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Developing a residential programme for children in response to trauma-related behaviours

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This paper describes the development by Parkerville Children's Home, WA, of a therapeutic residential programme, based on current research and clinical experience, relating to the impact of traumatic experience. It describes the theoretical framework, its incorporation into an intervention plan and the process of implementation. A case study is used to illustrate the process of assessment and implementation.

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Children who have experienced profound abuse and/or neglect can present with a range of trauma-related behaviours, some of which can be deeply challenging to carers and those who seek to assess and address the child's needs. If such needs are not successfully addressed, abusive experiences can act as critical antecedents to a range of risk-related behaviours leading to well-documented adverse health outcomes both in childhood and adulthood (Felitti et al, 1998; James, 1989; Johnson, 1998; Read, Mosher & Bentall, 2004).

Parkerville Children's Home (PCH) cares for the most vulnerable children in our community, through the provision of a family-style therapeutic environment utilising a range of professional services. Children are cared for by 'cottage parents' in accommodation where they can be placed with siblings groups. Children and cottage parents are supported by a multidisciplinary team which provides a range of therapeutic services.

Although residential care traditionally has been regarded as a service of 'last resort' (Davies, 1981), there is a growing awareness of the need for residential care to be utilised as a planned, therapeutic and flexible service option (Davies, 1981; Whittaker, 1979; Baldwin 1990; Ainsworth, 1997). For children who have been victims of severe abuse and neglect, and who need to be in out-of-home care, we believe that therapeutic residential care offers a service of first choice as it provides children with a holistic, dependable, predictable living environment, which can be used to challenge all the negative, direct and secondary, aspects of their abuse experience. PCH specialises in providing group home care for family groups.

According to Shonkoff and Phillips (2000):

> Caregiver characteristics that promote healthy child development include warmth, nurturance, stability, predictability, and contingent responsiveness. Children's characteristics that influence the nature of their interactions with their caregivers include predictability of behavior, social responsiveness, readability of cues, activity level and mood ... the quality of the caregiver-child relationship is influenced most by the goodness of fit between the styles of both contributors (p.353).

Training direct carers to understand the causes and effects of trauma, and the nature and scope of trauma-related

behaviours, and supporting them in learning how to respond to such behaviour appropriately, is central to a successful residential therapeutic programme.

THE NATURE OF TRAUMA

The Collins English dictionary (1990) defines trauma as 'An emotional shock that may have long lasting effects'. Trauma, as defined by James (1989),

> ... refers to overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control (p.1).

The traumatising event may be a single occurrence or a series of interactions which, in totality, are traumatic. The impact of any event(s) in a child's life should not be assessed out of context. As James (1989) advises,

> The child's constitution, temperament, strengths, sensitivities, developmental phase, attachments, insight, abilities; the reactions of his loved ones; and the support and resources available to him, all contribute to how an event is experienced, what it means to a child, and whether or not it is traumatizing at that specific time in the child's life (p.1).

Childhood trauma can result from all forms of abuse, disasters (natural and deliberate), witnessing violent events, divorce, bullying, assault, serious accidents, and loss, either specific losses or losses as a part of change. Writers such as Bowlby (1969) and Terr (1991) have described the patterns of anxiety disorder, chronic hyper-arousal and behavioural disturbances in children who have been traumatised as a result of discrete, one-time traumatic incidents. Increasingly, however, intra-familial abuse is recognised,

> ...to produce complex posttraumatic syndromes (Cole & Putnam, 1992), which involve chronic affect deregulation, destructive behaviour against self and others, learning disabilities, dissociative problems, somatization, and distortions in concept about self and others (van der Kolk, 1996, p.228).

The effects of such abuse can have a major impact on a child's physical, cognitive, linguistic, emotional, social and moral development. As Shonkoff and Phillips (2000,) note,

> Early child development can be seriously compromised by social, regulatory, and emotional impairments. Indeed, young children are capable of deep and lasting sadness, grief, and disorganisation in response to trauma, loss, and early personal rejection (p.5).

POST TRAUMATIC STRESS DISORDER

A useful explanatory construct available for making sense of the relationship between trauma and later reactions is that of post traumatic stress disorder (PTSD) and its recent addition, acute stress disorder. What distinguishes people (including children) who develop PTSD from those who are temporarily stressed, is that they become 'stuck' on the trauma. They keep reliving it in thoughts, feelings, action or images. This intrusive reliving, rather than the traumatic event, is responsible for the complex bio-behavioural change known as PTSD.

