The Changing Social Climate of Residential Work and its Challenge

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We are all concerned for the potentially damaging effects of long term residential care. I propose, in my first paper, to look at this change and its implications for residential work and residential workers, and in the second paper to concentrate more on those for whom I feel long term residential treatment is essential if they are not to become increasingly anti-social and eventually institutionally dependent.

I do not sense amongst you the underlying territorial skirmishing and the battles of reified platform of specialist dogmas that can be so harmful during periods of heart searching and change, but rather a wish to work together. Authentic residential work needs a very positive and passionate commitment if the task is to be other than warehousing or holding and, as David Wills has said, if a person has not got that sort of belief and faith, he would be better off either keeping bees or becoming a business tycoon. Unless, however, tasks are clear and staff are committed to them they are particularly vulnerable as fashions in social work change more in line with ideas and elegant theorising than realities.

We have our problems and you, no doubt have yours. Since it is only the problems with which I am immediately faced at home, and in that specific context with which I am really familiar, I can only speak of these, hoping that they will evoke useful, helpful echoes in your own experience, thought and search.

On balance, I would see it that you are more concerned for and have the space for new bottom up growth and from small new growing points, whereas we are trying to thread our way through entrenched institutionalised systems with a considerable investment in system maintenance and inertia and with very large inhibitions and resistances to change. We are also attempting to learn how to make bureaucracy work, whilst you, I think, are more in a position of your public systems supporting individual initiative and effort. At least, relatively so at this stage.

When people know what they are doing and know that it is really essential, is worthwhile, that it works, then they become committed to doing it. When they feel that they are merely perpetuating either a parasitic or mutually collusive system (some sort of club) the hollow shell may long be self perpetuated in a functionally autonomous way even when the system or enterprise is, in fact, counter productive and anti-task in the sense that it is not carrying out that primary task for which it exists.

Our task at the Cotswold Community has been a conversion task from a traditional penal institution. We have been working at this for eleven years. 87% of the young people who went through this place went on to Borstal and the totality of those particular young people on to prison. Our task was simply to see if we could do better with that "residual" population. It was a two world system in which staff lives, living and experience was completely split off from the reality of child lives, living and experience.

We cannot and must not be naively drawn back in a merely dreamlike or idealised way to some idyllic

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(usually phantasy) notion of the past. We can, however, try to define the essence of effective group living and effective education that is not dissociated from such experience. That which has been called milieu therapy.

The primary reference group is that group which bites on behaviour naturally because there is "we feeling". The model is perhaps the good enough family and the process of family decision making. At least it is the ideal model. Potentially mere separation from whatever sort of "family" we are thinking of is merely temporarily to separate and distribute a family and community problem. On this we would agree. It is also harmful in that in itself and in a very invidious way, a way which is often half hidden, it quietly engenders, like a cancer, in parents who are often already overwhelmed, over burdened and very uncertain of themselves and their value and worthwhileness, a particular form of additional rejection.

I became very aware of this in thinking of the loving residential care that was being offered to some aborigine children in Alice Springs where, for one reason or another, there was no such thing as a "family" or tribal responsibility. One child in a training centre had written, "In my dreams I hear tribe happily laughing and swimming in bush. All broken by rushing kids as day starts. I am away from home and yet I dream of my homeland — camp fire in bush among my own people sitting and talking and laughing on the ground — no wall around me. The stars all over me. A thousand camp fires in the bush are in my dreams". We respond instinctively to the underlying ideals and archetypes of the past. A Nigerian Chief, giving evidence to a U.N.E.S.C.O. discussion on conservation observed, "I can see that land belongs to a vast family, of which many are dead, few are living, and countless members are still unborn". In Dee Brown's moving book, "The Battle of Wounded Knee", an American Indian Chief writes of that battle, "A people's dream died there. It was a beautiful dream . . . the nation's hoop is broken, and scattered . . . there is no centre any longer, and the sacred tree is dead". Shalom!

