MODELS OF 'ORDINARY' AND 'SPECIAL' DAILY LIVING: MATCHING RESIDENTIAL CARE TO THE MENTAL HEATH NEEDS OF LOOKED-AFTER CHILDREN

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Abstract

This paper proposes a set of distinctions between 'ordinary' and 'special' modes of everyday living in residential settings for young people in the 'looked-after' system. The paper begins by reviewing both quantitative and qualitative evidence on the mental health needs of the young people, arguing that there is evidence of very high levels of mental distress and disturbance within this group, and that this distress is often undiagnosed and untreated both by psychiatric professionals and within the residential care system itself. There follows a commentary on the tacit assumptions underpinning much residential practice, especially the emphasis in some policy and legal documentation on the young people's need for 'ordinary' everyday experience. The concept of the 'ordinary' is problematised, and it is argued that while young people do need to be supported towards mainstream 'ordinary' everyday living, they also need specialised everyday care in which their emotional and psychological needs can be recognised and responded to. Four models of 'special everyday living' are proposed, based upon existing literature on residential practice, and it is argued that residential care programmes should be based upon a mix of these special and ordinary provisions if the young people's emotional needs are to be met.

Keywords: Residential Care, residential treatment, mental health, looked-after children, group care, therapeutic care

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How should residential staff look after the troubled young people in their care? Should they aim primarily to provide 'good ordinary care' for young people or should they tailor this care more specifically to the 'special' needs of individuals and groups - and if the latter, how should this be achieved? The significance of these questions is that, in a perceived shortage of useful and relevant theory (Bullock *et al* 1993), practitioners, managers and policy-makers are often left to make it up as they go along, sometimes apparently working without any theoretical frame of reference (Berridge and Brodie 1998) and sometimes relying more on official guidance and legislation than on theory and research. While official guidance certainly has its value, its limitation is that by its nature it tends to be generalised rather than specific, and protective and cautious rather than creative and responsive. In particular official guidance in the UK has increasingly adopted a tone of seeking to emphasize 'normal', 'ordinary' and 'mainstream' experiences for young people, in the hope of enabling the young people to remain or become more socially included and thus to have better life prospects, rather than emphasizing their special, individual or therapeutic needs. While these aims are admirable at an aspirational level, they perhaps take insufficient account of the reality that, given the great level of difficulty which those currently using residential services bring with them, achieving the 'ordinary' and rejoining the mainstream is a much harder and more problematic challenge than it may initially appear, requiring professional help based upon theory and research as well as on individual insight and skill. This challenge is probably also increasing since residential care now forms only 10% of care placements, meaning that the children (both individually and collectively) now present a more severe and complex set of needs than would have been the case in the past. This paper seeks firstly to explore the nature of this challenge and secondly to propose a

framework for planning to address young people's needs for both 'ordinary' and 'special' treatment.

Context: The emotional needs of young people in residential care.

To set the context for the ensuing discussion I want to draw attention to the nature of the contemporary residential child care task by reflecting on the levels of emotional and psychosocial need among the young people using the service. It is well established that many of the young people in residential care will have experienced extreme difficulties in their families of origin (Wade *et al* 1998) as well as in their ecological context of school, neighbourhood, and community (Bebbington and Miles 1989). They are very likely to have experienced abuse, neglect or other trauma as well as the effects of seriously distorted family relationships (Berridge and Brodie 1998), including many cases of both physical and sexual abuse (Barter *et al* 2004, Farmer and Pollock 1998). For many young people these difficulties will have been compounded by a series of (often unplanned or short-notice) moves from one family or environment to another (Utting 1997), sometimes including multiple changes of school, community and peer-group (DoH 1998a, Stein 1994). There is also powerful and compelling evidence, in the UK at least, about the effects on young people of these traumatic influences, including severe educational (Hayden 1997; Brodie 2001), health (Mather *et al* 1997) and economic disadvantage (Biehal *et al* 1995), and poor employment prospects (Stein *op.cit.*).

