Therapeutic Childcare Standards

Second Edition

Editors: Leyla Ury, Katy Carver, Niamh Roberts, Sam Dicken, Cat Stanesby, Beth Thibaut

Table of Contents

Therapeutic Childcare Standards Second Edition

Royal College of Psychiatrists

Centre for Quality Improvement

21 Prescot Street

London E1 8BB

Community of Communities (CofC)

Introduction

The second edition of the Therapeutic Childcare Standards has been revised by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI).

It is based on the first edition which was created by the CCQI and piloted in 2016. These standards were designed to support quality improvement in services which demonstrate a commitment to providing a clear model of therapeutic childcare for children and young people. This can include but not limited to, schools, foster services and children's residential services.

This addition has been developed for the purpose of review as part of the Community of Communities (C of C) network. They can also be used as a guide for new or developing services.

The standards cover the following topics:

- Statement of Principles and Practice (Practice Model)
- Relational Leadership and Management
- Caregivers
- Therapeutic/Care Plan and Framework
- The Physical Environment
- Building Relationships and Belonging
- Physical Intervention
- Therapeutic Governance and External Relations
- Social Media
- Equity, Diversity and Inclusion (EDI)

What is Therapeutic Childcare?

Therapeutic childcare has a clear psychosocial practice model is applied and understood at all levels of the organisation.

The service has leadership that is appropriately qualified and functions in a way that is consistent with the stated practice model.

Caregivers can describe the stated practice model, receive training in it and can demonstrate its application in their practice.

There are structures and routines in place that maintain the psychosocial model of practice, and Children and young people are active participants in the therapeutic environment.

Therapeutic childcare encourages play and playfulness, and the caregivers, children and young people are actively involved in the process of moving to and from the service.

The physical environment is planned and adapted to meet the purposes identified in the practice model.

The service also places an importance on building relationships and a sense of belonging. In addition, physical interventions delivered by appropriately trained caregivers are planned and engaged with proactively in accordance with the psychosocial model.

The Therapeutic / Clinical Governance structures ensure professional oversight of therapeutic planning and delivery and provide credible and objective oversight of the therapeutic model.

External relationships are sought and valued and the service uses data to measure progress, achievements, and placement objectives, and analyses these continually.

Also, the safe use of internet, email and social media is reflected on and supported in line with the psychosocial practice model.

Equity, Diversity and Inclusion informs the psychosocial model and service practices.
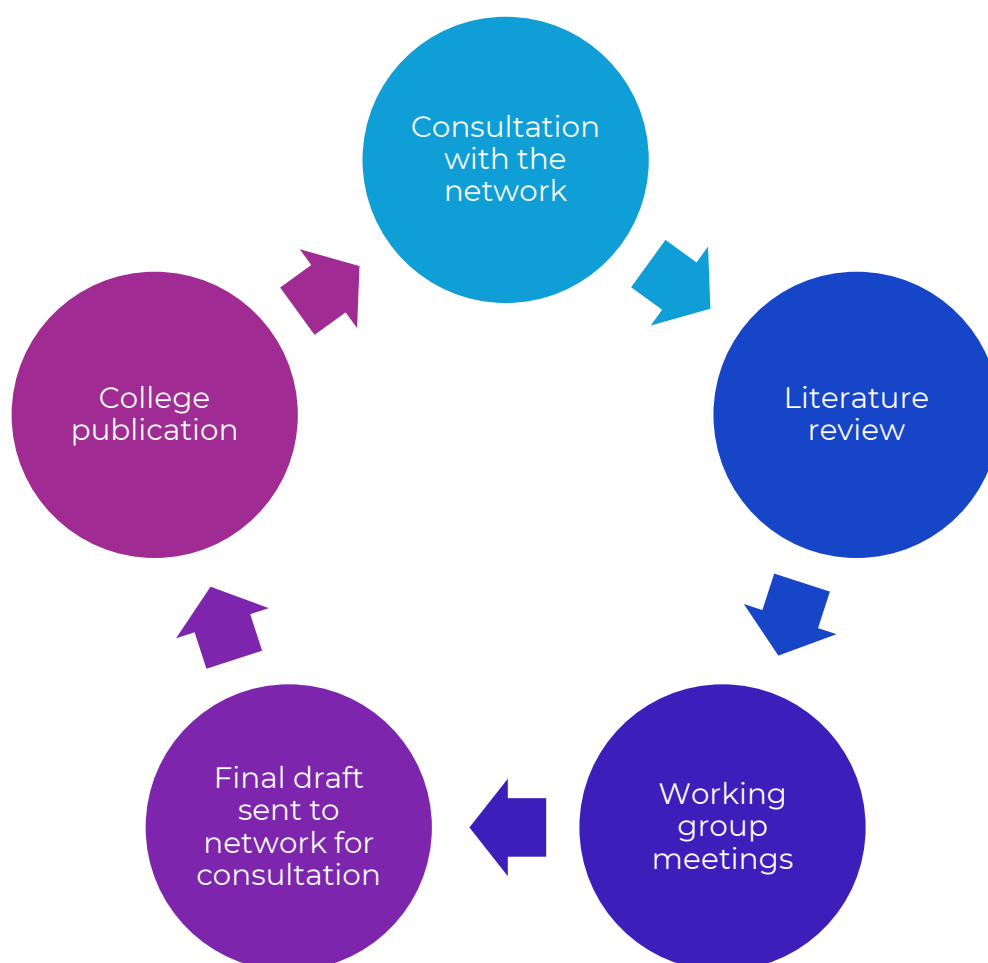
How the Standards were developed