This is a long, long way from a situation in which Professor Halsey can observe in this year's Reith lectures, "We have an economy which does not release our energies, a polity that does not secure our trust, and a culture which does not attract our affections".

At this stage I am trying to tease out the difference between what Ivan Illich describes as on the one hand the "convivial" culture, and on the other the "manipulative" culture. The difference, if you like, between a top down culture and a bottom up culture or between controls from without and controls from within. We have all been shocked by some of the manipulative slogan therapies that are around and that unhappy people and troubled people can so easily get drawn into, subjected or sentenced to, willy nilly. That of Ken Keysey's "One flew over the Cuckoo's Nest" is a good example. Platform people, in platform roles, carrying out slogan therapies. It sounds somewhat totalitarian. Like what was taken up of the Warrendale "technique" of physical holding in crisis breakdown. In any event, our specific task is to combat sub culture by a strong and positive enough culture with which those called clients can identify as for themselves (ego syntonic).

Ideally, the task of the therapist is to lead from within through facilitating the consciousness of the individual. Powerish specialisms always make the next of kin, as it were, feel like useless amateurs, be they parents or neighbours.

The principles of planned environment therapy have been conceptualised from the experiences of many people in living and working together with deviance and young people in trouble, in therapeutic communities. At the roots of identity lie meaningful sharing of limited resources, meaningful relationships, and meaningful activities. These young people need an immediately apprehended and cogent living morality. In general, youth today

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feels despairing, confused, unwanted and redundant. This for many is a root and live experience. It is a terrible era for many. The late E. D. Schumacher put this clearly, "the greatest deprivation that anyone can suffer is to have no chance of looking after himself and making a livelihood". We have come through a period in which young people have reacted strongly against prescribed authority and traditions, but now there is greater sadness, a sense of hopelessness and despair rather than violence. In a sense, we are moving away from increasing violence more towards increasing suicide. It is no wonder that in life-empty spaces the reaction is so much to stir up drama into destructive channels since there are no constructive channels for it.

At any rate, our previous very simple answers to complex problems are crumbling, as they deny the very complexity of the situations in which we are having to work. There is also radical questioning by all concerned at the moment of all our social, political and working institutions.

Those of us who have been involved in this work know that any therapeutic community, (and there are many kinds) is a very subtle, very hidden orchestration of presences and absences, sounds, smells, an orchestration of several distinct choirs responding simultaneously to fifty composers, composing and conducting as they go along, and their compositions are noisy, complex and chaotic, and one is often in doubt about who calls the tune and certainly who really pays the piper for exactly what. Yet without the vitality of this living care all the "specialist" etceteras are as nothing, a grotesque periphery of pale shadowy part time technicians or psyche commuters — in every sense outsiders. The very word therapy has its roots in that which means to accompany.

The essential elements of such a culture have been variously (and in a sense always unsatisfactorily of course) described. For example:

1. Democratisation. Maximum opportunity for everyone to take an active part in the business of the institution and in helping others.

2. Open and honest communication. Shared responsibility or self government and decision making, ideally by concensus, when this is appropriate.

3. Permissiveness. Tolerating a wide measure of deviance, together with opportunities for acting out and its understanding, and firm management giving additional security for localised regression, that is, regression within order rather than order within chaos.

4. Communalism. The development of formal and informal communication and the sharing of limited facilities. Carefulness with non-renewable resources and genuine inter dependence.

5. Reality Confrontation. Skilled help towards an optimal degree of environmental mastery, rather than dependence, and the continual presentation of the reality of the effect of one's own behaviour on others in a very direct and open way. Being an active healthy agent as far as possible, rather than emphasis on being a sick or passive "patient".

6. Usually fairly primitive and authentically interdependent communal living. Not the Victorian legacy where there is always, say, a cleaner, a cook, a seamstress, a lavatory cleaner, a banger in of nails, and so on. The emphasis is always on normality and normal functioning and support for this.