In particular there is evidence of very high levels of mental health difficulties among these young people. In 2002 a UK Government review of young people 'looked after' in residential care reported incidence rates for emotional disorders, conduct disorders and hyperkinetic disorders among of 17.7%, 56.2% and 7.9% respectively, compared with 5.6%, 6.2% and 1.5% among the general population (Meltzer *et al* 2002). Earlier work by Dimigen et al (1999) had indicated that young people typically *enter* care with these problems, rather than acquiring them after entering the care system. These figures confirm the findings of

qualitative researchers such as Sinclair and Gibbs who reported very high levels of unhappiness, loneliness and worse among the residents in children's homes:

> "Hardly any described themselves as often happy, and a staggering four in ten had apparently considered killing themselves in the last month"
>
> (Sinclair and Gibbs 1998, 190)

This picture is similar to the 'pain-based behaviour' found among young people in residential care in Canada (Anglin 2002).

For the great majority of these young people their mental health problems are neither explicitly recognised nor actively treated in their placement settings (Berridge 2002, Berridge & Brodie 1998), although it is clear that where specific help *is* offered by the residential staff, children's unhappiness may be considerably alleviated (Sinclair and Gibbs *op. cit.*), Whitaker *et al* (1998), Barter *et al* (2004). The general system of residential care, however, is simply not geared to systematically addressing the expressed and evident needs of the young people. Sinclair and Gibbs found that 'most homes described themselves as general purpose' (*op.cit.*, p.95) and very few could identify specific aims or methods. Likewise Berridge and Brodie (2000) found that only 5 of 12 homes studied had completed their statutorily-required 'Statement of Purpose and Function', and even fewer could articulate a coherent philosophy of practice. In practice, most of these homes become known as 'ordinary children's homes' often with no more specific remit than to admit children within a wide age range and to provide accommodation for them within broad categories such as 'short-stay' or 'long-stay'. The various typologies of home identified by researchers such as Sinclair, Brown and Berridge are perhaps less evident at ground level than in the academic texts, with the 'ordinary children's home' probably remaining the dominant model. In these circumstances, and with the continued lack of training and staff development opportunities available to many of them, residential staff are often left to improvise methods of care and treatment, and to

draw upon their individual and collective intuition including 'common sense' assumptions as to how everyday life should be handled.

In summary, the evidence confirms the challenge which residential staff increasingly face in providing good supportive and empowering everyday life experiences for young people who come from extremely troubled backgrounds, who carry high levels of mental distress and anxiety, and whose future is often very unclear and unpredictable. A significant aspect of this challenge is the question as to how we can balance between the needs for ordinary living and for special treatment?

1. Re-evaluating assumptions about 'ordinary' daily life:

Despite this data about the levels of emotional distress among children in residential care, much residential policy and practice in the UK appears to be currently guided by tacit assumptions about children's needs for so-called common-sense responses, rooted in a belief in the value of 'ordinary everyday experiences'. Such assumptions are sometimes made explicit in official guidance through an emphasis on (for example) the physical location or characteristics of homes, but they often extend beyond these physical characteristics to include expectations about 'ordinariness' in many other aspects of daily life.

There is certainly some validity in such an approach, and although I shall be arguing for a 'special' approach to everyday life, it is true that everyday life must also feel 'ordinary' if it is to be tolerable, relaxed and manageable - and, indeed, if the 'special' elements are to feel truly special. It can be argued that all children, including those who have lived in hostile, cold or confusing environments, need to be treated as if they are ordinary competent children, and to discover that this can be satisfying for them. The hope is that even those who have had very difficult and distressing earlier experience will benefit from being subject to

'normal' expectations, rather than always having allowances made which might emphasize their sense of being different and which thus might reinforce any secondary rewards which they may gain from behaving oddly or badly. It can be argued that emphasizing the 'ordinary' will have the effect of helping children to feel socially *in*cluded rather than *ex*cluded, *similar* to rather than *different* from other children, and valued rather than awkward or troublesome members of society (Gilligan 2004 and 2005) and that thereby a positive self-fulfilling prophecy can be set in motion. The hope is that the young people will be more likely to be able to rejoin family life (whether in their own or substitute families) and mainstream schooling and less likely to drift from into an institutionalised adulthood in hostels, hospitals and prisons.