PRIMITIVE RESPONSES TO DANGER AND FEAR

Parkerville Children's Home utilises a simple model, based on what is known about primitive responses to danger and fear, to inform our view of, and response to, trauma-related behaviours. Primitive responses to danger and fear are generated by the brain stem. They have been described as *flight*, *freeze* and *fight* (Rothschild, 2003; van der Kolk, 1996).

In a state of *flight* – a child may experience hyper-arousal, an inability to maintain boundaries and regulate feelings.

In *freeze* mode – a child may feel a sense of numbness, a feeling of being 'scared stiff'. They may present with flatten affect, profound sadness and/or depression.

In *fight* mode – a child may show aggression towards others as well as self-harming behaviours.

> *... there is a growing awareness of the need for residential care to be utilised as a planned, therapeutic and flexible service option.*

Traumatic stress is a predictable consequence of exposure to traumatic events. It is traumatic stress that causes hyper-arousal in the body's nervous system, making it possible to fight, flee or freeze in response to threat. Although an emotional response to any life event affects the body, it is believed trauma does so to the greatest degree. Rothschild (2003) describes the somatic consequences of trauma in the following terms:

> During a traumatic incident the neurotransmitters released from the brain's limbic system signal an alarm to the autonomic nervous system (ANS). These hormones activate one of the branches, the sympathetic nervous system (SNS), to its most extreme arousal: preparation for fight and/or flight. Blood flows away from the skin and viscera and into muscles for quick movement. Heart rate, respiration, and blood pressure all rise to give the muscles more oxygen. The eyes dilate to provide sharper distant sight. All of these elements of SNS are necessary to respond to threat. When fight or flight are not possible, or have not been successful, the limbic system may

> further signal the ANS to *simultaneously* activate its other branch, the parasympathetic nervous system (PNS). The SNS continues its extreme arousal while the PNS freezes the action of the body – the muscles becoming either slack like a mouse caught by a cat or stiff like a deer caught in the headlights (Gallup & Maser, 1977) ... Those who have experienced freezing commonly report that during such an episode time slows down and body sensations and emotions are numbed; it appears to be a kind of dissociation. As freezing only occurs when the individual's perception is that the threat is extreme and escape impossible, these reactions make perfect sense. ... Successful fight or flight is usually enough to discharge the arousal of the SNS. ... However, the outcome with freezing can be quite different (pp.6-7).

Though freezing may be an excellent survival mechanism, it appears to exact a higher psychological toll following a traumatic event than the fight or flight responses. Freezing during a traumatic event is a major predictor of who may develop PTSD. Somatic symptoms flourish as the hyper-arousal in both SNS and PNS persist chronically or are easily triggered by internal or environmental cues. The first goal of any trauma therapy must be helping the client to contain and reduce hyper-arousal (Rothschild, 2003).

Trauma may assault the child physically, cognitively, emotionally, and spiritually. Intervention strategies must deal with each of these dimensions.

TRAUMATIC MEMORY

In 1889, Pierre Janet philosophised that traumatic memories are stored differently in the brain than other types of experiences. He believed that traumatic memory is stored more as emotions and senses than as cognitions. Today, scientific evidence supports his theories (James, 1989; Rothschild, 2003; van der Kolk, 1996). There are basically two major categories of memory: explicit and implicit. Explicit memory is conscious and requires language. It comprises concepts, facts, descriptions, and thoughts. Implicit memory is made up of emotions, sensations, movements, and automatic procedures. Body sensations that constitute emotions (eg, terror) and physical states (eg, pain or ANS arousal) and the patterns that make up movements (eg, fight, flight, freeze) are all recorded in the brain. Sometimes the corresponding explicit elements (eg, the facts of the situation, a description of the events) are simultaneously recorded; sometimes they are not.

The most troublesome traumatic memories are those that involve body sensations and little else. In such cases, the body sensations associated with the traumatic memory are intact, but the other elements, particularly the cognitive aspects (ie, facts, narrative, time and space context) that could help the individual to make sense of the memories, appear lost. Working with implicit, trauma-based sensations, in the absence of a trauma narrative, can be difficult. The explicit memory may or may not emerge. In such cases it is sometimes necessary to find ways to ease the symptoms and/or increase their containment, as their origin might never be known. At the same time, reducing hyper-arousal as a goal in itself sometimes makes it possible to recall an otherwise lost event.