But it is simply not just a "family" model but a family plus and the plus means that it has to be very conscious and very sophisticated in the right sense. Providing a "good home" is not enough. A very high level of staff support and training is required, but at the moment we know so little of what constitutes either a "qualified" staff member or the supports needed. The "key person" or focal caretakers in treatment are those who look after the child round the clock and who have so often been looked at as mere functionaries at the base of a hierarchical or totem pole system. We need little or nothing of the mother's milk of theory that passes for training at present. Learning (not split from just "schooling") can only come out of the actual encounter with the challenges, ordeals and confrontations, the hopes and despairs of actual practice and that which threw us back onto ourselves and activates the instincts, feelings and the true sense of our hearts and minds as individuals in the uncharted inscapes in which we live.

For those who ***essentially*** need such treatment, the whole of daily life forms that treatment. It is no good, for example, splitting the basic aspects and elements of education which takes place within the primary reference group and "schooling". Both group living and educational staff must be primarily highly "qualified" therapists using the context of all day to day activities and experiences.

Much of the above is to do with

ideologies. So now, to come down to earth and to describe experience at the Cotswold Community over the last eleven years. This had certain antecedents to which I will return.

Basically, eleven years ago, the Cotswold Approved School was an institution. 87% of its inmates went on to Borstal. The task was (1) to attempt to introduce methods and strategies of working that might be less counterproductive and more effective and (2) to test the feasibility of carrying out such work within the public services.

As an off-loading place into which a rag bag of young people had been deposited, its top down ideology (and impression management) bore no relation whatsoever to the appalling bottom up reality of individual experience and particularly terrible experience within a grim sub culture of sadists and victims. In a sense, such a split system makes no demands on staff of clients. The task was two-fold, to help the client to come to terms with his own human-ness and to hold steady the light of self illumination in oneself and in others.

In a sense, our task, the task of all residential or social work, is how to make ourselves redundant. Ideally, we treat society, but there is no instant answer, and the task of pushing power, or self-respect rather, and responsibility downwards requires something more than the magic wand of theory. At any rate, the task was to change an institution centred regime; people fodder for a static institution, rather than a dynamic organisation for people called individuals.

The object of the 1969 Children's Act was to achieve an integrated range of ***services***. The inhibitions of a very deeply entrenched system with regard to the disposal of delinquent and anti-social children were certainly underestimated. For a long time the voluntary societies felt themselves to be no longer required in this particular field and moved out, concentrating increasingly in the non-residential area of community service (and an indefinable, fashionable but non-existent service called "Intermediate Treatment". The Massachusettes "experiment" became all the rage, a new panacea!) far from achieving that co-operative team work so essential to field and residential work, it caused an even greater abyss in that the key worker might well be in fact the residential worker, whereas statutory authority, under the Care Order, was vested the field social worker within the local Authority. I mention this, as again I feel that in many ways you have much more hope from where you stand at present of achieving a forward movement in integration in a "process" of change. Anyway, the voluntary societies on the whole lived off their efforts into the new and more popular and politically fashionable fields. On the more positive and clear side, voluntary societies are now providing much needed alternatives for those many children who have been dumped into vast sub-normality institutions and hospitals. In general, the directions of change I think are very similar, towards increasingly community based and centred work and support systems, preventative and crisis intervention, and state and independent partnership in integration of services, a much decreased volume of residential placement and needs and those only way essential and with far greater consciousness of individual need. This, though, requires greater specialisation and clarification of the primary task of specific residential establishments. Much is being achieved in special foster placements given skilled consultation and support, but again these do not break down for the integrated.