The previous standards were sent to the current services for consultation comments. We also asked children and young people what therapeutic childcare meant to them.

A literature review was also undertaken to identify any evidence published since publication of the first edition of the standards which could be used to update existing standards and create new standards. This was done by a group of multi-disciplinary professionals and CCQI staff.

We then formed a working group comprising of multi-disciplinary professionals and CCQI staff to review the standards, which had also been mapped on to CCQI Enabling Environments Standards, and the Social Care Common Inspection Framework.

Information from the consultation comments, literature review and working groups was used to create the Second Edition of the standards.

Figure 1, Standards Revision Process:

- Consultation with the network
- Literature review
- Working group meetings
- Final draft sent to network for consultation
- College publication

The Standards

The final standards, we believe, will enable participating services and reviewers to focus on the issues that are key to quality. The standards were guided by relational practice principles.

The TCC standards will be used by members of the Community of Communities network within the CCQI who opt to use these standards for quality improvement.

Use of terminology

The TCC standards use the terms 'children' 'young people' and 'caregivers'. The decision was made to use these terms during the consultation process for the second edition of the standards, moving away from using 'children' 'young people' and 'staff'. If these terms are not appropriate for the member using the standards, they can change these depending on their speciality.

Criteria

All criteria are rated as Type 1, 2 or 3.

- Type 1: Essential standards. Failure to meet these would result in a significant threat to the children and young people's safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.
- Type 2: Expected standards that most services should meet.
- Type 3: Desirable

Currently there is no Therapeutic Childcare Accreditation Process. However, all standards are structured into types so that services can prepare for that when it is launched post pilot.

Therapeutic Child Care Standards Second Edition

Standard Number	Standard	Typing
	Statement of Principles and Practice (Practice Model)	
1	• **A clear psychosocial practice model is applied and understood at all levels of the organisation.** **Guidance:** The model: - should be clearly defined in the statement of purpose. - should recognise the relevance of the external environment alongside the emotional and social internal experience of children and young people. - should define a supportive environment that acknowledges the living learning environment. - needs to be dynamic, thoughtful and reflect on the individual needs of the child or young person. The model needs to be considered at all stages. Stating that the service has a therapist is insufficient as the therapist is not the only person delivering care. Therapeutic care is undertaken by all the people children and young people spend time with, which can include, residential workers, carers, and parents. As such, these people need to be sufficiently trained and/or have an awareness and understanding of the model and why it is used to provide care.	N/A