This approach is sometimes advocated under the banner of normalisation, drawing upon the work of Wolfensberger (1983) and others, and indeed the concept of normalisation began with an emphasis on the quality of daily life (Nirje 1969). The broad principles of normalisation and 'social role valorisation' are undoubtedly of great value both as general principles and specifically for groups such as people with learning difficulties and with physical disabilities. However, in terms of the experience of young people with the level of emotional difficulties described above, it can be argued that normalisation is a more problematic concept and for some may realistically be a more distant goal. Thus Anglin (2002) emphasizes young people's struggle to achieve 'a *sense* of normality', referring to the individual's subjective experience and meaning-making rather than to the external imposition of 'normalising' arrangements. The proposal in the present paper, in fact, is that some young people may only be able to start feeling ordinary once their special and very individual needs have been understood and addressed (Maier 1981).

Implementing ordinariness

In current practice, an 'ordinary life' approach to residential care is often implemented through planning everyday routine events in such a way that they

will perhaps feel more like 'family life' than 'institutional living' (Berridge & Brodie 1998). Thus mealtimes will be relaxed and informal, using home-cooked food, sitting in 'ordinary' sized rooms and in small groups rather than at large refectory-style tables, all of which is now standard practice in almost all Western residential child care settings (Madge 1994, 58-9). Here the positive impact of normalisation is very clear. Other aspects of everyday life will be conducted in a similar spirit, including bedtimes, leisure activities and the handling of critical incidents (Whitaker *et al* 1998). Children will have patterns of interactions and relationships with neighbours, peers, schools and the local social environment which are intended to be similar to those of any other children (Berridge & Brodie 1998,104). This approach can also be seen in the move throughout the developed world from larger residential homes to smaller units of perhaps 5 or 6 children, and in some cases even fewer, usually accommodated in an 'ordinary house on an ordinary street'. Official Guidance in the UK stated: 'If possible a home should be indistinguishable from an ordinary family residence in outward appearance and siting' (Dept of Health 1991, 12). Arguments about what is 'ordinary' thus draw us quickly into debates about 'family' - what it is, what its values are, and what it represents in society. This is hardly surprising, since the task of residential care and treatment has always evoked powerful echoes of family (Davis 1981). On the other hand it also hints at one aspect of the problematic nature of the assumptions about ordinariness, since it is clear from the evidence (e.g. Berridge & Brodie *op cit*, Sinclair and Gibbs *op cit*., Millar 2005)) that many young people view residential care as a positive preference compared to the family (foster care) alternative.

Within this overall approach, adults will often also be seeking to provide an atmosphere of 'ordinary relaxed living', without excesses of stimulation or over-reaction. In terms of the handling of everyday interactions and incidents this might also be accompanied by an emphasis either on low-key responses to any problems which arise, or on so-called 'common sense' responses rather than those explicitly aimed at promoting insight or based upon therapeutic principles.

This approach is often combined with an unwillingness to categorize children in terms of their special needs, for fear of 'pathologising' them and their families, and sometimes with a reluctance to use or even an explicit rejection of the notion of a 'treatment' component in residential care. It is an approach which in the UK is sometimes associated with a values position emphasizing empowerment and social justice; for a clear account of a 'rights-based' approach to residential care see Frost *et al* 1999. This approach is also consistent with a 'strengths' perspective and an emphasis on supporting young people's resilience (Gilligan 2001, 2005). From a different perspective the 'common sense element of this approach may also be associated with an anxiety that it might be unhelpful or even harmful to young people if staff 'make allowances' or are perceived by young people as indulgent or 'soft'.

Critiquing ordinariness

This emphasis on the notion of 'ordinary' everyday life experiences has considerable appeal at many levels, and some of its elements are unquestionable. However, it also carries significant risks. It may appear attractive, for instance, just because it makes a very difficult task sound straightforward and achievable, whereas this may be quite misleading, given the nature of the clientele as discussed above. If staff are led to expect that "all these children need is a dose of ordinary parenting / family life", they are likely to discover before long that it will not always work like that.

The apparently simple concept of the ordinary, in fact, turns out to potentially problematic in several respects. For example, children who have lived for any length of time in families or other settings in which other people's behaviour is persistently confused, violent, bizarre, neglectful, abusive or otherwise distorted are likely to have learned that *that* is the norm. The result may be both that their own behaviour is seen as outside 'normal' acceptability, and that what others might call 'ordinary' or 'common sense' may be experienced by them as

confusing, bizarre or provocative. Staff therefore often have to manage the complex interplay between on the one hand their own normative assumptions and on the other hand the expectations of children whose perceptions of normal behaviour are quite different from their own. One consequence may be that if staff attempt to 'play down' the impact of young people's challenging behaviour this will have little effect. Thus, for example, Barter *et al* show that when staff attempt to minimise the impact of some young people's provocative behaviour upon each other, 'unfortunately in most cases this intervention (is) unsuccessful, probably reflecting the very complex problems and needs of the young people concerned' (Barter *et al* 2004, 169). In other words, 'normalising' assumptions do not always work.