It is estimated that up to 80% of the children at present placed residentially could be better otherwise helped and with less damage to themselves in non-residential situations. On the whole, this requires a perhaps somewhat idealised view of what these young people's "communities" actually are and certainly what their families are. As Chris Payne recently describes this, "The negative value of contemporary family life, its narrowness, self centredness, the emphasis on materialism and rampant consumerism go unchallenged". And on the residential side continuous changes in key focal people means that each child is exposed to a series of continuously accruing failed dependencies, — a recent study (Tizard and Hodges) "The effect of early institutional rearing of eight year old children". Journal of Child Psychology and Psychiatry. Volume 19. No. 2 (1978) showed that children in "Homes" had between age two and seven on average experience between forty and a conservative eighty key staff changes. No wonder the majority of these children live in continuous underlying fear and assumption of the "catastrophic relationship" and dare not attach themselves ever or trust on the basis that every environment will be a failed environment. Also that they lash back and test, limits of reliability to destruction to an ever increasing and unprecedented extent.

There is no such thing as the therapeutic community. The original concept of the classical therapeutic community has a certain slogan appeal, but we need to differentiate more clearly exactly who needs what in terms of help. There are certain periods when change can occur, moments of readiness for change, when the consiousness of need is already, as it were, on the tip of the tongue of the ego. These have been variously described (1) a stage of unrest with certain surrounding

social strains and tensions. (2) and enthusiastic mobilisation of popular appeal when the movement takes off. (3) a final stage of re-institutionalisation when there is often goal displacement and stagnation. Elegant and fashionable or high rise office decision making and planning is the polarised opposite of the pre-logical therapeutic process of empathetically working with, gradually understanding through involvement, pacing, following and leadership. Those at the top of the totem pole gain great job satisfaction, those at the bottom become increasingly uncertain of themselves, confused and feel unsupported, whilst the gulf between top down rhetoric and bottom up reality yawns increasingly between them. This is a process of which we all need to become a great deal more conscious before we can seek remedies to it.

And, whilst all this goes on, our Borstals and prisons increasingly bulge at the seams with the spillage.

I will try to distil out what I feel are some of the main elements at least of my own learning and experience in working with highly disturbed and acting out adolescents over the last thirty years. Firstly, in child guidance work where the whole approach was, of course, both non residential and focussed on working with the family and community. After the war, many of us were extremely disillusioned by the effects of residential incarceration, problem shelving and off loading, and the problem of collusion with that which merely further distributes disowned parts of one and their placement into another through such separations. But it was also quite clear that there was a proportion for whom no adequate treatment facilities existed and for whom such help and treatment was wholly inappropriate. I then founded a small single unit maladjusted school. We had not the experience to be particularly selective in terms of intake, but we quickly found that we had two relatively clear tasks on our hands which just could not be mixed without confusion and eventual breakdown in staff. On the one hand were those who obviously needed help to support their sense of achievement, of self worth, and their self image (their ego function). They needed help and support in terms of taking greater responsibility, they were, as it were, **characters**, although weak ones. These appeared to have had basically good experience in the earliest bonding and attachment stages with their mothers, but later, in one way or another, they suffered environmental failure and traumatic loss. They were those of weak ego function. If we define the ego as the officer in charge on the boundary of the envelope of the personality between what is inside and what is outside, then there was evidence of such structure and consciousness. We also found we were working with others who continuously acted out, who were in a continuous state of panic or anxiety who disrupted all group activities and who seemed entirely swamped and possessed by the rabble and chaos inside which was under no boundary control at all. They were not containers, as it were, and needed to be completely contained. Mixing these two groups was impossible, so eventually we decided to concentrate on the former. It also became increasingly clear that in terms of these particular young people, had there been better alternatives than residential placement many of them, if not most, would have been better so helped. I then worked for about ten years in an adult therapeutic community and carried out various studies in relation to young people in residential care. In the adult setting it became increasingly clear that so much of so called client behaviour was a reflection of staff attitudes, interaction and behaviour and that always acting out in clients was within the context of a breakdown in communication with staff and where staff had tensions between them which more simply not being worked out openly and directly. We have since in all this work become very much more conscious of incident prone staff, or teams, or worse accident prone "shifts" in residential work. I also, during this period, followed up numbers of children in different residential settings over a period of years. Again, it became increasingly clear that many when residential placements started were quite sturdy little characters, but these gradually faded and also their key relationships became more confused and complicated, most particularly those with their parents. Amongst these, however, again emerged those who seemed absolutely to need specialised residential treatment and this was simply not available for them. At least, with two of them it had been in a specialised unit for maladjusted children but this unit during that particular period was going through a very bad time in which it broke down and became very much more traditionally "educational" than therapeutic and what had been achieved was quickly lost again at a critical stage . . . Lastly, in the last eleven years, at the Cotswold Community, and in the change task from an approved school and where false self conformity meant early "release". Simply by immediately sending almost half the total population home, these particular young men went on and did not break down (previously 87% had gone on to Borstal after full "sentence"). There was also a proportion (they would be called neurotic or anxiety states) which I would estimate to be about 20%, of very weak ego structure, a high unconscious charge, and a very weak super ego, who would, I felt, have benefited from a relatively short stay in the traditional and classical shared responsibility of therapeutic community approach. These were character disorders such as I have

