

What have we done to Margaret?

The treatment of children in secure
accommodation: A psychological perspective

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Margaret's life before secure

.....*'she chose him instead of me'...*

- Exposure to a dangerous and unpredictable environment
 - Parental drug and alcohol abuse
 - Low monitoring – exposure to potentially dangerous adults
 - Possible sexual abuse (N.B. 60% of girls in CJS identified as having previous experiences of abuse: Montgomery, 2000)
 - Low levels of support/neglect – interpreted as complicit betrayal
 - Separation from sibling
 - Multiple placements
 - Revictimisation

Understanding Margaret's behaviour

'.....you can't trust people anyway....'

Negative adjustment outcomes associated with risk exposure:

- Social difficulties: Problems trusting others/forming positive relationships
- Emotional difficulties: Problems managing emotions
- Behavioural difficulties: fire-setting, deliberate self-harm, self-starvation
- Low motivation for change/low treatment engagement

Understanding Margaret's behaviour

Relational theory and trauma theory provide insights:

- Connection with others guides development for females
- Events that violate significant relationships (e.g. abuse) can be more damaging to females (Covington, 1998)
- Abuse + mother's failure to intervene can be viewed as especially damaging
- Reinforced by inconsistent care/re-victimisation – high risk of re-traumatisation

Understanding Margaret's behaviour

- Impact on cognitive-affective development
 - Cognitions:
 - sense of self as powerless/unloved
 - others seen as hostile/rejecting
 - linked to preoccupation with threat/ lack of trust/difficulty forming relationships over long term
 - Emotions:
 - experience of intense distress linked to unresolved trauma
 - poor/underdeveloped emotion regulation skills

Understanding Margaret's behaviour

- Destructive & antisocial behaviour provide means of gaining control/coping with emotional pain arising from trauma without risking reliance on others (Greenwald, 2002)
 - Fire-setting can be seen as a non-specific anger response to frustration, rejection, punishment and loneliness (Slavkin, 2002)
 - Deliberate self-harm – ‘release’ from ‘experiences felt to be ‘beyond words or understanding’ (Crouch & Wright, 2004; Spandler, 1996)
- Behaviours that are successful in eliciting a response/gaining control can be self-sustaining (Galloway, 2006)

What have we done?

'The last time I lived in a proper house was when I was 12'

- Care experience characterised by instability, disruption and re-victimisation – reinforces what has been learned through early experience

'...they just give me milk and tell me not to do it again'

- Inadequate/punitive response to 'coping' behaviours – failure to provide psychological/medical help

What have we done...?

'I hate them going through my stuff, they just do it even if I have only been with Helen'

- Controlling/disempowering environment where consequences for actions seem unjust
- Failure to develop positive relationships/provide positive role models (existing relationships threatened)

What have we done?

'...they make you take your clothes off...'

- Use of practices which may be experienced as re-traumatising

'they talk about me like I'm not there'

- Lack of involvement in decision-making



What have we done?

Overall, treatment is disempowering, encourages continued disconnection and reinforces maladaptive beliefs and coping strategies

...if we do not engage with Margaret, how can we expect her to engage with us?

Putting Margaret's story in context

- High levels of exposure to multiple risk factors among young people in secure (Richardson & Lelliot, 2003)
- High prevalence of mental disorder including CD and ED (Meltzer et al, 2004) and traumatisation (Dixon et al, 2004)
- High incidence of deliberate self harm (Apter & Freudenstein, 2000)

Putting Margaret's story in context

- Movement within care system appears to affect access to services (Lerpiniere et al, 2006)
- Lack of input from psychological services in secure care (Richardson et al, 2003) linked to “little awareness, competence and confidence in recognising mental health problems and concerns in young people” (Kurtz et al, 1998)

What can we do?

“...there is a clearly identified urgency to develop appropriate and accessible health services and information tailored to their particular needs which improves health outcomes” (Ridley, 2001, p.1)

BUT

- Change of emphasis required - more holistic, strengths- based approach is required
- Access to services described as ‘poor’ (Goldson, 2003)

What can we do?

- Effective programmes strengthen life skills, build social support and consult and involve young people (Health Scotland, 2006)
- Create a safe, positive and empowering environment where recovery can be facilitated
- Building positive connections and communication is essential groundwork
- Staff training and support is critical to facilitate the welfare of young people and staff members themselves

What can we do?

- Increase access to psychological services
 - More direct contact between staff and MH workers (visits, advice and direct support) (Kurtz et al, 1998)
 - Move away from 'clinic' model to provide services within young person's own environment before and after secure (Open Door : van Beinum et al, 2002)
- Complex needs can only be met by a range of services, multidisciplinary practice and strategic planning (Kendrick et al, 2004) where accountability and evaluation key

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