1.1	There is a stated psychosocial practice model that is shared with all Governance Partners. **Guidance:** The stated model should be shared in writing, and also in planning meetings, such as Placement Agreements and Care Plans. It might be in the child or young person's Education, Health and Care Plan (EHCP). This could be evidenced in a statement of purpose, or documents that show how you are going to meet the child's needs. For schools, this could be a prospectus. Governance partners could be internal and/or external. There should be a focus on reciprocal engagement between the service and Governance Partners. **Reviewer Guidance:** Please be aware that Governance partners may differ across devolved nations.	**1**
1.2	The stated practice model clearly links practice with recognised psychosocial theoretical frameworks. **Guidance:** This model should be recognised and supported by literature. It should be relevant to the needs of the children and young people, and coherently embedded in a thoughtful way.	**1**
1.3	The stated practice model informs caregiver recruitment and training, e.g. via a competency framework, or values based framework. **Guidance:** The values and qualities of a caregiver that are needed to deliver the model should be considered here.	**1**

1.4	The stated practice model is reviewed annually to ensure it meets the children or young people's needs, including input from children and young people, and caregivers. **Guidance:** The service should review the relevance, applicability and effectiveness of the model. Here, the focus is whether the model is continuing to meet the children or young people's needs.	**1**
	Relational Leadership and Management	
TCC2	**The service has leadership that is appropriately qualified and functions in a way that is consistent with the stated practice model.**	**N/A**
2.1	The service leadership is committed to the psychosocial model and supports caregivers to deliver it. **Guidance:** Leadership also includes members of the board of trustees. There should be evidence of: - Investment into training and practice of the model - Hiring practices (values of caregivers reflect the model) - Delivery of the model being prioritised - The model approach being incorporated into all functions and practices of the service and leadership	**1**
2.2	The service leadership is appropriately qualified and experienced. **Guidance:** There is not a prescriptive qualification required by leadership within TCC services; the service must demonstrate that qualifications held are relevant to the practice model.	**1**
2.3	The service's strategic/business plan demonstrates a commitment to the stated practice model approach.	**2**

2.4	Children and young people and caregivers feel supported by the leadership.	**1**
2.5	The leadership fosters a reflective, learning culture at all levels of the service, where power and authority are open to question by children, young people and caregivers.	**1**

Caregivers		
TCC3	**Caregivers can describe the stated practice model, receive training in it and can demonstrate its application in their practice.**	**N/A**
3.1	All caregivers can describe the service's psychosocial model of practice and how it is used to support child development.	**1**
3.2	Supervisors should be appropriately trained, experienced, knowledgeable and skilled in the psychosocial model. **Guidance:** For services that have clinical professionals, they must be suitably qualified.	**1**
3.3	Caregivers know how to prevent and respond to sexual exploitation, coercion, intimidation, and abuse.	**1**

3.4	Caregivers engage in continual professional development and training relevant to the psychosocial model. **Guidance:** Caregivers should receive training regularly, and have a clear CPD pathway. Everyone is required to fufill the basic level of training, whilst additionally having the opportunity to develop and complete progressional courses. Space should be provided for all caregivers to reflect on their continuing professional development and training needs.	**1**
3.5	Caregivers are encouraged and supported to communicate their thoughts and feelings in appropriate spaces. **Guidance:** This includes being mindful that communication can take different forms.	**1**
3.6	Regular caregiver individual supervision takes place monthly and involves reflective discussion about the children and young people, theory, practice, and reflection on experiential learning **Guidance:** There needs to be evidence that this time is planned, protected and effective. If it is not happening there has to be a process to record and escalate this. There also should be access to different types of the support, that caregivers can have access to. Leaders must be aware of compassion fatigue.	**1**
3.7	Monthly group reflective supervision for caregivers takes place and involves reflective discussion about the children and young people, theory, practice, and experiential learning. Reflective group supervision is used by caregivers to explore the relationships that exist between them and the impact these have on their work.	**2**
3.8	Caregivers can access a range of support in relation to health and wellbeing. **Guidance:** For example, this could include generous annual leave, flexible hours, access to leisure and recreation, counselling, and stress reducing strategies.	**1**