described above. A typical example of these were the many wartime evacuation breakdowns. The remainder seemed appallingly damaged. The overt symptoms of the whole were those of violence, acting out and stealing. But in this particular group one sensed an enormous amount of total despair and hopelessness, with panic not far from the surface. They continuously activated their environment in delinquent excitability, and there was always a sense of revenge in their behaviour. (This off loaded rag bag also included psychotic brain-damaged and severely sub-normal children). We have concentrated on work with such children. But over the last ten years the picture has changed. I recently very carefully worked through our last thirty-five referrals again. We had all begun to realise that we had never, in our experience, encountered youngsters who seemed so wholly and totally instinctually and culturally impoverished. Never had we worked with a group coming from such unmitigated social deserts. Never have we worked with so many children who create such a sense of hopelessness, helplessness and despair in the helpers. And it is so easy for this to get inside the helpers themselves. These young people have no experience of living together and sharing, no traditions, no "stern love", no order, no sense of well being, no sense of communal sharing or sacrifice, no ritual, no symbolic life, no meaningful routines or ceremonies or celebrations or any initiations. In the past, at least a proportion brought with them some aspects of conviviality, of a convivial, even a street culture, some aspects even of lively or enriching school experience. At least in a few cases their parents had loved their work and so put pride and craft into it. Now we are having to start at the very beginning without exception and with absolutely bleak backgrounds and without exception also with absolutely bleak foregrounds. In these referrals there was a much increased proportion of mental illness in the mothers, a massively increased number of attempted suicides on their part also, much increased sadism and violence between parents and children, totally bleak school experience, in fact, more often than not none at all in the preceding one or two years—just a bored street roaming, fathers exerting no authority, a massively increased number of failed **alternatives**, both of residential and non residential kinds, foster placements, residential placements and so on through one thing after another. Gone are the old heavy and brutish "authority" problems. These children have no experience of any kind of authority. They have experienced a kind of anomie, apathy, passitivity, withdrawal and a despairing permissiveness. We are dealing with something infinitely more complex and diffuse in terms of deprivation than ever in the past. It is a pervasive, frightening and bewildering phenomenon. They live one on top of another instead of beside each other in decaying areas, nothing to do and the only excitement delinquent. The apathy and withdrawal has carried over into their residential placements and into field social work itself and it comes to us from repeated broken placements that are the polarised opposite of the old punitive and repressive "warehousing" institutions. These young people know **nothing** of well being, comfort, joy, enchantment or constructive play.