Child care staff also need to be aware that one team member's belief about what is 'ordinary' may be quite different from another's. So even where a team might wish to work on this basis, they will need to compare the details of their individual assumptions and agree on a common approach on all key issues, otherwise children will find themselves subject to a whole string of different 'ordinaries', according to who is on duty. Across society as a whole, social class and other variables mean that there are probably very wide differences in assumption about 'ordinary' life for all children. This caution applies all the more strongly when we think about cross-cultural issues, in terms of the varying norms of family life and parenting practice in different cultural and religious groupings (Jones and Waul 2005, Singh 2005). With all this diversity, how can we know what is ordinary any more?

Finally it can be argued that in some cases, the desire of child care staff, including managers and policy-makers, to lay great or even sole emphasis on the ordinary may stem from a different and more problematic psychological root. It may relate to what has been called the 'assumption of ordinariness as a denial mechanism' (Trist 2003). This phenomenon was observed among coal miners who coped with inordinate danger and risk by telling themselves it was 'ordinary'

- thus putting themselves potentially at greater risk by ignoring real danger. The extrapolation to the present context would be that those working with children in the welfare system may sometimes find it too painful, too threatening (or, in the case of managers and policy-makers, too expensive) to acknowledge the depth of children's distress and to work explicitly with the impact and consequences of their trauma. They would prefer to cling on to the idea and aim of ordinariness rather than face the difficulties which any other view might imply.

For example, they may prefer to imagine that we can somehow start with a clean slate with a newly-referred child, as if we can enter into an unspoken contract with the young person that if *we* don't refer explicitly to their troubled history then hopefully *they* won't either - and that if *we* behave 'normally', then *they* will, too. Unfortunately, such an approach (which may affect broad policy as well as individual practice) does not always work, and it can be a most dangerous assumption, based on wishful thinking rather than on a genuine acknowledgement and understanding of children's needs. The evidence of the hazard to the young person of such an assumption can probably be seen from many of the cases in which children are continually moved on through a series of unsuccessful placements, but without adequate help in comprehending and recovering from what has happened in each placement. Each subsequent placement may be based on an idealised hope for a clean slate and a new start, but each of them is perhaps thereby rooted in denial and false hope, if the child's real needs are being denied or misunderstood.

Summary

To summarise this section, I am not, in fact, arguing *against* the ordinary, but *for* a reasoned and planned approach to its use. I propose that the benefit of the 'ordinary' approach will probably be greatest for those children who have had relatively 'ordinary' experience as well as for those who may be able to discover its rewards without too much conflict or confusion. It may also be more appropriate at a later stage in their residential treatment for those more troubled

children who have already, at an earlier stage, been able to make good use of the more 'special' kinds of care which I will describe in the second section, and who can now be expected to progress on to a more 'ordinary' approach in preparation for return to family life.

2. Models of special everyday living in residential child care

If 'ordinariness is not enough', then I propose that what is needed is an approach which I am calling 'special everyday living'. Thus daily life may be viewed as potentially offering a series of everyday challenges and opportunities for young people, in which they will need more or less support, encouragement and even correction, according to the nature and degree of their troubles. In particular, the focus here will be on the task and skills of the residential staff involved in the daily care of the young people, and on how adopting a 'special' approach can create and exploit the potential of learning and developing from the everyday. Not everybody will need the same kind of special provision, of course, and this paper will outline a number of variations on the theme of planning and providing this special everyday living.

Who needs a 'special' approach to everyday living?

While some of the children coming into residential care may have previously led relatively untroubled lives it must be recognised that even for these children, the experience of having to move away from home and into substitute care, even temporarily, will entail major experiences of separation, loss and the anxieties which these may bring. There is ample research evidence of the huge impact on even a relatively secure child's emotional well-being and sense of self which a major transition such as moving away from home and into substitute care may bring (e.g. Hayden *et al* 1999). For these children, something additional to the 'ordinary' will be needed if they are to be helped to survive the transition intact, and to understand and recover from the reality of their situation. For such

children, providing 'special' care is a way of recognising that life has become different and in some ways difficult, even if only temporarily so, and that they may need support to help them cope.