Traumatic events exact a toll on the body as well as the mind. More recently the somatic side of trauma has also been receiving attention so that the body itself is used as an important resource in the treatment of trauma (Levine, 1992; van der Kolk, 1996; Rothschild, 2003).

THE THERAPEUTIC PROGRAMME

Abused children carry with them a range of issues and unresolved conflicts arising from their abuse experiences and resultant behaviours. The fundamental goals of a therapeutic residential programme are globally applicable to all children in therapy (see below). The process through which they are attained, however, enables the therapeutic team (cottage parents and the professional team, but particularly the former) to identify and respond appropriately to the behaviour of particular children, to challenge, consistently and repetitively, any distorted life view, private logic and negative life script the child may have acquired, through the medium of an on-going, positive, life affirming, living experience.

The following points may be considered the fundamental goals of a therapeutic approach:

- to enable the child to deal with painful emotional issues;
- to enable the child to achieve some level of congruence with regard to thoughts, emotions and behaviours;
- to enable the child to feel good about themselves;
- to enable the child to accept their limitations and strengths and to feel OK about them;
- to enable the child to change behaviours that have negative consequences;
- to enable the child to function comfortably and adaptively within the external environment;
- to maximize the opportunity for the child to pursue developmental milestones.
  (Geldard & Geldard, 2002, p.6).

Carers in the programme are trained to manage trauma-related behaviours in ways that will not escalate negative, self-defeating behaviour, and to offer support and

encouragement for the development of constructive alternative behaviours. The environment must be protective, nurturing and liberating. Power struggles with the children are avoided where possible (for example, by offering constructive choices to support a preferred outcome, by agreeing behavioural contracts through negotiation, and by engaging in joint adult/child activities). Carers are encouraged to 'coach' rather than 'scold' and to encourage in the children a sense of belonging, mastery, independence and generosity (Brendtro, 2003). Emphasis is placed on helping the child develop positive self-regulation (through supporting the child's own non-destructive attempts to discharge hyper-arousal and the development of constructive, soothing sequences or rituals). Negative life scripts, self talk and private logic are continually reframed or challenged in a manner that invites the child to develop a more positive self view. The provision of a residential therapeutic programme seeks to offer traumatised children understanding and therapeutic support to maximise their attempts to restore some safety to their inner selves. To support their learning and understanding, PCH provides carers with an ongoing programme of integrated in-house training in the following areas:

- the causes and effects of trauma;
- the nature of traumatic memory;
- the nature of human brain development;
- traumatic experiences and their effect on brain development;
- the biology of trauma;
- recognising the on-going physiological presentation of trauma;
- recognising the behavioural presentations of trauma-related behaviour;
- recognising the cognitive and verbal (private logic) presentations of trauma-related behaviour;
- identifying negative, self-defeating behaviours;
- challenging/reframing negative life scripts or self defeating behaviours;
- managing trauma-related behaviours in ways that will not escalate negative, self-defeating behaviour;
- managing trauma-related behaviours in ways that offer support and encourage the development of constructive alternative behaviours;
- appropriately managing disclosures;
- understanding the need (and how) to create emotional and psychological safety as well as physical safety – a holistic, dependable, predictable living environment – which can be used to challenge all the negative (direct and secondary) aspects of their abuse experience;
- providing the safety for children to have outbursts and rage at past injustices before catching up on their lost development; and
- understanding and managing counter-transference and counter-aggressive impulses.

IMPLEMENTING A FRAMEWORK FOR ASSESSING AND RESPONDING TO CHILDREN'S NEEDS

The UK Department of Health (2000) model has been adopted as PCH's preferred assessment and response process. The assessment process begins as soon as a referral is made to PCH. The quality of the initial assessment, however, is dependent on the information PCH may access. The following principles underpin this assessment and response framework.

Assessments and responses:

- are child centred;
- are based on child development;
- are ecological in their approach;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identify difficulty;
- are a continuing process, not a single event;
- are grounded in evidence-based knowledge.

(Adapted from *Framework for the Assessment of Children in Need and their Families*, Department of Health (UK), 2000)

The assessment process:

1. provides an historical profile for the child;
2. provides historical description of needs/behaviours;
3. describes nature of any previous intervention(s).

On-going assessment

4. provides a current profile for the child;
5. provides an audit of current needs and strengths;
6. outlines goals for intervention;
7. develops a programme of group and individual interventions to address identified needs;
8. outlines measurable, evidence-based outcomes for behaviour;
9. evaluates the nature of behaviour change.