3.9	There is a process in place to gain input from children and young people and caregivers into each other's reviews or appraisals. For example, using 360-degree feedback.	**3**
3.10	There are sufficient caregivers to deliver activities and the therapeutic plan. **Guidance:** Sufficient staffing levels must be maintained to deliver activities without necessitating substantial and frequent overtime by caregivers.	**1**
Therapeutic/Care Plan and Framework		
TCC4	**There are structures and routines in place that maintain the psychosocial model of practice.** **Guidance:** The stated psychosocial model of practice is in place to support children, young people and caregivers to understand how they relate each other, with the corresponding therapeutic/care plan attending to agreed identified needs. The structures and routines in the service support delivery of the psychosocial model in place.	**N/A**
4.1	There is a clear structured therapeutic plan and/or approach used by the service. **Guidance:** This criterion refers to the overarching therapeutic plan, not the child or young person's individual care plan.	**1**
4.2	There is a consistent, planned, and purposeful routine with clear boundaries. **Guidance:** This is about providing a basis for emotional safety. This should take into account play, mealtimes, and should pay attention to transitions throughout the day between activities.	**1**

4.3	There is purposeful use of spontaneity and creativity, which is supported by the therapeutic/care plan. **Guidance:** For example, opportunity-led work, informal time, and children and young people's choice in activities.	**2**
4.4	The purposeful use of and quality of relationships is central to the service approach and to care planning. **Guidance:** There is a structure in place to ensure the purposeful use of relationships as a central tool used in the approach and care planning.	**1**
4.5	The therapeutic/care plan is non-punitive, and adopts reparative ways of resolving hurt, conflict and damage, which works towards a meaningful outcome	**1**
4.6	There are proactive measures to support the continuty of caregivers in all settings in order to maintain the therapeutic culture and relationships. **Guidance:** There are structures in place to thoughtfully address ruptures and disruptions.	**1**
4.7	Direct therapy is available for children and young people, and there is a clear process to access this. **Guidance:** This refers to direct therapy with therapists (internal or external to the service) and the direct process would involve clinical assessment. All caregivers should be able to inform children and young people of the process to access direct therapy.	**2**
TCC5	**Children and young people are active participants in the therapeutic environment**	**N/A**
5.1	Behaviour is understood as communication and is explored and discussed.	**1**

5.2	There are structures in place for children and young people's voices to be heard and acted upon.	**1**
5.3	Children and young people are encouraged and supported to communicate their thoughts and feelings. **Guidance:** This includes being mindful that communication can take different forms.	**1**
5.4	Children and young people are supported to understand and explore risks and risky behaviour and participate in positive risk. **Guidance:** This should also consider different types of risk in different settings, including within the service, external environments (including online), and the differences between physical and emotional risk.	**1**
5.5	Children and young people are supported to be actively involved in reviewing their care. **Guidance:** This includes involving the children in assessment, development goals, therapeutic plans etc.	**1**
TCC6	**The service encourages play and playfulness** **Guidance**: Play is fundamental, and fills in the developmental gaps where children and young people may have not had the chance to be playful. Play and playfulness can take many different forms (for example, relationships, creativity, art, music) and will need to be appropriate to the age and stage of the child or young person.	**N/A**
6.1	The organisation creates opportunities for children and young people to play and be playful, whether together or alone.	**1**