Beyond this group of relatively secure children, however, there will be many others with differing degrees of troubled experience in their history, including many, as we saw earlier, who will have experienced highly stressful and disturbing patterns of everyday life, and who may therefore find what others take to be 'ordinary' to be threatening and even alarming. For these children the 'ordinary daily life' model will certainly not be enough, as they will need an environment in which people will understand and make suitable allowances for their difficulties with some aspects of daily living.

What is the range of special everyday living?

Some aspects of what is special will be compensatory, in other words extra or complementary experiences to make up for those good experiences which the child may have missed out on, or to counteract the negative effects of earlier experiences - what Whitaker *et al* call 'reparative work' (1998, 58). Other aspects of the special will be more explicitly therapeutic, in the sense of providing focused, intensive but graduated support in a planned way, to address feelings of pain, confusion or anxiety which may relate to children's earlier experience and/or their current dislocated state. There will need to be considerable flexibility and adaptability within the planning of everyday life, to allow for the fact that some individuals may experience particular difficulties with some types of events.

I have identified a range of different modes of everyday living, although these are proposed not as different alternatives or as mutually exclusive - indeed in most residential units it will be appropriate to use some elements from each of these modes. For each mode I have highlighted its main assumptions, implicit theoretical roots, some of the techniques used, and some of the possible limitations.

Exploring the Modes of Everyday Living in Group care

1. Living Alongside: Being Ordinary

Assumption: Here the assumption is that all children, including those who have lived in confusing or stressful circumstances and those who have experienced sudden loss or transition, need to be treated as if they are ordinary competent children and to discover that this can be satisfying for them. Nobody, it is argued, likes to be made to feel 'different' and Anglin found that young people evidenced the need to develop 'a sense of normality', including 'a sense of belonging, a sense of self-worth, a sense of trust, or a sense of competence in some activity' (Anglin 2002, p.123).

Theory Base: The implicit theory base here is that it is 'common sense' to treat children as ordinary, and that we can all rely on the lessons from our own upbringing to guide us in our work with these children, just as we would in bringing up our own children. Other theories contributing to an emphasis on the ordinary include normalisation (Wolfensberger, 1983) and 'Strengths' and resilience perspectives (Saleebey 2005, Gilligan 2004).

Technique: This approach is usually operationalised through the cultivation of an atmosphere of what is assumed to be 'ordinary family life'. In terms of the management of daily life, staff will promote activities and schedules which are informal, low-key and age-appropriate, and in their handling of incidents and challenges they will usually aim for a rational and straightforward response. Gilligan (2005) has some moving examples of the positive impact of 'ordinary' activities and relationships. Staff will also probably aim to integrate children thoroughly into the activities and networks of the local community, keep them as close as possible to their home environment and maintain them in their original school where possible, all of which are clearly desirable aims for the majority of young people in residential care.

Limitations: The limitations of this approach to everyday life are that it only works if the children have the emotional stability and resilience and the intellectual capacity to handle it. We have already seen that some children cannot cope with 'normal' expectations, finding them threatening or confusing. In addition, it is clear that for many of the young people the intended parallels with 'family life' have associations which are predominantly negative rather than positive: in Sinclair and Gibbs's research (1998), 48% of the young people stated a preference for their current residential placement over their previous placements which were usually in foster care. In these circumstances, providing residential care based very closely upon tacit models of family life may not always be helpful (see also Millar 2005).

2. Living Alongside: Modelling Alternatives

Assumption: Here the assumption is that children, including children in a dislocated or distressed state, learn by observation and modelling in their social environment. They learn how to respond to the challenges of everyday life by observing how those around them respond. For example if children have grown up in restrictive or abusive environments they may have learned to cope with adversity by attacking others or perhaps by retreating into aversive or addictive patterns. However, staff can capitalise on this mode of learning by consciously modelling alternative and more positive ways of coping with difficulty, for example by remaining calm in the face of provocation, or by being willing to forgive minor insults. The aim of this approach is that children will thereby learn more positive ways of coping with the demands of everyday life.