All assessment and intervention procedures focus on:

- how the child expresses a sense of purpose, place, and belonging;
- the child's sense of continuity between their past and future worlds;
- the child's ability to express and contain their emotions.

Initial assessments are conducted by members of the multidisciplinary team. Regular meetings of the cottage team provide, and update, an audit of each child's current needs and strengths. Trauma-related behaviours are identified, and strategies are developed and implemented to reduce negative, self-defeating behaviours and to strengthen constructive, alternative behaviours. Each week the relative success of these strategies is rated and recorded, according to the observed frequency of the targeted behaviour. Within this model, information about strengths and needs are collated under the following headings:

Family relationships;
Social development;
Emotional & behavioural development;
Self care;
Health;
Education.

The application of one or more therapeutic techniques follows an audit of a child's needs and is offered in response to their individual case plan. On-going evaluation and monitoring seek to ensure that every intervention technique is assessed for maximum efficacy. An example of how impact issues can be matched to therapeutic goals and techniques is provided in Figure 1.

MULTIDIMENSIONAL STRATEGY

Trauma may assault the child physically, cognitively, emotionally, and spiritually. Intervention strategies must deal with each of these dimensions. Therapeutic intervention in just one area is usually not sufficient for achieving mastery and healing (James, 1989).

While adults may feel comfortable in a therapeutic space that focuses on language and speech, the differing skill range available to children can sometimes make it difficult for speech-focused therapeutic interventions to produce positive outcomes. There is a need to work creatively, as well as constructively, with children to support them in exploring their inner worlds and in their engagement with their emotions, memories and present realities. Play, action, drama, image making, imagination, story telling and story making are all part of a child's communicative repertoire, and it is in these modes that therapy can be most relevant to the developmental needs of children.

Figure 1: Parkerville Children's Home Therapeutic Programme

Impact Issues	Goals of Therapy	Therapeutic Techniques
Guilt/responsibility/self-blame	To validate the child's experience of abuse and alleviate any misplaced, self-directed guilt/responsibility.	Education and information on the dynamics of abuse and how abusers operate. Directive & non-directive play.
Fears and associated behaviours, eg, bed-wetting/nightmares	To build the child's strengths to overcome their fears by helping them develop strategies to achieve mastery. To assist caregivers to develop strategies to help the child manage their fear.	Dream-catchers, Nightmare Box, Relaxation and Drawing, Guided Fantasy. Use of Metaphor. Art and Drama.
Anxiety	To reduce anxiety levels and facilitate statements of support, belief and safety from caregivers and others.	Worry Trees, Relaxation, Scaling, Visualisations of Safe Places, Drawing. Art and Drama.
Anger	To externalise/express appropriately feelings of anger in a safe, non-abusive environment.	Body work, Empty Chair Exercise, Interviewing the Perpetrator, Angry Letter, Puppets, Art and Drama.
Depression, sadness, loss and other negative feelings.	To identify, name and understand the myriad feelings caused by abuse and to work towards resolution with the support of carers and others.	Body Charts, Identifying Feelings in Body, Externalising Feelings. Having a conversation with the feeling and giving it a name. Art and Drama.
Self esteem	To reclaim a positive self-image and enhance perception of self.	Interview the Problem, Drawing of Self/Strengths, Affirmation/Awards/Certificates, Rewriting the Story, Magic Mirror, What I Like about Myself, Therapeutic Letters, Art and Drama, Worksheets.
Sense of belonging	To resource and empower the child to feel a sense of purpose, place and belonging.	Eco Maps, PCH Life Story Book CD, Pictorial Record.
Sense of future	To resource and empower the child to integrate their experience of abuse by enhancing and building on their constructive survival skills.	Life Story Book CD, Journal/Diary, Rubbish Bin Exercise, Life Train Exercise, Hopes and Wishes Exercise

BASIC TREATMENT PROCESS

PCH's therapeutic interventions are structured on the work of Beverly James (1989) and are divided into four main categories.