6.2	The organisation creates opportunities for children and young people to play with caregivers.	**1**
6.3	Play and playfulness are used to explore the development of relationships and encourage emotional learning. **Guidance:** This could be done through the therapeutic approach e.g., PACE	**1**
TCC7	**The caregivers, children and young people are actively involved in the process of moving to and from the service**	**N/A**
7.1	There is a process that takes account of the current composition and needs of the environment prior to accepting new caregivers, children or young people.	**1**
7.2	There is thoughtful preparation for moving to and from the service that involves caregivers and children and young people, and recognises the impact of moving to and from new settings. **Guidance:** This includes having consistent and continuing conversations throughout the children and young people's time at the service to actively involve them in planning for their future.	**1**
7.3	The service promotes positive transitions by marking caregivers, children and young people moving to and from the service in a way that is appropriate for each individual.	**1**

7.4	Individual and collective achievements and milestones are celebrated by the service when marking transitions. **Guidance:** This could include qualifications, anniversaries etc.	1
7.5	There are processes in place to support unplanned movings to and from the service.	1
	The Physical Environment	
TCC8	**The physical environment is planned and adapted to meet the purposes identified in the practice model**	N/A
8.1	Appropriately resourced and protected spaces are available to deliver the therapeutic approach. **Guidance:** There is also clarity and consistency regarding what the space is used for. For example, if direct therapy is used, there is a personal, private, and confidential space.	1
8.2	Caregivers, children and young people work together to keep a clean, tidy and well-maintained space.	1

8.3	Caregivers and children and young people are involved in making decisions about their physical environment. **Guidance:** This involves sharing decisions about decoration, layout, colours etc.	**2**
8.4	Visitors find the environment to be welcoming. **Guidance:** This is mostly observational, however it could also be evidenced through recording and monitoring feedback from visitors.	**1**
Building Relationships and Belonging		
TCC9	**The service places an importance on building relationships and a sense of belonging**	**N/A**
9.1	There are policies and procedures to support the development and maintenance of a therapeutic culture. **Guidance:** Policies and procedures should protect the following domains as elements of the culture: - ideological: the prevailing values and beliefs as implemented by caregiver and managers - organisational: the way aims and values are enshrined in structures and caregiver roles - caregiving: the characteristics, training, and attitudes of caregivers - residents' responses: for example, whether there is learning or socialisation Such processes, such as regular caregiver support groups, training, induction, and supervision, would ensure the therapeutic culture is resilient as children and young people and caregivers leave.	**1**

9.2	The service has a therapeutic culture that supports and facilitates emotional containment. **Guidance:** Caregivers are trained and receive ongoing support to understand and reflect on any strong feelings and respond calmly to behaviours that challenge them. Relational dynamics, transference, countertransference, and reflection are discussed within the service.	**1**
9.3	Caregivers, children and young people feel that they are listened to and understood by others around them.	**1**
9.4	Peer support is recognised, valued and encouraged by caregivers, children and young people	**1**
9.5	There are expectations of behaviour that underpin the therapeutic culture, with processes to maintain and review them that involve children, young people and caregivers.	**1**
9.6	Everyone can describe how the therapeutic culture makes them feel emotionally and physically safe. **Guidance:** Caregivers and children and young people may reference ideas of containment, belonging, being cared for, building trust, having their needs met, etc.	**1**
9.7	There are clear boundaries regarding physical contact that are understood by all. **Guidance** These boundaries should focus on learning and development regarding touch and the understanding of it.	**1**

9.8	Caregivers, children and young people share an understanding of how physical contact can be used to support each other. **Guidance:** There should be an understanding of the benefits of positive touch and affection for healthy child development, whilst observing defined boundaries and individual preferences/needs.	**2**
9.9	Caregivers, children and young people share an understanding of language used in the service and the impact this has. **Guidance:** Everyone in the service can explain the impact of language and this is discussed. Caregivers, children and young people are concious of using terms such as "LAC", "caregiver", "on shift" or "contact" which can be institutionalising and stigmatising. Language used within the service is developed and understood collaboratively by children, young people and caregivers.	**2**
	Physical Intervention	
TCC10	**Physical interventions delivered by appropriately trained caregivers are planned and engaged with proactively in accordance with the psychosocial model.**	**N/A**
10.1	The service has a clear policy on the use of physical intervention that embodies the psychosocial practice model.	**1**
10.2	All children, young people and caregivers are able to describe why and when a physical intervention might be used.	**1**
10.3	All caregivers should be trained to understand how and when to safely perform physical interventions in adherence with any Regulatory Body specifications and NICE guidelines.	**1**

