavioural responses in relationships, and to help carers understand and respond appropriately to children's attachment related behaviours (Ryan, 2004) when there is no clear consistent and dependable adult in their everyday lives. The limits of the key worker relationship due to the fraught nature of residential care, work hours and a number of demanding children within the same environment could suggest that it is unlikely that an adult can take on the role of secure base for a young person. If residential care is to have a specific role for some children who have struggled with close relationships within foster care the role of attachment within this setting could benefit from further consideration and research. This links to the wider debate around the appropriateness of residential care and the limitations of what it can offer children and young people.

- Length of intervention

Typically, the play therapy interventions described were long term. Trainee play therapists are assessed using short-term interventions. This, together with the fact that play therapy has been described as a time-limited intervention (Ryan, 1999), suggests that it would be beneficial for training providers to discuss more

explicitly when long term interventions might be appropriate. It was clear from the interviews that there was no consistent system of weeks between reviews or decisions about interventions ending. Research more specifically identifying the most effective and beneficial play therapy systems for this context would be advantageous.

Helpful Aspects of Non-Directive Play Therapy When Working With Children in Residential Care

All the participants clearly felt that play therapy had many advantages for children in residential care due to its child-centred nature and use of play. It was referred to as providing an opportunity to hear the child's voice (Hattie); a safe space where they are accepted (Della), providing the opportunity for attunement and interactive play (Cassie) and generally contrasting to their everyday lives. Additionally the fact that it values and advocates for the involvement of carers, means it meets the aims set out by current government guidance of supporting the carers as well as the young people in relation to mental health issues (DfES, 2007; DoH, 2004).

Theoretically, play therapy appears wholly appropriate for a client group where more explicit interpretation of their play may be perceived as an impingement and threatening (Lanyado, 2004) and where staff support is as critical as individual work. However, quantitative changes or improvements for the children accessing play therapy appeared lacking from the interviews. This may be due to the interview structure but may also highlight how major change is unlikely for

children in residential care in the short to medium term. Only one participant made a clear reference to improved sociability and behaviour for young people; '*And there were benefits in, in most of the cases, there was an observable difference in how they socialised, a reduction in aggression at some level'*. Bella 623-625.

However, other participants referred to transitions to foster care and kinship care and perhaps it should be assumed that changes in behaviour or flexibility in the child's internal working model of relationships had occurred, to allow a move to happen.

One explanation for a lack of reference to positive changes for the young people could be due to the fact that the statistics for looked after children's achievements have been identified as so vastly contrasting to the general population (DfES, 2006), it could be suggested that what is viewed as a success could look very different to what one would expect (Weiner et al, 1999). Others may find subtle changes in thought processes or behaviour of young people hard to recognise as significant improvements. This suggests that if play therapy wants to evidence efficacy for young people in residential care, more detailed case studies, perhaps incorporating assessments or measures before and after interventions, or coordinated projects involving play therapy, similar to projects described in Kurtz & James (2002), are needed.

Advantages and Disadvantages of Therapists' Different Employment Statuses.

Residential care remains diverse (Sinclair & Gibbs, 1998) and this was seen through the examples given by participants. Some provisions include an integrated education provision and may even employ internal consultants such as therapists, psychologists and psychiatrists; others will rely on CAMHS provision and support within mainstream schools or special schools. CAMHS provision also varies across the country; it was interesting that no reference was made to the problems of CAMHS waiting lists that other research has highlighted as an issue (Kurtz et al, 1994 cited in Arcelus et al, 1999). It may be that if participants had been from different CAMHS teams their views might have been different.

No matter what the employment context of the participants, there was a consistent view that it was essential to have the opportunity to help carers understand the children better. In this study, when therapy was part of the organisation, the opportunities for joint working were seen to be well established but where the therapist was not part of the organisation there was more inconsistency. This suggests that if there are not well-defined systems and the therapist is external, the use of a contract or written information described by Ava and Gaby may be essential.

Systemic issues are referred to in psychotherapy literature with looked after children as difficult but critical (Sprince, 2000). Liaison can be time-consuming and complex (Hunter, 2001). This suggests that time and resources need to be planned to accommodate this need when working with children in residential care.