1. Communication – in which a child learns how to delineate and express complex feelings

Traumatised children do not have the language skills needed to communicate their feelings accurately (to a degree this may also be age-related). Children's feelings and emotions are likely to be too varied and too complex for them to describe. Children's feelings and emotions are often contradictory and they may have difficulty in expressing coexistent feelings. It is usually best to begin by teaching the child to identify and distinguish the various feelings and emotions common to all children. Emotions relating to the abuse should not be explored until the child has developed some skills in communicating emotions, and feels confident and safe in doing so. Having learned labels for various emotions, the child is taught how to express simultaneous, conflicting feelings and learns that it is acceptable to do so. The communication tools they learn in this phase will help them sort out their traumatising experience in the next phase of treatment.

2. Sorting out – where children explore their understanding of what has happened to them

A safe environment is required within the therapy setting so that the child and his/her carers can, at a pace suitable for the child, sort out:

- the child's understanding of what has happened;
- the meaning of the event(s)/process to the child;
- the child's feelings before, during and after the traumatic experience;
- the child's behaviours before, during and after the trauma;
- the child's worries related to self, siblings, and family, in the present and in the future.

Recollection of all aspects of the experience is necessary to identify the stimuli or cues which have abuse associations. Some episodes may be forgotten or repressed, or elements of different experiences mixed up. One method of addressing this is to have the child list everything which reminds them of the abuse or which creates anxiety. This list will include places, sounds, smells, and objects. By relating the emotions to specific triggers the child can anticipate or understand reactions and mobilise responses. Teaching strategies for managing fear and anxiety increases the child's sense of self-efficacy and control. Environmental alterations can be used to inhibit anxiety responses, and routines can be changed to ensure that the physical environment is/feels secure.

3. Education – where they learn to understand the specific elements of the traumatising experience

Direct and indirect teaching enables the child to understand, to the fullest extent possible, all the elements contributing to the trauma. There are a number of ways in which a child may come to adopt inaccurate or harmful beliefs about the abuse. They may misattribute responsibility for the abuse. There may also be a transfer of the offender's belief system/distortions. Children may also make attributions in the absence of direct statements from the offenders. They may 'logically' construe their own behaviour to be complicit.

What children believe, the source of the belief, and the purpose it serves, must be determined. This process helps avoid misinformation and misconceptions. Another part of the process is to have the child learn how to control any objectionable behaviours. When empowered, as part of a treatment team, to identify the factors that stimulate the unwanted behaviour and to learn techniques to gain control of the behaviours, the child is supported in learning appropriate ways of expressing themselves and/or having their needs met. Children also learn that they are responsible for their own actions, that adults can help them control and protect themselves, and that it is acceptable to ask for help.

4. Perspective – where the child's experience is accepted as something that has happened to them, without the need for minimisation or exaggeration of its impact

Through their relationship with their carers and their involvement in therapeutic exercises, the child develops a constructive sense of self. They learn that other children survived and so will they. They learn that it is not their job to make up for the experience. They are helped to recognise and appreciate their present physical and emotional strengths, as well as their limitations, without exaggerating or minimising reality. The trauma thus becomes integrated and fully accepted as part of the child's history (James, 1989).

A residential therapeutic approach recognises that a 'clinical approach' too often ignores that only a caring relationship can help traumatised children. We need to understand the children's feelings, reactions and view of things. When we work with hurt children, it is important to start with the child's basic physicality, concentrating on the initial feelings as they are expressed, then work through the child's blocks and traumas while constantly re-evaluating what is going on. It is important to form a relationship with the child that is honest and physically secure, and then to work uncompromisingly through the conflicts. As we become more familiar with the situations that children are unable to handle, we begin to understand the reasons for these situations.

CASE STUDY ROBERT, AGED 10 YEARS

PROFILE

(Each assessment provides a profile of the child which is used for behavioural analysis.)

Robert and his siblings have been known to the Department of Community Development since 1992.

Mother requested that the children be adopted or placed in out-of-home care. Issues of neglect were reported.

The children were placed with their father and stepmother in September 1994.

From 1995 to 1997 numerous reports were received of violence to and neglect of the children, and domestic violence against the stepmother.

In December 1997, their stepmother reported a very violent assault on an older brother.

The children were apprehended and taken into care. Numerous short term placements followed until March 1998 when the children were placed at PCH.

There was a plan to reunify Robert with his stepmother. Shared care started in March 2001.

In November 2001, Robert's stepmother moved away and ceased contact with him without warning.

Robert's agitated, aggressive and sexualised behaviours escalated greatly.

During one aggressive incident, Robert threatened his carers and other children in his cottage with knives. He also destroyed property in his cottage.