Theory base: The implicit theory base here includes both social learning theory (Hawkins 1989) and attachment theory (Bowlby 1988, Stern 1985). It is assumed that all children learn by modelling themselves on attachment and other significant figures, and by recreating patterns which they have experienced and observed around them (Brazelton and Cramer 1991). The assumption is applied

both in terms of explaining the maladaptive patterns of behaviour and relationships which they may have developed, and in terms of explaining how staff may seek to influence or change these patterns by actively modelling more appropriate or constructive alternatives (Maier 1981). It could also be argued that 'resilience based practice' includes a strong element of modelling.

Technique: Adults consciously model appropriate or pro-social responses to events and challenges and promote similar responses in young people through active modelling (Maier 1975). This is achieved in the residential setting primarily through the informal handling of everyday events (Fahlberg 1990) rather than necessarily through formal situations of observation and rehearsal as might be used in more clinical settings.

Limitations: This form of learning depends in part upon the cognitive abilities and emotional stability of the child. For some children, attachment disorders and other difficulties may interfere with both their cognitive and their emotional processes, preventing or distorting appropriate learning and development through this mode (Perry *et al* 1995). It can also be argued that children will model themselves not just on what we do but on the way that we do it, so it will be especially important that we are aware of the less conscious elements in our modelling.

3. Planned Environments: Group Living

Assumption: Here the assumption is that children are strongly influenced by the relationships within their peer-group and between the peer-group and the group of staff. Many of the informal groups and groupings which form and re-form during everyday life around activities and conversations have the potential for influencing children in positive directions (Brown and Clough 1989). There is also an assumption that the psycho-social experience not only of belonging to a group but also of helping others in a group can itself be positive and rewarding for young people (Smith 2005, Millar 2005).

Theory base: This model draws its theoretical base from theories of group interaction both in general (Whitaker 1985) and in the group care context with its interplay of formal and informal groupings (Douglas 1986, Brown and Clough 1989). It builds on an acknowledgement of the importance to all children of their peer-group (Cottrell 1996) including those in group care settings (Emond 2003, Hudson 2000). This approach has been more formally articulated in terms of 'positive peer culture' (Vorrath & Brendtro 1974) and in the concept of the therapeutic community (Ward *et al* 2003).

Technique: Adults monitor and seek to influence the overall group dynamics and emotional climate of the unit and to promote awareness in the young people of the potential for learning and development through using the group, its insights and concerns. They will make use of informal groups and groupings in everyday life to promote productive group interaction and awareness, and use more formal gatherings such as community meetings and other collective events to give more explicit focus to this work (Stokoe 2003).

Limitations: If this approach is over-used, then there is a risk either that the 'ordinary' quality of everyday life may become impaired or distorted, or that individual needs may become subsumed in the emphasis on the group. A different problem with using the 'Group living' model may be that the trend towards ever-smaller residential units means that the peer-group element in residential care may be at risk of disappearing (although, paradoxically, there is an opposite trend towards larger groupings in foster care).

4. Planned Help: Individualised support with daily living

Assumption: Children with emotional and psychological difficulties may have individual needs for highly personalised support in coping with daily living, in addition to the provision of suitable group living and physical environments. They will need to know that these individual opportunities may be offered not only at

planned times but may also be available at short notice in a crisis, or on request. If they do not believe that such support will be available, their needs will not disappear, of course, but the young people may be likely to take their own measures to express the needs, sometimes engineering intensive individual attention by less positive means, for example by what may then be seen as 'attention-seeking' demands or violent outbursts.

Theory base: In the UK context, Barbara Dockar-Drysdale described a model for providing 'adaptations' for young people in residential treatment, based not only on regular verbal communication, but also on the recognition and use of more symbolic means of communication (Dockar-Drysdale 1990). These would often take the form of regular 'special times' for individual children with their keyworker or 'special person' (Tomlinson 2004), which would be planned and provided as part of the overall programme of the unit rather than being a private or ad hoc arrangement. The argument for such provision is that if children come to feel that their everyday personal care is handled with real attention to their needs, and if they also know that they are guaranteed special individual time on a regular basis they will eventually learn to contain their distress rather than letting it overtake other aspects of their lives.