This may be particularly difficult to fund when working independently. The importance participants placed on the input from other professionals also indicates that independent work may have particular disadvantages when working with this client group. Specific research into the actual length and frequency of contact with the child's support systems would support a realistic understanding of the time commitment when working with this client group and could be useful for therapists in all work contexts to plan their working week accurately.

Challenges to Effective Play Therapy When Working With Residential Settings

There appeared to be agreement on the areas that were experienced as difficult or problematic for play therapists when working with residential settings. Therapists about to embark on working with children in residential care should be prepared to work with quite disparate multiple interested parties who will have varying investment in, and understanding of, play therapy. This is possibly even more likely where play therapy is not integrated into the residential provision and being sourced externally.

Information from these participants suggests that the negative aspects of group care highlighted by previous research (House of Commons, 1998; Utting, 1997) are likely to impact on the provision of therapy due to high staff turnover and shift work. Consistency issues are likely to pervade even in circumstances where there is a strong relationship with the home and clear systems agreed. This highlights the importance of a support network for therapists, which, in the case of those working independently, may rely solely on supervision.

The Struggle to Realise Stability and How This Impacts On the Appropriateness of Play Therapy.

While those interviewed indicated that a degree of stability is needed, waiting for permanence was viewed as unworkable. Many spoke of the stability brought by residential care and the fact that placements in residential care may continue for years.

The participants suggest intervention of some kind is appropriate for children in residential care. However, the participants interviewed were often speaking from their experience of working with a familiar residential care unit, with a known ability to cope with challenging behaviour; a situation implying an acceptable level of stability. The findings cannot be used to comment on the many short term stays young people have in residential care including assessment centres and emergency placements. The role of play therapy with the more transient members of the population of children in residential care requires more specific research and discussion.

Confidentiality Considerations

Play therapy seemed to provide parameters around confidentiality that resulted in participants having no more concerns in this setting than any other. Only Cassie spoke of large team approach similarly to past research (McMahon, 1992; Cant, 2002), these past studies and Cassie's place of work relate to provisions that are either therapeutic communities or an organisation with an established ethos,

incorporating therapy from within the organisation into the care plan for all the young people. Such homes may value shared knowledge and insight from the therapists more highly. In talking to only a couple of key figures, as was typical for the majority of the participants, confidentiality may be more respected but there is the risk that many direct carers are not privy to the insights of the play therapist. Similarly, the therapist has to rely on understanding gained by those present being incorporated into the care plan and shared appropriately through the communication systems in place within the unit.

Confidentiality may also be less of an issue in the residential context when prominent themes have clear links to inadequate care in the past and therefore can be conveyed to current carers without the risk of them feeling personally responsible or blamed. The lack of involvement of birth parents may lead to less tension for the therapist when sharing the child's themes; therapists may feel that there is less risk that what they have conveyed will have negative repercussions for the child. This again may be due to the specific cases referred to in this research project. There are children in residential care where parents are still strongly involved in contact and care decisions. If participants had had experience of these families, confidentiality issues discussed may have been more complicated. This suggests that research into play therapy's effectiveness when liaising with parents as well as residential care staff, for children in residential care, is needed.

It was striking that there were very few references to therapists working with birth families. Considering how many looked after children return to their birth

families or local area once they leave care this is a grave criticism. 'National Statistics / DfES (2005) show that 70% of children entering care in a given year will have returned to the parents or relatives within 2 years.' (Thoburn 2007:502). Therefore any provision that does not consider the child's future and their connection to their birth family could be accused of ignoring the reality for these children and young people.

Alternatives To and Interventions Evolving From Non-Directive Play Therapy

Helping the wider system better understand the child and their needs was seen by participants as a vital aspect of their work; not an alternative to individual sessions but carried out in conjunction with them. Such an approach has the benefit of supporting carers struggling with challenging behaviour as well as providing an individual space for the child.

While filial therapy was spoken of theoretically, only one participant had actually used filial therapy with a child in residential care and the success had been limited. It may be that, due to the lack of consistent figure for children in residential care, filial therapy may not be appropriate. However many participants liked the 'idea' of filial therapy and it may be beneficial to research whether filial therapy could be used or adapted, to provide an aspect of training for care staff to increase their empathic skills and communication with children in residential care. The findings also suggest that filial therapy may play a vital role for some children from residential care when they make the transition to foster care.

It was suggested that play therapy is an effective assessment tool to identify the child's views and needs. Research into play therapy as an assessment method for children in residential care and how it could identify specific pieces of work such as life story work and sex education needs, could be an interesting piece of research. The inclusion of additional specific pieces of work is supported by recent literature on working with severely traumatised children with complex histories 'treatment invariably needs to go beyond offering play therapy or psychotherapy' (McMahon, 2009:195). It also is in line with current government initiatives emphasising the importance of multi-agency intervention and integration (DoH, 2004; DfES, 2007).

Summary

While the participants viewed play therapy as beneficial for children in residential care, the findings suggest that further research is needed into its efficacy and the specific advantages for this client group. This research also suggests that in meeting the complex needs of young people in residential care, play therapy could have a key role in an intervention, but is unlikely to stand alone. Work with care staff to help them understand and support young people, as well as more directive pieces of work are likely to be necessary. Although working as an independent practitioner with children in residential care was not seen as impossible, it did appear that there were increased demands and difficulties for play therapists working independently. The participants highlighted the complexity in the children's histories and current circumstances and consequent benefits of integrated, multi-disciplinary working. While the experiences of participants

reflected a number of types of residential provision, there were clear gaps due to the variability of situations in which children are cared for. This diversity of residential services highlights the need for many of the issues raised in this study to be investigated further.

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Appendices

Appendix 1

Literature Search

In identifying relevant research literature a preliminary search was carried out using the PsycINFO database with date parameters of 1987-2009. The words 'residential', 'individual therapy', 'looked after', 'mental health', 'treatment', 'therapy', 'play therapy' 'carers' and 'child' were used in the search facility in various combinations, the titles and abstracts of the literature identified were then scanned for applicability. Those that appeared relevant were sourced either electronically or through libraries, including inter-library loans and a visit to the Tavistock library which held copies of journals difficult to locate elsewhere. Accessing these articles led to further books, government documents and research material of interest being identified and accessed. Government websites were also accessed for key reports, statistical information and current legislation and guidance, these websites included the Department of Health (DoH) and the Department for Children, Schools and Families (dcsf).

Appendix 2

Introductory e-mail

Dear Sir or Madam,

My name is Emily Carrick. I am completing my Masters in Non-Directive Play Therapy at York University. I am looking into the experiences of Play Therapists who have worked with children and young people who live within a residential setting. I am hoping to interview Play Therapists who have worked or who still work with referrals of children who live in residential care such as secure care, therapeutic communities, special residential schools, children's homes, and short-term residential respite homes. This work does not have to be extensive and may only consist of therapy with one or two children.

If you have worked, or still do work, with children in residential care and would be prepared to be interviewed, please get in touch. I will carry out the interviews at a place and time that is convenient to you. The interview should last about an hour and would relate to your experiences of working both with the children themselves and the systems around them.

If you would like more information please contact me by e-mail, xxx@york.ac.uk or telephone, mobile: xxxxx xxxxxx; home: xxxxx xxxxxx. I hope to complete the interviews by the end of December 2008 and therefore I would hope to arrange a time for us to meet at your convenience in the next few weeks.

I will need your permission to audio-tape the interview. To ensure anonymity, I will adapt names and identifying content. Transcriptions will not be submitted with the dissertation.

Your help would be greatly appreciated.

Yours faithfully,

Emily Carrick

Appendix 3

Interview Schedule

Thank you for agreeing to take part in this research. The interview should last less than an hour. I will be asking questions about your experience of working with referrals of children living in residential care. The interview is taperecorded and the results from all my interviews will be analysed by me and form part of my MA dissertation. Interviews will remain anonymous and if permission has been given for quotes to be used, identifying features will be altered.

Please feel free to clarify questions or have them repeated as some are quite long. There will also be an opportunity at the end to raise additional thoughts or highlight ideas that you don't think were covered. Please answer the questions as openly and honestly as you can and with examples if you wish. All the information that you provide is of course voluntary and you can choose not to answer questions if you feel unhappy about sharing the information suggested. You are also free to withdraw your involvement at any time.

Specific Information about the Play Therapist and the Residential Care Children have come from.

1. Please tell me a little about your training as a therapist. For example where and when you trained.

2. Other than your Play Therapy qualification, do you have any other qualifications or experience that you feel are relevant to your work with children in residential care?

3. Please tell me the extent of your experience of providing Play Therapy to children who live in residential care. For example, the number of children this has involved and the type or types of setting the children came from. (Prompts: Secure care, therapeutic community, special residential schools, children's home, respite care).

4. Where were the rooms that you used to practice Play Therapy when working with children from residential care? (Prompts: CAMHS service, private therapy room, school, family centre, room provided by the residential home or somewhere else)? What have been the advantages and disadvantages of the room you have used?

Referrals

5. How did you receive the referrals and do you find you get sufficient information about a child at referral?

6. Are there any referral criteria or information that you consider essential before deciding to accept a referral of a child in residential care?

7. Can you give me an overview of the range and type of reasons for referral for the child or children you worked with from residential care?

8. Who did you liaise with when setting up a Play Therapy intervention with a child in residential care?

Practical Arrangements

9. In some settings it is practice that the child's main carer waits in a nearby room while their child is in a Play Therapy session, in other settings such as a school, the therapist collects and returns the child to their class. With children in residential care who takes on responsibility for supporting the child to attend Play Therapy, is this the same person each week and do they wait during the session?

10. As a Play Therapist what is your role with the wider system around a child? For example, how do you feedback or consult with the adults involved in the young person's care about the child and their Play Therapy?
(Probes: If not why not? Anyone else? family, local authority and from residential establishment, how regularly do these meetings occur? Are all the people that you feel should be there there?)

11. Are the child's birth parents involved in the intervention and if so how?

12. Attendance can be irregular for children attending Play Therapy, what is your experience of this in relation to the children you work with from a residential background? (Is this better or worse than children from other settings)?

13. Have you experienced confidentiality issues when working with children from residential care? (How does this impact on the records and reports you write?)

14. Does the fact that the child is living in a residential establishment and not in a family environment affect the length of time that you see a child for individual sessions or influence when an intervention stops?

The Sessions Themselves

15. Do you feel that there are any themes that arise in therapy with children in residential care that are unique or typical of this particular group? (If yes what are they?)

16. What is your experience of limit setting with children from residential care and is this any different from your experience of limit setting with other referrals?

17. What did you see the role of Non-Directive Play Therapy for the children in residential care that you worked with?

18. What do you feel are the advantages and disadvantages generally of Play Therapy with children who live in a residential setting? Can you give some examples of these?

Working with Children in Residential Care

19. Do you feel any aspects of your training or your understanding of Non-Directive Play Therapy is adapted when working with children from residential care? Could you talk a little about any adaptations you feel you have made and why are they necessary?

20. Does anything about the children living in residential care prevent or help you carry out your job in the way you'd like to?

21. Some people would suggest that when a child is not in a permanent placement individual therapy is not appropriate and it is more sensible to act as a consultant to those working directly with the child. What is your view of this and how does this relate to your work?

22. Do you receive any specialist or additional supervision for your work with children in residential care?

23. What advice would you give a Play Therapist who was just about to start seeing a child who lived in a residential setting?

24. Is there anything else you would like to add about working with referrals from children in residential care?

25. Were you aware that I worked with referrals of children from residential care? Do you think knowing that I work as a Play Therapist in a Residential setting did or would have influenced your answers today?

Thank you

Appendix 4

Permission Agreement

Thank you for agreeing to be part of this research. Please could you sign below to demonstrate that you give your permission for this interview to be audio-taped and used in the research proposed

I agree to the interview being audio-taped

Signed:

Name:

Please indicate if you would be willing for sections of the transcription to be used from the interview in the dissertation (identifying details will be changed to maintain confidentiality of all concerned)?

Yes ☐ *No* ☐

Would you like a copy of the transcript to verify?

Yes ☐ *No* ☐

Would like a copy of the recorded interview on cd?

Yes ☐ *No* ☐

Would you like a copy of the dissertation e-mailed to you at the end of the research?

Yes ☐ *No* ☐

Appendix 5

Initial Notes Following An Interview

Ref:	
Interview location:	
Length of Interview:	minutes
Permission slip completed?	
CD wanted?	
Transcript wanted?	
Quotes allowed?	
Do they want a copy of the dissertation?	
Any issues that could impact on the standardisation of the interview?	
Significant issues?	
Any other relevant information / feelings / thoughts?	

Appendix 6

Example of an Individual Participant's Summary Table

Themes	Key words / quotes	Page reference and line number
Facts:	Roehampton xxxx, MA in Social Work	
Experience	5 children in same private provision and also others through a transition to or from residential care.	
Cluster Theme 1: Transition		
• worked with children through transitions	Been in residential care and then moved to foster care A lot of transitional work	40-42 46-47, 452-453
• Placement broke down so sessions ended	Practical terms distance means work doesn't continue	235 237-238
• Stability	Generally been quite stable	243
• Mixed feelings	Normal for LAC	443, 456-458
• Dated viewpoint	Children wouldn't be worked with if this was said	445 446-447, 460-461
• Importance of therapy through transition	We can actually act as the attachment figure through the transition	464-465 467-468
Cluster Theme 2: Benefits of different settings		
• Designated therapy rooms and facilities	Own therapy rooms Contained, safe space Separate from home – I don't feel it's appropriate to carry out therapeutic work in the child's home Transportation can be difficult as away	59 63-64 63-64 69-70

	from home Set waiting area	 141-142
• Set systems	Standard referral form Set formula for reports and meetings Same rules and boundaries Good attendance with all clients Confidentiality	84,99 147-149 195-196 205-206
• Funding issue	Extra requests will cost more Attendance at reviews costs more Referrals not from statutory setting is this due to funding issues – I think there's an issue around funding	160-161 183-184 253-256, 260-261 264-265, 267-268
Cluster Theme 3: Problems with residential home's role		
• Relationship and roles	Clear contract Make them aware of who you are and what you do	482 496-497
• Understanding therapy	Be very clear about what the therapy is Thinking of training staff about what they do	482-483 490
• Inconsistency	Multiple carers – frustrating, confusing, things get lost It's not always the same key worker It's not the same person Be very clear on the importance of consistency lucky unit identified as good	423, 425, 427 71-72 131 484-485 249
• Communication difficulties	Not sure communication's two way	72-73

	Doesn't get fed back Miscommunication sometimes	76 421
Cluster Theme 4: Children themselves		
• Challenging behaviour	Behavioural problems Tend to challenge limits more Two escorts due to the presenting difficulties Tend to be more challenging Tend to push the boundaries	103 137 293 293
• attachment difficulties		107
• Birth parents not involved.	Out of county placements No direct link	172-173 175
• Adolescents	Youngest is 12 Adolescent unit	297 313
• early trauma		
• Links to other LAC.	Tend to mirror the experiences of generally looked after children	274-275
• Identity issues due to location and distance from home	Out of county	279
Cluster Theme 5: Working with the wider system		
• Liaise with home	They are the referrer Important to help carer understand child Key worker and unit manager We very much try and work as part of the network	111-112 535-537, 545-546 120 504-505
• Meet SW at reviews	If SW at those meetings If requested	113-114 154

• Reports for LAC review		166
Cluster Theme 6: Confidentiality		
• Set system	No more than other settings	203
• Thematic feedback	Nothing too detailed very brief Feedback on themes	190 212
• Importance of sharing information	Sometimes information needs to be shared to help them look after the child better. So they can help you	509-510 514-515
• Child's consent	Join with child so they are part of that decision	511-512
Cluster Theme 6: Benefits of PT		
• To process unresolved trauma	Process grief, loss	328 325 341 401-402
• Establish relationship	Build on trust issues	328 327
• Child centred	Contrast to usually being assessed for an adult agenda Not trying to fix behaviour. Young person-centred	302, 335, 337-338 342, 344 332
Cluster Theme 7: Is it enough?		
• Impact of age	Sad intervention didn't come earlier Sometimes a bit late if older Name changed for older yp	560, 586-587 589 315-316, 350
• Preventative work	Therapeutic package might prevent RC Sad intervention didn't come earlier	561, 564-565 560

• Consultation	Work with carer and child separately Support worker in house to do directive work	541-542 413-415 545-546, 548-549
• Directive or educational needs	Life story might be recommended Anger management Educational component needed Leads to directive piece of work Directive work for sexual health reasons	360, 369, 371-372 399-400 374-375, 403-404 394 396-397, 399, 406, 408-409
• Thinking of developing some training for staff		490
• Spring board	We might… start off with a very nondirective approach Great starting point	353-354 401-402
• Developed thinking	Additional training highlighted importance of attachment to carers not therapist	529-531, 533-537

Appendix 7

Master Theme Tables

Master Theme 1: The Child and Their Presenting Problems

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Challenging Behaviour	360, 365-366, 1052	167, 185-187, 191, 507, 522, 525-528	202,276,713-718,736-739,742-744,901-902,759-762,773	141, 301,310,311, 316,319,278,298	249,252-253,257,477-478,598,604-605,609-613,640,256,652-653	103,137,293	495, 502-503
Links to other Looked After Children or traumatised children	1029-1031, 1078-1080, 1493-1494	499	676-679	279,281,421		274-275	
Attachment Difficulties - rare for parents to be involved	694	180	505,507,274-275,279,281,679-683 460-461, 469-470	149,208-209	566-567 438-439, 445-446	107 172-173,175	
Trauma or Abuse in history	336, 346		161,226,689-694,983,275,281-283				
Multiple placement		738-739	273-274	78	252		

breakdowns							
Boys	5 M 1 F				64		
Older			200,206,512-514		62	297,313	
Resistance to therapy					240-241		
Physical contact/ restraint					621,625,631		
Identity						279	

Master Theme 2: Helpful Aspects of Non-Directive Play Therapy When Working With Children in Residential Care

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Pre-verbal aspects of play and re-creation of mother infant interactions	1152-1158, 1160-1166, 1170,1226		792-802, 873-880	328, 332	683, 601		
Contrast to the young people's everyday experience	1183-1191	541, 554-555, 510		325		302, 335, 337-338, 342, 344	
Relationship aspects of NDPT is appropriate for these children with attachment difficulties	1231-1233					328, 327	529-530
To explore past experiences / internal world	1139-1143 1212-1214	533				328, 325, 341, 401-402	523
Work on current issues	1125-1131, 1133-1139						
Play metaphor arises naturally	1144-1151						

Play Therapist will learn important information to share with carers	985, 1235-1239, 1251-1253, 1258, 1273-1275			486-488	450-456		623-624
Level of limitation but still beneficial	613-614, 609, 621						
Changes in behaviour		623-625					
Child Centred Acceptance				323-332, 337-338	680, 702, 688	332	
Unclear				341, 351			
Outlet					671-672		
Begin to verbalise not just act out					656		

Master Theme 3: Advantages and Disadvantages of Therapists' Employment Statuses.

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Funding Issues	930-931, 969-971, 1002-1003, 1009-1011	350, 452, 472-475, 457, 461-463, 731	614, 628-629			160-161, 183-184, 253-256, 260-261, 264-265, 267-268	
Established Systems support therapy	501, 530, 559		53, 56-57, 135, 141, 167, 171, 185, 296, 484-485, 509-510, 496, 948-950, 718-720, 728, 784-786, 638		139-140, 170-171, 182-183	141-142 84, 99, 147-149 195-196, 205-206	190, 192, 201
Importance of a team for the therapist	1384, 1440-1442, 1445, 1450, 1453, 1475, 1481			563-567			141-151
Facility Issues	113, 124, 127, 160-161, 172, 185, 199, 203, 207-209, 515	80, 86, 89, 93-95, 100, 121, 128, 259, 261, 373	79, 82, 84, 90, 91, 108, 94, 97, 103-105, 121, 107-109, 115, 117-119, 121	89, 93	89, 96, 118, 127, 127, 129-131, 517	59, 63-64, 69-70, 141-142	93, 95, 97
Ability to Integrate with the team of carers		107, 143, 162, 270-271, 343, 638-639, 681, 710-711	323-324, 338, 951-958, 960-963, 323, 338, 344, 1088-	192, 490-492, 497, 486-488	731-732, 322-323, 415-417, 420-421, 450-451	535-537, 545-546, 120, 504-505	

			1089, 1093, 394, 396, 398, 644, 647, 1064, 1072-1074				
Having a voice	630	542, 97-99, 341	150-153, 192, 403, 405, 407-409		813-814, 788-790		
Systemic needs				105, 109, 153, 159, 576-578, 161-163, 581, 592-593, 455-458, 470	164-165, 329-330, 838-840, 858-859		44, 67, 167, 47-48, 151, 153, 155, 160-161, 49, 142, 133, 259, 382, 390, 141-151

Master Theme 4: Challenges to Effective Play Therapy When Working With Residential Settings

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Consistency Issues	484, 490, 1463, 372, 406, 469	218, 220-225, 164, 203-204, 279-280, 385, 379, 245-247, 651-652	299, 301, 309, 976, 969, 889, 893, 969, 383, 448, 894-900	360, 133, 183, 199, 364, 519, 367-374, 447	338-339, 302, 500, 502, 511, 570-571	423, 425, 427, 71-72, 131, 484-485, 249	530-531, 270
Understanding Issues	388-390, 421, 441, 786, 1319, 1325-1327, 1401, 1415	586-587, 655, 662, 712-714	487-488, 490-491, 1065, 496	137, 358, 360-364, 364, 447, 514, 519-523, 571-572	286-287, 291-292, 177-178, 346-347, 505-507, 217-219, 277-278, 831, 832, 836	482-483, 490	303-304, 163, 164, 296, 309
Communication Issues	394, 396-398, 402-404, 1417, 427, 549, 1396, 1399, 459, 1322, 1394, 1415	163	352, 357, 362-366, 1064	570, 575	860	72-73, 76, 421	
Importance of a relationship	293-297			358, 74, 121, 184, 357, 523	295-296	482, 496-497	530-531, 616, 637
Effort needed	413, 540, 427	240-241, 287-288, 310, 542		202-203, 455			

Master Theme 5: The Struggle to Realise Stability and How This Impacts on the Appropriateness of Play Therapy.

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
A degree of Stability is needed	304-308,918-919,925,1362,1367-1373		1010, 1016-1021, 1001-1005, 993-995	367	807-809		584-585, 588 (pros and cons)
Waiting for permanency unworkable	1346-1348, 1375-1379	609,613-614,611		478-480	220-221, 811	443, 445-447, 460-461	588-590
Temporary nature of residential care can cause issues	909	596-597	908-912, 905-906,929,919-921, 415-416, 665,889-892	249, 250,251,253	875, 807-809, 219, 785, 860-861	235, 237-238	
Change is normal	1350-1352,1354-1355,1359					456-458	
Work through transitions	934-935	75, 716		262, 460-461	220-221, 799-800	40-42, 46-47, 452,453, 464-465, 467-468	
Residential Care can be stabilising for some young people			422-423, 995-996,999-1000,427-428,424-425,683-686	220, 484, 485	269,271,482-483	243	
Consultation might be first step							582-584

Master Theme 6: Confidentiality Considerations

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Respects Privacy	863	100, 412-419, 425			127, 129-131, 517		
Thematic feedback	821-822, 825		553, 555, 575, 586, 602	528	391	190, 212	
Team approach to confidentiality			547, 938, 943, 548, 598, 554, 590, 593, 938				
Consent of Young People			549, 566, 579-581, 586-587		424-425, 427-428	514-515, 511-512	326
Consideration of who might have access to reports / notes etc			604, 606-607		540, 549-550		420
Hard not to share bits of play to help understanding					530-532		
Importance of sharing information						509-510	

Master Theme 7: Alternatives to and Interventions Evolving From Non-Directive Play Therapy

	Ava	Bella	Cassie	Della	Fern	Gaby	Hattie
Complex / on-going needs	942, 1484, 1271-1275, 1302-1308, 1431-1432		210-217, 236-237, 240-245, 861-863, 886-888			353-354, 401-402	
Too much for some young people	1204-1209						
Filial	945-952, 1288		881-882	264, 271	121		
Long haul	1419						
Consultation not either / or	1334-1335, 1484	612				541-542, 413-415, 545-546, 548-549	
Directive			805-806, 935-936, 821-823		704-705, 724, 769-770, 774	360, 369, 371-372, 399-400, 374-375, 403-404, 394, 396-397, 399, 406, 408-409	
Impact of Age			518, 520, 529-531			560, 586-587, 589, 315-316, 350, 561, 564-565, 560	675, 678-679
Additional bits				300, 388, 397, 417-419, 399-405, 407-409,		529-531, 533-537	551, 566, 656

				416, 425-427, 432-433, 437-438			
Change in workers				611-612		490	
Working with carer as well					726-727, 750		656