BEHAVIOURAL ANALYSIS

An analysis of Robert's responses was conducted by the Senior Clinical Practitioner at PCH, within a framework using the insights gained through use of the following questions:

- What is Robert's understanding of his stepmother's rejection of him?
- How can a 10-year-old boy understand rejection?
- How can he compensate for his loss?
- What are his compensatory mechanisms?
- Does he think he is responsible for the desertion – did he cause it? If the answer is yes, then does he think he is bad, does he feel guilty?
- How can he live with the guilt and remain sane? Does he project his guilt onto other people – everyone he meets?
- Can he trust anyone or will they let him down?
- Does he think they all expect something of him? Does this leave him open and vulnerable to their actions?
- How is his behaviour informed by responses to fear and threat (flight, freeze and fight)?
- Is there an element of self-punishment?
- How has he been re-traumatised by this event?
- Is he experiencing (or re-experiencing) a heightened stress response in his nervous system?
- Is he experiencing affective flashbacks ?

We need to help him understand, reduce, and deal constructively with his body sensations in ways that are not self-destructive. We need to act within his trust. There are many scenes of violence in his past, they live just below the surface ready to erupt at the slightest intrusion into his being.

INTERVENTION

A regular programme of body work, including therapeutic massage, was developed for Robert to enable him to discharge hyper-arousal. Visualisations were created to offer him 'safe places' to be when he felt anxious.

A metaphor focusing on 'time holes' (Hobday, 2001) was used to help Robert understand the nature of affective flashbacks. Strategies were developed with him to help him identify 'time holes' and avoid 'falling into' them. Further strategies were developed to enable him to 'escape' from a 'time hole' if he did start to 'slip' into one. One on one, direct therapeutic work focused on enabling Robert to identify his main concerns and to develop appropriate understanding and realistic coping strategies. Work on self-image, sense of self, and self-esteem was also prioritised. Prior to this intervention, Robert referred to himself as being 'trapped in my body.' As time progressed, he reported 'feeling like I am in control of my body, not others.' During the remainder of Robert's time at PCH he was not involved in further outbursts of such violent behaviour.

IN CONCLUSION

An additional goal of a residential therapeutic programme is to provide a constructive process of continuous knowledge generation, data collection and quality improvement of service delivery. The positive outcomes for PCH children through the adoption of a therapeutic model have been highly visible, particularly over the last twelve months. The next challenge for the programme team is to implement a viable system of measurement and information collation and documentation which will support ongoing evaluation and monitoring to ensure every intervention in the lives of our children is continually assessed for maximum efficacy.

Through the PCH Institute for Child Protection, PCH is developing a unique partnership with academics, students and researchers which will drive this vital link between research and practice. The concept of an Institute for Child Protection was developed as the focus of our centenary celebration in 2003. It is our intention to work, within partnership, to create a 'centre of excellence' in the provision of child protection services, and to make a significant contribution to social policy, research, community education and prevention in the areas of definition, prevention and response to child abuse, neglect and harm. □

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ADDITIONAL PCH PROGRAMMES

The PCH residential programme benefits greatly from in-house integration of complementary programmes:

- Our *Reconnect* programme works intensively with young people and families to prevent youth homelessness.
- *Families and Schools Together* (FAST) empowers parents as the primary protection agent for their children through a series of fun, family-based activities over two years. This programme brings together the two most influential aspects of a child's life, their parents and their school.
- *Education, Employment and Training* (EET) is a programme that caters for 14-18 year old youth who are not attending school and are not yet employment ready. This programme addresses their literacy and numeracy needs, as well as work preparation skills.
- The *PREPARE* programme provides our younger residents with a structured approach to developing the pre-learning skills children must have in order to achieve at school. PCH Education Officers also provide in-school support as well as after school extension and tuition time.
- *Parents' and Children's Therapeutic Service* (PACTS) provides a community treatment response to children who have been victims of abuse and their non-offending parents.
- *Seen and Heard* is a programme that provides a voice for young people living in the Shire of Mundaring. It offers an opportunity for young people to be involved in events, activities and recreation and provides support with relationships, school, work, health and any other concerns.
- *Belmont Residential Programme* is a medium term group living experience for teenagers which provides 24 hour care by qualified professionals, 365 days a year.
- *Jenny House* provides supported accommodation for at risk and vulnerable young women with and without children.

Accessing and working co-operatively across these programmes enables PCH staff to provide a continuum of care designed to strengthen families and meet the need for out-of-home residential and foster care.