We would, I think, agree that a child needs (short or long term) residential placement only if:

1. The child is a danger to himself or others.

2. The home background is non-existent or cannot be in any way helped or supported.

3. Where developmental needs dictate specific treatment in planned environments with clear and proven primary tasks.

There is now a very substantial literature on these very severely anti-social and also deprived children. To quote from Sula Wolff's summary of information (Children under Stress. Pelican 1974). "Deprived and severely delinquent children require total care. The reparatory processes necessary to make good their defects of ego and super ego development, that is, of emotional and intellectual functioning on the one hand and of conscience structure on the other, can occur only when the child spends twenty-four hours a day in an actively therapeutic environment. Moreover, recovery from gross deprivation or distortion of the socialisation process in early life takes many years. It is not surprising that society has not yet found a way of meeting adequately the treatment needs of these children". The task is to help these young people to develop a more rational control over their own behaviour, to be better able to discriminate between what to accept and what to reject, when to conform and when to deviate. In other words, to facilitate the development of ego functioning and the capacity to choose for themselves and to provide a milieu which does this.

In a sense, anti-task phenomena (always short lived, as they run counter to the primary task, being that task which the enterprise must perform in order to survive) are relatively comfortable and clubbable defences against the heightened anxieties and human demands of the task itself which calls for increasingly real commitment and involvement and painful change on everyone's part. They are just regressed, backward longing, tradi-

tional rituals, system maintenance and stiff depersonalising behaviour.

Insistence on the reality of individual responsibility means pushing this downwards in a conscious understanding, but firm way. To control transactions across the boundary between the self and the environment means controlling the boundaries between the self in many different roles and many different situations. It requires the ability to recognise situations for what they are, and when they change, and to respond appropriately in each. The young people with whom we work have had thrust upon them a very limited range of responses and have to survive in increasingly complex circumstances, circumstances which increasingly put pressure on them to get "into trouble" and only occasionally does the response match the situation they are in. They move forward into an environment which becomes increasingly complex and uncertain for adults, let alone for young people — one in which the management of uncertainty becomes increasingly vital.

An increasingly high level of individuation, that is, of the capacity to move flexibly within complex and changing situations without disentegration is required of them. To achieve this without loss of identity, still staying inside themselves, becomes increasingly difficult. The objective has to be to help children so that (as Winnicott puts it) "When faced with environmental abnormalities or dangerous situations, can employ any defence mechanisms, but are not driven towards one type of defence mechanism by distortion of personal emotional development".

In a sense (although this is a considerable over simplification), the task in working with the severely deprived and anti-social child falls into two main stages:-

1. The facilitating environment in relation to those who have not yet started, the unintegrated. Here the main needs are firm external containment, opportunities to reach dependence, and within a firm and well organised and supportive structure, opportunities for making individual adaptations to specific needs. These are the symbolic equivalent of missed earliest good enough experiences in maternal interaction at the beginning of life. Transitional objects. Winnicott defines these **more** than the mother objects as follows, "The symbol of the union of the mother and the baby at the place in space and time, where and when the mother is in process of transition from being merged in the infant to being experienced as an object to be perceived rather than conceived. The use of the transitional object symbolises the union of two now separate things, at the point of initiation of their separateness."

2. The second stage has been called many things but probably mainly "confrontation" (a very loosely used word) with reality and experience of an objective not self world that cannot be omnipotently created, manipulated or controlled. It is also in a sense a stage of "betrayal" or letting down into oneself to that place where one discovers what supports one when all else fails. At this stage we can help others sometimes to identify their own problems and find their own solutions for them and support them in this process. This is the stage at which there is ego function, that is of those young people who have now started, who have the beginnings of an identity, and can begin to take and feel responsibility, for the external environment is decreasingly going to provide support, guidance, or containment. Our organisations and staff have therefore increasingly to provide planned but dynamic responsive and changing models of behaviour and organisation relevant to this process of learning and experience. Denial of this increasing complexity can only be harmful.

This means clear selection in relation to the specific task of each unit. We need to know:

1. What is the damage?

2. What is the treatment needed?

3. Will this specific unit be able to help this particular person at this particular moment (that is, for whom is this unit at this point suitable or unsuitable?). This must take into consideration the total situation, the reality of present resources, the balance of grossly disturbed and recovering children, and the balance in terms of the ego function of the staff as a whole in relation to the ego function (or lack of it) of the children as a whole. These factors must be accurately and objectively assessed.

4. What is the specific criteria of successful outcome of task performance of the particular unit or enterprise? (It could be a successful burial say in a hospital).

5. Who can really use what? Can we contain this child in an open environment and staff survive?

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6. What level of integration has been achieved?

This sort of clarification is deeply resisted, as it is the opposite of investment in the phenomena of "the impossible task" and all the woolliness that goes with it described above, and the highly motivated confusion.

Thus the organisation, the behaviour, and the commitment of staff are crucial. Staff must be aware of their tasks and the boundaries between them. Unless boundaries of authority, individual tasks, task systems, responsibilities and control systems are clearly defined there will always be boundary skirmishing and eventual breakdown. Changing the focus of attention to the attitudes and behaviour of **staff** and their projections onto so called clients, focussing on transference and counter transference phenomena involves a painful degree of change towards self awareness. Focus comes off slogan therapies and false self roles and functions or handouts and reach me downs. The organisation has to provide well defined boundaries and adequate controls over transactions across them. The members must be clear about and committed to the task of the whole and the different tasks of its different parts and they must be clear about their structure and accept the different responsibilities and authorities of the different roles they play. They must be aware of changing situations and roles and change in response called for. In this way, and in this way only, can staff in the organisation, as a whole, provide that model of behaviour, and the staff of appropriate adult authority with which the boys can identify. The model must also be transferable to the external world in that it must be of use to those labelled clients when they leave. The organisation and the staff behaviour provide the only therapy that is available or can be positively effective.

In the present climate we are likely to see a return to problems of offloading, and therefore of warehousing, of unselected and custodial placements of residual populations. As this happens, residential staff will become further demoralised and confused. Those places that become selective in terms of those they can help and are organised to help and refuse to collude in the other process are going to be increasingly themselves labelled and scapegoated as, say, taking the "easiest cases", or whatever. Such isolation and labelling is one of the costs of change.

The two "stages" I have described earlier cannot be mixed without breakdown in a unit and in the staff morale of that unit. I will return to and concentrate on this in my second paper and on the needs of the unintegrated, that is, those who need long term residential therapy in a planned environment that gives them the safety and the additional security they need. An environment in which the "come-back factor" can remain human and caring and compassionate rather than rejecting, labelling and destructive because there is sufficient staff support and sharing of anxiety and a good enough supportive structure. It is also important, I think, to look at why we have to take these young people further forwards nowadays until they have established healthy and normal defences than we have had to do in the past and why therefore we are increasingly faced with a very complex second stage task towards what might be called de-integration as distinct from disintegration if we are to carry out our work adequately and sufficiently.

If the organisation, and structure, and behaviour of staff contradicts such a model of sound ego functioning, then it will break down. Thus it must be sophisticated, conscious, and planned, as well as being vitally and vibrantly human.

We would, I think, all subscribe to the following rather general ideals in residential treatment. They may sound like a sort of check list. That is the last thing I intend to convey. In my second paper I will concentrate more specifically on those of the various syndromes of deprivation of the unintegrated.

1. Total respect for the unique individual as a prerequisite to supporting his own unique inner resources, strength and potential.
2. Unconditional acceptance.
3. A key person, advocate and care-taker.
4. Open, honest and direct communication.
5. Contact, not impact or impingement. Working with, not to, or far.
6. Firm but lovingly and compassionately firm management and cover. Stern love.
7. Staff time primarily related to client need and task rather than some institutionalised routine.
8. Opportunity to reach dependence.
9. Firm but reasonable and rational setting of limits.
10. Opportunity to make mistakes, learn from them, and make reparations.
11. Opportunity to give and to live and work together.
12. Opportunity to reflect rather than act on impulse.
13. Opportunity to achieve, succeed and to remedy the total absence of self-worth and the appalling self image of these young people.
14. Opportunity to canalise and sublimate destructive aggression into creative channels and activities.
15. Opportunity to regress when this is necessary.
16. Opportunity for play.