10.4	Each child or young person's care plan should include all strategies to be employed before, during, and after a physical intervention, in accordance with the psychosocial model as well as individual communication and behaviour needs. **Guidance:** Each child or young person's care plan should contain alternative strategies used before physical intervention that are informed by the service's psychosocial model and adapted to individual behaviour and communication needs. Alternative interventions should use relational techniques to de-escalate and offer containment for children and young people's emotions. The plan should also document emotional and social care needs following a physical intervention. Caregivers should receive ongoing support about how to deliver this.	**1**
10.5	All incidents of physical interventions are reflected on within the context of the therapeutic culture and in ways consistent with the practice model, with the space for caregivers, children and young people to express and discuss their feelings. **Guidance:** Leaders provide clear structures for debriefings following physical interventions. Debriefings include discussion of strategies that were used prior to physical intervention and how these might be differently deployed in the future to avert physical intervention.	**1**
10.6	All instances of physical intervention are recorded and reported to the appropriate body. **Guidance:** The appropriate body could be Reg 45, for example.	**1**

10.7	Leadership collects audit data on the use of physical interventions, including the ethnicity of the children and young people, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. **Guidance:** Leadership routinely monitors data on physical interventions to identify any patterns or trends that may emerge. This should include the ethnicity and other protected characteristics of caregivers, children, and young people. Audit data should be used to compare the service to national benchmarks where possible. This standard cannot be scored as "Not Applicable".	**1**
Therapeutic Governance and External Relations		
TCC11	**Therapeutic / Clinical Governance structures ensure professional oversight of therapeutic planning and delivery and provide credible and objective oversight of the therapeutic model**	**N/A**
11.1	A clear Governance structure is documented. **Guidance:** Roles and responsibilities at the different levels of Governance are clearly documented.	**1**
11.2	The Governance reflects the expertise required within the practice model for the needs of the children and young people.	**1**
11.3	Governance structures / partners inform and influence the ongoing development of the psychosocial model and its implementation **Guidance:** This is clearly reflected in the service's plans/strategies for ongoing development.	**2**

11.4	Service self-evaluation structures involve consulting with Governance partners. **Guidance:** Governance partners have documented input into any form of self-evaluation and quality improvement the service undertakes, including assessment of strengths, weaknesses, goal-setting, and action planning engaged in for inspections e.g. Ofsted, CQC etc.		**3**
11.5	The service use effective safeguarding policies and procedures, and monitors the number of allegations and the ways in which they are identified, investigated, and responded to. **Guidance:** This should be in line with the practice model.		**1**
TCC12	**External relationships are sought and valued**		**N/A**
12.1	The service is committed to learning and sharing with external organisations, contributing to the shared evidence base for Therapeutic Child Care. **Guidance:** For example, attending events, actively engaging in review days (hosting and attending), producing and participating in research, conferences etc.		**1**
12.2	The service communicates and works with the children and young people's families and external support networks where possible.		**1**
TCC13	**The service uses data to measure progress, achievements, and placement objectives, and analyses these continually.** **Guidance:** There is no universal tool, therefore examples are (but not limited to) caregiver resilience, C Scale etc. It must be used as a working process, where feedback is a continuous system. This could include an external evaluation, where practice is reviewed using data from the service that it collects annually.		**N/A**