Technique A range of techniques and arrangements may be used, including some which are used not so much within the life-space but in planned quasi-clinical sessions between the young person and an individual worker. Within the life space itself, children may need specific support with aspects of daily life, often around the experience of personal care which others may find straightforward but which for them may be very challenging (Treischman *et al* 1973, Woodhead1999, Carter 2003 and Tomlinson 2004).

Limitations: The sort of provision described here may be perceived as elaborate and labour-intensive, although if it actually meets children's real needs it may well save time and effort in the long run. It certainly needs to be based upon careful

assessment of the child's needs and close communication with the child. It will not be so feasible in settings where levels of staffing or of staff training, support and awareness are insufficient. There is also perhaps a risk of becoming too 'precious' in the handling of everyday life, which would be counter-productive if it led to children only ever being able to cope if their every whim was catered for. Such arrangements need to be based on careful assessments and provided in graduated forms which will be modified in the light of re-assessment and review, rather than as 'blanket' policies.

5. Opportunity-led work: seeing the chance and using it.

Assumption: Not all individual need can be predicted and scheduled: in the group care setting much of it arises 'on the hoof' as incidents unfold, or as feelings evolve throughout the course of a number of events and interactions. There are thus potentially many opportunities for children to be offered special or 'therapeutic' help by staff through an immediate but thoughtful response to a challenge, incident or exchange. This may be especially valuable for those children who cannot store up their feelings until their 'special time' or visit from a social worker.

Theory-base: This aspect of the work was helpfully identified by Fritz Redl in his work on the concept of the Life Space Interview (Redl 1966). Redl applied this concept mainly to the management of difficult incidents, although it can be applied more broadly to include all of the range of opportunities for useful communication which may arise in the course of everyday life, which is why this has also been called 'Opportunity-led work' (Ward 1995, 2003).

Technique: Adults attend to the detail of interaction and communication, and seek to exploit opportunities for promoting reflection, insight and change which may arise. Phases in a typical exchange can be identified, including observation, assessment, action and evaluation. The aim is (where appropriate) to offer thoughtful and engaged communication at an immediate level, sometimes with

the aim of helping children to reframe their assumptions and learn new ways of interpreting events and responding to them. Sometimes such communication may in turn lead on to a more profound and therapeutic communication. The method depends upon the skill of the staff in identifying and capitalising upon the often-fleeting and subtle opportunities to engage young people in useful communication, and on the ability of staff teams to support each other in this task (Ward 1996).

Limitations: This mode of work is not a substitute for planned individual work with a child, but can usefully supplement it. Again, if this approach is over-used, so that supposed 'opportunities' are over-exploited, then the 'ordinary' quality of daily life may become impaired or distorted. Additionally, like the other 'special' modes, the ability to operate in this mode can be greatly enhanced by training and staff development, and supported by appropriate types of supervision (Collie 2002).

Conclusion

I have identified four different modes of 'special everyday living' which can all be used in conjunction with the mode which I have called 'being ordinary'. All of these modes of attending to the quality of daily living depend upon a number of factors without which they are unlikely to flourish. The necessary factors include:

- a clear and agreed system for the on-going assessment of children's needs and for the planning and implementation of programmes based upon these assessments,
- a staff team who have the ability, willingness, time and energy to invest thought and planning into their use of the everyday, and who are able to agree upon a common and consistent approach,
- an employing agency (and funding system) which values the staff and young people sufficiently to encourage, maintain and support a thoughtful approach to the everyday, by providing:

- opportunities for the staff themselves for communication, learning and development in support of this approach to their work.

Such factors do not themselves operate in a vacuum: indeed for them to apply positively, the whole system of residential care needs to co-ordinated into a coherent and purposeful whole (Clough *et al* 2006). Providing 'special' care and treatment cannot reliably happen without considerable effort, good will, understanding and determination throughout the system and it especially depends upon recruiting, training and supporting high quality staff.

My aim in this paper has been to address the polarisation which has sometimes been evident in the policy and practice of residential care in the UK between assumptions about the ordinary and the special. I have endeavoured to show firstly that the concept of what is ordinary needs to be rigorously challenged and examined, and secondly that there are many different versions of what might constitute the special in residential care and treatment. I have argued not for the rejection of the ordinary but for the recognition that it is both something to be worked towards and built upon.

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