13.1	The service collects and uses data which continually monitors progress and achievements for each child and young person.	**1**
13.2	The service conducts self-evaluations and collects data to measure effectiveness and quality of practice at least annually. Guidance: There should be a culture that encourages all stakeholders (this includes, children and young poeple, caregivers, external reviewers etc.) to openly feedback. This is gathered and utilised by the service.	**2**
13.3	The service comissions external evaluation to measure effectiveness and quality of practice **Guidance:** SERC Journal offers a list of tools. Services may use more then one and it should be relevant to the model. The Reg 44 is an evaluation against the standards, but for this criteria, there should be an evaluation on the quality of the practice.	**2**
13.4	The service has a system for receiving and responding to changes in the evidence base for Therapeutic Child Care. **Guidance:** This could include undertaking regular literature reviews.	**3**
13.5	Data and evaluation are used to inform and improve the work of the organisation. **Guidance:** There could be an annual meeting associated with self-evaluation findings and action-planning. Evidence could include the minutes/action plan.	**2**

	Social Media	
TCC14	**The safe use of internet, email and social media is reflected on and supported in line with the psychosocial practice model.**	**N/A**
14.1	There is a clear statement or policy regarding the use of internet, email and social media.	**1**
14.2	Children and young people and caregivers can describe the rules and boundaries surrounding internet, email and social media use. **Guidance:** This includes any use of online communication, including gaming systems. Descriptions are expected to differ according to age and stage.	**1**
14.3	Children and young people and caregivers can explore the impact of internet, email and social media, and openly discuss the risks involved in its use. **Guidance:** There is an expectation that alll children, young people and caregivers have the space to explore with one another the positives and negatives of social media and internet use. Evidence provided might include trainings, meeting minutes, learning agendas etc.	**2**
14.3	Incidents involving internet, email and social media use can be raised and openly discussed in the service. **Guidance:** The service allows a permissive environment for these kinds of incidents to be appropriately explored and discussed in a non-punitive way.	**1**

	Equity, Diversity and Inclusion (EDI)	
TCC15	**Equity, Diversity and Inclusion informs the psychosocial model and service practices.**	
15.1	There is an overarching EDI policy that demonstrates a clear understanding of intersectionality and the impact of diverse identities on the relationships and experiences of children, young people, and care givers. **Guidance:** a. The policy should recognise the impact of discrimination, privilege and past experiences in relation to children, young people, and caregivers' personal abilities, identities and backgrounds, including how this affects communication. b. The policy should recognise the ways that equitable care on an interpersonal and organisational scale is integral to the wellbeing and relationships of children, young people, and care givers. c. The policy should detail the service's inclusive accessibility provisions for all diverse identities, needs, and communication styles, regardless of the current composition or diversity within the service. e. All caregivers should be aware of and able to refer to this policy	**1**
15.2	The service actively considers intersectionality in the provision of its psychosocial model and practices to provide equitable care and support for all children, young people, and caregivers. **Guidance** a. The service should use inclusive and equitable practices in its recruitment, appraisal, and management processes for caregivers. b. Training and associated supervision for caregivers should support the development and application of skills and competencies required in the role to deliver equitable care. c. Both conscious and unconscious bias are examined and addressed within day-to-day processes. d. There should be provision of reasonable adjustments for the accessibility and communication needs of all children, young people and caregivers that are re-evaluated regularly in collaboration with the individual.	**2**

15.3	There are opportunities to recognise, celebrate, and explore different abilities, identities, and backgrounds for all children, young people, and caregivers that every individual is involved in. **Guidance:** This could be in the form of cultural celebrations, the provision of culturally specific materials (films, books, news articles, food, etc.), learning events surrounding diversity, and links to external networks that provide new cultural perspectives and relationships	**1**
15.4	There are learning opportunities to explore how communication differs between individuals based on their personal and cultural identities.	**1**
15.5	All caregivers, children, and young people feel that their personal differences are acknowledged, supported, and celebrated.	**1**
15.6	Issues and incidents regarding equality, diversity, and inclusion can be raised, openly reflected on, and appropriately acted on within the service.	**1**
15. 7	Feedback received from children and young people, and carergivers is analysed and explored to identify any differences of experiences by protected characteristics.	**2**
15.8	Data is collected and evaluated to identify differences in outcomes of children, young people, and caregivers in relation to protected characteristics and this is shown to inform policy and practice.	**3**

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C OF C

The Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB